Response to information requested by the Health, Social Care and Sport Committee September 2017

1. **Mental health**

a. The allocated spend on mental health services

The Health Board completes Programme Budget returns on an annual basis which shows the fully absorbed costs for a range of health conditions. This includes the cost of services provided by CTUHB and commissioned from other health boards plus overheads.

The latest published returns for 2015/16 show an allocated spend on mental health services of £75.2m; this compares to the mental health ring fence allocation of £65m.

The Returns for 2016/17 will be submitted on the 27 October 2017.

b. Spending on the mental health strategy and delivery plan

The following investments have been made over the past three years on the mental health strategy and delivery plan:

- 2015/16 – CTUHB received additional funding of £0.7m from the Welsh Government (WG) for investment in a psychological liaison service, psychological therapies, perinatal services and dementia support workers. The UHB also received £1.0m of additional WG funding for child and adolescent mental health services (CAMHS) and £0.5m Delivery Agreement funding for older persons community redesign.

- 2016/17 – The UHB received additional funding of £0.5m from the WG for inpatient psychological therapies, hospital based flexible resource and Local Primary Mental Health Support Services. (LPMHSS) as well as £96k development plan funding for community outreach.

- 2017/18- The UHB received additional investment of £1.1m to support a number of developments. This funding is being used to:
  - redesign our older persons mental health services by creating Dementia Care Hubs in Treorchy and in Merthyr Tydfil.
  - Extend the Psychiatric Liaison Service and provide additional health care support worker staff on inpatient wards.

Resources for primary and secondary mental health services

The following table provides further information on the breakdown of our £75.2m allocated spend on mental health services in 2015/16:

	2015/ 2016
	£m
General Medical Services (including Quality Outcomes Framework (QOF) and Enhanced Services)	3.0
Prescribing	3.8
Total Primary Care	**6.8**
Cwm Taf – Mental Health	40.9
Cwm Taf – Child and Adolescent Mental Health Services (CAMHS)	2.4
Other Welsh providers	1.0
Other secondary care	2.7
Welsh Health Specialised Services Committee (WHSSC)	4.0
Total Secondary Care	**51.0**
Continuing Healthcare	**17.4**
Grand Total	**75.2**

c. The impact of the Mental Health Measure on spending

As at Month 4 of 2017/18 the UHB is achieving all the Mental Health Measure (MHM) targets:

Target	**%**
Part 1 assessments in 28 days	94
Part 1 treatments in 28 days	89
Care and Treatment Plan (CTP) part 2	92
Part 3	100

The UHB received additional funding from the WG for the MHM in 12/13 (£0.36m) and 2016/17 (£0.14m).

d. Spending on mental health services delivered on the prison estate (where applicable)

The UHB does not deliver mental health services to the prison estate. However the UHB does provide a CAMHS service to Parc prison for a recharge of £50k per annum.

e. Patterns of demand and expenditure on mental health services in the last 5 years

The table below shows the patterns of expenditure (based on the programme budget data) for the last 3 years of published data.

	2015/16	2014/15	2013/14
	£m	£m	£m
General Medical Services (including Quality Outcomes Framework and Enhanced Services)	3.0	2.9	4.0
Prescribing	3.8	4.2	4.7
Total Primary Care	**6.8**	**7.1**	**8.7**
Cwm Taf – Mental Health	40.9	40.6	38.6
Cwm Taf - CAMHS	2.4	2.0	2.1
Other Welsh providers	1.0	1.0	1.7
Other secondary care	2.7	1.2	1.5
WHSSC	4.0	5.7	6.4
Total Secondary Care	**51.0**	**50.5**	**50.3**
Continuing Healthcare	**17.4**	**17.3**	**14.5**
Grand Total	**75.2**	**74.9**	**73.5**

The demand patterns in relation to the Cwm Taf Mental Health costs are as follows:

	2015/16	2014/15	2013/14
Mental Health Referrals	3485	3873	3528
Expenditure(£m)	40.9	40.6	38.6

f. Details of the operation of the ring fence for the mental health budget, including the extent to which it has determined spending on mental health; and the purpose and value of the ring fence.

The chart below illustrates the ring fenced allocation and the actual programme budget expenditure for the last 3 years of published data. Whilst we support the principle of the ring fence for this important area, it has not influenced spending decisions in CTUHB as we have consistently spent more than the ring fenced allocation.

	2015/16	2014/15	2013/14
	£m	£m	£m
Ring fenced Allocation	65.0	65.0	64.8
Total Programme Budget Return	75.2	74.9	73.5

2. Financial performance

a. Details of overspend / underspend and reasons for this

The UHB's financial plan for 2017/18 includes an in-year savings and cost reduction target of £13.5m which is circa 2.7% of a controllable budget of £500m:

	£m
Overspend reduction targets from 16/17:	
Medical pay	2.4
Ward nursing	3.0
Other pay	0.8
Total overspend reduction targets from 16/17	**6.2**
Savings delivery shortfalls from 16/17	2.2
New savings targets for 17/18	9.1
Total savings and cost reduction targets 17/18 - Recurring	**17.5**
Provision for part year effect	(4.0)
Total savings and cost reduction targets 17/18 – In Year	**13.5**

The Health Board reported a deficit of £0.4m for Month 4. The M4 year to date (YTD) position is a £1.4m overspend and the Health Board continues to forecast a break even financial position for 2017/18. The Month 4 (M4) position by expenditure category is summarised below:

	Annual Budget	Current Month Variance	M4 Year to Date Variance
	£m	**£m**	**£m**
Income	(82.1)	0.1	0.3
Pay	336.4	(0.1)	0.5
Non Pay	368.0	0.5	0.6
Delegated Saving Plans	(8.0)	0.4	2.1
Total Delegated budgets	**614.3**	0.9	**3.5**
Non Delegated Budgets	33.6	(0.5)	(2.1)
WG Allocations	(647.9)	(0)	(0)
Grand Total	**0**	**0.4**	**1.4**

The main driver of the M4 YTD deficit is the £2.2m YTD variance on shortfalls in savings delivery against the Delegated savings target of £14.5m. This includes shortfalls against the overspend reduction targets noted above for medical pay (£2.4m) and ward nursing (£3.0m).

It is important to note that the total over spend on ward and Accident & Emergency (A&E) nursing in 16/17 was £6.0m. Directorates have been fully funded for this overspend and have been given a cost reduction target for 17/18 of £3m (50%). The latest forecast indicates that only £1.5m of this target will be delivered in 2017/18 which would mean that the actual cost of ward and A&E staffing in 2017/18 would be £4.5m above the agreed establishments (circa 10%).

The M4 YTD total overspend on Non Pay of £0.5m is circa 0.5% compared to 4 months of the annual budget.

The M4 YD total overspend on Pay of £0.5m is also circa 0.5% compared to 4 months of the annual budget. A breakdown of the pay over spend is provided below:

	Annual Budget	Current Mth Variance	Year to Date Variance
	£m	£m	£m
Additional Clinical Services	38.5	0.7	0.6
Add Prof Scientific And Technical	12.2	0	(0.1)
Administrative & Clerical	44.5	0	0
Allied Health Professionals	19.7	(0.1)	(0.2)
Estates and Ancilliary	20.3	0	0
Healthcare Scientists	9.9	0	0
Medical and Dental	80.7	0.7	1.3
Nursing and Midwifery Registered	111.0	(1.6)	(1.2)
Students	0	0	0
Other	(0.4)	0.2	0.1
Grand Total	**336.4**	**(0.1)**	**0.5**

The key areas of over/under spending are in relation to Medical & Dental, Registered Nursing and Additional Clinical Services

Medical & Dental

The main reason for the significant overspend on Medical & Dental is recruitment difficulties in the following areas, resulting in agency spend of circa £1m per month:

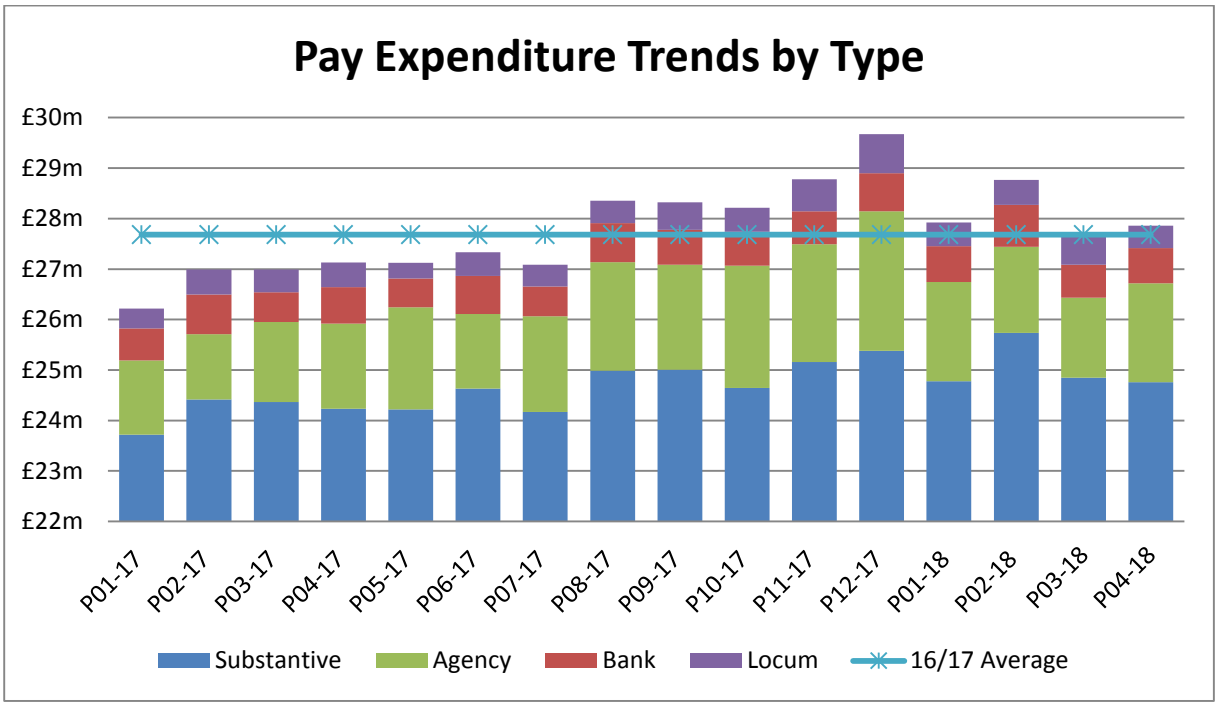
- Acute Medicine and A&E
- General Surgery, Trauma & Orthopaedics and Urology
- Anaesthetics, Critical Care & Theatres
- CAMHs
- Primary Care
- Obstetrics & Gynaecology
- Pathology

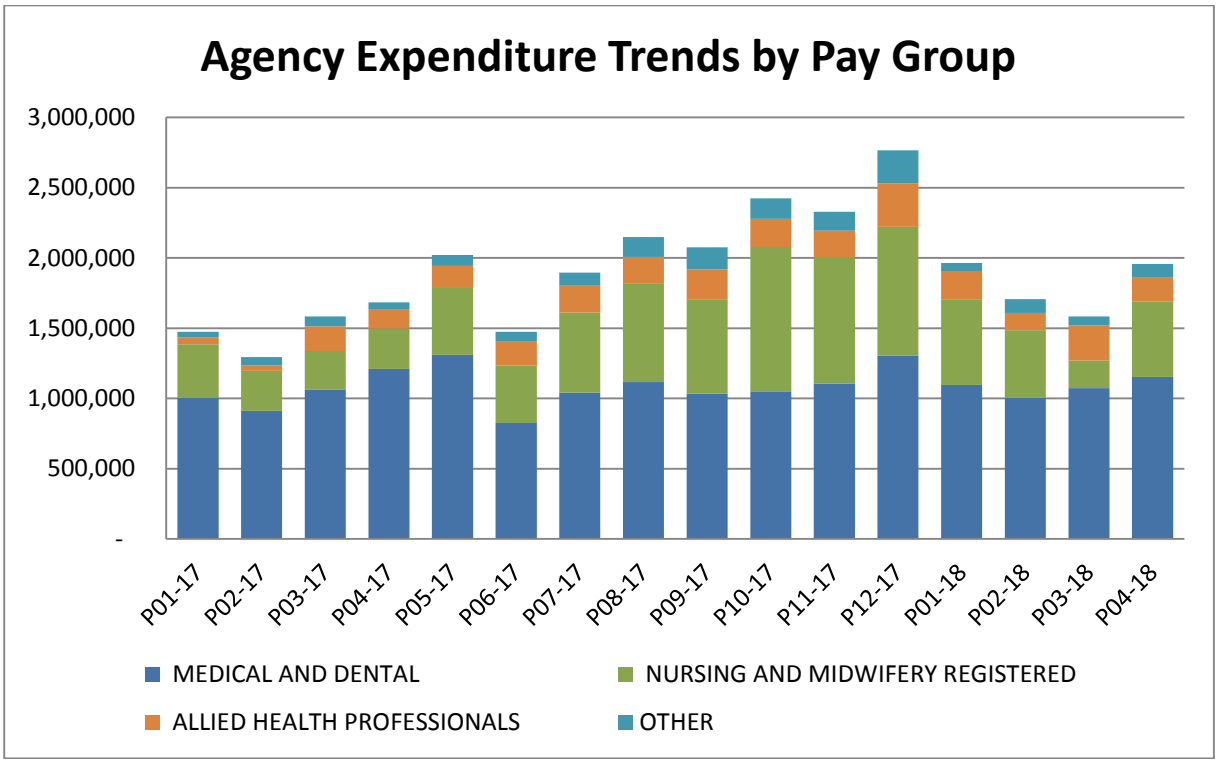
Registered Nursing & Additional Clinical Services

The under spend on Registered nursing is also due to recruitment difficulties which has resulted in additional agency costs and additional spend on Additional Clinical services. The M4 YTD position is a net under spend of £524k split between 'Wards and A&E nursing' of £236k and 'Other nursing' £286k.

b. **Key pressure areas and plans in place to make improvements**

The key pressure areas are medical and nursing agency which are illustrated in the charts below:





There are a number of actions in place to improve this position including recruitment, stabilisation of rates of pay, actions to manage growth in demand, and delivering on further opportunities for improvement. Further information on the plans to address our key workforce pressures and staff shortages is provided in Section 4.

c. Views on the perceptions that there remain opportunities for the NHS to make further efficiency savings

CTUHB has delivered financial balance for each of the last three years from 2014/15 to 2016/17. Each year we develop integrated plans which require us to deliver three groups of priorities:

- Quality of care (standards which increase year on year);
- Performance targets (such as waiting times);
- Financial balance.

Efficiency and productivity are key components of delivering quality, performance and financial objectives. Some of the efficiencies delivered are cash-releasing whilst others generate capacity that enables us to treat more patients within the same available resources.

The requirement to make continued efficiency savings year on year becomes increasingly difficult but we constantly use benchmarking data and best-practice guidelines to drive relative and actual performance in this respect. As noted in Section 2a, we are currently reporting a significant shortfall against our Delegated savings target of £14.5m but are working hard to bridge that gap in-year and on a recurring basis.

It should be noted that efficiency through better use of capacity is as significant in whole-system management of the NHS as cash-releasing efficiency savings given that demand for care is increasing in a cash-restricted public sector system.

d. Any projected spend on technology and infrastructure to support quality and efficiency

Discretionary capital

From 2016/17 the Health Board has had a recurrent discretionary capital allocation of £6.78M to direct towards the capital priorities within the organisation. The following table represents the current allocation of this funding for the 2017/18 discretionary capital programme.

	Amount of Allocation £000	Proportion of Allocation %
IT	1,602	24%
Equipment Replacement	2,239	33%
New Equipment and Service Redesign	1,287	19%
Statutory Compliance and Backlog Maintenance	1,653	24%
Total	6,780	

The need to ensure that scarce capital resources are directed to the areas where they provide the most benefit to the organisation means that the need to improve the quality of patient care, experience and environment feature highly in capital allocation as does the need to support efficiency in service delivery. However, this does have to be measured against the

critical requirement to maintain statutory compliance (including key health and safety issues) and equipment replacement to ensure service continuity. The replacement of equipment and the compliance agenda often lead to improvements in efficiency through improved technology and processes (e.g. some new high technology radiology equipment can result in higher throughput of patients within the same timescales).

Estates Strategy

Our refreshed Integrated Medium Term Plan (IMTP) sets out a number of service changes, many of which will have a significant impact on the estate. Our Estates Strategy sets this out in more detail, but some of the more major impacts include:

- A major redesign of services provided from Royal Glamorgan Hospital (RGH), which will require capital refurbishment as an enabler. This will include the development of the Diagnostic Hub, transfer of palliative care services onto the site, centralisation of breast services and a number of changes arising from the South Wales Programme including the introduction of a Paediatric Assessment Unit and Acute Medicine model.
- Establishment of a 'health park' type facility on the Dewi Sant site, with a mix of primary and community health care, social care and third sector partners using the site for ambulatory care. Again, capital will be a major enabler.
- Service remodelling which will see Tonteg Hospital and Pontypridd and District Cottage (Y Bwthyn) Hospitals becoming surplus to requirements, and further reviews on-going to determine whether any further community premises may be vacated in the future.
- Development of a purpose built Macmillan palliative care facility on the Royal Glamorgan Hospital site.

Over the coming three years, the strategic objectives for our estate are to ensure that:

- The estate is developed to meet emerging service models.
- All statutory and safety obligations are achieved.
- Backlog maintenance levels are reduced year on year to a nominal amount by 2017/18.
- Performance against the 6 national targets is improved, with the 90% target achieved by 2017/18.
- The cost per square metre is reviewed each year, reducing it if possible, taking account of the safety of the service.

Major capital investment

Major capital investment is required to implement a number of elements of the Health Board's 3 Year Plan. The Health Board has submitted to the Welsh Government a set of priorities for capital investment for the coming years, with schemes that enable service model changes, facilitate performance and efficiency improvements and maintain the Health Board's assets (estate and equipment) to a high standard. Specific major schemes include:

- Prince Charles Hospital (PCH) ground and first floor refurbishment project.
- Strategic programme to develop the primary care estate.
- Major radiology modernisation programme at both PCH and RGH.
- Creation of a new, expanded paediatric, obstetric and neonatal service at PCH to enable the outcome of the South Wales Programme
- Palliative care remodelling in conjunction with Macmillan to facilitate the move of palliative care services currently at Pontypridd and District Cottage Hospital to RGH and close Pontypridd & District Cottage Hospital (Y Bwthyn).
- Schemes to enable service model changes include:
  - Redesign of RGH to facilitate the outcome of the South Wales Programme, including the development of a Diagnostic Hub and suitable accommodation to meet the emerging requirements of emergency/acute medicine.
  - Reconfiguration of the Dewi Sant site to enable the development of a Health Park facility.
  - Potential joint development of a Satellite Radiotherapy unit at PCH as part of the new Hub and spoke delivery plan in development by Velindre.
  - Creation of an integrated primary and community care development in Mountain Ash.
- Schemes to facilitate improvements in performance and efficiency include:
  - Major Information Communication and Technology (ICT) investment to enable the move towards electronic health records, for example including electronic prescribing, document management technology, digital dictation and digitisation.
  - Energy management improvements to secure revenue reductions and digitisation
  - Centralisation of switchboards across the UHB.
  - Radiology Information system replacement
  - Radiology Information Technology performance and resilience
  - Welsh Community Care Information System (WCCIS) implementation
  - Major engineering infrastructure schemes with a particular focus on RGH including replacement of electrical and mechanical systems, generators, switchgear and air handling plant

A number of these schemes have already received Welsh Government funding approval and relate specifically to the organisation's quality and financial plans with capital funding required to facilitate the changes in service models that will lead to achievement of cost reduction plans. Work is on-going to ensure that the appropriate business cases are developed to secure the critical funding still required and that they are submitted in a timely fashion. Elements of this investment plan are already acknowledged by the Welsh Government and either already secured or included in the future All Wales Capital Programme.

A significant level of additional capital funding in 2016/17 has allowed the Health Board to address a number of risk areas through further medical

equipment purchase and ICT replacement, and has also enabled the implementation of a number of corporate priorities aimed at improving performance. The Health Board will continue to take advantage of any other funding opportunities or routes which become available, such as the Health Technology Fund, 'Invest to Save' and Integration Funds,

In summary, the following reflect the specific priorities for the coming year outlined in the Capital Plan and the Estates Plan:

- Further development and agreement of a Primary and Community Care Estates Development Plan, with associated integrated health and social care developments where appropriate, supporting the delivery of the Primary and Community Care Plan and implementation of the Social Service and Well-Being (Wales) Act 2014.
- Refurbishment of Tonypandy and Aberdare Health Centres.
- Further development of the Dewi Sant site into a Health Park facility, with consideration being given to how Ysbyty Cwm Cynon (YCC) and Ysbyty Cwm Rhondda may also be able to contribute to this service model in their respective communities.
- Commencement of the physical refurbishment works of ground and first floors at PCH to meet the requirements of a live Fire Enforcement notice.
- Continuation of the major radiology equipment replacement programme.
- Creation of a new and expanded paediatric, obstetric and neonatal service at PCH in line with the outcome of the South Wales Programme and investment in RGH to facilitate the Paediatric Assessment and Midwifery Units.
- Completion and submission of the Palliative Care Unit Business case.
- Development of phase 2 plans for the Diagnostic Hub.
- Significant changes to the RGH site,
    - developing detailed programmes for plant/ equipment replacement to ensure that the hospital retains a suitable physical condition and statutory compliance;
    - creating, revising and implementing site development plans for RGH to accommodate the changes outlined including a Breast Unit, co-located acute medicine service and ambulatory care services;
    - developing a suite of business cases to secure capital to enable these changes to be implemented.
- Digital health records management, implementation of the Welsh Community Care Information System and other ICT investment to support digital health.
- Continuation of a disposal programme, with disposal of Pontypridd and District Cottage Hospital (Y Bwthyn) and Tonteg Hospital.
- Review of community premises to determine whether there are further opportunities for site rationalisation.
- Further development of the Williamstown Warehouse to support the continued centralisation of medical records storage/ management and realise the opportunity for digitisation.
- Continuation of benchmarking of costs against English and Welsh providers,
- Negotiations with Welsh Government to secure the significant levels of capital to enable change.

- Undertake a Health Board premises review and facilitate redesign/ rationalisation outcomes.
- Development of an accommodation control plan for RGH.
- Secure and develop a suitably experienced management structure to deliver the expansive capital and estate development programme.
- Review priorities for the Discretionary Capital Programme, taking into account the needs of the organisation's 3 year plan including:
  - undertaking a range of actions as outlined in the energy management plan, including in particular continuing to seek capital funding for the major schemes required to reduce energy consumption.
- Working in partnership with Velindre NHS Trust on the potential for a Satellite Radiotherapy Unit at PCH.
- Working in partnership with the NHS Wales Collaborative on the establishment of the National Imaging Academy, with Cwm Taf UHB as the host organisation.

Information Communication and Technology - Digital Strategy

Investment in ICT is a critical enabler to allow the Health Board to support the challenge of working across the traditional boundaries and support integration between the various Health Services and other Public Sector bodies, in line with national policies and direction such as the South Wales Plan.

There is a commitment to provide increased care outside of the hospital setting, both near to and in the home of patients. From the patient perspective, the services should be integrated and seamless, with health, social care, and other professionals being able to work effectively and supported by common, reliable, up-to-date information. Patient treatment and care is becoming more fluid with care being provided by primary care and secondary care services in multiple Health Boards and Local Authorities.

For this vision to succeed, as the patient moves physically between care settings and providers, all the appropriate clinical and social care documents must be available at the point of treatment in a timely manner. Clinical teams must have the tools and ability to work in a more agile manner, access to the records of patients must move from inconvenient paper based and hospital based systems, to electronic records, accessible using the latest technology, and delivered in a manner that does not compromise patient confidentiality and safety.

To support this mobile working vision, ICT must be able to provide infrastructure and hardware to deliver the clinical record and applications at the point of care. The era of static working is rapidly becoming replaced with the concept of agile staff based and working where most appropriate to meet clinical needs.

Our IMTP sets out the strategic context in which ICT is operating, the Health Board's ICT requirements in line with the Corporate Business Plans

and the collaborative working with NHS Wales Informatics Service (NWIS) and other Health Boards. In summary, ICT aims to deliver:

- Robust ICT infrastructure to enable delivery of plans to change how and where staff work
- A move towards a digital health record as a key enabler for change
- An ICT model that supports patient care delivered from where it is best for patients, including support for greater integration of health and social care services
- ICT enablers for improved clinical efficiency
- An ICT Strategy and Standard Operating Procedure which sets out the approach and the resource implications of developments outlined above, including changes to governance of ICT incorporating a greater clinical leadership role.

Efficiency Through Technology Fund (ETTF) - 2017

The UHB welcomes the opportunity to make bids to the ETTF for revenue funding to increase efficiency. We have recently submitted five bids which make up a funding request of circa £1m.

Energy management

In terms of energy management, the Health Board recognises that the consumption of energy and water is necessary for the provision of healthcare services, but that it also has a responsibility to be energy and resource efficient by minimising unnecessary energy usage.

The Health Board has already invested in various low or zero carbon technologies which will help drive it to a zero carbon emitting organisation. The level of consumption in 2014/15 was (422 kWh/m^2) and was rated as an amber performance nationally but improvements made during 2015/16 reduced the consumption to 400 kWh/m^2 whilst CO2 (Kg/M2) emissions reduced from 113 to 106, which has moved the position from an amber to a green national performance indicator.

In 2015/16, the Health Board recorded a total energy cost of £3,810,037, compared to £4,273,329 reported the previous year. This was mainly attributed to a number of energy efficiency projects that have been completed which includes installation of LED lighting, voltage optimisers, efficient boiler replacement and Building Management systems.

The Health Board has agreed an Energy Management Plan which commits the organisation to a 7% reduction in consumption year on year. This includes the introduction of an energy awareness campaign together with a range of capital schemes identified to reduce usage. Much of this plan is dependent on capital becoming available.

e. Response to Wales Audit Office (WAO) report on the implementation of the NHS Finances (Wales) Act 2014 (introducing 3 year financial plans to enable longer term planning)

The UHB considers that through the implementation of the NHS Finance Wales Act 2014 this has helped to provide:

- Greater clarity on future funding levels,
- A clear planning and delivery framework
- An environment to support the development of robust plans, and
- An IMTP approval mechanism.

f. Views on the effectiveness of the 3 year plans

The UHB considers that the 3 year plan system is an improvement on the previous planning arrangement. The 3 year IMTP process provides a clear planning and delivery framework for the UHB to plan and deliver its services and associated strategic objectives and key performance targets. The UHB is also incentivised to ensure it has an approved 3 year plan with Welsh Government in relation to the increased autonomy that this provides plus any incentives this may bring such as increased discretionary capital allocations.

In developing 3 year plans however, there remains a natural inclination to have an increased focus on the first year and ensure in-year delivery of key performance deliverables and service quality improvements in addition to financial balance. Through each annual IMTP process the Health Board is developing its approach to ensuring that future year's plans are developed with the same degree of robustness as the first year component and focus on medium term financial sustainability as well as in-year financial balance.

g. The reasons why none of the NHS bodies have so far made use of the new financial flexibilities under the Act

Since the UHB has been able to achieve its statutory financial duty in recent years there has been no detailed consideration of the need to use some of the new financial flexibilities under the Act. In relation to the position of NHS Wales as a whole, a key consideration in exploring the use of the financial flexibilities under the Act is how the system as a whole would retain financial balance, and how longer term plans are developed with a sufficient degree of assurance and robustness that future flexibility can be planned with certainty and any risks mitigated.

3. The pace of change

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

Please refer to the response from the Welsh NHS Confederation.

b. The extent to which a preventative approach to funding services is currently possible

Please refer to the response from the Welsh NHS Confederation.

c. Action the NHS bodies would like to see from the Welsh Government to address these issues.

Please refer to the response from the Welsh NHS Confederation.

4. Workforce pressures

a. Details of particular pressures and staff shortages, and plans to address

As noted above, we have specific workforce challenges largely associated with recruitment difficulties in certain specialities and staff groups. There is also geographical variation. The main areas of pressure are with our Medical & Dental, Nursing & Midwifery and Allied Health Professional groups.

Medical workforce challenges

Recruitment of NHS staff is a UK wide problem with Health boards across Wales and the wider UK competing to attract a limited workforce. In particular, there are UK shortages in a number of medical specialties. These UK shortages are further compounded by other local and more strategic issues including: the impact of Deanery changes to junior doctor allocations which has affected Cwm Taf particularly in paediatrics, general surgery and A&E; the growth of the locum / agency sector workforce at the expense of the substantive; feminisation of the workforce and the increase in part time training and working patterns; changes to the pension and taxation regimes which are influencing the decisions individuals are making about their employment and retirement.

In Cwm Taf we match these UK areas of shortage with specific challenges in recruiting medical staff with particular difficulties in:

- Paediatrics
- Obstetrics & Gynaecology
- Accident & Emergency
- Trauma & Orthopaedics
- Psychiatry
- Pathology

The table below provides a snapshot of the staffing position in these key directorates at July 2017.

Specialty Area	Grade	CT Employed	CT Locums	Agency Locum	Vacancies
Paediatrics	Consultant	16.7	1	0	1.0
	Senior	9.2	1	3	2
	Junior	16.6	0	1	1.4
Accident and Emergency	Consultant	6.4	0	2	1
	Senior/Junior	19.2	0	6	4
Obstetrics & Gynaecology	Consultant	9.5	4	0	1.5
	Senior	13	0	0	3
	Junior	10	0	0	0
Pathology	Consultant	9.5	2	2	5
	Senior	2.8	0	0	0
Trauma and Orthopaedics	Consultant	12.85	3	0	0
	Senior	12	0	0	1
	Junior	5	0	3	3
Psychiatry	Consultant	15.6	0.5	0	2
	Senior	2	0	4	0
	Junior	10	3	0	2

The impact of these gaps in establishment clearly poses risks in terms of our ability to deliver against our performance targets, ensure that patient care is not compromised in terms of quality and significant financial risk associated with filling gaps with high cost agency locums and additional premium rate hours worked within CTUHB.

We have established a Medical Workforce Productivity Group (MWPG) which has been undertaking analysis of all the demand drivers and putting in place strategies to reduce the reliance on locum and agency staff and therefore the expenditure. In addition to identifying demand, the MWPG will also put in place controls to track and manage costs. They have identified there are common reasons for demand across each directorate, including:

- Permanent gaps in rotas that are difficult to fill – owing to recruitment challenges
- General turnover (e.g. retirements)
- Temporary gaps in rotas due to service redesign
- Short/long-term absences due to sickness absence and maternity
- Increased demand on services (may be seasonal)
- Inefficient rotas/sub-optimum control measures
- Trainee gaps in rotas due to withdrawal of trainees or inability to recruit to training places
- Restricted duties or other absences (maternity, suspensions etc)

In some areas we have in place long term locums and part of our strategy is to attract these over time to become permanent NHS employees (A&E is an example of this where we have had some recent success). This means that in some cases we are not actively recruiting against vacant

substantive posts. We are also participating in national recruitment campaigns through partnership with the British Association of Physician of an Indian Origin (BAPIO) with other HBs where we are recruiting Doctors from India. This sees them work in Wales undertaking Junior Doctor roles as part of their training for a two year period.

The UHB is heavily engaged in the current national work seeking to introduce controls to the cost of agency work, both medical and nursing and these will complement our local work.

We have been working on our recruitment presence and have been able to recruit to several consultant vacancies recently as a result of the innovative service change work underway in some of these specialties including acute physicians, psychiatric liaison and paediatrics.

To support our ongoing efforts to recruit to vacancies, we have recently launched our own Social Media recruitment campaign for Medical staff targeting the specialties we require, dovetailing with Welsh Governments "Train Work Live" recruitment campaign. Our GP cluster in the Rhondda (which is an area where historically it has been difficult to recruit to), have also developed a recruitment campaign and resource entitled Rhondda Docs, which features existing practitioners "selling the service".

However, in some areas where there are severe recruitment difficulties, e.g. within pathology and longer term solutions are required on a national basis.

Additionally an underpinning programme of work has been ongoing for the past 18 months following investment via the Invest to Save scheme to implement electronic rota management and job planning systems for medical staff. All consultants and Staff grade/Associate Specialists (known as SAS doctors) now have electronic job plans and all our medical rotas are on e-rostering for each speciality. Further work is underway to drive the efficiency of our medical workforce deployment through these systems which also allow us to manage annual leave, sickness etc through the e-roster.

Nursing workforce challenges

The increased demand for Nursing staff is also UK wide issue that has been driven up by unforeseen circumstances that were in the main not predictable. These include but are not limited to:

- The Francis Review (Mid Staffordshire), The Andrews Review (Abertawe Bro Morgannwg University Health Board) and resulting demand for higher qualified nursing levels.
- The Nurse Staffing Levels (Wales) Act 2016.
- The South Wales Programme outcome which impacted on the Royal Glamorgan Hospital (RGH) in particular with some destabilization of the workforce who were concerned about the impact of the changes on careers and job security. This

has led to increased turnover at RGH and higher levels of vacancies.
- Labour market changes – particularly the rise of premium agency contracts and the apparent shift in attitude about being employed in "permanent" NHS roles versus accepting more flexible higher paid temporary posts.

This has led to a shortage of available staff across the UK and all HBs in Wales are experiencing similar problems. Within Cwm Taf, the demand and shortages are more acutely felt in our Medicine & Surgical Wards in our District General Hospitals (including A&E), and in our Community Hospitals. This has therefore been our area of focus. We do though continue to actively recruit across the whole of the Nursing family including Mental Health, CAMHS, Localities and more latterly in Primary Care as the model of delivering care is reshaping.

We currently have vacancies for circa 60 Nurses in our Acute Wards, and the largest of the deficits is at the Royal Glamorgan Hospital, where geographically we compete with neighbours along the M4 corridor for staff. Over the last 24 months we have improved our general position, but despite all our best efforts the Royal Glamorgan remains in a static position. This then places a large demand for the use of Bank & Agency staff, which is more expensive than the substantive workforce. We have though removed the use of "Premium Agencies" and have achieved a position where all our agency usage is "on contract".

Regular adverts are placed across several jobs boards, including NHS Jobs, LinkedIn and Indeed.com as part of our efforts to market Cwm Taf. We engaged with an advertising agency to develop a national recruitment campaign to attract nurses to Cwm Taf from other parts of the UK, which launched in July 2016. We have included materials to promote our Health Board's innovative service changes and new roles alongside testimonial and video diaries. The campaign which is ongoing is targeting nurses further afield in the UK to relocate to Cwm Taf.

The Multi media campaign included the following components:
- Social media
- Catch up TV
- Press Adverts
- London Underground
- A dedicated recruitment microsite containing Cwm Taf case studies and news stories, information about local housing and promoting the quality of living and Careers in Cwm Taf. A key element is the video diaries of a number of our NHS staff, and a composite video of a range of nurses explaining in their words the benefits of working at Cwm Taf.

Whilst the microsite was initially being used for the Nursing campaign this has been developed to include more general recruitment vacancies in other occupational groups. For example, the Medical Campaign referred to above is now hosted on the same site which portrays a more professional

image of Cwm Taf UHB to external recruits. We also hosted the launch of Welsh Government's national nursing campaign led by the Cabinet Secretary for Health this July at our Keir Hardie University Health Park in Merthyr Tydfil.

We are actively recruiting nurses from overseas, but due to changes in the language requirements to meet the Nursing and Midwifery Committee (NMC) requirements using the international English language testing system (IELTS test) (which now requires degree level ability in English), this is proving to be a lengthy process with delays before we are able to get recruits on board. For example, 52 Filipino nurses were offered roles in December 2015, only 4 have arrived and 2 have now acquired their NMC registration enabling them to work as registered nurses.

We are currently focused on recruitment to our Allied Health Professionals and Additional Clinical Services as we need to actively recruit to these occupations. We are currently recruiting to support the establishment of the Diagnostic Hub at the Royal Glamorgan, and across a range therapy staff in physiotherapy and dietetics. A dedicated recruitment campaign is being developed to resource these areas.

Whilst the above examples highlight some of the challenges – there are also opportunities to reshape or redesign services and roles to support changing models of service delivery. Positive examples would include:

- Our new Acute Medicine service at the Royal Glamorgan which allows direct access to clinicians on the ward by GPs, Paramedics etc to avoid having to admit patients to A&E.
- Development of Advanced Practitioners in A&E to fill gaps on the rotas for Junior doctors that we are unable to fill
- The use of advanced paramedics in our GP out of hours service and A&E services
- Our Health Care Support Worker (HCSW) skills escalator development programme that is enabling HCSWs to safely undertake work within their range of competence that might previously have been undertaken by a registrant
- A part time degree nursing programme that allows our existing HCSWs to train whilst continuing to work as HCSWs and therefore opening access to those who could not afford to study full time.
- The use of Pharmacists and support staff in our community hospitals to undertake duties that would have fallen to a registrant
- The launch of a Multi Disciplinary staywell@Home service. This includes Occupational Therapists, Physiotherapists, Community Nursing support, Social workers and HCSWs that move patients to being treated in a home setting rather than on a ward. This brings together staff from the UHB and the Local Authorities in a joint team.
- Remodelling the radiography workforce reducing the need for additional radiographers through the introduction of increased administrative and health care support worker roles.

The picture therefore remains challenging – but we are making some progress.

b. Any planning/ assessment undertaken on future funding needs post-Brexit, for example given possible changes to agency staff costs

Our workforce planning determines the future requirements for the next 3 years. This includes modelling undertaken at directorate level of the retirement profiles, anticipated turnover and recruitment against projected service requirements. We do not currently hold data on the nationality of all our workforce (this is not a mandated data field in the Electronic Staff Record), however we do hold the data on a large enough sample (50%) to draw some conclusions.

Whilst the proportion of the workforce which is of overseas origin is around 5 – 6%, the data that we hold shows that the areas that we are experiencing recruitment difficulties do have higher percentages of staff from the EU and overseas.

	% EU	% Non EU
Add Professional Scientific and Technical	2.33%	2.44%
Additional Clinical Services	0.00%	0.36%
Administrative and Clerical	0.45%	0.11%
Allied Health Professionals	3.89%	1.87%
Estates and Ancillary	0.00%	0.00%
Healthcare Scientists	0.00%	1.08%
Medical and Dental	5.12%	44.26%
Nursing and Midwifery Registered	0.98%	4.04%
Grand Total	1.25%	4.51%

Currently nursing does appear on the Home Office shortage occupation list, which does mean we can recruit Nurses from overseas. As explained earlier there significant barriers to this through the NMC IELTS process. There is lobbying for the NMC to reduce the requirement for the current level 7 competence to 6.5 which has recently been introduced into the Republic of Ireland with anecdotal positive impact on recruitment.

The UHB does not employ a significant number of EU nurses and has been unsuccessful in recruitment from Europe in the past couple of years, individuals preferring to go to city locations. As such we do not anticipate that this poses any significant risks for us.

Our Medical & Dental workforce shows that we are heavily reliant on overseas recruitment to be able to establish our workforce to a safe level. Therefore, we have a risk if the overseas market were to view the UK as a less attractive location to relocate to in future. This does indicate that increasing investment in the training of the Medical Workforce would be an area that would benefit from Investment, ideally with resident employees who would wish to remain in the locality.

To date, we have not seen any loss of overseas staff which would be above that expected. We have also invested significant effort into staff engagement with positive medical Engagement Index Survey results last year. We consider the key challenges in respect of Brexit to be associated with ongoing positive relationship building and engagement of the workforce and ensuring that the career progression opportunities remain attractive.