

Information Request from National Assembly for Wales: Health, Social Care and Sports Committee.

Cardiff and Vale UHB Response

Mental health

A detailed breakdown of spend on mental health services for the last 3 years (including how total spend compares to the ring-fenced allocation);

The total spend on Mental Health Services is captured in the UHBs Programme Budgeting returns. The latest set available is for the financial year 2016/17 where the UHB spent £111.6m on Mental Health Services.

Year	£m					
	HCHS	Prescribing	GMS (QOF & ES)	Other Primary Care	Total Programme Budget Expenditure	Ring-Fenced Allocation
2014/15	94.158	5.358	0.981	4.256	104.753	96.453
2015/16	96.445	4.946	1.208	4.037	106.636	98.672
2016/17	103.055	4.286	1.541	2.763	111.645	99.325

The 2017/18 values are not yet available. Note the above costs include CAMHs services.

Mental Health services forms one of eight Clinical Service Boards within the UHB. The way the Mental Health Clinical Board is managed, both with regard to service provision and budgets, are no different to any other Clinical Board in the UHB. The Clinical Board is treated equally to all other areas in respect of budget setting and financial management. It gets internally funded for agreed cost pressures e.g. pay inflation, Continuing Healthcare growth and for service specific issues, and is required to live within agreed budgets. Specific Welsh Government investment funding is passed down to Mental Health Budgets and this is consistent with investments made in other service areas. This approach is not to the detriment of Mental Health services as the UHB spends significantly more on Mental Health services than the ring fenced amount which was £12.3m in 2016/17.

What mechanisms are used to track spend on mental health to patient outcomes;

The Mental Health Clinical Board delivers Inpatient and Community based Mental Health Services. The information provides details of the monitoring mechanisms.

- Through the PARIS patient record in C&V, there is a greater ability to track patient pathways, Care and Treatment Plans and Patient formal patient outcome measures, where they are used. All formal measures such as Tier 1 Targets related to the Mental Health Measure and Psychological Interventions RTT are taken from PARIS information through the Information Warehouse.
- The service is also now more able to track strategic information through PARIS as well as manual recording in relation to key gateways such as referrals into CMHTs. We monitor the experience people have as part of that referral to help decide where to target resources. For example currently the UHB is investing in extending specialist Mental Health support in GP practices due to the poor experience of many people inappropriately referred due to lack of previous alternatives. This then informs the IMTP process.
- Third sector contract monitoring for evidence based interventions such as CCI intervention model is monitored every 6 months through contract monitoring.
- Benchmarking – Cardiff and Vale MH services are now in the sixth year of UK MH benchmarking, where information is triangulated on capacity, quality, workforce and finance. This supports investment and prioritisation decision making.
- Service User evaluation – collated formally through engagement exercises, questionnaires and third sector feedback and complaints as well as through SU representation on business and service planning meetings. Again resources targeted at areas needing improvement or development.
- Patient Outcomes measured more formally through clinical tools, particularly where there are specialist services or developing services to inform clinicians and managers of areas of efficacy and thus investment.

Health board priorities for mental health services/spend for the next three years. How outcomes will be measured;

- C&V mental health services intend expanding liaison services into GP practices, EU, Nursing Homes and Police Liaison as preventative and transformational steps. Qualitative and Quantitative outcome measures built in to the service evaluation, including activity, satisfaction, performance and Health and Wellbeing measures
- Also support to coalesce services around the 14-25 year old age group to focus on need and not age with expanded first episode psychosis services and a trauma informed service model. Clear NICE guidelines evidence base to monitor.
- To establish a Recovery college supported by peer support workers to support empowerment and education of chronic service users. To monitor flow, health and well being improvements.

- Investment in Dual Diagnosis support through the Compass Model.
- Support the ‘team around the individual’ with dementia with investment in community dementia liaison into community resource teams – to evaluate EU attendances, admission rates and out of hours activity.
- Outcome measures built into all these projects – both qualitative and quantitative

The extent to which allocated mental health funding is being used to support other services, for example where patients have a primary diagnosis of a mental health condition but require treatment for other health conditions. Do funding arrangements, including the mental health ring-fence, strike the right balance between taking a holistic approach to meeting an individual’s needs, and ensuring resources for mental health are protected;

Mental Health ring fenced funding is not used to support other services or other health conditions.

The Programme Budgeting returns consistently illustrate that expenditure on Mental Health Services, including CHC placements, exceeds the Ring Fencing floor and include providing a holistic approach to meeting individual’s needs.

How demand/capacity and spend on mental health services not directly provided by the health board is captured (e.g. in primary care, voluntary sector);

Included in the Mental Health Clinical Board direct budgets are £2.8m 3rd Sector contracts. These are monitored and reviewed every 6 months to ensure they meet the needs of the Service.

A breakdown of spend on emotional and mental health services for children and young people (last 3 years). This should include information on all services, not only specialist CAMHS, and should be broken down by area (e.g. primary, secondary, crisis, therapeutic, voluntary sector etc.).

The expenditure on CAMHS is included in the Programme Budgeting returns. The Table below details the actual breakdown of costs in more detail.

CAMHS (actual)	2015/16	2016/17	2017/18
Primary Care Services	0.490	0.513	0.538
Secondary Care Services	1.177	0.867	1.040

Commissioned from Cwm Taf	3.076	3.480	3.294
Commissioned from CCG Emotional and Wellbeing Service		0.221	0.300
Total	4.743	5.081	5.172

The UHB also spent £0.100m on First Episode Psychosis services in 2017/18. This will be expanded in 2018/19 through investment in the service via the Transformation and Innovation funding to £0.350m.

Primary care/secondary care split

Health board spend on primary care for the last 3 years, including as a proportion of total health board spending. To what extent is this achieving the policy aim of shifting care from hospitals to primary care/community settings;

Primary Care Expenditure (Net of Retrospective Rebates) 2015/16 – 2017/18:

	2017-18 £'000	2016-17 £'000	2015-16 £'000
Total LHB Expenditure	1,306,878	1,303,119	1,222,840
Add Back Retrospective Rates Rebate	2,995	5,997	
Total LHB Expenditure Net of Retrospective Rates Rebates	1,309,873	1,309,116	1,222,840
Gross Primary Care Expenditure	228,347	226,115	229,428
Add Back Retrospective Rates Rebate	2,995	5,997	
Total Primary Care Expenditure Net of Retrospective Rates Rebates	231,342	232,112	229,428
Primary Care Expenditure as % of Total Expenditure Net of Retrospective Rebates	18%	18%	19%

We are working with our primary care clusters to ensure the sustainability of GP services going forward as they are the foundation of our clinical service model, as outlined in our ten year strategy, 'Shaping Our Future Wellbeing'. This includes developing the primary care multi-disciplinary team, and following successful pilots using Welsh Government cluster funding, we are rolling out the provision of primary care mental health and muscular skeletal clinicians – areas which account for a significant number of GP consultations and referrals onto other services. The provision of these services in primary care will mean that patients' needs are managed within primary care and GP time will be freed up to provide more support to patients with urgent medical needs and chronic disease management. This is very much in line with Shaping Our Future Wellbeing and the model of primary care outlined in 'A Healthier Wales'. We are building on a number of areas where we have moved services from being hospital based, to be focused in the community. For example, most of our diabetes care is now provided in primary care with our hospital specialists now supporting GPs in community clinics where this is needed. This model has been rolled out to cardiology, paediatrics and heart failure, where our secondary care consultants are providing support into primary care and community based clinics, providing the support to enable GPs to

manage more patients, appropriately in primary care. Technology is also being used to facilitate more care being developed in the community with GPs being able to access specialist advice regarding the management of a patient electronically rather than having to make an outpatient referral. This is being extended as part of our outpatient improvement programme. The roles of community pharmacists and optometrists have also been expanded as part of the development of multi-disciplinary cluster service models.

The Committee's report on the 2018-19 draft budget recommended that 'the Welsh Government should support and hold health boards to account to prioritise capital funding for primary care and ensure it improves the physical capacity for multi-disciplinary working and promotes new models of care'. What progress can the health board report in relation to this recommendation.

We have a long term strategy, 'Shaping Our Future Wellbeing', in place that sets out the direction of travel to provide more care closer to home. In order to ensure that all of the infrastructure that is needed in place to facilitate delivery of the ambitions set out in the strategy, we have a programme called Shaping Our Future Wellbeing in the Community which looks at how we develop our infrastructure to support new models of care. To this end we have received capital funding from WG to support the first tranche of projects – the development of a wellbeing hub in Maelfa linked to Cardiff Council's community hub, and a wellbeing hub in Cogan linked to the Vale of Glamorgan Council's leisure facilities. In both cases we will be including primary care facilities to replace a local GP practice facility which is not fit for purpose. We are also developing a new practice facility in Pentyrch funded by Welsh Government as the current facilities are not fit for purpose. The full Shaping Our Future Wellbeing in the Community Programme will see us developing Health and Wellbeing Hubs in each of our three localities (building on the facilities at CRI and Barry Hospital, and a new facility for north Cardiff), as well as wellbeing hubs to support our primary care clusters.) This will all be subject to securing funding through the completion of business cases to secure capital funding from WG. In relation to CRI, we are anticipating that a ICF capital funding bid will be successful enabling us to work with Cardiff Council to complete phase 1 of the redevelopment of the CRI chapel converting it into a community/information centre and library for use by health and care staff, and local communities as part of the development of CRI as a health and wellbeing hub.

We know that the population of Cardiff is growing rapidly and we are working with the primary care cluster to finalise plans to expand primary care capacity to meet this rapid increase in demand. This will involve the development of a new facility for the NW area of Cardiff and expansion in NE Cardiff.

We have submitted the Shaping Our Future Wellbeing in Our Community Programme Business Case to Welsh Government. The case sets out an ambitious programme for investment in new models of primary care estate, as outlines above. It describes the process

we have worked through to identify our preferred way forward and sets out the constituent capital projects we plan to implement alongside the service transformation programme, which will redesign service delivery models to focus on:-

- the health and wellbeing needs of our local population through the delivery of a social model of health;
- the promotion of healthy lifestyles;
- the reduction of health inequality;
- the planning and delivery of healthcare close to people's homes; and
- delivering services collaboratively with our partners and supporting economic growth.

Within the document we set out the case for delivery of the programme through a range of capital projects to be implemented in tranches. These will improve the effectiveness and capacity of our community based infrastructure to provide a network of flexible multi-functional accommodation solutions across Cardiff and the Vale of Glamorgan.

Over the past four years, we have used ICF funding to develop services which enable a single point of access to local authority services in order to provide early intervention and preventative support by the right member of a multi-disciplinary team. This has involved the use of independent living housing officers, for example, rather than an un-necessary referral for a full social care assessment. The models in operation in Cardiff and the Vale of Glamorgan are slightly different reflecting the different infrastructure in each of the Councils and the integrated health and social care locality model in the Vale of Glamorgan. The ICF funding has also enabled the commissioning of health and social care services (Community Response Teams, and 'discharge to assess' teams all aimed at preventing un-necessary escalation to hospital or facilitating a timely discharge to a person's home. The quarterly monitoring returns are scrutinised by the Regional Partnership Board to ensure that the expected outcomes are being developed (which are also submitted to WG).

The Cardiff and Vale Regional Partnership Board has also recently submitted a bid to the WG's newly formed Transformation Board seeking funding from the Transformation Fund that was launched with 'A Healthier Wales'. The feedback has been positive and a formal response is awaited. This will enable the Regional Partnership Board to make further progress towards the integration of health and social care (and housing) services, so that from the perspective of the person in need of care and support, they receive a seamless service which is tailored to their needs and the outcomes they want to achieve. The bid includes proposals develop the primary care clusters into locality health and social care teams, building on the progress made by the clusters to date, with a focus on prevention and early intervention, of which the expansion of the local model for 'social prescribing' is also a key element. This is aimed at tackling the issue of social isolation which was identified in our Population Needs Assessment as a key issue, and will mean that all of the assets available in the community, including those provided through the third sector and volunteering and available to provide support to an individual and that a preventative approach is in place

that means that the right support is available at the right time, avoiding un-necessary escalation of need.

Preventative spend/integration

Can the health board demonstrate a greater focus on prevention and early intervention in its allocation of resources;






The Health Board has implemented a range of measures through allocating resources to focus on prevention and early intervention. In addition to the developments described above, these include:

- Implementation of quadrivalent and trivalent flu vaccine for the at risk groups to prevent hospital admissions
- Health fairs to promote screening and wellbeing have been run in a number of clusters to provide a simple, coordinated way to educate people about healthy living practices and demonstrate a commitment to health and well-being
- Wellbeing coordinators to establish referral pathways to preventative and wellbeing services and activities in the community. They support individuals to build personal resilience in self managing their health and wellbeing through assessment and review of individual needs, development of individual wellbeing plans, and motivating behavioural change.
- Social prescribing has been developed in a number of clusters providing a systematic mechanism for linking people with wellbeing services as there is an increasing acceptance that sources of support in local communities have an important role to play alongside clinical care or even as an alternative in improving someone's individual health and wellbeing outcomes
- Diabetes education through supporting education to prevent long term complications
- Pulmonary rehabilitation in a cluster to increase ability to exercise and improve quality of life and hence reduce hospital admissions
- Third Sector brokers in the Vale facilitating more tailored and appropriate support services for local people. The brokers help to bridge the gap between statutory services and the third sector.

What evidence can the health board provide about progress made towards more integrated health and social care services;

Activity to drive the greater integration of services is taken forward through our Regional Partnership Board. We have been making significant progress in this area as recorded in the RPB annual report, as referred to in the previous sections.

Our priorities for integration 2018-2023 are

1. Older People  Older People, Including People with Dementia	OP1.1 Building on the First Point of Contact and Single Point of Access services, further develop digital services along with easily accessible telephone, online and face-to-face access points for the region, for both professionals and the public.
	OP1.2 Develop resilient communities with local services, infrastructure and strong community networks to meet local needs where older people live.
	OP1.3 Develop and provide a range of future accommodation options to meet demand and enable people to remain at home for as long as possible
	OP1.4: Develop improved assessment, diagnosis and care planning practices which are built upon genuine collaboration with older people and their carers and families, so that their plans reflect what is important to them and achieves the outcomes they seek.
	OP1.5 Develop Cardiff and Vale of Glamorgan as a dementia friendly region
2. Children with complex needs  Children with Complex Needs	CYP1.1 Improve provision for children and young people with Additional Learning Needs
	CYP1.2 Improve integrated provision for children with complex needs, including the transition between children and adult services
Disability and Autism  Learning Disability and Autism	LDA.1.1 People with learning disabilities are supported to maximise their independence
	LDA.1.2 People with learning disabilities are supported to play an active role in society and engage in meaningful day time activities and employment or volunteering.
	LDA.1.3 People with learning disabilities are valued and included, supported to have a voice, and able to exercise choice and control over all aspects of their lives
	LDA.1.4 People with learning disabilities are enabled to stay healthy and feel safe.
	LDA.1.5 People with learning disabilities are supported to become lifelong learners.
	LDA.1.6 Develop a new Integrated Autism Service which all agencies working in integrated, multi-disciplinary ways will provide appropriate services for children, young people and adults with an autism spectrum disorder, addressing their education, health, employment, social interaction and emotional needs
4. Integrated Family Support Services  Integrated Family Support Services	IFSS1.1 Continue to provide an intensive intervention with families referred by Children's Services where there are serious child protection concerns as a result of parental / carer substance misuse, domestic abuse or mental health.
	IFSS1.2 Explore the extension of the Integrated Family Support Service model to include other parental additional needs (e.g. learning disability) and consider how it can help tackle adverse childhood experiences.
5. Adult and Young Carers  Adult and Young Carers	AYC1.1 Identify and implement a carer engagement model based on best practice
	AYC1.2 Improve physical and emotional support for young carers, including emergency and pre-planned respite and reducing the risk of Adverse Childhood Experiences (ACEs)
	AYC1.3 Improve physical and emotional support for adult carers, including emergency and pre-planned respite
	AYC1.4 Involve carers, including young carers, in the planning of hospital admission and discharge if the person they care for is in hospital
	AYC1.5 Provide easily accessible information to carers and relatives in a range of formats and languages, through existing information points, such as primary care and libraries.
	AYC1.6 Raise awareness around caring and carers among public and health and social care professionals, (e.g. adopting an approach similar to Making Every Contact Count), to ensure that carers are identified as early as possible and all involved are aware of their rights as a carer

Particular progress includes:

The First Point of Contact (FPOC) is the initial stage of triage to Preventative Services and Adult Social Care in Cardiff. Through the provision of information, advice and assistance and using better outcomes conversations, this partnership between Cardiff Council's Preventative Services and Social Care looks to find alternative solutions to social care and improve independent living and well-being outcomes.

Further triage can also include assessment with the social worker element of FPOC, who can provide a more comprehensive assessment for alternative solutions and determine eligibility for social care. As a result of skilled outcome focused discussions, FPOC are able to identify solutions and link and direct clients to other teams within preventative services where a particular intervention maybe required such as Occupational Therapy, Day Opportunities, Independent Living Officers and Disabled Facilities. However, a full understanding of a person's well-being outcomes and Independent Living needs cannot always be achieved over the phone and so a home visit can also be required

The Single Point of Access (SPoA) Service in Vale of Glamorgan provides signposting and information and advice for a range of health, local authority and third sector services. Call Handlers manage requests and triage where appropriate. They provide Information, Advice and Assistance and facilitate assessment and access to the Community Resource Service, Social Work assessment, and District Nursing. Age Connects is also located within the Customer Contact Centre through a partnership delivery structure. The objectives of the service are to:

- Reduce unscheduled admissions to hospital
- Assist with providing solutions to accelerate discharge from hospital
- Support delivery of the information, advice and assistance service
- Develop preventative services and trial new models of working
- Facilitate access to reablement for service users to independence
- Support development of greater integrated health and social care
- Deliver prudent health and social care

Accommodation Solution services have continued to be developed across the region, with Support Officers working closely with hospital staff to expedite discharges wherever possible. The team is supported by the provision of step down/step up accommodation for short term use, and also a Rapid Response and Adaptation service provided by Care & Repair. As of March 2018:

- 422 referrals have been made to the Housing Solutions Team since April 2017 from a variety of ward and hospitals across the region
- 166 patient discharges have been assisted directly by the team, with 148 being listed as Delayed Transfers of Care
- Provision of 8 step down flats have been used by 36 patients as interim accommodation following a hospital stay
- An estimated 2,278 bed days have been avoided through the use of step down accommodation over the 2017/18 financial year

- This equates to a cost avoidance saving of £639,875

The Joint Equipment Service (JES) and JES Occupational Therapist utilises a pooled budget arrangement to deliver an efficient, integrated equipment loan service to residents of Cardiff and the Vale of Glamorgan. The service enables timely discharge from hospital by providing equipment to support discharge.

3.37 In 2017/18:

- The JES arranged 35,450 deliveries and 21,293 collections
- 77% of these deliveries were made within 5 working days
- There was a 33% reduction in adult Disabled Facilities Grant (DFG) completion times (235 days to 172 days)
- 3,807 JES Occupational Therapist referrals were received, which represents a 10% increase in referrals compared to 16/17
- 1,164 DFG assessments were completed
- 99% of these cases were assessed within a 4 week waiting time

Pool Budgets From 1st April 2018 a non-risk sharing pooled budget for older people's care home accommodation has been in operation across the Cardiff and Vale of Glamorgan region. The total pooled budget equates to approximately £46m per annum, and is being managed by Cardiff Council in the first year on behalf of the three statutory organisations. Alongside this, the partners have been working together to produce an outcomes-focused joint specification and common contract for care home accommodation services across the region. These will be shared with stakeholders as part of a formal consultation process later this year.

The aim of the Integrated Care Fund (ICF) is to drive and enable integrated working between social services, health, housing and the third and independent sectors across services throughout Cardiff and the Vale of Glamorgan. A signed Memorandum of Understanding has been agreed by partners and the ICF budget is being managed as a pooled budget (albeit without a section 33 agreement).

The 2017-18 revenue funding has continued to support the following initiatives and population groups:

- older people to maintain their independence, avoiding unnecessary hospital admission and preventing delayed discharges.
- integrated services for people with learning disabilities.
- an integrated autism service in Wales; and,
- integrated services for children with complex needs;
- support the development of the Welsh Community Care Information System.

The revenue funding had the following objectives:

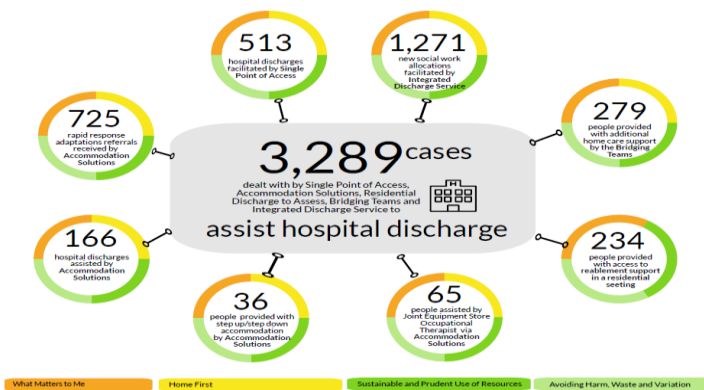
- improve care coordination between social services, health, housing, education and the third and independent sector through innovating and enhancing schemes which support frail and older people;
- develop integrated services for people with learning disabilities and children with complex needs;
- develop an integrated autism service, focusing on a multidisciplinary team to support autism in adults and enhancing existing children’s neuro-developmental services;
- strengthen the resilience of the unscheduled care system;

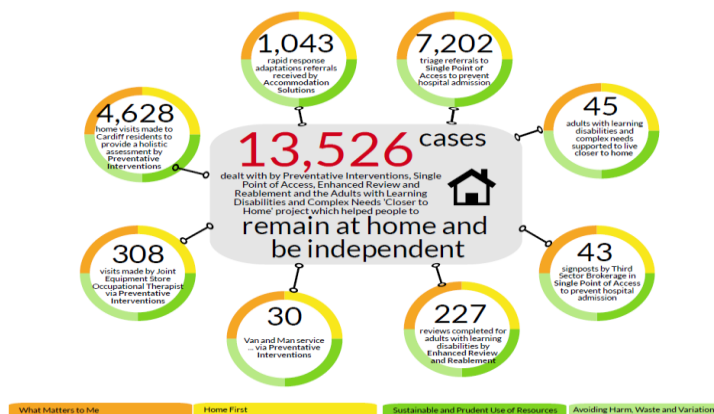
How will outcomes be measured, given that the benefits of preventative activity may only be seen in the longer term.

The impact of the delivery of greater integrated services is reported via the Regional Partnership Board’s annual report. A suite of high level indicators is used by the Health Board to track progress in the delivery of Shaping Our Future Wellbeing. This includes measuring the continued reducing in the rate of admissions to hospital of people over 65, despite the absolute numbers increasing because of the significant growth in the population aged over 65.

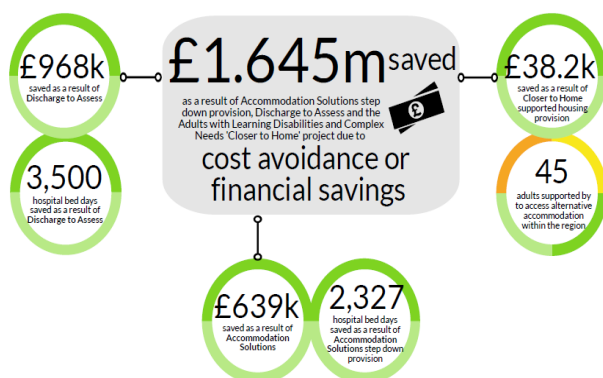
The Regional Partnership Board monitors closely the impact of the services funded via the Intermediate Care Fund.

Some of the measures of impact are included below.





What Matters to Me Home First Sustainable and Prudent Use of Resources Avoiding Harm, Waste and Variation



What Matters to Me Home First Sustainable and Prudent Use of Resources Avoiding Harm, Waste and Variation

Admitted patient care

Spend on both elective and non-elective admitted patient care in each of the last three years. Projected demand and spend for both elective and non-elective admitted patient care for the next three years.

The total expenditure net of local income for acute admitted patient care (APC) has been taken from the UHB's costing system; the datasets supporting the Welsh Costing Returns for respective financial years. It excludes Mental Health, which is subject to a more detailed analysis in this response. The final return for 2017/18 is yet to be finalised and published, due to the ongoing implementation of the revised All Wales Costing System. As such, an estimate has been provided for this based on the provisional overall quantum.

Table 1 – Acute Admitted Patient Care Expenditure (Excl. Mental Health)

Financial Year	Elective £m	Non-Elective £m	Total £m
2015/16	145	200	345
2016/17	144	209	353
2017/18 (est.)	147	213	360

Forward projections of demand and expenditure are subject to several variables and unknowns. As such, there is a high degree of uncertainty in such profiling.

Factors that influence any forecast include, but are not limited to:

- Technological development, including advances in medicines and therapies
- The impact of preventative schemes and greater integration of health and social care
- Inflation, cost pressures and changes in government policy
- Demographic change

The projection below has considered the likely **population growth statistics only**, as the driver behind demand assumptions.

Table 2 – Acute Admitted Patient Care Catchment Growth (Excl. Mental Health)

Financial Year	Elective	Non-Elective	Total
	£m	£m	£m
2018/19 (proj.)	148	214	362
2019/20 (proj.)	149	215	364
2020/21 (proj.)	150	216	366

Workforce

Progress in addressing workforce pressures identified by the health board ahead of last year's budget;

The Workforce Plan is integrated with the service and finance objectives outlined above. In 2017/18 the Pay budgets were well managed, achieving a cumulative month 12 budget underspend of £2.54m. The focus on recurrently reducing workforce headcount and pay costs in 2018/19 will continue in order to meet the proportionate pay savings requirement of the 3% and 1%; as well as contribute towards the £9.3m improvement target to reduce our underlying deficit.

- **2018/19 Workforce WTE Plan:**
 - Workforce Plans currently show 153 worked wte reduction
 - Workforce cost reduction currently identified at £8.9m
 - Cross Cutting Schemes target of £5 million on pay savings
 - Continuation of detailed scrutiny of vacancies and variable employment costs
 - Managerial and Administration costs being considered and challenged across all functions and clinical boards
 - Further organisational reductions in plan - link to transformation programme described below

Detailed plans sit behind these savings and Clinical Boards and corporate areas continue to refine their plans and opportunities. The Director of Workforce & OD is leading these conversations to enable and challenge the development of integrated workforce plans.

High Level Workforce Key Performance Indicators	2018/19 Target
Sickness Absence	4.60%
PADR	85%
Voluntary Resignation Turnover (regrettable leavers)	Improvement
Job Planning Compliance (12 month review)	85%
Paybill	Underspend
Variable Pay Rate	Trend reduction
Medical Hard to Fill Vacancies	Trend reduction
Statutory and Mandatory Fire Training	85%
Increase Staff Survey Response rate	45% minimum
Improve UHB Engagement Score to above Wales average	Increase from 3.63

Key Performance Indicator	2017-18 Outturn	YTD	Monthly Actual	2018-19 Target
1. Sickness Absence Rate	4.87%	4.66%	4.84%	4.60%
2. Job Plan Compliance	50.80%	50.05%	50.15%	85.00%
3. Voluntary Resignation Turnover Rate (WTE)	6.34%	6.32%	6.37%	6.34%
4. Pay Bill Over/Underspend	-0.43%	+0.05%	-0.05%	Underspend
5. Variable Pay Rate	8.06%	8.46%	8.42%	Improve
6. Actual (Contracted) WTE	12758.00	12778.46	12778.46	12726.00
7. Fire Safety Mandatory Training Rate	65.32%	67.61%	67.61%	85.00%
8. PADR Rate	57.19%	59.35%	59.35%	85.00%

Where are we at month 5 against wte budget and plan?

- Core staffing: 38.94 wte under plan
- Variable workforce: 276.6 wte over plan
- Agency: 32.77 wte under plan

We have taken a deliberate plan to increase variable workforce as opposed to agency as these include our part-time substantive staff who work additional hours, those working overtime and bank workers, where the pay rates are below premium rates. Aligned to this our bigger plan is to recruit to the substantive vacancies.

We are underspent at month 5 cumulative against pay budget by £0.070m.

Actions taken to ensure a sustainable workforce following the UK's withdrawal from the EU. What assessment has been made of future funding needs post-Brexit;

In terms of the bigger picture, the United Kingdom's vote in the European Union (EU) referendum to leave the EU will have created significant uncertainty among the UK NHS workforce. In the UK, our EU staff are a valued and appreciated group of the 1.2 million workers in the NHS. It is important that they are provided with the certainty they need to continue living and working in the UK. NHS Employers on our behalf continue to influence the UK government's negotiating priorities and position in the interest of the NHS.

One of the main considerations for us as a local employer, to ensure a sustainable workforce, is understanding the impact on our existing staff of the new right to remain in the UK for qualifying EU citizens that will effectively replace permanent residence following Brexit. In June 2018, the Home Office launched a toolkit designed to help provide clear and consistent messaging to a wide range of audiences including: EU employees and their families, senior leaders, HR colleagues and line managers of EU staff. The scheme, which was announced in June, will allow individuals and their families to apply for pre-settled or settled status, allowing them to continue to live and work in the UK. As a Health Board we will support our staff as they apply for pre-settled or settled status.

A further consideration for us is the continued supply of EU recruits to the organisation. We will continue with our plans to recruit from the EU, especially in clinical roles. We are closely monitoring the changes to immigration rules in relation to Tier 2 Certificates of Sponsorship and the current guidance, dated 23 July 2018, states that Nurses are exempt from the £30,000 salary threshold until 1 July 2019. At present, there are two sets of salary thresholds – one for new entrants, which include individuals under 25 and one for experienced workers which includes anyone aged 25 or over. The £30,000 threshold relates to experienced workers. The implication is that if we are looking to recruit a new Band 5 Staff Nurse from overseas after 1 July 2019, if they're over 25, they will have to be earning £30,000 in order to be given a Tier 2 Certificate of Sponsorship. This could impact on Band 5 Nursing recruitment from overseas, however, we await further home office guidance on this before determining if this actually poses any risk as given the Home Office recently lifted the visa cap on medics and nurses gives greater confidence that we can influence this.

Evidence about progress made in reducing and controlling spend on agency staff.

For a number of years we have been actively controlling agency expenditure, especially in nursing. We have achieved and are maintaining 100% switchover to on contract agencies and we do not engage any off contract agencies. The Welsh Government Off Contract Framework for Nursing is established to support this.

Overall UHB expenditure on agency in 17/18, 18/19 is reducing and we continue to maximise our ability to use bank workers which are paid against agenda for change pay rates, avoiding premium agency costs. (see table below).

We have seen an increase in nursing agency expenditure over the past year in certain areas such as Medicine and Surgery. We have plans to drive this expenditure down by filling vacancies and increasing capacity into the bank, however, we still anticipate an overspend in these areas needed to match the increased bed capacity and requirements of the nurse staffing act. Also the UK nursing supply remains a national shortage.

The UK shortage in supply of nurses and doctors especially in specialist areas means we still require agency workers and premium rates. Our nursing recruitment and retention strategies are aiming to address this, however, realistically the gap will continue to be a challenge as the supply of nurses in the UK is not meeting demand. We are currently working on retention strategies to slow down the leavers from band 5 nursing posts and exploring alternative ways of working to maximise use other professions e.g., Therapy, OT and Rehabilitation roles.

In Wales this year we are introducing a new way of recruiting Band 5 Student Nurses through the All Wales Student Nurse Streamlining Project. This new process will mean we avoid “competing” for student nurses with fellow health boards and should be able to predict more accurately the cohort of nurses coming into the UHB in March 2019. Also, notably, from next September we should see an increase in the supply of qualified student nurses in Wales as a direct result of the increased Education Commissioning which Welsh Government supported 3 years ago.

From November 2017 we have implemented the Welsh Government Medical and Dental Agency cap. This has meant more scrutiny than ever and has seen a reduction in medical agency expenditure in the majority of areas. Unfortunately, in areas such as Emergency Medicine, Integrated Medicine, Paediatric Surgery, Psychiatry, this remains a challenge and we have seen an increase in internal locums as we remain unable to fill all our vacancy gaps due to the national shortage of qualified doctors, especially at middle grade. We have been more successful in recruiting to Consultant posts. We continue to monitor this with rigour through weekly Scrutiny Panels chaired by the Medical Director and through Clinical Board Director leadership.

