National Assembly for Wales
Audit Committee

The Management of Sickness Absence by NHS Trusts – Follow Up Report

June 2009

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THE NATIONAL ASSEMBLY FOR WALES
AUDIT COMMITTEE

Report presented to the National Assembly for Wales on June 23 2009 in accordance with section 143(1) of the Government of Wales Act 2006

The Management of Sickness Absence by NHS Trusts – Follow Up Report

ANNEXES

Summary

1. In January 2004, the previous Auditor General for Wales published a report on the management of sickness absence by NHS trusts in Wales[1]. The Audit Committee then published its own report on the same subject in August 2004[2]. Both of these reports pointed to concerns about the levels of sickness absence across the NHS trusts in Wales (reporting a sickness absence rate of six per cent for the 2002-03 financial year). The two reports also highlighted the generally poor quality of trusts' management information on sickness absence, inconsistencies in approaches to the management of sickness absence cases including variable access to Occupational Health services, and the need for trusts to improve workplace health and well-being.
2. On the basis of a follow-up report prepared by the Auditor General[3], we took evidence from Mr Paul Williams OBE (Chief Executive of NHS Wales and Director General of the Assembly Government's Department of Health and Social Services) and Ms Sheelagh Lloyd-Jones (Director of Human Resources for NHS Wales). Mr Williams and Ms Lloyd-Jones joined the Assembly Government in December 2008 from their former positions as Chief Executive and Deputy Chief Executive respectively at Abertawe Bro Morgannwg University NHS Trust.
3. We examined whether good progress had been made to improve the management of sickness absence across the NHS trusts in Wales and Powys Local Health Board[4] over the previous five years, as well as considering the possible impact of the plans for NHS reorganisation. We have concluded that, although not without its risks, the NHS reorganisation also presents an opportunity to drive forward further improvements and consistency of approach in the management of sickness absence, building on the general progress made over the past five years.

[1] AGW report, *The Management of Sickness Absence by NHS Trusts in Wales*, 30 January 2004, http://www.wao.gov.uk/assets/englishdocuments/Management_of_Sickness_Absence_by_NHS_agw_2004.pdf
[2] Audit Committee report, *The Management of Sickness Absence by NHS Trusts in Wales*, 5 August 2004, http://www.assemblywales.org/N00000000000000000000000000023067.pdf
[3] AGW report, *The Management of Sickness Absence by NHS Trusts in Wales – Follow Up Report*, 29 January 2009, http://www.wao.gov.uk/assets/englishdocuments/NHS_trusts_sickness_absence_update_eng.pdf
[4] Collective references to NHS trusts in the rest of this report include Powys Local Health Board.

The stresses and distractions associated with the NHS reorganisation could yet reverse the overall reduction in sickness absence reported since 2002-03

4. NHS trusts' average annual rate of sickness absence stabilised at between 5.3 and 5.4 per cent in the period from April 2004 to March 2008, compared with the 6.0 per cent figure reported previously for 2002-03. This reduction in absence is estimated to have generated extra staff time in work worth £6 million a year and should also have helped to avoid some additional expenditure on replacement staff, such as agency nurses. However, most trusts could not readily quantify the extent to which replacement staff costs were the result of staff sickness absence.

5. The average sickness absence rate in 2007-08 appears to have been better, or at least no worse, than the performance of the NHS in other parts of the United Kingdom. Nevertheless, trusts' sickness absence rates are still relatively high compared with wider public and private sector trends, although there are circumstances peculiar to the NHS that may contribute to the levels of absence. The provisions of the Agenda for Change pay agreement, which allows staff to retain pay enhancements for working anti-social hours even if they call in sick, may also have encouraged some additional sickness absence.

6. There are also still substantial differences in the sickness absence rates reported by individual trusts, ranging from 4.1 per cent to 7.0 per cent in 2007-08. These differences cannot, in our view, be explained simply in terms of factors outside the control of individual organisations. The available evidence certainly suggests that where trusts have focused particular attention and resources on this issue then it has been possible to reduce sickness absence rates.

7. Although it is still too early to assess its impact, we are concerned that the process of NHS reorganisation could lead to an increase in sickness absence rates. The reorganisation could exacerbate problems with morale and workforce engagement and increase stress. Steps taken by the Assembly Government to address this risk include the clear no-redundancy policy that has been established as part of the reorganisation process and the appointment of Transitional Directors. However, while it may be true that the reorganisation will have a negligible impact on the day-to-day work of the

majority of frontline clinical staff, if managed badly the reorganisation could still have a detrimental impact on morale. Staff turnover and vacancies may also increase the pressure and stress on staff.

8. Trusts' sickness absence management arrangements have generally improved over recent years, including:

   - an increased emphasis on pro-active intervention to resolve long-term absences, such as phased returns to work and redeployments;
   - improved sickness absence management training, including the recent development of an e-learning tool (NHSWales@Once); and
   - closer monitoring of sickness absence management activity by Human Resources staff.

   However, there is still evidence that core procedures are often not being adhered to and the reorganisation may itself distract attention from the management of individual sickness absence cases. For example, Human Resources staff and certain managers may have less time available to deal with sickness absence cases or changes in line management may also bring a short-term loss of focus.

There are opportunities to drive forward further improvements and consistency of approach in sickness absence management alongside the process of NHS reorganisation

9. NHS trusts are still to realise the full benefits from its investment in the new England and Wales-wide Electronic Staff Record system. The initial focus in implementing the system was on ensuring that the payroll function was working correctly. Paying staff correctly is clearly important but it is still disappointing that trusts have not realised more quickly the sickness absence-related benefits of the system, the rollout of which had already taken considerably longer than first anticipated. These potential benefits include being able to improve the analysis of sickness absence trends and the general processing of information, including real-time recording of sickness absence cases. Concerns about data quality and a certain lack of understanding of the system also affected the pace of benefits realisation.

10. The Assembly Government has indicated that, from 2007-08 to 2014-15, the Electronic Staff Record will cost the NHS in Wales some £18.1 million, set against projected cash releasing benefits of £20 million. It remains to be seen

whether the projected benefits, the full basis of which has not been made clear to us, will actually be realised in practice.

11. There have been examples of local improvements in the provision of Occupational Health services. However, insufficient progress has been made in terms of improving the overall level and consistency of Occupational Health provision across the NHS trusts. While more money may be needed to help provide better services, the NHS reorganisation may also deliver some economies of scale. The reorganisation also presents a more general opportunity to think again about how Occupational Health services should be best provided. Prompt completion of the long awaited review of Occupational Health provision and of the planned Occupational Health and Safety Framework guidance therefore takes on added importance.

12. The reorganisation also provides an opportunity to foster a more positive working environment across the NHS. The inclusion of Human Resource Directors at Board level within the new local NHS bodies should, in principle, provide a higher profile for people management issues. That these issues do not always appear to have been given sufficient prominence is itself surprising given that the NHS is fundamentally a people organisation. Despite some improvements in trusts' Corporate Health Standard ratings and an increasing focus on stress management in particular, results from the 2007 NHS Opinion Survey demonstrate that there is still a long way to go in terms of promoting a positive working environment across the service.

13. The Assembly Government's existing sickness absence target for the NHS of 4.2 per cent has no clear basis and the Assembly Government has not itself published trusts' performance against this target. Whatever new targets might be developed, the reduction in the number of local NHS bodies should make it easier for the Assembly Government to carry out its own performance management of the service. The planned introduction of a Wales-wide sickness absence policy should also make for greater consistency of approach between individual organisations. However, the Assembly Government will still need to demonstrate that it is asking searching questions of organisations that are failing to perform.

Recommendations

(i) We recognise that there are competing priorities during the process of NHS reorganisation. However, we believe that the recommendations in the Auditor General's report represent sensible short to medium-term priorities and should help to manage some of the sickness absence risks and opportunities associated with the reorganisation. **We therefore recommend that the Assembly Government provides us with a formal response setting out the action that it intends to take or has already taken to address the Auditor General's recommendations and updating us trusts' reported sickness absence rates for the 2008-09 financial year and, in so far as is possible, for the start of 2009-10.**

(ii) Recommendation 3c in the Auditor General's report stated that the Assembly Government should publish headline trends in sickness absence alongside other key staffing information, repeating the recommendation made previously by the Audit Committee. **We expect to see the Assembly Government reporting this information in the future and recommend that figures are reported at an organisational level and for common staff groups, drawing on the information available from the Electronic Staff Record.**

(iii) The Assembly Government has funded the development of an e-learning tool for NHS Wales (NHSWales@Once) which provides guidance on sickness absence management and other people management practices. **The issue of management training has featured in the Committee's previous work on sickness absence in the National Assembly for Wales/Assembly Government and in Further Education. We recommend that the Assembly Government should evaluate the effectiveness of the NHSWales@Once e-learning tool and, taking account of the results of that evaluation, explore the feasibility and cost-effectiveness of commissioning the tool (or an adapted version of it) for wider use across the public sector.**

The stresses and distractions associated with the NHS reorganisation could yet reverse the overall reduction in sickness absence reported since 2002-03

Average sickness absence rates have fallen since 2002-03 although we are concerned about the extent of the variation in the performance of individual NHS bodies

Average sickness absence rates have fallen since 2002-03, providing financial and operational benefits

14. NHS trusts' average annual rate of sickness absence stabilised at between 5.3 and 5.4 per cent in the period from April 2004 to March 2008[5]. The reduction in this overall sickness absence rate when compared with the 6.0 per cent figure reported previously for 2002-03 is a notable achievement. The Auditor General estimates that this reduction in sickness absence has generated extra staff time in work worth at least £6 million a year[6]. This is time that can be spent improving patient care.

15. The overall reduction in sickness absence should also have helped to avoid some expenditure on replacement staff, such as agency nurses. We were surprised to find that relatively few trusts were readily able to quantify the extent to which their replacement staff costs were the result of sickness absence[7]. Mr Williams emphasised that the demand for replacement staff can sometimes be due to more than one issue, for example sickness absence combined with vacancies[8]. However, given the money that is being spent on replacement staff, we would still expect trusts to be doing more to quantify the reasons for this expenditure. Evidence of potential replacement staff cost savings could be used to justify investment in measures to reduce sickness absence.

16. Trusts had been set the target of reducing their expenditure on agency nurses and locum doctors to not more than two per cent of their total staff costs for 2007-08[9]. Mr Williams has confirmed that, with the exception of Gwent Healthcare NHS Trust, which reported a rate of three per cent against this target, and North West Wales NHS Trust for which figures have not been provided, trusts met this target. Based on their 2007-08 performance, many

[5] AGW report, paragraph 1.13
[6] AGW report, paragraph 1.14
[7] AGW report, paragraph 1.9 and figure 1
[8] Annex A, paragraph 22
[9] AGW report, paragraph 1.7

trusts had also achieved, or were close to achieving, the more stretching 2008-09 target that agency and locum costs should not exceed 0.8 per cent of total staff costs[10].

17. However, Mr Williams also pointed to particular service pressures last winter which might have created an unexpected level of demand for agency staff, thereby affecting performance against the 2008-09 target. While these pressures may have been particularly acute last winter, we were also concerned that winter pressures can be used too readily to explain a failure to hit performance targets. Trusts still need to plan effectively to manage these pressures and to reduce their reliance on more costly agency staff. One way in which trusts can reduce agency nursing costs is, as Mr Williams emphasised, by developing their own bank nurse arrangements[11].

18. We were pleased to learn that trusts' overall sickness absence performance in 2007-08 appeared better, or at least no worse, than the performance of the NHS in other parts of the United Kingdom[12]. Mr Williams and Ms Lloyd-Jones could not comment on why sickness absence figures for the NHS in England had not been published since 2005. For 2005, the Information Centre for Health and Social Care in England reported an average sickness absence rate of 4.5 per cent across full range of primary care trusts, health authorities, acute, mental health and community NHS trusts. However, Ms Lloyd Jones explained that she had been told informally that sickness absence rates in England were currently running at between five and six per cent[13].

19. Nevertheless, trusts' sickness absence rates remain relatively high compared with wider public and private sector trends[14]. We recognise that comparisons between the NHS and other parts of the public and private sectors need to take account of the particular working conditions within the NHS. However, NHS employers also need to take seriously their wider responsibilities in terms of protecting the health and safety of their workforce and promoting a positive working environment (see paragraphs 40 to 42). By way of example, Mr Williams described the potential benefits of using electrical profiling beds to reduce the manual handling risks to staff. By 31 July 2010 NHS bodies will

[10] Annex B, item 1
[11] Annex A, paragraphs 25-28
[12] AGW report, paragraph 1.14 and appendix 2
[13] Annex A, paragraphs 51-53
[14] AGW report, appendix 2

be required to have in place suitable and sufficient electrical profiling beds in all areas where patients are being nursed in bed[15].

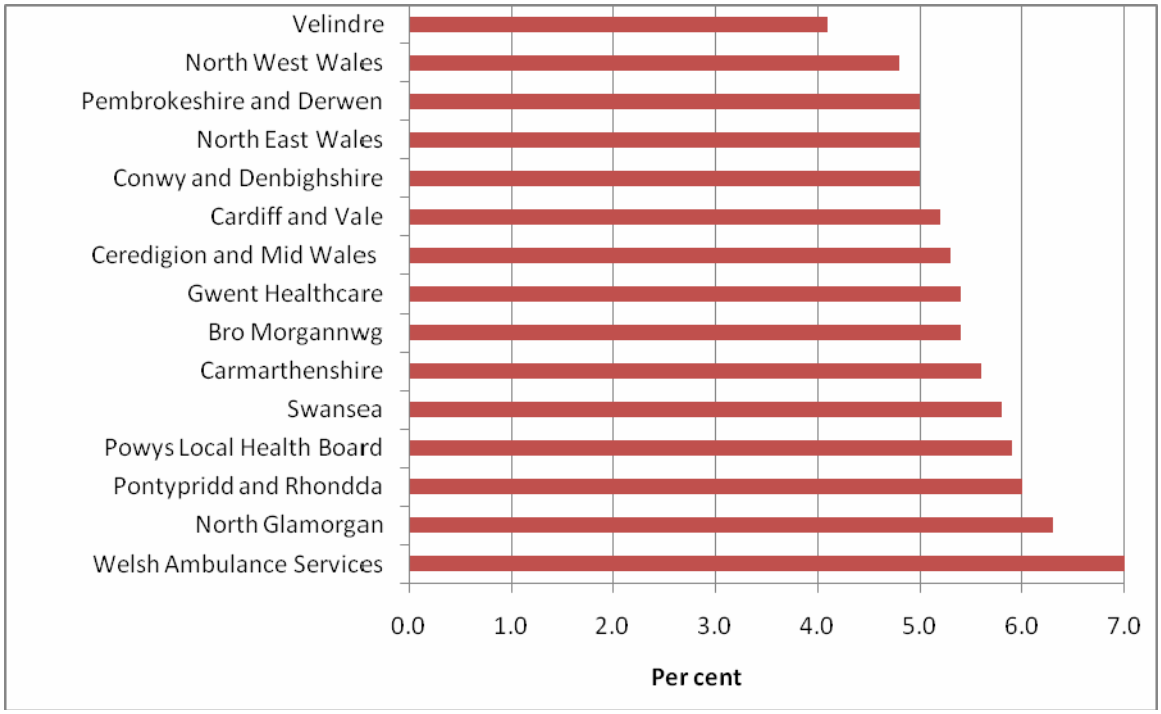
20. There have also been concerns that, despite increasing the annual leave entitlement for many NHS staff, the UK-wide Agenda for Change pay agreement might also be encouraging higher rates of sickness absence. Under Agenda for Change, staff retain pay enhancements for working anti-social hours even if they call in sick. Ms Lloyd-Jones indicated that more work would be required to determine whether the concerns identified at Conwy and Denbighshire NHS Trust reflected a wider trend, before then considering whether to raise the issue at a UK-wide level[16]. We recognise that an increase in sickness absence linked to these provisions may reflect staff who are genuinely unwell and who would otherwise have attended work because they could not afford to lose their allowances. In attending work, those staff could have presented health and safety risks to patients. However, there is also the risk that these provisions have encouraged some staff to call in sick despite being well enough to work.

The extent of the variation in sickness absence performance between individual NHS trusts is still a cause for concern

21. Despite the overall reduction in sickness absence since 2002-03, there are still substantial differences in the performance of individual NHS trusts. In 2007-08, the reported levels of sickness absence ranged between 4.1 per cent, at Velindre NHS Trust, and 7.0 per cent, at the Welsh Ambulance Services NHS Trust (see Figure 1)[17]. We recognise that local circumstances may help to explain some of this variation in sickness absence rates. However, we do not believe that these differences can be explained simply in terms of factors outside the control of the individual organisations.

[15] Annex A, paragraph 67 and Annex B, item 2
[16] Annex A, paragraphs 29-32 and AGW report, paragraph 1.6
[17] AGW report, paragraph 1.17 and figure 2

Figure 1: Reported sickness absence percentage rates (April 2007 to March 2008)



Source: AGW report, Figure 2.

22. The Auditor General's report does point to a general sharpening of trusts' focus on sickness absence management due, in part, to the pressure within the service to identify and deliver efficiency savings[18]. For example, Swansea NHS Trust had identified sickness absence as one of its three key corporate performance priorities. The Trust had reported a rate of absence approaching seven per cent in 2004-05 but, by 2007-08 had gradually brought this down to below six per cent. The Trust had also recovered just under £73,000 during 2007 in sickness absence salary costs resulting from incidents involving third-party claims[19].

23. Nevertheless, Mr Williams felt that not all organisations have perhaps been giving this issue the priority that it demands and indicated that he would be looking into this in more detail[20]. What is clear is that targeted action to address sickness absence rates can have a positive impact. For example, Pembrokeshire and Derwen NHS Trust had successfully reversed a sharp

[18] AGW report, paragraphs 1.1-1.10
[19] AGW report, paragraphs 1.4, 1.10, and figure 2.
[20] Annex A, paragraph 56

increase in sickness absence in its Mental Health and Learning Disabilities division during 2006-07[21].

The stresses and distractions associated with the reorganisation could yet contribute to higher sickness absence rates

The process of reorganisation could, at least in the short-term, exacerbate problems with morale and workforce engagement and increase stress

24. The findings of the NHS Wales 2007 Staff Opinion survey are very worrying, pointing to low levels of morale and workforce engagement, as well as concerns about job security[22]. We share the Auditor General's view that, even if well managed, the process of NHS reorganisation is unlikely to improve this situation in the short-term[23].

25. Mr Williams recognised that all of the evidence on mergers and reorganisation suggests that they can be stressful and that routine business objectives can be lost. However, he also indicated that the majority of clinical staff would not be directly affected by the reorganisation[24] and emphasised:

- that the clear no-redundancy policy would help to address some of the potential anxiety;
- the importance of good communication throughout the reorganisation process; and
- the role that the Transitional Directors would be playing in ensuring business continuity prior to the appointment of the Chief Executives for the new Local Health Boards.

26. The direct impact of the reorganisation on the day-to-day work of the majority of frontline clinical staff may well be negligible. However, the process of reorganisation, if managed badly, could still have a detrimental impact on the morale of NHS staff, regardless of their role. Staff turnover and vacancies during the process of re-organisation may also increase the pressure and stress on staff.

27. The evidence from the recent round of Trust mergers is mixed, with an increase in sickness absence during 2007-08 across some, but not all, of the Trusts involved in mergers since 1 April 2008. At Cwm Taf NHS Trust, HR managers recognised that the merger of the former North Glamorgan and

[21] AGW report, paragraph 1.19
[22] AGW report, paragraphs 1.16 and 2.34
[23] AGW report, paragraph 1.16
[24] Annex A, paragraph 48

Pontypridd and Rhondda NHS trusts was likely to have been a factor in the increased sickness absence rate across both organisations during 2007-08[25].

The demands of the reorganisation may distract attention from the management of sickness absence cases

28. The Auditor General's report points to a range of general improvements in trusts' sickness absence management arrangements. These improvements include:

- An increased emphasis on pro-active intervention to resolve long-term absences, such as through the negotiation of phased returns to work and/or redeployments[26]. Mr Williams also indicated that the issue of fast tracking NHS staff for medical treatment was under discussion again with the British Medical Association[27].
- Improved sickness absence management training for staff with line management responsibilities, including the recent development and launch of an e-learning tool (NHSWales@Once) for NHS Wales[28]. Mr Williams has reported that this e-learning tool, developed at a cost of £40,000, has been accessed by over 300 NHS staff since June 2008. We would expect to see this number increase significantly given the overall size of the NHS workforce, delivering further economies of scale in terms of the development cost[29].
- Closer monitoring of sickness absence management activity by human resources staff and closer working between managers, human resources and occupational health staff to resolve problem cases[30].

29. Despite these improvements, there are still inconsistencies in the local application of sickness absence policies and procedures. For example, audits at North Glamorgan NHS Trust had identified substantial variations in compliance with core procedures across three directorates[31]. Moreover, we are concerned that that the demands of the NHS reorganisation could distract attention from the issue of sickness absence management. Any such

[25] AGW report, paragraph 1.18
[26] AGW report, paragraphs 2.5-2.9
[27] AGW report, paragraph 2.8 and Annex A, paragraph 77
[28] AGW report, paragraphs 2.10-2.11 and case study D
[29] Annex B, item 3
[30] AGW report, paragraphs 2.12-2.13 and 2.28
[31] AGW report, paragraph 2.14 and case study D

loss of focus could be in terms of the attention paid to this issue within trusts' overall performance management arrangements or the time available to certain managers and human resources staff to deal with individual absence cases. Changes in line management responsibilities could also affect the management of individual cases.

It is still too early to assess the possible impact of the NHS reorganisation on sickness absence rates

30. Mr Williams told us that the sickness absence figures for the 2008-09 financial year were, at the time of our evidence session, running at an average of 4.99 per cent[32]. The Auditor General's report notes that, given the wider context of the NHS reorganisation, achieving an average sickness absence rate of five per cent or less could be regarded as further significant progress[33]. However, Mr Williams also recognised that these figures did not take full account of the winter period when sickness absence rates might be expected to increase. Regardless of the year end performance for 2008-09, it is still too early to assess the possible impact of the NHS reorganisation on sickness absence rates.

There are opportunities to drive forward further improvements and consistency of approach in sickness absence management alongside the process of NHS reorganisation

The NHS in Wales is still to realise the full benefits from its investment in the Electronic Staff Record

31. The Auditor General's report states clearly that the new Electronic Staff Record, now operating across the NHS in England and Wales, is not yet being used to its full potential to support sickness absence management[34]. Of course the introduction of this system cannot, by itself, prevent sickness absence cases from occurring. But the information that the system has the potential to provide should help NHS managers to identify and address underlying trends in sickness absence.
32. Mr Williams and Ms Lloyd-Jones both appeared enthusiastic about the potential opportunities afforded by the Electronic Staff Record, referring in particular to:

[32] Annex A, paragraph 7
[33] AGW report, recommendation 1
[34] AGW report, paragraphs 2.15-2.25

- the scope for real-time recording of sickness absence[35];
- improved analysis of sickness absence trends[36]; and
- being able to use the system to link up with staff rostering information[37].

Ms Lloyd-Jones also pointed to the wider benefits of the system in facilitating a move into electronic recruitment[38].

33. Ms Lloyd-Jones recognised that the development of the Electronic Staff Record had been a very ambitious project and emphasised the initial importance placed on ensuring that the system's payroll function was absolutely robust[39]. We would not dispute the importance of paying staff correctly and on time. However, it is still disappointing that trusts have not been able to realise more quickly the sickness absence related benefits of the system, especially given that the rollout of the system had already taken considerably longer than first anticipated. The pace of benefits realisation appears to have been affected, at least in part, by initial concerns about the accuracy of information generated from the system[40]. We have not explored the wider process which underpinned the development of the Electronic Staff Record. Nevertheless, we are surprised that these data quality issues were not resolved during the testing of the system prior to rollout or that trusts did not perhaps have a better understanding of how to produce and interpret sickness absence data from the system.

34. Ms Lloyd-Jones explained that, through a steering group, she would be looking afresh at how to get the best out of the system over the coming year[41]. The work of this group is, in our view, critical to ensure that the NHS in Wales derives maximum benefits from its financial commitment to the system, not to mention the time that will have been spent dealing with its implementation. Mr Williams has provided details of the ongoing costs of the system from 2007-08 through to the end of the current ESR contract in 2014-15. These figures show projected costs of £18.1 million being exceeded by total cash releasing benefits of £20 million, yielding a £1.9 million surplus. However, the figures provided do not specify the system's development costs

[35] Annex A, paragraphs 106 and 110
[36] Annex A, paragraphs 63-64 and 106
[37] Annex A, paragraph 106
[38] Annex A, paragraph 111
[39] Annex A, paragraph 102
[40] AGW report, paragraphs 2.15-2.19
[41] Annex A, paragraph 102

or realised savings prior to 2007-08[42]. The basis of the projected cash releasing benefits is also unclear, although Mr Williams did describe how at least some of this cost related to the costs of other systems being removed[43]. It remains to be seen whether these benefits can actually be delivered.

35. At a time when information security is increasingly in the public eye, we also wanted some assurance that the information held on the Electronic Staff Record was being appropriately processed and secured. Mr Williams explained that there had been some questions asked about the level of detail that should be available on the system, such as the reasons for absence. However, while recognising the need to be vigilant about data protection, Mr Williams also endorsed the importance of collecting information on the reasons for absence to support efforts to address sickness absence problems. Ms Lloyd-Jones also referred to there being rigorous rules controlling access to the system[44].

The provision of and access to Occupational Health services remains inconsistent

36. The Auditor General's report points to some local improvements in Occupational Health services for NHS staff. These improvements include:
    - the introduction of new software to assist with case management; and
    - expansion of the range of services offered to staff such as physiotherapy and counselling support[45].

37. Nevertheless, we are very concerned about the ongoing inconsistency across NHS Wales in the provision of and access to these services. The overall rate of progress in this area is particularly disappointing given that the Audit Committee recommended in August 2004 that the Assembly Government should establish its own guidance and standards for the provision of Occupational Health services across NHS Wales. It is also difficult to understand just why the 'root and branch' review of Occupational Health provision agreed by the Welsh Partnership Forum during 2005-06 has still not reached a resolution[46].

[42] Annex B, item 4
[43] Annex A, paragraph 110
[44] Annex B, paragraphs 113-116
[45] AGW report, paragraph 2.29
[46] AGW report, paragraph 2.27 and Annex A, paragraphs 119-120

38. Mr Williams stated that Occupational Health provision is now clearly on the agenda. Mr Williams also recognised that, if consistent and high quality occupational health services for NHS staff are the aspiration, more money will be needed to resource those services. The Assembly Government will also need to ensure that there is sufficient Occupational Health expertise within NHS Wales[47].

39. The NHS reorganisation provides an obvious opportunity to think again about how Occupational Health services should be best provided in the future. We recognise that there are likely to be competing priorities in planning for the reorganisation. However, we would be extremely disappointed if the opportunity were not taken to drive forward the work required to finalise the proposed Occupational Health and Safety Standards framework guidance and complete the long-awaited review of Occupational Health provision as part of the reorganisation process. While financial constraints may limit the scope for new resources, we would also expect that the NHS reorganisation will deliver some economies of scale in the provision of Occupational Health services.

The reorganisation provides an opportunity to foster a more positive working environment across NHS Wales

40. Looking ahead to the NHS reorganisation, Mr Williams explained that he was putting great store on the fact that HR Directors will, within the structure of the new Local Health Boards, be part of the Board. Mr Williams also pointed to the presence of public health directors on those boards and explained that he was keen to see the new organisations demonstrate working practices that reflect best practice and for the local health boards to be exemplar employers and ambassadors for health and well-being in their communities[48]. Ms Lloyd-Jones also emphasised the importance of effective people management, looking well beyond a more narrow focus on sickness absence management, as a means of managing staff to keep them in work[49]. Similarly, Mr Williams pointed to there being a positive link between good team working, sickness absence and good patient care[50]. That these issues

[47] Annex A, paragraphs 118-120
[48] Annex A, paragraphs 86 and 124
[49] Annex A, paragraph 88
[50] Annex A, paragraph 11

do not always appear to have been given sufficient prominence is itself surprising given that the NHS is fundamentally a people organisation.

41. Based only on trusts' progress in relation to the Assembly Government's Corporate Health Standard, there is clearly more that trusts could be doing to promote workplace health and well-being. As at March 2008, still only six trusts held the gold Corporate Health Standard although this compared with only two trusts in January 2004[51].

42. The Auditor General's report points to a particular recent focus on stress management linked to the development of the Health and Safety Executive's stress management standards. Cardiff and Vale, Gwent Healthcare and Pembrokeshire and Derwen NHS Trusts, had each established employee well-being services in addition to their core Occupational Health provision. These well-being services had a particular remit in terms of providing counselling, delivering stress awareness training and designing organisational interventions to tackle work-related stress[52]. Trusts have also been developing a wider range of policies to support work-life balance. Nevertheless, we note that the 2007 NHS Opinion Survey reported that 20 per cent of staff still disagreed that they were able to strike the right balance between their home and work life with 32 per cent reporting that they could not meet the requirements of their job without regularly working excessive hours[53].

The reorganisation should make it easier for the Assembly Government to oversee the sickness absence performance of individual NHS bodies

43. The Assembly Government had set all NHS organisations the target of reducing sickness absence to a rate of 4.2 per cent or less[54]. The scale of the challenge to achieve this target for most of the NHS trusts is apparent from the rates of absence shown previously in Figure 1.

44. The exact basis for the 4.2 per cent target is unclear. Mr Williams explained that there was a view within the service that the target had been set simply because it was the lowest rate of absence reported by any of the trusts at the time of the previous Auditor General's report. Mr Williams stopped short of saying that the 4.2 per cent target was an impossible goal but he noted that,

[51] AGW report, paragraph 2.32 and figure 4
[52] AGW report, case study H
[53] AGW report, paragraphs 2.34-2.35
[54] AGW report, paragraph 1.2

while Velindre NHS Trust had achieved the target, that Trust's make-up is unique[55].

45. The Auditor General's report recommends that the Assembly Government should discontinue its use of the generic 4.2 per cent sickness absence target. In place of this target the Auditor General recommends an approach to target setting that reflects the circumstances of individual NHS bodies, with a focus on continuous improvement[56]. Mr Williams appeared to subscribe to such an approach and also indicated that there might be scope to set sub-targets for specific staff groups[57].

46. Whatever the new targets might be, Mr Williams suggested that the reduction in the number of NHS bodies across Wales should make it easier for the Assembly Government to carry out its own performance management of the service[58]. The move towards an NHS Wales-wide sickness absence management policy[59] should also make for greater consistency of approach and support more consistent performance management. Ms Lloyd-Jones confirmed that, in developing that policy, she would also be looking to agree consistent trigger points for management intervention in response to long term and frequent short-term absence[60]. Trusts have, to date, adopted different thresholds for management intervention[61] and Ms Lloyd-Jones noted that this had been a source of concern to the trade unions and staff.

47. Mr Williams indicated that, in his experience as a Trust Chief Executive, sickness absence had been discussed regularly with Assembly Government officials and with Local Health Boards as the commissioners of Trust services[62]. However, that the Assembly Government has continued to operate with a sickness absence target the basis for which is unclear with no obvious external pressure to achieve it does not fill us with confidence and raises questions about the wider performance management regime across the NHS. We trust that, as a consequence of the NHS reorganisation, not only will it be administratively easier for the Assembly Government to

[55] AGW report, paragraph 1.3 and Annex A, paragraphs 14-15 and 42
[56] AGW report, recommendation 1a
[57] Annex A, paragraphs 14-15 and 46
[58] Annex A, paragraph 108
[59] AGW report, paragraph 2.4
[60] Annex A, paragraph 73
[61] AGW report, paragraph 2.2 and case study A
[62] Annex A, paragraphs 18-20

oversee the performance of individual NHS bodies, but that searching questions will be asked of those organisations that are failing to perform.

48. Mr Williams was not able to account for the previous failure of the Assembly Government to publish information on trusts' sickness absence rates, as had been promised in response to the Audit Committee's previous recommendations. However, he could see no reason why this information should not be reported in this way and we expect that this will now be the case, starting with the figures for the 2008-09 financial year[63].

[63] AGW report, paragraph 1.5 and Annex A, paragraph 20

Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Mercher, 4 Chwefror 2009
Wednesday, 4 February 2009

Cynnwys
Contents

Aelodau Cynulliad yn bresennol
Assembly Members in attendance

Lorraine Barrett	Llafur Labour
Lesley Griffiths	Llafur Labour
Huw Lewis	Llafur Labour
David Melding	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Janet Ryder	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Gillian Body	Swyddfa Archwilio Cymru Wales Audit Office
Jeremy Colman	Archwilydd Cyffredinol Cymru Auditor General for Wales
Ian Gibson	Swyddfa Gydymffurfiaeth y Cynulliad Assembly Compliance Office
Sheelagh Lloyd-Jones	Cyfarwyddwr Adnoddau Dynol, GIG Cymru Director of Human Resources, NHS Wales
Matthew Mortlock	Swyddfa Archwilio Cymru Wales Audit Office
Paul Williams	Pennaeth yr Adran Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Head of the Department of Health and Social Services, Welsh Assembly Government

Swyddogion Gwasanaeth Seneddol y Cynulliad yn bresennol
Assembly Parliamentary Service officials in attendance

John Grimes	Clerc Clerk
Abigail Phillips	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.30 a.m.
The meeting began at 9.30 a.m.

Cyflwyniad ac Ymddiheuriadau
Introduction and Apologies

[1] **David Melding:** Good morning, everyone. I welcome you to the Audit Committee. I will start with the usual housekeeping announcements. These proceedings can be conducted in Welsh or English. When Welsh is spoken, translation into English is provided on channel 1. Should you be hard of hearing, amplification of the proceedings can be heard on channel 0. Please switch off all electronic equipment as it will interfere with the broadcasting. We do not expect a fire drill this morning. If you hear the fire alarm, please follow the instructions of the

ushers in order to leave the building safely. We have received apologies from Mike German, who is on Commonwealth Parliamentary Association business in London, from Bethan Jenkins, who is unwell, and from Irene James, who has been delayed because of the inclement weather. Janice Gregory has an unavoidable clash as she is in a meeting of Legislation Committee No. 3 this morning. Janet Ryder is replacing Chris Franks as a member of this committee, and we welcome her to her first meeting. I understand that this is the first time that you have attended an Audit Committee meeting, Janet, so this is a new experience. We are delighted that you are joining this committee, and we look forward to your contributions.

9.32 a.m.

NHS Sickness Absence
Absenoldeb Salwch yn y GIG

[2] **David Melding:** We will now discuss the findings of the Auditor General for Wales's follow-up report: 'The Management of Sickness Absence by NHS Trusts in Wales'. This is a good opportunity for us to consider the progress made since the report on the same subject by the previous auditor general in January 2004, and the subsequent report by the Audit Committee. While this latest report points to an overall improvement in NHS trusts' management of sickness absence, and in the average rate of absence, the committee has the opportunity to consider what needs to be done to build on this improvement through the process of NHS reorganisation.

[3] I welcome the witnesses. Would you please introduce yourselves for the record so that you can be identified as proceedings go forward?

[4] **Mr Williams:** I am Paul Williams, head of the Welsh Assembly Government's Department of Health and Social Services, and the chief executive of NHS Wales.

[5] **Ms Lloyd-Jones:** I am Sheelagh Lloyd-Jones, director of human resources for NHS Wales.

[6] **David Melding:** I welcome the witnesses, who are attending in an official capacity for the first time. Paul, you may be familiar with our proceedings. The questions will be principally addressed to Paul, and he may want to defer. Sheelagh, if you want to contribute at any stage, just catch my eye and I will bring you in as appropriate. We have a range of questions that Members will put to you, after which there may be supplementary questions. You will soon get the flow of how we work. Paul, I would like to give you the opportunity to make a general response to the report, in the knowledge that we will then drill down to all the detail in our subsequent questions. Would you give a headline response to the report to start this evidence session?

[7] **Mr Williams:** Thank you, Chair. As you said in your introductory remarks, this is a helpful report, and it indicates that the NHS has made progress, moving from the 6 per cent shown in the original report and steadying out at about 5.3 to 5.4 per cent. So far this year, the figures indicate a rate of around 4.99 per cent. Clearly, we are still in the winter period, therefore we will have to see whether we have improved on that progress or whether we have reached a plateau at around 5.3 or 5.4 per cent. This work and the report indicate that this is an excellent opportunity for the Wales Audit Office, the Welsh Assembly Government and the NHS to work together to identify and spread good practice, and we need to build on that.

[8] We need to look at sickness in terms of its relationship with absence, because they are not necessarily always related. In terms of sickness itself, it must be recognised that NHS staff are a part of the population of Wales and are therefore subject to the same exposure to illnesses. Issues of absence and sickness related to caring for family members, young children

and elderly relatives can impact on the way in which we manage the situation, but we must not mitigate those problems in the NHS in any particular way. If we have staff who are exposed to infections, then our infection control procedures need to be good. If there are problems relating to carers, for instance issues around childcare, we need to think about dealing with those issues as a positive way in which to improve attendance rates.

[9] Most NHS staff tend to be recruited locally, and we have sites in areas with deprived populations. We also have increased sickness levels in Wales, and it is those areas that we have been traditionally tackling in terms of our health and wellbeing agenda, so we just need to recognise that these issues need to be taken on board.

[10] At some stage, we will probably be discussing the use of good information. We now have the electronic staff record, and we will need to address how we can use that information more intelligently. Within that, we will need to consider ways in which we can be more sophisticated in targeting. The report quite rightly addresses the fact that we are now entering a period of major change. Will that major change cause some difficulties with the constant progress that we have been making? What are we doing to anticipate potential issues around organisational change?

[11] Finally, based on my recent experience as a chief executive in the NHS, I think that we need to be looking at ways in which we can develop and foster a more positive culture, so that staff feel that they are being properly supported and are then available to improve patient care. I think that there is a positive link between good team working, sickness absence and good patient care. There are important links there that we might wish to consider. They would be my introductory remarks, Chairman, but I am sure that you will want to either come back on these points or that you will have others that you feel are even more important.

[12] **David Melding:** Thank you for that; that is precisely what we will do. You have touched on some of the most pertinent issues that we will want to follow up in depth, but there are a couple of other issues and there may also be supplementary questions to follow up on various points. I know that I speak for the whole committee in welcoming the fact that you accept that this report is very useful and needs to be acted upon. We will pursue some of the points, starting with Lesley Griffiths.

[13] **Lesley Griffiths:** The report describes how the Welsh Assembly Government has set a target of 4.2 per cent for NHS trusts and other organisations, which they think is ambitious and probably unrealistic—you said in your introductory remarks that the best up until now has been 4.99 per cent. How do you intend to identify more realistic absence targets?

[14] **Mr Williams:** First and foremost, there has been a debate around the 4.2 per cent target and how it was arrived at in the beginning, which is quite interesting. The view in the service is that the target was probably taken from the Velindre NHS Trust back when this work started. That trust was running at about 4.2 per cent and there may therefore have been an assumption that if that trust was the best on benchmarking, the NHS could move to everybody achieving that figure.

9.40 a.m.

[15] We might want to explore that in relation to the fact that organisations comprise different staff groups, different gender balances, and different age ranges, and all those things need to be factored into the appropriate target. I am saying that as someone who comes from a school of continuous improvement. I am not saying that 4.2 per cent is impossible, but we need to have realistic targets. I would not say that, on hitting 5.2 per cent, that is it; I would say, ‘Now let’s start looking at the information that we have to see how we can gradually work that through’. The targets might be differentials within organisations, to recognise the

difference in gender balance or staff groups.

[16] The indication is that NHS Wales is not doing too badly when compared with comparable UK health sectors. That needs to be borne in mind—again, I do not offer that as an excuse; I just ask that we remain mindful of the existing evidence and then say, 'If we are going to be best in class, what can we learn and how can we take it forward?'

[17] **Lesley Griffiths:** What have been the consequences, if any, for NHS organisations that have not reached the 4.2 per cent target?

[18] **Mr Williams:** It is part of the performance management. The regional offices look at the sickness absence rates against the 4.2 per cent target. I had robust discussions in my previous role with regional colleagues about my performance management, but I have to say, as far as I was concerned, most of the pressure in my trust came from me and from my colleagues. You can translate sickness absence into a not insignificant saving—a 1 per cent saving in a large organisation can run to well over £1 million. You can look at it in a positive light and work particularly with trade union colleagues, who are supportive in this area, to say, 'If we get this right, it will mean getting people back to work earlier and contributing', and a positive effect of that is that the number goes down and the costs are reduced. I always see this as a very positive issue, which is why I have always put it on my agenda as one of the important things to tackle.

[19] **Lesley Griffiths:** Thank you. Paragraph 1.5 of the report notes that the Assembly Government has not yet published trusts' sickness absence rates alongside other key workforce information. Why is that?

[20] **Mr Williams:** I cannot speak for the previous Assembly, but I see no reason why that should not be done. I will be looking at the performance management regime that I will want developed for the new local health boards. The information is there, and I see no reason why it should not be in the public domain for discussion. You will find that, in the day-to-day performance management, it is there and it is being discussed regularly between Welsh Assembly Government officials and trusts, sometimes through the regional office and sometimes directly, as well as being discussed with the LHBs as commissioners, because they needed to know—in a previous incarnation—whether they were getting value for money from their providers and whether there were positive ways of reducing cost or improving capacity as a result of addressing sickness and absence.

[21] **Darren Millar:** You mentioned the need to recognise that there are efficiency savings to be made by trusts. NHS bodies have had some tough financial settlements, and if they can reduce their sickness absence, then replacement staff cover costs should not be incurred, and the money saved could be invested in front-line services. Between paragraphs 1.6 and 1.10, the auditor general's report tells us that not all the trusts were able to identify what the cost of replacement staff was and what the proportion of replacement staff related to sickness was. If they are not able to quantify what the savings may be if they tackle sickness absence and reduce replacement staff cover, what incentive do they have to tackle sickness absence?

[22] **Mr Williams:** I do not condone trusts that are not able to make those links. As I said, in my trust, we gave this the highest priority. However, it may not be as simple as it would appear, because, if you are partly alluding to having to replace staff with agency staff, which is an expensive way of doing things, I give you the simple example of a member of ward staff who is sick, and that ward team may be under some pressure, but can carry that vacancy for a short time, then some patients are admitted who may require one-to-one care, and perhaps three nurses on a shift. That would suddenly force the organisation to look outside and to get agency cover. That sort of dynamic is not always recorded in a way that one can analyse

afterwards and say, ‘Those are the linkages’, and see whether there was something unavoidable and therefore justified. When we start using the electronic staff record, we will start to get into real-time recording, because those dynamics exist, and they need to be understood.

[23] **Darren Millar:** I appreciate what you say about the fact that, according to clinical need, you might have to increase staffing ratios, but if some trusts are able to record this at the moment, surely others ought to be able to do the same. Provided that there is consistency in the guidance as to what will be considered a replacement cost for sickness purposes, we should be able to quantify that, should we not?

[24] **Mr Williams:** ‘Consistency’ is the watchword. I assume that what lies behind your question is why some trusts are better at this than others, and why it is not given the same priority. They are fair questions, and that must come out in performance management. The other point on consistency is that, as you will see from the report, we have a number of working groups, such as the electronic staff record working group, through which we will be ensuring that consistent standards will apply across Wales. In future, we will be dealing with seven organisations, and it will be easier for us to manage this on an all-Wales basis and to have dialogue if we feel that an organisation is not giving it due attention.

[25] **Darren Millar:** From an efficiency point of view, people need these data to be able to react to them and to ensure that this is a priority, particularly during difficult financial times. That provides an additional incentive to manage this. Are trusts on track to achieve the target reduction in agency and replacement staff cover of 0.8 per cent of staff costs? That is what it needs to be reduced by, is it not, in 2008-09? Will that be achieved this year or not?

[26] **Mr Williams:** I am not sure whether that will be achieved this year. Significant progress has been made. Another driver in this system, which is not necessarily to do with sickness absence, is capacity, because, particularly now with winter pressures and the requirement to reduce waiting times, there are more patients in the system. A number of trusts have experienced difficulties around intensive care and are using agencies, so we may not hit the target on agency costs, or it may creep up, but that may not be related to sickness; it may just be a way of switching on capacity in the short term. I am not a big fan of using agencies as a mechanism to bridge a capacity gap. It should, and can, be done more effectively by using bank staff, and we are working on this with the partnership forum, because our issue is with the fluidity of the labour market and pricing it in a way that allows us to retain bank staff, rather than their looking to work through agencies, because they know that they can earn more through an agency. So, there are issues about the sensitivity of labour markets. I may be making too much of this, but the point is that we need to be driving down the use of agency staff. It is coming down, but I cannot guarantee that we will hit the target this year. As I said, it will probably be exacerbated by the peculiar winter pressures currently, and by the need to make sure that we have more capacity in the system.

9.50 a.m.

[27] **Darren Millar:** You mentioned winter pressures, but that seems to be the annual excuse, if you like, for not hitting targets. If we will not hit those targets this year, would it be fair to say that that is because this year is worse than others? Are the difficulties that the hospitals have, such as capacity, particularly unusual this year, or is it a typical year? If it is typical, why is there still a problem?

[28] **Mr Williams:** First and foremost, I would not say that it is an excuse; it is a reason. We are not just dealing with widgets; we are dealing with a shifting population and all the vagaries that go with that. To take the ambulance service as an example, in December, it had a 16 per cent surge in demand, which was not peculiar to Wales; that was happening across

England and Wales. You cannot legislate on that sort of surge, but the service must go on. However, there is a degree of predictability in emergency pressures that must be planned for, and we could legislate on that. I would not defend poor planning, but we need to recognise that where there is a need to flex, we need to flex—although I would not necessarily suggest going for the most expensive option, we could look at how to mitigate all those factors. That is where the more successful trusts have been able to look much more holistically at the range of issues to make sure that their costs and efficiency are at the highest levels.

[29] **Darren Millar:** The auditor general also draws attention to 'Agenda for Change' and the fact that, under the new pay system, there will still be an entitlement for staff to retain pay enhancements for anti-social hours if they are off for sickness reasons. It sounds slightly barmy to me that that provision is still offered. Do you think that that encourages sickness absence? For example, paragraph 1.6 mentions that there was a marked increase in the levels of absence in Conwy and Denbighshire NHS Trust on weekends and bank holidays when the enhanced pay rates would be available for staff to claim. Clearly, there is a correlation in Conwy and Denbighshire, although I do not know whether that is the case elsewhere in Wales. How do you think that those pay entitlements contribute to sickness rates?

[30] **Mr Williams:** I might ask Sheelagh to supplement my answer, but I have heard, anecdotally, that the shift from paying plain time to enhanced rates, on a weekend, say, may incentivise. I did not negotiate 'Agenda for Change', but that is what we have to deal with. I understand that this issue is being reconsidered nationally, because some drivers may not be advantageous, but we have to work with what we have currently.

[31] **Darren Millar:** So, is that incentive something that you are trying to overcome?

[32] **Ms Lloyd-Jones:** What is in the auditor general's report refers to two wards in Conwy and Denbighshire. We do not have robust evidence that that is a problem that the trust has identified across the service. We need to do some more work to see whether that happened to be a blip in those two wards or whether there is an underlying problem. As Paul said, 'Agenda for Change' is a national agreement that covers staff across the UK. Any changes to the provisions of that agreement will be made through UK negotiations. We just need to be aware of whether there is an underlying problem. If so, we have to go back to the negotiators and say that perhaps that needs to be reviewed.

[33] **Darren Millar:** Okay. Turning to—

[34] **David Melding:** Could I just check whether I have fully understood the target of 0.8 per cent and no more to be spent on locum and agency staff in 2008-09? At the moment, you do not know whether that target is likely to be met, but I presume that you will at some point. I do not think that you actually answered the question of whether last year's target of no more than 2 per cent was met. Do you know whether it was?

[35] **Mr Williams:** I do not have that figure to hand, Chair.

[36] **David Melding:** That is fine, as long as you tell us directly if you do not know. Could we have a note on whether last year's target was achieved, and, as soon as administratively possible, a note on whether this year's target of no more than 0.8 per cent was achieved? It is important that we get that evidence.

[37] **Darren Millar:** Turning to the subject of targets, you mention that you are on track this year to secure another reduction in sickness absence, which is encouraging, and I am pleased to hear that. You said that the target of 4.2 per cent sickness absence was ambitious, but achievable in the long term.

[38] **Mr Williams:** I did not quite say that it was achievable.

[39] **Darren Millar:** You said ‘not impossible’.

[40] **Mr Williams:** I said that we must always strive for it.

[41] **Darren Millar:** To quote you, you said that it was ‘not impossible’ to hit that target. You talked about looking at the issue by job type, about monitoring realistic progress in the short term, setting some shorter-term goals, setting targets by gender because of different pressures on parents, and so on. How can you achieve things in the shorter term, and what realistic targets should be set?

[42] **Mr Williams:** I do not want to backtrack on saying that it is ‘not impossible’, and it clearly was achieved at Velindre NHS Trust. The point that I was making was that Velindre may not be representative. That trust is peculiar in the skills mix that it has. We need to look at the skills mix and gender balance at every trust, and then start working through what is truly achievable. That is where the analysis of electronic staff records will help us to achieve continuous improvement, along with improved learning, and the consistency that you mentioned.

[43] **Darren Millar:** So, you think that 4.2 per cent is achievable, but there is no short to medium-term strategy for making progress towards that, other than the use of the electronic staff records.

[44] **Mr Williams:** It was clearly achievable at Velindre, but Velindre is different from most trusts. The make-up of the staff is different, as is the size of the trust. It draws some of its support services from other trusts, so, for instance, ancillary workers had higher sickness levels on average than other categories of staff, but most of those services are not provided by Velindre, but are called in from other trusts. Therefore, Velindre’s figures are slightly skewed, but other trusts have a higher percentage of sickness absence.

[45] **Darren Millar:** There are significantly different absence rates for clerical NHS staff, for nursing staff, facilities staff, those involved in heavy lifting, and so on. Do you propose to set targets for those different groups?

[46] **Mr Williams:** Yes, and I think that we should go further than that. We certainly need to look at each of the major staff categories, but, even within them, we need to understand whether there is a difference between a highly pressurised intensive care nurse and a nurse working in rehabilitation, for example. Both jobs are important, but is it right to assume that one is more stressful and pressurised and therefore will result in more sickness absence? My experience is that it is not necessarily so. This comes back to my point about high morale, good team-working, and effective supervision. We need more management time to look at this issue, decide what is achievable, and then move towards continuous improvement.

[47] **Darren Millar:** We are all keenly aware of the impact of NHS reorganisation at the moment, given its potential impact on staff morale across the NHS in Wales. What work is being done by the department to ensure that it does not have an adverse impact on absence rates?

10.00 a.m.

[48] **Mr Williams:** There are a number of issues here. First and foremost, in any reorganisation, it is important that we remove as much anxiety as possible. For example, there is a clear no-redundancy policy. Some of the anxiety will simply be about the unknown, and we need good communication on what the reorganisation means. The majority of clinical staff

will not be affected. However, many managers will be, and that raises a question of whether one impact could be a lack of focus and attention in the interim on the issues that we were just discussing. One thing that I have done to address that is to appoint seven transitional directors—very senior people—who are overseeing not just the reorganisation but what I would call business continuity, working with the trusts and local health boards to ensure that we are managing an effective transition until we have the new chief executives in place.

[49] At the national level, we are working with the partnership forum to develop a suite of policies that will be available when the new health bodies are in place. That is to ensure the consistency that we were talking about earlier. So, a number of factors are being built into this, because all of the evidence on mergers and reorganisation suggests that they can be stressful and that the day-to-day business objectives can be lost. We must avoid that, because, at the end of the day, this comes back to the impact on patient care. We need to make sure that we have continuity and consistency, underpinned by a suite of national policies and a clear direction and sense that this is important for us.

[50] **Darren Millar:** Thank you. It is good to hear that you are aware of it and that you are seeking to manage it properly. On a personal note, I must say that I think that the management of the reorganisation through transitional arrangements is very good at the moment, and seems to be working quite well.

[51] I wish to turn everyone's attention to appendix 2, which contains comparisons of sickness absence rates across the UK and the private sector. It makes comparisons between NHS staff absence in Wales, Scotland and Northern Ireland, but not England. Are we able to access information through the electronic staff records to make a comparison with England? If not, why not, and would it be useful?

[52] **Mr Williams:** If I may, I will turn to Sheelagh to answer the question of why that might not be possible. I understand that there was a period during which we began to share data and that the indications for England were that it was running at about 6 per cent, which would suggest between 14 and 16 days lost through sickness absence. I do not know why the information is not readily accessible at the moment.

[53] **Ms Lloyd-Jones:** 'Neither do I' is the short answer. England has stopped publishing its figures. In my new role, I meet the human resources directors from the four countries; we met last week and I took the opportunity to inquire about the sickness absence level in England, which is running at between 5 and 6 per cent. I will ask the question each time I meet with them.

[54] **David Melding:** Turning to Janet Ryder's questions, as is the way, some of these have been touched upon, but the bulk has not. I am sure that Janet can pick those out with her usual skill.

[55] **Janet Ryder:** You talked about the differences between countries and between staff groups, but there are still significant differences between trusts. Although some have improved a great deal, others have not. To what extent is the current variation between trusts' sickness absence acceptable?

[56] **Mr Williams:** From where I am sitting, I need to be convinced that the reasons are justifiable. I just have a feeling that not all organisations have given this the priority that it demands. That also reflects on investment in human resources directors, for example. That is why I am delighted to see that, in the new local health boards, a main board member will be from HR, because we are a people organisation. So, I share your anxiety. Where there are inconsistencies, we should ask the local management why that is the case, to find out whether the reasons are all justifiable or whether it is the case that due attention has not been given to

this very important subject. From that follows your question about performance management and consistency. I will certainly be looking at such things.

[57] **Janet Ryder:** I do not suppose that we could put a timescale on that, could we?

[58] **Mr Williams:** It will not slip off the agenda; I can give you that assurance. It comes back to the previous question of whether the reorganisation will cause a lack of focus. If we were to come back next year, would we see a dip in performance as a result of the reorganisation? We are hoping that this will not be the case, and we are working hard on that. However, I want to bring the level of best performance up as quickly as possible.

[59] **Janet Ryder:** You have talked about different groups of workers, but are there any particular groups of staff that are more prone to high levels of sickness? I think that you might have touched on why, but would you like to elaborate on why those groups of workers might be more prone to sickness?

[60] **Mr Williams:** That is a difficult one. Traditionally, doctors have low sickness absence rates; the figure is between 1 and 3 per cent. Ancillary workers tend to be at the higher end, while nurses are in the middle. That may reflect the type of work that people do. Ancillary workers may suffer from injuries as a result of their work. That gets you into health and safety matters. There is the question of whether it is related to the age range. In some of these working groups, you tend to have people at the higher age ranges. Around 30 per cent of our workforce is over 50 years old. Among people under the age of 25, sickness absence rates run at about 3.2 per cent. For those between 55 and 60, it works out at about 5.9 per cent. For those over 60, it runs at 7 per cent. So, we need an analysis of the gender balance, of the age ranges and occupational groups in order to get a far better understanding.

[61] In our previous trust, we looked at redeploying staff. As they get older, they may need to think about taking on lighter duties and so on, rather than thinking that they can perform at the same level for 40 years. There needs to be some creativity in this in terms of understanding these issues and dealing with them. That is where HR may not have been as proactive and may not have given it the profile that it deserves. Again, the three trusts for which I have been the chief executive have always given HR a main board position. Not all trusts saw this in the same way. I am very supportive of this area, and there is more to do. Your questions and testing are very pertinent to try to understand why these figures present in this way, rather than taking them for granted.

[62] **Janet Ryder:** I can certainly sympathise with getting older and not being able to do what you used to be able to do. Can you quantify it in any way? Is it possible to quantify the amount of sickness that is due to specific things, such as vomiting or severe weather conditions? Is it possible to break the figures down even further and say what might be attributable to what?

[63] **Mr Williams:** Again, Chair, I might defer to Sheelagh, as she is more of an expert on this than I am. We have an electronic staff record and the data warehouse, which means that the data can be interrogated in a way that could not be done before. That will help us to navigate more focused solutions for particular problems.

10.10 a.m.

[64] **Ms Lloyd-Jones:** ESR does allow us to understand the causes of sickness absence, but we have to ensure that the data is entered so that we can do the analysis. That is a challenge. Also, I think that the occupational health departments could do more to help us, through their services, to understand the nature of the illness that they are dealing with. We will be looking at a sickness absence policy for Wales in the coming year and, when we look

at that, we also have to look at how we can get a much better understanding of exactly what is causing our ill health, so that we can have better solutions for it.

[65] **Janet Ryder:** Will you be able to pick out local variations?

[66] **Ms Lloyd-Jones:** Yes, we should be able to.

[67] **Mr Williams:** I will offer one practical example around back injuries, again drawing on my past experience of working with the Health and Safety Executive. In our work on sickness absence, we had picked up that back injuries were a constant and worrying feature, so we decided many years ago, as a trust, to invest over £1 million in electronic profile beds, which are now the norm, but they were not then. We were able to demonstrate to the board at the time that investing in those beds would improve sickness absence rates. That is a practical example. I think that when we have more such information, we will be able to decide how to invest or what actions need to be taken in a way that has not been done before.

[68] **Lorraine Barrett:** I am looking at paragraphs 2.1 to 2.6, and I want to ask you about the NHS Wales-wide sickness absence policy that you intend to develop. How will you ensure that that will incorporate best practice from existing policies?

[69] **Mr Williams:** We are drawing on the experience of not only the HR directors, but our trade union colleagues. We are also casting the net wider in terms of best practice to include the private sector and other parts of the public sector. We are pretty confident that the policies that we are developing will be of a high calibre.

[70] **Lorraine Barrett:** Will that generic sickness absence policy allow for local discretion in certain areas? We heard about the specific trigger points that you need to respond to in patterns of absence.

[71] **Mr Williams:** I will start on this point, but Sheelagh may like to come in, because she is involved with it on a daily basis. When we have consistent or generic policies, I think that they need to set a level below which we will not fall, but I think that we also need to be promoting best practice and pioneering good ideas. A lot of work has been done on the inconsistency about these trigger points, for instance.

[72] **Lorraine Barrett:** Will the policy be implemented in advance of the reorganisation?

[73] **Ms Lloyd-Jones:** Okay; there are two answers to that one. We will be looking to have a consistent approach to trigger points, because it is a source of concern that you have one measure in one trust and another measure in another trust. That is a source of concern to the trade unions and the staff, so we will look for consistency. Our target for getting the policy agreed is October, so we have quite a challenge ahead.

[74] **Lorraine Barrett:** Thank you. Looking a bit further on, in paragraphs 2.5 to 2.9, it says that trusts have placed greater emphasis on phased returns to work, redeployments and, in some cases, dedicated or fast-tracked access to treatment. Do you think that trusts could be doing still more to resolve long-term absence cases, building on some of the examples described in the report?

[75] **Mr Williams:** Yes, we do. I think that this is where occupational health comes in. Occupational health has not been developed consistently, and that is why we are focusing on improving occupational health and access to it. Within that, there is the whole issue of long-term sickness and the need to get people back to work early and to look at light duties and retraining. All of these things ought to be the business of occupational health and HR managers, working with local managers. This is not just the province of the HR department;

the line supervisors, the day-to-day managers for the divisions, directorates or departments are interfacing with and have responsibilities for their colleagues. However, more needs to be done on this so that we are employing best practice in this issue.

[76] **Lorraine Barrett:** Going into a bit more depth on the fast-tracking for medical treatment, I can think of other key workers who should, perhaps, be considered for it. Is there support within the service for any more overt fast-tracking of treatment?

[77] **Mr Williams:** This is a difficult one, as you can appreciate: should NHS staff get preferential treatment or take clinical priority over the general public? We would say 'no'. Having said that, I have found that clinical colleagues are sympathetic, and they will often give of their own time to ensure that staff are seen and 'fast-tracked'. We are discussing this issue formally with the British Medical Association to see whether there is a policy that would be acceptable, but it has to be defendable. By and large, I would hope—and it is my experience—that everybody recognises the importance of getting staff back to work, fit and healthy, as soon as possible.

[78] **Lorraine Barrett:** To ensure that their patients are cared for.

[79] **Mr Williams:** That is why having an effective occupational health department is so terribly important.

[80] **Lorraine Barrett:** How easy is it in practice to reach an appropriate resolution to long-term sickness absence cases before staff exhaust their occupational sick pay entitlement?

[81] **Mr Williams:** That is something that needs to be managed adequately. In the past, there have been examples of staff whose problems have not been addressed at the right time, and that is poor management practice and poor occupational health.

[82] **Lorraine Barrett:** I was going to ask the question about back problems, thinking back to 40 years ago when I was nursing and the lifting that we used to do—those new beds are amazing, and it is great for the patients to be able to manage their mobility. I do not know if it exists, but it would be interesting to see evidence of an improvement in back problems. Perhaps at some point in the future, you will be able to provide that evidence.

[83] **Mr Williams:** I produced a presentation on my old trust for the Health and Safety Executive, and I think that such information is now being collated nationally. We can look into that for the committee and give you a note on it if it would be helpful.

[84] **David Melding:** We would be happy to receive any further evidence if you think that it will inform our proceedings. Huw Lewis will take us on to look at the issue of management and HR in greater detail.

[85] **Huw Lewis:** I am looking at paragraphs 2.10 to 2.14 in particular, and they tell us that HR departments have been more active in support of the management of sickness absence. Are you confident that NHS managers are better equipped than they were to fulfil their responsibilities in respect of sickness absence? Is the necessary HR support available to enable them to do that?

[86] **Mr Williams:** The profile of the issue has been raised, so those who were not giving it attention are now required to do so, because we now have performance management, and we will improve that performance management. We have increased the number of HR staff. I am concerned for the future, because, as I said, we can make HR a main board function, and in doing that, we need to increase the profile even further. That will be a challenge for us in ensuring that we have HR directors in those organisations who are top of their class and that

they will then develop their departments.

10.20 a.m.

[87] The work that I alluded to with regard to what is happening on an all-Wales level to develop national policies and looking at best practice gives me some comfort. The National Leadership and Innovation Agency for Healthcare has been doing a lot of development work around HR and leadership, and we need to continue to invest in that. Sheelagh may want to say a bit more about this because, as a HR professional, it is close to her heart.

[88] **Ms Lloyd-Jones:** We need to understand that managing sickness absence well is not just about managing sickness absence. Managers must develop skills in effective staff management, and most trusts, to my knowledge—certainly the trusts that I was in—ran an introductory course for all managers on the basic skills needed not just to manage staff effectively, but to be a manager, particularly a first-level manager. We need to ensure that ongoing skills development is embedded in all organisations, because when someone gets their first management role at ward level, for example, and steps away from the group, they might have to talk to someone with whom they might be nursing a sick patient one day about their sickness absence the next. It is a change that we have to help staff to make. The message that I will have to give to the new organisations is that we must train people across the range of effective staff management, be that sickness absence management, or, frankly, managing staff to keep them in work, which is a more positive way of looking at it. It is a key skill, and we have to ensure that managers have it.

[89] **Mr Williams:** This is simply not an optional extra. It has to be done day in, day out consistently, and, as Sheelagh said, it is a case of effective staff management. In terms of front-line supervision, we have done an awful lot of work with ward managers who managed a large proportion of the workforce on a day-to-day basis. The sessions that we put on for ward managers were well received, because they felt that, in the usual training, they assumed the role of a senior supervisor without having necessarily had the training to which we are alluding. So, professional HR departments will provide that, but it was for the front-line supervisors to take that on and to know that they could come back and seek advice and support. The message that was often given was, ‘If you are in difficulty, please come back and get the support you require’.

[90] **Huw Lewis:** I take on board what you are saying, but what comes across to me from the report is that compliance with the core sickness absence procedures is still not there in many cases. We are talking about basic issues that are nowhere near being rolled out. Something is made of the NHSWales@Once e-learning tool in the report. Is that working, how much did it cost and is there any evidence that it provides value for money?

[91] **Mr Williams:** To clarify, are you talking about e-learning or the electronic staff record?

[92] **Huw Lewis:** Not the staff record, but the NHSWales@Once e-learning tool. I will come on to the electronic staff record in a minute.

[93] **Ms Lloyd-Jones:** I am sorry, but you have caught me a bit with the e-learning tool. May I have a couple of minutes?

[94] **Huw Lewis:** Sure.

[95] **Mr Williams:** Which paragraph are you talking about?

[96] **David Melding:** If you are completely flummoxed and genuinely did not anticipate

this line of questioning, we will accept a note afterwards. In general, your answers have been candid and direct, and we accept that you are not walking encyclopaedias. However, we will require a full note to cover that.

[97] **Huw Lewis:** I think that there are references to the tool in paragraphs 2.10 to 2.14 of the report, Chair. An e-learning tool is a fashionable thing, but fashions come and go, do they not?

[98] **Ms Lloyd-Jones:** I would appreciate time to come back to you with an answer on how effective it has been.

[99] **Mr Williams:** I think that the general point is that, as you said, we can provide these e-learning services, which are helpful and facilitate learning, but they do not guarantee that staff will automatically adhere to the policies. It comes back to effective performance management.

[100] **Huw Lewis:** Of course it does, but there is obviously a cost attached to the development of such things, and I think that the committee would like to know whether this is a displacement activity or whether it is having some kind of effect.

[101] Moving on to the electronic staff record itself, it is clear from your previous answers that it is not quite there yet in terms of what it could be doing for us if it were meeting its full potential. However, I gather from one of your previous answers that you are looking to this calendar year as being the time when the staff record comes of age, so to speak. Is that correct? I am not misinterpreting what you have said, am I?

[102] **Ms Lloyd-Jones:** The electronic staff record was a very ambitious project across England and Wales to introduce a new payroll and workforce information system. Without a doubt, the focus in the first few years was ensuring that the payroll function was absolutely robust, because one sure way of demoralising staff is not to pay them. This year, through a steering group, we will be looking generally at ensuring that we are getting the best benefit out of the information available to us through the electronic staff record, so that we can use it effectively as a management tool.

[103] **Huw Lewis:** Effectively, it is a kind of database is it not?

[104] **Ms Lloyd-Jones:** Yes.

[105] **Huw Lewis:** I remember a long time ago at university being told that databases rely entirely upon what you input, which is something that you have touched on yourself. If you put rubbish in, you will get rubbish out, and one of the clear problems that the report before us points to is that, right across the NHS in Wales, in the sense of the wider systems and the issue of managing staff absence, there is inconsistency. There is patchy compliance with sometimes even the basic issues of managing staff absence. Therefore, is it really the case that the electronic staff record will be a useful tool, or are we going to be going back to the situation where it may be a useful tool in Denbighshire, but not in Pembrokeshire or wherever? How are we going to ensure compliance with it this time?

[106] **Mr Williams:** For me it comes back to the way in which we develop our performance management. Clearly, sickness absence is an issue that we must keep high on the agenda. Previously, we may have heard a particular hypothesis as to why the reasons were as they appeared. Now, we have this excellent data warehouse through which we can interrogate the data and begin to ask a whole suite of questions that we probably could not before. That is what we need to do, and, as I said, that will be underpinned by effective policies. If the policies are not effective, again, we can look at modifying them in the light of the information

that we have. This will now be a much more virtuous cycle of improvement using the data. We are also quite excited by the prospect of managers having real-time access to real-time data. I can see the benefits of that and the way in which it can be linked to staff rostering. If rosters are being prepared in such a way as to cause difficulties with staff attending or if staff rosters are not being matched to demand, that can put pressures on the system, which might then create staff absence or sickness. Using this information, all of these things now need to come together in a way that perhaps they have not before.

[107] **Huw Lewis:** I do not think I am getting to the issue that I am chasing. Are you confident that you have a system that is going to ensure buy-in from across the NHS in Wales? You mention rostering. Presumably there are trusts that have used software-based rostering programmes, and I imagine that there are all sorts of make-do-and-mend systems that have developed over the past few years. People tend to stick with what they know. If you have this brand-new, shiny, electronic staff record system appearing in their environment, how are you assured that they will latch on to it to realise its potential and to get on with it?

10.30 a.m.

[108] **Mr Williams:** I think that that will happen through the national working group. As I said, from performance management, we will be able to see where best practice does not appear to have been applied. We can now start to talk to those people responsible for providing this service on a day-to-day basis and ask a suite of questions that will focus minds in a way that has perhaps not happened before. We were previously dealing with up to 14 trusts and 22 local health boards, which might all have a different view and where things might vary. That makes performance management much more difficult. We will have a much more coherent profile of organisations to deal with in the future, which will make life easier.

[109] **Huw Lewis:** Presumably, the electronic staff record development must have cost something. We would like to know the cost, but if you do not have that to hand, then it can be provided later. Can you reassure us that we will not go through a period where the electronic staff record developed at x cost is running alongside those other software-based rostering systems that are also costing money, so that, in effect, we have dual systems running in certain parts of the country?

[110] **Mr Williams:** We can certainly give you a note on the cost development, but there has been an Office of Government Commerce gateway review looking at costs. It would appear from recent evidence that, as the electronic staff record system comes in and alternative systems fall away on an annual basis, it is almost cost neutral. This indicates to me that, as we have invested in ESR, we are now seeing the benefits in terms of other systems being switched off and using staff more effectively. There is more to do on that. As I said, I am keen that we exploit the full suite of opportunities within ESR, including the exciting opportunity afforded by real-time management and electronic rostering to use our resources much more effectively. If they are not used in this way, then questions should be asked through performance management.

[111] **Ms Lloyd-Jones:** One of the key benefits that has come about as a result of our having ESR is a move into e-recruitment. That is a benefit that the whole service has felt, and it has been a major benefit as regards cost savings. Without ESR, we could not have moved to e-recruitment. We now need to move into the other benefits that should come from the system. As you said when you talked about your experience, it is about making people understand that the information is valuable to them. Therefore, it is important that they put in the information, because it is how they will manage. That is part of the development of managers' skills.

[112] **Lesley Griffiths:** Staying with the ESR, while accepting that it still has not reached

its full potential, there is an acceptance that the information being inputted is being expanded. I would like to ask you two specific questions about it. In the light of the recent concerns about data protection in the public sector, how concerned do you think we should be about the ESR?

[113] **Mr Williams:** Some questions are being asked about the level of detail that should be available, such as the reasons for sickness absence. Obviously, we have to be vigilant in terms of data protection, but I think that we will have sufficient anonymous data to give us the information that we require to tackle key issues.

[114] **Ms Lloyd-Jones:** There are also rigorous rules relating to who can access what. It is very much on a need-to basis.

[115] **Lesley Griffiths:** How important is it for trusts to be able to identify the reasons for sickness absence?

[116] **Mr Williams:** It is vital. It is what they are there to do in management terms. How on earth can you address some of these issues if you do not know why things are happening and whether they are happening consistently? We have moved from pen-and-paper systems to real-time information, and that has to be used. We need to ensure that our managers are capable of using that information and then, as I said, I hope that we can take it forward in a positive way and work in partnership with trade unions to get the benefits that I discussed, because this is a positive way to get better patient care at a lower cost.

[117] **Lesley Griffiths:** Has the information enabled occupational therapy units to function much more efficiently?

[118] **Mr Williams:** It has, undoubtedly. Again, with all the pressure on resources, we will have to find more money to invest in occupational health, so that we have an effective, consistent and high-quality occupational health service across the NHS in Wales.

[119] **Janet Ryder:** Looking ahead, if you improve occupational health, does the occupational health expertise necessarily exist in NHS Wales to support that improvement, and, if not, what can be done about it?

[120] **Mr Williams:** That is a good question, because, clearly, it does not. It is not just a question of money, but whether we are training sufficient occupational health consultants, nurses and other professionals. It is something that we need to be and are taking on board through the occupational health delivery group and workforce planning.

[121] **Janet Ryder:** Why is it taking so long to complete the ongoing review of occupational health?

[122] **Mr Williams:** I cannot answer that question, in a sense. We have always had an occupational health department and striven to improve it. It is now clearly on the agenda, so it will be addressed.

[123] **Janet Ryder:** Okay. Finally, looking ahead to the new local health boards, what needs to be done by those new local health boards to further improve workplace health and wellbeing, given trusts' current performance with regard to the corporate health standards and the cultural issues involved, such as the concerns about employee engagement and work-life balance that have been highlighted?

[124] **Mr Williams:** I am placing great store on the fact that we will have HR directors on the boards. We will be working with those HR directors to develop an approach that, while it

will be corporate in terms of expectations across Wales, will also need to reflect local requirements. In many ways, it is not just a question of some of the policies, procedures and the issues that we have talked about; I am also interested in the health and wellbeing agenda, and the fact that we will also have public health directors on those boards. We want to make local health boards exemplars as good employers and for the employees to become general ambassadors for health in their communities. There are important links here in terms of health and wellbeing that we need to look at. Our working practices are top of the class, and we can use that, working in partnership with other organisations, to demonstrate best practice.

[125] **David Melding:** Before we conclude, Darren Millar wants to return to the point on occupational therapy.

[126] **Darren Millar:** That is right. What you said is illuminating; there is obviously a shortage of OTs, which you have identified. What are you going to do in the short term to bridge the gap in the availability of occupational therapists to NHS Wales as part of the strategy to reduce sickness? Will you try to train up line managers to provide a degree of occupational therapy for staff members? How will you manage that gap in provision?

10.40 a.m.

[127] **Ms Lloyd-Jones:** In terms of occupational health, I do not think that we can train up line managers, because it is a specialty. A key part of an occupational health service is the consultant medical lead, so we have to consider across what kind of area that lead can be. It is then a matter of ensuring that we have the right number of nurses trained in occupational health and other skills, such as physiotherapy, which is key, and stress counselling and management. Through the group, we have to determine the right set-up for a standard occupational health department, and look at how we can get the resources in, possibly from other parts of the LHB that will have input into occupational health in the short-term while we look at the training needs of the specialist nurses and the resource issues.

[128] **Darren Millar:** Is this lack of occupational therapists a barrier to making significant progress in the short term?

[129] **Mr Williams:** It has been what we call a shortage specialty, particularly as far as doctors are concerned. It is a demand-led service.

[130] **Darren Millar:** There has been progress, though?

[131] **Mr Williams:** Oh, yes. Progress has been made, but it has been slow, and I think that the NHS could be criticised for not putting enough emphasis on occupational health—as I said, it is a people organisation. That is why I am delighted to have this occupational health review group to take this forward and maintain a high profile for it.

[132] **Darren Millar:** The question was, however, whether this shortage in occupational therapists will impede your progress towards reducing sickness absence in the NHS in the short term.

[133] **David Melding:** I think that, by definition, it will. If you accept that it is a significant factor, then if is not at an optimum level it will impair the level of improvement that we might otherwise have had.

[134] **Mr Williams:** We also need to look at how occupational health staff are employed. There is a correlation between lower sickness levels and good occupational health departments. According to the information that we have, the correlation is not perfect, but I would agree with the general thrust of your remarks.

[135] **David Melding:** Thank you. That concludes our questions to you this morning. I thank both the witnesses for their help. We have established some useful evidence, and that will now inform our report on this important matter of absence and sickness in the NHS. You have agreed to send us some notes providing further evidence, and the clerk will liaise with you to ensure that we receive them in good time. We will need them in time to inform our deliberations, of course.

[136] I should have congratulated Paul Williams at the start on his new role as head of the Department of Health and Social Services.

[137] **Mr Williams:** Thank you.

[138] **David Melding:** One of the incubi—if that is the plural of incubus; I am afraid that my Latin is not brilliant—is that you are probably the most frequent witness before the Audit Committee. Indeed, we shall see you at our next meeting, on 25 February, to look at NHS violence and aggression, which is another important subject. We appreciate the ability to get effective evidence from you, and it is best to proceed on that basis and not give long, convoluted answers that do not establish evidence terribly effectively. We always admired your predecessor, even when we were critical, because we had a good, candid relationship with her, and I am sure that it will be the same with you.

[139] You will be sent a transcript of proceedings to check for any transcription errors. You cannot change what you said, but if there are errors in how we have transcribed the meeting, you will be able to pick that up. Thank you for your attendance this morning. That concludes this particular item.

10.44 a.m.

Datganiad Polisi ar Arolygu, Archwilio a Rheoleiddio
Policy Statement on Inspection, Audit and Regulation

[140] **David Melding:** The Minister for Finance and Public Service Delivery is undertaking this consultation process, which is designed to provide better services to citizens. The consultation paper has been circulated to Members. The matter is not directly on audit, but it does touch many of the issues that we cover in our work in the Audit Committee. It might therefore be appropriate for me to write a letter on behalf of the committee members in response. I would be pleased to hear any views that you have; I have a few comments to make. Perhaps we can start with you, Jeremy. You have looked at this consultation paper with interest, and we would appreciate your views on it.

[141] **Mr Colman:** I have done more than look at it, Chair. The successive drafts of this document have been in preparation for a very long time, and they have been discussed by a body known as the Heads of Inspectorates Forum, which comprises me, the chief executive of Healthcare Inspectorate Wales, the chief executive of the Care and Social Service Inspectorate Wales, Her Majesty's chief inspector of education and the regional director for the Food Standards Agency. The body has been consulted very extensively by Assembly Government officials on the drafting of the statement, which is not to say that we drafted it; indeed, there are parts of the document that I personally would not have drafted, because I disagree with them.

[142] The document has been developed over a very long time, and to the extent that it touches on the activities of the auditor general, it is generally satisfactory. It also touches upon the activities of bodies such as HIW, CSSIW and Estyn, where I have a role as the auditor of those bodies. So, I am concerned in that regard that the policy statement should be

consistent with those bodies delivering services that are value for money. Therefore, I am extremely interested in the document. My third layer of interest in it is that among the major activities of the Wales Audit Office, although not one that comes to this committee, are those in connection with the Wales programme for improvement in local government. Local government has been a very important part of the policy statement, because it is in that area that one hears the greatest complaint about lack of co-ordination, unnecessary burdens, and so forth.

[143] So, the basis of the policy statement is to state a principle that the activities of audit, inspection and regulatory bodies should be proportional to the situation. You may notice that the role of risk in the statement is considerably reduced to almost nothing, which is a reduction that I greatly welcome. In the parallel development of an Assembly Measure on the Wales programme for improvement, which hitherto has been prominently based on risk, risk has disappeared entirely. I am very happy to explain why I think that that is a welcome development, but the idea that the work of audit, inspection and regulation should be proportionate to the situation is sound.

[144] However, there are a few areas where I am slightly concerned about what is in the document, which touch upon this committee's work. The first one is a constitutional issue. The office of the Auditor General for Wales is part of the machinery for holding the Assembly Government to account. For that reason, the constitutional position of the auditor general is very carefully kept completely independent of the Assembly Government. Therefore, it is not for the Assembly Government to direct me—the Public Audit (Wales) Act 2004 says very clearly that the Assembly Government cannot direct the auditor general. As regards the accountability of the auditor general for delivering value for money in the services that I provide, my accountability is to this committee and not to the Assembly Government. There are parts of the policy statement that could be read as the Assembly Government purporting to tell me how to do my job, which is constitutionally unacceptable, even if what it is telling me to do is something that I am very happy to do—and for the most part, it is. So, there is a constitutional point, and in my response to the policy statement I will be making that clear.

[145] Why does that matter? It matters when it comes to the issue of co-ordination. The policy statement develops the concept of a lead inspectorate. It notes that the auditor general has that role in relation to local government inspection, and that is sort of true, but it is slightly less true than it was, because the proposed Measure on the Wales programme for improvement has changed since the consultation document was written, and the role of the auditor general in local government co-ordination is rather less than it was.

10.50 a.m.

[146] Anyway, on the concept of the lead inspector, what does the lead inspector do? If the lead inspector for the NHS, for example, was the Healthcare Inspectorate Wales, would that mean that the Healthcare Inspectorate Wales could tell the auditor general not to inspect a particular trust or matter? I do not think so. The Healthcare Inspectorate Wales is a fine body, and we work with it a lot, but, constitutionally, it is a part of the Assembly Government, and it is not for the Assembly Government to tell the auditor general not to look at something in the NHS, if it were necessary to do so. So, it is that constitutional point that concerns me, which leads me to be concerned about the role of the lead inspectorate, given the potential for it to stray into constitutionally inappropriate areas. In practice, I hope that—indeed, I am confident that—that danger is not a real one, but that does not mean that it is not worth referring to.

[147] We work extremely closely with the Healthcare Inspectorate Wales and with CSSIW in practice, and we very regularly look at our work programmes and ideas for work. It is a

matter of pretty much constant discussion whether I need to do something if HIW is doing to it, for example, or whether HIW and the audit office can do something together, which we frequently find that we can, and so on. The day-to-day co-ordination already happens, although it could definitely be improved. I regard myself to be a champion of improvement of co-ordination, and the policy statement is consistent with that.

[148] To sum up, from my point of view, the policy statement is very much along lines that I could support and it does not impede my work. There is the constitutional issue that needs to be stated and made clear. However, as far as I understand it, the Assembly Government does not have any malign intent towards the constitutional position of the auditor general, which is good, so my response to the consultation will be reasonably positive.

[149] **David Melding:** That is helpful, Jeremy. I will now take comments from committee members. If it is the committee's wish, I could respond on behalf of the committee. That might be the best way for us to make a response, if we wish to do so.

[150] **Darren Millar:** Given the information that we have had from Jeremy, perhaps a copy of his letter could be circulated to members of the committee, which would be helpful, along with the proposed response on behalf of the committee from you, Chair, and then we can comment as we see fit.

[151] **David Melding:** Are there any other comments? I see not, but I had a couple. Consultation documents can, by their nature, be ambiguous in certain areas because they are trying to capture a range of potential views. I suspect that the Government has no intention of limiting the audit function, but we need to remind it of how important that is. On the citizen focus and the extra value that we get out of the audit commission's work, we are looking at the media strategy, particularly how to get into the regional media and independent radio and that sort of thing. It is important that citizens receive good-quality information; we cannot rely on their listening to *Good Morning Wales* or reading the *Western Mail*. So, we are trying hard and that is important.

[152] On the citizen focus in section 2 and the need for benchmarked data that citizens can readily understand, we are often frustrated because we feel as though we do not have very good data, there are no obvious comparators, and it is then an issue of trying to establish the evidence. We have a lot of time to investigate issues, but if the public is reading a newspaper article about the quality of its public services, it needs fairly effective benchmark data so that it can readily understand the issues and be informed.

[153] I think that Jeremy's point on the improvement agenda and the Wales programme for improvement is very important. It informs our work. We have never casually issued counsels of perfection; we really do try to look at where people are and at how they can make solid improvements. That is a very important point and is clearly one of the central points about inspection and audit. Sometimes, we identify very poor, even dangerous, practice, which has to be highlighted, but the general purpose is to improve the quality of services.

[154] The other points that I wanted to raise have just been addressed by Jeremy. Therefore, I suggest that we respond, emphasising the points that I have just made, the central importance of improvement to inspection, and the constitutional independence of this committee and the auditor general, which must be remembered in any more co-ordinated system of inspection and regulation. Quite often, the auditor general will want to make a specific decision on his own; he certainly will not want to be subject to any form of enforceable direction. That is the fundamental basis of effective audit, and so we should also emphasise that, Jeremy.

[155] Without further ado, we will move on.

10.56 a.m.

Cynnig Trefniadol
Procedural Motion

[156] **David Melding:** I propose that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37(vi).

[157] I do not see any Member objecting, so I ask the ushers to clear the public gallery and the broadcasters to switch off the recording equipment.

Derbyniwyd y cynnig.
Motion carried.

Daeth rhan gyhoeddus y cyfarfod i ben am 10.57 a.m.
The public part of the meeting ended at 10.57 a.m.

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

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Eich cyf / Your ref:
Ein cyf / Our ref: PMW/tv/Robinson

30 April 2009

Dear John

FURTHER INFORMATION RESULTING FROM ASSEMBLY AUDIT COMMITTEE EVIDENCE SESSION, 4 February 2009 - NHS SICKNESS ABSENCE

Further to the Committee's session on 4 February, 2009, I undertook to write to you with further information on a number of aspects/issues.

1. Locum and Agency Staff Expenditure

1.1 *Are Trusts on track to achieve the target reduction in agency and replacement staff cover of 0.8% of staff costs?*

Provided below is a table which outlines the % spend on bank and agency staff for 2007/08.

NHS Trust	Total agency spend (nursing) 000's	% of staff costs	Total Locum spend (medical) 000's	% of staff costs	Total % of costs
Bro Morgannwg	550	0.25%	1,234	0.57%	**0.82%**
Cardiff & Vale	2,066	0.46%	1,431	0.33%	**0.79%**
Carmarthenshire	78	0.067%	112	0.097%	**0.16%**
Ceredigion and Mid Wales	27	0.06%	108	0.25%	**0.31%**
Conway and Denbighshire	96	0.05%	1,327	0.77%	**0.82%**
Gwent	6,792	1.8%	4,607	1.2%	**3.0%**
North East Wales	487	0.3%	835	0.53%	**0.83%**
North West Wales	12	0.007%	4,522	2.7%	**2.7%**
North Glamorgan	171	0.16%	652	0.8%	**0.96%**
Pembs and Derwen	1005	0.1%	867	0.86%	**0.96%**

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Pontypridd and Rhondda	132	0.09%	870	0.61%	**0.7%**
Swansea	490	0.18%	4,743	1.74%	**1.92%**
Velindre	97	0.1%	229	0.25%	**0.35%**
Powys LHB	105	0.22%	703	1.47%	**1.69%**

1.2 *Has last year's target of no more than 2.0% been met?*

All organisations have met the target with the exception of Gwent Health NHS Trust.

2. Reduction on back injury sickness rates

2.1 The conclusions of a study undertaken by Bro Morgannwg NHS Trust and the Health and Safety Executive (HSE) showed that the use of electric profiling beds not only reduced the risk of musculoskeletal injury posed by each manual handling task but also significantly reduced the extend to which staff were exposed to that risk. Staff providing direct patient care in the hospital using electrical profiling beds carry out 10 manual handling operations of medium to negligible risk per shift, in contrast to those staff working with standard beds, who carry out 33 high-risk tasks per shift.

2.2 As a result of the findings from this study and the close working partnership between the HSE and the Welsh Assembly Government, Ann Lloyd (Chief Executive NHS Wales) wrote on 3 January 2008 informing that it had been decided that all NHS organisations in Wales would ensure they have in place by 31 July 2010 suitable and sufficient electric profiling beds in all areas where patients are being nursed in bed. Health Inspectorate Wales and the HSE (Wales) will ensure these essential health and safety requirements are regularly monitored and assessed.

3. NHSWales@Once e-learning tool

3.1 NHSWales@once is situated on NLIAH's Learning@NHS Wales portal, and is an innovative e-learning tool providing NHS managers with up to date and comprehensive advice and practical guidance about employment law practice. NHSWales@once provides training on demand at a time and place that suits managers and provides access to a variety of learning packages and associated reference materials. The modules were designed by Morgan Cole and adapted for NHS Wales. The four key topic areas currently being piloted are:

- Handling employee grievances and dignity at work issues
- Investigating and disciplining for misconduct
- Handling poor performance
- Absence management

Absence management contains the following:

- An employer's obligation in relation to disabilities
- The stages of a fair procedure
- Tactics for dealing with persistent intermittent absence
- Tactics for long-term sickness absence including return to work interviews
- The importance of obtaining medical advice
- Tips on dealing with challenges which arise

The Learning Framework was officially launched on 11th December 2008 and the leaflet describing NHSWales@once contains a quote from Tracy Myhill as HR Director of NHS Wales (at that time) which states:

"Developing core management skills and delivering knowledge of this nature to large, dispersed numbers of staff presents HR with many major challenges. E-learning is a cost effective and extremely efficient way to assist NHS Wales in developing the skills of supervisors and managers which enables them to be innovative and lead change."

The development of the sickness absence module was funded by the NHS Wales HR Division for a total cost of £40k. Over 300 people have accessed the Core Skills e-learning package since June 2008.

4. Electronic Staff Record

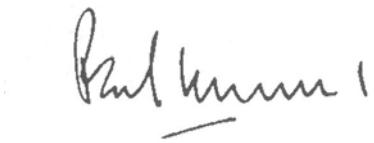
4.1 *Provide the cost of the development and implementation of ESR in NHS Wales.*

Provided below is a table that outlines the total costs of ESR for the years 2007/08 to 2014/15, the end of the current ESR contract. Also identified in the table are the anticipated savings associated with the ESR system as identified in the recent Business Case that was considered as part of the national OGC review.

	Profile - £m								
	2007/8	**2008/9**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**Total**
Total costs	2.397	2.273	2.507	2.538	2.344	2.437	2.509	1.088	18.093
Total cash releasing Benefits	2.467	2.525	2.590	2.660	2.748	2.832	2.922	1.273	20.019
Net Surplus	0.07	0.253	0.083	0.123	0.404	0.395	0.413	0.185	1.926

I am copying this letter to the Auditor General for Wales and the Corporate Governance Unit.

Yours sincerely



Mr Paul Williams
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