	ABM University Health Board
Health Board	**Meeting on: 26th January 2017**

Subject:	Performance Report- A Fully Engaged and Skilled Workforce

ABMU Key Priorities : A Fully Engaged and Skilled Workforce

Improved Performance	1 Measures
Sustained Performance	0 Measures
Decline in Performance	1 Measures
Trend	

Measures	Period	Value	Target Attained	Trend
% workforce sickness absence (Rolling 12 months)	Oct-16	5.65%	✗	
% staff (medical & non medical) undertaking performance appraisals	Nov-16	55.4%	✗	

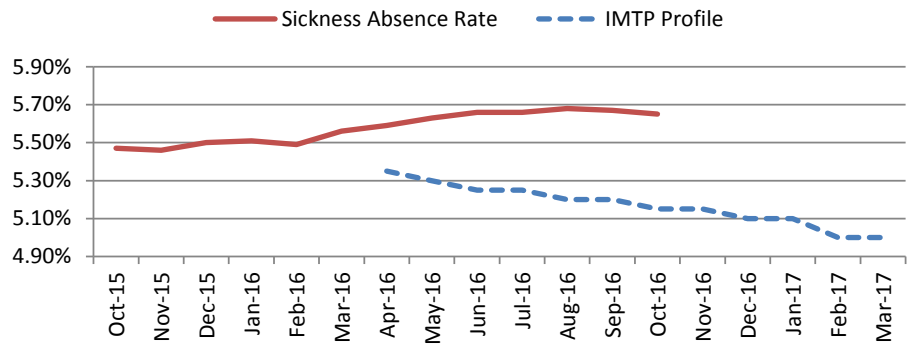
OUR STAFF & RESOURCES - PEOPLE IN WALES CAN FIND INFORMATION ABOUT HOW THEIR NHS IS RESOURCED AND MAKE CAREFUL USE OF THEM

Measure 1: % workforce sickness absence

Strategic Aim : A Fully Engaged and Skilled Workforce	**Strategic Change Programme: Workforce and OD**	**Executive Lead : Bev Edgar**

Period : Oct 16	**IMTP Profile Target : 5.2%**	**WG Target : Improve**	**Current Status :** ✖	**Movement :** ↓ **Worsening**

Current Trend: Oct 15 - Oct-16



How are we doing ?

Rolling 12 month performance:-

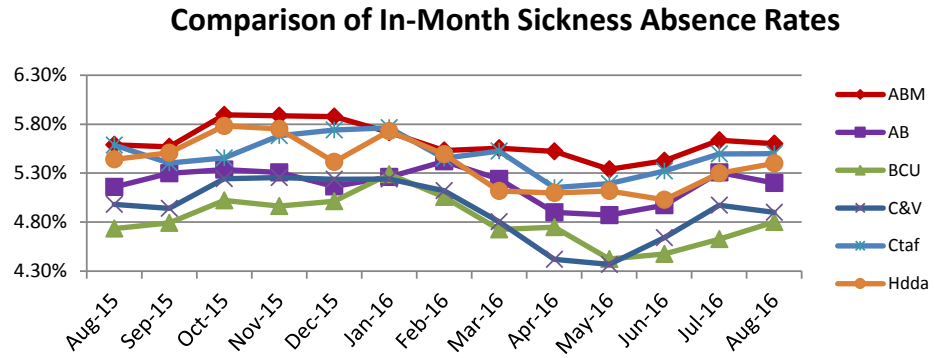
- Nov 14 - Oct 15 =5.46%
- Oct 15 - Sept 16 = 5.65%
- Nov 15 - Oct 16 = 5.62%

The long term sickness (LTS) rate for Oct 2016 was 4.17% with the short term sickness (STS) rate being 1.62% compared with 4.25% and 1.67% for the same period last year.

In Month performance:

- Sept 16 = 5.43%
- Oct 16 = 5.79% (was 6.0% in Oct 15)

Benchmark



What actions are we taking?

- Nursing and Midwifery (N&M) sickness for 12 months to the end of Oct 16 was 6.31% and 0.7% higher than all Wales performance. Hotspot areas for N&M sickness in each unit have been identified and Human Resource Managers will be working with Unit teams to develop plans to address this trend.
- Development of 'Wellbeing Champions' has commenced. 80 staff attend the initial Wellbeing Champion Workshops and are now undertaking the role within their work places. The aim of the role is to increase awareness of staff health and wellbeing services so staff can access these early when needed. It is also about promoting public health campaigns in the workplace and the wider wellbeing agenda e.g. encouraging walks at breaks, healthy eating. Further workshops are planned for March and due to the high amount of sickness due to stress/anxiety/mental illness we hope to facilitate sessions on understanding mental health in the workplace with colleagues from 'Time to Change Wales.'

How do we compare with our peers?

The latest 12 month cumulative differential between ABMU and the all-Wales performance is 0.47%.

- The latest differential between our monthly sickness absence rates and the all-Wales average is 0.43%.

What are the main areas of risk?

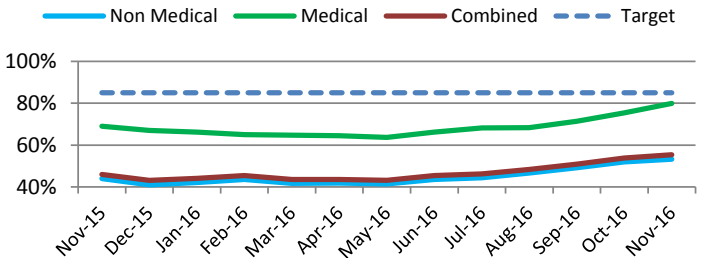
- Failure to maintain continued focus on sickness absence performance may lead to levels increasing.
- Singular focus on sickness management without measured attention on supporting staff attendance through health and wellbeing interventions congruent with our organisational values.
- Direct effect on costs in terms of bank, agency and overtime.
- Increasing levels of sick absence increases pressure on those staff who remain at work.

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (DECEMBER 2016)

OUR STAFF & RESOURCES - PEOPLE IN WALES CAN FIND INFORMATION ABOUT HOW THEIR NHS IS RESOURCED AND MAKE CAREFUL USE OF THEM

Measure 1: % staff (medical & non medical) undertaking performance appraisals

Strategic Aim : A Fully Engaged and Skilled Workforce		**Strategic Change Programme: Workforce and OD**	**Executive Lead : Hamish Laing/Kate Lorenti**	
Period : Nov 16	**IMTP Profile Target : 85.0%**	**WG Target : Improve**	**Current Status :** ✗	**Movement :** ↑ **Improving**

Current Trend: Nov 15 - Nov 16	**How are we doing ?**
 **Source of figures:** • Non Medical: Electronic Staff Record (ESR) • Medical : Medical Appraisal and Revalidation System (MARS)	**Medical:**• The positive upward trend in the 12 month rolling average continues, reflecting increased compliance with annual appraisal, engagement with Unit Medical Directors (UMD's) and the effects of active implementation of Exception Management processes •Figures do not allow for 'exemptions' - only calculated annually (approx 10% overall 2015/2016) **Non Medical:**• Reporting figures demonstrate the continued gradual increased compliance (46.63% in Aug to 53.23% in Nov2016). Attention remains focused on enabling areas to report accurate figures with ESR System and training of managers. • Pilot at Morriston where figures are centrally reported on ESR has now ended. Measurable improvement is over 10% from start of pilot(June 2016) where compliance was 34.44% to Oct 16 where compliance was 47.75%). This will be monitored as the SDU are supported to enter their own data onto ESR. • Supporting units through regular communication and engagement met with NPT SDU SMT Nov 2016 to support the SMT and explain actions. • Group PADR Pilots having a positive impact on staff engagement and reported figures.
Benchmark	**What actions are we taking?**
	Medical: • Medical Director has written to all secondary care doctors stressing requirement to engage with appraisal• Appraisal Leads to be appointed and in post by end March 2017 • Quarterly exception management to continue, focussed on getting doctors back into Appraisal Quarter (AQ) schedule to meet GMC and revalidation requirements **Non Medical**:• Training Managers in Values Based PADR (47 managers attended training sessions in 10-11/2016). • Group PADR pilot further role out-HSDU in MSDU/POWH, Facilities Glanrhyd, Catering POWH. Meeting arranged with Pathology in Dec 2016 to discuss role out pilot. Positive feedback/evaluation -fed into Values Board. • Roll out of ESR supervisor self service continues with focus of Singleton SDU + Morriston SDU 6 sessions complete.
How do we compare with our peers?	**What are the main areas of risk?**
• Peer data is not currently available.	**Medical:**• Doctors fall behind on timescale to complete enough appraisals for next revalidation recommendation: stress for doctor; diversion of doctor's and management time / resource; potential delayed revalidation; significant consequences for licence to practise if ultimately fail to engage • Poor quality appraisals - lack of personal / service development and progression; continuation of sub-optimal practices; resistance to change **Non Medical:**• Dependence on roll out of Supervisor self service for PADR Reporting data accuracy, double reporting, use of ESR, accuracy of ESR, IT skills of staff. • Time to complete PADR's in clinical areas- risk around the quality of PADR versus the target figures • Local administrators and locally held data – change of culture and the time scales to do this. • IT Equipment supporting the running of upgraded ESR Programme.

Source : ESR and MARS