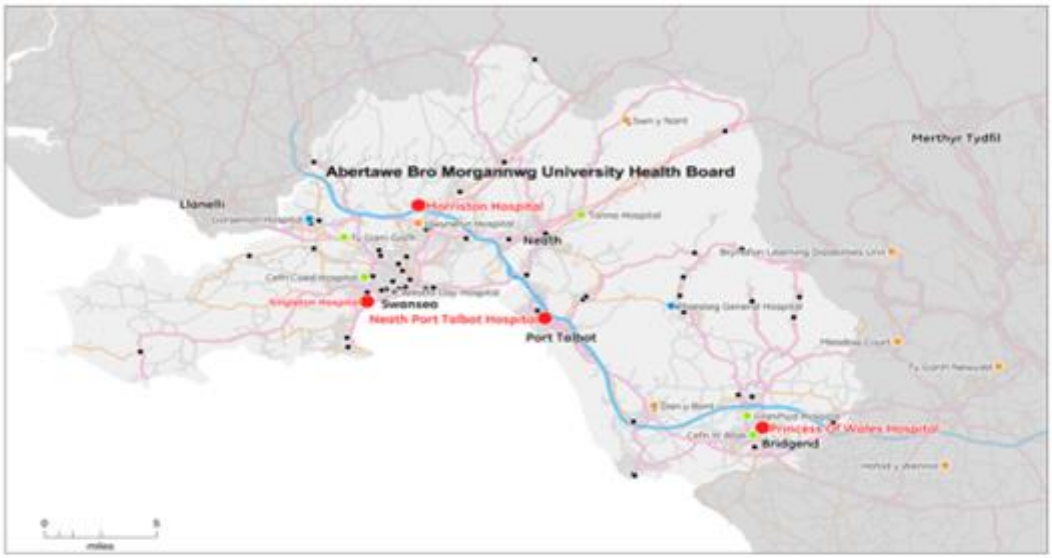
Response to Information request by the Health, Social Care and Sport Committee

INFORMATION REQUESTED BY THE HEALTH, SOCIAL CARE AND SPORT COMMITTEE

ABOUT ABMU HEALTH BOARD

Figure 1: ABMUHB Local Catchment Area and Healthcare Services



ABMU Health Board has the third largest population of the seven Health Boards in Wales, serving a population of approximately 500,000 across three local authorities: Bridgend, Neath Port Talbot and Swansea. The Board is responsible for assessing the needs of our population and delivering care to meet those needs. The Board commissions primary care services and also directly provides almost all community, secondary, mental health and learning disability services for our resident population. We also provide tertiary care for some specialist services over a wider population.

The Health Board also serves a wider catchment given the regional and specialist role of a number of its services.

The financial turnover of the organisation is approximately £1.3bn and we employ around 16,000 staff.

MENTAL HEALTH EXPENDITURE

The Health Board's operating structure includes a Mental Health and Learning Disability Unit which is responsible for the delivery of primary mental health, older people's mental health services, adult mental health services, specialist mental health services, and a range of learning disability services to our own population as well as Cwm Taf Health Board and Cardiff and Vale Health Board. Child and Adolescent Mental Health Services are delivered by Cwm Taff Health board via the CAMHS network.

The total spend on Mental Health Services is captured in the UHBs Programme Budgeting returns.

The latest set available is for the financial year 2015/16 where the UHB spent £123.5m on Mental Health Services against an allocation of £98.6m.

The Delivery Unit budget and expenditure for the last financial year and 2017/18 year to date are provided below:

Please note that the Mental Health element of the 17/18 budget is 74% (£68.5m) and 50% of the Continuing Health Care budget (£10.45m) whereas Mental Health CHC spend to date is 41% of the total (£4.47m).

	2016/17		**2017/18**		
	Budget £'m	**Actual £'m**	**Annual budget £'m**	**Month 5 budget £'m**	**Month 5 Actual £'m**
Mental Health and Learning Disability Division (excl. CHC)	84.8	86.9	92.6	38.5	35.6
Continuing Health Care	16.4	25.1	20.9	8.8	10.9
Total	**101.2**	**112.0**	**113.5**	**47.3**	**46.5**

The allocation for 17/18 is £105.8m. However, from 1st April 2017 a budget rebasing exercise was undertaken across the Health Board which led to the MHLD Delivery Unit receiving an additional £8.5m to reflect actual expenditure.

In addition, the Health Board received additional funding of £3.5m in 2017/18 to support delivery. However, Continuing Health Care (CHC) continues to be a significant pressure. Despite these pressures, the overall budget for the Delivery Unit remains within budget.

Spending on Mental Health Strategy and Delivery Plan

The 'Together for Mental Health' Delivery Plan and 3 year strategy 2016 - 2019 is being progressed through local Mental Health plans. The local delivery plan has been supported by new Welsh Government Investment into Mental Health Services - set out below:

Service Investment Mental Health	2015/16 Funding £'000	2016/17 Funding £'000	2017/18 Funding £000
Psychological Therapies	257	321	321
Psychiatric Liaison Services	342	684	684
Occupational Therapies	83	83	83
Perinatal Services	118	236	236
Local Primary Mental Health Support Services		125	249
General Hospital Based Flexible Resource Teams for Psychiatric Liaison Services		136	384
Inpatient Psychological Therapies		86	192
Gatekeeping / Case Monitoring (Forensic)		97	228
Early Intervention Psychosis		26	26
Memory Clinics (Non Recurrent Funding)		56	

'Together for Mental Health' recognises that people have medical, psychological and social needs and we are increasingly aware of the complex patterns of co-morbidities. Our strategy also recognises that our services need to deliver integrated holistic care focussing on recovery and emphasises active rehabilitation.

Key priorities for mental health within the 2017/18 Health Board Annual Plan include:

- Complete Strategic Frameworks for Mental Health and Dementia.
- Implement Mental Health Delivery Plan.
- Older People's Service Model and scope the enhancement of community services.
- Local referral dementia pathway.
- Mental Health Triage for primary and secondary care services.
- Early Intervention in Psychosis (EIP) service model and pathway.
- Psychiatric Liaison services in acute hospital settings - operations and resources.
- Scope and deliver third sector provided "sanctuary" services as part of alternatives to hospital crisis provision.
- Review use of specialist residential service and, acute assessment and treatment unit resources.
- Integrated Autistic Spectrum Disorder service.

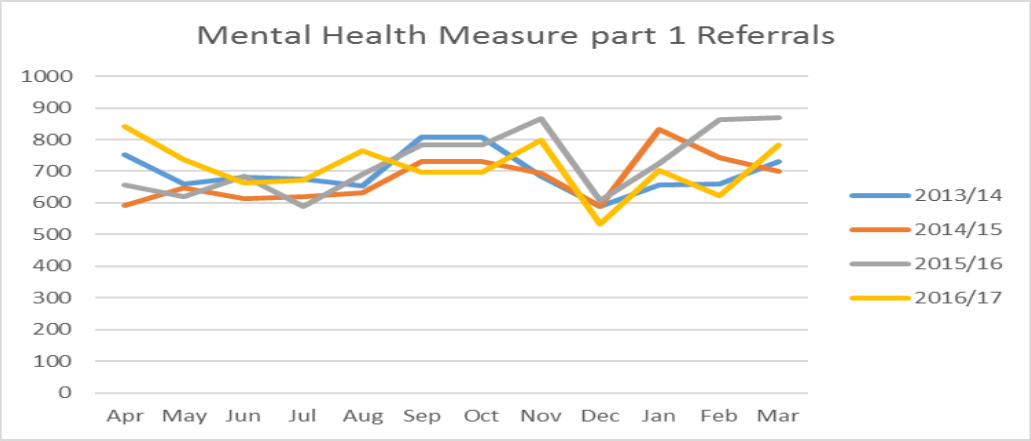
Key priorities will be taken forward using the total resources available for Mental Health services including the allocation uplift provided in 2017/18.

Resources for Primary and Secondary Care Funding

The UHBs Programme Budgeting returns are inclusive of expenditure within Primary Care and Secondary Care settings, these include services provided under the GMS contract, investment by GP clusters, including dementia link workers, and care within acute hospitals. Within Mental Health Services, the 2017/18 budget includes £2.233m for Local Primary Mental Health Support Services (LPMHSS) and £77.827m within secondary care, such as hospital and community services.

Impact of the Mental Health Measure on Expenditure

ABMU currently employ practitioners at a rate of 1.4 per 20k based on the original guidelines. Since the establishment of the service the population has increased and a number of staff have stayed in post beyond midpoint which has created a cost pressure which has had to be supported by redirection of other mental health provision. The following table outlines Part 1 Mental Health Measure referrals:



With the introduction of the Measure, patients previously known to Services now have a statutory right to self-referral directly into secondary care services for reassessment (Part 3). The volume of patients who have referred themselves in this way is relatively small and has had limited financial impact.

In addition, it has become clear that although there is some evidence that demand on secondary care has reduced in terms of follow up appointments the availability of dedicated mental health teams in primary care has in fact highlighted a significant, previously unmet, need and Community Mental Health Teams continue to experience high caseloads.

Prison Estate Funding

ABMU Health Board has a budget of £0.734m in 2017/18 for Mental Health prison estate services. ABMU is facing on going pressures on its secondary care mental health in-reach team serving HMP Parc. This service was originally commissioned based on a prison population of 800. Since the service was commissioned planned developments within the Prison involving the prison service and Welsh Government, have resulted in the prisoner population rising to 2000, (a rise of 150%) whilst level of in-reach resource has remained static. This issue has been raised at the HMP Parc Partnership Board meetings and escalated to Welsh Government. The Health Board estimates a pressure of approximately £400k.

Operation of the Ring-Fence

The Health Board Allocation is derived from the Mental Health Programme Budget and consequently includes not only Direct Hospital and Community Mental Health service costs, but also:

- Overheads and Indirect Costs
- Services commissioned by WHSSC attributed on an apportionment basis
- Prescribing
- Continuing Healthcare

- The cost of patients treated in acute settings with diagnoses such as dementia or substance misuse
- GMS, Local Authority and voluntary funding

The ring-fenced allocation provides a snapshot of the Programme Cost which is subject to significant fluctuation. For example, prescribing price fluctuations, small changes in Patient activity in high cost/low volume specialist services, for instance Continuing Healthcare. The allocation does not therefore provide an appropriate measure of direct investment in Mental Health Services. This could be better understood by considering Delivery Unit budgets and expenditure.

In terms of the delegated budget allocated to Mental Health Services as part of the ring fence this has been protected since its inception. The Delivery Unit is not required to deliver a specific CIP to support the cost pressures identified in acute and other services, however it is required to manage its own internal cost pressures within its ring fenced resource.

Notable Demand Trends with Mental Health Services

Within Adult Services the volume of admissions has remained largely consistent over the five years since 2012/13 however, the length of stay has improved significantly. This has allowed increasing numbers of individuals to be cared for within the available capacity. This reduction in length of stay has been accompanied by a rise in outpatient activity indicating a move away from inpatient care to care in a less restrictive environment.

Within Older Peoples Services, National Benchmarking has shown ABMU Health Board to be an outlier in terms of bed numbers and admission rates. Investment in Community Services is enabling the Health Board to realign capacity moving care out of hospital into the home. This is reflected in a reducing trend in hospital admissions across Older People's Services. The Outpatient referrals remains static overall, however, there is a reducing trend in the number of follow up appointments. This reflects the impact of The Measure, which has moved more activity into primary care.

Community data within Mental Health Services is currently limited. (ABMU's adoption of the Welsh Community Care Information System (WCCIS) will resolve this in future). However the caseload data available for the years since 2013/14, indicates a static position within Adult CMHT's, whilst activity in Older Peoples CMHT's has declined slightly. Both Older and Adult Services consistently achieve the target for Part 2 of the Mental Health Measure for 90% of patients who are in receipt of secondary mental health services to have a valid Care and Treatment plan (CTP). Referral activity within LPMHSS (Part 1 of the Mental Health Measure) demonstrates relatively consistent demand within MH Primary Care services.

FINANCIAL PERFORMANCE

Historical Financial Context

The Health Board has two key statutory duties to achieve:

- To submit an Integrated Medium Term Plan (IMTP) to secure compliance with breakeven over 3 years

- To achieve financial breakeven over a rolling three year period (the first of which commenced on 1st April 2014 and ended on 31st March 2017).

IMTP

The Health Board had an approved IMTP for 2014/15-2016/17 and 2015/16-2017/18, however the 2016/17-2018/19 plan submitted to Welsh Government was not approved and the Health Board and therefore operated under an Annual Operating Plan for 2016/17 and is currently operating on a similar basis in 2017/18.

2016/2017 Financial Position

The Health Board delivered financial breakeven in 2014/15 and 2015/16 and had done so since its formal creation in 2009 i.e. the Board achieved a breakeven position in six of the last seven years. Although financial balance was achieved in both 2014/15 and 2015/16 it should be noted that this was achieved by the use of non-recurrent funding and non- recurrent savings. In the financial year 2016/17 the Health Board reported a £39.317m overspend, against a forecast deficit of £20.1m. The Health Board year-end outturn position was therefore £19.217m above the financial plan of the IMTP.

2017/2018 Financial Position

The Health Board submitted a financial plan for 2017/18 which contained a projected end of year deficit of £36 million.

Movement of Opening Financial Plan to forecast outturn

The Health Board has submitted an Annual Operating Plan for consideration. The Interim Resource Plan within this currently shows a deficit of £36m as set out in the table below:-

Costs	**£m**	**Savings/Funding**	**£m**
2016/17 Underlying Carry Forward Deficit	53.0	Savings	(25.0)
<u>2017/18 New Costs</u>		<u>Additional Funding</u>	
Cost Growth		WG General Allocation Uplift	(16.1)
Service Growth	19.2	WG Treatment Fund	(2.8)
	9.7	WG Mental Health/ICF	(2.0)
Total	**81.9**	**Total**	**(45.9)**
DEFICIT			**36.0**

At the end of August 2017 (P5) the Health Board was reporting a year to date deficit of £17,007 million which was £2m deterioration on the planned year to date position. However, at this stage the Health Board has maintained its year-end forecast of £36 million. The adverse position is primarily due to the non-achievement of the full-targeted cash releasing cost improvements together with medical and nursing variable pay pressures and a number of non-pay pressures including medical consumables.

Key Pressure Areas and Plans to make improvements;

Underlying Causes of the Deficit

The underlying causes fall broadly into two categories those relating to cost drivers and spending decisions and those relating to governance and accountability.

a. Cost Drivers and Spending Decisions

The cost drivers include:

- Long term care
- Staffing costs
- Clinical supplies
- Efficiency and productivity performance such as length of stay.

During the last three years the Health Board has also invested in key priority areas to deliver improvements in quality and access, including:

- Critical Care capacity
- Unscheduled Care services
- Surgical capacity
- Cleaning and Nutrition standards
- RTT delivery
- CNO Nurse Staffing requirements
- Community Services
- Sustaining Services e.g. Rotas
- Trusted to Care.

The Health Board has undertaken a review of the financial position from 2014/15 which marked the start of the IMTP regime to track key movements and issues. The Health Board financial deficit has built up over a number of years. Cost drivers and investment in key priority areas were not mitigated by the required level of savings, resulting in an increasing level of carry forward deficit year on year.

Our examination of the detail has shown us that the costs in some key spend areas have grown significantly over the last three years:

- Long Term Care £16m
- Clinical Supplies £30m
- Staff Costs £72m

b. Governance and Accountability

The underlying causes of the Health Board's deficit have informed work to improve the Board's governance and accountability framework. This has led to:

- More focus on adopting a value-based Healthcare approach to system and service transformation;
- A more rigorous approach to planning and delivery against agreed in-year savings plans and reducing reliance on non-recurrent opportunities;
- The establishment of an Investment and Benefits Group and the promotion of Business Case good practice in investment decision making to ensure benefits are realised;
- More rigorous identification, tracking, measuring, reporting and accounting for financial and non-financial benefits;
- Implementation of more robust controls on expenditure in key areas, especially workforce.

Actions have been taken and further plans are in place to address financial governance and accountability issues.

Action on Reducing the Deficit

The Health Board has taken significant action over the last 10 months to address its financial position. However, whilst it recognises that progress has been made in the last few months of the current financial year, the pace of delivery throughout the rest of the year needs to improve to provide assurance about the achievement of the year-end position of a deficit of £36m. In recognition of this, we have and continue to strengthen our Recovery and Sustainability Programme. We have Executive-led work streams focussing on opportunities to improve efficiency and value drawing on the work of the National Efficiency and Value Board:

- **Workforce** – focussed on sickness absence reduction; improved rostering; reduced recruitment time; incentivising bank take up; job controls/grading drift.

- **Medical Workforce** – focussed on job planning to improve productivity; amending junior doctor rotas to reduce spend/make sustainable; reducing agency spend.

- **Patient Flow** – focussed on reducing bed days used, reductions in length of stay, reducing internal hospital transfer delays; increasing discharges before 11.00am and 4pm.

- **Outpatients** – targeting reduced follow ups; reduced 'Did Not Attends' (DNAs); reducing the need for patients to attend outpatients through development of alternative models – linked to targets identified in benchmarking reports.

- **Theatres**- aims to achieve optimal use of existing theatres across all sites; reduce cancellations, increased throughput – linked to targets identified in benchmarking reports.

- **Capacity Redesign** –encompasses all service changes leading to transfer of capacity between hospital and community settings.

- **Medicines Management** – this is developed work programme targeting nationally agreed programme as well as local hot spots in ABMU.

- **Procurement** – Via establishing of a Non-Pay control panel explicitly targeting and stopping discretionary non-clinical spend, and variation in clinical consumables where it is safe to do so. Also reviewing procurement delegations and accountability.

- **Back Office and Estates** – to focus on the rationalisation /disposal of underutilised properties; minimise financial risk of vacant floor of HQ; identification and delivery of Corporate CIP.

- **Unwarranted Clinical Variation** - this work stream has provided Units with a tool to analyse and review their services.

Views on the perception that there remain opportunities for the NHS to make further efficiency savings

We recognise there are still opportunities to make further efficiencies. However, we recognise that a focus on cost management will not totally address the underlying deficit and during 2017/18 the Health Board is increasing developing a value driven approach to inform how to best to allocate resources to get the best outcomes for patients.

We need to continue to strive to get more output for the same input, e.g. by active benchmarking against top quartile performers from across the whole of the UK as well as building upon the work of the National Efficiency and Value Board.

To improve Allocative Efficiency we are looking to improve outcomes for our patients through pathway change and more strategic solutions rather than simply fine tuning existing treatment regimes. This will include switching to community-based services and a heavy focus on an upstream health promotion and maintaining a good health agenda. These actions should not only ease the pressure on secondary care but greatly benefit the patients and their carers by preventing unnecessary admissions. The Health Board is actively participating in measuring outcomes using the ICHOM framework.

Projected spend on technology and infrastructure to support quality and efficiency

The adoption of technology to support quality and efficiency across ABMU is a high priority and underpinned by our Digital Strategy 'Destination Digital'. We refreshed our Informatics Strategic Outline Programme and submitted to Welsh Government in July 2016. The programme described the need to invest £20m across 7 themes / enablers:

- Digital Patient Record
- Patient Flow
- Mobilising the Workforce
- Patient Empowerment
- Streamlining Business Processes and Communication
- Digital Infrastructure & Cyber Security
- Business Intelligence

In 2017/18 we have committed £3.5m discretionary capital to our Informatics plans and await confirmation of our allocation from the Welsh Government Digital Strategy capital fund.

NHS Finances (Wales) Act 2014

The Health Board acknowledges the useful contribution made by the Wales Audit Office in its report in the implementation of the Act and fully concurs with the responses made by the Welsh Government to this report.

Aligned to the Act, ABMU welcomes the research based approach which the Welsh Government is increasingly adopting in financial policy development, such as the Institute of Fiscal Studies report into the Welsh budgetary trade-offs; the Health Foundation's' report on the Financial sustainability of the NHS in Wales or the Nuffield Trust's 'Decade of Austerity in Wales' report. Such evidence is focussing on the longer-term resource requirements of the NHS and will service to ensure that Wales is well placed to adopt best practice in resource allocation.

Consequently, it is important that there is stability and consistent in the overall NHS budget alongside a recognition of the growing pressures facing the system.

The Board welcomes the fact that over the last budget cycle, the funding allocation to the NHS has broadly followed the recommendations in the Nuffield Trust and the Health Foundation reports.

It is important to recognise that healthy lives are determined, not just by spending directly on health, but through communities which are prosperous, secure, active, well-educated and well-connected. The broader policy framework from Welsh Government has become increasingly consistent. Linking the NHS Finances (Wales) Act with the Wellbeing of Future Generations Act, for instance, has increased the focus on long term planning and collaboration with public sector partners. Likewise, prudent healthcare and the development of the value agenda helps to provide a longer term solution to address the issues facing the NHS.

Views of Effectiveness of the 3 year Plans

The Health Board had its three year plans approved for the first two years of their implementation – 2013/14 and 2014/16, since then annual plans have been prepared and implemented. Three year plans provided a good basis for longer term change and improvement, and provided a more strategic focus for organisations in the development of their plans. In reality, plans were primarily focussed on the first year of implementation and this was reflected in the need to achieve financial balance and deliver performance targets on an annual basis.

The Health Board was placed in Targeted Intervention in late 2016 and has not submitted a three-year plan. As a result of this, the Health Board has been operating under Annual Operating Plan arrangements. Coupled with the significant underlying deficit the Health Board has not been in a position to consider the flexibilities that the Act provides. However, the underlying principle of developing three year plans provides a clear framework to support longer term planning which is to be encouraged.

THE PACE OF CHANGE

Views on how effective current funding mechanisms are in driving transformational change

Current funding mechanisms support to a large degree transformational change within Health Board organisational boundaries – given the constraints set out above of the requirement to deliver financial balance on an annual basis. The shortage of NHS Wales Capital funding in the foreseeable future will, however, be a constraint within this, and further advice and support on securing alternative sources of funding would be welcomed.

Further work is required to consider how funding mechanisms should operate more effectively on a regional basis, and the recent White Paper which sets out requirements to plan on a population basis rather than an organisational one may support this. Agreements to enable this – eg for paediatric and neonatal services in the South Central Acute Care Alliance too significant time and agreement between Chief Executives before they were implemented.

These arrangements will require significant further effort as services increasingly become planned and delivered on a regional basis.

Relatively small amounts of monies which are made available for specific services (eg through the national Delivery Groups) can make it more difficult to support local transformational change. This has also been some of the experience with some of the primary care investment to cluster networks, which has delivered on very local priorities but has consequently not been targeted at opportunities to make system wide changes in pathways and models of care.

The extent to which a preventative approach to funding service is currently possible

This can be challenge given the time taken to deliver return on investment – and the three year planning timeframe may be too short for some changes. Through its commissioning work the Health Board made a start in these areas, and undertook preventative work on eg bowel screening, PBMA work on MSK services and atrial fibrillation and breast feeding. All of these activities are resource intensive in terms of data gathering, clinical engagement and agreeing new models of care, however, it is vital to continue this to secure improvements in health and well being and reduce demand on core health services. The Health Board is continuing to progress this through Value-based healthcare, however progress will be determined by capacity to develop new models through re-investment "upstream" of resources, given the current financial position of the organisation.

Action the NHS Bodies would like to see from the Welsh Government to address these issues

In recent years the Welsh NHS has managed to deliver an overall reasonable, but still challenging financial settlement. There are competing demands on this however, as some resources have been used to provide structural support to financially struggling organisations and to take forward Welsh Government priorities and policy developments. In addition, a significant proportion of the NHS allocation is ring-fenced. Relaxing ring fencing arrangements and providing a greater level of discretionary growth would provide greater flexibility in the delivery of sustainable services.

WORKFORCE PRESSURES

Details of particular pressures and staff shortages and plans to address this

Medical Workforce

Reflecting national shortages in a number of key disciplines ABMU has experienced difficulties in recruiting sufficient numbers of medical trainees to fulfil work rotas on all health board sites. The same issues affect the Health Board's ability to attract non-medical training grades. Some Consultant posts are difficult to recruit to in some areas such as Radiology, Oncology, Pathology, Respiratory, Gastroenterology and Psychiatry.

International Recruitment and Medical Training Initiatives

Following three overseas recruitment initiatives with Health Care Locums Limited, Medacs Agencies, and the Royal College the following number of doctors have now started employment within the Health Board. The remaining doctors are due to start between now and October subject to passing the International English Language Testing System language tests. Of the number of doctors who have started in post five have resigned.

Specialty	Unit	No. Started	Nos. To start March – June 2017
Medicine	Morriston	13	9
Medicine	Singleton	0	1
Surgical Specialties	POW	3	0
Surgical Specialties	Morriston	3	0
Anaesthetics	POW	1	1
Anaesthetics	Morriston	0	1

British Association of Physicians of Indian Origin Recruitment (BAPIO)

The following specialties participated in the All Wales BAPIO Recruitment scheme. The doctors have anticipated start dates of March to June depending on the International English Language Testing System language tests.

The remaining doctors are due to start between now and October depending on the International English Language Testing System language tests.

Specialty	Unit	No. Started	Nos. To start March – June 2017
Anaesthetics	POW	0	2
Anaesthetics	Morriston	0	1
Medicine	NPT	0	1
Paediatrics	Morriston	0	2
Neonates	Singleton	0	3
Surgical Specialties	Morriston	0	2
Surgical Specialties	POW	0	7

BAPIO Recruitment Initiative 2017

A second BAPIO recruitment initiative will take place from 16th September 2017 – 23rd September 2017. ABMU Health Board has confirmed they wish to participate along with 5 other Health Boards. The initiative will include Emergency Medicine, Medicine, Mental Health, Paediatrics, Neonates, General Surgery and Trauma & Orthopaedics.

BAPIO have been requested to obtain applications for both MTI at lower and higher level where the Royal College approve both levels. If the Royal College only approves posts at a higher level then applications will be processed for equivalent Core Training posts and Health Boards will apply for Tier 2 Visas, the doctor will not be on the MTI scheme but employed as an equivalent trainee. Each Health Board will be a lead for a designated specialty to deal with the administration of applications, shortlisting, interview schedule etc.

The health board constantly monitors our recruitment position in terms of medical staff with reports to Executive Team and Board via Medical Director and Medical Workforce Board. The health board seeks to work closely with the Deanery to ensure training posts are filled. Specialty based local workforce boards are in place to monitor and control specific issues.

The health board has run recruitment campaigns including overseas for additional non-training posts to fill gaps.

Part of our strategy is to reduce turnover and we monitor leavers' data to identify local hotspots and agree local plans to address areas with higher than average turnover. We have introduced a revised exit interview process built on the health board's values system.

There is significant evidence to suggest that an engaged workforce will be more productive and effective an outcome of which would be lower levels of turnover, therefore one of the outcomes from the effective implementation of our strategy will be lower levels of leavers, particularly within the first 12 months of service.

Nursing Workforce

The national shortage of qualified nurses continues to be a challenge, particularly in acute care areas. In response the heal board has been mitigating the risk through a number of approaches identified below. The health board has also undertaken a baseline review against the potential reporting requirement within the Nurse Staffing Act Wales guidance 2016. A health board task and finish steering group has been established to manage implementation of the act. The initial baseline review identifies significant challenges and deficits in terms of agreed budgets and vacancies to meet the act requirements. Considerations and plans are in place to address these requirements through ward re-modelling, reducing average length of stay revalidation of acuity and operational management, and redefining ward profiles and definitions.

Nurse Recruitment

The Health Board is currently recruiting nurses within the UK, Europe and overseas and, also investing in a variety of options which includes;

- Enabling successful existing Health Care Support Workers (HCSW) to become Registered Nurses by supporting a new part time degree in nursing programme at Swansea University, which commences September 2017. This programme allows HCSW's to train as a registered nurse whilst still maintaining their role as a HCSW.

- Supporting a new 2-year full time Master's programme for existing HCSW's with an existing degree.
- Implementation of a new development programme to enable HCSW's with overseas registration to become registered nurses in the UK.
- Development of a specific Health Board Nurse Recruitment Campaign
- Fully engaged with the Wales Train WorkLive campaign since its launch in May 2017.
- Supporting a new all-Wales approach to student recruitment which is called the Student Streamlining Project.
- Return to Practice programmes are delivered annually by both Swansea and South Wales University.
- A joint Health Board and Higher Education Institute Task & Finish group will lead on The NMC Programme of change for Education.

Nurse Retention

The following actions are being taken to improve retention

- Implementation of an improvement initiative to analyse the themes and trends in exit interviews
- Review of clinical supervision strategy/plan with a periocular focus on nurses qualifying in the first year of practice.
- Improving access to post registration development and PDR' in line with revalidation requirements
- Development of a nursing and midwifery strategy listening from ground floor practitioners at all stages of their career.
- Monitoring wellbeing at work in line with prevention and sickness and absence trends.

Impact of Brexit

The challenges we face will not related solely to Brexit but to the wider UK Immigrations policies and regulations which are yet to be determined.

The Health Board has looked to the EU in recruiting both medical grades and nurse for some years, however the popularity of this approach within the NHS UK wide has negatively affected the numbers of staff available. The Board has looked abroad both to the Indian subcontinent to recruit Doctors and the Philippines to recruit Nurses and continues to look further abroad to fill gaps which cannot be filled with UK staff due to shortages in trained nurses.

We are monitoring any potential impact on existing employees from the EU, particularly as to how any decisions regarding their right to remain in employment in the UK is affected. Any reduction in our ability to retain and recruit from the EU whist the shortage of nurses and medical staff exists is naturally unwelcome.

Primary Care

There are also significant pressures facing primary care, with difficulties in recruiting GPs, leading to sustainability challenges for the current pattern of GMS provision. The Health Board has established a Primary Care Support Team to advise, support and assist practices who run into difficulties by reviewing models of service and opportunities to improve multidisciplinary working.