University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 4 April 2019

	Trust Board paper R
Report Title:	**People, Process and Performance Committee – Chair's Report** (formal Minutes will be presented to the next Trust Board meeting)
Author:	Helen Stokes – Corporate and Committee Services Manager

Reporting Committee:	**People, Process and Performance Committee**
Chaired by:	Andrew Johnson – PPPC Chair and Non-Executive Director
Lead Executive Director(s):	Rebecca Brown – Chief Operating Officer Hazel Wyton – Director of People and Organisational Development (OD)
Date of last meeting:	28 March 2019
Summary of key public matters considered by the Committee and any related decisions made:	

This report provides a summary of the following key public issues considered at the People, Process and Performance Committee on 28 March 2019:-

- **National NHS Staff Survey 2018**
  Further to previous discussion in January 2019, PPPC now reviewed the expanded, finalised dataset from the 2018 national NHS staff survey. Rather than 'key findings' as in 2017, for 2018 the 90-question survey aligned to 10 key themes which now also included staff morale. UHL's response rate to the survey was 37%, and PPPC was advised that UHL's results against those 10 key themes placed the Trust largely in the middle of the pack nationally. In broad terms, in 2018 UHL had improved its scores in terms of staff recognition, changes made in response to incidents, the number of staff satisfied with their pay, and in managers supporting staff to receive training, learning or development identified in appraisals. However, there were also areas in which scores had declined from 2017.

  Within UHL, work was underway on a number of fronts by the Staff Engagement Team to analyse (and thus respond to) its 2018 national NHS staff survey results, noting the need to appropriately draw together the various different workstreams and sources of information. Chaired by the Chief Nurse, the Trust's Patient Involvement, Patient Experience and Equality Assurance Committee (PIPEAC) would also be involved, eg exploring any correlation between staff experience and patient experience. Non-Executive Directors sought assurance on whether appropriately timely feedback was being provided to staff following the survey, and queried whether more immediate action was being taken ahead of the larger-scale involvement events planned in June 2019. The PPPC Chair echoed the need for timely feedback and suggested that it might be useful for the survey results to be discussed at the CMGs' service-level performance review meetings. In response, PPPC received assurance from HR representatives that information was being widely shared with staff, and that there was an appropriate focus on quick win areas in addition to the longer-term work.

  PPPC also particularly discussed the internal benchmarking information re: staff engagement, showing the responses from different staff groups in terms of levels of perceived advocacy, involvement, and motivation. PPPC considered that there was a need for appropriate empowerment of staff to enable them to feel able to make improvements actually happen in their areas (which was scoring lower than the number of staff who felt able to suggest improvements). This was particularly in relation to the block graphic which showed where the hotspots could be found, for example "Involvement" in Estates and Facilities staff scored low across the board. PPPC was advised that targeted workshops were planned with staff in particularly low-scoring engagement areas, and noted a suggestion that it might be helpful also to look at higher-scoring areas to learn any transferable lessons.

  In response to a query from the PPPC Chair, HR representatives confirmed that disability was a key focus area for the Trust's equality and diversity work and advised (for example) that a 'UHL differently able voice' staff support network had recently been established.

- **Gender Pay Gap Report 2018-19**
  PPPC reviewed UHL's report on gender pay gap information for 2018, required to be published by 31 March 2019 in line with the Equality Act 2010 [Gender Pay Gap Information] Regulations. At 28% and 15%, UHL's 2018 mean and median gender pay gap (respectively) had both decreased by 1% from 2017. Very detailed discussion had taken place on this report at the March 2019 Executive Performance Board, and PPPC was advised that the gender pay gap was driven primarily by the number of men as compared to women in the upper quartile pay

groups, particularly medical and dental staff, and Very Senior Managers. In response to a query from the Audit Committee Non-Executive Director Chair, it was confirmed that there was no difference between pay rates for men and women in any of UHL's pay bands (equal pay was therefore in place). The Medical Director outlined the background of the historic higher numbers of men in the Consultant workforce, and advised that this would change over time to reflect the fact that there were now more women at medical school than men.

PPPC suggested that there was an opportunity to expand the principles of the gender pay gap action plan beyond gender, to cover other issues such as diversity and disability. PPPC also queried how to help managers implement/progress flexible working in practice, and commented on the need to ensure that recruitment panels were themselves appropriately diverse. PPPC agreed that appropriate role modelling was key and recognised the need to avoid unconscious bias. HR representatives welcomed these points, and provided assurance that a more detailed action plan underpinned the overarching themes set out in the report. PPPC also noted the need for appropriate comms to accompany the publication of this report on UHL's external website, to provide appropriate context and briefing information.

UHL's gender pay gap report 2018-19 was endorsed (noting the suggested comments on the action plan), and recommended for Trust Board approval. It is appended to this summary accordingly.

- **LLR Local Workforce Action Group Update**
  PPPC received this update for information, noting UHL's very active role on these groups.

- **Junior Doctors' Contract – Guardian of Safe Working Quarterly Report (1.12.18 – 28.2.19)**
  The quarterly update advised that 117 exceptions had been recorded between 1 December 2018 and 28 February 2019 (112 of which were work pattern/hours related and 5 of which were education exceptions). This was a fall from the 189 recorded in the previous 3-month period.
  The junior doctors' contract Guardian of Safe Working quarterly update was endorsed, and recommended for Trust Board approval. It is appended to this summary accordingly.

- **Urgent and Emergency Care Performance Report – Month 11**
  The Chief Operating Officer noted an improved position within emergency and urgent care as at the end of February 2019, with UHL performance at 71.6% despite a 10% rise in attendances compared to February 2018. Injuries, children's and primary care performance had remained stable, there had been no 12-hour trolley breaches, super-stranded patients were trending downwards, non-admitted breaches had stabilised and delayed transfers of care (DToCs) remained low compared to national benchmarks. The Chief Operating Officer considered that this indicated that more sustained control was in place. The system-wide, multi-agency MAAD event had been very useful, and progress on the related action plan would be reported to PPPC as part of the standing monthly urgent and emergency care performance updates. Improving ambulance handover performance continued to be a priority, and LLR system-wide working was in place accordingly. The Chief Operating Officer and the Medical Director also noted continued positive culture and behavioural changes in ED, in addition to increased clinical ownership.

  It was acknowledged, however, that March 2019 urgent and emergency care performance was more challenging than February, with a continued rise in attendances. The urgent and emergency care action plan was being reviewed to gauge the impact of the current activity levels. The Chief Operating Officer also noted the likely impact of the (LPT-provided) Primary Care Coordinator (PCC) service ending in March 2019 as it was no longer being commissioned. Some mitigating measures would be in place via the Integrated Discharge Team. In response to PPPC queries, the Chief Operating Officer confirmed that the cessation of the PCC service had been communicated and she provided assurance that no adverse quality impact was expected as a result, although target performance might be affected.

  In response to a query from the PPPC Non-Executive Director Chair, the Chief Operating Officer advised that the new charging regime was not expected to impact on clinical delivery. The PPPC Non-Executive Director Chair also queried whether further discussion was planned on the replacement of the 4-hour ED target – in response, the Chief Operating Officer advised that UHL had volunteered to be a test site and – even if not selected – would shadow run any new indicator(s). PPPC would of course be kept informed of progress on this issue. In further discussion, Non-Executive Directors queried what intelligence was available on ED attendance hotspots, to inform discussions with CCGs about demand management. In response, it was noted that most walk-in patients were Leicester City patients.

  In conclusion, the PPPC welcomed the progress made but did not have assurance that the Trust was currently able to meet its targets for Urgent and Emergency Care performance.

- **CMG Performance and Accountability Framework**
  PPPC reviewed the proposed CMG performance management and accountability framework, which would be added to the existing overarching UHL performance management and accountability framework. The aim

of this CMG-level framework was to provide a clear structure and ensure consistency in how CMGs held their services to account – in response to Non-Executive Director queries the Chief Operating Officer advised that it was intended to use the same format reporting pack as that currently in place for the CMGs' own monthly performance management review meetings with the Executive Team. Following discussion at the March 2019 Executive Performance Board, it was now proposed to refer to "at least bi-monthly" service/specialty performance review meetings by the CMG rather than "monthly" ones, as it was not feasible for CMGs housing multiple specialties to review them all each month. The Audit Committee Non-Executive Director Chair sought assurance on where risk was captured in those reviews – in response the Medical Director confirmed that discussion of all risk (including, eg, financial) sat under the 'quality' domain of the performance pack. PPPC requested that this be made explicit, and the Chief Operating Officer agreed to amend both this CMG-level framework and the overarching UHL performance and accountability framework accordingly at the annual review stage (October 2019) – the updated overarching document would be re-presented to PPPC at that point.

- **Armed Forces Covenant**
  Col (Ret'd) I Crowe, Non-Executive Director and Armed Forces Champion for UHL presented an update on the Trust's support of the Armed Forces Covenant during the past 18 months. He also outlined his plans to meet with the Deputy Director of Learning and OD to discuss training aspects, and noted more long-term plans to explore a future, more intuitive patient administration IT system to flag when patients were Armed Forces veterans (in light of potential related discharge/treatment needs). PPPC thanked Col (Ret'd) I Crowe for his commitment and work on the Armed Forces Covenant.
  PPPC supported the work of the Armed Forces Covenant and agreed to highlight this issue to the Trust Board. The report is appended to this summary accordingly.

- **UHL Annual Operational Plan (AOP) – Workforce Plan**
  The Workforce Development Manager provided a verbal update on this issue, noting that the AOP itself was being discussed in the joint session with QOC members. The workforce plan this year was focusing on supply (including retention, as a key element of supply) rather than demand, which was welcomed by PPPC. The PPPC Non-Executive Director Chair noted the need to understand UHL's workforce competitors in order to be able to attract candidates to come to the Trust. PPPC also discussed changing workforce requirements, and reiterated the importance of the 'team around the patient' initiative. PPPC received a brief update on the position re: Nursing Associates and Physician Associates.

- **Items for Information**

  Workforce and Organisational Development Data Set
  The slide deck accompanying this report to the Committee captured key workforce datasets for February 2019. Non-Executive Directors queried the position re: sickness absence, and were advised that Facilities staff would be migrating on to the SMART absence management system used by the rest of UHL (date for that migration to be confirmed outside the meeting). Non-Executive Directors also sought (and received) assurance that appropriate sickness absence management action was taken where required, and that where plans were in place the level of sickness absence would be expected to reduce. PPPC noted that UHL performed well regionally in respect of sickness absence levels.

  Executive Performance Board – minutes from 29.1.19: noted

Joint PPPC and QOC session

- **Final draft – Annual Operational Plan (AOP) 2019-20**
  Joint paper 1 comprised the latest iteration of the Trust's AOP for 2019-20, reflecting feedback from NHS England/NHS Improvement. The AOP had also been discussed at UHL's March 2019 Executive Performance Board and Finance and Investment Committee. The updated version of the LLR system-level plan was not yet available. In discussion on the draft UHL AOP 2019-20, PPPC and QOC noted comments from the QOC Patient Partner re: reliance on primary and social care partners in reducing longstay patients in hospital; a perceived lack of detail on either the role of Patient Partners or wider patient and public involvement in the document (in response, it was advised that the format of the AOP was predicated by NHS England/NHS Improvement), and a query on the meaning of 'superstranded' and 'stranded' patients. These terms were now explained, but the Trust Chairman echoed the need to avoid jargon – in response, it was confirmed that a user-friendly patient/public version of the plan was required to be developed, for publication in July 2019. In response to comments from Non-Executive Directors, it was acknowledged that the AOP did not include a longer-term (eg 5-10 years) view, although that would be referenced in the system plan.

- **Quality and Performance Report – month 11**
  Joint paper 2 detailed performance against quality and performance indicators as at Month 11 (period ending

28 February 2019), using a new, more visual format (eg greater use of SPC charts). The Medical Director noted a significant improvement in VTE assessment performance, linked to the new medchart system (a VTE risk assessment module would be added to NerveCentre for use at the LGH site). Stroke performance was variable, but previously-reported service changes were about to embed and stabilisation was expected to occur. The Chief Nurse drew attention to an improvement on falls performance, and to a deterioration in Hospital Acquired Pressure Ulcers (grade 2) which were now flagging as red; no particular trends had been identified on that indicator. The Chief Nurse also expected that the 1 MRSA case in February 2019 would be classed as a 3rd party attributed case.

Detailed discussion took place on the deterioration of the cleaning metrics, as also discussed at the March 2019 Executive Performance Board and Infection Prevention and Assurance Committee (IPAC) meetings. Although confident that an Estates plan was in place, the Chief Nurse noted the need for potential appropriate interim measures to address any immediate issues. The Head of Business, Commercial and Contracts outlined the planned cleaning audits, and described what further 6-week work was being undertaken to assess where additional cleaning was needed. Non-Executive Directors voiced concern over the deterioration in the cleaning metrics, and it was agreed that a further assurance report was needed at the next joint PPPC/QOC session on this issue, covering (i) what constraints had been in place contributing to the current standard of cleaning performance, and what the baseline cleaning requirements were; (ii) what interim/short-term remedial actions were proposed/in place, and (iii) the timeline and milestones for any longer-term plan. The Head of Business, Commercial and Contracts confirmed that national cleaning standards were met, and the Chief Nurse noted her understanding that cleaning issues related more to corridors/stairwells than to clinical areas; she also advised that Infection Prevention outcomes had not worsened. It was recognised that differing national cleaning standards applied to areas depending on their risk classification. However it was reported that Place Reviews had also deteriorated in certain areas. The PPPC Non-Executive Director Chair voiced concern over the reduction in cleaning standards attained and queried the position in respect of potential increases to wte establishment/hours worked in the new financial year as the resource provision was recovered.

In further discussion on the month 11 quality and performance report, Non-Executive Directors sought (and received) assurance that there was appropriate visibility on patients who experienced multiple hospital cancellations. It was also agreed that future iterations of the report would include figures for patient cancellations. Noting concerns voiced re: outpatient clinics, the QOC Non-Executive Director Chair suggested (and this was agreed) that the existing outpatient transformation dashboard be amended to include detail on (i) outpatient appointment cancellations and (ii) outpatient clinic waiting times. The QOC Patient Partner advised that cancelled operations were a key concern for the public and patients.

- **Cancer performance month 9**
  The Director of Operational Improvement highlighted a difficult month re: cancer performance, noting that (as predicted) 2 of the 9 standards had been achieved in January 2019. Although the 62-day cancer target remained the most challenging indicator for UHL, PPPC/QOC also noted the impact of a significant (13.4%) increase in 2-week wait referrals compared to January 2018. Performance against the cancer standards was expected to improve in February 2019, and PPPC/QOC noted that an intensive internal support team was now in place in Urology. In response to a query from the PPPC Non-Executive Director Chair, the Director of Operational Improvement confirmed her confidence that all cancer standards would be met by the end of 2019-20. In response to Non-Executive Director queries, she also outlined the reduced staffing vacancies in oncology, and noted plans to develop an appropriate business case to rebalance staffing across the tumour sites. Further discussion also took place on the potential scope for charitable fundraising for an additional robot for the Urology department in Leicester as Derby had been very successful in a similar project.

- **CMG Performance Review Slides: received and noted**

Matters requiring Trust Board consideration and/or approval:

Recommendations for approval:-

1. Gender pay gap report 2018-19 (appended)
2. Junior doctors' contract – Guardian of Safe Working quarterly update (appended)

Items highlighted to the Trust Board for information:

1. Armed Forces Covenant (appended)

Matters referred to other Committees:

None

Date of Next Meeting:	25 April 2019

Gender Pay Gap Report

Author: Louise Gallagher/ Bina Kotecha / Joanne Tyler- Fantom
Sponsor: Hazel Wyton Director of People and OD Date: PPPC 28th March 2019

Paper D

Executive Summary

Context

Under legislation effective from 6th April 2017 (The Equality Act 2010 (Gender Pay Gap Information) Regulations, require organisations employing over 250 people to publish their Gender Pay Gap within 12 months of 31 March 2018. University Hospitals of Leicester published the information covering March 31st 2017 by the end of March 2018 as required.

The publication accompanying this report will once finalised, be placed on the Trust website. A summary of this information also has to be published on the Government website www.gov.uk/government/news/view-gender-pay-gap-information)

The legislation specifically details the elements of the Gender Pay Gap which must be published and includes:

- **Mean** gender pay gap in hourly rate
- **Median** gender pay gap in hourly rate
- **Mean** bonus gender pay gap
- **Median** bonus gender pay gap
- Proportion of males and females receiving a bonus payment
- Proportion of males and females in each pay quartile.

In addition this report contains more detailed analytics which are intended to help us understand what is driving our gender pay gap and therefore the most appropriate actions to address this.

Questions

1. What is our mean and median gender pay gap?
2. What is the gender pay gap for bonus payments (Clinical Excellence Awards)?
3. What is the distribution of males and females in each quartile of our hourly pay rate?
4. What is driving this gender pay gap?
5. What actions is the Trust taking to reduce the gender pay gap?

Conclusion

1. The **mean** gender pay gap is 28% which is a 1% reduction on the mean gender pay gap for March 2017 and the median gender pay gap is 15% suggesting the pay differential is skewed in the upper quartile. This is again a 1% reduction on the mean gender pay gap for March 2017.

2. The **mean** gender pay gap for bonus payments is 27% which is 3% higher than last year and the median gender pay gap is 34% which is 16% lower than last year. NHS Employers have advised that the only payment which constitutes a bonus is a Clinical Excellence Award. Since this is only payable to medical consultants 0.74% (compared to 0.72% in March 2017) of the female workforce are in receipt of this and 6.52% (compared to 6.85% in March 2017) of the male workforce.

3. The distribution of males and females in each quartile is defined in figure 2. The largest differences are in the upper quartile and a there is a positive difference in the lower.

4. The gender gap is principally driven by differences in the upper quartile including a higher proportion of men in this workforce and higher rates of pay for males in receipt of Very Senior Management pay and consultants.

5. Actions to address our gender pay gap include:
    - improved analysis and subsequent marketing to senior management and consultant posts to improve the pool of female applicants
    - continued unconscious bias training as part of recruitment and selection training
    - appropriate service level agreements with Executive Search organisations
    - exploration of innovative approaches to flexible working to extend access into senior grades so they are more attractive to women
    - continuation of pay scrutiny and promotion decisions
    - increased equality impact analysis of clinical excellence award payments prior to payments being confirmed
    - increased access for women to coaching and mentorship as part of an enhanced approach to talent management and succession planning
    - enhanced health and well-being strategies that specifically support women in the workplace throughout their careers and also help line managers to understand how best to provide extra support when this is most needed. This will be developed with feedback from women across the Trust.

Input Sought

The PPPC is asked to:

1. Endorse the Gender Pay Report and recommend to the Trust Board
2. Note the actions and further developments required which will form the basis of a refreshed action plan.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[No]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[No]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[No]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[Not applicable]
Board Assurance Framework	[Yes]

3. Related Patient and Public Involvement actions taken, or to be taken: Patient representatives involved in key OD initiatives / intervention

4. Results of any Equality Impact Assessment, relating to this matter: [TBC]

5. Scheduled date for the next paper on this topic: [TBC]

6. Executive Summaries should not exceed 1 page. [My paper does comply]

7. Papers should not exceed 7 pages. [My paper does comply]

University Hospitals of Leicester NHS
NHS Trust

REPORT TO: **PEOPLE PROCESS AND PERFORMANCE COMMITTEE**

REPORT BY: **DIRECTOR OF PEOPLE AND ORGANISATIONAL DEVELOPMENT**

REPORT FROM: **LOUISE GALLAGHER, WORKFORCE DEVELOPMENT MANAGER**

DATE: **28TH MARCH 2019**

SUBJECT: **GENDER PAY GAP REPORT**

1.0 BACKGROUND

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 legislated that Public Sector organisations must publish their gender pay gap information within 12 months of 31st March 2017 and thereafter annually. This means that our Gender Pay Gap information must be published by March 30th each year on both the Trust website and the Government website.

The Regulations specify that the information published must relate to Public Sector employees for the pay period which includes 31st March. In addition the Regulations stipulate what constitutes a full pay relevant employee ie those not receiving reduced pay for reasons such as maternity leave. Pay excludes overtime but includes shift working allowances, recruitment and retention premia, on call allowances but not hours worked.

The Regulations state that the following must be published:

- Mean gender pay gap in hourly rate
- Median gender pay gap in hourly rate
- Mean bonus gender pay gap
- Median bonus gender pay gap
- Proportion of males and females receiving a bonus payment
- Proportion of males and females in each pay quartile.

2.0 INTRODUCTION

2.1 The gender pay gap calculations are based on derived mean averages of pay as specified in the Regulations. Data on actual payments paid in the period including 31st March 2018 have been derived from the ESR system.

2.2 For the purposes of our calculations a number of assumptions have been made in order to identify both full pay relevant employees and the correct inclusions in respect of pay. All assumptions have been documented. Assumptions include the exclusion of employees who did not receive full pay in the four week period containing 31st March 2018; exclusion of on call payments for hours worked but inclusion of the on call payment, inclusion of bank only staff but exclusion of additional bank contracts as this is deemed overtime.

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3.0 PRINCIPLE FINDINGS

3.1 The principle findings of this detailed analysis are as summarised below:

- Workforce profile: 77% (76% 2017) female, 23% (24% 2017) male

- Mean gender pay gap 28% (29% 2017) (£15.32 per hour: £21.28 per hour)
- Median gender pay gap 15% (16% 2017)
- Mean bonus pay gap 27% (24% 2017)
- Median bonus pay gap 34% (50% 2017)
- 0.74% of females receive a bonus: 6.52% of females receive a bonus
- % females in lower quartile of pay is 80% (79% 2017)
- % females in lower middle quartile of pay is 82%
- % females in upper middle quartile of pay is 82% (83% 2017)
- % females in upper quartile of pay is 63% (61% 2017)

The above shows that higher levels of females are in the first three quartiles of pay than are represented in the workforce and lower levels of females are in the upper quartile of pay (14% less than the constitution of the workforce as a whole).

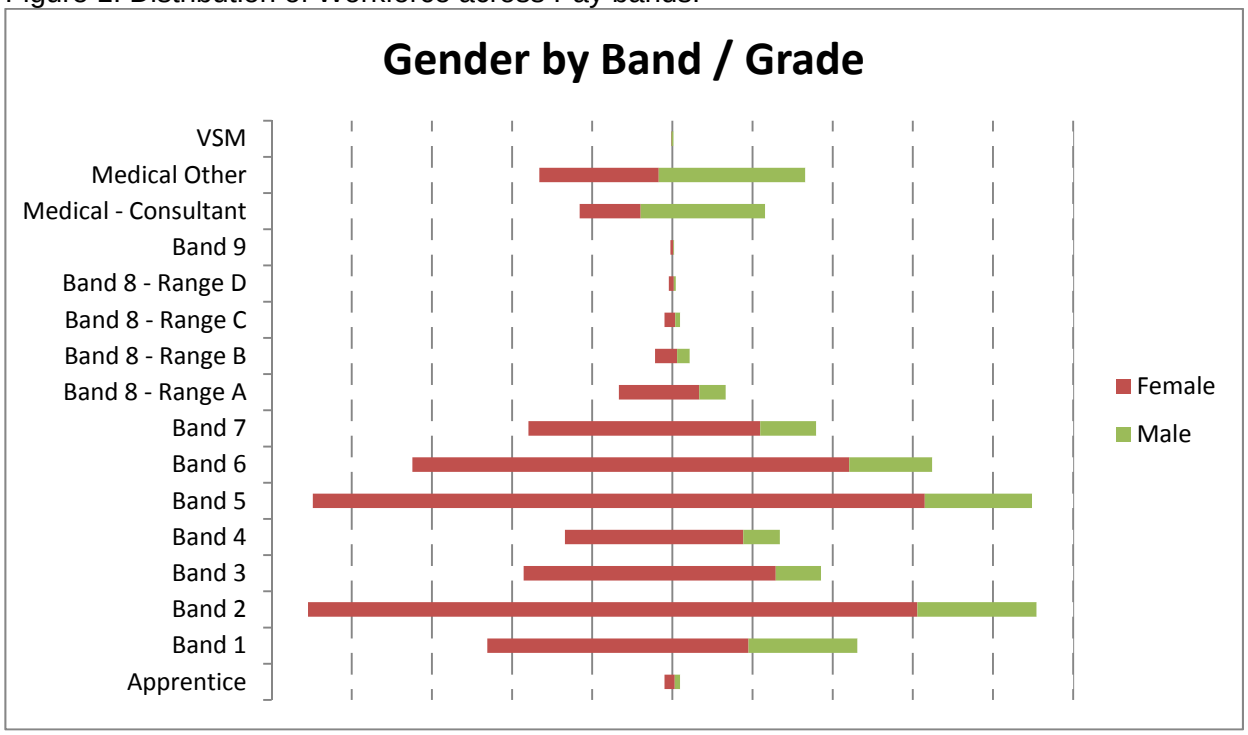
3.2 The mean gender pay gap for Agenda for Change **only** staff is 0.23%

3.3 This summary data is contained in the overall Gender Pay Report shown in appendix 1. It is proposed that the attached is used for the purposes of the Trust's formal publication.

4.0 Detailed Analysis

4.1 In order to understand what is driving our gender pay gap, a number of detailed analytics have been undertaken. In order to focus our attention, a more detailed analysis of each pay band (Figure 1) shows that there are more females concentrated in the lower pay bands of the organisation:

Figure 1: Distribution of Workforce across Pay bands:



4.2 Figure 2 shows the gender pay gap within the pay quartiles and shows the largest differences are in the upper quartile. There is a positive pay gap in the lower quartile and a negative pay gap in the upper quartile:

Figure 2: Pay gap by Quartile:

Calculations					Pay Gap		
Quartile	Gender	Headcount	Sum of Hourly rate	Average hourly rate	2018		2017
Lower	Female	2860	24921.89	8.71	-1.48%		-2.17%
	Male	734	6302.62	8.59			
Lower Middle	Female	2936	34713.68	11.82	0.17%		0.82%
	Male	657	7780.85	11.84			
Upper Middle	Female	2957	48424.99	16.38	-0.52%		-0.06%
	Male	636	10361.91	16.29			
Upper	Female	2260	60640.03	26.83	24.01%		25.86%
	Male	1333	47066.92	35.31			
Grand Total		14373	240212.90	16.71			

4.3 Two significant staff groups within the upper quartile include consultants and Very Senior Managers. We know that the gender pay gap for Agenda for Change staff only (excluding medical and dental, Very Senior Managers and locally agreed pay rates) is 0.23%. The gender pay gap for consultants is shown in Figure 3 and that for Very Senior Managers is shown in Figure 4. It should be noted that if Clinical Excellence Awards are excluded for consultants the gender pay gap is reduced to 4.98% from 6.74%. It is recognised that the highest levels of Clinical Excellence Awards are paid to long serving consultants and we know that there has been increasing female representation in recent years. It is anticipated that as females acquire seniority in the consultant workforce this pay differential will reduce.

Figure 3: Consultant Gender Pay Gap

Calculations				Gender Pay Gap		
Gender	Headcount	Sum of Hourly rate	Ave	2018		2017
Female	232	10598.50	45.68			
Male	474	23180.18	48.90	6.58%		6.74%
Grand Total	706	33778.68				

Figure 4: Very Senior Manager Gender Pay Gap (sensitive information excluded)

Gender	Headcount	Sum of Hourly rate	Mean hourly rate	VSM Mean Gender pay gap
Female	2	[redacted]		17.55%
Male	8			
Grand Total	10			

This is an increase on the 2017 VSM gender pay gap of 10.24%. It is expected the gap will close in the 2019 calculations following the successful appointment of an additional female director.

4.4 A detailed analysis of gender pay gap by staff group is shown in Figure 5 below:

Figure 5: Gender Pay Analysis by Staff Group

	Gender						
	Female		Male		Headcount	Total Sum of Hourly rate	Mean Gender Pay Gap
Staff Group	Headcount	Mean Hourly rate	Headcount	Mean Hourly rate			
Add Prof Scientific and Technic	348	17.02	114	17.44	462	7912.62	2.40%
Additional Clinical Services	2091	10.88	326	10.87	2417	26302.08	-0.17%
Administrative and Clerical	2322	12.38	524	15.50	2846	36871.84	20.15%
Allied Health Professionals	515	18.09	148	17.19	663	11861.61	-5.28%
Estates and Ancillary	1181	9.43	670	10.37	1851	18089.78	9.04%
Healthcare Scientists	292	19.35	189	19.08	481	9256.85	-1.39%
Medical and Dental	686	32.39	1030	37.39	1716	60733.26	13.36%
Nursing and Midwifery Registered	3577	17.59	359	17.40	3936	69177.92	-1.11%
Grand Total	11013	15.32	3360	21.28	14373	240212.90	28.03%

4.5 Figure 5 shows that the gender pay gap is highest in the medical and dental, administration and clerical and estates and ancillary staff groups

4.6 Figure 6 below shows the split of male and female workers across each of the quartiles by age profile in order to ascertain if the pay gap is improving over time.

Figure 6: Gender Pay Analysis by Age Band

Headcount		Quartile			
Gender	Age Band	Lower	Lower Middle	Upper Middle	Upper
Female	<=20	83.75%	8.75%	7.50%	0.00%
Male		88.89%	5.56%	5.56%	0.00%
Female	21-30	26.41%	36.47%	30.33%	6.79%
Male		25.77%	28.87%	24.59%	20.77%
Female	31-40	19.47%	24.31%	32.58%	23.63%
Male		16.87%	19.48%	20.84%	42.80%
Female	41-50	21.61%	22.98%	28.26%	27.14%
Male		17.03%	14.95%	16.80%	51.22%
Female	51-60	29.65%	24.87%	21.66%	23.82%
Male		24.08%	17.24%	16.42%	42.27%
Female	61-70	39.30%	29.75%	18.02%	12.94%
Male		31.45%	18.95%	14.11%	35.48%
Female	70+	36.84%	35.09%	14.04%	14.04%
Male		40.00%	6.67%	0.00%	53.33%
Female Total		25.97%	26.66%	26.85%	20.52%
Male		21.85%	19.55%	18.93%	39.67%

This shows that for females in the age category 21-40 there is a higher than average split of female workforce in the upper middle quartile. This bodes well for future closure of the gender pay gap to redress the imbalance in the upper quartile for males in the 41-50 age group. Since 2017 the percentages of 41-50 and 51-60 year old females in the upper quartile has increased from 26.76% to 27.14% and from 21.24% to 23.82% respectively.

4.6 Analysis of the gender pay gap comparing full time staff with part time staff shows that the part time gender pay gap is 19.98% (21.3% in 2017) suggesting that females are affected by decisions to work full time.

4.7 These detailed analytics show that our attention needs to focus on the upper quartile and medical and dental and administration and clerical staff groups to have the maximum impact on our gender pay gap.

4.8 At the time of writing 21 NHS Trusts over 5000 employees have reported their gender pay gap for 2018 with results ranging from -29.7% to 37.2% mean GPG. On average this equates to a 21.16% mean GPG. Six Trusts in this comparison group have a GPG higher than UHL.

5 Action Planning

5.1 The Trust is fully committed to addressing the gender pay gap particularly given the high proportions of females in our workforce overall. The analytics above indicate where our actions will have maximum impact.

5.2 The themes contained in our action plan include:

- improved analysis and subsequent marketing to senior management and consultant posts to improve the pool of female applicants
- continuation of unconscious bias training
- appropriate service level agreements with Executive Search organisations
- innovative approaches to flexible working
- rigorous application of pay policy rules
- impact analysis of clinical excellence award payment and applications for Heads of Service roles
- coaching and mentorship for females to ensure a robust approach to talent management and succession planning
- appropriate health and well-being strategies to support females in the workplace throughout their careers.

6 CONCLUSIONS

6.1 The gender pay gap is 28% and is principally driven by differences in the upper quartile of our workforce.

6.2 The mean gender pay gap for Agenda for Change only staff is 0.23% when excluding Medical and Dental, VSM and locally agreed pay rates.

6.3 There is a greater representation of males at the more senior levels in the organisation, particularly medical and dental consultants which will account for a proportion of the gender pay gap.

6.4 Focusing on the upper quartile and medical and dental and administration and clerical staff groups, where the differential is greater, will enable us to prioritise actions which will have the greatest impact.

7.0 RECOMMENDATIONS

PPPC is asked to note:-

7.1 The adherence to Gender Pay Gap legislation from March 2017.
7.2 The position of University Hospitals of Leicester in relation to the legislative requirements
7.3 The underpinning analysis of factors driving our Gender Pay Gap

PPPC is asked to approve:

7.4 The formal publication of the Gender Pay Gap
7.5 The proposed action plan based on detailed analytics

DRAFT for
March 2019

Caring at its best

NHS
University Hospitals of Leicester
NHS Trust

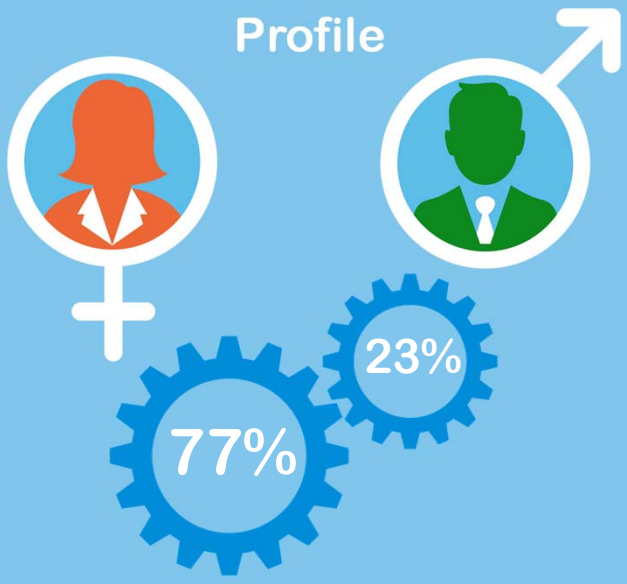
Gender Pay Gap Reporting

- **University Hospitals of Leicester NHS TRUST is fully committed to promoting equality and fairness in its employment practices across all protected characteristics as part of our pursuit of an inclusive and diverse culture.**
- **76.6% of our workforce are female and therefore we are particularly committed to ensuring equality of pay in respect of gender.**
- **We actively support all staff through access to flexible working, good holiday entitlements, education, development and training opportunities, and a range of salary sacrifice schemes, which includes childcare vouchers, cars, bikes and computers.**
- **We use job evaluation to determine pay grades for jobs and pay policy to provide consistency on pay for people, e.g. via NHS Agenda for Change.**
- **We have clear policies in place to support fair recruitment – this includes balanced panels, monitoring employment practices and training on unconscious bias.**
- **Our analysis of the Gender Pay Gap will help to identify and address the issues and close the gap, and to clearly measure our progress.**
- **This report details our headline pay gap figures, a brief analysis of why we have a pay gap and an overview of our actions to close the gap.**

Our Gender Pay Gap

Mean 28% (29% 2017)
Median 15% (16% 2017)

Our Workforce Profile



Headline gender pay gap figures

- The Gender Pay Gap is defined as the difference between the **mean** or **median** hourly rate of pay of men and women.
- The **mean** gender pay gap is the difference between the average hourly earnings of men and women.
- The **median** hourly pay gap is the **difference between the midpoints** in the ranges of hourly earnings of men and women. Pay excludes overtime payments but includes enhancements for shifts and weekend working.
- Our mean gender pay gap is 28% (an improvement of 1% on 2017) and is calculated on the basis of earnings as at the pay period which includes the 31.03.18.
- Our median gender pay gap is 15%(and improvement of 1%, for the same period. This suggests that our pay gap is skewed by the highest (male) earners in the organisation.

Draft – March 2019

Caring at its best

NHS
University Hospitals of Leicester
NHS Trust

Gender Pay Gap Reporting

Proportion of men and women receiving a bonus

- At University Hospitals of Leicester NHS Trust only medical Consultants receive a payment that must be classed as a bonus. The payments are called 'Clinical Excellence Awards' and come from the national contract for Consultants, plus a separate local scheme. These Awards are paid on a pro rata basis linked to how many hours a week each Consultant works for the Trust.
- UHL employs 706 Consultants - 33% were women in March 2018- an increase of 1% since March 2017.
- Of all Medical Consultants eligible to receive an Award, 37% (same as 2017) of female consultants and 47.7% (down from 50% in 2017) of male consultants were in receipt of an award.
- For the whole workforce, these figures translate into 0.74% of women received an Award (Bonus) payment compared to 6.% of the men.
- This helps to explain the whole workforce mean bonus pay gap of 27% (up from last year 24%) and the median bonus gap of 34.29% (down from 50% in 2017).

'Bonus' Pay Gap

Mean 27% (24% 2017)
Median 34% (50% 2017)

Staff Receiving 'Bonus'

0.74% (0.72% 2017)

6.52% (6.85% 2017)

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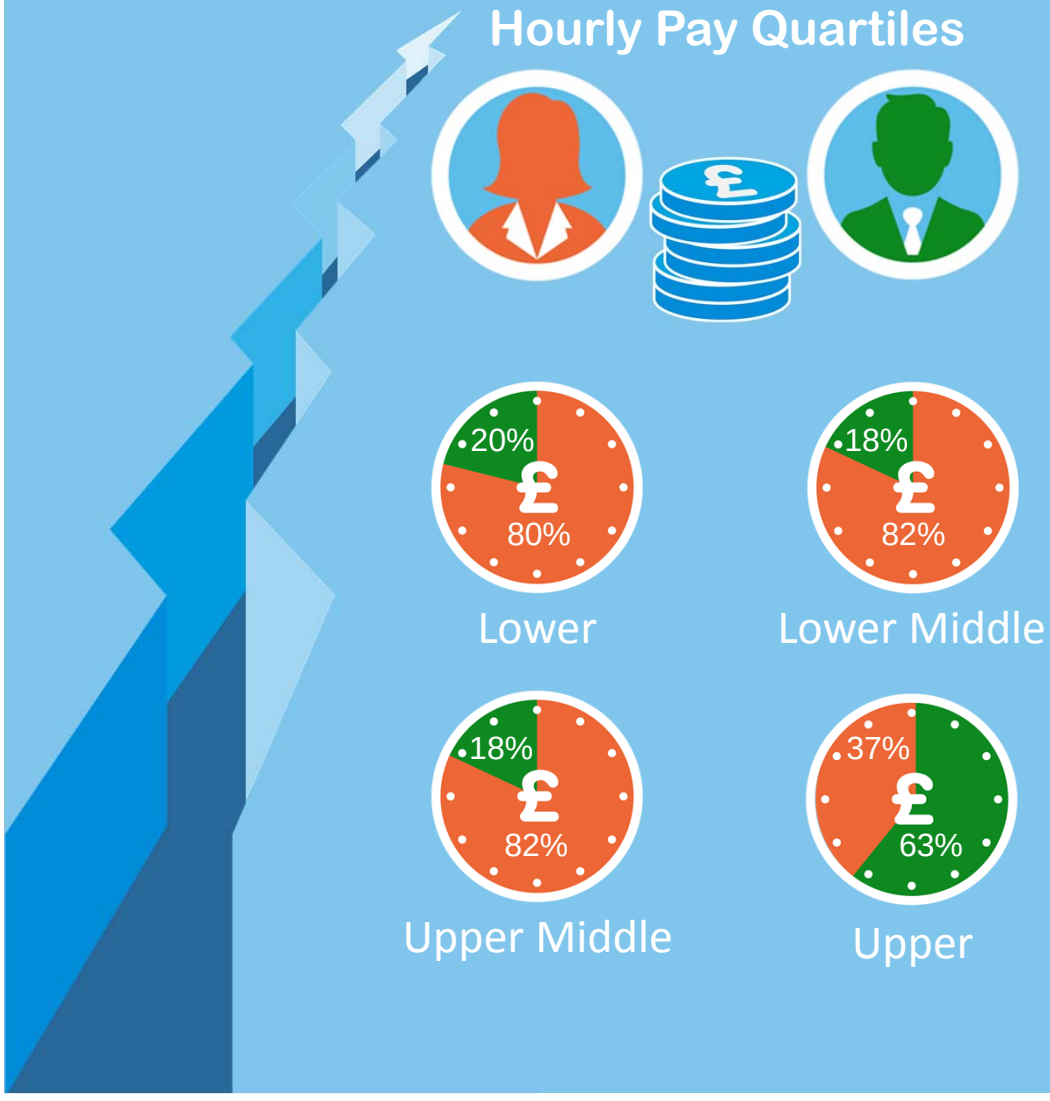
NHS
University Hospitals of Leicester
NHS Trust

Gender Pay Gap Reporting

Proportion of men and women in each pay quartile

- 77% of our workforce are women compared 77% for the NHS as whole (source: NHS Digital 2018).
- The gender split when we order hourly rate of pay from the highest to the lowest and group in four equal quartiles is shown below
- The lowest pay quartile is 80% (79% in 2017) female and the highest pay quartile is 63% (61% in 2017) female.
- Since the lower middle and upper middle quartiles are 82% female, the gender pay gap is principally driven by the differences in the upper quartile.



Draft March 2019

Caring at its best

NHS
University Hospitals of Leicester
NHS Trust

Gender Pay Gap Reporting

Why do we have a gender pay gap?

- We are confident that men and women are paid equally for doing equivalent jobs across the organisation because of tight pay policies, job evaluation and national pay structures.
- The main reason for the gender pay gap is an in-balance in the numbers of men and women across the whole workforce and a 26% pay gap in the upper quartile.
- The Medical Consultant workforce is predominantly male (67%) and Consultants are in the highest paid group of staff - this difference is influencing the gender pay gap.
- The gender pay gap for the medical and dental workforce overall is 13.36% (16.48% in 2017) which suggests a lack of pay consistency but an improving position. The bonus analysis shows fewer women receive Clinical Excellence Awards than men, and the value of these is also is less for women as they are more likely to work part time.
- There is a positive gender pay gap for healthcare scientists, qualified nursing and midwifery staff and allied health professionals.
- For administration and clerical staff the pay gap is 20.15% (23% in 2017) , which is attributable by the disproportionate number of men in the most senior manager roles, e.g. Directors.
- The mean gender pay gap for Agenda for Change staff **only** is 0.23% excluding Medical & Dental, VSM, and locally agreed payments.

How are we addressing the gender pay gap?

- We will ensure that women are encouraged and supported to apply to become Consultants and senior managers. More us of flexible working will help with this.
- We will provide the right support and opportunities for the increasing number of women entering the medical profession to move into consultant roles.
- We will ensure that all Recruitment panels are gender balanced wherever possible.
- We will explore any barriers to the female consultant workforce entering leadership positions and actively encourage applications for leadership roles through mentoring and leadership development.
- We will proactively encourage female applications for Trust Board and senior roles so we meet the NHSi target of 50/50 Board representation by 2020.
- We will develop a clear strategy to ensure inclusivity and diversity across all of our protected characteristic groups supported by the expertise of our Equality and Diversity team.

Recruitment

- We will ensure our Graduate Management Training scheme [illegible]umni describe their own career progression to ensure a strong female pipeline. Our latest schemes have appointed 67% fe[illegible]ndidates.
- We will support middle grade and senior staff to pursue flexible working options.
- We will develop health and well being strategies ,which recognise the particular challenges faced by women in the workplace.

Education, Training and Development

- We will utilise the apprenticeship levy to enable staff to pursue development activity, which enables career progression.
- We will expand our succession planning and talent management strategies to expose staff to experiences that will enable career progression including secondments, work shadowing and mentorship.

Junior Doctors Contract Guardian of Safe Working Report

Author: Jonathon Greiff, Guardian of Safe Working, Consultant Anaesthetist, Joanne Tyler-Fantom, Deputy Director of Human Resources and Vidya Patel, Medical Human Resources Manager
Sponsor: Hazel Wyton, Director of People and Organisational Development

Executive Summary

Paper F

The 2016 Junior Doctors Contract has now been fully implemented at UHL and in line with the requirements of the 2016 Contract; this report provides a quarterly update on Exception Reporting activity at the Trust.

Context

This report has been produced in line with the requirements of the 2016 Junior Doctors Contract, whereby the Guardian of Safe Working (GSW) will provide a quarterly report (April, July, October and January) on the management of Exception Reporting and rota gaps.

In the last three month period from 1st December 2018 to 28th February 2019 there have been 117 exceptions recorded, of which 112 were work pattern/hours related and 5 were Education exceptions. This is less than previous 3 months (189).

Questions

1. How many Exception Reports have been received at UHL in the last quarter and how are Exception Reports being managed?
2. How many junior doctor vacancies exist at the Trust?

Conclusion

1. From December 2018 to February 2019, 117 exceptions reports have been recorded. The Exception Reporting procedure was initially implemented in December 2016.

2. As at March 2019 there are 60.5 vacancies on junior medical staff rotas. Active recruitment is on-going to fill any remaining gaps. Locum backfill is arranged where required.

Input Sought

We would like the Trust Board to note the progress being made and provide feedback if required.

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[**Yes** /No /Not applicable]
Effective, integrated emergency care	[**Yes** /No /Not applicable]
Consistently meeting national access standards	[**Yes** /No /Not applicable]
Integrated care in partnership with others	[**Yes** /No /Not applicable]
Enhanced delivery in research, innovation &ed'	[Yes /No /**Not applicable**]
A caring, professional, engaged workforce	[**Yes** /No /Not applicable]
Clinically sustainable services with excellent facilities	[Yes /No /**Not applicable**]
Financially sustainable NHS organisation	[**Yes** /No /Not applicable]
Enabled by excellent IM&T	[**Yes** /No /Not applicable]

2. This matter relates to the following **governance** initiatives:

   a. Organisational Risk Register [Yes /**No** /Not applicable]

   If NO, why not? Eg. Current Risk Rating is LOW

   b. Board Assurance Framework [**Yes** /No /Not applicable]

   If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

3. Related **Patient and Public Involvement** actions taken, or to be taken: [NA]

4. Results of any **Equality Impact Assessment**, has been undertaken and shared with the Executive Workforce Board on 17th January 2017.

5. Scheduled date for the next paper on this topic: July 2019

6. Executive Summaries should not exceed **1page**. [My paper does comply]

7. Papers should not exceed **7 pages.** [My paper does comply]

1. Introduction

1.1 In line with the requirements of the 2016 Junior Doctors Contract, the Guardian of Safe Working (GSW) will provide a quarterly report to the Trust Board (April, July, October, and January) with the following information:

- Management of Exception Reporting
- Work pattern penalties
- Data on junior doctor rota gaps
- Details of unresolved serious issues which have been escalated by the GSW

1.2 These reports shall also be provided to the Local Negotiating Committee and the Trust Junior Doctors Forum.

2. Background

2.1 The 2016 Junior Doctors Contract came into effect on 3rd August 2016. In line with the national timescales transition of doctors in training to the new contract at UHL has been as follows:

- December 2016 - All Foundation Year 1 doctors
- February to April 2017 - All F2, CT, ST3+ doctors in Paediatrics, Pathology and Surgery
- August 2017 - All remaining doctors with the exception of doctors in training whose contract of employment expiry was beyond August 2017. All doctors are now working on the new contract.

3. Management of Exception Reporting

3.1 In line with the Trust procedure for Exception Reporting, doctors that have transitioned to the new contract will raise Exception Reports on work pattern or educational problems using a web based package.

4. Reporting on the Number of Exceptions

4.1 The method of recording exceptions changed in February 2019 following requests from the Guardians Nationally. Previously doctors were able to record a number of breaches under the same exception, from February 2019, the software package has been changed and each breach is recorded as a separate exception. Work is being undertaken to manually re-calculate the number exceptions logged in each quarter from December 2016 (when exception reporting commenced), to ensure we have comparable data for future reports.

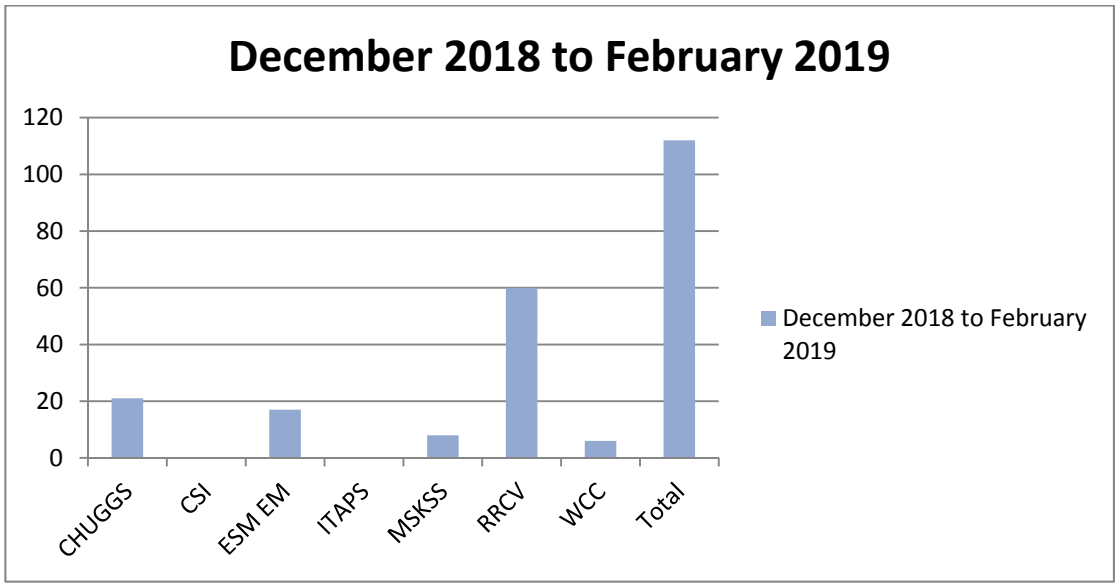
4.2 At UHL all junior doctors (including Trust Grade Doctors) are encouraged to raise exception reports if there are concerns with their work patterns and/or education.

5 Number of Exceptions Recorded

5.1 From 1st December 2018 to 28th February 2019, a total of 117 Exception Reports have been recorded, of which 5 are Education exceptions.

5.2 Graph 1 provides an overview of the number of Work Pattern exceptions received by CMG in the last quarter.

Graph 1 Work Pattern Exception Reports



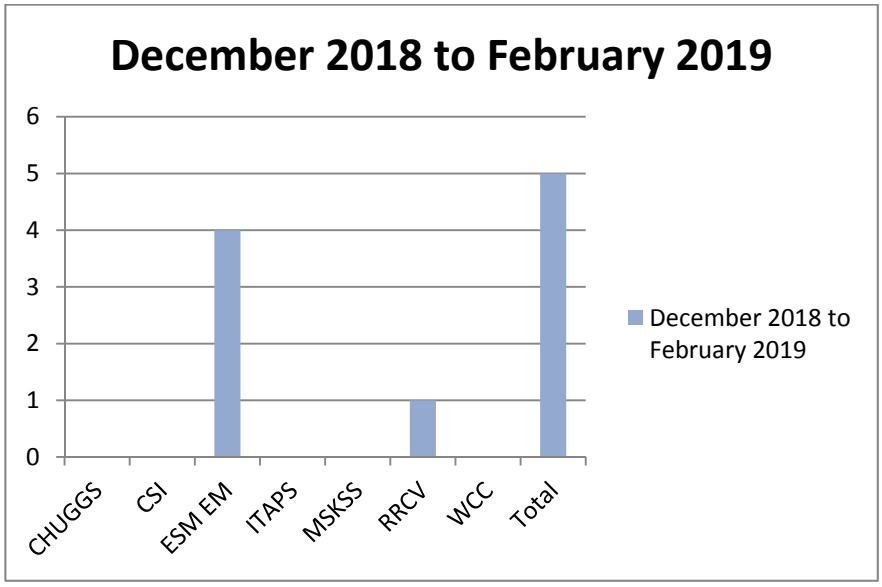
5.6 In this quarter there is significant increase in the number of exceptions recorded in RRCV. Of the 60 exceptions recorded in RRVC:

- 27 exceptions recorded in respiratory where there have been a number of vacancies which have been backfilled with locum doctors. However, a number of new Trust Grade doctors have been appointed and following a shadowing period, are expected to be in post from April 2019.
- 21 exceptions recorded in cardiology, majority related to additional hours work due to work pressures, there were 2 gaps in cardiology, however both were locum backfilled.

5.7 In the last report, we reported significant increase in the number of exceptions raised in Vascular Surgery, in this quarter 10 exceptions have been recorded in comparison to 41 exceptions in the last quarter, which is a much improved position. The Guardian will continue to monitor reports in vascular surgery and take any required action.

5.7 Graph 2 provides an overview of the number of education exceptions received by CMG for each quarter and in the 12 month period.

Graph2 Education Exception Reports



5.8 The five education exceptions recorded during this quarter were due to:

i. One doctor Cardiology was unable to attend Clinic as they were required to provide ward cover.

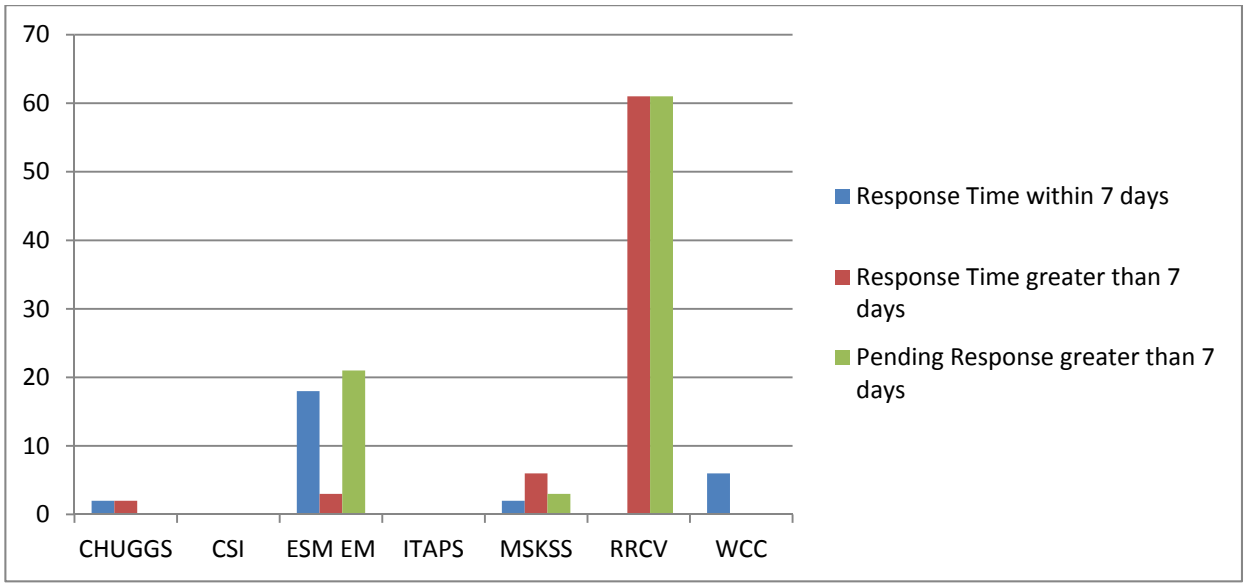
ii. Four Educational exceptions have been logged by one doctor. On three occasions CMT teaching session were cancelled due to patient care demands. On one occasion the doctor was moved during the evening shift from AMU to cover medical outlier wards.

6. Outcome of the Exception Reports

6.1 For the majority of the Exception Reports time off in lieu (TOIL) is allocated. In the last quarter out of the 112 work related exceptions received, TOIL has been allocated for 37 exceptions. Two doctors will receive additional payment for extra hours worked. Further information has been requested from 13 doctors and 11 exceptions required no further action. There are 49 exceptions still open and require a response. Clarification is being sought through CMG's.

6.2 Junior Doctors are required to raise Exception Reports with 14 days (7 days if payment is being requested) of the issue occurring. The Trust has 7 days to provide a response. Delays in responses are being pursued with CMG's. The response time for exceptions in the last quarter is detailed in the graph 3 below:

Graph 3 Response Time



7. Work Schedule Changes

7.1 There have no work schedule changes in the last quarter as a result of Exception Reporting.

8. Junior Medical Staff Vacancies

8.1 Both trainee and trust grade vacancies are provided as they work on joint rotas, therefore any vacancies at this level will have an impact on trainee doctors. The number of junior medical staff vacancies currently is provided in table below:

CMG	Establish-ment	FY1	FY2	CT1/2	TG F2/ CT1/2	ST3+	TG ST3+	Total	Percentage Vacancy
CHUGGS	**133**	0	0	2	4	1	1	**8**	**6.0%**
CSI	**63**	0	0	0	0	0	0	**0**	**0%**
ESM EM	**287**	0	0	3	5	8	3	**19**	**6.6%**
ITAPS	**84**	0	0	0	0	0	0	**0**	**0%**
MSKSS	**129**	0	0	0	0	0	2	**2**	**1.5%**
RRCV	**153**	0	2	1	2	4	10	**19**	**12.4%**
WCC	**172**	0	3	1	2	3.5	3	**12.5**	**7.2%**
Total	**1024**	**0**	**5**	**7**	**13**	**16.5**	**19**	**60.5**	**5.9%**

8.2 During this period there are a total of 60.5 vacancies which equates to 5.9% of the total junior medical staff establishment.

8.3 Recruitment is being actively managed where gaps exist, to look to fill substantively fill posts and where possible avoid premium pay. A joint medical education and workforce committee has been established to provide oversight and management of the medical workforce agenda, the terms of reference for this group is currently under review.

9. Conclusion

9.1 Exception reports are being reviewed and changes being implemented as required, including enhancing Trust processes such as response time.

9.2 The next Guardian of Safe Working report will be provided in July 2019.

10. Recommendations

10.1 Trust Board members are requested to note the information provided in this report and are requested to provide feedback on the paper as considered appropriate.

Armed Forces Covenant

Author: [Ian Crowe Armed Forces Champion] Sponsor: [Hazel Wyton Director of Workforce and OD]

Executive Summary Paper J

Context

This paper provides a short update regarding the Trust's commitment to the **Armed Forces Covenant.** The Trust signed the covenant in November 2015, pledging the support of Leicester's Hospitals to the armed forces. The purpose of the covenant is to encourage support for servicemen and women, their families and veterans and to recognise and remember the sacrifices they have made. It encourages everyone within the Trust to offer support to the local armed forces community, making it easier for service personnel, families and veterans to receive help from the Ministry of Defence, charities and voluntary sector groups.

Questions

1. How has the Trust supported the Armed Forces Covenant in the past 18 months?
2. How is the Trust to continue its support of the Armed Forces Covenant?

Conclusion

1. There has been considerable support for the Armed Forces Covenant over the past 18 months and efforts of Trust staff have been recognised by the presentation of a 'gold award' in the Defence Employer Recognition Scheme 2018.

2. Support for the covenant is continuing and further initiatives are planned or in progress, including the Trust joining the Veterans' Covenant Hospital Alliance.

Input Sought

The committee is requested to note this update and make suggestions to maintain and improve our support of the covenant. It is recommended this paper be forwarded to the Trust Board for information.

For Reference

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Not applicable]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & Ed	[Not applicable]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Not applicable]
Financially sustainable NHS organisation	[Not applicable]
Enabled by excellent IM&T	[Not applicable]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[Not applicable]
Board Assurance Framework	[Not applicable]

3. Related Patient and Public Involvement actions: [Not applicable]

4. Results of any Equality Impact Assessment: [Not applicable]

5. Scheduled date for the next paper on this topic: [March 2020]

6. Executive Summaries should not exceed 1 page. [My paper does comply]

7. Papers should not exceed 7 pages. [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TO: **PEOPLE, PROCESS AND PERFORMANCE COMMITTEE**

FROM: **HAZEL WYTON, DIRECTOR OF WORKFORCE AND OD**

DATE: **28 MARCH 2019**

SUBJECT: **ARMED FORCES COVENANT**

1. Introduction

1.1 This paper provides a short update regarding the Trust's commitment to the **Armed Forces Covenant.** The Trust signed the covenant in November 2015, pledging the support of Leicester's Hospitals to the armed forces. The purpose of the covenant is to encourage support for servicemen and women, their families and veterans and to recognise and remember the sacrifices they have made. It encourages everyone within the Trust to offer support to the local armed forces community, making it easier for service personnel, families and veterans to receive help from the Ministry of Defence (MOD), charities and voluntary sector groups.

1.2 Six key work streams have been identified to enhance the Trust's commitment to the covenant. Within these work streams a number of activities have been undertaken and plans made to further enhance our commitment. The six key work streams are:

(a) to support regular armed forces personnel in maintaining their professional skills by offering **work placements**;

(b) to support regular armed forces personnel and their families **transiting to civilian life**, via the Career Transition Partnership (CTP), the official providing of Armed Forces resettlement;

(c) to support armed forces **reservists and cadet instructors** amongst our staff and to encourage the recruitment of more reservists from the Trust's workforce;

(d) to support staff who have **family members** serving in the armed forces;

(e) to support **veterans** to ensure they receive the care they need;

(f) to celebrate and actively participate in key dates in the **armed forces calendar**.

2. How has the Trust supported the Armed Forces Covenant in the past 18 months?

2.1 The Trust has continued its support of the Armed Forces Covenant in a number of different ways. This support was recognised by receipt of a **Gold Award** in the **Defence Employer Recognition Scheme 2018**. The Scheme encourages employers to support defence and

inspire others to do the same. The scheme encompasses bronze, silver and gold awards for employer organisations that pledge, demonstrate or advocate support to defence and the armed forces community, and align their values with the covenant. To date, just over one hundred organisations have received 'gold' status in the five years of the scheme. The awarded was presented by HRH Prince Edward, Earl of Wessex, at an event at Lancaster House, London, on 12 November 2018. The Trust was represented by the Chairman, Director of Workforce and OD and the Trust's Armed Forces Champion.

2.2 In December 2017, the Trust joined the **LLR Civil and Military Partnership Board**. This Board gives strategic direction and provides oversight of the implementation of the covenant. It also fosters engagement across LLR. All local authorities are represented on the board, as are local military units, local health service providers and local and national charities. Meetings are held quarterly.

2.3 In January 2018, the Trust Board resolved to sign the **Step into Health** pledge. This is a national initiative between the NHS and the MOD to support service leavers and their families. The programme enables armed forces personnel to join the NHS. It recognises the transferable skills and cultural values that armed forces personnel develop whilst serving, and how they are compatible with those required within NHS roles. By signing the pledge, the Trust actively promotes around 350 NHS jobs and careers, offer work placements, and ensure that ex-forces staff who join the Trust are able to access support to make a successful transition into the NHS. Currently there are 44 service leavers employed by the Trust. To support this activity, Trust staff have forged an effective and meaningful relationship with CTP and the MOD Regional Resettlement Centre (RRC), based near Cottesmore in Rutland.

2.4 The Trust conducted a local survey to identify reservists, cadet instructors, service leavers and the spouses and partners of service personnel. With this information human resources staff have been able to better address the needs of these groups.

2.5 The Trust has continued to be a **strong advocate** for the Armed Forces and uses its staff magazine, website and social media channels to promote the covenant at every opportunity. Specifically, the Trust celebrated 'Reserves Day' with a poster campaign highlighting our support for reservists and our special leave policy. Reserves stories, photographs and video interviews were also released via social media. The Trust has also promoted the covenant through its human resources and procurement channels, encouraging all partners to sign the covenant.

2.4 The Trust has continued to be well represented at **armed forces events**. In June 2018, the Chairman represented the Trust at the Trooping of the Colour, on Horse Guards Parade, London. Whilst in November 2018, the Trust's Armed Forces Champion presented to the East Midlands NHS Employers Armed Forces Network. The Champion has also represented the Trust at quarterly meetings of the Leicestershire and Rutland RFCA Counties Committee, a 'Walking with the Wounded' event (as it passed through Leicestershire),

Remembrance Services and Armed Forces Day Services and Parades in Leicester and Oakham.

2.5 In August 2018, two members of staff were deployed on **Exercise Askari Serpent**, an annual exercise where the British Army deploys a Medical Regiment in support of the Kenyan Health Service. The purpose of the exercise is to prepare and train Army Medical Services personnel for future operations and conflicts around the world. The exercise provides an opportunity for doctors, dentists, nurses, combat medics and vets to hone their skills in Kenya, by providing essential medical treatment and care to the poorest communities. The staff members involved provided some first-rate articles for the Trust's staff magazine and social media channels and had an excellent experience.

2.6 In November 2018, the Trust unveiled two **war memorials** in the Victoria Building, LRI. These memorials were recovered from the chapel that was demolished to make way for the new emergency floor.

2.7 The Trust has continued to reach out to the armed forces and **engage at a local level**, for example:

(a) The Trust has invited staff from the Surgeon General's Department (now based in Litchfield) to attend meetings to gain a better understanding of NHS governance processes.

(b) The Trust has continued to accept clinical and non-clinical placements from local Army units to enhance their development and understanding of the NHS.

(c) The Trust has developed strong relationships with local Reserve units to encourage staff to join the Reserves. Specifically, a group from the Trust's Procurement and Supplies Department have visited exercises involving 158 Regiment, Royal Logistics Corps and recruiting events have been run in conjunction with 222 (Leicester) Medical Squadron, part of 254 Medical Regiment.

(d) The Trust has regularly released staff for Defence events, such as 'Executive and Future Leaders', to help build an understanding of the armed forces and develop their leadership skills.

2.8 The Trust has also continued to provide **engagement at a national level**, having contributed to the Future Reserves Research Programme and an All-Party Parliamentary Group review of the Armed Forces Covenant.

2.9 The Trust continues to support the Defence Medical Rehabilitation Centre, following its move to the new **Defence and National Rehabilitation Centre**, Stanford Hall. Senior staff are members of the National Work-Stream Steering Group and Trust staff have held discussions with DMRC personnel regarding local contracts, civilian recruiting, training and R&D opportunities.

2.10 The Trust continues to support **Mesothelioma UK** (a charity supported by the Trust) following their successful bid for LIBOR funds in 2016. The funds provide specialist support services for veterans and armed forces personnel diagnosed with Mesothelioma. The charity is also sponsoring research into the incidence of this terminal disease amongst service personnel and veterans.

3. How is the Trust to continue its support of the Armed Forces Covenant?

3.1 Trust staff are to continue supporting the Armed Forces Covenant along the six key work streams previously mentioned and further specific initiatives are planned or in progress.

3.2 Our intent is for the Trust to join the **Veterans' Covenant Hospital Alliance** within the next 12 months. Veteran aware hospitals are leading the way in improving veterans' care within the NHS for veterans and their families. To date, 25 NHS acute hospitals have been accredited and are part of the alliance. The veterans' aware initiative has been included in the **GIRFT programme** and is being administered by that team. Trust staff are also in discussion with staff from the LPT to collaborate on this initiative. This will be the first-time veterans' awareness has been addressed across an STP.

3.3 Trust staff are working closely with members of 254 Medical Regiment to encourage the **recruiting of reserves** from the Trust's workforce. A number of events has already taken place across the three main sites and more are planned.

3.4 Trust staff are continuing to work closely with the CTP and the RRC to **offer second careers** in the NHS to service leavers.

4. Conclusion

4.1 There has been considerable support for the Armed Forces Covenant over the past 18 months and the efforts of Trust staff have been recognised by the presentation of a 'gold award' in the Defence Employer Recognition Scheme 2018.

4.2 Support for the covenant is continuing and further initiatives are planned or in progress, including the Trust joining the Veterans' Covenant Hospital Alliance.

4.3 Two members of staff are worthy of praise for their work in support of the covenant, Diane Bailey and Conor Ward.

4.4 The committee is requested to note this update and make suggestions to maintain and improve our support of the covenant. It is recommended this paper be forwarded to the Trust Board for information.

Hazel Wyton
Director of Workforce and OD

28th March 2019