



Ein cyf/Our ref: MA/JMHSC/1706/26

Peter Fox MS
Chair, Health and Social Care Committee

SeneddHealth@senedd.wales

26 March 2026

Dear Peter,

I wrote to you in July with an update on several recommendations within the Health and Social Care Committee's report - *Nurse Staffing Levels (Wales) Act 2016: Post-legislative scrutiny*, published in April 2024.

In that letter, I committed to write again before the pre-election period to update you specifically on recommendation 3. However, as we are approaching the end of this government term, I feel it would be appropriate to update you on each of the report's 11 recommendations, note those that have been completed, and provide assurance against those that are ongoing.

To date there have been three ministerial letters to the Committee regarding the report's recommendations dated 17th June 2024, 17th October 2024 and 7th July 2025. For ease of reference, all three letters are attached at **Annex 1**.

Ahead of April's dissolution of the Senedd, I hope that this letter provides assurance of the significant progress that has been made against the Committee's report recommendations.

Yours sincerely,

Jeremy Miles AS/MS
Cabinet Secretary for Health and Social Care
Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Recommendation 1. *The Minister for Health and Social Services should clarify the consequences for non-compliance with sections 25B and C of the Act and consider including provision for this in the NHS Wales Escalation and Intervention Arrangements.*

Status: Complete

This recommendation was addressed in the initial response letter of 17th June 2024.

Recommendation 2. *The Minister for Health and Social Services should write to us within 6 months of publication of this report to provide an update on progress by health boards in consistently displaying information about nurse staffing levels on wards where section 25B applies.*

Status: Complete

This recommendation was resolved in the 14-month update letter of 7th July 2025.

Recommendation 3. *The Minister for Health and Social Services should bring forward clear operational guidance to support the consistent application of section 25A across health boards in Wales. She should report back to us on progress with developing this within 6 months of publication of this report*

Status: In progress - on schedule for completion by April 2027

As mentioned in previous letters, this recommendation represents the most substantial output in the work programme of the AWNSP. Development of a practically valuable piece of operational guidance that is applicable in *all* 25A settings is a complex task, requiring a multi-step approach including real world testing.

Since my last letter, the dedicated national subgroup leading this work has completed its scoping phase, devised a Universal approach to the triangulated calculation methodology, and identified a list of 12 distinct 25A areas in which to test that approach and ensure that it is adaptable and applicable in all settings:

- District Nursing services
- Mental Health admission and treatment wards
- Health Visiting services
- Community hospital wards
- Emergency Departments
- Critical Care Departments
- Community Psychiatric Nursing services
- Community Children's Nursing services
- Medical Assessment Units
- Systemic Anti-Cancer Therapy service
- Outpatients services
- Learning Disability services

A key aim of this initial cohort is to ensure a suitably varied range of settings to rigorously test the applicability of a universal methodology. The areas represent a breadth of variables across different criteria:

Physical setting - Ward-based, community-based, clinics etc.

Patient demand - services with high and low capacity/patient turnover

Workforce diversity - size and scope of the workforce within each service, ensuring a balance between large, well-established clinical setting, smaller, more specialised services, and services which are overtly multi-professional in nature.

Workforce Planning Tool Availability - Whilst the presence of an existing workforce planning tool would be a significant benefit to support the application of the triangulated methodology, the list deliberately includes areas without established tools to identify what approach should be taken to address such gaps.

Clinical/strategic priority - consideration of priority based on system risk, patient safety and criticality of a setting's role in care pathways as well as strategic national health policy and agendas.

Over the coming months, these 12 areas will serve as a testing ground to help identify a full range of enablers and barriers to universal application of the triangulated methodology, informing the development of operational guidance which will happen in parallel.

The final output will be the publication of that practically tested operational guidance ahead of April 2027 for it to be rolled out to all 25A areas.

Recommendation 4. The Minister for Health and Social Services should commission a mapping of the digital systems involved in complying with the requirements of the Act to enable an honest appraisal of the work that still needs to be done to improve the efficiency and connectivity of those systems, and the timescales for this. This should include consideration of the role of digital technology in enabling nurses to provide better patient care.

Status: Complete

Healthcare Innovation Consortium was commissioned by the AWNSP in March to deliver this work, and the resulting report is attached at **Annex 2** for your information.

The recommendations from that report have informed the work plan of the Digital and Data subgroup of the All-Wales Nurse Staffing Group (AWNSG), in particular the creation of a national dashboard containing live information on nurse staffing levels, patient acuity and quality metrics.

Recommendation 5. The Minister for Health and Social Services should commit to undertaking a full and academic review of the Act as soon as the data to support this work is available.

Status: Deferred

In the Welsh Government's initial response to the Committee's report recommendations (17th June 2024), this recommendation was accepted in principle but deferred for the present. This was on the basis that shortcomings in the digital systems to date would hamper the undertaking of such a full academic review given that it would require several years' worth of reliable data.

As per the report attached at **Annex 2**, despite significant progress in this area in recent years, there are still clear gaps and barriers within the digital landscape that require addressing. As mentioned above, the work plan of the Data and Digital Subgroup of the AWNSG reflects these requirements, which will provide the governance oversight to ensure momentum is maintained and progress is made.

However, it remains my view that we are not yet in an adequate position on a digital evidence base at present to commission a full academic review of the Act. It would be difficult to make a value for money case for such a significant expense given the data limitations that would be placed on the research at its outset.

The AWNSG has established a dedicated Research and Evaluation Subgroup whose purpose is to explore and pursue opportunities for research into nurse staffing levels, and it will continue to monitor this area and advise the CNO.

Recommendation 6. *The Minister for Health and Social Services should commission a piece of research into the use of the Welsh Levels of Care workforce planning tool to date, including consideration of how Wales compares with the other UK nations in terms of improved nurse staffing levels and patient safety.*

Status: In progress – to be completed in 2026/27 financial year.

As above, this recommendation was also accepted in principle in the initial Welsh Government response.

As the digital components of the nurse staffing landscape have evolved – namely the national rollout of e-rostering and the embedding of the Safecare ward management module – there is a growing appetite within health boards for a bolstering of the evidence-based assurance around patient acuity and its relationship with nurse staffing.

Therefore, the AWNSP is now actively pursuing the commissioning of a focussed, objective and impartial assessment of the Welsh Level of Care tool’s design, functionality, robustness and practical application in clinical settings, including clear recommendations for any necessary improvement or future augmentation. Resource has been identified within 2026/27 budgets to fund the work, and the AWNSP team will commence the procurement exercise in earnest following the election in May.

We will of course keep the Committee updated and share with you the outcomes of the work.

Recommendation 7. *The Minister for Health and Social Services should provide a written update, within 6 months of publication of this report, on the success of actions to improve nurse recruitment and retention and ensure a sustainable supply of nurses, including reference to international recruitment and the use of agency staff.*

Status: Complete

This recommendation was addressed in the 6-month update letter of 17th October 2024.

Recommendation 8. *The Minister for Health and Social Services should:*

- *confirm that the introduction of the registered nursing associate role will be fully funded, and set out where that funding will come from;*
- *provide assurance that the role of registered nursing associate will be an addition to the current workforce and not a substitute for registered nurses; and set out the extent to which the Act mitigates the risk of substitution;*
- *set out how the requirements of the Act will apply to the registered nursing associate role; and*
- *provide details of any assessment of the risk to patient safety that has been or will be done in all areas where registered nursing associates will be employed.*

Status: Complete

This recommendation was addressed in the initial response letter of 17th June 2024.

Recommendation 9. *The Minister for Health and Social Services should report back to this Committee within 9 months of publication of this report on the use of the draft Welsh Levels of Care Tools for mental health and health visiting by health boards, providing an evaluation of how they are contributing to the development of a sustainable workforce and improved patient care in this area.*

Status: Complete

This recommendation was addressed in the 6-month update letter of 17th October 2024.

Recommendation 10. *The Minister for Health and Social Services should use the All-Wales Nurse Staffing Programme to commission a mapping of the other workforce planning tools that are available, and to develop the principles and guidance to ensure a consistent approach to their application across Wales.*

Status: Complete

The initial response to the recommendations dated 17th June 2024 clarified that the work described within this recommendation would be undertaken as part of the AWNSP's commitment to delivering the operational guidance referenced in recommendation 3. As described above, this work has been completed.

Recommendation 11. *The Minister for Health and Social Services should share with the Committee the findings of the All-Wales Nurse Staffing Group's assessment of the impact of the Act on multi-professional working.*

Status: Complete

The second phase of this work was concluded recently by the designated subgroup of the AWNSG.

Phase 1 focussed largely on: a scoping exercise to identify and evaluate the use of multi-professional team workforce models and current ways of working within Health Boards/NHS Trusts, exploring how the terminology and requirements set out in the Act and Statutory Guidance impacts on the ability for Health Boards/NHS Trusts to implement multi-professional team workforce models and the implications for practice; exploring how Health Boards/NHS Trusts have understood, interpreted and applied the Act & Statutory Guidance in relation to implementation of multi-professional workforce models and the implications for practice.

Phase 2 focussed on establishing clearer definitions and standard practice within the Act's operational processes and governance around multi-professional working.

The recommendations have been accepted by the CNO/EDoN Forum, and the Nurse Staffing Levels (Wales) Act 2016 Operational Guidance document has been amended accordingly.

The combined reports for phases 1 and 2 are attached at **Annex 3** for your information.

ANNEX 1 – All previous Ministerial correspondence

Eluned Morgan AS/MS
Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol
Cabinet Secretary for Health and Social Care



Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref
Ein cyf/Our ref MA/EM/5226/24

Russell George MS
Chair
Health and Social Care Committee
Senedd Cymru

SeneddHealth@senedd.wales

17 June 2024

Dear Russell,

Thank you for sharing the Health and Social Care Committee's final report about its post-legislative scrutiny of the Nurse Staffing Levels (Wales) Act 2016.

Please find attached my response to the committee's recommendations.

Yours sincerely,



Eluned Morgan AS/MS
Cabinet Secretary for Health and Social Care
Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Written response from the Welsh Government to the Health and Social Care Committee’s report *Nurse Staffing Levels (Wales) Act 2016: Post-legislative scrutiny.*

A detailed response to each of the recommendations is listed below.

As requested, I will provide the committee with a written update by 17 October about the recommendations identified below.

Recommendation	Accept / Accept in principle/ Reject	Welsh Government response
<p>Recommendation 1. <i>The Minister for Health and Social Services should clarify the consequences for non-compliance with sections 25B and C of the Act and consider including provision for this in the NHS Wales Escalation and Intervention Arrangements.</i></p>	<p>Accept</p>	<p>I am happy to clarify in writing in this response to the committee which was touched upon in evidence last year.</p> <p>The Nurse Staffing Levels (Wales) Act 2016’s (“the 2016 Act”) operational guidance is clear on this point:</p> <p><i>“It is the health boards/trusts at an executive level that are accountable for compliance with the Act. Any instances of non-compliance will be considered under the Joint Escalation and Intervention Arrangements that have been in place since 2014. Under these arrangements, the Welsh Government meets with the Wales Audit Office and Healthcare Inspectorate Wales twice a year to discuss the overall position of each health board/trust. A wide range of information and intelligence is considered to advise on the escalation status, any issues and ensure they are resolved effectively. Non-compliance with a piece of legislation such as the Nurse Staffing Levels (Wales) Act would be considered under these arrangements.”</i></p> <p>During the committee’s hearings none of the witnesses to whom the duties of the 2016 Act apply reported any lack of clarity around the consequences for non-compliance with the legislation.</p>

		<p>The Executive Directors of Nursing are very familiar with these escalation processes given their executive responsibilities within their respective organisations. They are also familiar with how these processes would play out in the context of non-compliance with the 2016 Act, because – as I mentioned in my 6 December evidence – they have seen it applied in practice. Lack of compliance with the 2016 Act was cited as one of the reasons Cwm Taf University Health Board was placed into targeted intervention status in 2019.</p> <p>A refreshed NHS Oversight and escalation framework was published in January 2024. It describes the escalation, de-escalation, and intervention process in more detail, building on the learning from our experiences with Cwm Taf Morgannwg and Betsi Cadwaladr university health boards.</p> <p>This document – in combination with the 2016 Act’s operational guidance – contains all the clarity required for health boards/trusts to understand the consequences of non-compliance with the 2016 Act.</p>
<p>Recommendation 2. <i>The Minister for Health and Social Services should write to us within 6 months of publication of this report to provide an update on progress by health boards in consistently displaying information about nurse staffing levels on wards where section 25B applies.</i></p>	<p>Accept</p>	<p>The chief nursing officer (CNO) has raised this issue with the Executive Directors of Nursing. The reporting subgroup of the All-Wales Nurse Staffing Group (AWNSG) is already working through the detail of the necessary steps to ensure a return to nurse staffing level information being displayed consistently across Wales.</p> <p>I will include more detail about our progress on this action in my follow-up six-month update.</p>
<p>Recommendation 3. <i>The Minister for Health and Social Services should bring forward</i></p>	<p>Accept</p>	<p>Developing operational guidance setting out consistent use of a triangulated calculation approach in 25A areas is now a central part of the refreshed work programme for the All-Wales Nurse Staffing Programme (AWNSP).</p>

<p><i>clear operational guidance to support the consistent application of section 25A across health boards in Wales. She should report back to us on progress with developing this within 6 months of publication of this report</i></p>		<p>There is significant work that will need to be completed to underpin this guidance, but it has already commenced, and I will include detail of the programme's progress in my follow-up six-month update.</p>
<p>Recommendation 4. <i>The Minister for Health and Social Services should commission a mapping of the digital systems involved in complying with the requirements of the Act to enable an honest appraisal of the work that still needs to be done to improve the efficiency and connectivity of those systems, and the timescales for this. This should include consideration of the role of digital technology in enabling nurses to provide better patient care.</i></p>	<p>Accept</p>	<p>As with the above recommendation, this work is already reflected in the AWNSP's refreshed work programme. The programme team has encountered issues recruiting digital expertise in the past, and I am aware that the programme manager is exploring potential solutions for employing short-term support to make rapid progress against the digital elements of the work programme.</p> <p>I will include detail on progress against this recommendation in my six-month update.</p>
<p>Recommendation 5. <i>The Minister for Health</i></p>	<p>Accept in principle</p>	<p>I support the principle of independent evaluation of legislation passed by the Senedd. However, as the CNO set out to the committee in December, it is hard to make an</p>

<p><i>and Social Services should commit to undertaking a full and academic review of the Act as soon as the data to support this work is available.</i></p>		<p>argument for commissioning such evaluation work at this time given the fractured implementation of the 2016 Act, due in part to the disruption caused by the pandemic, and the digital issues that have hampered data capture to date.</p> <p>Such evaluation is only typically commissioned once – we should therefore do this when we have the robust data required to underpin an academically rigorous evaluation. April 2024 marked the beginning of the third three-year reporting period – the first since the Safecare ward management module has been rolled out to all 25B areas. We expect this to result in the capture and analysis of more robust data. The conclusion of this reporting period would present an opportunity to undertake the independent evaluation of the 2016 Act.</p> <p>I have asked the AWSNP to include an action in its work programme to periodically review the situation and update the CNO.</p>
<p>Recommendation 6. <i>The Minister for Health and Social Services should commission a piece of research into the use of the Welsh Levels of Care workforce planning tool to date, including consideration of how Wales compares with the other UK nations in terms of improved nurse staffing levels and patient safety.</i></p>	<p>Accept in principle</p>	<p>Research into the implementation of the Welsh Levels of Care tools to date would form a significant component of the legislative evaluation described in recommendation five and would not be commissioned as a separate piece of work. The same barriers described above would also therefore apply to commissioning this type of research at the present time.</p>
<p>Recommendation 7. <i>The Minister for Health and Social Services should provide a written</i></p>	<p>Accept</p>	<p>I will include details of our progress in these areas in my six-month update.</p>

update, within 6 months of publication of this report, on the success of actions to improve nurse recruitment and retention and ensure a sustainable supply of nurses, including reference to international recruitment and the use of agency staff.

Recommendation 8.
The Minister for Health and Social Services should:

- *confirm that the introduction of the registered nursing associate role will be fully funded, and set out where that funding will come from;*
- *provide assurance that the role of registered nursing associate will be an addition to the current workforce and not a substitute for registered nurses; and set out the extent to which the Act mitigates the risk of substitution;*

Accept

If the registered nursing associate (RNA) role is introduced in Wales, it will be the only band 4 role in our nursing workforce following a period of transition. Therefore, the funding currently allocated to the education and training of band 4s would be reallocated to the education and training of RNAs.

Phase 2 of the band 4 project work is in its early stages, and over the coming months the subgroups of its programme board will lead on identifying the detail and potential timeline of that funding transfer. The four workstreams are: workforce, legislation, parameters of practice and education, and all four will be making financial considerations in respect of those specific areas. I will include details on this work in my six-month update to you.

The CNO and I are very clear on the point of substitution. Over time, the registered band 4 role will be replacing the current band 4 healthcare support worker (HCSW) role, not registered nurses. Registered nurses are an irreplaceably important feature of the workforce, and they will be more effectively supported by registered band 4 colleagues with a higher level of education than current band 4 HCSWs. The primary mitigation against registered nurse substitution will be the development of unequivocally clear parameters of practice which distinguish an RNA from a registered nurse. This document will be developed by the parameters of practice subgroup, with a full consultation on the document to follow.

<ul style="list-style-type: none"> ▪ <i>set out how the requirements of the Act will apply to the registered nursing associate role; and</i> ▪ <i>provide details of any assessment of the risk to patient safety that has been or will be done in all areas where registered nursing associates will be employed.</i> 	<p>There is additional mitigation – the 2016 Act’s statutory guidance states: “The nurse staffing level is the number of nurses appropriate to provide care to patients that meets all reasonable requirements in the relevant situation. The number of nurses means the number of registered nurses (this being those with a live registration on sub parts 1 or 2 of the Nursing and Midwifery Council (NMC) register).”</p> <p>The RNA would not be on those parts of the NMC register so there will be no blurring of boundaries within the context of the 2016 Act.</p> <p>The requirements of the 2016 Act would apply to an RNA in the same way they currently apply to a HCSW. The statutory guidance states: “In calculating the nurse staffing level, account can also be taken of nursing duties that are undertaken under the supervision of, or delegated to another person by a registered nurse.”</p> <p>“Another person” includes the current role of a HCSW, and would include an RNA if introduced. The AWNSG will, as a matter of course, review all templates and guidance and make any necessary adjustments to include specific references to the new role.</p> <p>Questions of patient safety in relation to the introduction of an RNA role are counterintuitive. As referenced above, the RNA would be a replacement role for the currently unregulated band 4 HCSW.</p> <p>As part of the project work that informed my decision to pursue introduction of the RNA in Wales, there was a comprehensive review of literature and clinical, academic professional and trade union opinions. Part of that work was effectively a risk assessment to patient safety of the <i>current</i> model of unregistered, unregulated band 4 HCSWs. The outcome of that investigation was that regulation minimises risks, increases patient safety and enhances public confidence because of the consistent standards of practice and education, as a result of NMC regulation.</p> <p>According to the literature (and reiterated by academics in Wales), the current absence of regulation is what poses a risk to patient safety, not least due to the enhanced scope of practice of band 4s.</p>
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		<p>Platform 5 in the NMC Standards of Proficiency for the RNA includes improving safety and quality of care. These standards do not exist for the current unregulated band 4 role in Wales. The RNA role is also covered by the NMC Code, which includes a requirement to practise effectively and preserve patient safety. As with registered nurses, RNAs are required to revalidate on a cyclical basis, regularly redemonstrating competency.</p>
<p>Recommendation 9. <i>The Minister for Health and Social Services should report back to this Committee within 9 months of publication of this report on the use of the draft Welsh Levels of Care Tools for mental health and health visiting by health boards, providing an evaluation of how they are contributing to the development of a sustainable workforce and improved patient care in this area.</i></p>	<p>Accept</p>	<p>As raised during the committee’s evidence gathering, there are some distinct barriers to the standardised use of the mental health and health visiting WLOC tools at present – the lack of digital platforms to enable data collection.</p> <p>As part of the AWNSP’s refreshed programme of work, the programme manager intends to undertake a stock-take audit to gain an understanding of how the draft tools are being used and better understand any barriers. The results will be vital for informing the programme’s broader work around standardising triangulated staffing calculations in 25A areas.</p> <p>I will include details in my follow-up six-month update.</p>
<p>Recommendation 10. <i>The Minister for Health and Social Services should use the All-Wales Nurse Staffing Programme to commission a mapping of the other workforce planning tools that are available, and to develop</i></p>	<p>Accept</p>	<p>This work is already reflected in the AWNSP’s refreshed programme of work. This scoping work will be the first step towards developing operational guidance to ensure a once-for-Wales approach to consistently applying a triangulated calculation approach in all 25A areas, mentioned in recommendation three.</p>

<i>the principles and guidance to ensure a consistent approach to their application across Wales.</i>		
Recommendation 11. <i>The Minister for Health and Social Services should share with the Committee the findings of the All-Wales Nurse Staffing Group's assessment of the impact of the Act on multi-professional working.</i>	Accept	When the AWNSG has concluded its work assessing the relationship between the 2016 Act and multi-professional working, I will share its findings/recommendations with the committee.

Jeremy Miles AS/MS
Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol
Cabinet Secretary for Health and Social Care



Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref:

Russell George MS
Chair, Health and Social Care Committee

SeneddHealth@senedd.wales

10 October 2024

Dear Russell,

In June, the then Cabinet Secretary for Health and Social Care wrote to you in response to the Health and Social Care Committee's report - *Nurse Staffing Levels (Wales) Act 2016: Post-legislative scrutiny*, published on 17 April.

In that letter, the Cabinet Secretary agreed to write again six months after the report's publication to update you on five of the recommendations as requested.

Before I provide an update position on each of those recommendations, I would like to include some context around the All-Wales Nurse Staffing Programme (AWNSP) that has impacted how much progress has been made in the months since your report was published.

During that time, the Programme has transferred from its former host organisation in HEIW to the NHS Executive, along with several other national programmes of work. The transfer of the Programme team also presented the opportunity to refresh its programme of work, which is now reflective of the recommendations from your April report. Naturally this has been a disruption to business as usual as the nursing structure in the NHS Exec has established itself over the summer.

Further to that, the longstanding Head of the Programme, Joanna Doyle – who you will recall from your October hearing - left her position in July to take up a senior nursing role in the paediatric service. As with any recruitment at that senior a level, it has taken time to fill the vacancy, meaning the Programme has been without a head for three of the six months since the publication of your report. However, I am happy to share with you that the new Head of Programme – Rhys Roberts – began in post on 30 September. I am confident that under his leadership, the Programme will quickly regather pace. Especially once he is able to recruit to the other vacant posts within the Programme team.

With that in mind, I would propose a further written update to the HSC Committee on these recommendations 8 months from the date of this letter. This would follow the health boards' next annual assurance reports.

Recommendation 2. The Minister for Health and Social Services should write to us within 6 months of publication of this report to provide an update on progress by health boards in consistently displaying information about nurse staffing levels on wards where section 25B applies.

I can confirm that the all-Wales template for the Nurse Staffing Levels (Wales) Act 2016 annual assurance reports was amended earlier this year to include a section focussing specifically on this duty.

In their next annual reports to their respective boards (May 2025), executive directors of nursing will need to “provide assurance that through a 6 monthly audit, all actions have been taken to inform patients of the Nurse Staffing Levels”.

During the CNO’s most recent meetings with EDoNs across Wales’ health boards and trusts, each confirmed that audits have been undertaken in their respective wards where section 25B applies. All have reported generally high compliance with displaying nurse staffing levels, but there is now a need to systematise that auditing into a consistent and regular practice to ensure that compliance is maintained. The Reporting subgroup of the AWNSG is tasked with ensuring a once-for-Wales approach is taken to this work.

The Frequently Asked Questions document explaining the duties of the 2016 Act is another crucial component of informing the public on nurse staffing levels. To date, this document has only been available on wards in hard copy, requiring space to display them, and for copies to be replenished when depleted. During the outbreak of the Covid-19 pandemic, heightened infection prevention protocols determined that paper documents and posters were forbidden in ward settings. The Reporting subgroup of the All-Wales Nurse Staffing Group has been exploring a more agile and future-proof solution to distributing this FAQ document whereby the display board containing the nurse staffing levels information template will also feature a large QR code. Patients and ward visitors will be able to scan this code on any smart phone and be directed to the FAQ document online in Welsh, English or easy read version.

On 3 September, the office of the CNO welcomed an NHS secondee undertaking a clinical fellowship programme. The primary focus of her fellowship project will be the development of a ward manager’s toolkit to prepare, develop and support aspiring ward managers and those already working in the role. The aim will be to drive a consistent approach to ward management and underpin key quality indicators and current system needs on standards, reporting processes and systems to enable safe, quality care delivery. Part of this toolkit will include the legislative duties which are relevant to ward managers, including the duty to keep nurse staffing levels information boards up to date and accurate.

Recommendation 3. The Minister for Health and Social Services should bring forward clear operational guidance to support the consistent application of section 25A across health boards in Wales. She should report back to us on progress with developing this within 6 months of publication of this report.

I can confirm that the production of operational guidance for section 25A of the Act is included as a key action in the refreshed work programme of the AWNSP

There are several steps required before operational guidance is drafted and published, and each is included as a distinct action in the Programme’s work plan. These include:

- Establishing a national task and finish group that will oversee the development of the operational guidance;

- Linking with national clinical networks for the various care settings;
- Scoping existing evidence-based tools, standards and guidance for the various care settings that can form part of the triangulated calculation process;
- Scoping work to determine which quality indicator data will be used in each setting;
- Setting the principles for consistent triangulated staffing calculation in 25A areas.

Prior to the departure of the former head of Programme, terms of reference were drafted for the proposed task and finish group and an initial fact-finding exercise was conducted with health boards to gather their views on what they would expect/wish to see included in operational guidance.

This is a recommendation where progress has clearly been hampered by the temporary absence of a head of the AWNSP. However, I am confident that the foundations are in place for the new head of Programme to push forward at pace, and I would expect the next written update to the Committee to reflect this.

Recommendation 4. *The Minister for Health and Social Services should commission a mapping of the digital systems involved in complying with the requirements of the Act to enable an honest appraisal of the work that still needs to be done to improve the efficiency and connectivity of those systems, and the timescales for this. This should include consideration of the role of digital technology in enabling nurses to provide better patient care.*

The Chief Nursing Officer has commissioned this work on my behalf, and it is included as a priority action in the AWNSP's programme plan. Now that the new Head of Programme has started in post, I expect this work to progress at pace.

Recommendation 7. *The Minister for Health and Social Services should provide a written update, within 6 months of publication of this report, on the success of actions to improve nurse recruitment and retention and ensure a sustainable supply of nurses, including reference to international recruitment and the use of agency staff.*

Nursing is the largest workforce in the NHS and plays a pivotal role in delivering quality patient care. Despite the unprecedented pressure on Welsh Government budgets, record numbers of people, including nurses, are employed by NHS Wales organisations.

The **number of registered nurses** working in NHS Wales has increased from 21,367 full time equivalents (FTEs) in 2019 to 24,882 FTEs in 2024 – an increase of 16.4%. The actual staff headcount has increased from 24,637 in 2019 to 28,514 in 2024 – an increase of 15.7%. (source: StatsWales 31 March 2019 and 31 March 2024).

The Welsh Government has also maintained the **education and training budget** at record levels for the academic year 2024-25 - £281m. Pre-registration nurse training places have increased from 1,911 in 2019 to 2,400 in 2024.

Nursing and midwifery student recruitment has generally increased following a UK wide fall in 2022-23. The number of students starting nursing programmes overall is increasing, reflecting successful student recruitment initiatives with increases in rates between commissioned, recruited and student who have started course. HEIW is delivering a programme of work to further increase applications to nursing programmes; additional health care support workers and part times places are being supported, and funding for international places has increased the number of international students being recruited to nursing programmes in Wales. All international students will be

supported into posts on graduation as part of the tie in arrangements to stay in Wales for a minimum of two years.

While recruitment to adult and child field places is positive, both mental health and learning disability places remain difficult to fill. HEIW is currently leading on several solutions to ensure that recruitment to these fields of nursing continue to increase.

The **All-Wales International Recruitment Programme** is a national strategic workforce programme supported by Welsh Government and delivered by NHS Wales Shared Services Partnership in partnership with health boards and trusts across Wales. Established during the second half of 2021 in the context of a national shortage in the registered nurse workforce, the programme has recruited over 1,000 internationally educated healthcare professionals into the NHS Wales workforce, the vast majority of which have been internationally educated nurses.

A government-to-government memorandum of understanding agreement established between Welsh Government and the state government of Kerala, India, will support further international recruitment to the NHS Wales workforce on an ethical, not-for-profit basis.

HEIW's Nurse Retention Plan, launched in September 2023, is supporting NHS Wales organisation in developing local retention plans for improved staff experience at work, including wellbeing, engagement, flexible working, flexible retirement, continuing professional development and culture. The retention programme is supported by a circa £0.75m investment to support the appointment of retention leads in each health board and trust.

The 12-month turnover rate for nursing and midwifery registered staff to March 2024 was 5.2%, compared with a 12-month rate to 6.5% to March 2023 (source: NHS Wales management date).

The Welsh Government has agreed in social partnership to work collectively with health organisations and trade unions to drive a collective reduction in **agency spend** across Wales and incentivise substantive employment within the NHS in Wales. This includes a revised control framework for expenditure and a number of actions that will be both more cost effective and provide more opportunities for the substantive workforce, including more opportunities for flexible working and advanced rostering to improve workforce planning.

A direct correlation exists between the number of vacant posts within NHS Wales and expenditure on agency staff. By addressing recruitment and retention, NHS Wales aims to reduce the number of vacant posts and, consequently, reduce reliance on agency staff, leading to improved efficiency and financial sustainability.

Nursing and midwifery agency spend for the previous two financial years, and the forecast position for the current financial year, are shown in the following table.

	Nursing and midwifery registered
2022-23	£155.925m
2023-24	£150.712m
2024-25	£82.784m (forecast)

(source: NHS Wales Financial Returns)

In addition to the actions and data presented in this written update, HEIW is developing a **strategic nursing workforce plan** to ensure a sustainable nursing workforce that will continue to deliver quality patient care. The plan will support NHS Wales to recruit into the profession, to train more nurses, to retain more nurses and to transform the way nurses work. The plan is expected to be published by the end of 2024.

Recommendation 9. *The Minister for Health and Social Services should report back to this Committee within 9 months of publication of this report on the use of the draft Welsh Levels of Care Tools for mental health and health visiting by health boards, providing an evaluation of how they are contributing to the development of a sustainable workforce and improved patient care in this area.*

The above recommendation set a nine-month deadline for an update on the use of the WLOC tools in mental health and health visiting. However, given the timelines involved in procuring/implementing the necessary digital systems for progressing this work, I can see no reason to wait an additional three months to update the Committee.

The *Welsh Levels of Care* (WLOC) is an acuity tool designed and created specifically in and for Welsh settings. The tool sets out descriptions of patients across five archetypal levels of care, from routine and simple to critical and unpredictable. These descriptions are broken down into typical patient needs, conditions and situations and the corresponding clinical assessments, interventions and tasks undertaken by nurses. The original WLOC tool was developed for adult acute medical and surgical wards where it was refined and tested over two years. A similar process was followed to create the paediatric inpatients WLOC ahead of the extension of section 25B of the 2016 Act to that setting.

The purpose of the WLOC tool is to provide nursing teams with nationally standardised advice, guidance and definitions required to consistently assign individual patients to a level of care. The level of care is the principal data of the national acuity audits that take place every six months. This data is collated and analysed to inform the biannual nurse staffing levels calculations in 25B ward areas.

Draft WLOC tools were developed for Mental Health and Health Visitor settings by the respective project leads within the AWNSP. The tools' descriptors and definitions were signed off by the CNO/Executive Directors of Nursing forum in August 2023. The tools have not been tested in the same way as previous WLOC tools due to the lack of suitable digital platforms in those settings to undertake such work.

Producing the draft tool is a vital first step, but there is a clear need for a digital platform to a) test and evaluate the tool, b) record WLOC data and c) enable the extraction and use of that data in a way that is practically valuable to workforce planning. As has already been identified as a theme during this Committee session, there are currently significant gaps in digital systems being used in these settings.

Before leaving the role in July, the head of the AWNSP surveyed the health boards on their use of the draft mental health WLOC tool to date.

As with adult medical/surgical wards and paediatric inpatient wards, the Safecare ward management tool would be the digital means for recording WLOC data in mental health inpatient wards. Presently, four of the seven health boards have rolled out Safecare to their mental health admission and assessment wards. The remaining three health boards have mental health wards within their Safecare implementation schedules. Capture of WLOC acuity data is therefore variable across Wales at present.

Further to that, as with adult medical/surgical and paediatric inpatient wards where Safecare is already being used, extracting the WLOC data in a practicable dashboard format has been challenging. Conversations are ongoing between NHS Wales Shared Services Partnership and the AWNSP team with the software provider behind Safecare about modifications to the module that would allow efficient and effective articulation of WLOC data into reports and visual dashboards. Progressing this is a key priority for the new Head of Programme now that he is in post.

In Health Visiting, the ability to *record* WLOC was added into the existing Children and Young Persons Integrated System (CYPrIS). This is a system developed by NHS Wales Informatics Services and introduced in 2018 as an active care record for all children in Wales. CYPrIS is used daily by child health departments when conducting visits for a number of functions including monitoring uptake of immunisation and screening programmes, and supporting the delivery of the Healthy Child Wales Programme (HCWP).

However, it has limitations. The recording of a child's level of care can only be updated during the fixed contacts (minimum of nine through the course of childhood) which health visitors make under the Healthy Child Wales programme. If there is a change in the level of care in between visits, there is no option for a new form to be created for visits outside those which are core to the HCWP.

Another limitation is that health visitors themselves are not inputting data into devices at the visits. CYPrIS entries are still filled in on paper or electronic forms by health visitors and then submitted centrally to be inputted digitally onto the system. Therefore, although the WLOC is recorded, it is not *live* data as would be captured in a ward-based system like Safecare where acuity levels are updated daily.

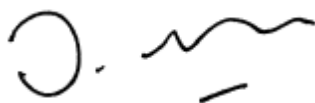
The functional value of the WLOC data recorded in CYPrIS is further limited by the inability of the app to export it in a useable format. CYPrIS was not developed with live reporting functionality in mind and its digital platform simply lacks the capability to extract data in the way that would be required for it to then be used to inform staffing calculations and workforce planning. For those reasons CYPrIS was only ever seen as a stop gap solution due to being the only common system used by all HV services in Wales.

Digital Health Care Wales (DHCW) is developing a specification brief for a new full patient electronic record platform across the whole life course which will include community settings (including health visitors) and mental health wards. As part of that specification, both the recording and reporting/extraction of WLOC data is being considered so that the functionality can be included from its inception as opposed to the retroactive bolt-on approach that was necessary with both CYPrIS and Safecare. This work is in its early stages, but procurement is due to take place in 2025.

Given that the WLOC tools for health visiting and mental health have already been drafted, they will undoubtedly be used as part of the triangulated calculation method for those settings as part of the work described above against recommendation 3.

Solutions to the current digital barriers are therefore intrinsic to that work and form an explicit action of the AWNSP's programme plan. Executive oversight of this programme is provided by the CNO/Executive Directors of Nursing forum, and I am confident that they will ensure tangible progress is made against this recommendation now that the new Head of Programme is in post.

Yours sincerely,

A handwritten signature in black ink, consisting of a large, stylized 'J' followed by a series of wavy lines and a short horizontal stroke at the end.

Jeremy Miles AS/MS

Cabinet Secretary for Health and Social Care

Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol

Jeremy Miles AS/MS
Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol
Cabinet Secretary for Health and Social Care



Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref:

Peter Fox MS
Chair, Health and Social Care Committee

SeneddHealth@senedd.wales

7 July 2025

Dear Peter,

In October last year, I wrote to the Health and Social Care Committee Chair with an update on the recommendations within the Committee's report - *Nurse Staffing Levels (Wales) Act 2016: Post-legislative scrutiny*, published in April 2024.

In that letter, I committed to write again before summer recess to update you on three specific recommendations.

I am pleased to be able to inform you that all three posts within the All-Wales Nurse Staffing Programme (AWNSP) team are now filled. The band 5 business support manager has been in post since early May and has already proved invaluable by releasing capacity of the Programme Lead to undertake the more complex and strategic work required. The band 8a Programme Manager role was appointed in June and will begin in post later in the summer. Given the progress already made by the team with the constraints of vacant roles, I am sure we will now see even more rapid delivery against the remaining recommendations from your report.

Recommendation 2. The Minister for Health and Social Services should write to us within 6 months of publication of this report to provide an update on progress by health boards in consistently displaying information about nurse staffing levels on wards where section 25B applies.

Since my October letter, the AWNSP team has worked with health boards to establish a robust once-for-Wales system to ensure this issue is sustainably resolved.

Executive Directors of Nursing have agreed to a three-layered internal assurance process:

1. A clearly established daily responsibility for ward managers update Nurse Staffing Level information displays.
2. Integration within existing regular ward audits of questions on compliance with Nurse Staffing Levels information displays.
3. Randomised spot checks by the health boards' nurse staffing operational leads.

Every health board already undertakes monthly audits of their wards using digital tools such as AMAT, IRIS and Tendable. These audits provide assurance to health boards around key safety measures in their wards such as Infection Prevention Control checklists, resuscitation trolley standards, hand hygiene etc. Some health boards had already taken the initiative of adding questions around the display of Nurse Staffing Levels information into those existing audits but there is now a standard set of questions being used by all health boards which are audited every 6 months.

During the undertaking of this work, the opportunity was taken to refresh the display posters. Although the Act only requires the display of the calculated nurse staffing levels it is clear that there is limited value in that information without also displaying what the actual deployed planned roster is alongside it. Health boards are now displaying the calculated nurse staffing levels at the ward entrance that will be updated at least every 6 months or more frequently if a ward recalculation is deemed necessary. Inside the ward there is a secondary display showing the planned roster and the actual deployed roster side by side which is updated daily. As there are wards of varying designs and layouts, there is no single location for this second display that would be appropriate for all. Therefore, the CNO has given a pragmatic direction of placing the display wherever is most appropriate for a particular ward to ensure that it is both clearly visible to patients and easy for the ward manager to update daily.

The revised poster design also contains a QR code that once scanned takes a patient or ward visitor to a landing page where they can open the frequently asked questions document in English, Welsh, Easy Read format and a version specifically designed for paediatric inpatient wards which is appropriate for younger people.

The AWNSP team is exploring the idea of using digital screens within 25B wards that would automatically display the planned roster vs deployed roster. The functionality to do so already exists within the Safecare ward management module, but realising this digital solution is complicated by issues of installation, varying ward designs and of course the necessary capital investment.

I foresee that the idea may well be implemented in the future as a system improvement, however I am satisfied that the once-for-Wales process already now in place is robust enough to resolve the issues raised by the RCN in its 2023 evidence to the Committee. The CNO's office will monitor the new audit process via the health board's annual assurance reports.

Recommendation 3. *The Minister for Health and Social Services should bring forward clear operational guidance to support the consistent application of section 25A across health boards in Wales. She should report back to us on progress with developing this within 6 months of publication of this report.*

A dedicated subgroup of the All-Wales Nurse Staffing Group (AWNSG) was established in the new year with the purpose of delivering against this recommendation. The group's first meeting took place in March 2025 and has been undertaking the necessary scoping work to map out all the different care settings within our health service and determine the initial cohort of areas which will form the basis of the development work to come.

The group's plan is to develop and test a standardised calculation methodology within this broad cohort of care settings so that it can be articulated within an operational guidance document in such a way that will enable and empower all other care settings in Wales to apply the same methodology needing only minimal central support.

As with all workstreams under the AWNSG, this significant undertaking will be delivered via an established governance process with the CNO and Executive Directors of Nursing providing oversight and assurance.

As I have mentioned in prior correspondence, this is the most sizeable piece of work captured within the Committee's recommendations and will naturally take a significant amount of time to arrive at the final product of published operational guidance. The provisional timetable is to have all the necessary work completed so that the operational guidance is published by April 2027 in time for health boards to implement it for the 2027/28 financial year. I will write to you again in 6 months ahead of the pre-election period to update the Committee on the further progress made against this recommendation.

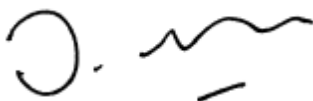
Recommendation 4. The Minister for Health and Social Services should commission a mapping of the digital systems involved in complying with the requirements of the Act to enable an honest appraisal of the work that still needs to be done to improve the efficiency and connectivity of those systems, and the timescales for this. This should include consideration of the role of digital technology in enabling nurses to provide better patient care.

At the end of March 2025 following a competitive tender process, the AWNSP commissioned Healthcare Innovation Consortium (HIC) to undertake the independent digital-systems review outlined above in Recommendation 4. The company is highly qualified for this work and has extensive relevant experience of the digital healthcare landscape including: a digital workforce optimisation assessment at Worcestershire Acute Hospitals NHS Trust, an interoperability review of clinical and operational systems at Alder Hey Children's NHS Foundation Trust, and the development of data-sharing frameworks for North East/Yorkshire NHS Genomic Medicine Service.

I understand that their team has been engaging intensively with stakeholders within NHS Wales over the last three months with a focus on mapping the current systems infrastructure involved in discharging duties under the Act; identifying gaps and issues in that infrastructure; and recommending solutions to how we might arrive at a more effective and inter-connected suite of digital tools which supports health boards in efficiently meeting their statutory obligations under the Act and also offers tangible benefits to the day-to-day operational management of nurse staffing and the delivery of patient care.

The deadline for HIC's final report is 30 September this year, and I will ensure that it is shared with you for your information along with an indication of the AWNSP's next steps relating to this work.

Yours sincerely,



Jeremy Miles AS/MS

Cabinet Secretary for Health and Social Care

Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol



Healthcare Innovation Consortium

Because innovation is everyone's business, we've made it ours

NHS Wales, NHS Nurse Staffing Levels (Wales) Act (2016), Digital Capabilities Assessment Project Phase 2 Final Report



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Outline Project Plan Approach

Version Control

Version	Date	Changes and Person Responsible
0.1	12/09/2025	First Draft, Hadleigh Stollar
0.2	20/09/2025	Next Draft, Hadleigh Stollar
0.3	23/09/2025	QA, Chloe Weatherhead
0.4	24/09/2025	Review andy Meiner
0.5	26/09/2025	Schematics, Ben Cook
1.0	28/09/2025	REVISED FINAL VERSION
2.0	29/09/2025	FINAL VERSION TO BE SHARED WITH NHS WALES
2.1	02/10/2025	Rhys Roberts comments
2.2	06/10/2025	Ben Cook edits
3.0	07/10/2025	Next version to share with Wales team
4.0	07/10/2025	Next version to share with Wales team
4.1	16/10/2025	Rhiannon Jones comments
5.0	17/10/2025	Final version following SRO review
6.0	20/10/2025	Published Version

Approvers

Name	Signature	Title/Responsibility	Date	Version
Hadleigh Stollar	H.Stollar	SRO, HIC	20/10/2025	6.0
Sarah Patmore	S. Patmore	SRO, NHS Wales	20/10/2025	6.0

Foreword

We would like to begin by expressing our heartfelt gratitude to NHS Wales for commissioning Healthcare Innovation Consortium to deliver this Digital Capabilities Assessment in support of the Nurse Staffing Levels (Wales) Act 2016. It has been a true privilege to work alongside dedicated and knowledgeable teams across Health Boards and national programmes. The openness, engagement and insight shown by everyone who took part have been instrumental in shaping our findings and illuminating the proposed path ahead.

One conclusion stands out from this extended engagement (Phase 2) – this moment calls for transformation, rather than incremental change. Meaningful improvements in nurse staffing cannot be achieved through small adjustments alone.. There needs to be a move beyond complexity and compromise towards a future of clarity, cohesion, and confidence in the digital systems that underpin safe staffing. Achieving this future depends on the seamless integration and interoperability of digital systems, ensuring that data flows securely and efficiently across platforms, enabling informed decision-making, reducing duplication, and supporting a unified approach to workforce planning and patient safety.

Throughout this piece of work, we have been continually inspired by the professionalism, passion and collaborative spirit of everyone involved. The willingness to share candid reflections and constructive ideas has not only enriched this work but also helped to lay a strong foundation for genuine change and creating momentum. We look ahead to Phase 3 and beyond with optimism, as work progresses to build a more connected, intelligent and equitable digital infrastructure for nurse staffing across Wales

In particular, we would like to extend our heartfelt thanks to Rhys Roberts for his invaluable guidance and unwavering support throughout this project. From day one, Rhys provided thoughtful insight, strategic direction and a clear vision of the broader context – all of which were crucial in shaping our approach and keeping us aligned with frontline realities. His remarkable ability to connect people, foster collaboration and maintain momentum ensured that our efforts stayed focused on what truly matters. Rhys’s responsiveness, attention to detail and dedication have been a source of confidence for our team and we are truly grateful for the expertise and energy he brought to every stage of the work.

As you turn the pages of this report, we hope you find it informative, engaging and above all, inspiring. You’ll see a proposed path from today’s fragmentation to a connected future: stabilising in 2025 with shared data standards (including WLoC), SafeCare-HealthRoster interfaces and an MVP national dashboard; optimising in 2026–27 through all-Wales real-time dashboards, streamlined incident reporting (WNCR→Datix) and integration with the new EPR; and transforming by 2028–29 with predictive/AI-assisted staffing, national benchmarking and a “one-system” experience for users.

Thank you for joining us on this journey; we warmly welcome you to the Phase 2 Final Report and to the work ahead – building connected, intelligent and equitable digital foundation for safe staffing across Wales.

Glossary of Acronyms

Acronym	Full term
AI	Artificial Intelligence
API	Application Programming Interface
BI	Business Intelligence
CNIO	Chief Nursing Information Officer
Civica	Civica Scheduling
DHCW	Digital Health and Care Wales
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FHIR	Fast Healthcare Interoperability Resources
HB	Health Board
HEIW	Health Education and Improvement Wales
HEPMA	Hospital e-Prescribing and Medicines Administration
HIC	Healthcare Innovation Consortium
HL7	Health Level Seven International
IG	Information Governance
NDR	National Data Resource
NHS	National Health Service
NSLWA	Nurse Staffing Levels (Wales) Act
MVP	Minimum Viable Product
PID	Project Initiation Document
RL	RL Datix (incident-reporting vendor) / e-rostering supplier
SRO	Senior Responsible Owner
UK	United Kingdom
UX	User Experience
WGLL	<i>What Good Looks Like</i> framework
WLoC	Welsh Levels of Care
WNCR	Welsh Nursing Care Record

Executive Summary

Introduction

This document provides an executive summary of the Phase 2 Final Report for the NHS Wales Digital Capabilities Assessment, commissioned in support of the Nurse Staffing Levels (Wales) Act 2016. Phase 1 identified significant digital fragmentation, siloed systems, and a reliance on manual processes, which collectively place an undue burden on clinical staff and undermine the ability to comply with the Act.

Phase 2 moved from assessment to action, presenting a comprehensive, stakeholder-validated implementation plan for 2025–2029. The plan is designed to create a cohesive, interoperable, and intelligent digital ecosystem for nurse staffing. Its core objectives are to improve real-time, data-driven decision-making, integrate staffing data with patient safety metrics, and align with national digital standards. The following proposed timeline outlines the key dates and phased activities to achieve this transformation.

Immediate Next Steps and Key Dates

The project will transition immediately from planning to execution, with the following critical milestones scheduled:

Date	Milestone
October 2025	Formal submission of the Phase 2 Final Report and Implementation Roadmap to NHS Wales leadership.
Q4 2025	Establishment of the formal governance structure, including a Digital Nurse Staffing Steering Group.
October 2025	Commencement of all primary implementation workstreams (Technical, Training, Benefits, and Engagement).
By December 2025	Delivery of initial outputs, including a technical blueprint for the national dashboard and a comprehensive training needs analysis.
By March 2026	The benefits realisation tracking framework will be fully operational with baseline metrics captured to measure progress.

Implementation Roadmap: A Three-Horizon Approach

The proposed implementation is structured across three distinct but interconnected horizons, balancing immediate stabilisation with long-term transformation.

Horizon 1 (2025): Stabilise – Building the Foundation

The immediate priority is to address critical technical gaps, standardise data, and deliver early wins to build momentum and demonstrate value.

- **Data Standardisation (End of 2025):** Define and agree upon core data standards for (for inclusion in the national data dictionary) patient acuity and staff skill mix across all Health Boards to ensure data is consistent and comparable.
- **System Integration (Q1 2026):** Implement foundational technical integrations, focusing on creating an automated link between Safecare/HealthRoster and Datix Cymru to eliminate duplicate data entry.
- **Real-Time Dashboards (Q1/Q2 2026):** Launch pilot versions of a live, real-time staffing dashboard in select clinical areas. These pilots will provide the proof-of-concept and feed data into a prototype All-Wales Nurse Staffing Dashboard.
- **Incident Reporting (Q4 2025):** Commence the redesign of the nurse staffing incident reporting process to create a streamlined, single-entry workflow between the Welsh Nursing Care Record (WNCR) and Datix Cymru.
- **Workforce Engagement (from Q4 2025):** Initiate targeted training programmes and establish a network of ward-based "Digital Champions" to support adoption and provide peer support.

Horizon 2 (2026 – 2027): Optimise – Scaling and Enhancing Capability

This phase focuses on the nationwide expansion of successful pilots, enhancing system functionality, and embedding new digital practices across NHS Wales.

- **Nationwide Rollout (2026-2027):** Expand the real-time dashboard solution from the pilot phase to all Health Boards and Trusts, establishing a fully operational and standardised national dashboard.
- **Digitise Key Processes (2026-2027):** Introduce and scale digital tools to capture crucial contextual data, including staff wellbeing metrics, missed breaks, and intra-shift redeployments.
- **Deeper System Integration (2026-2027):** Complete key integrations with the national Electronic Patient Record (EPR) and Datix Cymru. A Single Sign-On (SSO) experience will be implemented to reduce friction for users.
- **Introduce Automation and Analytics (from late 2026):** Pilot AI-assisted tools, including a forecasting module to predict staffing shortfalls 2-4 weeks in advance and decision-support tools for charge nurses.
- **Foster confident and supported use of digital tools across the workforce by the end of 2027,** ensuring that every member of staff feels empowered, equipped, and valued in their engagement with digital systems, not just as users, but as contributors to safer, smarter care. A comprehensive national training curriculum will be established and delivered, with a target of achieving over 80% active and proficient use of the core digital staffing tools.

Horizon 3 (2028 – 2029): Transform – Achieving a Fully Integrated Ecosystem

The final phase will deliver a fully integrated, intelligent, and predictive nurse staffing ecosystem that is sustainable for the long term.

- **Predictive and AI-Driven Staffing (from 2028):** Implement fully predictive staffing models and AI-driven scheduling systems that can optimise rosters and provide real-time recommendations based on predicted patient demand.
- **Unified National System (by 2029):** Achieve a seamlessly integrated national workforce management experience, creating a "one system" feel for all users through complete interoperability across all platforms.
- **National Benchmarking and Transparency (by 2029):** Establish national benchmarks for safe and effective staffing, integrated into digital dashboards. Introduce patient-facing tools to provide public transparency on staffing levels.
- **Sustainability and Continuous Improvement (by 2029):** Formalise permanent governance structures and a Community of Practice to ensure the digital ecosystem continues to evolve and improve beyond the project's formal conclusion.

Parallel Focus: Technology-Enabled Care (TEC)

Throughout all phases, a dedicated roadmap will ensure the nurse staffing system evolves to support modern care models. This includes mapping virtual ward deployments in **2025**, linking remote monitoring alerts to staffing systems in **2026-2027**, and achieving fully integrated dashboards that reflect all care settings by **2029**.

Across all phases, a dedicated roadmap will guide the evolution of the nurse staffing system to align with emerging models of care that are increasingly virtual, data-driven, and patient-centred. This includes mapping virtual ward deployments in 2025, linking remote monitoring alerts to staffing systems in 2026–2027, and achieving fully integrated dashboards that reflect all care settings, from hospital to home, by 2029.

Conclusion

This time-bound and prioritised roadmap provides NHS Wales with a clear and actionable path to modernise its digital nurse staffing capabilities. By executing this plan, NHS Wales will not only ensure robust compliance with the 2016 Act but also empower its nursing workforce with the tools needed to deliver safer, more effective patient care. This time-bound and prioritised roadmap offers NHS Wales a clear, strategic pathway to transform its digital nurse staffing capabilities. By delivering on this plan, NHS Wales will not only more easily and demonstrably meet the statutory requirements of the Nurse Staffing Levels (Wales) Act 2016, but also the conditions will be created for a digitally-enabled and confident nursing workforce, equipped with the tools, insights, and systems needed to deliver safer, smarter, and more responsive care across all settings.

Final Implementation Plan

Phase 1 of this project identified critical digital shortcomings that undermine the ability for NHS Wales to demonstrate compliance with the Nurse Staffing Levels (Wales) Act 2016. While core tools (e.g. SafeCare, HealthRoster, Datix Cymru) are utilised, their current usage is fragmented, with many workflows still reliant on standalone spreadsheets and only partial integration between systems. These gaps, compounded by poor user experience and data lags, increase the burden on staff and compromise real-time visibility into staffing and patient acuity. Phase 2 shifted the focus from assessment to action, delivering a comprehensive implementation plan to address this fragmentation and transform nurse staffing digital capabilities across NHS Wales. The plan directly targets the Phase 2 objectives:

- **Address digital fragmentation:** Create a more cohesive, interoperable ecosystem in place of the current siloed systems.
- **Improve real-time decision-making:** Enable timely, data-informed operational decisions through live dashboards and alerts.
- **Embed data-driven staffing and patient safety:** Integrate nurse staffing data with patient safety and quality metrics to support demonstrable, evidence-based compliance with the Act.
- **Strengthen technology-enabled care:** by embedding innovations such as virtual wards, remote monitoring, and AI-powered tools directly into the nurse staffing strategy. These technologies must not sit on the periphery, they should actively inform staffing decisions, enhance clinical oversight, and expand the reach and responsiveness of care across all settings.
- **Align with WGLL framework and standards:** Ensure all solutions adhere to national “What Good Looks Like” digital standards and NHS Wales policies.

To achieve these aims, the implementation plan is structured across three distinct horizons (2025–2029). This phased approach balances immediate fixes with longer-term transformation, enabling iterative refinement and stakeholder input at each stage. The plan is summarised as follows:

- **Horizon 1 (now – early 2026) – Stabilise:** In the first phase, the priority is to shore up fundamental technical gaps and establish a uniform foundation. This includes patching critical interfaces between existing systems to reduce duplicate data entry and manual workarounds (for example, bridging Safecare/HealthRoster and Datix Cymruso that information flows automatically) – a direct response to frontline frustrations that “the systems don’t communicate”. A national digital nursing dashboard (Minimum Viable Product) will be introduced, providing a basic real-time view of staffing across all Health Boards. *By mid 2026 each Health Board will have a local dashboard feeding key data to a central NHS Wales view*, enabling initial benchmarking and oversight. In tandem, core data definitions and standards will be agreed – notably a standard acuity and dependency classification (e.g. Welsh Levels of Care) – to ensure all organisations are “speaking the same language” in terms of staffing data. Horizon 1 also initiates foundational workforce upskilling: delivering targeted training so staff can confidently use SafeCare, e-rostering and reporting tools. This must be carefully integrated into existing mandatory training schedules so as not to overburden staff with additional training beyond their routine and ensure the entire workforce is prepared for the upcoming integrations.
 - This addresses the knowledge gaps identified in Phase 1 and echoed by survey respondents who called for dedicated training and protected time to learn new systems. By stabilising interfaces, establishing common standards and boosting user competence, Horizon 1 lays the groundwork for safer real-time staffing management in the immediate term.
- **Horizon 2 (2026–2027) – Optimise:** The second phase focuses on enhancing functionality and expanding deployment once the fundamentals are in place. Key systems will be further integrated and automation introduced for routine processes.

- For example, automated data synchronisation between rostering/acuity tools and incident reporting tools to support predictive staffing forecasts (anticipating demand surges or shortfalls a few shifts ahead). Real-time reporting capabilities will be rolled out fully: what begins as pilot dashboards in Horizon 1 will evolve into robust, live nurse staffing dashboards used across all Health Boards by 2027, delivering the “visibility in real time” that stakeholders have requested.
- Efforts will also concentrate on user experience improvements and standardisation – streamlining interfaces and workflows so that by the end of 2027 the core digital staffing tools are intuitive and universally adopted (targeting >80% regular use by staff) across Wales. In practice, this means reducing clicks and form-filling burden in software (many Phase 1 participants stressed making systems easier to use, in line with the WGLL ethos to “make it easy to do the right thing”). Also planned is to digitise processes that are still paper-based or ad hoc – for example, logging staff well-being checks or intra-shift redeployments – so that important contextual data (like workload pressures, skill mix issues) is captured automatically rather than in notebooks. By Horizon 2, nurse staffing systems will begin to proactively support decision-making: for instance, sending automated alerts for staffing risks (e.g. acuity spike on a ward or a missed nurse-to-patient ratio) and flagging potential solutions (such as redeploying staff from a lower-risk area).
- Mid-term optimisation will also start to tie nurse staffing data into other key systems: integrations with the national Electronic Patient Record (EPR) and Datix Cymru incident system are planned in this horizon. This will enable a two-way flow – e.g. staffing levels can be viewed alongside patient outcomes, and an incident report can automatically update the staffing dashboard – moving us closer to a truly data-driven, safety-focused staffing model. By late 2027, the aim is an optimised digital environment where frontline staff have timely information at their fingertips and many manual tasks have been automated or simplified, yielding efficiency gains and freeing up time for patient care.
- **Horizon 3 (2028–2029) – Transform:** The final phase represents a fundamental transformation to a fully integrated, intelligent nurse staffing ecosystem. By 2028 we anticipate embedding nurse staffing functions seamlessly into enterprise-level systems. All nurse staffing tools (rostering, acuity, etc.) will be fully integrated with the EPR and other clinical systems, creating effectively *one integrated system* for users – or as one stakeholder put it, “one integrated system, no duplication for any health professional”. This means data will only need to be entered once and will populate all relevant places, eliminating the frustrating double-entry and inconsistent records that plague the current state. Advanced analytics and decision support will reach maturity in this phase: AI-enabled staffing forecasts and scheduling will be deployed nationally. For example, the system could automatically generate an optimal roster or suggest reallocating staff based on predicted patient acuity, something stakeholders see as a major opportunity (e.g. “*evidencing and predicting safe staffing*” was highlighted as a key future benefit). Any AI tools will be introduced with appropriate governance and clinician oversight – aligning with the recommendation to maintain transparency and clinical control over AI-driven insights.
- By 2029, the vision is to enable a single, patient-centered view of staffing on a national scale. Executives and care teams alike will be able to see, in real time, how staffing levels correlate with patient needs and outcomes anywhere in Wales. National benchmarking will be fully in place – boards can measure their staffing metrics against all-Wales standards – supporting a culture of continuous improvement and shared learning. This horizon also emphasises sustainability: the new digital infrastructure will be firmly embedded into business-as-usual, with ongoing support and innovation pipelines. In summary, Horizon 3 delivers the “future state” – a Wales where digital tools actively enable safer staffing and adaptive decision-making at every level of the health system, consistent with the aspirational WGLL framework and the Nurse Staffing Levels Act (NSLWA)’s intent.

Throughout all phases, this implementation plan will remain iterative and responsive. At each milestone (end of Horizons 1, 2 and 3) stakeholder review checkpoints will need to be conducted to validate progress and adjust as needed.

This ensures the plan stays grounded in operational reality and retains alignment with both frontline needs and national strategic directives (e.g. the Digital Health and Care Wales (DHCW) architecture and *What Good Looks Like* standards). By phasing the work over 2025–2029, NHS Wales can build momentum with early wins (in 2025), achieve substantive improvements in the medium term (2026–27) and realise a digitally transformed nurse staffing environment by 2028–29, all while continuously involving the staff and leaders who will ultimately make these solutions work.

Prioritised Roadmap

Translating the above proposed plan into action requires a clear and prioritised roadmap. The roadmap outlines what needs to happen and in what sequence, to deliver the desired outcomes. It distinguishes short-term imperatives from longer-term initiatives, ensuring that foundational issues are tackled first. This section details the roadmap's key components, sequenced into near-term, medium-term and long-term priorities, along with a dedicated track for technology-enabled care. Each action item has been co-designed with stakeholders and chosen for its impact on the objectives (fragmentation, real-time data, etc.) and feasibility within the given timeframe.

Near-Term Priorities (Now – early 2026): The immediate focus is on quick wins and building the base for change. These actions are either already underway or should be initiated within the next 3–6 months:

- **Integrate and Standardise Data:** *Define core data standards for acuity and skill mix* across NHS Wales. This involves agreeing on common definitions (e.g. what constitutes each acuity level, how skill mix is recorded) so that every Health Board captures staffing data in a consistent, comparable way. Standardisation is foundational – it underpins effective integration and benchmarking. In parallel, work will begin on *technical integration of existing systems*. High-friction interface issues will be addressed immediately – for example, enabling automatic updates between Safecare/Healthroster and Datix Cymru to allow triangulation of the impact of the roster/acuity on clinical incidents). Early feedback underscores the urgency of this step, as fragmented data and lack of system communication are currently causing delays and “data lag” in staffing decisions. By creating links between systems and establishing a single “source of truth” for key data fields, we can start reducing the current reliance on laborious manual reconciliations.
- **Streamline Incident Reporting:** instigate a redesign of the nurse staffing-related incident reporting process, in conjunction with workforce and quality teams. The goal is to make incident logging and escalation faster and integrated. In practice, this may involve configuring the Welsh Nursing Care Record (WNCR) as the primary interface for front-line staff to report staffing issues or patient safety incidents, with behind-the-scenes integration pushing that information to Datix (the national incident system) automatically. This addresses a major pain point – currently incident reporting is time-consuming, often requiring duplicate data entry. Under the “*What Good Looks Like*” vision from Phase 1, an ideal future state was described where an incident could be logged once in ≤5 minutes and relevant staffing dashboards would update instantly. The short-term roadmap will initiate steps toward that vision, such as defining requirements for a simplified incident form and identifying any quick technical solutions (e.g. interim data export processes) to link WNCR and Datix Cymru. Even before full automation is achieved, simply clarifying reporting workflows and responsibilities will yield improvements – staff will know *how* and *where* to report staffing red flags so that nothing is missed.
- **Pilot Real-Time Dashboards:** Launch small-scale pilot projects to demonstrate the value of real-time data. A few wards or hospital sites will be selected in different Health Boards to trial a *live staffing dashboard* that pulls data from e-rostering, acuity and incident reporting systems throughout the day. These pilot dashboards (likely developed in close collaboration with NHS Wales Informatics/DHCW) will be used to refine requirements and resolve technical snags in a controlled environment. Crucially, pilot data will be funnelled to a central dashboard hosted by NHS Wales Performance and Improvement – creating the first iteration of an All-Wales Nurse Staffing Dashboard. This central view will initially be basic (perhaps showing key metrics like fill rates and patient acuity by site), but it establishes the mechanism for national oversight.

- By the end of this phase, we expect each participating Health Board to have a functioning local dashboard and NHS Wales to have a prototype national dashboard aggregating those feeds. This aligns with the recommendation from Phase 1 to *“accelerate the delivery of the national dashboard”* while acknowledging local components need to come first.
- **Engage and educate Staff:** Ensure the workforce is ready to embrace the new tools, in line with the HEIWs Strategic Nursing Workforce Plan. Near-term, this means delivering awareness sessions and fundamental training alongside the pilot technologies. For example, if a ward is piloting a new dashboard or a revised incident form, on-site orientation will be provided so nurses and managers are comfortable using it. Digital champions will also be identified and supported – staff members with an interest in digital who can help peers and feedback issues. Early engagement is critical; as one respondent noted, using *“language that staff can understand when delivering training”* and providing support (especially *“out of hours support when technology goes down”*) will be vital to successful adoption. These considerations are being built into the rollout. By front-loading training and user engagement in the short term, we aim to build enthusiasm and reduce anxiety about the upcoming changes.

Many of these near-term actions are already in motion. By focusing on integration, standardisation and quick demonstrations of value, the roadmap’s first stage creates a platform on which more ambitious changes can confidently be launched.

Medium-Term Priorities (2026–2027): Once the groundwork is laid, the emphasis shifts to scaling up and adding more advanced capabilities. Over the 2026–27 period, the roadmap calls for the following:

- **Nationwide Rollout of Real-Time Tools:** Expand the dashboard and reporting solutions from pilot phase to all Health Boards and Trusts. Each organisation will implement the agreed standard dashboard model, tailored as needed to local workflows but adhering to national data standards. The NHS Wales central dashboard will move from prototype to production, aggregating data from all sites to provide a true national picture. By 2027, executive teams and operational managers anywhere in Wales should be able to pull up a live dashboard showing staffing status and risk indicators (e.g. hotspots of low coverage or excessive workload) across the system. The roadmap prioritises this rollout because it directly improves **real-time decision-making and transparency**, a core objective. It also replaces the patchwork of manual reports with a consistent digital solution – addressing the Phase 1 finding that reliance on spreadsheets must be reduced.
- **Digitise Wellbeing and Movement Logs:** Introduce new modules or system features to capture data on staff wellbeing, fatigue and redeployment. As recommended in Phase 1, adding fields for break monitoring, overtime, staff movement between wards, etc., will provide richer context for staffing decisions. By mid-2026, we plan to pilot “check-in” prompts in e-rostering systems for staff to indicate if they missed breaks or experienced high stress on a shift and to log any intra-shift transfers of staff (e.g. if a nurse is pulled from Ward A to Ward B to help cover). By 2027, these features should be standard, giving nurse leaders visibility into the human factors (wellbeing, experience mix) alongside the raw numbers. This will help in proactively managing risk – for example, if data shows a particular ward consistently redeploys staff and those staff miss breaks, it flags a need to adjust staffing or provide extra support. In alignment with the Nurse Staffing Act’s focus on both staffing levels *and quality*, these wellbeing and skill-mix insights will help ensure safe care is delivered by a supported workforce.
- **System Integrations and Single Sign-On:** Throughout 2026–27 progressive integration of the nurse staffing digital ecosystem with other key clinical and administrative systems will continue. One priority is linking staffing systems to the new Electronic Patient Record (EPR) being procured nationally. As soon as the EPR’s architecture is defined, work will be carried out alongside DHCW to ensure APIs or data feeds connect it with SafeCare/rostering data and clinical incident data. The aim is that by 2027, information such as patient acuity or nurse staffing levels can flow seamlessly between the ward’s EPR view and the staffing dashboard – eliminating the need to check multiple systems.

- Similarly, integration with Datix Cymru will be completed so that incident data (e.g. falls, pressure ulcers) and staffing data inform one another. This fulfils the aspiration to link staffing levels to patient outcomes as part of quality improvement and assurance. For staff, a single sign-on user experience will be pursued wherever possible, so that nurses and managers can move between rostering, acuity, incident and EPR systems without juggling separate logins. This aligns with WGLL principles around user-centric design and reducing friction. By integrating systems, we also address digital fragmentation at its root – moving from siloed applications to an interoperable suite that behaves like one system.
- **Automation and Advanced Analytics:** Introduce AI-assisted decision support tools on a trial basis. Mid-term, this could include a *forecasting module* that uses historical data and machine learning to predict staffing shortfalls 2–4 weeks ahead. For example, by late 2026 we might deploy an automated roster analysis that suggests where additional staff might be needed (considering patterns of sick leave, expected patient surges, etc.). By 2027, we plan to pilot an AI-assisted professional judgement tool – essentially a smart advisor that can consider multiple data points (patient acuity trends, nurse experience levels, ward layout, etc.) and offer staffing recommendations to support the nurse in charge. Importantly, these tools will be co-designed with clinical stakeholders to ensure they are helpful, not intrusive. The AI’s role is to aid human decision-making, not replace it; as such transparency will be maintained on how suggestions are generated and allow staff to provide feedback on AI recommendations. The roadmap gives priority to these analytics in the medium term because they are potential “force multipliers” for staffing efficiency and safety – the Cardiff case already showed how leveraging data smartly can yield significant savings and improvements. By developing these capabilities by 2027, we position Wales at the forefront of data-driven nurse staffing, while still having time to refine and scale the tools in the final phase.
- **Drive User Adoption and Culture Change:** With many new systems and processes coming online, a concerted effort in 2026–27 will go toward embedding these changes in practice. The roadmap allocates resources for a comprehensive training and change management programme (building on the groundwork from Horizon 1). This includes developing a *national training curriculum* for digital nurse staffing tools – covering everything from basic IT skills and data literacy for frontline staff to advanced analytics training for nurse leaders and informatics personnel. Regular refresher sessions will be implemented alongside peer learning (via the Community of Practice forum, if established, per Phase 1 recommendation) and on-demand e-learning modules. By the end of Horizon 2, the goal is that use of the digital tools is routine and trusted at all levels – in other words, that a critical mass of staff feel confident and competent in the new way of working. We are targeting over 80% of relevant staff actively using the systems by 2027 (based on login metrics and survey self-reports), which we see as a proxy for successful adoption. This goes hand in hand with culture shift: reinforcing that these tools are there to help clinicians (not to monitor or penalise them) and celebrating wins when, for example, real-time data prevents an incident or saves staff time. By prioritising user adoption as a deliverable in the roadmap, we acknowledge that technology implementation is as much about people as about IT.

In sum, the medium-term roadmap focuses on scaling up the infrastructure (dashboards across Wales, integrated systems) and scaling up the capabilities (automation, analytics), while ensuring the people using these systems are supported and skilled. This period turns the initial concepts into everyday practice and builds resilience and intelligence into the nurse staffing approach.

Long-Term Priorities (2028 and beyond): The latter part of the roadmap (2028–2029) is about achieving the visionary end-state and ensuring longevity of improvements. Key long-term initiatives include:

- **Predictive Analytics and AI-Driven Staffing:** By 2028, implement fully predictive staffing tools that can model different scenarios and optimise staffing in real time. This means going beyond short-term forecasts to tools that continually learn and improve. For example, an AI scheduling system could automatically generate optimal rosters a month ahead, accounting for predicted patient loads and staff availability and continuously adjust suggestions as new data comes in (e.g. unexpected surges or absences).

- The roadmap will see the prototyping of such a system in 2027, with refinement and full deployment by 2028 if viable. Additionally, *AI-assisted professional judgement* tools will be expanded – for instance, enhancing the early decision-support pilots into a robust feature embedded in daily operations (imagine a nurse manager getting an AI-driven alert: “tomorrow’s evening shift in Ward X has high predicted acuity and predominantly junior staff – consider reallocating an experienced nurse from Ward Y”). By the end of Phase 3, these predictive and AI capabilities should be integrated enough that the system can not only flag issues but also suggest actionable solutions, elevating the proactivity of nurse staffing management across Wales.
- **National Workforce Management Integration:** The long-term roadmap culminates in a scenario where all nurse staffing functions are unified at the national level – effectively operating as one system. Practically, this could mean moving towards a single national platform (if not in literal IT terms, then via complete interoperability) that covers rostering, real-time monitoring, incident logging and workforce planning, with all Health Boards connected. The “one integrated system” vision voiced by stakeholders will be pursued either through convergence of existing systems or by adopting a next-generation solution (depending on what evaluations determine is most feasible and cost-effective). A national approach also implies benchmarking and transparency: by 2029, every Health Board will be measured with the same metrics and definitions of safe staffing, facilitating apples-to-apples comparisons and shared accountability. The roadmap includes establishing national staffing benchmarks and KPIs (e.g. fill rate targets, time-to-fill vacancies, etc.) and building them into the digital dashboards so that deviations are immediately visible. Furthermore, the long-term plan considers patient-facing transparency – fulfilling the recommendation to provide patients and the public with accessible information on staffing levels. For example, by 2029 wards might have electronic displays or an app showing the planned vs actual staffing, updated in real time, to promote trust and allow feedback. Achieving a truly unified, transparent system will solidify Wales’s position as a leader in nurse staffing digitalisation.
- **Sustainability and Continuous Improvement:** Finally, the roadmap emphasises that 2028–29 is not an endpoint but a turning point into continuous improvement. Thus, a long-term action is to establish permanent governance and support structures so that the digital staffing ecosystem continues to evolve beyond this project. This might include formalising the All-Wales Digital Nurse Staffing Community of Practice (initially proposed in Phase 1) to continue sharing innovations and troubleshooting issues as a network. It also involves integrating the nurse staffing digital programme into the broader NHS Wales digital transformation strategy – aligning future upgrades with national policy changes, technical standards and the WGLL framework (which remains a touchstone for digital maturity). By the end of 2029, the expectation is that all Health Boards and the NHS Wales centre will operate under a cohesive governance model for nurse staffing data (e.g. data quality checks, security standards, change control for system updates), ensuring the gains made are maintained and built upon. Additionally, benefits realisation tracking started in Phase 2 will be an ongoing activity: collecting data on outcomes such as financial savings, reduced agency usage, improved care quality indicators, etc., to verify that the roadmap’s changes are delivering the promised value. This continuous feedback loop will help course-correct any elements that are not yielding expected benefits and will support the case for any further investments required.

The prioritised roadmap outlined above is ambitious but grounded in stakeholder input and phased to manage risk. Short-term, we tackle the “low-hanging fruit” and set standards; medium-term, we implement the core systems widely and embed new ways of working; long-term, we leverage advanced technologies and fully harmonise the approach across Wales. Each step is designed to build confidence and capability toward the next, ensuring that by the final stage NHS Wales has a sustainable, future-proofed digital infrastructure for nurse staffing that directly contributes to safer patient care and better workforce experiences.

Technology-Enabled Care Roadmap: In parallel with the nurse staffing-specific actions, Phase 2 also addresses the broader objective of enhancing technology-enabled care (TEC) in nursing. This involves integrating initiatives like virtual wards, remote monitoring devices and telehealth into the overall strategy. A dedicated workstream will map out current and planned TEC deployments across Wales and ensure the nurse staffing digital plan aligns with and supports them.

As of 2025, the adoption of virtual wards (providing hospital-level care at home or in community settings) is in early stages in NHS Wales. Several stakeholders highlighted virtual wards as a major opportunity – for example, implementing virtual wards for paediatric patients to “move towards care closer to home” and to add a “tier of care” that alleviates pressure on hospital beds. The roadmap will coordinate with such efforts by determining the staffing models and digital tools needed to support virtual ward care. For instance, if a Health Board plans to stand up a virtual ward for chronic disease management, we need to ensure that SafeCare/rosters can account for community nursing shifts, that remote monitoring data (from devices in patients’ homes) can be viewed by those staff and that any patient acuity flags from virtual wards feed into the same dashboards used for hospital units. By 2026, we aim to document all ongoing virtual ward projects and integrate their staffing data requirements into our system specifications. By 2027, the goal is to pilot linking remote patient monitoring dashboards with nurse staffing alerts – so if, say, multiple patients on a virtual ward trigger alerts overnight, the system could recommend dispatching additional nursing resources.

Remote monitoring devices and telehealth consultations are similarly on the rise. Our survey found interest in these: for example, respondents mentioned pursuing “improved virtual consultations” as an opportunity. However, it also revealed that knowledge around these options is uneven – one participant confessed “*I do not know enough about the above options and their capabilities to make an informed decision*”. This indicates a need for clear guidance and shared learning about TEC. The roadmap will therefore produce an “innovation inventory” – a catalogue of which digital health tools (like wearable patient monitors, telehealth platforms for follow-up visits, etc.) are in use or planned in each Health Board, along with evidence of benefits. Additionally, there will be workshops or innovation labs where early adopters (for example, a team that has trialed a telehealth clinic) can showcase their experience to peers. The outcome will be a realistic, context-aware TEC adoption pathway: not every site will use every technology, but all will benefit from a coherent view of what’s available and what infrastructure/staffing adjustments each requires.

By aligning the nurse staffing digital improvements with the TEC roadmap, we ensure that as care delivery evolves (more care at home, more digital therapeutics, etc.), the staffing systems and processes evolve too. The nurse staffing platform being built will be flexible enough to accommodate new care settings and modalities. For example, if remote monitoring generates an alert that a patient’s condition is deteriorating, it could interface with staffing systems to suggest a community nurse visit. Such integrations will likely come in the later horizons once core systems are in place, but planning for them starts now. Our approach to TEC enablement is collaborative: working closely with DHCW and existing national programmes (e.g. the Virtual Ward programme) to avoid duplication and ensure support. One stakeholder rightly noted that linking with DHCW plans and securing their support is “*crucial to the success of this roadmap*” – accordingly, the TEC roadmap will be developed jointly with DHCW’s digital hospital and digital community initiatives.

In summary, the prioritised roadmap does not treat technology-enabled care as a separate silo; it is interwoven. As new digital care models come online, the nurse staffing digital ecosystem will incorporate them. This ensures that the benefits of innovation (like improved patient monitoring or home-based care) can be fully realised, because the necessary staffing adjustments and data flows will be in place. By the end of Phase 2, there will be a clear plan for TEC integration and by the end of Phase 3, we expect many of these care technologies to be operating hand-in-hand with nurse staffing systems, collectively contributing to the overarching goal: better, safer care delivered by empowered, digitally-enabled nursing teams.

Feasibility Assessment

A thorough feasibility assessment underpins this implementation plan and roadmap to ensure the proposals are realistic and achievable. We examined feasibility across three dimensions: cost-effectiveness, resource requirements and scalability. For each dimension, we identified potential challenges and mitigation strategies, informed by both data analysis and stakeholder input.

Cost-Effectiveness: The plan's financial viability is crucial, given that 83% of stakeholder respondents flagged funding as a main constraint to digital and technical improvements. Our assessment includes a high-level cost-benefit analysis of the roadmap initiatives. Early findings indicate strong potential for return on investment. For example, smarter rostering and use of data have yielded savings in Cardiff and Vale UHB, where leveraging SafeCare's backend data to optimise staffing reportedly created savings in agency spend. Scaling such efficiencies across Wales could recoup a significant portion of the investment needed for new systems. During Phase 2, we modelled a range of ROI scenarios – comparing the projected cost of implementing dashboards, integrations, etc., against benefits like reduced agency shifts, time saved in reporting and avoidance of penalties or adverse events. The emerging conclusion is that the programme could pay for itself within a reasonable period (several years), especially when intangible benefits are considered (e.g. better staff retention due to improved working conditions). That said, up-front funding will be required and the proposed plan assumes a degree of central funding. We have aligned our recommendations with ongoing national investments (for instance, capitalising on the EPR procurement to fund some integration work). If certain items fall outside existing funding streams, targeted business cases will need to be developed or innovation grants explored. The emphasis on cost-effectiveness is not just about *saving* money but also about demonstrable value - tracking metrics such as reduction in manual reporting time (Phase 1 estimated an 80–90% reduction is possible) and improvements in safe staffing compliance, which have quality and reputational benefits. In summary, the feasibility analysis to date gives confidence that the roadmap is financially sound if executed diligently – the benefits in efficiency, safety and quality justify the investment and indeed *not* addressing these issues may incur higher costs long-term (through inefficiency and risk).

Resource and Workforce Capacity: Implementing this plan will require sufficient human resources and expertise. We assessed whether Health Boards have the capacity and skills to deliver the roadmap components. Stakeholder feedback underscored concerns in this area: 75% of survey respondents selected *staff availability* (capacity) and 58% selected *digital skills and literacy* as key constraints to change. We have taken these signals seriously. Our feasibility plan includes a detailed look at the people needed to drive the changes – from IT specialists and data analysts to clinical trainers and “super-user” nurses on the wards. One risk identified is over-reliance on a few key individuals. Phase 1 highlighted, for instance, that Cardiff's impressive digital progress was heavily dependent on a single data analyst – an unsustainable single point of failure. To mitigate this, the roadmap incorporates building broader capacity: each Health Board should ideally have a small team (or at least one dedicated role) focusing on nurse staffing data and systems. We are exploring shared service models to support smaller organisations – for example, creating regional analytics hubs or a central NHS Wales digital nursing team that can assist all boards. The feasibility study considered different models for this and leans toward a hybrid approach: a core national team providing standards, training and technical support, combined with local “boots on the ground” who understand site-specific workflows.

Training is a major part of the capacity building. Leveraging the national nurse staffing programme infrastructure to embed digital skill development, this will ensure that by the time new tools are rolled out, there are enough competent users and support persons to sustain them. The good news is we have strong stakeholder willingness to learn – many respondents asked for more training and support, not less, indicating receptive attitudes if time and resources are allotted. To avoid adding burden on already stretched staff, we propose measures like backfilling posts to free staff for training (some Health Boards have begun doing this for other initiatives). We also flagged to the Executive Directors of Nursing that without protected time for staff to engage in this digital transformation, the benefits may not fully materialise.

In feasibility terms, this is about organisational commitment: our plan is contingent on each organisation allocating the necessary people and time. Early validation suggests high-level support for this (e.g. recognising that some non-clinical tasks might need pausing or reallocating to let nurses focus on learning new systems). This will be formalised in a *Resource Plan* accompanying the roadmap, detailing the roles, estimated effort and where each responsibility lies (as outlined in the RACI matrix).

Overall, while resource constraints are real, our mitigation strategies – shared expertise, thorough training and leadership commitment – make the plan feasible on the workforce front. We also have contingency options (e.g. phasing rollouts more slowly in sites that are under extreme pressure or enlisting temporary project staff to fill gaps) to ensure no Health Board is left behind due to capacity issues.

Scalability and Adaptability: Given the diverse contexts across Wales (large tertiary hospitals, small rural hospitals, community nursing, paediatric units, etc.), we assessed whether the proposed solutions can scale and adapt beyond the initial focus (adult acute wards under Section 25B of the Act). The feasibility analysis involved testing the roadmap assumptions against various scenarios – for example, *“Would this approach work in a community hospital with few staff and different workflows?”* or *“How does this apply to paediatrics or mental health wards which are not fully within the Act’s current scope?”*. We deliberately included stakeholders from all seven Health Boards, plus Trusts and sought input from areas like paediatrics and community nursing during Phase 2 to capture these perspectives.

The consensus is that the core needs – real-time data, integration, user-friendly systems – are common across settings, but one size may not fit all in execution. For instance, real-time dashboards are universally useful, but a community nursing service might need to see caseload and travel time info on their dashboard, whereas a surgical ward focuses on patient acuity and skill mix. Our plan’s flexibility was scrutinised for such scalability. We have built in a modular design principle: the core systems (like the dashboard) will have a base set of features common to all and additional modules or configuration for specific contexts (like a community nursing module). This modularity ensures that improvements “scale out” to all services without forcing irrelevant processes on them. We also considered infrastructure differences – e.g. connectivity (some remote areas have Wi-Fi challenges, highlighted by comments such as “Wi-Fi not the best” in current state). Part of feasibility is ensuring investment in IT infrastructure accompanies the digital rollout, so we have flagged any network or device upgrades needed to support new systems in certain locations. Another aspect of scalability is policy and standards alignment: we checked that nothing in the roadmap contradicts national policies or emerging standards. In fact, aligning with national frameworks (like WGLL and technical standards by DHCW) is a criterion for each action. For example, if a new API is to be built, it must conform to Wales’s NHS Digital Architecture standards; if data is to be shared, it must respect NHS Wales data governance rules. We have been in dialogue with the relevant national bodies to ensure our plan complements other initiatives (like the upcoming EPR, national workforce systems, etc.), thereby increasing the likelihood that our solutions can plug into the wider ecosystem and remain supported long-term.

We also examined the legal and regulatory side (information governance, patient confidentiality for cross-system data, etc.) and found no insurmountable barriers – all planned data sharing is permissible within NHS Wales’s frameworks as long as proper controls are in place. The scalability feasibility is perhaps best summarised as making sure the roadmap is inclusive and future-proof: it should benefit all care areas and be able to adapt if, for instance, the Act is expanded to new settings. This is why Phase 2 objectives explicitly included extending beyond Section 25B environments. We are confident the roadmap meets this test – it has the agility to be applied broadly and our stakeholder validation included testing it with community and paediatric leaders to confirm its relevance.

Key Risks and Mitigations: The feasibility assessment also identified some cross-cutting risks and how to mitigate them. One significant risk is lack of stakeholder buy-in or change fatigue – if staff or leaders lose momentum, the best plan could falter. To mitigate this, we built a strong stakeholder engagement component (see next section) to maintain buy-in and incorporate feedback continuously. A stakeholder rightly warned that *“without that crucial first step [strategic engagement and securing buy-in], this work will not progress”*.

We have heeded this: gaining clear endorsement from top leadership (Executive Nurse Directors, CIOs, the Chief Nursing Officer, etc.) is a precondition of moving forward at each phase. Another risk is technological dependency: if one solution (say SafeCare or the national data repository) fails or is delayed, it could bottleneck the whole effort. Our mitigation is to remain technology-agnostic where possible (focus on outcomes, not specific vendors) and have fallback options.

For example, if full integration via APIs is slow, interim data export/import scripts will be used; if the national EPR deployment is delayed, there will be concentration on local integrations that can later map to the EPR. We have also incorporated risk logs from the start, regularly updated with input from each Health Board, so that emerging issues (like a sudden staffing crisis or a technical setback) can be managed with contingency plans. Lastly, we considered timeline feasibility: can we realistically do all this by 2029? Phasing helps here and we also sanity-checked each milestone. We believe the timeline is tight but achievable, with the caveat that some advanced features (AI in particular) may need more time to mature – however, those are end-horizon goals and do not derail earlier achievements if they slip a bit.

In conclusion, the feasibility assessment affirms that the Phase 3 roadmap is viable if key conditions are met: sustained funding, dedicated people time and continued stakeholder support. It is evidence-based (drawing on real-world data like Cardiff's experience and the survey results) and it is flexible enough to navigate uncertainties. We have strong grounds to proceed, with the understanding that active risk management and adaptability will be essential throughout the implementation. Phase 2 has produced not just a wish list, but a grounded plan with clear awareness of its practical demands – and equally clear strategies to meet them.

Risk Description	Consequence	Likelihood	Risk Level	Mitigation Strategy
Lack of Stakeholder Buy-in and Change Fatigue <ul style="list-style-type: none"> Staff, leadership, or other key stakeholders lose momentum, withdraw support, or actively resist the project, causing it to stall or fail. 	High	Medium	High	<ul style="list-style-type: none"> Proactive Stakeholder Engagement: Implement a continuous engagement and feedback component. Leadership Endorsement: Make clear endorsement from top leadership (e.g., Executive Nurse Directors, CIOs) a precondition for advancing through each project phase.
Timeline Slippage <ul style="list-style-type: none"> The project milestones are not met, leading to a failure to deliver the full scope of work by the 2029 deadline. 	High	Medium	High	<ul style="list-style-type: none"> Phased Implementation: Break the project into manageable phases with sanity-checked milestones. Prioritisation: Differentiate core deliverables from end-horizon goals (e.g., advanced AI features), allowing less critical items to slip without derailing early achievements.
Technological Dependency and Single Points of Failure <ul style="list-style-type: none"> The failure or delay of a single core technology (e.g., a specific EPR, SafeCare, national repository) creates a bottleneck that halts progress across the entire project. 	High	Medium	High	<ul style="list-style-type: none"> Technology-Agnostic Approach: Focus on achieving functional outcomes rather than committing to specific vendors or solutions. Fallback and Interim Options: Develop contingency plans such as interim data export/import scripts if API integration is slow and focus on local integrations if a national system is delayed.

Emergence of Unforeseen Issues <ul style="list-style-type: none"> Unexpected operational issues, such as a sudden staffing crisis, budget cuts, or a major technical setback, disrupt project plans and resources. 	Medium	High	High	<ul style="list-style-type: none"> Dynamic Risk Logging: Maintain a live risk log from the project's start. Collaborative Updates: Regularly update the risk log with input from each Health Board to identify emerging issues early. Contingency Planning: Develop and maintain contingency plans to manage identified issues as they arise.
Insufficient or Unsustained Funding <ul style="list-style-type: none"> Failure to secure and maintain the necessary funding throughout the project's lifecycle, leading to a halt in activities. (Inferred from "sustained funding" as a key condition). 	High	Low	Medium	<ul style="list-style-type: none"> Secure long-term funding commitments upfront. Regularly report on progress and value to justify continued investment.
Lack of Dedicated Personnel / Resource Allocation <ul style="list-style-type: none"> Insufficient allocation of "dedicated people time" prevents project tasks from being completed effectively and on schedule. (Inferred from "dedicated people time" as a key condition). 	Medium	Medium	Medium	<ul style="list-style-type: none"> Secure commitments for dedicated staff resources from leadership at the outset. Clearly define roles, responsibilities, and time commitments for all project personnel.

Table Key

	Consequence	Likelihood
High	Would likely cause the project to fail or miss its primary objectives.	Very likely to happen
Medium	Could cause project delays, budget overruns or reduced scope.	Could happen; has a reasonable chance of happening
Low	Could cause minor delays or additional work; unlikely to affect primary objectives	Unlikely to happen

Final Stakeholder Validation

A defining feature of this project has been the deep involvement of stakeholders at every stage. In Phase 2, after developing the draft implementation plan and roadmap, we carried out extensive stakeholder validation to refine the proposals and ensure they have front-line buy-in. This validation phase engaged a broad cross-section of NHS Wales nursing and digital leadership, reflecting the end-users and sponsors of these initiatives.

Engagement Overview: We convened targeted workshops and feedback sessions with key groups identified in the Project Initiation Document. These included Executive Directors of Nursing and Deputy DoNs from each Health Board, members of the All-Wales Nurse Staffing Group, senior representatives from Digital Health and Care Wales (DHCW), clinical informatics leads, workforce planners, as well as ward managers and front-line nursing staff for practical insights. In addition, a Phase 2 online survey gathered wider input – 52 stakeholders responded, representing roles ranging from Nurse Staffing Leads (around 31% of respondents) and frontline nursing staff (~27%) to informatics/digital specialists (~12%) and others (ward managers, matrons, etc.). This diverse participation ensured that validation wasn't done in an echo chamber of project team members, but truly *by the people who will implement and use the solutions*.

Key Feedback Themes: The overwhelming feedback was supportive of the direction set in the roadmap. Stakeholders confirmed that the focus areas identified are the right ones. For instance, when asked which digital changes would most help day-to-day work, 84% of survey respondents selected “better integration between existing systems” as a top priority and 81% selected “easier access to real-time dashboards and reports”. This directly validates the plan’s emphasis on system interoperability and live data visibility. Improved user experience and mobile access were also highly ranked (71% and 61% respectively), reinforcing the need to make tools intuitive and accessible – goals which the roadmap’s UX improvements and tablet deployment in wards will address. This quantitative feedback gave us confidence that the main pillars of the plan (integration, real-time data, usability) resonate strongly with staff needs.

Qualitative feedback provided richer context and helped fine-tune specific aspects. Integration and “one system” vision: There was a clear endorsement of the goal to break down digital silos. Participants echoed sentiments from Phase 1, often in very straightforward terms – e.g. “*All systems linking in*” and “*for all clinical systems to communicate with each other*” were repeated as the ideal end state. This has underscored the importance of our interoperability work – in response, we’ve ensured the roadmap includes concrete integration milestones (not just aspirational statements).

Stakeholders also advised involving vendors in this conversation: one pointed out that vendors should be contractually obliged to fit their products into our ecosystem and provide open means of accessing data. As a result, we have added an action in the implementation plan to review vendor contracts and, where possible, enforce integration-friendly clauses (for example, requiring that our system suppliers expose certain data to our national dashboard).

Many front-line nurses welcomed the promise of real-time staffing information. We heard anecdotes during workshops of how lack of timely data today forces workarounds – e.g. shift coordinators maintaining whiteboard tallies or WhatsApp groups to share who’s short-staffed, which is neither efficient nor reliable. The validation sessions allowed us to demo a prototype dashboard to a group of ward managers, who gave practical feedback (such as requesting a simple traffic-light indicator for when a ward falls below its planned staffing level, to grab attention). We’ve incorporated these interface suggestions into the dashboard development brief. Some stakeholders voiced a cautious note about data overload: *if* real-time systems generate a lot of alerts, how to ensure staff aren’t overwhelmed? We plan to manage this by calibrating alert thresholds carefully (with clinical input) and perhaps introducing alerts gradually. One concrete change from validation is the inclusion of a pause/snooze function for alerts, as suggested by a senior nurse – so that if an issue is already known and being handled, the system’s alarm can be temporarily quieted. This kind of fine-tuning will make the tools more user-friendly in practice.

A strong theme was the need for adequate support as new systems roll out. Stakeholders stressed that without proper education, even the best system will falter – a point we fully acknowledge. Comments such as “*funding, training and more staff to be able to release people to train and utilise the systems effectively*” encapsulate this concern. We took this on board by beefing up the training component of our plan: the final plan now explicitly includes a national training programme with dedicated time for every staff member who will use the new systems and additional backfill funding so wards can spare staff to attend training. Also, based on feedback from a validation workshop with ward sisters, we are adopting a train-the-trainer model: identifying local “super users” in each area who get advanced training and can thereafter serve as on-site support. The idea of ward-based digital champions was very popular among stakeholders and we’ve reflected that in the roadmap human resources plan. We also clarified the need for ongoing support, not just one-off training. For example, participants noted that *initial enthusiasm can wane* if there isn’t follow-up – someone said we need to avoid the “here’s a new system, good luck” scenario. In response, we’ve planned for multi-phase training (intro, advanced, refresher) and embedded user support (helpdesk, drop-in sessions) especially around the time of each major go-live. Furthermore, recognising the comment about “*language that staff can understand*”, we are reviewing all training materials to keep them jargon-free and practically oriented.

Stakeholders appreciated that Phase 2 was trying to be practical. In fact, one respondent urged digital leads to “*get a sense for clinicians’ experiences to understand their frustrations... without that lived experience, it’s difficult to understand the barriers*”. We heeded this by validating the plan with numerous real-world scenarios (some of which we included in the Phase 1 report as “day in the life” use cases). During validation, we walked through a hypothetical busy shift and showed how the future tools would slot in – stakeholders were quick to point out if something seemed unrealistic. For example, initially we had assumed nurses would proactively check dashboards; a ward sister noted they often don’t have time, so *notifications must push to them*. Thus, the final plan places more emphasis on push alerts (via mobile device or pager) rather than expecting users to continuously monitor screens. This kind of insight was invaluable and directly shaped the implementation tactics.

We presented the draft roadmap to the Executive Director of Nursing (EDoN) group and the Chief Nursing Officer. Their feedback was largely positive, commending the comprehensive nature of the plan. Importantly, they provided guidance on governance – specifically, the need to dovetail with the national Nurse Staffing Programme governance and perhaps set up a dedicated digital sub-group. They also stressed aligning with Welsh Government expectations, noting that this project was initiated in response to a Health Committee recommendation. This validation at the executive level resulted in the addition of a governance section in our final report (detailing RACI, reporting structure, etc.) to ensure clarity on how the roadmap will be overseen. Moreover, the EDoNs collectively agreed to champion this work within their organisations – a very encouraging outcome of validation. Several said they would take personal responsibility for driving the necessary culture change, which bodes well for implementation.

After gathering all the above feedback, we made a series of adjustments to the plan. Some have been noted already: bolstering training, tweaking dashboard features, adding vendor engagement, etc. We also sharpened the prioritisation within the roadmap. Stakeholders helped us identify which initiatives should come first when there’s a resource clash. For example, both improved incident reporting and wellbeing monitoring are important – but feedback indicated fixing incident reporting has a more immediate patient safety impact, so it was prioritised slightly higher in the sequencing. Likewise, integration tasks were sequenced by difficulty and impact, with advice from technical stakeholders – e.g. integrating Safecare/Health Roster with Datix Cymru is relatively straightforward and high-impact, so it’s in Horizon 1, whereas integrating with EPR depends on EPR timelines, so that sits in Horizon 3. The result is a more nuanced, realistic roadmap than the initial draft. Stakeholder validation essentially pressure-tested our plan and the plan held up, with some refinements.

The final output of this phase – this report and the appended detailed roadmap – carries with it the stamp of stakeholder approval. In fact, the final stakeholder validation workshop ended with unanimous support for the roadmap’s content and direction. The plan was formally signed off by the SROs (Senior Responsible Officers) representing both NHS Wales and HIC, indicating that the key sponsors and stakeholder groups are satisfied that their input has been incorporated and the roadmap is ready for implementation. One tangible sign of this buy-in is that a few Health Boards have volunteered to be early adopters for certain initiatives (we have on record offers from two Boards to pilot the new incident reporting process as soon as it’s ready).

In conclusion, the stakeholder validation process has not only refined the plan but also built trust and momentum. Frontline nurses, managers and executives see their fingerprints on this roadmap. This sense of co-ownership will be critical as we move to execution – people support what they helped create. We are confident that the validated roadmap now represents a consensus path forward, one that is ambitious yet attuned to on-the-ground realities and most importantly, one that *the people implementing it believe in*. With this, we move into the next steps of turning the plan into action, backed by a strong coalition of stakeholders across NHS Wales.

Next Steps and Deliverables

With Phase 2 complete and the final roadmap validated, the project now transitions from planning to implementation. The following are the immediate next steps and key deliverables as we move forward:

- **Formal Submission and Dissemination (October 2025):** This Phase 2 Final Report and the accompanying Implementation Roadmap will be formally presented and submitted to NHS Wales Performance and Improvement, the Office of the Chief Nursing Officer (CNO) and the Executive Directors of Nursing group by 26th September 2025. Alongside the report, a slide deck and an executive summary will be circulated to facilitate communication of the findings and plans to wider stakeholders (e.g. Health Board CEOs, Medical Directors, Workforce Directors). This step ensures top-level awareness and approval, securing the mandate to proceed with implementation.
- **Establishment of Governance Structure (Q4 2025):** Immediately following sign-off, a governance and delivery structure will be activated to drive Phase 3 (implementation phase). As agreed in validation, a **Digital Nurse Staffing Steering Group** will be formed under the auspices of the All-Wales Nurse Staffing Programme. This group will include representatives from each Health Board (nursing and digital leads), the NHS Wales PandI team and DHCW and will meet monthly to oversee roadmap execution. A detailed RACI (Responsible, Accountable, Consulted, Informed) matrix has been developed to clarify roles in implementation – for example, assigning who is accountable for each major deliverable and who needs to be consulted. One of the first tasks of the Steering Group will be to review and approve the implementation project plan (a more granular Gantt chart derived from the roadmap) and to confirm resource allocations from each organisation. By putting formal governance in place, we ensure there is continuous leadership attention and problem-solving capacity as the work kicks off.
- **Activation of Implementation Workstreams (October 2025):** Initiation of the main workstreams as identified in the plan: (1) Technical Implementation, (2) Training and Change Management, (3) Benefits and Feasibility Monitoring and (4) Stakeholder Engagement Continuation. In October, each workstream will hold a launch meeting to agree on immediate tasks and timelines. For instance, the Technical workstream will likely start with a workshop to map out the data integration approach (involving IT staff and vendor reps), while the Training workstream will convene nursing education leads to plan the curriculum roll-out. These workstreams correspond to the focus areas laid out in Phase 2 objectives and will operate in an integrated fashion (with cross-working as needed). Notably, a series of co-design workshops is scheduled for October–November 2025 (as was foreseen in the PID) – these will bring together mixed groups of end-users to collaboratively design specific solutions (for example, designing the dashboard interface, or the new incident e-form). By commencing these activities in Q4 2025, we maintain the momentum of Phase 2 and begin tangible progress on deliverables.
- **Early Deliverables by End of 2025:** We anticipate a few quick deliverables by year-end as proof of concept and to build confidence. These include: a Month 1 progress report and updated risk log (to be delivered to the Nurse Staffing Programme board in November 2025), the technical blueprint for the national dashboard (outlining data sources, technical architecture and a prototype design, expected by December 2025) and a training needs analysis report (identifying the gaps in digital skills among nursing staff, to guide the training rollout). Additionally, we aim to complete a procurement or development plan for any necessary software tools by the end of 2025 – for example, if an integration engine or dashboard platform needs to be procured, that process will start immediately so that it doesn't delay implementation in 2026.
- **Monitoring and Communication:** As we proceed, regular monitoring of progress and open communication will be crucial. Quarterly progress updates will be produced for the CNO and Executive Nurse Directors, summarising achievements, upcoming activities and any issues. These updates will keep leadership informed and engaged.

Also, a stakeholder newsletter or bulletin will be maintained (perhaps quarterly or bi-monthly) to share success stories, such as “Board X launched their pilot dashboard” or “Nurses in Board Y saved Z hours with the new reporting tool this month”. Celebrating early wins and keeping the narrative of improvement alive will help sustain engagement on the front line. The Nursing Times and NHS Wales internal communications may also be leveraged for broader dissemination of progress, highlighting NHS Wales as a pioneer in this space.

- **Benefits Realisation Tracking:** By March 2026 (six months into implementation), we plan to have the benefits tracking framework fully operational, with baseline metrics captured to later measure against. This is a deliverable carried over from Phase 2 – we started mapping benefits and now phase 3 will finalise KPIs and data collection methods. For example, baseline data for things like average time spent on staffing reports per month, agency spend, staff survey results on workload, etc., will be gathered by end of 2025. Delivering this Benefits Realisation Plan will allow us to quantify progress in 2026–2027 and ensure we remain outcome-focused.

Looking further ahead, Phase 3 (Implementation) is expected to run through 2026–2029 following the roadmap. By the end of Phase 3, the deliverables will include fully implemented systems and processes as described and a closing report evaluating the improvements against the Act’s requirements and original objectives. However, it is worth noting that in many ways this digital transformation will be an ongoing journey beyond formal project phases – continual improvement will be part of the new normal.

In summary, the next steps are clear: secure formal approval, set up strong governance, launch workstreams and begin delivering incremental improvements immediately. The transition from planning to doing is always challenging, but we have laid a solid foundation. The engagement and validation exercises mean we enter Phase 3 with stakeholders primed to act. As one of the final survey respondents wisely advised, it’s critical to *“link in with DHCW plans and gain their support... have a section up front in the roadmap around strategic engagement and securing buy-in”*. We have done exactly that – strategic engagement will continue to be our mantra as we take these next steps.

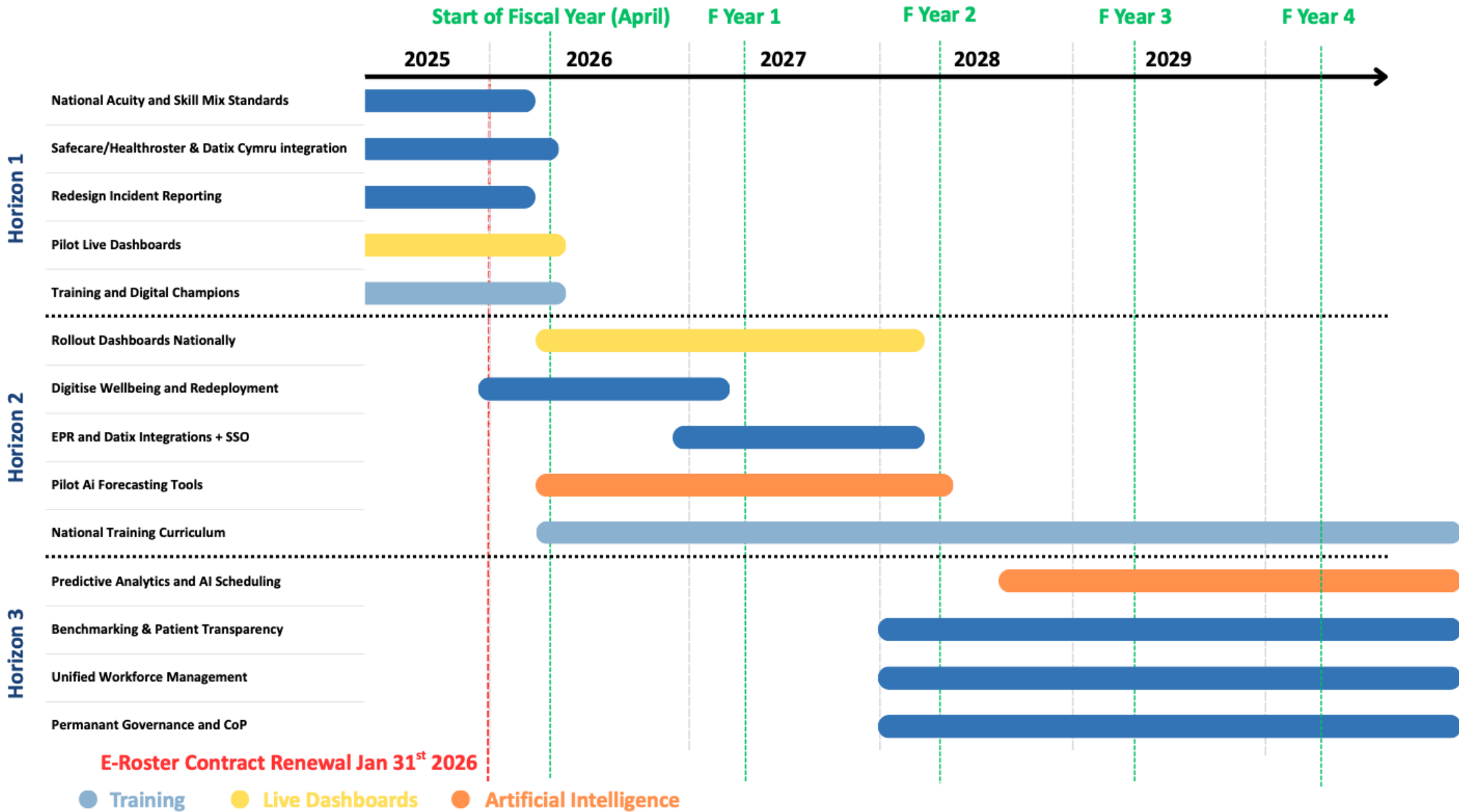
This Phase 2 report marks the culmination of the discovery and design effort. It provides NHS Wales with a clear, evidence-based plan to transform digital nurse staffing capabilities. The focus now shifts to execution. By following this roadmap with discipline and adaptability, NHS Wales is poised to achieve a step-change in how nurse staffing is planned, managed and optimised – ultimately supporting the delivery of safer care and better outcomes for patients and staff alike. The journey from fragmentation to digital excellence is mapped out; the next steps will turn that map into reality, one milestone at a time.

NHS Wales Digital Capabilities Assessment – Phase 2 Final Report

Final Implementation Plan – Overview

Horizon Summary (2025–2029)

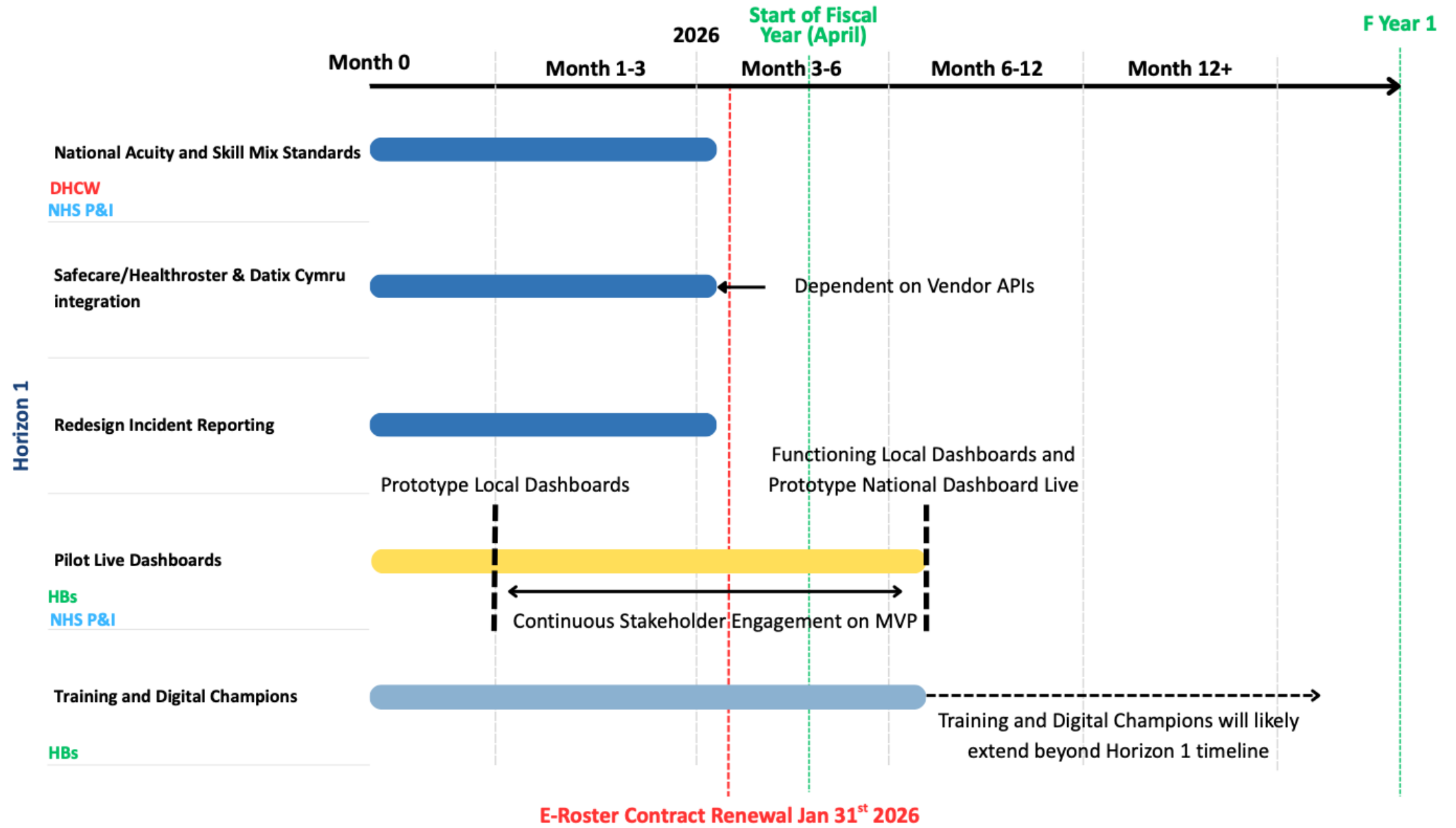
Horizon	Timeframe	Aim	Key Actions	Outcomes
H1 – Stabilise	Q4 2025 – Q2 2026	Fix critical gaps	Patch interfaces; define data standards; MVP dashboard; training	Reduced duplication, early visibility, shared definitions
H2 – Optimise	2026–2027	Scale and automate	Nationwide dashboards; wellbeing and redeployment logs; EPR/Datix links; automation pilots	Trusted real-time data, efficiency gains
H3 – Transform	2028–2029	Full integration and AI	EPR integration; predictive scheduling; national benchmarking	One-system feel, proactive planning, transparency



Prioritised Roadmap

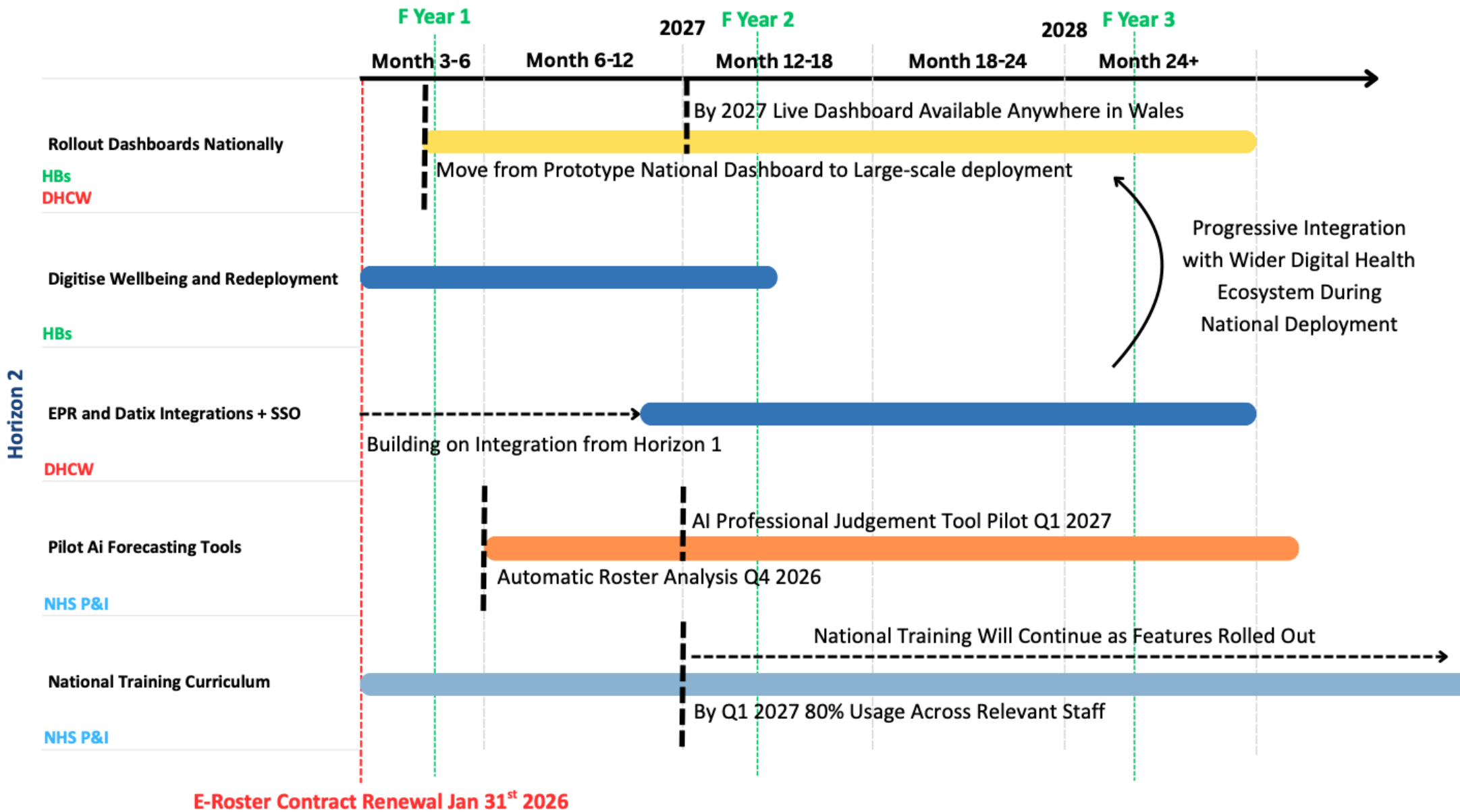
Short-Term (Now–early 2026)

Action	Why	Dependencies	Owner
Define national acuity and skill mix standards	Consistency	Clinical sign-off	NHS Wales PandI, DHCW
Safecare/Healthroster with Datix Cymru	Reduce duplication	Vendor APIs	Local digital leads
Redesign incident reporting (WNCR → Datix)	Faster, single entry	IG approvals	Workforce and Quality teams
Pilot live dashboards	Prove value	Data pipelines	NHS PandI and HBs
Training and Digital Champions	Drive adoption	Backfill for staff	HBs



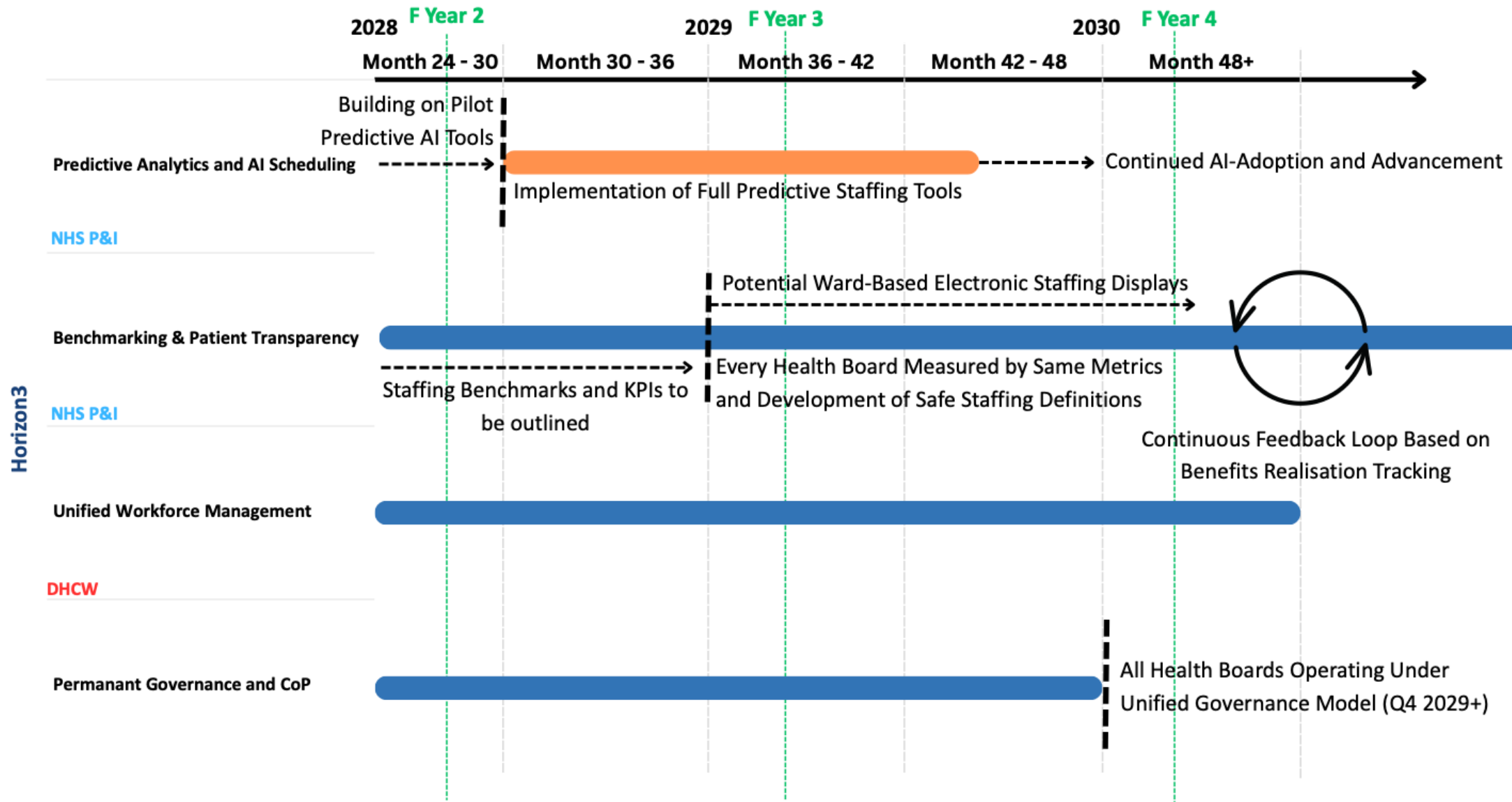
Medium-Term (2026–2027)

Action	Why	Dependencies	Owner
Rollout dashboards nationally	Standardised visibility	Common data model	DHCW and HBs
Digitise wellbeing and redeployment	Capture context	Vendor config	HBs
EPR and Datix integrations + SSO	End fragmentation	National IT schedule	DHCW
Pilot AI forecasting tools	Proactive staffing	Data availability	NHS PandI
National training curriculum	Sustain adoption	Funding and faculty	NHS PandI and HEIW



Long-Term (2028–2029)

Action	Why	Dependencies	Owner
Predictive analytics and AI scheduling	Optimised rosters	Governance	NHS PandI
National benchmarking and patient transparency	Assurance	KPIs, comms	NHS PandI
Unified workforce management experience	“One system”	Vendor strategy	DHCW
Permanent governance and CoP	Sustainability	Programme resourcing	Nurse Staffing Programme



Technology-Enabled Care (TEC) Roadmap

TEC Focus	2025	2026–27	2028–29
Virtual Wards	Map deployments	Link alerts to staffing	Integrated dashboards
Remote Monitoring	Inventory and design data flows	Pilot alert-driven redeployments	Scaled pathways
Telehealth	Share playbooks	Define rota models	Embedded in planning

Start of Fiscal Year (April) F Year 1 F Year 2 F Year 3 F Year 4

2025 2026 2027 2028 2029

Virtual Wards

Map Deployments Q4 2025

Link Alerts to Staffing

Integrated Dashboards

Remote Monitoring

Inventory and Design Data Flows

Pilot Alert Driven Redeployments

Scaled Pathways

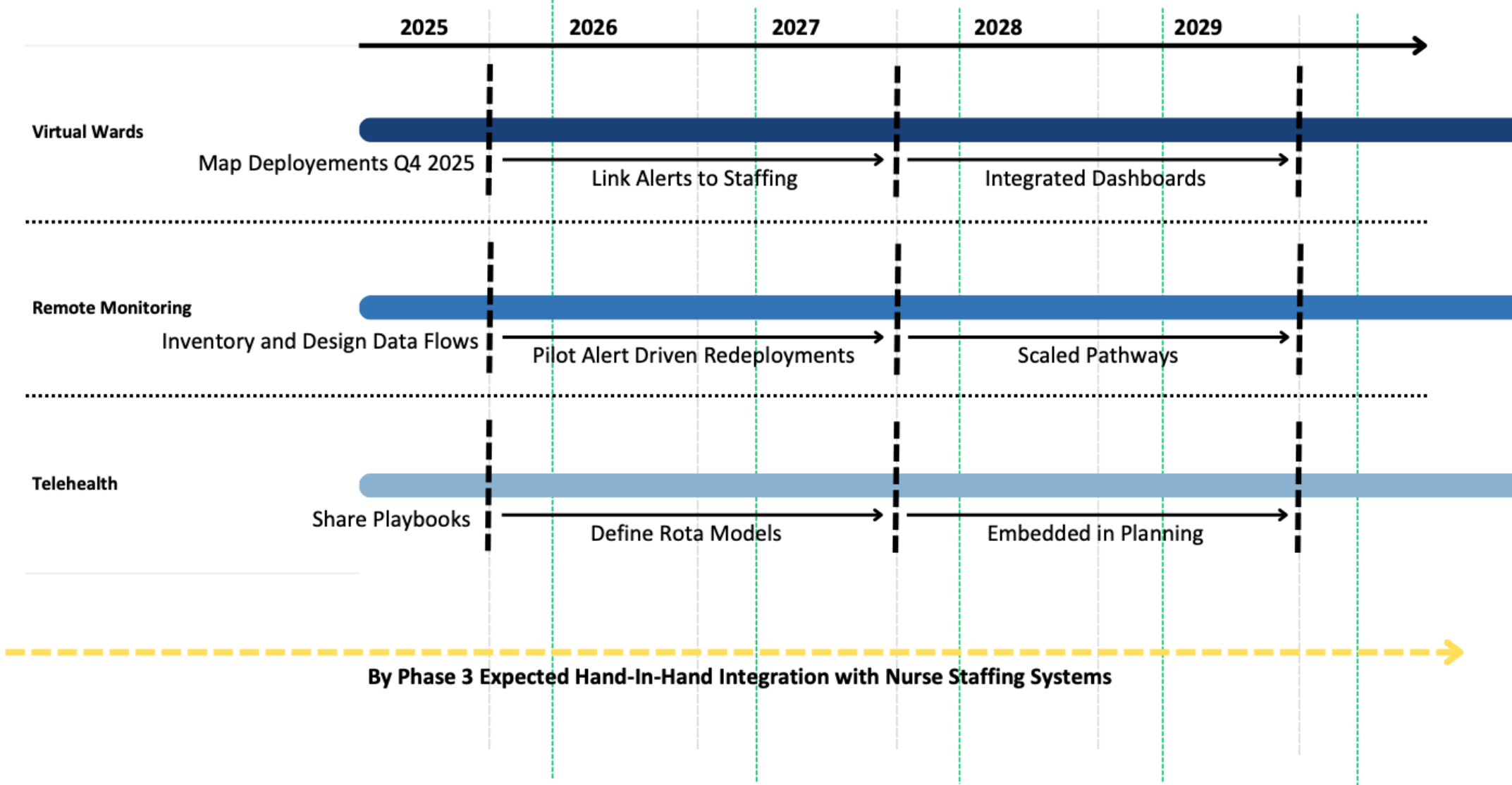
Telehealth

Share Playbooks

Define Rota Models

Embedded in Planning

By Phase 3 Expected Hand-In-Hand Integration with Nurse Staffing Systems



Feasibility Assessment Summary

Domain	Evidence	Risks	Mitigation	Implication
Resources	Skills and time constraints noted	Over-reliance on few staff	Shared hubs, training, backfill	Feasible with planning
Scalability	Needs differ by setting but core common	Connectivity gaps	Modular design, infra upgrades	Adaptable

Stakeholder Validation

Aspect	Details
Groups engaged	EDoNs, DDoNs, Nurse Staffing Group, DHCW, digital leads, frontline staff
Approach	Workshops, demos, survey, interviews
Top priorities validated	Integration, dashboards, mobile access, UX
Adjustments made	Alert snooze, vendor clauses, push notifications, stronger training and backfill
Outcome	Unanimous support, formal sign-off, early adopter offers

Next Steps and Deliverables

Deliverable	Due	Owner
Report and roadmap submission	26 Sep 2025	NHS PandI / CNO / EDoNs
Governance group established	Q4 2025	Nurse Staffing Programme
Workstream kick-offs	Oct 2025	Workstream leads
Early deliverables: risk log, dashboard blueprint, training needs analysis	Q1 2026	Programme team
Benefits framework baseline	Mar 2026	Benefits lead

Conclusion

Phase 2 has confirmed both the urgency of the challenge and the pathway forward. Across NHS Wales, core staffing tools exist but remain fragmented and siloed, with many wards forced to rely on manual workarounds and spreadsheets. This fragmentation – compounded by data lags and poor user experience – burdens staff and compromises real-time visibility into nurse staffing and patient acuity. Inconsistent approaches to recording acuity across health boards further hinder a unified view, underscoring the need for standard definitions so everyone is “speaking the same language”. Likewise, limited training and support have created user adoption barriers, as many nurses are not fully confident with the digital tools at hand.

These Phase 1 findings set a clear mandate: the status quo of disconnected systems and ad hoc processes is not sustainable if NHS Wales is to meet the NSLWA’s intent for safe, data-informed staffing.

Opportunities and Solutions in the Roadmap: The Phase 2 implementation roadmap directly addresses these challenges with targeted digital improvements. Key solutions and opportunities include:

- Immediate integration of Safecare/Health Roster with Datix Cymru to eliminate duplicate data entry and ensure staffing information flows automatically between systems. This will reduce manual rework and begin to close the communication gaps that today cause delays and “data lag” in decision-making.
- Deployment of local and national live nurse staffing dashboards to provide timely, transparent oversight. By establishing a basic All-Wales digital nursing dashboard (MVP) and feeding it with data from each Health Board, NHS Wales will gain its first unified, real-time view of staffing levels and acuity across the country. As pilots evolve into robust dashboards, executives and front-line managers alike will have on-demand visibility of staffing risks and benchmarks system-wide.
- Progressive integration with the EPR and Datix Cymru incident system to break down information silos. By 2026–27, nurse staffing data will seamlessly link with patient outcomes and safety incident data – for example, staffing levels visible alongside patient acuity in the EPR and incident reports automatically updating staffing dashboards. This two-way flow between staffing, clinical and quality systems will support a truly data-driven, safety-focused staffing model. Single sign-on will further simplify the user experience, allowing staff to move between rostering, acuity, incident and clinical systems without multiple logins.
- A comprehensive digital skills training programme and on-ward support to ensure these new tools are effectively used. Short-term actions include targeted training sessions and the introduction of Digital Champions on wards to build confidence and “reduce anxiety about the upcoming changes”. By investing in user education and change management, the plan aims to embed a culture of digital competency and enthusiasm, tackling the Phase 1 observation that technology is only as good as its adoption.
- Laying the groundwork for AI-driven decision support in nurse staffing. In the longer term, the roadmap envisions advanced analytics that can forecast demand surges and suggest optimal staffing configurations. For example, the system could automatically propose roster adjustments based on predicted patient acuity – a capability stakeholders have identified as a major opportunity for “evidencing and predicting safe staffing”. These AI-enabled staffing tools will be introduced with appropriate governance and clinical oversight to ensure transparency and trust. Taken together, these innovations position NHS Wales at the forefront of data-driven nurse staffing, aligning with the “What Good Looks Like” digital standards and enabling more proactive and efficient staffing decisions.

Maintaining Momentum into Implementation: With this roadmap agreed in principle, the strategic importance of moving swiftly into Phase 3 (implementation) cannot be overstated. The next steps are clearly defined – from securing formal approval and establishing strong programme governance to launching dedicated workstreams for immediate improvement and understanding resource requirements for successful implementation.

The transition from planning to doing is always challenging, but Phase 2 has laid a solid foundation. Thanks to extensive engagement and preparation, we now *enter Phase 3 with stakeholders primed to act*. The sense of urgency is shared across the system: early feedback from the front lines has underscored that resolving data fragmentation and lag is critical and cannot be delayed. NHS Wales's leadership and project teams must capitalize on the momentum generated and avoid any loss of pace at this crucial juncture.

Collaborative Commitment: It is also important to acknowledge the invaluable contributions of stakeholders in shaping this plan. The Phase 2 stakeholder validation process has not only refined the roadmap but built trust and momentum behind it. Frontline nurses, managers and executives can see their own "fingerprints" on the plan, fostering a sense of co-ownership that will be critical in the execution phase. This collaborative approach – engaging those who will ultimately use and benefit from the systems – means the roadmap arrives at implementation with a broad base of support. People support what they helped create and NHS Wales can be confident that the nursing workforce is invested in the success of these digital improvements. The project team extends its gratitude to all contributors for their candour, ideas and validation of the proposed solutions. Their input has ensured the roadmap is realistic, evidence-based and aligned with both frontline needs and national strategic priorities.

In closing, NHS Wales now has a clear, evidence-based plan to modernise its nurse staffing capabilities. The focus shifts to execution and delivery. By following this roadmap with discipline and adaptability, NHS Wales is poised to achieve a step-change in how nurse staffing is planned, managed and optimised – ultimately supporting the delivery of safer care and better outcomes for patients and staff alike. Robust programme governance will be established to steer this multi-year effort, ensuring accountability for each milestone and addressing risks proactively. Equally, continued strategic engagement with health boards, informatics teams (DHCW) and clinical leaders will remain a mantra as we proceed – sustaining the alignment and buy-in that are keys to success.

We conclude this report with a confident outlook: the journey from fragmentation to digital excellence is now mapped out and the next steps will turn that map into reality. With a shared commitment from leadership and frontline staff, NHS Wales will deliver a more digitally mature, safe and effective nurse staffing model – one that empowers nursing teams and ensures *better, safer care* for every patient across Wales. The groundwork has been laid; it is time to move forward together and make this vision a reality.

Annex 3 – Multi-professional team working and the Nurse Staffing Levels (Wales) Act 2016 Combined Phase 1 (page 1) and Phase 2 (page 23) reports



Phase 1 report (August 2024)

An assessment of the impact of the Nurse Staffing Levels (Wales) Act 2016 (‘the Act’) on multi-professional workforce models and the impact of multi-professional workforce models on the Nurse Staffing Levels (Wales) Act 2016; with a focus on Wards where Section 25B of the Act applies i.e. adult acute medical and surgical inpatient wards and paediatric inpatient wards.

Prepared by the ‘Assess the impact of new multi-professional team workforce models on implementation of the Nurse Staffing Levels (Wales) Act 2016: Working Group’

Acknowledgements:

The working group would like to extend its thanks to everyone who took the time to contribute to this piece of work either by completing the questionnaire or by attending the engagement workshops.

Glossary of Terms

Nurse Staffing Levels (Wales) Act 2016	“The Act”
Chief Nursing Officer	CNO
Health Education Improvement Wales	HEIW
Community Infrastructure (CI) Programme	CI Programme
Nursing and Midwifery Council	NMC
Royal College of Nursing	RCN
Multi-disciplinary team	MDT
Health & Care Professions Council	HPC
Registered Nurses	RN
Health Care Support Workers	HCSW
Welsh Nursing Care Record	WNCR

Situation:

Multi-professional team working is not a new concept but *“is pivotal for assessing, planning, delivering and evaluating treatment and care and should be designed around person centred needs assessments”* (Health Education and Improvement Wales, 2020). *A Healthier Wales (2018)* highlighted the importance of delivering care closer to home through a multi-professional and multi-agency team around the patient model of care. Achieving this vision is reliant upon working across traditional professional and organisational boundaries to deliver high quality seamless care, maximising skills, and exploring new roles and ways of working to meet the holistic needs of the patient/ person. This requires Health Boards/NHS Trust to create effective multi-professional teams

and co-ordinate the delivery of multi-professional care by implementing multi-professional workforce models. The Health Education and Improvement Wales (HEIW) (2020) document 'A healthier Wales: our workforce strategy for health and social care', states, "*By 2030, multi-professional and multi-agency workforce models will be the norm*".

This report sets out the outcomes of phase 1 of this work i.e. assessing the impact of the Act on the implementation of multi-professional team workforce models and vice versa, in wards where Section 25B of the Act applies and makes recommendations for phases 2 and 3 of the work.

A working group, a subgroup of the All-Wales Nurse Staffing Group, consisting of local nurse staffing leads and members from health - nursing, medical, dental, allied health professionals, health care scientists and pharmacy was established to oversee the work programme (see Appendix 1 for the membership of the group).

Background:

The Chief Nursing Officer for Wales (CNO) (2022) priorities for 2022-2024, set the strategic direction for the Nursing and Midwifery professions and aid in the delivery of 'A Healthier Wales' (2018) and stated that "*the future model of nursing care will be grounded in multi-disciplinary working. The idea of a "team around the patient" to deliver the appropriate care is the right direction for how we structure our workforce going forward, and I believe it is important that the nursing voice is underpinned throughout that approach.*" The CNO's ambition for the workforce was "*to close the vacancy gap and to attract, recruit and retain a competent, motivated, skilled nursing and midwifery workforce who have the capacity and attributes to assume their roles with confidence in meeting the needs of the population, whilst working to their full potential. We will grow and transform our workforce promoting multidisciplinary, multi-professional teams collaborating to improve outcomes through innovative ways of working, supported by technology.*"

Extensive work, highlighting the importance of multi-professional and multi-organisational working aimed at delivering patient/person focused care is being undertaken at a national level through the Strategic Programme for Primary Care. The Community Infrastructure (CI) Programme focusses on how Primary and Community Care services work collaboratively together to provide place-based care and seeks to define the fundamental infrastructure required to deliver place-based 24/7 integrated care and support. The programme has developed a [Multi-Professional Framework for Integrated Working](#) for Wales, underpinned by a literature scoping review and group concept mapping, with an evaluation tool or [Development Matrix for multi-professional working](#). The aim of the Multi-Professional Framework is to support organisations to deliver joined up, outcome focused, evidence-based community services, through a place-based multi-professional working model of care.

The Nurse Staffing Levels (Wales) Act 2016 (the Act) requires Health Boards/NHS Trusts to have regard for the provision of appropriate nurse staffing levels where nursing services are provided, and where nursing services are commissioned to a third party. In addition, wards where Section 25B and Section 25C of the Act applies i.e. acute adult medical and surgical wards and paediatric wards have a duty to use a triangulated methodology to calculate nurse staffing levels and take 'reasonable steps' to maintain nurse staffing levels. Section 25E of the Act requires organisations to submit a three-year report on the extent to which the nurse staffing levels have been maintained in those wards where Section 25B applies and organisations are required to consider the impact of not maintaining nurse staffing levels has had on care provided to patients by nurses and demonstrate the actions taken.

Since the final sections of the Act came into effect in 2018, the focus for nursing has been on establishing the processes required so that Health Boards/NHS Trust can meet their statutory responsibilities. Now that each health board and NHS trust have embedded these processes, the next step is to understand the impact of the Act on multi-professional team workforce models and explore how Health Boards/Trusts can be supported in implementing multi-professional team workforce models, whilst taking account of the statutory requirement set out in the Act.

The National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenge (Welsh Government, 2023) also identified a requirement for HEIW to 'assess the impact of new multi-professional team workforce models on implementation of the Nurse Staffing Act'.

A working group was set up, as a subgroup to the All-Wales Nurse Staffing Group, with the following objectives:

- Assess the impact of new multi-professional team workforce models on implementation of the Nurse Staffing Levels (Wales) Act
- Assess impact of the Act on the implementation of multi-professional team workforce models
- Consider how multi-disciplinary workforce planning would affect the Health Boards/ NHS Trusts' ability to discharge their duties as set out in the Act

The Executive Directors of Nursing agreed, in August 2023, that there would be three phases to this work:

- Phase 1: wards where Section 25B of the Act applies (i.e. adult acute medical/surgical inpatient wards and paediatrics inpatient wards)
- Phase 2: inpatient areas (scope to be confirmed)
- Phase 3: community services

The All-Wales Multi-Professional Workforce Planning Task & Finish Group has also been established.

Methodology: An initial scoping exercise and engagement with Health Boards/NHS Trusts informed the work programme. The group has also drawn on local and national programmes. HEIW, the All-Wales Nurse Staffing Group, Deputy Directors of Nursing Peer Group, and the Executive Directors of Nursing Peer Group have received regular updates on progress.

The key deliverables set out in the Working Group's Terms of References were as follows:

- Conduct a scoping exercise to identify and evaluate the use of multi-professional team workforce models and current ways of working within Health Boards/NHS Trusts
- Explore how the terminology and requirements set out in the Act and Statutory Guidance impacts on the ability for Health Boards/NHS Trusts to implement multi-professional team workforce models and the implications for practice
- Explore how Health Boards/NHS Trusts have interpreted and applied the Act & Statutory Guidance in relation to implementation of multi-professional workforce models and the implications for practice
- Through workshops, engage with Health Boards/NHS Trusts, members of the multi-professional team, workforce & OD (Organisational Development), finance, to understand how, based on their experience, the impact of the Act on the implementation of multi-professional team workforce models.

- Identify the enablers and barriers to successful implementation of multi-professional workforce models, taking into account the legislation.
- Produce a report providing an overview of the use of multi-professional workforce models across NHS Wales, how Health Boards/Trusts have interpreted and applied the Act & Statutory Guidance, the impact of legislation upon implementation of multi-professional workforce models and the implications for practice.

Initial scoping exercise: A scoping exercise, undertaken by the All-Wales Nurse Staffing Programme Manager, with the support of the Health Boards/NHS Trust's Nurse Staffing Programme Leads, to identify the roles that make up the multi-professional team, demonstrated the increasing number of roles that make up the multi-professional team on wards where Section 25B of the Act applies. This scoping exercise found over 450 role titles working across wards where Section 25B of the Act applies, 361 of which contribute to direct patient care, to varying degrees. Approximately 14 of the role titles were part of the nursing profession and were registered nurses or were roles that were working under the delegation of a registered nurse. However, without undertaking a detailed review of job descriptions, it is not clear whether a role title in one health board/NHS trust is known by a different role title in another health board/NHS trust, but both roles may undertake a similar/same role e.g. rehabilitation assistant in one health board, rehabilitation support worker in another.

Questionnaire (see Appendix 2 for additional information): A Microsoft Forms questionnaire was shared; aimed at seeking the views of member of the multi-professional team on their use of multi-professional workforce models within adult acute medical and surgical inpatient wards and paediatric inpatient wards, within the context of the Act. The questionnaire was open from 12 September 2023 to 8 December 2023.

The number of responses received was 283, from several different professional groups, with 52% from nursing and midwifery. Both registered and unregistered staff completed the questionnaire. The professional groups included in the questionnaire were those set out in ESR (Electronic Staff Record) (pharmacy staff are included under Additional Professional Scientific and Technical group).

There were responses from all participating Health Boards/NHS Trusts. Powys Teaching Health Board did not participate in the questionnaire, as they do not have wards where Section 25B of the Act applies. Of the 283 responses, not all respondents would have completed every question – as progression through the questionnaire was dependent on the answer selected.

Engagement Workshops: In addition to the questionnaire, three, two hour long, virtual workshops were planned over a two-week period to get a better understanding of the impact of multi-professional working on the Act and the impact of the Act on multi professional working. The purpose of the workshops was to build on the information gathered through the questionnaire. Registration for the events was lower than anticipated with the third event not reaching the minimum number required, resulting in the cancellation of the third event.

Thirty people attended the engagement workshops, with 40% representing nursing and midwifery, with the remaining 60% representing the other professional groups (pharmacy, physiotherapy, occupational therapy, psychology and speech and language). Of those who attended, 66% had direct involvement in one or more Section 25B ward, with 29% of participants having direct involvement in all the wards where Section 25B applies.

Limitation: The number of participants for the questionnaire and the engagement workshops was a

small percentage of the multi-professional team members that work on wards where Section 25B of the Act applies and generalising the views expressed to a wider population may not be possible. However, there were similarities in the views expressed by those responding to the questionnaire and those who attended the workshops.

Understanding of the topic area under discussion was variable and is likely to have influenced the views expressed. Of the respondents to the questionnaire, 64% utilises multi-professional workforce models within their area of work and 63% stated that they were aware of the Act, of which 41% were nursing and midwifery. However, those attending the engagement workshops felt that the term multi-professional working was 'poorly understood', with the terms multi-disciplinary or interdisciplinary being more widely used. It was also felt that the Act was 'poorly understood' outside of nursing and the Section 25B settings where it currently applies.

Assessment

Definitions: The definitions subgroup was asked to look at the definitions of key statements referenced in the Act, Statutory Guidance or relevant to this piece of work, referring to definitions already in use in practice and relevant literature/guidance. The subgroup referred to existing documentation for guidance including, amongst others:

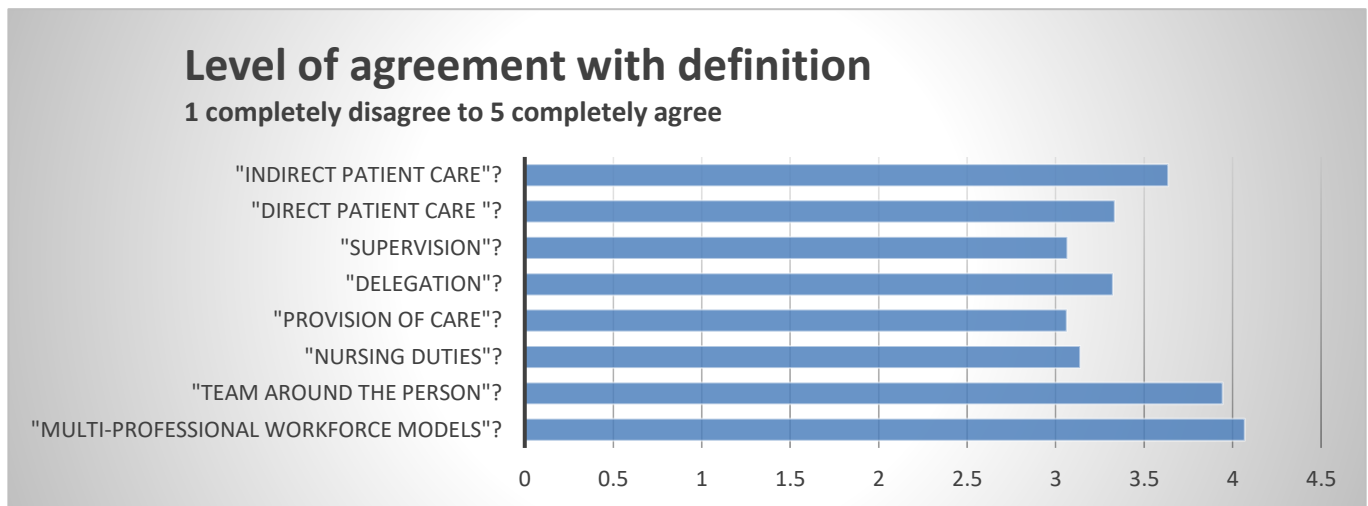
- All Wales Guidelines for delegation (HEIW, 2020)
- Nursing and Midwifery Council (NMC) Code (NMC, 2015)
- Guidance on accountability and delegation (NMC, 2019)

The list of key statements included the following:

- Multi-professional workforce models
- Team around the patient
- Provision of care (Act)
- Nursing duties (Statutory Guidance)
- Delegation (Act & Statutory Guidance)
- Supervision (Act & Statutory Guidance)
- Direct Patient Care
- Indirect Patient Care

The working definitions agreed by the definition subgroup were shared with the participants at the workshops and a poll of the level of agreement with each definition was undertaken. Figure 1 sets out the level of agreement with each definition.

Figure 1 – level of agreement with each of the working definitions



The nursing duties definition was the most discussed definition. The term ‘nursing duties’ is difficult to define as those duties that are routinely undertaken by a nurse continues to grow. Furthermore, some aspects of care traditionally undertaken by a registered nurse, have been assigned to others (e.g. staff now undertake administrative tasks previously undertaken by nurses, and the administration of medicines can be undertaken by/delegated to a pharmacy technician). This demonstrates how the ‘traditional role’ of the nurses is constantly evolving and emphasizes the need to delegate aspects of the role to enable nurses to deliver care that only they have the skills to provide. The working definition discussed at the engagement workshops referred to aspects of care (e.g. IV drug administration) that would have been undertaken solely by nurses, however, these aspects of care are now being undertaken by other members of the MDT (if appropriately trained), which was a point raised at both engagement workshops. In January 2024, the Royal College of Nursing (RCN) released a definition on nursing and the definition included below reflects the RCN (2024) definition.

The engagement workshops discussion recognised that agreeing definitions across one professional group is often a challenge, let alone agreeing definitions across more than one professional group. There has been work undertaken by allied health professional groups to define key terms, but getting a consensus has proved difficult, with no formal definitions yet signed off.

The subgroup reflected on the feedback from the engagement events and the following are the definitions agreed by the working group in the context of this work.

- Multi-professional working is defined as *a group of individuals across health, social care, independent and third sector, working together in a professional way as equal partners to ensure effective and smooth coordination in the delivery of person-centred care and support. Individuals working in this way may belong to separate professional groups, organisations, or different disciplines within a professional group. Individuals who work in a multi professional way may be located in a variety of bases/or organisations or co-located. The use of technology may be critical in ensuring individuals working in this way are able to develop a shared understanding of each other’s roles, skills, and purpose in providing wrap around care for the person* (This is based on the definition in the Multi-Professional Framework for Integrated Working, 2023).
- Team around the person is *the delivery of effective, safe, holistic, person-centred care that uses the knowledge, skills, and competence of a multi-professional team as well as family and*

community support networks to achieve optimum experience, outcomes, and safety for the individual. It aims to deliver the right care, in the right place, delivered by people with the right skills, based on a good understanding of the individual's needs and what matters to them. The provision of this care may consist of direct and indirect care.

- *Provision of Care is care provided to an individual which assists the person with activities of daily living (such as dressing, toileting, nutrition, hydration) enabling a person to live as independently as possible. Care provided may be direct or indirect and by different members of the multi professional team.*
- *Nursing Duties consists of many specialised and complex interventions. Their vigilance is critical to the safety of people in their care using decision-making skills and their professional and clinical judgement in the prevention of avoidable harm and the management of risks regardless of the location or situation. Working alongside the multi-disciplinary team (MDT), and delegating tasks to others, in line with the NMC code (RCN, 2024).*
- *Delegation is the process by which the delegator allocates clinical or non-clinical care and support to a competent person (the delegatee). The delegator will remain responsible for the overall management of the individual, and accountable for their decision to delegate. The delegator will not be accountable for the decisions and actions of the delegatee. (All Wales guidelines for delegation, 2020, page 10)*
- *Supervision is the level of support to those who you delegate work to; this can be through reflection or observing the individuals undertaking a task to ensure they are competent to carry out the task under indirect supervision. (Health & Care Professions Council (HCPC), 2021). The NMC "Future nurse: standards of proficiency for registered nurses" (2018) references effective supervision, teaching, and performance appraisal through the use of "clear instructions and explanations when supervising, teaching or appraising others" (4.1.1) and "clear instructions and check understanding when delegating care responsibilities to others" (4.1.2).*
- *Direct patient care is any intervention delivered by members of the multi-professional team relating to an individual's care or treatment that involves face-to-face or remote contact with the person or their care network (family, formal or informal carers). Direct patient activity helps inform future care delivery.*
- *Indirect patient care is any activity undertaken by members of the multi-professional team relating to an individual's care or treatment that does not involve direct contact with that person or their care network (family, formal or informal carers). Examples of this are contact with members of the multidisciplinary team, completion of referrals, handover or completion of documentation.*

Recommendation:

- Adopt the definitions set out above to the key statements referenced in the Act and the Statutory Guidance to ensure consistency and a 'Once for Wales' interpretation.

Assessment of the impact of the Act on multi-professional workforce model

Of the respondents to the questionnaire,

- 59% felt that the Act has had impact on multi professional workforce model, although not necessarily a positive impact (23% stating a positive impact, 5% stating a negative impact, and 31% stating both a positive and negative impact).
- 16% stated that there had been no impact, and
- 25% were unsure.

It is evident that the Act has had a positive impact in raising the profile of nursing, empowering nurses and highlighting the importance of ensuring appropriate nurse staffing levels. One respondent noted that the Act *“ensures patients’ needs are put first. Makes best use of staff skill set,”* whilst another stated the Act has had a positive impact as it *“ensures that there are always correct staffing levels according to the quantity of patients on the ward, this in turn enables us to do our jobs to the best of our ability”*.

The Act requires Health Board/NHS Trusts to calculate the *“number of nurses appropriate to provide care to patients that meets all reasonable requirements in the relevant situation”*. *“In calculating the nurse staffing level, account can also be taken of nursing duties that are undertaken under the supervision of or delegated to another person by a registered nurse (paragraph 4, Statutory Guidance, 2021)*. In 2018, when section 25B came into force, nursing teams in acute adult medical and surgical wards across Wales had a relatively consistent workforce of band 5, 6 and 7 Registered Nurses (RN) and band 2 Health Care Support Workers (HCSW). In preparation for the Act coming into force in 2018, and following extensive work, the All Wales Nurse Staffing Group issued guidance on interpreting the requirements set out in the Act and Statutory Guidance. This guidance stated that in its strictest terms, the definition of *“a person, other than a nurse acting under the supervision of, of or discharging duties delegated to the person by a nurse”* (Nurse Staffing Levels (Wales) Act 2016, S25A (6a), would only include the traditional Health Care Support Worker (HCSW) (Band 2). This was to ensure Health Boards/NHS Trusts followed a consistent, ‘Once for Wales’ approach.

Since the introduction of the Act in 2018, and to enable HBs/Trusts to demonstrate their compliance with the requirements of the Act, nursing teams on adult medical and surgical wards (and paediatric wards since October 2021) have developed different nursing workforce models; with a wide range of unregistered nursing roles developed, to whom nursing tasks can be delegated. In adult inpatient wards there are assistant practitioners, frailty workers, wards assistants, and rehabilitation support workers and within paediatric wards, play workers. Examples include the Core Care Model, developed, and implemented within ABUHB and the Team around the Patient model of Care within HDUHB (Hywel Dda University Health Board) (Walsby et al., 2023). These nursing roles are part of the nursing structure and, they work under the delegation of a nurse to support the delivery of care (although in some cases they can be delegated tasks from other professional groups e.g. physiotherapy, occupational therapy, and dietetics, although in theory they would be excluded from the restrictive interpretation of the legislation agreed in 2018. They are included on ward rosters for the purpose of operational delivery as they work exclusively on the ward.

In theory, the restrictive interpretation of the legislation agreed in 2018 i.e. the nurse staffing levels only includes Registered Nurses and Band 2 HCSWs means that any new nursing roles that sit under the nursing structure (e.g. Assistant Practitioner roles) would not be included in the nurse staffing calculation. These roles would also not be included in the planned roster and required establishment reported to Welsh Government, even though they play a vital role in the delivery of patient care. However, based on the findings of the scoping exercise undertaken, there is some variation between Health Boards/NHS Trust, in terms of which roles are considered as part of the

calculation and included within the planned roster and required establishment.

The fact that the legislation is uni-professional (nursing) has not deterred Health Boards/NHS Trust from developing and implementing multi-professional working. However, an unintended consequence of the legislation is that there is a belief that there is not the same level of priority or recognition given to the contribution, and the staffing requirements, of other members of the multi-professional team. The feedback from the engagement workshops echoed the comments made by the respondents to the questionnaire. The participants felt that although the Act had a positive impact on improving capacity for nursing teams to

deliver sensitive and high-quality care, there was some concern that this was sometimes at the detriment to staffing levels in other professions. The feedback at the engagement events also suggest that the contribution of the multi-professional team is not always considered on a wider level. Participants noted that the staffing discussions within organisations, e.g. managing winter pressures, tend to focus on the additional nursing and medical resources required with the additional therapies and pharmacy resources required not being considered as part of the discussion.

There was clear agreement from those at the engagement events that multi-professional working was not about substituting one profession for another, or filling gaps in a roster, but about improving safety and effectiveness and patient care by maximising the opportunities of the knowledge and skills that different professions contributed to the team.

The Act applies only to the nursing profession, however, within the Statutory Guidance and the Operational Guidance for both adult and paediatrics, there is recognition that when calculating the nurse staffing level for a ward, there needs to be consideration given to:

- The multi professional team dynamics (paragraph 38 (iv))
- The extent to which the nurses providing care are required to undertake administrative functions (paragraph 38 (ix)) and

As nurse staffing is now in a formal act it is given priority and limits the opportunities for transformation around wider HCP (Health Care Professionals) workforce.”

The Act “encourages 'silos' working and take the focus off multi-professional team working. More often than not, the concentration is on ensuring that the minimum nursing staff numbers are met, with less consideration to other members of the team, and their contribution to patients/service users' holistic care.”

“The (Act) feels exclusive and focused on one professional group, which in turn is not reflective of a multi professional workforce model.”

- Services or care provided to patients by other health professionals or other staff (for example health care support workers) and their qualifications, competencies, skills, and experience, in relation to the care that needs to be given, and the requirement for registered nurses to support, delegate and supervise. For example, the service of food and drinks, and the one-to-one supervision of patients (paragraph 38 (vii)).

Members of the multi-professional team who deliver direct patient care are not currently included within the nurse staffing level calculation, as they do not generally work under the supervision/delegation of a registered nurse (e.g. dietician, doctors, occupational therapist, physiotherapist, and pharmacy teams). In the main, health professionals are line managed by, accountable to, and worked under the delegation of their professional lead. Although there are examples where other health professionals (whilst still being aligned to their professional group) are line managed by nurses and vice versa. Achieving the vision set out in *A Healthier Wales (2018)* is reliant upon working across traditional professional and organisational boundaries to deliver high quality seamless care, maximising skills, and exploring new roles and ways of working to meet the holistic needs of the patient/ person.

“We are asked the question what multi professional teams do we work alongside on the ward”

“The agreed Nurse Staffing Levels give no consideration for the MDT on duty. Whilst the ward area can be safe due to the presence of the MDT, the MDT are not included in the recording of the achieved staffing levels”

“At present (The Act) only takes into account the direct staffing of the ward and other services e.g. therapies, pharmacy are excluded - including all of the input areas to the ward would allow for standardisation across services”.

“High level of agency staff (in nursing) who are not familiar with the area ...Competent band 4 nurse practitioners and AHP who are familiar with the areas would be a better fit”.

The definition of ‘required establishment’ set out in the Statutory Guidance (2021) is *“the total number of staff to provide sufficient resource to deploy a planned roster (determined using the triangulated method in section 25C) that will enable nurses to provide care to patients that meets all reasonable requirements in the relevant situation”*. Supernumerary staff, such as the ward manager, are not included in the planned roster. It could be argued that members of the multi-professional team who work across several wards and follow the patient pathway rather than work on one dedicated ward are deemed to be ‘supernumerary’ to the planned roster of the wards where Section 25B applied (under the current interpretation of supernumerary). This would mean they would not be included under the planned roster.

Organisations should use their professional judgement to take into account the contribution made by the multi-professional team. However, the feedback at the engagement events suggest that the contribution of the multi-professional team is not always being considered when the nurse staffing levels are being calculated (only 12% of the respondents indicated that the multi-professional team is considered when determining the nurse staffing level).

It is not clear why the contribution made by the multi-professional team is not considered when calculating the nurse staffing levels on wards where Section 25B of the Act applies. Further work is required to ensure that the existing processes for calculating the nurse staffing levels on wards where Section 25B of the Act applies takes account of the contribution made by the multi-professional team. The wording within the operational guidance and the supporting documentation (for both adult and paediatric wards) may need to be reviewed and consideration given to strengthening the references to taking account of the multi-professional team.

Recommendation: To ensure consistency in application and reporting across NHS Wales,

- There is a need to revisit the interpretation agreed in 2018 on the definition of what “a person, other than a nurse acting under the supervision of, of or discharging duties delegated to the person by a nurse”; with the aim of agreeing an interpretation that is reflective of the current nursing workforce., and
- Consideration needs to be given as to whether “a person, other than a nurse acting under the supervision of, or discharging duties delegated to the person by a nurse” should include members of the multi-professional team.
- Ensure that the existing processes for calculating the nurse staffing levels on wards where Section 25B of the Act applies takes account of the contribution made by the multi-professional team.

Reviewing the current interpretation would provide an opportunity to consider whether there are any additional roles, other than Registered Nurses and HCSWs (Band 2), that should be included within the nurse staffing level, i.e. the “*required establishment and the planned roster*” (paragraph 4, *Statutory Guidance, 2021*). The inclusion of the other roles would provide a more comprehensive picture of the workforce that is required and deployed. This would provide a greater level of assurance that Health Boards/NHS Trusts are ensuring that the wards have the right number and skill mix of appropriate staff, be those nurses or others, to meet the needs of patients.

The impact of multi-professional workforce models on the Act:

The understanding of what multi professional workforce models are varied between the participants at the engagement workshops, with participants stating that terms such as multi-disciplinary or interdisciplinary were more widely used and understood. Some of the models described are nursing teams with additional nursing roles, whilst other are models made up of multiple professional groups.

There are examples in the literature of multi-professional/multidisciplinary team working being integral to the implementation of appropriate patient centred care in a variety of clinical settings (Ellis & Sevdalis, 2019; Rossell et al., 2022). The majority of the examples put forward at the engagement events of good multi-professional working and agreement that multi-professional working models had a positive impact on patient care, were in areas where Section 25A of the Act applies. Examples included the poly-trauma unit in the Major Trauma centre in Cardiff, a ward where Section 25B of the Act applies and stroke rehabilitation, complex discharge planning (with Velindre cited as a good example); and the Frailty Front Door Team in Bronglais General Hospital, areas where Section 25A of the Act applies. The impact of the Act on multi-professional workforce models and vice versa for areas where Section 25A of the Act applies is phase 2 and phase 3 of the working group’s programme of work.

“There are examples of this (multi-professional) workforce within many clinical teams, however those co located which evolved within a defined part of the pathway appear to function well with clear lines of accountability and purpose. These models work best where there is a clear vision and accountability. Integrated teams with a shared budget & ways of working avoids barriers and conflict too”

Working together (across professions) to provided patient centre care and planning safe and timely discharges.”

“MDT workforce model is used on a daily basis for all patient care, family care/support matters affecting the IPU in general; a weekly formal MDT meeting involving nurses, doctors, consultants, OT, PT, chaplaincy, patient flow”

Although it was widely agreed that multi-professional working has a positive impact on the quality of patient care in inpatient settings, it was felt that where

multi-professional workforce models have been implemented the Act had not been explicitly considered. An explanation for this might be because the multi-professional workforce models referenced have been implemented mainly in areas where Section 25B of the Act does not apply. All participants were in support of strengthening opportunities for multi-professional working and valued the opportunity to participate in this work.

It is evident that there are many barriers to improving multi-professional working, some of which may have implications on how the Act is applied. These include:

- Lack of understanding of the contribution of each professional group.
- Separate documentation – it was noted that some professional groups are using the Welsh Nursing Care Record (WNCR) in some areas, but that this was as well as their own profession's documentation and there was a need for one multi-professional electronic document.
- Current management and leadership structures, with each professional group having their own hierarchy of line management, which can lead to teams working in silos and addressing their profession's priorities rather than working together to meet the priorities of patients.
- Existing pathways to registration (for example apprenticeship and grow your own models) tend to be focused on nursing.
- The lack of nationally agreed/mandated staffing principles/standards for other members of the multi-professional team – there are some nationally agreed multi-professional staffing principles/standards for some specialties e.g. national clinical guidelines for stroke but the availability of agreed staffing standards across more general services is limited.
- Different rostering practice - Inpatient wards, where Section 25B of the Act applies, operate 24 hours, seven day a week rosters, whilst members of the multi-professional team generally operate five day working week rosters with on-call arrangements for some professional groups. The staff on the inpatient wards are usually exclusively based on that ward (although there may be occasions, they are deployed to another ward for that shift) whilst members of the wider multi-professional teamwork work across several clinical areas.
- Use of bank and agency staff - There are established processes in place to cover both short- and longer-term staffing deficits within nursing, through bank and agency staff, which is not the case for other professional groups, and
- The financing of the professional groups – budgetary factors can limit the opportunities for multi-professional working.

However, there was agreement that there is value in continuing to improve opportunities and effectiveness of multi-professional working and the opportunities included:

- Learning from existing examples of 'good' multi-professional workforce models.
- Improving understanding of different professions knowledge, skills, roles, and responsibilities
- Developing multi-professional leadership and management structures, workforce planning tools and joint electronic documentation systems with shared aims.
- Develop multi-professional workforce models based on the needs of the patients and taking into account the acuity/specialty of the ward.

The themes that emerged during the discussion, on how to maximise the potential for implementing multi-professional workforce model, which reflect the themes included in the Development Matrix for Multi-Professional Working (June 2023) developed as part of the multi-professional framework for integrated working (2023), included:

- The need for strong leadership, with common aims and effective communication, joint documentation, and co-location of the multi-professional team on the ward.
- The need for a clearer understanding of multi-professional workforce model, professional roles and the specific knowledge and skills that each profession can contribute. Multi-professional workforce models are about professions better supporting each other to deliver person centred care and not replacing them. One size does not fit all areas and there will be a need for different models in different clinical settings, depending on acuity and speciality of specific wards.
- There is a need to build on the examples of multi-professional workforce model that work well (both in Wales and elsewhere).
- The implementation of multi-professional workforce models requires multi-professional management structures, including joint funding schemes, rostering, and equity in use of bank and agency staff.

Implementation of multi-professional workforce models needs careful planning, with tools developed to support it. The implementation of multi-professional workforce models is not role or profession substitution, they support other professions and cannot replace them. Nursing teams on inpatient wards work exclusively on that ward, whilst allied health professionals work across several wards/clinical settings and there is not existing capacity in many parts of the workforce to fully implement multi-professional workforce models, with AHPs (Allied Health Professions) being rostered in the same way as nursing staff. It is easier to implement multi-professional workforce models in new services as they are set up, than in well-established services with a more medical model.

NHS Scotland's Health and Care Act (2019) comes into force in April 2024. The Act differs to the Act in Wales, as it applies to all those involved in care of the individual, not just nursing staff. The Act refers to two groups of staff, those involved in direct care and those involved in allied services such as maintenance and housekeeping. The Act also requires local authorities to report on planning and securing services. Their approach has been to look at multi-professional tools from the outset. They achieve this by using 'common staffing method' in all areas where there are workforce and workload planning tools set out in legislation. Currently this includes nursing staff apart from emergency departments where medical staff are included. This whole system approach is more in keeping with the multi-professional workforce team models of today.

Recommendations:

- Consider using the [Development Matrix](#) developed as part of the Multi Professional framework for Integrated working to help support the understanding of people and barriers/enablers to implementing multi-professional workforce models in settings other than community services. Although the tool is focused on community services, the work is underpinned by an extensive literature scoping review, which has identified similar themes and consideration needs to be given to how the tool can be applied in other settings.
- Consider the work being undertaken by NHS Scotland and whether the multi-professional tools being developed and the 'common staffing method' and/or the principles underpinning these tools can be utilised in NHS Wales

Conclusion:

This paper has taken a first step to assessing the impact of the Nurse Staffing Levels (Wales) Act 2016 on the implementation of multi-professional workforce models and assessing the impact of multi-professional workforce models in inpatient (adult and paediatric wards) where Section 25B

applies. However, there is further work required. Whilst recognizing that this paper is based on the views of a small percentage of the multi professional team that would work across Section 25B wards, the key messages include:

- Implementing multi-professional workforce models is about supporting each other's professions not replacing one with another.
- There is a need for a strong, joined up leadership approach across all professions to multi-professional team working and workforce planning at national and organisational level.
- There is a need to improve understanding of the scope, skills, and capabilities of different health care professionals and what they can offer in different ward settings.
- All professions need a better understanding of the Act and what multi-professional working means for them.
- Whilst the Act has empowered nurses and ensured a focus on the nursing workforce, the unintended consequence is that there is a belief that the essential and complimentary contributions of other professional groups to direct care does not have the same level of priority.
- There is a need to embed multi-professional workforce planning within health boards/NHS trust to minimise variation in the workforce.
- The multi-professional workforce model depends on the clinical setting and the care needs of the people/patients within that setting.
- The need to extend the existing pathways to registration (apprenticeship, grow your own models) to other professional groups.
- There is a need to continue to develop integrated multi-professional team models within health boards/NHS trust whilst being mindful of each health board/NHS trusts statutory responsibilities under the Act.
- Standards need to be updated to keep pace with the evolving multi professional team around the patient to make best use of everyone's skills and provide safest, most flexible workforce models for NHS Wales

Recommendations:

The Executive Directors of Nursing are asked to

- note the content of this paper, and
- consider the recommendations included in this paper, and set out below:

Nursing:

- Agree that the group will now proceed with agreeing the work plan for phase 2 of the work i.e. assess the impact of the Act on multi-professional workforce models and vice versa in inpatient areas where Section 25A of the Act applies
- Agree that the relevant learning from this initial scoping work will be used to inform the refreshed work programme of the All-Wales Nurse Staffing Programme. With the aim of, presenting options on how the issue of the uni-professional nature of the Act vs the multi-professional nature of workforce planning can be overcome for wards where Section 25B wards applies.
- Consider whether a Task & Finish group should be set up to review the 2018 definition of what "*a person, other than a nurse acting under the supervision of, of or discharging duties delegated to the person by a nurse*"; with the aim of:
 - agreeing an interpretation that is reflective of the current nursing workforce, and
 - consider the inclusion of multi-professional roles that are required.
- Agree that the existing processes by which health board/trusts consider the contribution of the multi-professional teams' input in calculating the nurse staffing levels on Section 25B wards are reviewed, with a view to strengthen these processes if required.
- Agreed to adopt the definitions set out in this report for the key statements referenced in the Act

and the Statutory Guidance to ensure consistency and a 'Once for Wales' interpretation.

Multi-professional

- Agree that this report can be shared with the All-Wales Multi-Professional Workforce Planning Task & Finish Group so that the relevant learning can be used to inform the Task & Finish group's work programme
- Consider using the Development Matrix for Multi professional working to implementing multi-professional workforce models in settings other than community services.
- Consider the work being undertaken by NHS Scotland and whether the multi-professional tools being developed and the 'common staffing method' and/or the principles underpinning these tools can be utilised in NHS Wales.

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Annex 1 - Assess the impact of new multi-professional team workforce models on implementation of the Nurse Staffing Levels (Wales) Act Working Group

Member	Title	Organisation
Helen Humphreys,	Head of Nursing, Professional Standards and Nursing Regulation	HDUHB (chair)
Emma Davies	Nurse Staffing Programme Lead	CVUHB (vice chair)
Joanna Doyle	Associate Director/ Head of All Wales Nurse Staffing Programme (July-September 2023)	HEIW
Julie Flower	Nurse Staffing Programme Lead (October 2023 to March 2024)	HEIW
Michelle Price	All-Wales Lead for Person-Centred Rehabilitation	HEIW
Jamiee Barnes	Clinical Lead for urgent primary care	HEIW
Kate Jones	AHP Lead for South Wales Trauma Network	CVUHB
Michele Sehwat	Head of Pharmacy workforce planning	HEIW
Chiquita Cusens	National Lead Nurse for Primary and Community Care	Strategic Programme for Primary Care
Kerrie Phipps	National AHP Lead for Primary and Community Care	Strategic Programme for Primary Care
Lesley Jenkins	Associate Nurse Director	SBUHB
Louise Leach	Programme manager AHP	HEIW
Nicky Thomas	Interim associate director AHP	HEIW
Helen Annandale	Clinical Director of Therapies and Audiology	SBUHB
Siobhan Pearce	Therapies	Velindre
Colin Gibson	Rehabilitation Engineering	CVUHB
Rebecca Boore	Design and Development Manager Strategic Perinatal Workforce Plan	HEIW
Laura Thompson	Nurse Staffing Lead	ABUHB
Jo Brown	Nurse Staffing Lead	BCUHB
Emma McGowan	Nurse Staffing Lead	Powys TUHB
Catrin Jones	Nurse Staffing Lead	HDUHB
Tanya Tye	Nurse Staffing Lead	CTMUHB
Rhian Wright	Nurse Staffing Lead	Velindre

Cath Morgan Edwards	Nurse Staffing Lead	SBUHB
Hywel Williams	Policy Lead	Welsh Government

Annex 2 – Breakdown of results from the questionnaire

Figure 1 Breakdown of professional groups. NB: Pharmacy staff are included within the Additional Professional Scientific & Technical staff group

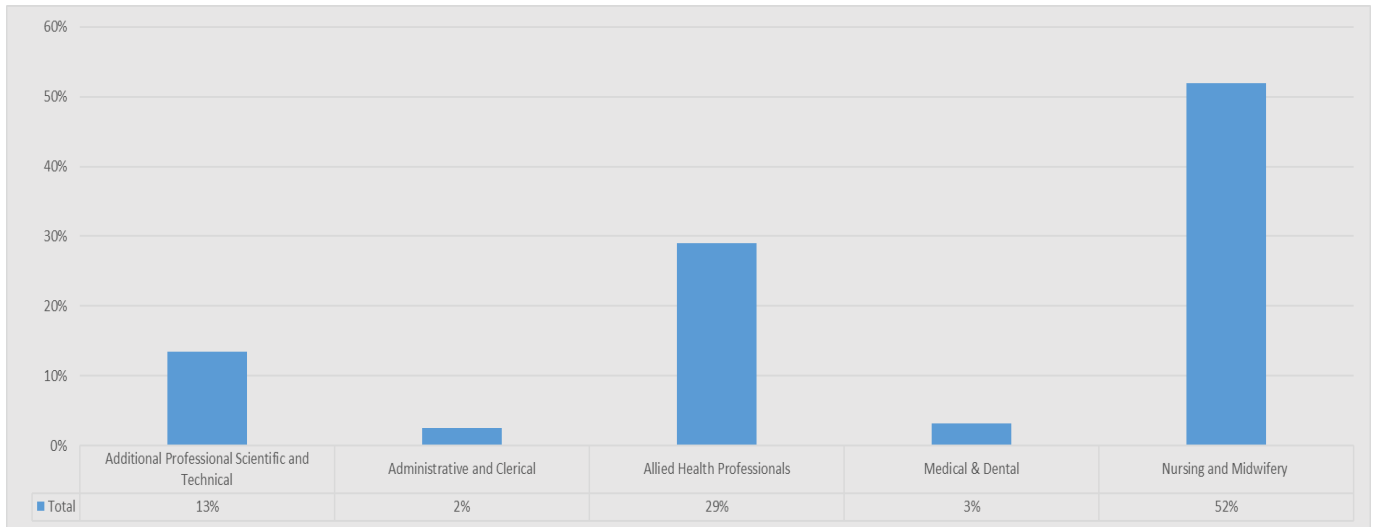


Figure 2: Breakdown of respondents by participating Health Board/Trust

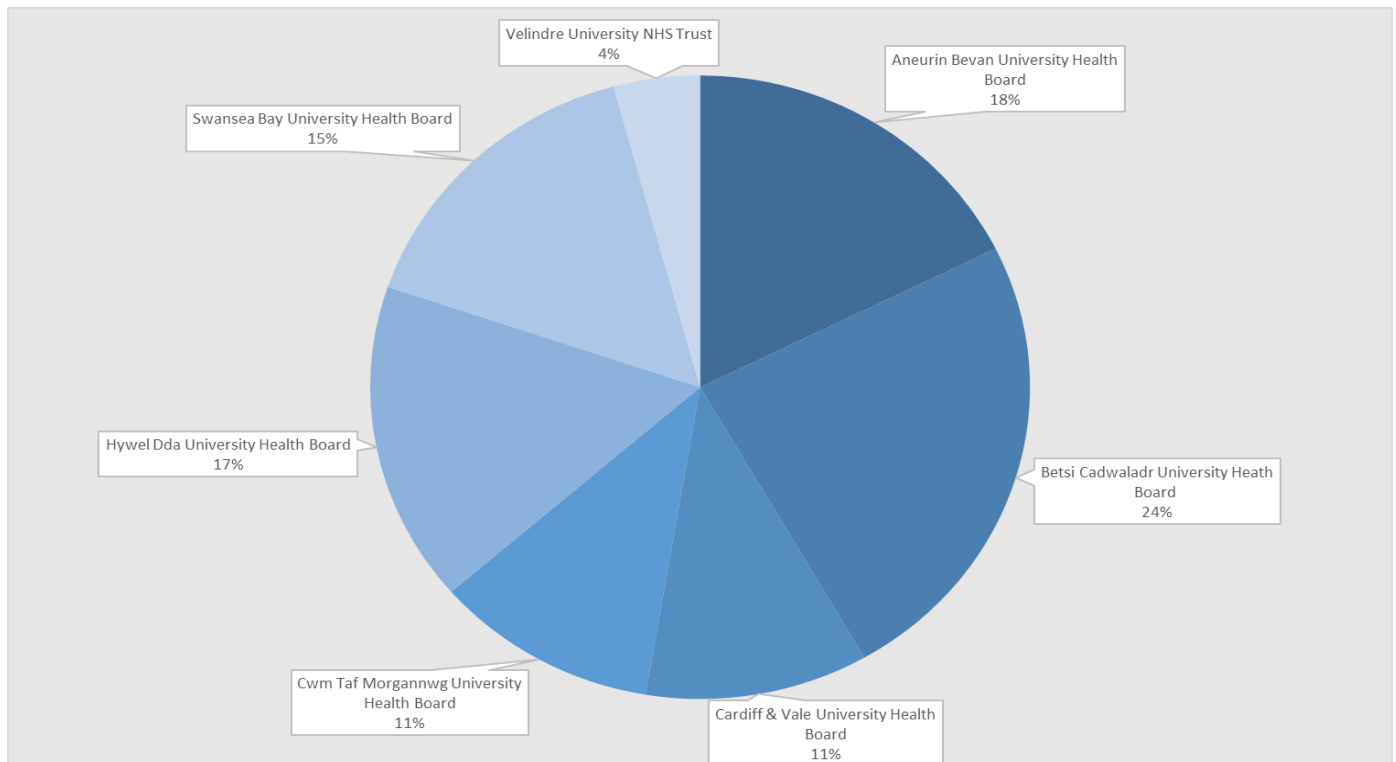


Figure 3: number of respondents per question

- Q1 Which Health Board or NHS Trusts do you work for? Completed by all (283 respondents)
- Q2 What professional group do you belong to? Completed by all (283 respondents)
- Q3 Please select your area of practice. Applicable to Nursing & Midwifery registrants only (140 respondents)
- Q4 What is the title of your role? Completed by all (283 respondents)
- Q5 Which service/area of work do you predominantly work in? Applicable to Nursing & Midwifery registered and unregistered staff only. If working within Section 25B area can proceed, if not questionnaire ends (154 respondents)
- Q6 Do you work within any of the following areas? Completed by all who remain after Q5 (244 respondents)
- Q7 Do you utilise multi-professional team workforce models within the area where you predominantly work? Completed by all who remain after Q5 (244 respondents)
- Q8 Please describe the use of multi-professional workforce models within the area where you predominantly work. Completed by only those that responded YES to Q7 (157 respondents)
- Q9 When the nurse staffing level is determined / calculated, are members of the multi-professional team taken into account within the area where you predominantly work? Completed by only those that responded Yes to Q7 (157 respondents)
- Q10 When the nurse staffing level is determined / calculated HOW are members of the multi-professional team taken into account? Completed by only those that responded YES to Q7 & Q9 (19 respondents)
- Q11 Are you aware of the Nurse Staffing Levels (Wales) Act? Completed by all remaining after Q5. If answered NO questionnaire ends (244 respondents)
- Q12 Do you think that the Nurse Staffing Levels (Wales) Act impacts on the implementation of multi professional team workforce models? Completed by only those that responded YES to Q11 (153 respondents)
- Q13 Provide justification for your answer above. Completed by only those that responded YES to Q11 (153 respondents)

Figure 4 Breakdown by professional groups for the responses to the question “Do you utilise Multi-Professional Workforce Models within your area of work?”

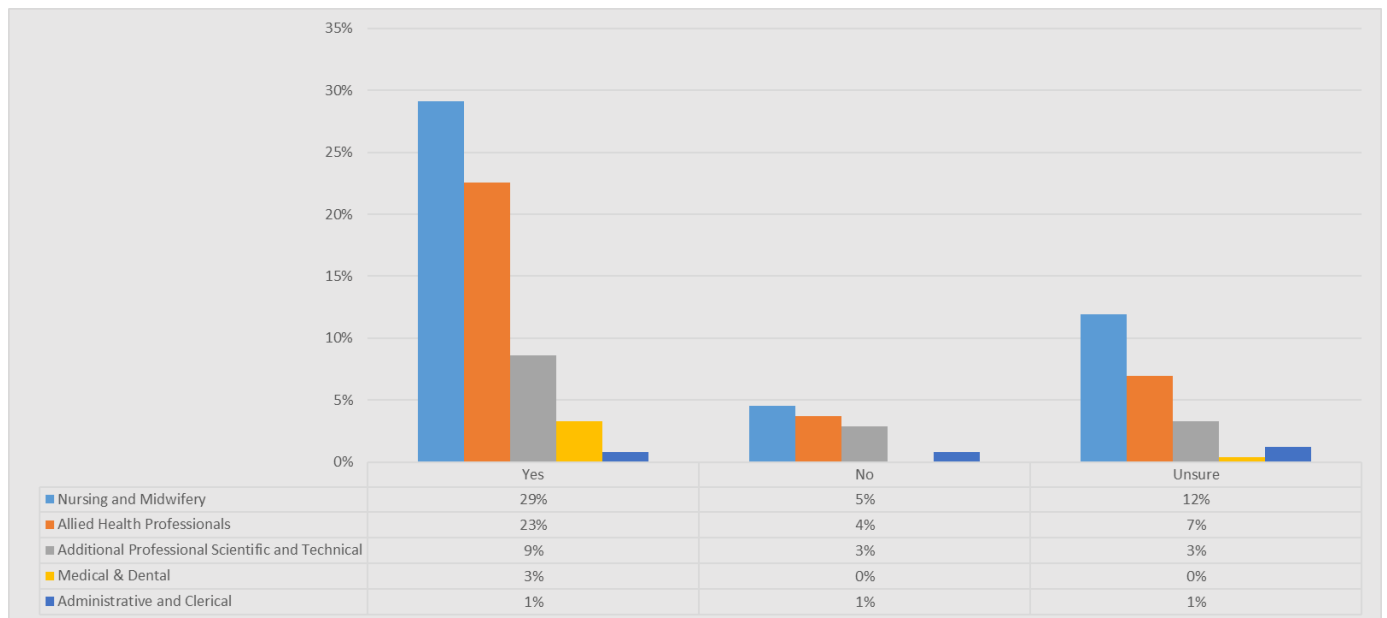


Figure 5 breakdown by professional group for the responses to the question “Are the Multi-

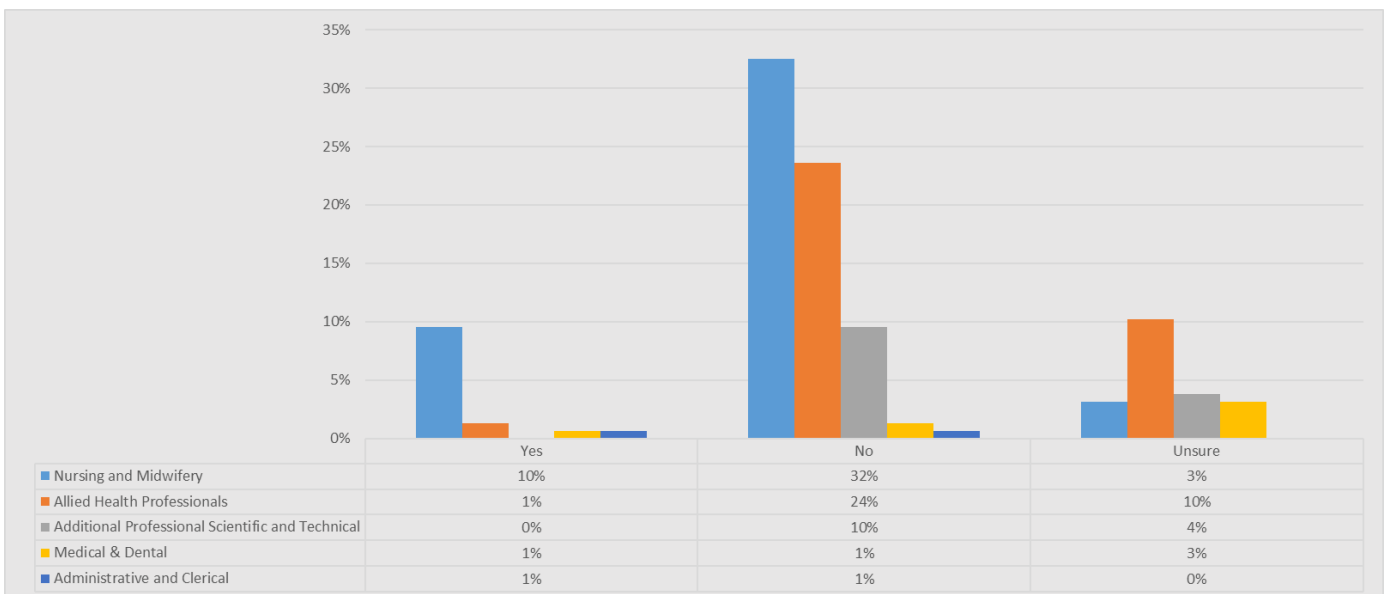


Figure 6 breakdown by professional groups for the responses to the question Are you aware of the Nurse Staffing Levels (Wales) Act 2016.

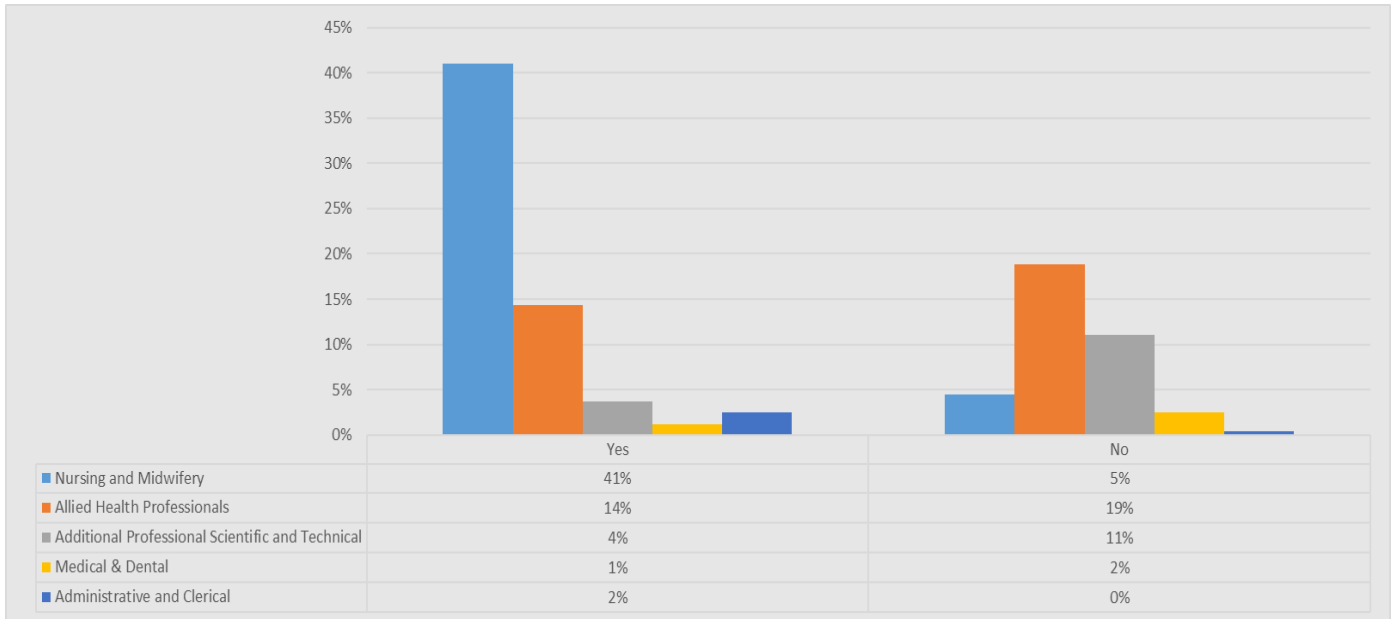


Figure 7 breakdown of responses to the question “Do you think the Act has impacted on Multi-Professional Workforce Models?”

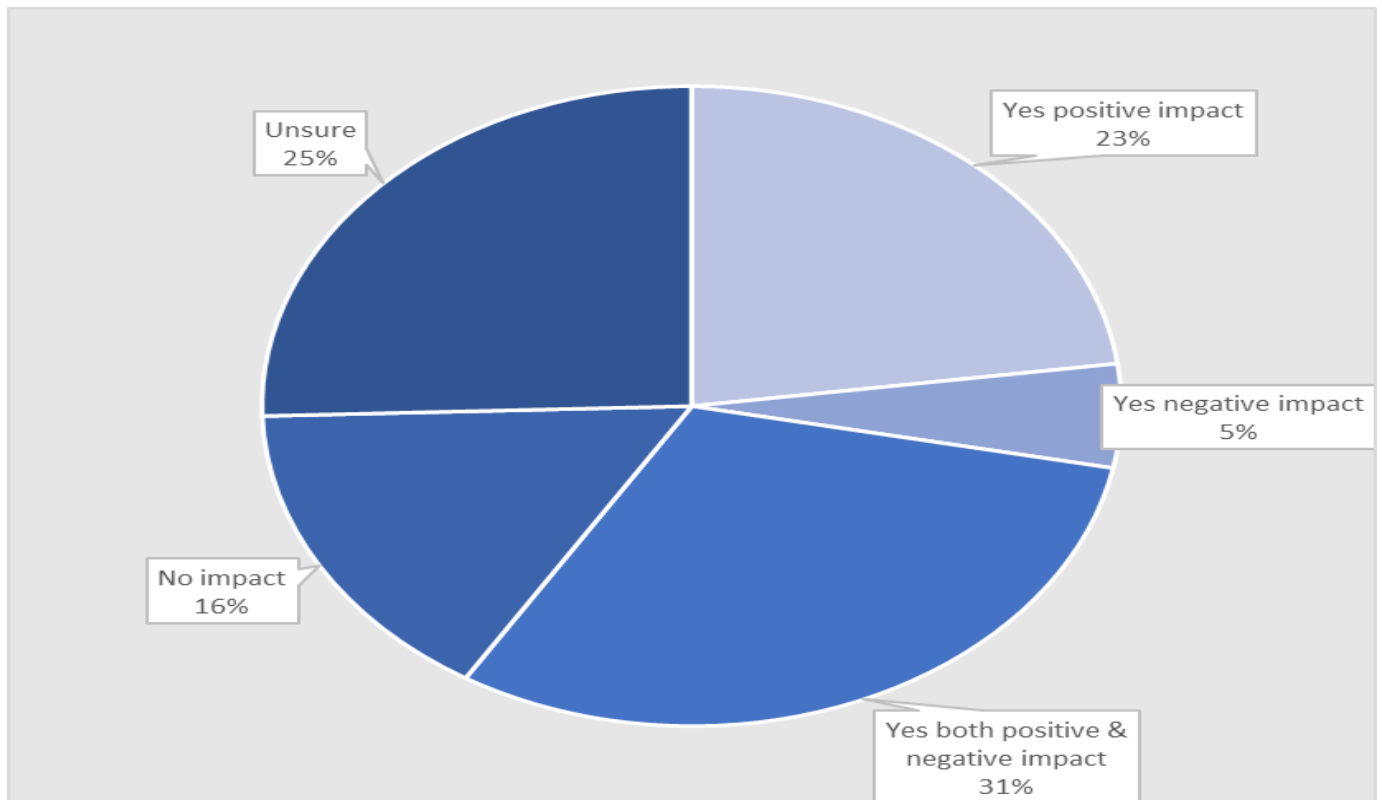
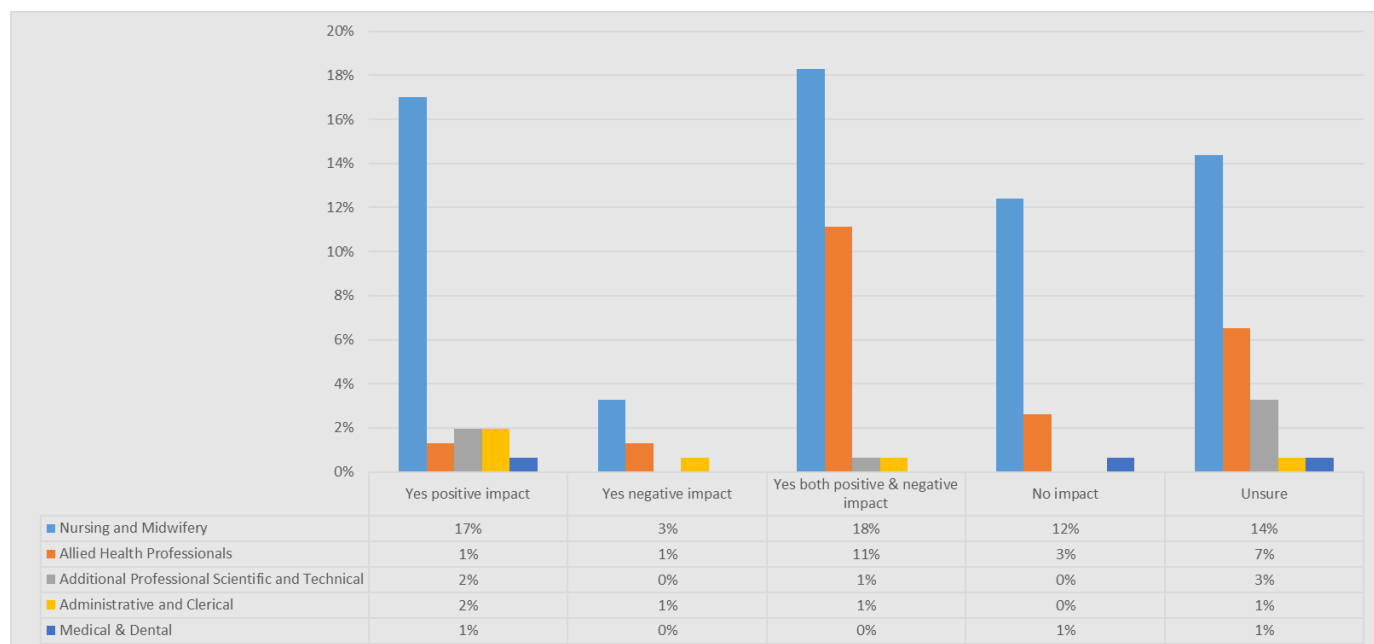


Figure 8 breakdown by professional groups to the question “Do you think the Act has impacted on

Multi-Professional Workforce Models?"



Phase 2 report (March 2026)

Introduction:

A Healthier Wales (2018) sets the vision for delivering care closer to home through a multi professional, multi-agency “team around the patient” model with an emphasis on breaking down traditional professional and organisational boundaries to deliver seamless, high-quality care, maximising existing skills and exploring new roles and ways of working to meet holistic patient needs.

The HEIW Workforce Strategy (2020) states that by 2030, multi professional and multi-agency workforce models will be the norm across health and social care.

The Chief Nursing Officer for Wales’ Priorities (2022–2024) endorsed a future nursing model grounded in multi-disciplinary working and emphasises the importance of embedding the nursing voice within multi professional teams.

The more recently published CNO Strategic Vision for Nursing and Midwifery (2025-2030) includes “Innovation in care and workforce models” as a distinct theme. It sets the ambition that *“In 2030, nurses and midwives drive transformation, implementing agile, multi-professional models that maximise expertise, embed digital and technological fluency and improve outcomes.”*

The Nurse Staffing Levels (Wales) Act 2016 (‘the 2016 Act’) requires Health Boards/NHS Trusts to ensure appropriate nurse staffing levels in both direct and commissioned services.

As the powers of the 2016 Act only extend to *nursing* staff, multi-professional roles are not included within the nurse staffing levels, (the planned roster and the required establishment). However, the Act does recognise that nurses work as part of wider multi-professional teams and Health Boards/NHS Trusts must *take into account* the presence and contribution of the wider multi-professional team and other healthcare professionals in the delivery of patient care and consider the potential impact of their absence on the duties required of the ward nursing team to ensure the provision of safe, effective, and compassionate care.

It is crucial therefore to establish clarity around the use of the words *included* and *considered* within the context of the nurse staffing calculation process.

Staff *included* within a nurse staffing levels calculation can only be registered nurses and the nursing/healthcare support workers to whom they have delegated nursing care duties. They will form the required establishment and the planned roster for each ward.

However, the impact of non-nursing staff on the delivery of patient care should be *considered* for each ward when undertaking the nurse staffing levels calculations.

Phase 1: In settings where section 25B of the 2016 Act applies: assess both the impact of multi professional team workforce models on implementation of the 2016 Act and conversely assess the impact of the Act on the implementation of existing and new multi professional team workforce models.

The Phase 1 report, produced in 2024, took an initial step in assessing the impact of the 2016 Act on the implementation of multi professional workforce models, and assessing the impact of these models in inpatient (adult and paediatric wards) where section 25B applies. However, the report concluded that further work was required for both nursing and the wider multi professional team. The recommendations made to Executive Directors of Nursing were:

Recommendation	Outcome
<p>Agree that the group will now proceed with agreeing the work plan for Phase 2 of the work i.e. assess the impact of the Act on multi professional workforce models and vice versa in inpatient areas where section 25A of the Act applies.</p>	<p>The MDT and the Act Group, a subgroup of the All Wales Nurse Staffing Group, was established to oversee the Phase 2 work.</p>
<p>Agree that the relevant learning from this initial scoping work will be used to inform the refreshed work programme of the All-Wales Nurse Staffing Programme, with the aim of presenting options for addressing the challenge of overcoming the uni-professional nature of the Act versus the multiprofessional nature of workforce planning, particularly in wards where section 25B applies.</p>	<p>The relevant learning has informed the refreshed work programme of the All Wales Nurse Staffing Programme.</p>
<p>Consider whether a Task & Finish group should be established to review the 2018 definition of what <i>“a person, other than a nurse acting under the supervision of, of or discharging duties delegated to the person by a nurse”</i>: with the aim of:</p> <ul style="list-style-type: none"> ○ agreeing an interpretation that is reflective of the current nursing workforce, and ○ consider the inclusion of multi professional roles that are required. 	<p>This action has been included as an objective of the phase 2 work plan of the multi professional team and the Act subgroup.</p>
<p>Agree that the existing processes by which health board/trusts consider the contribution of the multi professional teams' input in calculating the nurse staffing levels on section 25B wards are reviewed, with a view to strengthen these processes if required.</p>	<p>This action has been included as an objective of the phase 2 work plan of the multi professional team and the Act subgroup.</p>
<p>Agreed to adopt the definitions set out in this report for the key statements referenced in the Act and the Statutory Guidance to ensure consistency and a ‘Once for Wales’ interpretation.</p>	<p>This action has been included as an objective of the phase 2 work plan of the multi professional team and the Act subgroup.</p>
<p>Consider the work being undertaken by NHS Scotland and whether the multi professional tools being developed and the ‘common staffing method’ and/or the principles underpinning these tools can be utilised in NHS Wales.</p>	<p>This action has been included as an objective of the Section 25A subgroup work plan.</p>
<p>Agree that this report can be shared with an All-Wales Multi professional Workforce Planning Task and Finish Group, so that the relevant learning can be used to inform the group’s work programme.</p>	<p>The Executive Directors of Nursing agreed that the report could be shared via the group members to their relevant professional groups.</p>

Effective care delivery depends on well-designed multidisciplinary teams (MDTs), where the right professionals work together, at the right time, with clarity of roles and shared accountability for outcomes. It is acknowledged therefore that workforce modelling must move beyond single-profession approaches and instead support integrated team-based care as the foundation of safe, high-quality services.

Given the specific focus and scope of this workstream (i.e. assessing the intersectional impacts of the 2016 Act on multi-professional team working and vice versa), it was acknowledged that a broader, more comprehensive, national workstream would be required to drive the development of sustainable multi-professional workforce planning and rostering models for NHS Wales.

To progress this agenda an All-Wales Multi professional Workforce Planning Task and Finish Group, co-chaired by the WG Director of W&OD and the CNO was established. That Task and Finish group has been in a period of temporary hiatus; however this report will be used to initiate its revival and recommence the wider work around multi-professional workforce modelling.

Phase 2: Strengthening Governance and Operational Alignment for wards where section 25B applies.

The aim of Phase 2 of the work programme has been to strengthen the governance and operational alignment for multi professional teams working in those wards where section 25B of the Act applies and reinforce the narrative within the section 25B operational guidance.

This has been achieved by:

- Reviewing the 2018 definition of what “*a person, other than a nurse acting under the supervision of, of or discharging duties delegated to the person by a nurse*” to ensure that the definition is contemporary, inclusive, and operationally relevant.
- Evaluating how we currently take account of “*the conditions in which care by a nurse is provided including multi-professional team dynamics*” (paragraph 28, iv of the statutory guidance); the “*services or care provided to patients by other health professionals or other staff*” (paragraph 28 vii) and “*the extent to which the nurses providing care are required to undertake administrative functions*” and identifying opportunities to strengthen and ensure a ‘Once for Wales’ approach.

Who do we currently *include* in the nurse staffing calculation?

A scoping exercise was undertaken with Nurse Staffing Operational Leads from Health Boards/NHS Trusts to ascertain which staff are currently included in the nurse staffing calculation and whether there was inconsistent application/understanding across Health Boards/Trusts. The scoping identified that, in practice, the nursing workforce included in the nurse staffing level calculation in each Health Board/Trust is:

- the number of registered nurses (those with a live registration on sub parts 1 or 2 of the Nursing and Midwifery Council register) (Band 5 and Band 6).
- the number of rostered Assistant Practitioners (Band 4).
- the number of Nursing Support Workers (Band 3).
- the number of Health Care Support Workers (Band 2).

It is noted that:

- **one Health Board included** dietetic assistants in its nurse staffing level calculations for some areas that **none of the other Health Boards/Trust** currently include. This highlights the need for a consistent, ‘Once for Wales’ approach to role inclusion.

- the ward manager is not included in the planned roster and the required establishment needed to deploy it; however, each ward will have a supernumerary ward manager.

Who do we *consider* and who should we not *consider* when we calculate the nurse staffing levels?

In accordance with the Nurse Staffing Levels (Wales) Act 2016, multi professional roles cannot be *included* within the nurse staffing level calculation (the planned roster and the required establishment). However, the impact of non-nursing staff on the delivery of patient care should be *considered* for each ward when undertaking the nurse staffing levels calculations. This means both a) the positive impact due to the presence and contribution of the multi-professional team members and b) the negative impact due to the lack of multi-professional team members may have on the duties the ward nursing team will need to undertake to ensure the provision of appropriate patient care.

For example, the nurse staffing requirements on acute stroke Ward A with three consistently resident physiotherapy staff would be considered differently to stroke Ward B with only one physiotherapist attached. The smaller multi-professional establishment on Ward B may result in nursing staff regularly assuming additional responsibilities relating to patient mobilisation and rehabilitation, which would be supported by the specialist colleagues in Ward A.

The contribution of the multi professional team and other health professionals should form part of the nurse staffing calculation discussion and should inform the nursing workforce required for that ward. A workshop was conducted with the Nurse Staffing Operational Leads from Health Boards/NHS Trusts and members of the All-Wales Nurse Staffing Group to explore. While the focus of the workshop was on wards where section 25B of the Act applies, some participants represented areas where section 25A of the Act applies.

The two questions considered were:

- which roles should we take account of when calculating the nurse staffing levels?
- which roles should we not take account of when we calculate the nurse staffing levels?

Feedback from the workshop has been used as the basis of the principles outlined in the information to be included in the operational guidance document, as a new section titled ***Multi Professional Team and Other Health Professionals to be Considered*** (see Appendix 1).

The information set out in Appendix 1 has been circulated to the Nurse Staffing Programme Leads who are not members of the subgroup, for comments.

Recommendations:

The Executive Directors of Nursing are asked to:

- Note the content of this paper.
- Agree that the information included in Annex 1 will be incorporated into section 25B of the Operational Guidance.
- Agree that the information set out in the report can be shared with the Senedd Committee as part of the update.
- Note that the information in Annex 1 will inform the content required for inclusion in the section 25A Operational Guidance, specifically regarding considerations from a multi professional perspective for section 25A areas. This action will form part of the S25A Subgroup work programme.
- Note that the Multi Professional Team and the Act Subgroup has completed the actions set out in its work programme and will be stood down. (The chair of the All-Wales Group can request for the group to be reconvened if further work falling within its remit is identified).

Annex 1: clarifying narrative to be inserted into revised operational guidance

(To be inserted in main body of operational guidance under 'calculating nurse staffing level' section):

Who is *included* in the nurse staffing level calculation?

The designated person must calculate the *nursing workforce* appropriate to provide patient-centred care that meets all reasonable requirements in that situation.

In practice the nursing workforce means:

- the number of registered nurses (those with a live registration on sub parts 1 or 2 of the Nursing and Midwifery Council register) (Band 5 and Band 6)
- the number of rostered Assistant Practitioner (Band 4) (this will be superseded by the Registered Nursing Associate role once introduced in Wales)
- the number of Nursing Support Workers (Band 3)
- the number of Health Care Support Workers (Band 2).

The ward manager is not included in the planned roster and the required establishment needed to deploy it. However, each ward will have a supernumerary ward manager.

What roles should be *considered* when calculating the nurse staffing levels?

Nurse staffing should **not be planned in isolation** but rather **in the context of the whole multi professional team (and other health professionals) presence and capacity** to ensure that care is coordinated and patient-centred.

In accordance with the Nurse Staffing Levels (Wales) Act 2016, multi professional roles cannot be *included* within the nurse staffing level calculation (the planned roster and the required establishment). However, the impact of non-nursing staff on the delivery of patient care should be *considered* for each ward when undertaking the nurse staffing levels calculations. This means both a) the positive impact due to the presence and contribution of the multi-professional team members and b) the negative impact due to the lack of multi-professional team members may have on the duties the ward nursing team will need to undertake to ensure the provision of appropriate patient care.

For example, the nurse staffing requirements on acute stroke Ward A with three consistently resident physiotherapy staff would be considered differently to stroke Ward B with only one physiotherapist attached. The smaller multi-professional establishment on Ward B may result in nursing staff regularly assuming additional responsibilities relating to patient mobilisation and rehabilitation, which would be supported by the specialist colleagues in Ward A.

The contribution of the multi professional team and other health professionals should form part of the nurse staffing calculation discussion and inform the nursing workforce required for that ward.

In practice this could be prompted by the simple question *“how (if at all) has the multi-professional team changed on this ward in the 6 months since the last calculation and how might these changes positively or negatively impact the delivery of patient care?”*

For example, has a long-standing vacancy within the multi-professional team recently been filled, or conversely has a substantial post within the multi-professional team recently been vacated and defunded long term? The key points of any such considerations should be captured within the “Professional Judgement” narrative box of the calculation template at Appendix 6.

Multi professional working enhances care delivery through shared expertise, and relies on mutual respect and role clarity, ensuring that collaboration does not equate to substitution.

Principles:

When assessing the required nurse staffing establishment for a ward area, the team should:

1. Consider which members of the multi-professional team and other health professionals provide and support the delivery of care on the ward (this will vary from ward to ward, could change between 6-monthly calculations and is dependent on the nature of the care being provided).

The following are some of the roles that need to be considered but is not an exhaustive list.

- Allied health professionals, e.g. physiotherapists, occupational therapists, pharmacists etc.
 - Play specialist/nursery assistants
 - Practice development nurses
 - Advanced nurse practitioners/advanced clinical practitioners
 - Clinical nurse specialists
 - Support workers e.g. rehab, dementia, frailty, nutrition, discharge etc.
 - Hotel services including catering, cleaning and portering staff
 - Admin staff e.g. ward clerk, ward assistant etc.
2. Assess how consistently the multi professional team and other health professionals are available to contribute to and support patient care within the given care environment.
 3. Assess the impact on the nursing team when the multi professional team or other health professionals are limited or unavailable.
 4. Retain up-to-date knowledge of the multi-professional team make-up on each ward, and consider how changes to that team between 6-monthly nurse staffing calculations might influence your nurse staffing requirements.

The following table sets out some examples where the availability or unavailability of the multi professional team and other health professionals may increase or decrease the nursing team's workload (this is not an exhaustive list).

Multi professional team and other health professionals	Impact on nurse staffing if the role is available	Impact on nurse staffing if the role is unavailable
Hotel Services e.g. portering, catering and cleaning staff	Nurses are relieved of non-clinical transport duties (e.g., moving patients, specimens, equipment, timely meal provision), allowing them to focus on direct care.	Nurses may need to escort patients to diagnostics, theatre, or other departments, assist with meal distribution and cleaning tasks diverting time from direct patient care.
Play Specialists	Provide therapeutic play and emotional support tailored to developmental needs, enhancing child-centred care.	In paediatric settings, nurses may need to provide therapeutic play or emotional support without specialist training.
Administration and clerical e.g. ward clerks	Manage documentation, communication, and coordination tasks reducing the administrative burden on nurses.	Nurses may take on administrative tasks such as answering phones, managing patient records, and coordinating appointments.
Specialist	Provide targeted	Nurses may need to

nursing roles e.g. play specialist role, rehabilitation assistants, dietician assistant, discharge liaison nurses	interventions enhancing care delivery and coordination	coordinate discharge planning, nutritional assessments, or specialist interventions reducing time for other nursing duties.
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It is recognised that members of the multi-professional team have their own responsibilities of patient care delivery within their professional remits. However, on occasion particular aspects of patient care may be delegated by a registered nurse to members of the multi-professional team. In line with the *All-Wales Guidelines for Delegation*, Registered Nurses may allocate “*clinical or non-clinical care and support to a competent person*”, which in this case could be members of the multi professional team or other health professionals. The Registered Nurse “*will remain responsible for the overall management of the individual, and accountable for their decision to delegate. The delegator will not be accountable for the decisions and actions of the delegatee*” (All-Wales Guidelines for Delegation, 2020, p.10).

At least every six months, or when calculating the nurse staffing levels, the ward team should consider:

1. Has the input of the multi professional team and other health professionals changed since the last calculation cycle?
2. If the input of the multi professional team and other health professionals has changed, what is the impact of this change on the nursing team?

What roles should we not consider when we calculate the nurse staffing levels?

Roles that do not provide a consistent, reliable, and predictable presence within the ward environment, and are not contractually obligated to be present, should not be considered as part of the nurse staffing level calculation. This includes individuals whose contribution to patient care is intermittent, ad hoc, and those whose presence cannot be guaranteed or scheduled consistently. Whilst these roles are valuable in supporting patient experience and care, they must not be factored into the calculation of nurse staffing levels. These roles include:

- Student healthcare practitioners – whilst the designated person should consider “any requirements set by a regulator to support students and learners” (paragraph viii) as part of calculating the nurse staffing level, the number of students on the ward at any given time should not be included when calculating the nurse staffing level for that ward.
- Volunteers – whilst volunteers can play a vital role in supporting care delivery, they are not employed or contractually obligated to provide care, their presence is variable and cannot be relied upon.
- Family and carers - although family members and carers may support aspects of care in some clinical areas, they are not part of the employed workforce, and their involvement is voluntary and unpredictable.
- Medical staff, including consultants, junior doctors, physician associates and other members of the medical team are recognised for their vital contributions to patient care. However, they are not taken into consideration during the calculation of nurse staffing levels for the ward, as their roles have limited impact on the direct delivery of nursing care.

(To be inserted in Appendix 5 of operational guidance – ‘Factors which must be considered during the calculation process’):

Multi professional team and other health professionals

Nurse staffing should be planned in the **context of the wider multi professional team and other professionals**, not in isolation. Nurse staffing reviews should consider:

- Which multi professional team and other health professional roles contribute to care delivery
- Their availability and reliability
- The impact of changes in their input on nursing workload.

It may be useful for these considerations to be guided by the prompt: *“how (if at all) has the multi-professional team changed on this ward in the 6 months since the last calculation and how might these changes positively or negatively impact the delivery of patient care?”*