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

COFNODION HEB EU CYMERADWYO GRŴP STRATEGOL CYNLLUNIO AC ADDYSG POBL
UNAPPROVED MINUTES OF STRATEGIC PEOPLE PLANNING AND EDUCATION GROUP (SPPEG)

Date and Time of Meeting:	10.30am - 12.30pm, 29 July 2025
Venue:	Board Room, Glien House, Glien Road, Johnstown, Carmarthen, SA31 3RB

Present:	Professor John Gammon (JG), Special Adviser, (Workforce, Education & Training) (SPPEG Chair) Tracy Walmsley (TW), Head of Strategic Workforce Planning & Transformation James Severs (JS), Executive Director of Allied Health Professions and Health Science Samantha Hughes (SH), Primary Care & Community Services Academy Manager Claire Steel (CS), Future Workforce Programme Manager Shayne Phillips-Edwards (SPE), Learning and Development Manager Rachel Williams (RW), Head of Assurance and Risk Anthony Tracey (AT), Digital Director Helen Sullivan (HS), Head of Partnerships, Diversity and Inclusion Michelle James (MJ), Head of Resource & Utilisation Ruth Bowman (RB), Clinical Education Manager Sally Hore (SHo), Head of Research and Development Bethan Lewis (BL), Interim Assistant Director of Public Health Janice Cole-Williams (JCW), Assistant Director of Nursing
In Attendance:	Gareth Cottrell (GC), Deputy Chief Operating Officer Robin Benton (RBe), Educational and Training Lead Pharmacist Elizabeth Tooby (LT), Clinical Programmes Manager Scott Thomas (ST), Learning and Development Operational Manager Rachel Perry (RP), Clinical Induction coordinator Helen Humphrys (HH), Head of Nursing for Professional Standards and Regulation Indeg Jones (IJ), Secretariat

Agenda Item	**GOVERNANCE AND RISK**	**Action**
1.1	**Welcome, Introductions and Apologies**	
	Professor John Gammon welcomed everyone to the meeting. Apologies for absence were received from: Mrs Amanda Glanville (AG), Assistant Director of People Development (Vice Chair) Anand Ganesan (AGa), Associate Medical Director for Medical Education & Training Charlotte Wilmshurst (CW), Assistant Director of Assurance & Risk Helen Thomas (HT), Head of Medical Education & Professional Standards Huw Thomas (HT), Director of Finance Jo Bradburn (IB), Deputy Director of Allied Health Professions Rhian Bond (RBo), Assistant Director of Primary Care Simon Chiffi (SC), Head of Operations, Facilities Martin Riley (MR), HEIW Representative	

	Jonathan Arthur (JA), Deputy Director of Health Science William Mackintosh, General Practitioner, Clinical Lead Primary Care Academy Mary Owens (MO), Head of Dental and Optometry Catherine Rees (CR), Head of Organisation Leadership Development Helen Morgan Howard (HMH), Head of Engagement and Transformation Programme Office Simon Day (SD), Head of Maintenance & Engineering Stuart Rees (SR), Clinical Director of Pharmacy & Medicine Management Leon Popham (LP), Senior Finance Business Partner Lesley Hewer (LH), Head of Nursing Ceri Griffiths (CG), Assistant Director of Nursing Acute Services Sara Quarrie (SQ), Service Director for Allied Health Professions and Health Sciences Carly Hill (CH), Assistant Director Leighton Pillips (LP), Director Research, Innovation and Value	
1.2	**Declarations of Interest**	
	Declarations of interest noted were: **JG** declared he is a Board Member with HEIW in relation to agenda item 3.1	
1.3	**Minutes and Table of Actions**	
	The minutes of the meeting held on 03 March 2025 were approved as an accurate record, subject to the amendment of James Severs' job title to Executive Director of Allied Health Professions and Health Science. See Table of Actions for updates	
1.4	**SPPEG Workplan**	
	JG noted that a further review of the work plan was needed due to evolving strategic priorities and the group's development over the past year. **JG** highlighted that due to the volume of agenda items, some had been deferred, underlining the need to streamline and ensure balanced representation across the Health Board—including non-clinical and Primary and Community Care areas. Executive input, including **AG's** one-to-one meetings with key stakeholders as helping shape this direction. **JG** advised that a reassessment of both the scope and focus of the work plan was necessary to ensure it remained relevant, manageable, and aligned with the group's purpose.	
1.5	**Risk Approach**	
	TW apologised to the group for the late distribution of the paper, explaining that the item was originally intended to be presented verbally. **TW** provided an overview of the paper, noting that the summary had been regularly reported to PODCC over the past 12–18 months. It outlined workforce-themed risks across the organisation by professional group and service area. Due to the Datix system refresh and the alignment with new clinical care groups, this version was the most current available. The report highlighted a total of 198 workforce-related risks, ranging from manual handling and training issues to broader workforce themes linked to strategic pillars.	

	TW asked the group to reflect on whether this approach of identifying critical risks by service and profession and receiving targeted action plans, should be adopted within SPPEG to better address workforce risk. **JG** emphasised two key points regarding the Group's approach to risk: 1. **Action-Oriented Risk Management**: Members should not only identify risks within their portfolios but also propose solutions and actions to address them. 2. **Synergy with PODCC**: There must be alignment between SPPEG's approach to risk and that of PODCC. The paper aimed to ensure both committees adopt a consistent and coordinated strategy for identifying and managing workforce-related risks. **TW** also highlighted the importance of aligning workforce-related risks discussed within SPPEG, such as statutory and mandatory training, with broader organisational risks across professional groups. This alignment supported a more integrated approach to risk management. **TW** encouraged members to consider not only the risks already identified but also to reflect on potential gaps or risks that may be missing from the current framework and should be explored in future discussions. **JG** requested that any comments related to the paper be sent to **IJ** by 12 August.	**All**

2.0	**EDUCATION AND WORKFORCE PLANNING**	
2.1	**Digital Update – Digital Skills Development Pathways**	
	AT thanked the Chair for delaying his paper as his previous meeting had over run. **AT** summarised the paper highlighting some key points: • A digital capability pathway had been developed by the Digital Inclusion Team in collaboration with Workforce and Organisation Development (WF&OD). • The pathway aimed to address digital capability and confidence gaps among staff • It would be tiered and phased, modelled loosely on the former ECDL approach, ranging from beginner to expert/system admin levels. • The team planned to integrate this into PADRs and explore CPD accreditation for digital training. **AT** asked if the group would consider endorsing the approach, allowing formal proposals to be developed with WF&OD. **SPE** asked whether the Wales Essential Skills Digital Toolkit, which allowed for benchmarking digital skills, had been considered as part of the work. **AT** confirmed the team were using the Wales Essential Skills Digital Toolkit alongside the HEIW framework in a hybrid approach. **AT** also noted	

that establishing a baseline was key, and would confirm details with his team, asking them to follow up if needed.

SHo asked how would the basic skills be assessed and how the effectiveness of the training package would be measured?

AT explained that the team currently used basic questionnaires during one-to-one and team sessions to assess digital skills but recognised the need to formalise this process to better establish a baseline. Targeted conversations had provided richer insights than self-assessments alone, which could be unreliable.**AT** also noted the team planned to use this data in their annual digital inclusion report, focusing on whether staff felt their skills had improved, rather than just tracking course completion.

TW thanked **AT** and highlighted the need to ensure meaningful access to learning provision and identifying any gaps. **TW** welcomed the focus on establishing a baseline.

AT agreed with **TW** and emphasised the need to establish a clear baseline to guide digital training. While current efforts focussed on staff involved in systems like Flow, OPS, and EPMA, **AT** stressed the importance of expanding to other groups such as facilities and estates to ensure inclusive access. **AT** also highlighted that adoption, not system quality, was the key challenge, and successful uptake would be essential to realise the intended benefits and efficiencies.

SH asked about the scope to extend the offer to independent contractors in primary care.

AT confirmed independent contractors had not been previously considered in this context but would now be taken into account in future planning.

JS expressed support in principle but advised that a baseline assessment should be completed before endorsing the pathway. **JS** also asked if there were any limitations which could affect the ambition to deliver the pathway effectively.

AT acknowledged that resources may be a factor and agreed the importance of first understanding the baseline and committed to bringing timelines to the group for when the baseline assessment would take place, which would help clarify resource requirements.

HS raised the importance of ensuring accessibility for staff with communication and learning needs, particularly those in roles that had not previously been digitised. As digital systems were introduced, additional support may be required to meet those emerging needs.

AT agreed noting that understanding staff learning and communication needs would support digital adoption across the Health Board. **AT** also highlighted that this insight would help inform device procurement.
CS highlighted study leave allocation as a potential challenge, noting the importance of ensuring staff had time to complete training and the impact this may have on operational pressures being experienced across the Health Board.

	JG welcomed and endorsed the proposed approach, reflecting the group's overall support. **JG** summarised the key points raised, including: • the need for clear mechanisms for evaluation and monitoring to better understand baseline data and impact. • The importance of linking the pathway to other systems and frameworks along with consideration for primary care and the independent sector. • Risks such as accessibility, study leave, and resource implications were noted, with a request for clearer identification of these risks in future documentation to enable the group to support mitigation efforts. **JG** proposed that once the baseline assessment and monitoring mechanisms were in place, a follow-up paper be brought back to the group outlining implementation plans and timelines.	
2.2	**Maturity Matrix for Workforce Planning - Progress Report**	
	TW provided a progress update on the development of the Workforce Planning Maturity Matrix. A paper had recently been submitted to the Strategic Workforce Planning Forum within HEIW to update members on the work to date and to gauge readiness and interest in continuing development. **TW** advised that feedback from the Forum indicated support for the small working group to continue its development work and to explore future opportunities which included Strategic Workforce Planners from across Wales. While the ambition outlined in the accompanying slides was not discussed in detail, **TW** confirmed that the next steps will include a stocktake, followed by further reflection with the group.	
2.3	**Radiology Workforce Plan & Risk Mitigation**	
	TW gave a position update and advised of the £3.4 million investment made into the Radiology team. **TW** also noted the recent appointment of Sara Quarrie **(SQ)** as the new Service Director, who was currently undertaking a review of all risks within the service area, providing an opportunity to pause, reflect, and reset the workforce planning approach for Radiology. **TW** confirmed that a revised workforce plan would be brought back to SPPEG for further consideration, building on work that had already been progressed through the Executive Team.	
2.4	**Medical Associated professionals - Action Plan Update**	
	TW provided an update on the MAPs group, noting that work had continued with a focus on stabilisation. Helen Thomas **(HT)** and Carly Hill **(CH)** had taken ownership of the action plan and were progressing on a number of actions. **TW** advised a fuller report would be presented at the next meeting.	

	JS asked if there were any updates on Physician Associate regulation in England and how this might impact Hywel Dda or Wales, in light of some organisations restricting PA practice due to patient safety concerns. **TW** clarified that the Leng Review did not cover Wales, and that the Welsh Government was reviewing its implications. Feedback would be provided through the Medical Associate Professional Oversight Group and then into the MAPs Group. **TW** also noted that there was an assurance process in place regarding scope of practice, which was being followed to ensure safe and appropriate practice within Wales.	
2.5	**Healthcare Science (HCS) in Hywel Dda University Health Board**	
	JA sent apologies and requested that the update be deferred to the next meeting **JG** emphasised the need to progress the workstream and noted he had facilitated meetings to support this area of education. **JG** requested an email update from **JA** on current progress.	
2.6	**University Partnership Arrangements Update Report**	
	SHo summarised the current status of arrangements with key university partners, noting that two refreshed Memoranda of Understanding (MOUs) have been completed, with the third scheduled for early September. **SHo** also advised that Governance arrangements have been revised, moving from biannual individual meetings to annual meetings with each university and one combined meeting with all three, an approach supported by the universities and Swansea University had taken up representation on the R&I Subcommittee. **SHo** noted a further update paper would be brought to the group once all three MOUs were finalised. **JG** queried how the Health Board captured the impact of its university partnerships status on service delivery and outcomes for the population. **SHo** welcomed further discussion on the evolving university partnership arrangements, noting the need to clarify how feedback and reporting would be structured under the new governance model. **JG** added that as the group reviewed its scope and work plan, the importance to align with other education-related committees across the Health Board and the need to apply consistent governance principles to the University Partnership Board and consider how it integrated with groups such as the Faculty of Education.	
2.7	**Support Worker Induction Programme Review**	
	LT provided an update on the revised clinical induction programme for Bands 2 to 4, which had been aligned with similar programmes across other health boards. **LT** noted the updated induction now formed part of a broader educational journey, encouraging engagement with a new development programme tailored to staff roles and the revised programme	

	had been shared for consultation with various clinical and staff groups prior to presentation at SPPEG. **TW** thanked Liz, Ruth, and Rachel for their work on the paper and queried what infrastructure was in place to support the implementation and delivery of the proposed programme? **LT** confirmed that following consultation with clinical areas, subject matter experts had been contacted to refine the clinical induction programme and noted that the new programme would better support the revised Band 2 to 3 nursing roles. **LT** also noted collaboration with HEIW and other health boards to revise the Agored qualification in line with the changes. **JG** welcomed the paper, noting its ambition and the inclusion of benchmarking, particularly around simulation. **JG** raised concerns about the potential impact on team capacity and emphasised the importance of clearly identifying associated risks to ensure successful delivery. Additionally, **JG** queried whether discussions had taken place with Swansea University regarding potential access to simulation mannequins located at St David's Park. **LT** outlined that the six-day induction programme will be reduced to five days, freeing staff to support the development programme and simulation would be phased in, supported initially by tools like educational board games, with trainers currently being upskilled. **LT** also advised the development programme, funded by HEIW, was already running and would be expanded. **LT** confirmed while there hadn't been discussions with Swansea University regarding mannequins, this could be explored although the greater need was in Pembrokeshire and Ceredigion to ensure consistent induction experiences across all counties. **JG** highlighted the importance of monitoring the new programme's activities and evaluating its impact and requested that, at a later stage, the group be updated on how outcomes were being measured and tracked. **SHo** raised the potential to explore access to high-fidelity simulation suites through university partners, particularly in Ceredigion where underutilised resources, such as mannequins, could be available to support consistent delivery of the induction programme across counties. **RB** to explore with **SHo** outside of the meeting. **JCW** confirmed that the programme supported future developments of the Band 3 and 4 staff particularly around the Registered Nursing Associate (RNA) role and welcomed further discussion around the logistics and access to ensure effective implementation. **JS** welcomed and supported the paper, but raised several points for further discussion outside the meeting, regarding: • Need for feedback from operational teams and the operational impact of shifting WNCR training to local delivery, especially on nursing teams and existing support workers. • Clarification on the distinction between the induction and development programme.	**RB/SHo** **JCW/LT**

	• Concerns about the programme's suitability for Allied Health Professional (AHP) support workers. • A challenge around the decision for face-to-face delivery considering the Health Board's digital leadership goals. **LT** explained the lack of practical WNCR training, noting it was limited to PowerPoint slides and did not offer hands-on experience and emphasised the programme's interprofessional approach. **LT** explained that Induction was for individuals without prior clinical experience or those changing roles and was mandatory for anyone delivering clinical care and the Development Programme offered ongoing, bite-sized CPD for Bands 2 to 4, acting as a central hub for accessible training. **LT** addressed AHP concerns by highlighting the programme's foundational content (e.g., pressure ulcers, nutrition, speech and language therapy), which provided a strong base for progression and noted positive feedback from radiologists who had attended some of the training. **LT** to meet with **JS**, **JB** and **JA** outside of the meeting to discuss in more depth. **BL** expressed support for the paper and raised a query regarding Band 3 and 4 roles within public health that may not fully align with clinical pathways in the development programme and suggested exploring how the programme could be adapted to ensure inclusivity for these roles. **JCW** suggested exploring the possibility of adding bespoke content to the programme to better support specific specialties, enhancing its relevance and effectiveness. **JCW** also offered support for implementing more interactive, workplace-based training as an alternative to the less effective classroom-based approach in relation to WNCR training. **LT** to follow up outside the meeting with **JCW** and **BL** to explore bespoke content for specific specialties and ensure inclusion of Band 3 and 4 roles in public health and related areas. **JG** noted the recommendations and expressed support for the programme, approving the content in part, emphasising the importance of ensuring the programme reflected the needs of the wider Health Board community and welcomed potential changes to achieve this. **JG** proposed that, once updates had been made, a progress report should be brought back to the group to reflect on implementation and the discussions held during the meeting.	**LT/ JS/ JB/ JA** **LT / JCW / BL**

3.0	**MONITORING AND COMPLIANCE**	
3.1	**Higher Awards Update**	
	ST provided an update on the Higher Awards application window for 2024 - 2025 and highlighted key points: • The successful transition to a digital system, which improved data quality and enabled more detailed analysis. • Challenges, included withdrawals due to course cancellations, personal reasons, or staff departures resulting in an underspend, particularly in HEIW-funded areas and a 5% over-allocation was proposed for the next application window to mitigate underspend.	

- Concerns about equity of access, citing a significant funding disparity between clinical and non-clinical staff and confirmed ongoing discussions with HEIW and workforce planning to address these disparities.
- Assured the group that governance, transparency, and strategic alignment were improving and risks around equity, data, and funding utilisation were being actively managed.

SHo queried the £1,000 funding cap for PhD students, questioning whether it was a legacy arrangement and whether further support could be offered in line with ambitions to strengthen research pathways across all professions.

ST explained that the £1,000 cap for PhD funding was put in place as historically, the Health Board funded 75% of course fees, but this changed around two years ago to cover 100% of fees, with the cap introduced due to the extended duration of PhD programmes. The cap was currently outlined in the Learning and Development Policy, which was due for review, and ST suggested this could be an opportunity to revisit the funding limit.

ST explained that the £1,000 PhD funding cap was introduced when the Health Board shifted from covering 75% of course fees to fully funding them, with the cap introduced due to the extended duration of PhD programmes. **ST** suggested this could be reconsidered as part of the review of the Learning and Development Policy.

TW welcomed the paper and the opportunity to explore in more detail and highlighted the importance of thinking strategically about how this information could shape future direction and decision-making.

TW/ST

JS raised a question regarding the inequitable use of the funding pot and asked what could be done to address it and emphasised the importance of engagement and encouraged any challenges to be raised so they could be addressed collaboratively.

ST explained that the disparity in funding was due to HEIW allocations being designated for advanced practice and only accessible to clinical staff and as a result, staff in Estates and Facilities were excluded. **ST** also noted uncertainty around whether these teams engage with workforce planning, which could help inform future funding decisions.

TW and **JS** to explore workforce planning for Estates and Facilities outside the meeting.

TW/ JS

BL acknowledged the support received from ST and the team, particularly from a public health perspective, and noted that Public Health was not classed as a priority group for clinical funding support. **BL** also welcomed the paper's focus on equity, including service areas, headcount, and access, but highlighted ongoing challenges as Public Health teams, often aligned to admin and clerical roles, faced disparities in accessing Higher Awards funding.

	SH expressed appreciation for the support given to Primary Care, noting that the Primary Care Academy were now a part of the Higher Awards Panel. **SH** suggested that earlier engagement with the Primary Care Academy ahead of the next application window would help increase awareness and access, proposing the development of an engagement plan to support this. **ST** and **SH** to look at developing an engagement plan for Primary Care **HS** referred to the equality monitoring data mentioned in the paper and asked whether it had revealed any insights into opportunities for progression, citing findings from the Workforce Race Equality Standard report and staff survey which highlighted concerns from minority groups about limited access to development opportunities and asked whether training data reflected this disparity. **ST** acknowledged that while the Higher Awards data hadn't yet been specifically analysed in relation to equality, this was the first year the data had been available to do so. **ST** confirmed the data could be cross-referenced with ESR data and agreed to explore further and offered to provide further insight once the analysis was completed. **JG** highlighted ongoing concerns around equitable access to funding across staff groups and welcomed the improved data systems now supporting more informed decisions. **JG** encouraged consideration of how the budget could better support research-active staff and raised the need to review education commissioning practices to reduce reliance on a limited number of providers and mitigate associated risks. **JG** confirmed the group's assurance in the revised processes	**ST / SH**
3.2	**Annex 21: A Streamlined Process**	
	SPE outlined progress in strengthening governance and consistency within the Annex 21 process and asked the group to acknowledge ongoing operational improvements and challenges, and to take assurance that the process was being effectively managed and refined. **JS** commended the progress made over the past year and raised a question regarding the relationship between CEGG and Annex 21 in the context of clinical roles and suggested reviewing this further and offered to take the discussion forward outside the meeting. **JG** welcomed the paper and noted that while key risks were identified, particularly around communication with departmental managers and monitoring individual competency, there was a need for clearer proposals on how these risks would be managed. **JG** confirmed that the group could take assurance from the Annex 21 paper and the newly proposed streamlined process.	**JS/ SPE**
3.3	**All Wales Career Framework Update**	
	CS gave an update on the paper, highlighting some key points: • A significant increase in compliance had been observed, attributed to actions taken following the last meeting • The team also benchmarked against other Welsh health boards and identified that many were using clinical induction as the starting point	

	for the framework, an approach now adopted following discussions with HEIW.
	• Continued collaboration with HEIW was planned, including:
	  ◦ Addressing career roles that don't align neatly with the framework.
	  ◦ Supporting HEIW's review process and nominating staff to contribute.
	• Discussions were ongoing around the lack of an equivalency framework for experienced staff without formal qualifications. HEIW was reviewing this as part of their broader process.
	
	JS raised two queries:
	• Whether there were national discussions underway regarding the potential expansion of the All Wales Career Framework to include non-clinical professions, alongside clinical roles.
	• Whether this framework aligned with the Advanced Enhanced Consultant Practice Framework.
	
	CS responded that while the first question had not yet been raised directly, they would follow it up. The team was working closely with HEIW and had begun identifying anomalies within the framework, such as the nursery nurse role, which did not align well. These issues were being fed back to HEIW on an ongoing basis. **CS** confirmed that HEIW was planning a full review of the framework. Regarding the second point, **CS** was unsure and would seek clarification.
	
	JG expressed thanks and appreciation was given for the work involved, particularly the positive actions taken which led to improved compliance and noted that the paper provided assurance.
		CS

3.4	**Statutory & Mandatory Training Organisational Compliance Update**	
	SPE summarised the paper, noting that it outlined the current position, challenges, and improvement actions relating to mandatory training compliance across the Health Board. The group was asked to: • Note the compliance data; • Endorse the proposed review of non-core skills training framework modules; • Take assurance that actions were in place to improve compliance, streamline reporting, and align training with workforce needs. **GC** expressed concern over low compliance rates in key training areas, noting the risks this posed to the Health Board. He emphasised the need for regular access to compliance data and suggested a breakdown by staff group to identify specific challenges. **GC** committed to raising the issue at an operational level to drive improvements, highlighting the importance of ensuring staff have the core skills required to maintain patient safety. **JS** advised that the issues raised should be flagged as an alerted item to the IQFPD forum and requested that **GC** take the conversation forward. **JS** emphasised that the concerns related to clinical and quality risk, making IQFPD the appropriate forum for escalation. **JS** also requested that compliance reports be presented monthly at Health Board level to IQFPD for monitoring, and that a report be shared with CCG Directors for their business plan performance meetings. Additionally, **JS** asked for the data to	**GC**

	be broken down by profession and made accessible to Deputy Directors and Executives to support targeted action. **SPE** noted that ongoing strategies were in place to improve compliance across the Health Board, with targeted support for areas showing low compliance though challenges remained around digital access, email availability, and time within the working day to complete training. **SPE** confirmed several meetings had taken place to address these issues and acknowledged the points raised during the discussion. **GC** made an observation regarding the volume of mandated training modules, noting that there were over 25 currently required. **GC** highlighted the time involved in completing these modules and acknowledged that while some modules were mandated by Welsh Government, questioned whether all 17 locally mandated modules were essential for safe organisational operation. **JG** acknowledged that the volume of mandated training had been previously discussed and agreed it contributed to lower compliance. **JG** suggested revisiting the scope of locally mandated modules in light of the current discussion and confirmed that further conversations may be needed to reassess staff training requirements. **JCW** noted that a mandatory training review was currently underway, which considered mandatory and CPD requirements by professional group, and suggested that the concerns raised be fed into that group for further discussion. **TW** to raise with **AG.** **TW** also to raise as an alert for PODCC through the 3a paper update **JG** summarised that, although assurance had been provided, there was a need to agree how compliance data was distributed, to whom, and when. **JG** confirmed that **IJ** would liaise with **GC** and **JS** to identify the appropriate forums for circulation, ensuring **SPE** had the necessary details. **JG** also noted that the paper should place greater emphasis on risk management, and that a follow-up paper should include deeper analysis by professional group to support targeted action.	**TW/AG** **TW** **IJ/ GC / JS**

4.0	**POLICIES**	
4.1	*Not applicable for current meeting*	

5.0	**INNOVATION AND COLLABORATION**	
5.1	*Not applicable for current meeting*	

6.0	**UPDATE POSITION PAPERS/ SUBGROUP UPDATE**	
6.1	**Future Workforce Governance Group**	
	Update noted by group	
6.2	**Statutory and Mandatory Training Group**	
	Update noted by group	
6.3	**Clinical Education Governance Group (CEGG)**	

	Update noted by group	
6.4	**Interprofessional Education Governance Group (IPEGG)**	
	Update noted by group	
6.5	**Medical and Dental Oversight Group**	
	Update noted by group	

7.0	**OTHER BUSINESS**	
7.1	**Any other business**	
	7.1.1 Primary Care Education Transformation **SH** noted the intention to bring forward two papers to the SPPEG: • The first paper would explore collaborative working with the People Planning team to prepare for the shift of services into the community. **SH** acknowledged that this aligned with developing the Primary Care Strategy and highlighted the importance of aligning workforce planning with available funding. • The second paper to be brought forward, would focus on ensuring equity and parity in the educational offer for all primary care staff, including independent contractors. **SH** highlighted ongoing efforts to build inclusivity through the Primary Care Academy and stressed the importance of equitable access to funding from HEIW and other sources. The paper would explore how resources could be fairly allocated across primary care to support education and development. **IJ** to note as actions for future meetings **JG** emphasised the need for the committee to consider its strategic role in supporting the Health Board's shift from acute to community-based services and highlighted the importance of preparing and developing the workforce to deliver care in line with this direction of travel, noting that the current focus had largely remained within secondary care. **JG** clarified that the intention behind raising this as an AOB was to broaden the focus and consider the wider context of primary and community care.	**IJ**
7.2	**Date & Time of Next Meeting**	
	JG thanked all who attended and contributed to the meeting. Details of next meeting: 24 September: 9.30am Board Room, Glien House	