

Swansea Bay University Health Board
Unconfirmed
Minutes of the Workforce and OD Committee
held on Thursday, 2 October 2025
Microsoft Teams

Present:		
Reena Owen	(RO)	Independent Member
Martin David Lloyd	(MDL)	Independent Member
Anne-Louise Ferguson	(ALF)	Independent Member
Andrew Griffiths	(AG)	Independent Member
In Attendance:		
Len Cozens	(LC)	Head of Compliance
Elizabeth Davies	(ED)	Human Resources – Business Partner
Rhodri Davies	(RD)	Associate Service Group Director – Surgery
Melanie Dellibovi	(MD)	Workforce Business Partner
Benjamin Dicken	(BD)	Consultant Cardiologist
Richard Evans	(RE)	Executive Medical Director
Ceri Gimblett	(CG)	Service Group Director – Neath Port Talbot and Singleton
Catherine Harris	(PD)	Professional Head of Staff Health and Wellbeing
Sophie Herbert	(SH)	Corporate Governance Officer (Secretariat)
Louise Joesph	(LJ)	Assistant Director of Workforce and OD
Hazel Lloyd	(HL)	Director of Corporate Governance
Mark Madams	(MM)	Associate Director of Nursing and Patient Experience

Christine Morrell	(CM)	Executive Director of Allied Health Professions & Health Science
Emma Owen	(EO)	Head of Workforce Effectiveness and Analytics
Jessica Rogers	(JR)	Head of Human Resource Operations
Tina Ricketts	(TR)	Executive Director of Workforce & OD
Neil Thomas	(NT)	Assistant Head of Risk and Assurance
Gareth Westlake	(GW)	Assistant Director of Digital Services
Craige Wilson	(CW)	Interim Service Group Director – Primary, Community and Therapies
Sharon Vickery	(SV)	Assistant Director of Workforce and OD
Apologies:		
Liz Rix	(LR)	Executive Director of Nursing & Patient Experience
Matt John	(MJ)	Director of Digital

The meeting commenced at 9.30am.

Minute No.	Item
PART 1: PRELIMINARY MATTERS	
76/25	WELCOME AND INTRODUCTIONS
	RO opened the meeting and welcomed all present to the meeting of the Workforce and OD Committee.
77/25	DECLARATIONS OF INTEREST

	There were no additional declarations outside of those already on the Declarations of Interest Register.
78/25	MATTERS ARISING
	There were no matters arising
79/25	TRAINING PROVIDED TO STAFF ON INFECTION CONTROL
	<p>The Committee RECIEVED an update on training provided to staff on Infection Control.</p> <p>MM provided an overview of the organisation’s integrated approach to Infection Prevention and Control (IPC) training, noting that compliance rates were above target: Level 1 at 91% and Level 2 at 85%. He highlighted the development of an integrated action plan for Emergency Department (ED) IPC training, following a departmental review. This plan focused on cleanliness standards and the implementation of increased cleaning hours, which had already been actioned.</p> <p>MM reported that training for high consequence infectious diseases had been strengthened, transitioning from a single four-hour session to two separate two-hour sessions. He further advised that a full business case was in development to support the long-term implementation of enhanced cleaning measures within the ED.</p> <p>RO thanked MM for the update, she noted that infection control training and compliance was a particular concern because it was one of the measures being scrutinised by the Welsh Government.</p>
80/25	WORKFORCE RISKS AND ISSUES OVERVIEW REPORT: NEATH PORT TALBOT/SINGLETON GROUP
	<p>The Committee RECEIVED an overview report of workforce risks and issues affecting the Neath Port Talbot/Singleton Service Group.</p> <p>CG drew attention to the following points:</p> <ul style="list-style-type: none"> - A report was presented summarising key workforce performance metrics. This included data on sickness absence, with breakdowns

of long-term and short-term sickness, as well as actions being taken and specific focus areas such as anxiety, stress, depression, musculoskeletal issues, and seasonal trends.

- The challenge of managing vacancies was highlighted. It was noted that historical vacancies and budget adjustments had impacted establishment figures, with a more accurate representation expected from month six onwards.
- Medical workforce challenges were identified, particularly due to the specialist nature of roles and associated recruitment difficulties. Staffing issues within perinatal services were also noted.
- The low staff survey response rates were reported. Targeted actions were described to improve engagement and participation.
- The implementation of action plans was underway as well as further work in hotspot areas. Particular attention was drawn to sickness management and compliance with Performance Appraisal and Development Review (PADR) processes.
- Feedback was invited to the format and level of detail of the report to inform future updates.

RO thanked CG and invited questions.

AG commented the report was both interesting and clear but expressed uncertainty regarding the issue of "deficit and removal of vacancies." He requested clarification on this point.

In response, CG explained that historical vacancies had been removed from the service group's budget as part of a financial adjustment. As a result, the establishment figures did not reflect these changes until month six. The process involved identifying which posts would be removed and assessing the impact on recruitment capacity. The establishment figures had since been adjusted to align with the revised budget.

ALF raised several concerns, firstly regarding the implementation of sickness management actions, such as absence summits. She queried how widely these actions were being applied and whether they reached all responsible managers, not solely senior staff. She also questioned the effectiveness of these measures and how they were being monitored. CG

confirmed that absence summits were being conducted at ward level, involving ward managers, matrons, junior sisters, and the wider team. She noted that these summits were being extended to non-ward areas. Monitoring was being undertaken through business assurance meetings and regular tracking, with early signs of improvement observed in hotspot areas.

ALF raised concerns about low Performance Appraisal and Development Review (PADR) compliance rates and their impact on sickness management. She asked how rigorously PADR compliance was being managed. CG acknowledged disappointment with current PADR rates and explained that improvement plans were in place for areas falling below target. She confirmed that PADR compliance was regularly discussed at divisional and senior team meetings, and that improvement plans for non-compliant areas were being closely monitored and managed.

ALF requested clarification regarding the fill rates referenced in the report. CG explained that the fill rate referred to the percentage of posts filled against a set overhead. She noted that there had been a recent change in approach, whereby posts were now filled to a 21% overhead, with the remaining requirement met through bank and agency staffing. This replaced the previous practice of fully filling to a 26.9% overhead.

RO raised some questions and observations. With regards to sickness absence trends; she enquired whether there was a broad split between anxiety-related and musculoskeletal-related sickness absence, and whether any patterns were observed around holidays or specific days of the week. CG confirmed that cases of anxiety, stress, and depression were more than double those related to musculoskeletal issues. She noted that short-term sickness absence typically increased during summer and holiday periods, but no specific trends were identified for Mondays or weekends.

In relation to Mandatory Training Compliance of Medical Staff, RO raised concerns regarding low compliance rates for mandatory training among medical staff and asked what measures were being taken to improve this. CG responded that the compliance target was set at 85%, and that rates among medical staff were improving. She explained that regular monitoring was in place and that leadership teams were actively involved in driving improvement.

In relation to vacancies and service impact, RO expressed concern about vacancies in critical service areas, such as neurodevelopmental disorders

	<p>(NDD). She queried whether these vacancies were opportunistic or based on service need, and whether staff could be redeployed to cover gaps. CG explained that vacancy removals were largely opportunistic, driven by financial pressures rather than strategic planning. She confirmed that mitigation strategies and staff redeployment were considered where feasible, although recruitment remained challenging in certain areas. She added that the process required time to ensure the most appropriate approach was taken.</p> <p>RO asked whether actions from the previous year’s staff survey were being implemented to encourage participation and engagement. CG confirmed that the team had acknowledged past shortcomings and was committed to acting on feedback received. She outlined steps being taken to improve staff engagement and increase response rates for the current year’s survey.</p> <p>RO asked whether there was scope to move vacancies or redeploy staff across different areas to address service gaps, particularly considering critical shortages in some areas and unfilled posts in others. CG explained that this had been considered as part of the vacancy adjustment process, which contributed to the timeline extending to month six. She noted that teams had worked to identify potential mitigations and determine which posts could be removed or reallocated. However, she acknowledged that certain areas, such as pharmacy and NDD, were historically difficult to recruit to. While staff movement was explored, options were limited due to recruitment challenges and financial constraints.</p> <p>The Committee:</p> <ul style="list-style-type: none"> - CONSIDERED the Service Groups Workforce Metrics, Risks and Staff Survey Progress. - TOOK ASSURANCE from the actions being taken to ensure compliance with workforce metrics to support and improve the health and wellbeing of staff.
<p>81/25</p>	<p>STRATEGIC RISK REGISTER</p>
	<p>The Committee RECEIVED a report on Strategic Risk Register.</p>

LC presented an extract from the Health Board's (HB) Strategic Risk Register and explained that the Risk and Assurance Team had been supporting a reset of risk management within the organisation.

He described the development of the Strategic Risk Register, which aimed to clearly distinguish between strategic and operational risks. Each risk had been assigned to the relevant Board Committee's to ensure appropriate scrutiny and oversight.

LC stated that there were currently 17 entries on the Strategic Risk Register, with a further eight in progress. He noted that work was underway to develop a Corporate Risk Register, which would sit beneath the Strategic Register and focus on high-priority operational and cross-cutting risks.

He invited the Committee to determine how frequently they would like to receive the extract of the Strategic Risk Register relevant to their remit, noting that regular updates would be aligned with the Board reporting cycle.

TR responded to LC's query by recommending that each Committee meeting should begin with a review of the strategic risks relevant to that Committee. She explained that this approach would help set the context for the agenda and ensure that updates on mitigating actions were provided. TR noted that this method aligned with her previous experience and was consistent with the structure of a template agenda she had used.

RO thanked LC and welcomed questions.

RO expressed her satisfaction with the template and the areas it covered, particularly in relation to strategic risks associated with Workforce and Organisational Development (OD). She supported the inclusion of the Strategic Risk Register at the beginning of each agenda, noting that it could be effectively linked to both the new Corporate and Workforce Risk Registers. She confirmed that she had no objection to this approach being adopted for future meetings.

LC clarified that the current HB Risk Register, which was scheduled for discussion later in the meeting, would be discontinued once the Strategic Risk Register and the new Corporate Risk Register were fully implemented. He confirmed that these two new registers would replace the existing HB Risk Register.

The Committee:

	<ul style="list-style-type: none"> - CONSIDERED the position in respect those strategic risks which had been assigned to the Committee for scrutiny and oversight. - AGREED the regularity with which the Committee would like to receive the Strategic Risk Register extract going forward. - CONSIDERED whether there were any specific areas where members feel that further assurance was required, in order that these can be taken forward by the Lead Director.
<p>82/25</p>	<p>DIRECTOR OF WORKFORCE AND OD REPORT</p>
	<p>The Committee RECEIVED the Director of Workforce and OD report. In introducing the report, TR drew attention to:</p> <ul style="list-style-type: none"> - This new horizon scanning report covers national, regional, and local Workforce and OD issues that may impact SBUHB, including financial implications. - There were several key issues highlighted, including delays in Band 2 to 3 pay progression, the review of Band 5 to 6 nursing job descriptions, changes to the resident doctor's contract, and potential industrial action related to cost-of-living pay. - It was explained that SBUHB had delayed Band 2 to 3 payments to align with national arrangements. The decision resulted in media attention and a formal notification of possible industrial action from Unison. - A commitment was confirmed to doing what is right for colleagues within the permissions and authority available, with the aim of reaching a resolution. - There was ongoing liaison with the Welsh Government and NHS Employers, with further meetings planned to address the situation and differing views among trade unions. - The importance of preparing for the risk of industrial action was emphasised, including ensuring they were reflected on the risk register and that appropriate mitigations were developed.

- Assurance was provided that the Committee would receive the horizon scanning report as a standard item going forward.

RO commented that TR's horizon scanning report had been very helpful in bringing the Committee up to speed on emerging issues and identifying potential risks. She emphasised that the Committee should have visibility of these matters, as they represented potential risks that required ongoing monitoring. She also supported the inclusion of this type of report as a regular item on the Committee agenda.

RO thanked and welcomed questions.

MDL asked whether TR had any links to the All-Wales position on the band 2/3 matter and suggested it would be beneficial to explore the workforce perspective for the HB. TR responded that she and SV had been liaising regularly with NHS Employers and the Welsh Government. She noted that a recent meeting had taken place between the Minister and trade unions at national level.

TR explained the timelines for national negotiations might not align with the deadline for the local agreement, and further discussions were planned at the Board Executive Team. She assured colleagues that the team was acting in the best interests of our band 2 colleagues and was working towards a resolution.

RO raised a query regarding item 2.3, the on-call review. She referred to the mention of service fragility and sustainability and questioned whether the current on-call arrangements not aligning with local or national agreements posed a problem, particularly in the context of fragile services. She suggested that payment may be necessary to maintain service continuity.

TR confirmed the HB was currently paying above standard rates for on-call duties in some fragile services. She noted that recent reports had been submitted to the Management Board to extend these arrangements, pending the outcome of a national review. She explained SBUHB was awaiting the national review before implementing further local changes.

SV added these fragile services had been unsustainable since 2012. She stated that the fundamental issue was the need for service modernisation and workforce transformation. She advised an All-Wales

	<p>review was ongoing, although it remained unclear whether these services could be transitioned to national arrangements.</p> <p>CM provided examples from Radiography and Cardiac Services, highlighting efforts to harmonise arrangements and reduce pressure on small workforce groups.</p> <p>RO concluded that this was an area which should be monitored closely.</p> <p>The Committee:</p> <ul style="list-style-type: none"> – Were ADVISED by the information provided in the report.
<p>83/25</p>	<p>PEOPLE STRATEGY</p>
	<p>The Committee RECEIVED a report on Progress against the People Strategy.</p> <p>TR highlighted both areas of progress and areas where progress had been limited. She noted that the capacity within the Workforce and OD Directorate had been impacted due to the need to focus on changes related to variable pay.</p> <p>She reported that the senior team had met to prioritise actions within the resources available. At the next Committee meeting, they intended to present a clear 18-month plan outlining 19 priority areas for approval and would seek Committee input on the proposed order of work.</p> <p>TR explained the aim was to combine the metric report with the People Strategy report to enable tracking of the effectiveness of actions. She advised that the current report was a work in progress and would be refined over time, but it provided a useful sense check of the status against the strategy.</p> <p>She clarified the staff engagement score was derived from the staff survey, using a combination of questions and a national algorithm. She also confirmed plans to introduce quarterly pulse surveys to gather more regular engagement data.</p> <p>RO thanked TR and invited questions.</p> <p>ALF thanked TR and commented that the bullet points within the report were insightful in relation to the projects and issues presented. She expressed concern regarding delays in onboarding, noting that the All-Wales target was 44 working days, while the current position stood at 65.5 days. She stated that this was difficult to justify, even when considering</p>

Welsh language translation requirements and delays in administrative and clerical recruitment. She queried what actions were being taken to improve the situation.

In response, TR clarified the matter related to the next report on the People Strategy. She acknowledged the concern and explained that internal processes were being reviewed, including a revamp of the vacancy process and the use of the Track system to improve timelines. She noted that most delays were attributed to shortlisting and recruiting manager responsibilities.

EO added comprehensive guidance had been developed for managers, and that the new process ensured all steps were completed prior to advertising. She advised that this should help improve onboarding times and confirmed that continuous monitoring and improvement efforts were ongoing.

ALF reiterated that such delays reflected poorly on the organisation and were likely to be perceived as inexplicable by candidates.

RO commented she particularly appreciated the tables included in the People Strategy report, noting that they were very easy to understand. She enquired about the source of the engagement score and how the percentage was calculated.

In response, TR explained the engagement score was derived from the staff survey, which used approximately three or four questions and an algorithm to calculate the score.

TR noted the staff survey was currently conducted annually, but she expressed her intention to introduce quarterly pulse surveys to provide more regular engagement data. She also offered to share further background information on how the score was formulated, clarifying that it was determined nationally through the staff survey. RO agreed that understanding the source and methodology of the engagement score would be beneficial if the Committee were to receive it on a regular basis.

ACTION: TR

AG referred to a mention of carers leave within the People Strategy report and sought clarification regarding its distinction from sickness leave. He queried whether carers leave was being conflated with sickness absence and requested that it be considered separately.

TR advised that Occupational Health and Employee Wellbeing Services had identified instances where colleagues utilised sickness absence due to caring responsibilities. She noted that the team had collaborated with a

	<p>third sector organisation to provide free resources for carers within the workforce. TR acknowledged further development of local policies was required to ensure staff felt adequately supported. She emphasised that sickness absence should not be used for caring duties, nor should special leave be applied for this purpose. Instead, she advocated for the organisation to work with individuals to adjust working patterns or hours to accommodate their caring responsibilities.</p> <p>The Committee:</p> <ul style="list-style-type: none"> - ASSURED by the report which was provided for assurance.
<p>84/25</p>	<p>HEALTH BOARD STRATEGIC WORK PLAN OVERVIEW AND PROGRESS</p>
	<p>The Committee RECEIVED a Health Board strategic workforce plan overview and progress updates report.</p> <p>TR confirmed that the report would become a standing agenda item and comprised two components: a preliminary framework described as a “plan for a plan” in light of the current absence of a strategic workforce plan, and comparative benchmarking tables assessing the workforce against other health boards in South East and South West Wales.</p> <p>She outlined a timeline targeting March 2026 for the completion of the strategic workforce plan, noting that it represented a substantial undertaking. The plan would be aligned with the annual planning cycle and incorporate a bottom-up refresh of workforce plans across all service groups.</p> <p>TR explained that the benchmarking tables were designed to challenge assumptions and identify opportunities. She highlighted that Swansea Bay Health Board (SBUHB) was the “richest” in terms of workforce-to-population and workforce-to-bed ratios, even after adjustments for hosted services.</p> <p>She further noted that, once hosted services were excluded, the medical and dental workforce figures aligned with those of other health boards. Opportunities were identified to review the composition of the workforce, particularly in relation to Band 5 nursing and Band 8 roles.</p> <p>TR emphasised that this work marked the starting point for strategic workforce planning and would prompt further questions and</p>

development, especially as the organisation progressed through the “Organised for Success” initiative.

She confirmed that a six-month timeline was realistic, particularly with support from Deloitte, and stated that she would personally lead the work. TR stressed the importance of adhering to this timeline to gain a clear understanding of future workforce requirements.

RO thanked TR and invited questions.

CM expressed her appreciation to TR and other contributors for their work, noting that the report raised important questions regarding the workforce. She emphasised the need to ensure appropriate coverage of regional services, such as learning disabilities provision across South Wales, which has implications for higher band healthcare professionals.

CM referenced ongoing benchmarking efforts with TR and the workforce team, aimed at comparing bandings and levels, including achieving parity with other health boards for equivalent services.

She observed that consolidating healthcare professionals should enhance the organisation’s ability to review spans of control, management structures, and clinical job planning - areas currently lacking for higher band roles.

CM further noted that the distribution between higher bands and support bands may not be optimal, suggesting that support levels may be underdeveloped. She indicated that this would prompt further work and raise additional questions.

MM acknowledged that, within nursing and midwifery, the organisation remained highly cognisant of the Andrews Review, which had led to the introduction of certain Band 8 roles as part of its recommendations. He emphasised the importance of maintaining focus on leadership for clinical safety, particularly in relation to the older population.

He stressed the need to ensure that Advanced Nurse Practitioners (Band 8s) were appropriately job planned and operating at the top of their licence, given the substantial investment in their education and remuneration.

He then highlighted the importance of efficiency and ensuring that these roles were aligned with future service requirements. He noted that the proportion of Band 5 roles was slightly higher than in comparable general services but justified this by the complexity and acuity of the local population.

	<p>He also referenced ongoing reviews across district nursing, community services, mental health, and learning disabilities, aimed at assessing the balance between registered and unregistered staff.</p> <p>AG welcomed the inclusion of workforce figures and contextual information, stating that it provided a valuable overview of the workforce composition and structure. He acknowledged that some variation across services was to be expected but emphasised that the data served as a useful benchmark for the organisation. He noted that it helped to establish direction and tone for future workforce planning. He expressed support for the development of a workforce plan at the earliest opportunity to guide organisational strategy.</p> <p>RO echoed AG’s comments, stating that the report and associated plans were highly valuable, particularly the workforce profiles presented. She queried whether the proposed timeline for developing the strategic workforce plan, completion by March 2026 - was realistic, given the scale and complexity of the work involved.</p> <p>In response, TR confirmed that a six-month timeframe was achievable based on previous experience, particularly with support from Deloitte. She emphasised the importance of adhering to this timeline to enable a clear understanding of future workforce requirements.</p> <p>The Committee:</p> <ul style="list-style-type: none"> - CONSIDERED the timeline for the development of the strategic workforce plan. - DISCUSSED the high-level comparison of our workforce when compared to other HB’s. - ASSURED by the report for the development of the strategic workforce plan.
85/25	VARIABLE PAY PLAN OVERVIEW AND PROGRESS
	<p>The Committee RECEIVED the variable, pay plan overview and progress update report.</p> <p>In introducing the report, TR drew attention to the following points:</p>

- Variable pay was identified as a key organisational priority, closely linked to the financial plan. The report aimed to provide assurance regarding the new controls and processes being implemented.
- A Variable Pay Steering Group has been established, comprising eight work streams. Each staff group was assigned as an executive sponsor responsible for overseeing all aspects of variable pay. The group met weekly to approve or reject requests.
- New standard operating procedures have been introduced to strengthen the approval process. Improvements in variable pay were observed in month five, with expectations for continued progress.
- Additional scrutiny and procedural steps were implemented due to the limited impact of previous controls on variable pay during the first four months of the year.
- The current approach was described as a temporary “belt and braces” measure, intended to remain in place until sufficient traction was achieved. Once progress was evident, greater autonomy would be returned to budget holders and recruiting managers where they were managing within budget.

RO thanked TR and welcomed questions.

RO questioned whether the vacancy scrutiny process appeared overly onerous and administratively complex. She expressed concern that the number of procedural steps might create barriers to filling key posts in a timely manner.

TR explained the additional steps had been introduced because previous processes had not delivered the intended impact on variable pay. She noted that the revised approach was based on recommendations from Deloitte and acknowledged that the process was more stringent than preferred. However, she emphasised the measures were temporary and would remain in place until the organisation achieved sufficient traction, at which point greater autonomy could be returned to managers.

EO added that, while the process may appear onerous on paper, many of the steps had already existed informally. She clarified the new structure served to formalise and streamline escalation and reporting procedures, aligning with best practice observed in other health boards.

AG asked about bank staff working above the pay cap and the circumstances under which this occurred. EO explained that some bank staff, often substantive employees undertaking additional hours, were paid

	<p>above the cap due to regional rate card variations and market pressures. She confirmed that work was ongoing to review and revise these rates.</p> <p>AG also questioned whether the vacancy control process could be simplified and suggested that reporting on where posts were held or approved might help educate managers. TR stated that the current process was a “belt and braces” approach, implemented to strengthen performance management. She emphasised that the long-term goal was to empower managers once sufficient traction had been achieved.</p> <p>EO confirmed that future reporting would include visibility of held or approved posts, which could support process improvements.</p> <p>CM expressed support for the vacancy scrutiny process despite its time-consuming nature. She highlighted the value of improved workforce intelligence and oversight in enabling better decision-making.</p> <p>MM noted that the increased scrutiny had led to positive behavioural changes within nursing and midwifery, including improved preparation and enhanced opportunities for internal promotion.</p> <p>RE observed a shift in focus from scrutinising individual shifts to understanding the underlying causes of variable pay expenditure. He indicated that plans were in place to begin prospective tracking of spend trajectories.</p> <p>The Committee:</p> <ul style="list-style-type: none"> - ASSURED by the report.
<p>86/25</p>	<p>DIGITALLY READY WORKFORCE REPORT</p>
	<p>The Committee RECIEVED the Digitally Ready Workforce report.</p> <p>GW drew attention to the following points:</p> <ul style="list-style-type: none"> - The digital workforce strategy was aligned with the overarching digital strategy. It was emphasised that technology alone cannot drive transformation; a confident, skilled, and digitally enabled workforce is essential to achieving meaningful change. - Significant progress had been made, including the appointment of a Digital Adoption Manager and the establishment of a Microsoft 365 Champions network comprising over 1,000 staff. This network supports peer learning and sharing best practices. - A system co-design approach was being implemented, involving end users in the configuration and rollout of digital systems.

Robust project support and comprehensive end-to-end user training were provided as part of this process.

- A data literacy programme had successfully trained over 129 managers and 90 primary care staff in the use of data in their daily work. Digital systems training was also embedded in junior doctor induction programmes.
- A further development was required, with the strategy calling for a comprehensive digital skills programme. This would embed digital literacy across all staff groups and leverage national partnerships to support delivery.
- The current digital investment stood at 2% of turnover. The strategy aimed to increase this to 4.6%, with a significant proportion of the uplift dedicated to workforce digital enablement.
- Considering financial constraints, a collaborative approach was proposed with the Workforce and OD teams. This would focus on embedding digital "golden threads" within staff faculties and establishing a programme to progress incrementally.
- The Committee was asked to endorse the proposed next steps, which included the formation of digitally supported faculties and prioritisation of partnership working with Workforce and OD.
- It was noted that a more defined action plan and timeline were required. These would be developed collaboratively and reported to the relevant committees.

RO thanked GW for the report and welcomed questions.

AG enquired about the timeline and planning process for implementing the digitally ready workforce strategy. GW stated that a defined timeline had not yet been established. He confirmed that planning would be undertaken collaboratively with Workforce and OD teams, with work expected to commence in earnest in the coming weeks.

AG suggested that the plan should be presented to the Digital and Data, Research and Innovation (DDRI) Committee. GW agreed and confirmed that the plan would be developed and reported to both relevant committees.

ACTION: AG

ALF asked whether there had been any obstacles during the implementation of new digital systems, and how ongoing usage was

being monitored. GW acknowledged that some resistance was typical but emphasised that involving staff in co-design and providing on-the-ground support had facilitated adoption. He noted that investment in change management was essential. Monitoring was conducted through system audits and engagement with nursing leads to ensure appropriate usage and to prevent workarounds

RO queried whether digital enablement was consistent across the workforce or if gaps existed and asked how assurance could be provided to the Board. LJ responded that a needs analysis and baseline assessment were required to identify gaps and allocate resources effectively. She highlighted the importance of considering generational differences and varying levels of digital proficiency.

GW added that establishing a baseline was challenging, but tools such as the Health Education and Improvement Wales (HEIW) digital capabilities framework were being refined to support assessment and guide training efforts. He noted that there were pockets of both high and low digital skills across the organisation, and that efforts were being made to ensure access and support for all staff.

The discussion focused on the need for a clear action plan and timeline for the digitally ready workforce strategy, challenges in digital adoption and monitoring, and the importance of assessing and addressing digital skills gaps across the workforce.

RO stated that, while the current update was helpful, it did not provide the full level of assurance required regarding the digitally enabled workforce and organisational readiness. She requested that a further, more detailed report be brought to the Committee with a view to providing greater assurance and specific detail on digital readiness.

ACTION: SH

The Committee:

- **CONSIDERED** the update on the work already underway to support workforce digital readiness and;
- **ENDORSED** the formation of digital supported faculties and prioritise partnerships working with the Workforce and OD Directorate.
- **TOOK SOME ASSURANCE** from the report but requested a furthermore detailed report be provided.

87/25	EFFECTIVE ROSTERING OF NURSING WORKFORCE
	<p>The Committee RECIEVED a report on effective rostering of the nursing workforce.</p> <p>MM drew attention to the following points:</p> <ul style="list-style-type: none"> - All rosters were subject to thorough scrutiny both prior to and following publication. The approval process was currently set at six weeks in advance, with plans to extend this to eight weeks. - The detailed key performance indicators (KPIs) were in place to support reporting, trend analysis, and challenge processes. Formal reporting occurred within service groups, with escalation to the Nursing and Midwifery Workforce Board as required. - Rostering incorporated not only staffing numbers but also patient acuity. This was supported through both digital and non-digital solutions, including twice-daily acuity assessments to inform redeployment decisions and staffing huddles. - There was recent alignment with variable pay controls which had led to improved understanding and adherence to good rostering practices. This contributed to a reduction in unnecessary variable pay expenditure. - There was an observed increase in staff willingness to be redeployed based on acuity and service need. This shift was supported by leadership and a fair approach to redeployment requests, helping to address staffing gaps caused by unavailability. - The primary challenge affecting variable pay and roster gaps was staff unavailability, including sickness and maternity leave, rather than deficiencies in rostering processes. Daily adjustments were made to manage risk, although high levels of unavailability sometimes made this unfeasible. - Rosters were frequently rejected if they failed to meet KPIs or were deemed unsafe. In such cases, line managers were required to revise and resubmit rosters for approval. - In areas not covered by the Nurse Staffing Act, professional judgement and tailored staffing models were used to ensure safe staffing levels. Work was ongoing to adapt digital solutions to support these areas.

	<p>RO thanked MM for the report and invited questions.</p> <p>AG asked whether staff unavailability should be considered a rostering issue. MM responded that unavailability was not attributable to poor rostering processes, but rather to factors such as sickness and leave. He explained that rosters were adjusted daily to manage risk; however, high levels of unavailability could make adequate coverage unachievable.</p> <p>RO queried whether twice-daily huddles were efficient or posed operational challenges. MM clarified twice-daily huddles were held on each ward to assess patient acuity and inform redeployment decisions. In addition, site-wide huddles were used to plan for current and upcoming shifts, ensuring safe staffing and enabling proactive adjustments.</p> <p>RO further asked whether the same level of scrutiny was applied to areas not covered by the Nurse Staffing Act. MM confirmed that, in Mental Health and Learning Disability services, professional judgement and tailored staffing models were used. He noted that work was ongoing to adapt digital solutions to support these areas.</p> <p>MM also reflected on the quality assurance process for rosters, confirming that rosters were frequently rejected if they failed to meet KPIs or were deemed unsafe. In such cases, line managers were required to rework and resubmit rosters for approval.</p> <p>The Committee:</p> <ul style="list-style-type: none"> - CONSIDERED the current position and information and SUPPORTED the ongoing efforts being made strategically and operationally by the Nursing and Midwifery workforce to ensure that every effort was being made to promote high quality care within the agreed financial resource. - TOOK ASSURANCE from the report.
88/25	SICKNESS ACTION PLAN: PRIMARY, COMMUNITY AND THERAPIES SERVICES
	<p>The Committee RECEIVED a detailed sickness absence action plan for Primary, Community and Therapies Services, including timelines, milestones, and a review of the wellbeing offer and staff engagement strategy.</p>

CW drew attention to the following points:

- A slight increase in sickness absence was reported, rising to 7.24%. However, long-term absences continued to show a steady decline. The primary causes of absence were anxiety, stress, depression, and "other causes," with coughs, colds, and flu also noted as significant contributors. A more granular analysis of these categories was identified as necessary.
- In reviewing the wellbeing offer, it was noted that personal stress remained the main driver of sickness absence. Key contributing factors included bereavement, caring responsibilities, and general stress. The current wellbeing support offer includes flexible working arrangements, bereavement support, and access to wellbeing resource packs.
- Over the past 12 months, 492 employees have been referred to Occupational Health. Of these, 35 were approaching half pay and 12 had reached nil pay. All individuals had undergone formal absence meetings prior to reaching 12 months of continuous absence. Audits and monthly scrutiny meetings were in place, and training had been rolled out to support both short- and long-term absence of management.
- The staff engagement strategy now incorporates discussions on work-life balance and wellbeing within the PADR process. Despite these interventions, overall sickness rates had not reduced as significantly as anticipated, although the service group's rates remained among the lowest. There was a renewed focus on intensifying actions to achieve the 25% sickness absence reduction target, as outlined in the workforce themes agreed with Deloitte.
- There were actions to address sickness absence that were ongoing, supported by monthly scrutiny and regular audits. The 25% reduction target remained a key milestone, although no specific future dates were provided for its achievement. Progress continued to be tracked through regular reporting and reviews of the associated action plans.

RO thanked CW and welcomed questions.

ALF sought clarification on the discrepancy between the relatively low figures for long-term sickness cases approaching half or nil pay and the

significantly higher figures for long-term sickness reported overall. CW explained that the lower figures referred specifically to those reaching half or nil pay, whereas the long-term sickness category included any absence exceeding one month, resulting in a higher total.

ALF also enquired about the adequacy of the drop-down options used to record reasons for absence and raised the issue of support for staff with school-age children. CW responded that further work was required to improve the categorisation of "other reasons" for absence. He noted that most caring-related absences were linked to elderly dependents rather than school-age children.

RO asked whether there was confusion between carers leave and sickness leave, and whether staff had the option to take unpaid leave or bring forward annual leave. MD confirmed that carers leave was available but acknowledged that some situations extended beyond what the policy could accommodate, resulting in sickness absence. She stated that flexible working and unpaid leave were available options, although bringing forward leave from the following year was not typically permitted.

AG emphasised the importance of promoting flexible options to prevent unnecessary sickness absence and asked whether more could be done to raise awareness. CW agreed, noting that individuals often did not recognise the impact of their circumstances until they became acute.

EO provided reassurance that Human Resource (HR) Business Partners regularly discussed available options with staff, including unpaid leave and career breaks.

MD highlighted the complexity of sickness absence, noting that it was often linked to employee relations issues and organisational culture. She identified community nursing as a hotspot area and confirmed that work was ongoing to address root causes, including leadership and workload pressures.

RO asked whether sickness audits had identified further actions. MD confirmed that audits were recent and ongoing, with findings actively being followed up.

The Committee:

- **CONSIDERED** the measures introduced to support a reduction in sickness absence across the Service Group.

	<ul style="list-style-type: none"> - CONSIDERED the additional support and scrutiny, with a particular focus on adherence to the Managing Attendance at Work Policy, leadership support and improvement in hotspot areas. - TOOK ASSURANCE from the report.
<p>89/25</p>	<p>THEATRE PERFORMANCE AND SICKNESS MANAGEMENT</p>
	<p>The Committee received a report on Theatre Performance and Sickness Management to include: The engagement action plan after the completion of the listening and engagement phase.</p> <p>CG drew attention to the following points:</p> <ul style="list-style-type: none"> - The report was presented as a follow-up to a previous update, focusing on actions taken to address sickness absence within theatre departments. - The sickness absence data was broken down by hospital site - Morriston, Neath Port Talbot, and Singleton, due to differing themes and risks associated with each location. - It was highlighted that the sickness management improvement plan, which had previously experienced delays, was now back on track and had been completed. - There were specific audits conducted within theatre staff groups that demonstrated good compliance with the sickness management policy. In addition, environmental and cultural factors were being explored through staff listening events. - Ongoing work was being undertaken to address both personal and professional causes of sickness absence. It was noted that some high percentage figures were linked to small staff numbers, which could show overall data. - Theatres were acknowledged as challenging work environments, with Morriston identified as particularly demanding due to workload and operational pressures. - Listening events and staff engagement activities had yielded valuable insights, which were being used to inform action plans aimed at improving staff experience, wellbeing, and retention. - CG confirmed that a more detailed action plan and update would be brought back to the Committee. Members were encouraged to

visit theatre sites to gain further understanding of the working environment and challenges faced.

RO thanked CG and invited questions.

RO expressed concern regarding the high sickness absence percentages within theatre departments. She questioned whether the working environment itself was a contributing factor and requested further assurance on the underlying causes, specifically distinguishing between work-related and personal factors.

CG confirmed that theatres were indeed challenging environments, with Morryston Hospital identified as particularly demanding due to workload and operational pressures. She stated that both personal and professional issues contributed to sickness absence and that listening events and targeted audits were being used to better understand and address these concerns.

ALF raised a query about the sharp increase in sickness absence at Neath Port Talbot Hospital, asking about the number of staff affected and whether the rise was linked to holidays or infection. CG clarified that the increase was not due to infection and involved a small number of staff.

CM asked whether there were differences in sickness rates between staff groups, such as nurses, Operating Department Practitioners (ODPs), and support workers. She also raised concerns about the career structure for ODPs. CG noted that the unregistered workforce exhibited higher sickness absence rates, consistent with patterns observed in ward-based staff.

RE queried why Orthopaedic scrub roles were particularly difficult to recruit for. RD explained that there was less interest in Orthopaedic scrub positions compared to more specialist areas, which contributed to recruitment challenges.

ALF asked whether benchmarking was being conducted against other theatre departments. CG confirmed that Deloitte was undertaking benchmarking work for the nursing workforce and anaesthetics, with results expected in due course.

RO requested a more detailed action plan and suggested that Committee members consider visiting theatre sites to gain further insight into the working conditions. CG agreed to provide a broader paper and facilitate site visits to support further understanding.

ACTION: SH

The Committee:

	<ul style="list-style-type: none"> - ACKNOWLEDGED the progress taken by the Theatre Team to make improvements to the management of sickness absence and support employee wellbeing. - NOTED the high sickness absence percentages in theatre departments, particularly peaks reaching 12–13%, should be considered a matter of concern and flagged as an ALERT to the Board. The impact of these figures on performance and staffing was emphasised.
<p>90/25</p>	<p>HEIW QUALITY ASSURANCE REPORT AND ACTION PLAN FOR GENERAL INTERNAL MEDICINE & GASTROENTEROLOGY</p>
	<p>The Committee RECEIVED the HEIW Quality Assurance Report and Action Plan for General Internal Medicine (GIM) and Gastroenterology.</p> <p>RE introduced the HEIW Quality Assurance Report and Action Plan. He explained that HEIW triangulated evidence from specialties to ensure that the training provided was compliant with national General Medical Council (GMC) standards.</p> <p>He stated that, where concerns were identified, HEIW undertook targeted visits and assigned risk scores, which were tracked using a risk matrix included within the report.</p> <p>He advised that the purpose of presenting these reports to the Committee was twofold: to ensure the Committee and Board were kept informed of visits, and to provide assurance that concerns were being addressed, with actions and progress monitored through the HEIW risk report.</p> <p>He clarified that each HEIW visit report and associated action plan would be presented to the Committee, with ongoing progress tracked and reported accordingly.</p> <p>He noted that the most recent visit had been undertaken for General Internal Medicine (GIM), and that Ben Dickin (BD) would present the findings, summary, and associated actions.</p> <p>BD drew attention to the following points:</p> <ul style="list-style-type: none"> - The most recent HEIW visit for GIM took place on 30th June 2025 and resulted in a reduction of the risk score from 9 to 6. - The visit was largely positive. Residents reported a positive learning culture and a pleasant working environment.

Communication channels, particularly the resident doctor's forum, were highly valued.

- Induction was considered adequate; however, residents expressed a need for clearer guidance regarding on-call shift patterns and patient distribution.
- Initial delays in meetings with supervisors have been resolved. Supervisors were described as accessible and supportive.
- Access to clinics has improved. The acute clinical experience in the Same Day Emergency Care (SDEC) unit was appreciated, although residents requested more regular rostering to SDEC.
- The residents received rotas in a timely manner and were generally positive about the rota application.
- The reduction in the risk score was confirmed, and a further targeted visit is scheduled to take place in six months. HEIW made six key recommendations, and a service action plan is in place to address them.
- He emphasised that the report was detailed but positive overall, and he anticipated further improvement in the next review.
- He explained that a "reverse ward round" refers to a registrar leading the ward round instead of the consultant, as preparation for future consultant roles.
- He clarified that the high number of HEIW visits was due to initial serious concerns. Improvements have since led to a reduction in risk, which should result in fewer visits going forward.
- There were improvements, such as enhanced induction, which are being implemented across other departments, not solely within GIM.

RO thanked BD and invited questions.

ALF asked why there has there been so many HEIW visits to GIM. BD explained there were initial serious concerns about GIM, leading to multiple visits. Improvements have reduced the risk score, and fewer visits are expected in the future.

ALF enquired if improvements are being shared across other departments. BD confirmed that improvements, such as enhanced induction, are being applied to other specialties, not just GIM.

The Committee:

	<ul style="list-style-type: none"> - TOOK ASSURANCE from the action plan now in place to address the findings and recommendations. - ACKNOWLEDGED progress would be reported through the HEIW risk register report to the Committee.
91/25	WORKFORCE AND OD RISK REGISTER
	<p>The Committee RECIEVED the Workforce and OD Risk Register.</p> <p>NT reported that there was very little to note on the risk register since the previous meeting, except for a reduced risk which was discussed during the closed session.</p> <p>He confirmed that the risk register should be noted and that the risk scores remained as presented.</p> <p>The Committee:</p> <ul style="list-style-type: none"> - TOOK ASSURANCE from the Workforce and OD Risk Register.
92/25	MATERNITY STAFFING: MANAGEMENT OF SICKNESS ABSENCE
	<p>The Committee RECIEVED an update report on maternity staffing; Management of Sickness Absence.</p> <p>In introducing the report, CG drew attention to the following points:</p> <ul style="list-style-type: none"> - The sickness data demonstrated variable improvements. Graphs and numerical data were included in the report to provide assurance regarding management at the team level. - A hotspot area, specifically Ward 20, was identified and noted within the report. - The report also referenced broader initiatives, including work on staff availability, listening events, and progress on improvement actions and staff wellbeing <p>RO thanked CG and CH then welcomed questions.</p> <p>ALF enquired about current staff morale and whether any areas of concern remained within the department. CH reported that morale and staff perceptions of support had significantly improved. However, she acknowledged that occasional staff sickness continued to impact shift coverage and create operational challenges. She emphasised that support</p>

	<p>mechanisms and escalation processes remained in place, and overall, the situation had improved markedly.</p> <p>ALF further asked whether any areas still required improvement. CH confirmed that while some improvement work remained ongoing, audits and training had received excellent feedback, with only minor outstanding issues.</p> <p>RO queried whether the publication of the independent review had affected workforce morale or sickness levels. CH responded that staff had been well-prepared for the review, recognised the findings, and were already engaged in improvement efforts. She did not believe the review had had a significant negative impact.</p> <p>CG added that the anticipation of the review had been more stressful than its release, and no increase in sickness had been observed following publication.</p> <p>MM commented that consistent, caring leadership and support from the Board had been instrumental in the positive turnaround in staffing and morale.</p> <p>The Committee:</p> <ul style="list-style-type: none"> - ACKNOWLEDGED the progress the Service Group was taking to address the findings of the deep dive sickness exercise to improve the management of sickness absence and support employee wellbeing across Maternity Services. - ASSURED by the progress against the action plan.
<p>93/25</p>	<p>COMMITTEE EFFECTIVENESS REPORT</p>
	<p>The Committee RECIEVED the Committee Effectiveness report.</p>
<p>94/25</p>	<p>MINUTES OF PREVIOUS MEETING</p>
	<p>The minutes of the meeting held on 14 of August 2025 were RECIEVED and CONFIRMED as a true and accurate record.</p>
<p>95/25</p>	<p>ACTION LOG</p>
	<p>The action log was RECIEVED and CONFIRMED.</p>

96/25	COMMITTEE WORK PROGRAMME
	The Committee RECIEVED the Committee Work Programme.
97/25	ITEMS FOR REFERRAL TO OTHER COMMITTEES
	- Digitally Ready Workforce Report; DDRI Committee.
98/25	ANY OTHER BUSINESS
	There wasn't any other business.
99/25	DATE OF NEXT MEETING
The next Workforce and OD Committee was confirmed as: Thursday, 11 December 2025	

The meeting closed at 12.17pm