Meeting Date	**16th August 2018**	**Agenda Item**	**2a.**
Report Title	**Workforce Risks - Stocktake**		
Report Author	Hazel Robinson, Director of Workforce and OD		
Report Sponsor	Hazel Robinson, Director of Workforce and OD		
Presented by	Hazel Robinson, Director of Workforce and OD		
Freedom of Information	Closed		
Purpose of the Report	The report provides a stocktake of key workforce risks identified by the Director of Workforce and OD 3 months after taking up post in April 2018.		
Key Issues	Workforce has been described as the biggest organisational risk facing ABMU. The Health Board currently faces huge performance, financial and quality and safety challenges and the role and contribution of the workforce are material in ensuring that the organisation is best placed to manage and deliver on these challenges. An efficient, effective and responsive workforce and OD function, with both the capability and capacity to support the BAU and strategic workforce agendas underpins and is a critical enabler of organisational delivery.		
Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
		✓		
Recommendations	Members are asked to: • Note the report • Agree a process for monitoring progress against the identified risks and how this should be reflected in the annual work programme			

Stocktake of Workforce Risks and Challenges
Director of Workforce and OD Reflections at 3 months

1. Introduction

On joining ABMU in April 2018 I was advised that 'workforce' has been identified as the biggest organisational risk.

An initial draft paper has been prepared for consideration and comment of the Workforce and OD Committee and the feedback received has been used to further inform this paper. Further feedback has been requested from Executive and Unit Directors.

The content of this stocktake has been informed by my perceptions since I took up post in April 2018, supplemented by the views and experience of the Assistant Directors of Workforce and a number of other key stakeholders. It is possible that there are further potential risks and challenges that have not been identified within this paper.

Please note there may be further work to complete in relation to the financial implications of the issues outlined in this document. This assessment is complex and has not yet been tested with finance colleagues.

2. Assessment of Risks

The assessment of risks has been presented in two parts. Firstly an assessment of functional workforce risks and a further section outlining my assessment of organisational risks. Although they are presented in two broad sections the issues are inextricably linked with one impacting directly on the other.

2.1 Functional Workforce Risks

Capacity of Workforce and OD Function within ABMU

Since the establishment of the Health Board in 2009 there has been a significant reduction in the workforce and OD staffing levels. The current capacity of the team and the team's ability to provide appropriate, high quality and timely advice on both operational and strategic issues is a significant area of professional concern.

Current resourcing levels have been benchmarked with other Health Boards (to date only for the core workforce arm of the function) demonstrates that ABMU has the lowest ratio of workforce staff to staff headcount of all Health Boards in Wales. Benchmarking of the LD/OD function will also be undertaken in the near future.

These historical reductions were made as part of a wider corporate savings programme and were implemented on the basis that the model of HR delivery would change with managers taking a greater role and responsibility in dealing independently with their people management issues.

This operating model was predicated on the basis of establishing 2 additional 'invest to save' posts within the structure whose role it would be to intensively roll-out people management skills training across the Health Board and therein build organisational capability and sustainability. These posts were not created due to financial constraints

and therefore the anticipated surge and impact in developing the 'people management' skills of our managers did not transpire. It is not surprising, therefore, that the anticipated changes in the competence and skill of managers has not been achieved. However, from a personal and professional perspective the potential for success in this approach was flawed. Whist there must be a desire and commitment for managers to manage staff well the expectation in managers to 'fly solo' on complex HR issues may be considered to be an unreasonable expectation given the complexity and breadth of their roles.

My reflection is that the impact of these reductions has had a negative impact on a wide range of workforce issues and performance. Examples of the impact of this are summarised below and explained more fully later in the paper:

- Inability to support sickness absence cases adequately
- Inability to coach, train and informally support managers to be better people managers, capable of nipping issues in the bud
- Inability to case manage ER cases meaning cases drag on affecting resources and the health and wellbeing of staff
- Inability to manage SAR cases on time facing possible fines from the Information Commissioner
- Inability to develop operational workforce staff by getting them involved in a broad range of Delivery Unit business, as core operational work and caseloads are too high. This results in a lack of therefore lack of succession planning and professional development.
- Reputational risks as we are unable to support the Delivery Units adequately and this affects the reputation of the workforce function
- The management of personal files continues to be a significant risk with too few resources to manage these effectively
- There are no resources in either the operational teams or the Medical HR team to pro-actively support medical sickness which traditionally has not been managed, or to scrutinise the activity of the Delivery Units around the medical workforce efficiency agenda E.g. job planning, efficient rostering practices, locum and agency deployment and usage
- No resources to support the working longer review or dealing with the challenge of managing a workforce with the generational differences from Baby Boomer to millennial.

A specific funding issue is also brought to the attention of the Committee. The ESF funded 'In Work Support Service' has been a partnership between the Health Board and Welsh Government and since 2015 has provided approximately 500K funding per annum to support the multidisciplinary clinical and administrative team - the current funding agreement ends in August 2018. ABMU has become accustomed to the service provided by the Wellbeing through Work team and this is now an established and reputable support service.

Written assurance has been provided by Welsh Government Project Leads that extension funding will be provided and this has been planned until 2022, however, the Health Board has not yet received written confirmation from the related Cabinet Secretaries (Economy and Health & Social Care) nor written agreement from WEFO that this will commence form 1st September 2018. Correspondence from Welsh

Government has stated that Cabinet Secretary confirmation should be communicated shortly to the Health Board and that the current priority for WEFO is completing the extension partnership agreement and funding arrangements.

Should funding not be forthcoming, then the Wellbeing team would not be able to provide its current early intervention /prevention health and work service to the Health Board population and there may be associated redundancy costs for staff who cannot be redeployed within the Health Board.

As part of the previous organisational restructuring which established the Delivery Units the workforce function was also restructured into Unit based teams (as far as resources would allow). This has created challenges in sustaining a 'one team' philosophy and ensuring consistent working practices and standards across Unit teams.

I would contend that the reduction in workforce resourcing has had a disproportionate and significant negative impact of the performance of the wider ABMU workforce, which has resulted in false economy with the cost to the organisation now significantly greater than the savings attributable to the reduction in workforce and OD team staffing levels.

2.2 Operational and Strategic Organisational Workforce Risks

Outlined below are a wide range of organisational workforce risks. A number of these risks relate directly to the impact of the capacity issues outlined above. Other issues are not and will not be given appropriate strategic attention to develop positive organisational strategies to support improvement, delivery and cost reduction. In additional there are new, emerging risks and significant workforce challenges which need to be delivered.

2.2.1 Doing the Basics Brilliantly

Sickness Absence Management - significant levels with ABMU reporting the highest levels of S/Abs in NHS Wales. The current rolling average is reported at XXX%.

There is a need to manage long term sickness more proactively which takes time, both managerial and workforce. It is perceived that workforce practitioners get involved in many cases at a late stage, thus elongating periods of absence that could have been resolved at an earlier date. There is also a perception that there is an organisational culture of 'I don't like something so I will go on the sick'.

Further issues relating to sickness absence include a limited focus on **sickness absence of medical staff**. There is likely to be under-reporting of current levels of absence and a lack of clarity and lack of resourcing about the lead responsibility (with the workforce team) for managing this exacerbates the problem.

Also, following negotiations at a national level, the re-introduction of **unsocial hours pay for sickness absence** with effect from December 2017 may have the impact of further driving up sickness rates in some staff groups. This needs to be closely monitored. In relation to this Welsh Government has set a national target of 4.2% to be achieved by March 2019.

The provision of **Occupational Health** services is a critical enabler to support the effective management of staff well-being and sickness absence cases. There has been increasing demand for Occupational Health services in the last few years with a year on year increase in management referrals (18% increase between 2015 and 2017). Recruiting specialist Occupational Health Nurses and Medical staff has been challenging and the team has a reduced experience base compared to previous years resulting in some delays, particularly in relation to recruitment clearances and reports to managers to support sickness (51% of staff were cleared within 5 days of receipt of the health declaration in May 2017 compared to 35% in May 2018).

Actions already in hand to address this include gaining resource to develop a digital, scanned record, a text reminder service to reduce DNA's and automatic clearance when applicable for non-patient and non-food handling staff.

However, the future provision on OH services requires urgent strategic review to determine the most appropriate future operating model as it is perceived that access to and delivery of OH services is currently an obstacle in the timely and robust management of sickness absence within the HB.

Sickness absence is one, amongst many other measures of employment engagement and symptomatic of organisational culture. In the publication 'Engaging for Success – Enhancing performance through employee engagement' MacLeod & Clarke (2012) cited that engaged employees in the UK take an average 2.69 sick days per year, versus 6.19 taken by disengaged employees. Therefore effective management of sickness absence is far greater than dealing with sickness absence per se; it requires a concerted effort to build an engaged organisational culture, built on authentic visible leadership which allows individuals to perform, innovate and grow.

High levels of sickness absence can be a symptom of an unengaged workforce but in parallel with effective S/Abs manage practices the HB must also treat the underlying cause.

Sickness absence and stress and work pressure – Mental health related sickness absence is now the primary reason for long term sickness absence within the Health Board with 30% of long term absence being attributable to this. As a result, additional staff counselling support has been made available and the Invest to Save two year funded 'Staff Wellbeing Advice and Support Service' has recently been launched, providing fast access for staff for health support. Training in 'Understanding mental health in the workplace' for managers is now available along with training in using HSE Stress Management standards to assess the risk of work related stress.

It is recognised that staff in many parts of the organisation are under significant strain with unrelenting demand and the pressure of service delivery. Staff burnout is reported anecdotally as a cause of significant concern at the current moment in time.

In this context the **financial cost of sickness absence** needs to be understood.

At current levels the total cost of sickness absence is calculated as £24m. This measures the 'value of staff time' lost essentially. This figure is broken down by staff group below:

Absence Timeline Detail 1 Jun 17 to 31 May 18

		Absence % (FTE)	Absence Estimated Cost
130 Abertawe Bro Morgannwg University NHS Trust.	Add Prof Scientific and Technic	**3.98%**	**704,087.53**
130 Abertawe Bro Morgannwg University NHS Trust.	Additional Clinical Services	**7.82%**	**4,369,042.98**
130 Abertawe Bro Morgannwg University NHS Trust.	Administrative and Clerical	**5.31%**	**3,371,230.02**
130 Abertawe Bro Morgannwg University NHS Trust.	Allied Health Professionals	**3.41%**	**1,266,623.90**
130 Abertawe Bro Morgannwg University NHS Trust.	Estates and Ancillary	**8.08%**	**2,212,379.23**
130 Abertawe Bro Morgannwg University NHS Trust.	Healthcare Scientists	**3.46%**	**452,952.56**
130 Abertawe Bro Morgannwg University NHS Trust.	Medical and Dental	**2.15%**	**2,266,786.78**
130 Abertawe Bro Morgannwg University NHS Trust.	Nursing and Midwifery Registered	**5.96%**	**9,437,748.84**
130 Abertawe Bro Morgannwg University NHS Trust.	Students	**0.00%**	**0.00**
Grand Total		**5.79%**	**24,080,851.84**

If Sickness levels can be reduced by 1% to 4.8% (an actual reduction of 18%) a reduction in 'cost' of sickness absence of circa £4.1m would be achieved across all staff groups.

Given the current staff shortages and vacancy levels it is likely that in a number of staff groups much absence is covered by overtime, bank, agency or locum staff at an enhanced rate.

A prudent assessment of the reduction in the value of staff time lost from just registered nursing alone are circa £1.7m. In addition to this direct cost there are additional costs which are incurred as a consequence of additional overtime, bank and agency cover. If only 50% of lost shifts are cover at A&C rates this incurs an additional organisational cost of circa £800K.

However, it is recognised that given current vacancy levels it is likely that the backfill rate may be in excess of 50% and of course the actual cost of this will be at a higher premium whether they are covered through overtime, bank or agency staff.

If the same assessment is undertaken for medical staff the value of staff time lost is calculated at circa £408K. It should be recognised however that it is generally believed that medical S/Abs is under reported not only in ABMU but nationally.

Using a 50% backfill ratio and standard costs principles the additional backfill costs will be in excess of £200K although in reality both backfill and the pat rates are likely to be significantly higher.

For all staff groups the cost impact on quality, safety, performance, continuity of care has never been costed but the impact on staff absence on these non-financial measures are well recognised and of equal importance.

Casework – the number of Disciplinary, Grievance, and Dignity at Work etc cases is currently at an exceptionally high level at circa 180 cases in total. By way of comparison C&V (70) AB (60) H Dda (70) CT (30). This is a huge resource drain on both the workforce team and managers.

The impact of these volumes is that cases take a very long time to resolve, the workload takes an inappropriate and disproportionate amount of the time of the workforce team, no dedicated investigation resource which adds to the burden of managers, workforce, elongates timescales and causes significant stress to staff (who then often go sick as a consequence).

A review of the current situation has been commissioned which has highlighted the following: (NB this is based on the partial results from 2 Units as the full review is yet to be completed)

- The cost of suspensions has been quantified at in excess of **£100K** pa in one unit alone (MH&LD). Across the HB, if extrapolated this figure is move close to **£1M**

- Based on the evidence presented by one Unit circa **20% – 25%** of staff subject to a 'process' go on the sick during the process. Without calculating this in a case by case basis it is impossible to come up with an exact cost.

  However, based on the evidence that there are circa 180 on going cases approx. 40 cases result in a member of staff reporting sick and that cases can take on average a full year. At an average salary cost of say £25K x 40 the full year cost will be in the region of **£1M.** If staff only go sick for half of the duration the costs are still potentially in the region of **£500K.**

- Over **25% of staff are 'redeployed'** to another work area during processes. Many of these will be nursing posts which will attract significant additional costs to cover the gap. A number of specific examples have been shared by the RCN where costs have been identified as significant running in tens of thousands of pounds.

There are quite a number of highly complex, very long running ER cases (over many years) that it is proving challenging to resolve.

Given the recent changes in rules relating to the costs of submitting on Employment Tribunal claim there is a real risk that the number ETs will increase significantly in the future.

The skills of **investigation officers (IOs)** has been of concern and the current organisational structure supports the potential for variation in practice and standards. Of the cases reviewed on 20 – 25 % of occasions the delays were related to the progress/pace of IOs. A previous HIW investigation recommended the establishment of an investigation team to deal with complex cases as there has been severe criticism on the quality of investigations and the HB did commit to address this. A bid has been developed for IBG which outlines costs and benefits of resourcing an IO team.

The workforce function has no way of tracking progress of cases which when numbers were lower was not of great concern. In response to the current volumes an investment case has been approved by the IBG for a casework management system which will help track and manage the progress of future cases.

There remains a significant challenge of how to deal which the current volumes of cases given conflicting organisational priorities and capacity.

Employee Relations – the climate in ABMU is very challenging. Partnership working in the truest sense is not understood and partnership behaviours exhibited in ABMU are not what most organisations would recognise as constructive partnership working. This is in part borne out in the case work volumes reported above and the (understandable) frustration that TUs have in relation to this.

As a very generic reflection and there are some very constructive TU reps but the whole ER environment needs significant improvement and investment in time to build constructive relationships and move forward in a positive way.

The impact of poor employee relations also manifests itself in many other ways. The desire to resolve things on an informal basis seems lacking in ABMU which issues immediately and often inappropriately escalated to senior levels and only resolved through formal mechanisms. This is a significant demand on resources of the workforce team. The people skills of managers may be a contributory factor here as well as the availability of the workforce team to nurture and support managers on how to handle difficult situations before they escalate. The current culture also impacts on our ability to manage change constructively through a partnership approach.

Developing the people skills of managers are vital to improving this environment. To address this the HB should both invest in resources to train Line Managers in HR policies and soft skills (see leadership section later in the document) whilst adopting a coaching approach to management, as well as invest in developing our operational HR teams to foster a different climate of employee relations.

Individual discussions are being held with TUs and as required with full time officers to try to develop better, more constructive, trusting working relationships.

E learning and Statutory & Mandatory Training – the progress against the achievement of the 85% Welsh Government target has been well rehearsed at a

previous Audit Committee. Although compliance levels are improving ABMU currently has the lowest levels of compliance across NHS Wales.

There is currently no dedicated infrastructure in place to support e-learning, despite the core mandated training dictated and monitored by Welsh Government being on an e-learning platform. Within the L&D team, one member of staff takes on a supportive role, answering queries and running reports, however, this is in addition to his principal role which is a L&D facilitator, with responsibility for leading on coaching skills development and roll-out across the organisation. This is a shared risk with IT – as systems and/or software are often not compatible and user error is significant which requires resourcing to support.

Work continues to improve compliance levels but the only sustainable way of achieving and maintaining compliance is through the correct usage of the ESR Self Service portal and the pre-loading of all mandated e learning so easy user access and reducing user error can be improved.

Furthermore, the revised Agenda for Change Framework (or pay progression framework??) stipulates that compliance with mandatory training is a key component in determining pay progression for all staff. This will create an even greater urgency for staff to have the skills to complete e-learning and be supported by their managers to do so. Organisationally, we therefore need to invest in a dedicated resource to support e-learning. Resource is required to profile the mandatory competencies across the organisation, facilitate the development of appropriate e-learning and other learning solutions, and influence subject matter experts in the development of materials and methodologies to support different roles and different environments. Linking with national groups would also be a key component of this role to ensure prudent delivery of mandatory training across NHS Wales.

PADR – organisational wide PADR compliance currently stands at circa 63% (check figure). Again compliance levels have been improving but ABMU still reports the lowest levels of compliance across NHS Wales currently. The proper use of the ESR ESS/MSS portal will help improve this figure but a concerted effort is needed to focus managerial efforts to ensure compliance levels are improved to at least the target figure.

It should also be recognised that an effective appraisal mechanism is a fundamental building block in employee engagement.

Furthermore, the proposed changes to the Agenda for Change Framework and the earning of incremental points will bring PADR into sharp focus from the implementation date of the NHS Wales pay changes (anticipated October 2018). We will need to prepare for the changes, engage with staff and develop managers in the new process. Local processes in ABMU will need to be developed, aligned to NHS Wales and underpinned by the principles of the Framework.

There is a real danger that unless the new arrangements are implemented effectively it will lead to more grievances if managers try to prevent (even appropriately) pay progression.

Further consideration will be needed with the local ESR team about how the information is recorded and uploaded to ensure seamless transfer of information for this pay impacting change.

Recruitment and Vacancies – the challenges of current vacancy levels and recruitment issues are well rehearsed and are a UK wide if not an international issue. There are acute shortages of both nursing and medical staff which fundamentally impact on ABMUs ability to meet targets (performance, financial and quality/safety).

As part of the 'living our values' work programme, a commitment was made to roll out Values Based recruitment methodology in the Health Board. A pilot project was established in Mental Health Services for Health Care Support Worker staff. This has worked well but no further plans are underway to rollout the methodology further as there is currently no dedicated resource within the HR / Values Team to continue this work.

A further **international recruitment campaign** is being developed to source overseas nurses but to learn lessons from previous campaigns the Health Board has determined that nurses will only be interviewed if they hold the appropriate IELTS qualification. This will speed up the recruitment timeline significantly and should be a better operating model as long as companies can furnish staff with the appropriate IELTS standard.

The impact of the Nurse Staff Act will further highlight and increase the reported vacancy levels within the Health Board.

Turnover and Retention – this is clearly linked to the vacancy challenge referred to above. When the recruitment market is so competitive all efforts must be to retain the staff we currently have as far as possible. Global turnover rate of circa 9% is not dis-proportionately high (this still equates to circa 1500 staff each year) but when looking at the detail there are some hots spots that need to be addressed and includes in particular the number of nursing staff that leave with 2 years of appointment.

The Health Board does not have any consistent way of conducting exit interviews which are critical to know how to address turnover and improve staff retention. The corporate nursing division has operated a 3 month exit interview pilot (ending June 2018) which if successful (early indications are that it is) should be adopted as a model for the Health Board.

However, the volume of data will mean that it will be difficult to roll out the trials methodology across all parts of the HB. There is software commercially available that allow large volume of exit interview data to be captured and be available for detailed analysis to obtain a true and detailed picture of the reasons for staff leaving the organisation which we are able to report upon it. This will ensure that any actions taken are evidence and data based and not conjecture or anecdotal.

There are a number of systems on the market there is a UK based system available today for as little £4K per annum, including set up, design of questions, regular reporting and analysis.

Bank - The internal bank service reports very high fill rates which is very positive. Similarly the Health Board has been able to 'turn off' all off contract agency usage, again a positive development. The next steps must now be to further develop the capacity of the bank to provide additional capacity and broaden the range of staff roles that can be bank sourced eg A&C staff.

Personal Files - since the inception of the Health Board in 2008, there have been two different methods of retaining personal files. In the East of the Health Board, managers retain personal files, whereas in the West personal files are centralised within the HR Teams. Whilst this is not ideal, the system has worked adequately in the past.

Slowly as HR resources diminished due to cost improvement programmes, the HR Teams in the West were unable to adequately maintain personal files. Also, as geographical changes have occurred, often moving to smaller offices, there no longer is the space to retain personal files. Please note for the last few years since Shared Services have undertaken the Health Board's recruitment services, they have sent the documentation electronically to line managers and not to HR, meaning that personal files now in the West increasingly are being held by line managers.

Personal Files are legal documents. The inability to store files safely raises both reputational and actual risks for the Health Board through possible Information Commissioner fines which can be considerable. The files currently held at Gorseinon, Cefn Coed, Singleton and with Robbins Brothers need to be culled and ideally scanned. Looking to the future a full digitisation solution should be considered.

GDPR - does expand the rights of staff as it applies to the security, handling and storage of their sensitive personal data. Whilst much of the detail of the new GDPR regulations bare similarities with its predecessor the DPA ,the rights of individuals and the clarity of how data can be use are significantly enhanced. The basic principles of the GDPR are not new but in a practical sense there are risks in terms of the ability of the organisation to be able to adhere to the revised terms.

Of particular concern is the new deadlines for releasing personal data under the statutory Subject Access Request (SAR) and the publicity around GDPR which may of itself increase the likelihood of staff seeking to see their data. We are currently looking at a revised SAR policy and the optimum way to make staff aware of both their rights and the HB responsibilities. The current post that supports this activity is currently not funded.

Welsh Language Standards - revised Welsh Language Standards will come into place in 2018 and we met recently with the Welsh Language Commissioners team to discuss the revised standards and the impact on the Health Board. The 2018 standard's widened scope and application increase the impact both on our services and patients but also as the new standards apply to our staff. For ABMU the implications of providing training and support to staff who wish to learn the welsh language has both costs and resource implications.

Staff will also be able to require the health board to conduct all forms of internal processes e.g. disciplinary, sick absence management through the medium of the

welsh language, this will be challenging in a practical context for both managers and workforce staff.

2.2.2 Managing the Medical Workforce

Medical staff are our most costly resource. Nationally medical staff account for 8% of staff but 20% of cost. There is a significant under capacity in this team who struggle to meet all the demands of Units on the medical workforce agenda. There are a number of risks and opportunities which are outlined below:

The level of **Medical vacancies** remain a challenge and again there is no quick fix. Work is ongoing with MEDACS to support the recruitment of doctors to substantive vacancies. However, given the positive changes to the immigration rules consideration should be given to specific International recruitment campaigns. Although this is not a quick fix increasing the supply of medical staff is key to meeting the agency cap challenge and premium payment issues which will significantly reduce cost. This mechanism can be further enhanced by ensuring access to robust language training to help get doctors through either IELTS or OELTS. The medical workforce team are unable to find the capacity to work with the Delivery Units on innovative recruitment campaigns

To help mitigate the **recruitment and retention** risks faced a further initiative to support medical recruitment and retention would be the establishment of a Junior Doctor Welfare Officer which will help with the recruitment and retention specifically of junior medical staff. They could also lead some work around medical engagement. This concept has already discussed with the Junior Doctor Engagement Group which believe this would solve a lot of problems with the juniors' experience which will help them navigate their problems, improve their staff experience and improve the feedback from the GMC trainee survey which will have a knock on effect to recruitment. The junior doctors have said they will also be much more willing to fill locum shifts if they feel better about work.

Agency and Locum usage – expenditure on contingent workforce is regularly reported and shows a general improvement on spend trajectory. The current reporting against the Welsh Government Locum and Agency cap standards shows positive progress which must be maintained. In term of specific risks anecdotal reports suggest that other Health Boards are paying (sometimes significantly) above the cap for some specialities which makes sourcing doctors a significant challenge. ED is a specific issue regularly mentioned.

Job Planning –as the Health Board seeks to dive out efficiency one major and significant area for review relates to the medical workforce. The job planning process and the content of consultant job plans would benefit from significant focus and attention to ensure that the Health Board is deriving best value in terms of both performance and cost from its medical workforce. This is a significant and complex area of work that requires dedicated resourcing to be undertaken effectively aligned to the role out of the e job planning system.

To resource this an Invest to Save Bid is being submitted to Welsh Government which will provide much need resource to scrutinise the job plans for consultants and SAS

doctors, review annual leave patterns and to complete the roll out e job planning to ensure full benefits realisation.

Junior Doctor rostering – again it is recognised that there may well be benefits and efficiencies of undertaking a wholescale review of the current junior doctor rosters. These are developed and managed by in excess of 100 local rota coordinators. Given the medical resourcing challenge it would seem prudent if a comprehensive review is undertaken to ensure efficient and effective rostering practices. This work will support the ongoing drive to reduce medical locum and agency expenditure.

In addition there are a number of very fragile rotas that need urgent attention, for example the ED rota in Morriston where the Deanery has threatened to remove training posts unless improvements are made. There are a number of new challenges flowing from changing the Shape of Training. This could be a considerable amount of work around rota redesign and in implementing the changes. Further attention needs to be given to provide Rota Coordinator and Service Manager training around medical workforce issues.

Succession planning is a key risk in the short term as the most senior and experienced medical workforce team are moving swiftly to retirement. The need to upskill junior staff in the complexities of M&D T&Cs will become very acute in the next 2 years.

We also need to recognise the risk arising from the loss of the Executive Medical Director and the Deputy Executive Medical Director which presents additional risk given that they have become very skilled Medical Workforce Managers. It is likely that the new incumbents are likely to need a much higher level of support from the Medical HR Department.

2.2.3 Looking to the Future

In addition to addressing the here and now issues there an equally important need to ensure the workforce function is able to pro-actively focus on the strategic developmental agenda. The team's ability to do this at the current time is severely restricted by the workload associated with the day to day operational demands.

Service and workforce redesign – recognising difficulty of recruiting doctors and nurses the organisations need to develop a more strategic and co-ordinated approach to re-profiling the workforce and support the development of the non- registered workforce.

In relation to this the Health Care Support Worker Framework is a mandated framework by Welsh Government and the responsibility for implementation sits with Nurse Director. However, with the development of the framework to include all clinical and non-clinical support workers, there is a debate about where responsibility for the framework will sit in the future. This is a risk and will need to be resourced appropriately if / when the framework is rolled out further than nursing health care support workers.

The current risk is that the overwhelming 'operational' workload previously referred to detracts for the planning, attention and intervention needed on this strategic need.

Linked to this ABMU (as does the rest of NHS Wales) has a very challenging **aging workforce** profile. Attention need to be given as to how we manage and support an aging workforce and keep people working longer to ensure we can achieve the required future staffing levels

Workforce of the future – there is no resource to coordinate work experience in ABMU or to work with schools and colleges through career fairs to ensure widening access to clinical and medical careers locally. Two bids were made to Charitable Funds to fund a Band 6 Widening Access Coordinator, but this was turned down on the basis that it was core HR business. Some work does happen but this is down to individuals with the good will and passion to make this better and takes place in their own time. There is no non pay budget to support this work either.

Further work is also anticipated during autumn in the coordination of a high profile HRH Nurse Cadet Scheme. This is highly confidential at present but further details will be provided shortly. The intention is develop a 2 year cadet scheme for 70 students and grow this to include other professions such as OTs and Physios in subsequent years.

Given the size of the organisation and our recruitment challenges, this is a risk for the organisation and consequently we are falling behind other organisations in meeting the minister's mandate on widening access. This is a pivotal area of work that is not resourced at the current time, both in terms of staff and materials.

Digital Workforce Solutions – ABMU is significantly behind the pace with the implementation of digital workforce solutions, including ESR. In the past it may be that this has not been a priority for the Health Board and the resource investment made by other organisations has not been mirrored within ABMU.

The impact of this position is that there is significant waste and duplication in many of our core workforce processes. In addition there is a lack of up to date workforce information and analytics to support evidence based practice.

The Board has received a presentation on a digital workforce vision for ABMU which was strongly supported. It has been agreed that an investment business case will be developed. It should be noted that there is a 3-4 year journey to fully achieve an integrated and sustainable digital way of working for ABMU which would need pump priming of this to get the HB up to speed before we would settle to a steady state.

Employee Engagement/Culture – The MacLeod Review (MacLeod & Clarke 2009) highlighted the importance of employee engagement for organisational success, productivity and performance and individual employee wellbeing. The review describes that engagement works best where people 'can be the best they can at work', where they are 'respected, involved, valued, heard, well led and valued by those they work for and with'.

Capacity to support staff engagement and culture is therefore vitally important as we face unprecedented financial and operational challenges. With more change ahead, we will need to ensure that staff are sighted and understand the need for change, are

fairly dealt with through the process of change and keep staff, focused and engaged with the direction of travel.

The Kings Fund (2011) research describes the level of staff engagement as predictors of organisational success, including staff absenteeism, patient satisfaction, mortality and safety measures, including infection rates. Boorman (2010) takes this one step further and recommends that organisations look at engagement and well-being together as there is 'clear evidence that high levels of well-being (especially psychology well-being) help to build and sustain successful performance'.

The outcome of the current staff survey will provide an insight and an important baseline into the current levels of engagement and specific issues that need to be addressed.

Values – following the publication of 'Trusted to Care' a significant amount of work was undertaken on the development of organisational values. There remains however a sense that much more work needs to be taken forward in regard to the fully embedding of values with the workforce. Specific concerns remain about a bullying culture in some parts of the Health Board.

Due to a retirement and vacancies held within the team, there is no resource to deliver listening events to continue to engage with our staff and embed our organisational values. This will be a critical resource as the results of the staff survey are published in September and therefore the need to release the held posts within this team is vitally important.

Organisational Change - reflecting on the year ahead and beyond the organisations continues to face a period of significant organisational change. Given experience of recent change programmes there is evidence that whist the process of change may be successfully managed the organisation is not always successfully in embedding and sustaining a change.

The tendency seems to have been that the journey of change stops once a change is implement and the next change is initiated without the realisation and that focus on post change activity is required for change to be successful.

People Skills of Managers and management capability – the model of HR practised within ABMU where managers are required to 'fly solo' on many HR issues puts a great deal of emphasis on the manager to manage initial stages of workforce process. To do this effectively managers must be skilled and trained to be able to fulfil these responsibilities in a competent and confident way as well as have the time to undertake these responsibilities in a timely manner.

There is much evidence that these people management responsibilities are not discharged effectively which in no doubt negatively influences our employee relations climate as well as negatively impacting on the employee relations culture.

There remains much to be done to support the **development of our leaders and managers** which is pivotal to all areas of performance in the Health Board, from staff engagement to the effective management of sickness absence, good employee

relations, recovery and sustainability and service transformation. The Boorman Report on the Health and Well Being of NHS Staff (2010) emphasised the key role that leaders and managers play in determining the well-being of staff. This behavioural-based, person- centred approach to leadership development led to the creation of a new strategy in ABMU.

In 2017, W&OD took the strategic decision to focus on behavioural leadership and developed a new internal programme called **Footprints**. Bands 4-7 were identified as a priority group and in 12 months approximately 400 managers have attended footprints over 26 cohorts. Despite its impact, 400 managers just makes a small dent into the size of the development need across the whole of ABMU. Much more work is needed to spread the learning and, during a recent performance review, at the request of the COO, our priority must also shift to developing more senior managers (bands 8a and above) to embed and sustain the leadership change.

This is an organisational risk given the size of the team who are involved in running the training. Footprints currently runs on a weekly basis (3 days per week) and is delivered by 2 Learning & Development facilitators. One member of staff is fixed term and despite his contract being renewed twice previously based on vacancy restrictions, this will come to an end in December and the organisation will no longer be able to run Footprints.

There is no capacity currently to roll-out the 'Bridges' programme to Bands 8a and above. To enable the Health Board to continue to roll-out Footprints to the size and scale needed and to provide leadership development to Bands 8a and above ('Bridges'), a long-term investment in teaching staff is needed as well as administrative support.

In addition, to individual leadership development, there is an increasing demand to support new teams, 'teams in trouble' and bespoke training requirements within teams, including the supporting of development events. There is significant empirical evidence over the past 20 years in the NHS which correlates effective team working with lower patient mortality, higher patient satisfaction, innovation and improved levels of workforce wellbeing (West and Aston OD, 2009). However, there is no resource within the team to respond to these 'team requests' and when the most urgent are identified, there are often significant delays in supporting these. Given the potential impact on organisational effectiveness and individual well-being, this is an organisational risk. There are currently 20 requests for team development support alone and many of these will require 3 to 4 interventions per team. These requests are often for teams identified as 'in trouble' where significant input and skill is needed to challenge and develop interpersonal relationships. There is a need for additional support to meet the current backlog and to meet the predicted rise in demand for team development and team effectiveness associated with organisational change and reconfiguration.

Vocational Training (1 x Band 7, 1 x Band 5 (1 x Band 5 vacancy) & 0.86 x Band 3) – self funded and in place since 1986. The team is established on the basis that they are self-funding (circa £120K) through income generation. Providing essential / life-line access to work based learning opportunities for the unemployed in our

community. These include 'employability skills programme for adults and Engagement programmes for 16-19 year olds.

Since January 2017, 121 adult learners have enrolled onto these programmes and 40% of these have secured permanent employment following the programme. There has been an increase in the numbers gaining employment due to progression onto apprenticeships across the Health Board. Discussions are ongoing with Swansea Council about widening access programmes for 2018/19.

If we fail to meet the income generation target, the team is at risk as they are no longer financial viable. The timing of invoice payments is linked to the academic year and not the NHS financial year. This means that not all income generated within the year is paid before the financial year and this has caused us problems in the past. Also, when the Welsh Government changes programmes and suppliers, this often causes delay in us being able to respond. In 2017/18, we were unable to deliver training for the first 5 months of the year, due to reasons out of our control and associated with our suppliers, Rathbone.

This is small but impactful team for the community and our unemployed with a solid track record for performance and any decisions taken around the future of the team should be taken in relation to impact and corporate social responsibility. At one time, there are an average 80 trainees in post filling essential roles in the Health Board at no cost to departments or the Health Board as a whole.

Other Learning and Development related risks –

- **Internal Graduate Scheme** – cohort 2 is pending confirmation of funding from the units, despite success of Cohort 1, impact and calibre of students. The risk is that if no funding is forthcoming, all work set up for running our internal graduate scheme will be lost, unless the organisation is willing to centrally fund the students.

- **Apprenticeship Academy** – currently our successful apprenticeship academy has 2 coordinator and 1 apprenticeship post which are funded externally by our partners, Neath and Bridgend colleges. Provided we meet our performance indicators, this funding will continue. However, there is a risk that the funding could be withdrawn if there are changes to education policy or if we don't meet our numbers (e.g. in Bridgend – currently not meeting our targets as focus on boundary change). Bridgend has very recently formally served us notice and our contract will end in September 2018.

- **No non pay budget** within Learning & Development to cover travel expenses. This is significant for the team as our role is a peripatetic one and requires travel across the Health Board.

- **Medical Education** – with the departure of Medical Director and the Assistant Medical Director and the imminent retirement of the Clinical Governance Coordinator, there is a leadership risk and a significant loss of organisational knowledge at a senior level, this will place increasing pressure on the Medical Education Centre Manager, in particular to manage forward plans and the relationship with the Deanery and the University.

Bridgend Boundary Change – this strategic change creates very significant additional workload and risk for the workforce team. The process of managing the transfer and TUPE transfer process – identifying those affected, running the consultation process, managing the organisational change processes by April 2019 are enormous. The scale and complexity of the work required is unprecedented. Additional resources are critical to the delivery of this work programme and bids have been submitted to Welsh Government in this regard.

There is a danger that the required resources – either in terms of money or people, will not be able to be identified which puts both the successful delivery of the boundary change and the delivery of all BAU activity at significant risk.

Recovery & Sustainability Programme – again this programme of work makes significant demands on the workforce team. Short term finding has been provided and further financial support requested from Welsh Government. Unless 'additional' staff can be secured to focus on the work required there is a danger that delivery if the BAU agenda will further suffer.

One specific example is the resource support needed to support the A&C vacancy control processes which is negatively impacting on the job evaluation activity which can negatively affect recruitment timescales and good governance practices.

Priorities – there is an urgent need to agree and commit to a smaller range of workforce organisational priorities as the current resource constraints make it extremely challenging to operate effectively across all areas of activity. The workforce team has been asked to identify a list of activity that can be stopped to enable better focus on priority areas of work.

Reputation – the workforce function wishes to both improve reputation within and value to ABMU. A significant number of limited assurance internal audits is a key focus of improvement.

Governance and Assurance							
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships		
Link to Health and Care Standards ***(please ✓)***	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources

Quality, Safety and Patient Experience
High levels of staff engagement materially impact on quality, safety and patient experience. High level of vacancies, turnover and sickness absence impact directly on these factors.
Financial Implications
The Health Board currently faces significant financial challenge. The financial cost of poor employee engagement, low morale, high levels of sickness, poor employee relations inefficient working practices are outlined in detail in the paper. As a consequence of historical dis-investment in the workforce and OD function the function now severely struggles with the capacity to fully and proactively support BAU and strategic issues at an appropriate level.
Legal Implications (including equality and diversity assessment)
Capacity within the workforce and OD has resulted in the legal requirements of GDPR, mandatory training, welsh language not being fully met. It also presents risks to the Health Board at Employment Tribunals as a consequence of management and timescales of employment casework.
Staffing Implications
Significant staffing implication across the organisation which are outlined in ful in the paper. The current demand on the function in relation to the capacity it has to deliver has created unacceptable levels of stress for the workforce and OD Team.
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015 - https://futuregenerations.wales/about-us/future-generations-act/)

Report History	The Workforce and OD Committee considered a draft paper at its meeting held in July 2018. Following discussion at the Committee and a request for further work to be undertaken on the financial implications the paper has also been shared with the Executive Team and Unit Directors. The paper has also been shared with the Audit Committee. Work is being taken forward in partnership with the Board Secretary to incorporate the risks identified into the organisations risk register. The Audit Committee has asked that the paper be considered at a Board meeting.

	Reponses and challenges have been invited from all recipients and to date the feedback received has been that the paper has presented a fair and recognisable reflection of the current situation within the Health Board.
Appendices	