UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 29 JULY 2021

Title:	**ANNUAL WORKFORCE REPORT 2020/21**
Responsible Director:	**Cathi Shovlin, Director of Workforce**
Contact:	**Cathi Shovlin, Director of Workforce**

Purpose:	To present an update to the Board
Confidentiality Level & Reason:	None
Board Assurance Framework Ref: **Strategy Implementation Plan Ref:**	BAF - SR5/18 - Unable to recruit, control and retain adequate staffing to meet the needs of patients SIP - #11 Optimise workforce supply to ensure sufficient staff and roles to meet patient demand SIP - #12 Provide high quality education and training to support a highly skilled and effective current and future workforce SIP - #13 Promote inclusion, health and wellbeing and diversity
Key Issues Summary:	Provides an update for the Board of Directors against key Workforce workstreams. Key areas of update include: • Gender Pay Gap • Workforce planning and supply • Employee relations issues • Sickness absence levels • Organisational change • Occupational health provision
Recommendations:	The BOARD OF DIRECTORS is asked to: 1. Receive the 2020/21 Annual Workforce Report 2. Accept the workforce priorities for 2021/22 3. Approve the publication of the Annual Workforce Report

Signed: Cathi Shovlin	**Date:** 21 JULY 2021

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 29 JULY 2021

ANNUAL WORKFORCE REPORT

PRESENTED BY DIRECTOR OF WORKFORCE

1 Introduction

1.1 The aim of this Annual Workforce Report is to provide an update to the Board of Directors on key staffing activity in the period April 2020 to March 2021 delivered through Workforce against priority issues, and to agree the Workforce priorities for the next period.

1.2 The Annual Workforce Report also contains workforce statistics that meet the Trust's statutory responsibilities under the Equality Act 2010, and are attached at Appendix 1.

1.3 The Annual Workforce Report illustrates the wide range of activities towards people management and staff experience. There are some significant workforce issues that the Trust is facing currently in an uncertain and shifting pandemic, and a significant patient backlog to address against a backdrop of workforce capacity constraints. The workstreams are on-going in order to mitigate risk to patients, staff or the Trust. There are also many opportunities that we can maximise to strengthen our staff experience, learning the lessons of the pandemic and creating a fairer culture for everyone to revive and thrive in.

1.4 Close partnership working with our trade union representatives is going to be critical to supporting management and our staff through challenging times, and the Trust is grateful to our Staff-Side colleagues for their approach to partnership working which has enabled rapid and significant changes to happen. We commit to strong and open partnership working for the year ahead.

1.5 We must also acknowledge the extraordinary pressures that our staff have faced, and continue to experience at unrelenting pace. Whilst exhausted, it is a testament to their vocation that they remain highly committed and well-motivated to deliver the best care for our patients and wider communities.

2 Workforce Governance

2.1 Key activity 2020/21

2.1.1 <u>Gender Pay Gap</u>

Under the provisions of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, the Trust is required by law to publish an annual gender pay gap report as it is in the pay period at 31 March each

year. There is a separate requirement to publish gender bonus gap information, based on data for those employees in receipt of bonus pay during the 12 months to 31 March.

The gender pay gap is the difference between the mean or median hourly rate of pay that male and female colleagues receive. The mean pay gap is the difference between average hourly earnings of men and women. The median pay gap is the difference between the midpoints in the ranges of hourly earnings of men and women.

UHB data as at the snapshot date of 31 March 2020:

- The mean gender pay gap for the Trust is **28.14%**
- The median gender pay gap for the Trust is **13.24%**
- The mean gender bonus gap for the Trust is **44.92%**
- The median gender bonus gap for the Trust is **66.67%**
- The proportion of male employees in the Trust receiving a bonus is **6.29%,** and the proportion of female employees receiving a bonus is **0.75%**.

The proportion of male and female employees in each quartile is shown below:

Quartile	Males	Females	Description
1	22.41%	77.59%	Includes all employees whose standard hourly rate places them at or below lower quartile
2	18.61%	81.39%	Includes all employees whose standard hourly rate places them above the lower quartile, but at or below the median
3	18.76%	81.24%	Includes all employees whose standard hourly rate places them above the median, but at or below the upper quartile
4	37.32%	62.68%	Includes all employees whose standard hourly rate places them above the upper quartile

Bonus payments relates exclusively in this Trust to Clinical Excellence Awards, payable to eligible Consultants who apply successfully. A higher number of male consultants have been eligible for awards, and a legacy impact is also apparent when comparing the total value to each employee as the bonus payments are cumulative and local awards are made for the tenure of the employee.

2.1.2 Workforce Policies and Procedures

Post-merger alignment of the full suite of workforce policies and procedures continues, to provide a fair and consistent approach to managing workforce matters. Phases 2 and 3 of the 4-phase alignment are complete, with the following published in-year:

- Pay Policy
  - Pay Protection Procedure
  - Job Evaluation Procedure
  - Salary Variation Procedure

- Work Life Balance Policy
  - Maternity, Adoption, Shared Parental Leave and Paternity Leave Procedures
  - Flexible Working Procedure
  - Annual Leave Procedure
  - Special Leave Procedure.

2.1.3 Job Evaluation

Prioritisation has been given to ensuring that posts could be recruited to without delay to support pandemic pressures and the continuing growth in resourcing needs. Over the last 12 months, just short of 200 new posts or modified jobs have been evaluated.

2.2 Key priorities 2021/22

2.2.1 Through stakeholder engagement, define and deliver actions to address the gender pay gap.

2.2.2 Complete the phase-4 alignment of workforce procedures.

2.2.3 Develop a benefits and rewards strategy to increase the appeal of the Trust's employment to potential applicants, and aid staff retention.

2.2.4 Design a transparent and equitable job evaluation process for roles that are out of scope of Agenda for Change, built on fairness and equality.

3 Workforce Planning and Analytics

3.1 Key activity 2020/21

3.1.1 Workforce Planning

The priority in the latter part of 2020/21 was to complete a six-month workforce forecast to September 2021. Bank and agency usage has been forecast to continue at 20/21 levels due to Nursing and Midwifery vacancy levels and the Trust's drive to recover and restore services.

As a major contributor to the Birmingham and Solihull (BSol) ICS workforce plan, and the system lead on workforce transformation, work on the planning and associated analysis on workforce capacity has driven more detailed discussion at the BSol ICS People Board. This work will continue in 2021/22.

Performance against plan is monitored on a monthly basis. There has been, in conjunction with Corporate Nursing and Finance, a targeted focus on the Nursing and Midwifery staff group. This has resulted in a consistent approach to the recording of Nursing and Midwifery vacancies, and initiated Trust-wide action in respect of data quality.

3.1.2 Workforce Reporting

Over the past year, routine reporting against key workforce indicators at Trust and Divisional levels has continued. Additionally, pandemic reporting has been in place on Covid-related and non-Covid absence levels and staff vaccinations.

From June 2020, there was daily Covid-19 absence reporting to fulfil the requirements for internal intelligence on staff availability.

Working in conjunction with ICT, a Covid-19 Absence Reporting Tool was developed, enabling wards/departments to add new absences and update existing absences at source. This addressed the burdensome process of absences being collated at Divisional level, and the manual processes necessary to update and report this information centrally; this improved data integrity and reduced time lags in absences being known.

Weekly data has been reported through Strategic Covid meetings which has provided an overview of staff testing, test and trace notifications, shielding, absence levels and vaccination uptake. As system lead for workforce transformation, we have also produced a BSol dashboard; this has enabled early discussions to take place across the system regarding workforce capacity and risks.

Work has been underway with the Liaison Group to establish a workforce analytics platform capable of producing insights additional to the standard reporting suite. The platform will create a more interactive and immersive view of data, enabling Workforce and operational leads to quickly identify areas for action; development continues.

3.1.3 Merge Electronic Staff Records System (ESR)

In partnership with colleagues in Finance, Education and ICT as well as the external partner IBM, we delivered the merger of the Queen Elizabeth and the Heartlands, Solihull and Good Hope ESR systems.

Supported by a dedicated Project Manager and Business Analyst, enabling risks to be highlighted and mitigated at an early stage, the merge event was completed successfully in February 2021. This has

enabled streamlined reporting into a single instance. A necessary data cleanse was also undertaken to achieve the PAYE merge for April 2021.

This completed the first phase of the ESR roadmap and has paved the way for the second phase – the full integration of two legacy organisational structures, and future systems development associated with the Trust's Enterprise Resource Planning programme.

3.1.4 Rollout of ESR Employee Self-Service

As part of the Trust's sustainability programme, paperless payslips were rolled out in May 2020. As at 31st March 20/21, 84% of staff were logging into their self-service account on a regular basis. Paper payslips reduced per month from over 22,000 plus Bank payslips to less than 1,000.

In addition to the environmental benefits, self-service enables members of staff to have on-demand access to their P60, Total Reward Statement and Annual Pension Statement, and to update their personal details so that we have accurate staff records.

Self-service roll-out has, however, generated 650 queries per month, an increase in activity of circa 300%. This has necessitated a review of common themes, highlighting areas for process improvement in addition to improved guidance, and is informing a strategic review of the electronic staff records system requirements moving forward.

3.2 Key priorities 2021/22

3.2.1 Embed workforce planning within the Trust's annual planning cycle, positioned alongside financial planning at Divisional level, to enable effective design and forecast of workforce transformation. It is anticipated that this will also enable forecasts to be more robustly triangulated during the annual planning cycle at ICS level.

3.2.2 Roll-out Liaison Analytics platform for use within the Workforce Directorate and Divisions, providing meaningful workforce data insights that drive targeted, data-led workforce actions.

3.2.3 Lead workforce intelligence gathering of stakeholders needs to inform a fit-for-workforce Finance Systems SAP programme implementation.

3.2.4 Undertake a systematic review of data quality within ESR, as an expansion of targeted work undertaken with Corporate Nursing to encompass role titles. Improving data quality is key to increasing confidence in workforce information and will be necessary as part of the overall ERP programme.

4 Medical Resourcing

4.1 Key activity 2020/21

4.1.1 Recruitment

There were 1,709 medical and dental posts/new starters during the year, resulting in 3,496 recruitment episodes:

Grade	Number of Posts/Starters	Recruitment episodes
Foundation	298	894
CTS	312	624
ST1-ST2	220	440
ST3+	430	860
JSDS	229	458
Consultants	61	61
Honorary	159	159
Total	**1709**	**3496**

The JSD programme, already well established at Queen Elizabeth Hospital, gained more momentum at other hospital sites as its aim and ability to supply staff has been more widely understood. The JSD programme has 450 to 500 doctors, and with prospective recruitment can expand to provide a future UK workforce. Outside of the HEE programme, it is a mainstay of the junior doctor workforce.

The ‘grow your own doctors’ ambition took significant strides forward with a real embedding of the FY3 concept, encouraging current UK/UHB FY2 doctors to stay and enhance their skills with an extra year placement locally.

There has been continued expansion of the CESR programme with several successful CESR applications. A clinical tutor has been appointed to support and develop the CESR programme using JSD higher posts.

4.1.2 International Fellows

The successful International Fellows programme continued, training international doctors to then return to their home countries. The Trust had 101 such doctors in 2020/21. Agreement was also reached to train doctors from Saudi Arabia as part of the HEE training programme organised through the Trust.

4.1.3 Recruitment Challenges

The UK's system of workforce planning for medical and dental staff is undertaken nationally and geared to the level of consultants needed in 25/30 years. The numbers in training through Health Education England (HEE) are worked from this level – and have been mostly underestimated, meaning the UK does not train sufficient medical and dental staff to match the supply needs and creates significant shortages of doctors at all grades. UHB has sought to address those challenges through the JSD and CESR programmes for a future UK workforce, as well as the Internationals programme for some junior doctor supply.

Speciality areas with significant recruitment challenges during 2020/1 were:

i. Consultants – Acute Medicine; ED; Elderly Care; Ophthalmology; Obstetrics; Anaesthetics and Imaging.

ii. Junior Workforce – Elderly Care; ED; O&G; Anaesthetics.

4.1.4 Establishment

Significant work has been undertaken to build intelligence on the identified budgeted posts, to continue the development of the prospective recruitment processes which had achieved considerable success in the JSD programme at Queen Elizabeth Hospital. Work was put on hold during the intense Covid peaks, but further progress has now been made to embed across all sites. Capacity/demand work by operational teams will further refine our doctor requirements.

4.1.5 Covid Rotas

Moving and redeploying all grades of doctor during the pandemic was a major challenge. A number of new rotas were introduced and changed several times during the year as we responded to peaks and recovery. Each rota change would lead to salary adjustments assessed on an individual doctor basis to compare specific pay points and protection arrangements. There were approximately 3,250 additional salary assessments and payroll submissions.

4.1.6 SAS Contract Reform

SAS doctors and dentists are substantive career grade clinicians below the level of Consultant (pre-CCT grade, not on the Specialist Registers). Grades include Speciality Doctor and the closed grades of Associate Specialist, Staff Grade and SCMO. These grades are quite senior and well paid but unless they return to training, have no further career progression.

Reforms have been introduced nationally for 01 April 2021 to raise the profile and status of SAS roles to attract and retain.

The reform has 2 distinct parts:

i. an updated Speciality Doctor grade with new terms and conditions of service and an increase in basic pay;
ii. a new 'Specialist' grade – the creation of such roles driven by local employer need to meet service requirements.

Existing doctors in the closed Associate Specialist grades may transfer to the new Specialist grade, but thereafter any newly created roles must go to open competition.

Existing doctors in the Speciality Doctor, Staff Grade, SCMO and other similar grades may automatically transfer to the new Speciality Doctor terms (with increased pay) on the agreement of a new job plan.

An implementation plan is in place for these reforms. UHB will have approximately 130 staff affected by this contract change but many are very part time. The new framework encourages organisations to develop a new strategic role to promote and improve support for SAS doctors' health and wellbeing, and this is under consideration.

4.2 Key priorities 2021/22

4.2.1 Complete the junior doctor establishment requirements for funded posts, with development of a database to track recruitment and movement in to those posts.

4.2.2 Tighten timetables for junior doctor template rotas to ensure operational and financial approval is achieved (at 11 weeks prior to rotation) to meet the 8 and 6 week contractual requirements for provision of template rotas and rosters to junior doctors.

4.2.3 Design a programme of work to improve the junior doctor experience.

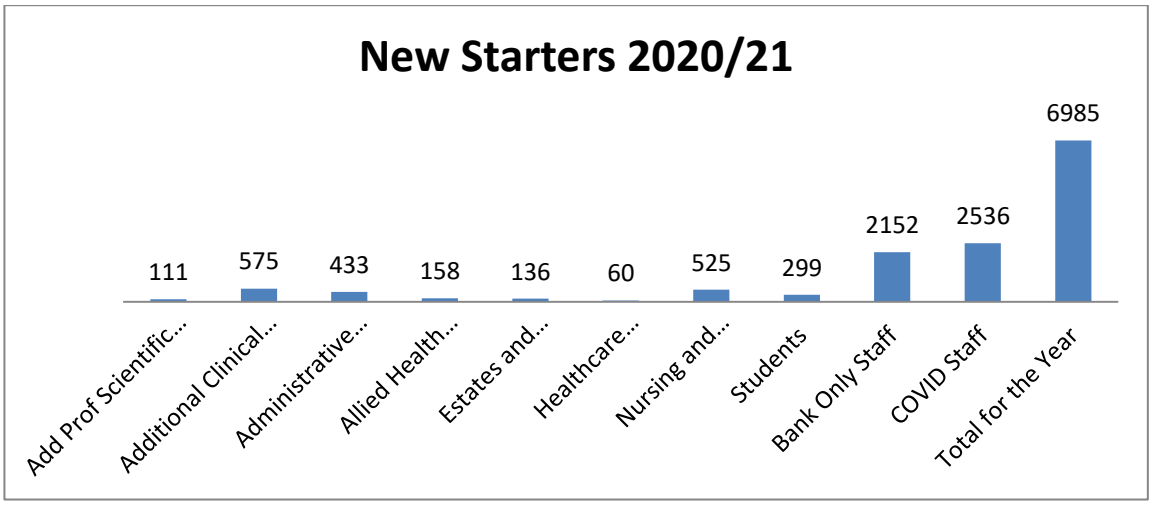
4.2.4 Implement the 2021 SAS contract.

5 Non-Medical Recruitment

5.1 Key activity 2020/21

5.1.1 <u>New Starters</u>

The number of new starters that have joined the Trust between April 2020 to March 2021 is set out in the chart below:



Recruitment of 6,985 individuals has been a substantial increase on the previous year's activity of 2,750 new starters. In addition, there have been 2,008 internal staff movements, and the implementation of 106 general honorary contracts and 98 military honorary contracts.

Face to face interviews were suspended and replaced with video interviewing to keep recruitment progressing where lockdown restrictions prevented on-site attendance and travel. This was largely positive for recruiters and candidates, and we saw a lower DNA rate than with face-to-face interviews.

A Bring Back Staff (BBS) national campaign sought to attract recently retired staff. Unfortunately, clearances undertaken by BBS did not include full checks and documentation was not shared, so we had to undertake local clearances which duplicated activity both for us and for candidates. Referred candidates were not well assessed nationally, which saw significant numbers unsuitable for deployment locally (a number were overseas staff/ pregnant/ out of practice for some years). The number of staff the campaign delivered was small.

5.1.2 <u>Time to Hire</u>

Recruitment activity heightened significantly during Q3 and Q4 which impacted on time to hire at an average 22 working days against a KPI of 21 working days. Recruitment clearances for bank staff also transferred in-year from UHB+ to the Recruitment Team.

Changes were made to ensure workforce supply could support Covid demands:

- Fast track recruitment processes were introduced for pre-registration staff and for 'Returners', 'Refer a Friends' and 'Bring Back Staff' candidates. DBS checks were accepted from another employer, or undertaken through a fast track DBS service. Occupational Health clearances were vetted in Recruitment and only positive declarations referred.

- Verification of right to live and work and pre-employment documents were checked remotely and vetted in person on first day of employment;
- References were reduced to a minimum requirement of one from current or previous employer, and start dates progressed where the reference was the only outstanding clearance;
- Memorandums of Understanding (MOU) were signed up to by local Trusts, health care providers, University of Birmingham and Royal Centre for Defence Medicine to share workforce without the need for separate employment checks in host location.

During 2020 an audit was undertaken to ensure that there were no heightened risks from the significantly increased number of staff being recruited in response to the Covid-19 pandemic and the urgency with which their on-site presence was required. The audit recommended that all scanned documentation be checked against the original documents within a reasonable timeframe. Guidance was subsequently issued from the Home Office which confirmed no requirement to retrospectively check the right to work of employees appointed using the Covid-19 adjusted checking guidance; this arrangement remains in place until 31st August 2021. The audit assured safe recruitment practices, even when operating with high volume at pace.

5.1.3 Supporting Divisional Devolution

The Recruitment Team has been reconfigured to move from an offer-to end to an end-to-end recruitment service. This will provide a structured, consistent and efficient way of managing all non-medical recruitment activity. Each Division and Corporate area now has a dedicated Recruitment lead responsible for the coordination of clearances, providing a single point of contact and greater Divisional oversight.

5.1.4 EU Settlement Scheme

From 31 December 2020, the free movement of people within the EU ceased and staff had until 30 June 2021 to complete an EU Settlement application. Targeted communications have taken place across the Trust to support staff with applying for their settled or pre settled status.

5.2 Key priorities 2021/22

5.2.1 Work closely with workforce planners and operational teams to plan against demand and capacity issues, flexing the recruitment strategies and resources accordingly.

5.2.2 Deliver an attraction programme that ensures vacancies are efficiently filled with diverse talent that also addresses broader community objectives tackling health inequalities through good employment.

5.2.3 Implement an internal and external talent engagement programme, facilitated in part through the introduction of a new Applicant Tracking

System which will also introduce efficiencies to improve the candidate experience and time to hire.

5.2.4 Create fair recruitment practices and experience through a targeted programme of work that addresses flashpoints in the recruitment cycle.

6 Employee Relations Team

6.1 Key activity 2020/21

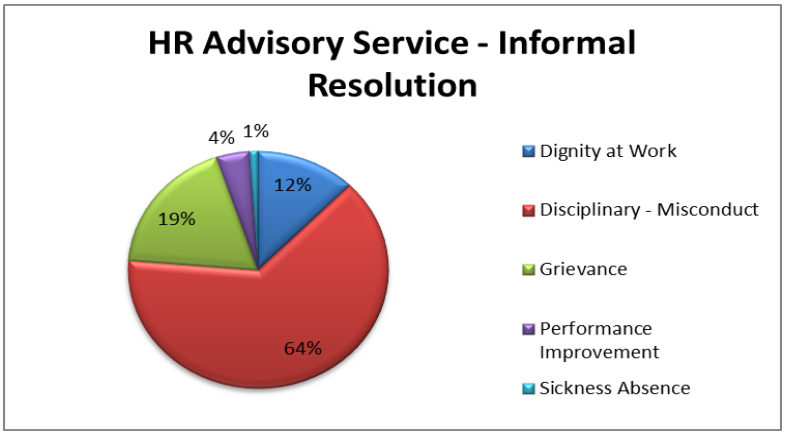
6.1.1 Supporting Divisional Devolution

The Employee Relations team have undergone a restructure to support and strengthen the divisional link between HR and Operations. A dedicated HR Manager oversees and co-ordinates employee casework/ sickness management for each Division, identifying any emerging or recurring themes within their areas. Divisional alignment is enabling more visibility of people management training needs, and the sharing of best people management practice.

6.1.2 Informal Resolution

A just and learning culture has been adopted, including early intervention, effective triaging, coaching and facilitation of mutually agreed informal resolution where possible. Resolution outcomes include mediation, facilitated discussions, local management or informal action. There has been informal resolution of 108 cases.

The below shows the split of cases resolved informally:



6.1.3 Mediation

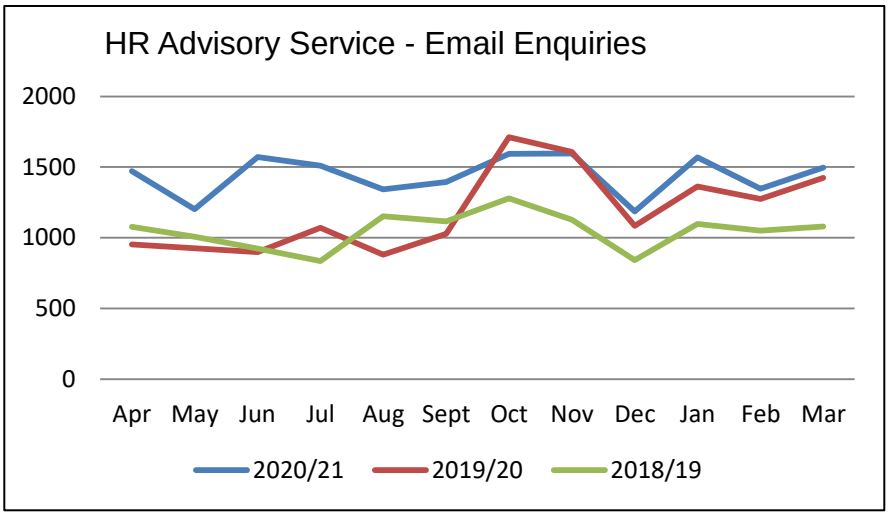
A trained Mediator has been appointed to the team, and in-year successfully resolved 7 workplace disputes. These have been mediations between two individuals, or groups of individuals, and have been at peer level and staff-manager level. Mediation has been utilised by non-clinical, nursing and medical staff groups. Cases have been complex, with entrenched positions, but through skilful mediation we

have supported individuals to move forward positively. Follow-ups take place, with sustained improvement to working relationships.

6.1.4 Advisory Service

The HR Advisory service (previously known as First Contact) is the central point of contact for all HR enquiries across the Trust.

There have been 3,037 calls and 17,281 email enquiries, a 20% increase in activity on the previous year.



The majority of enquiries relate to absence and Covid absence, annual leave, terms and conditions, and general staffing matters.

Content on the HR intranet is being expanded to provide on-demand resources for staff and managers, which we envisage will reduce the volume of enquiries.

Much advice has been in response to the changing Government pandemic guidance and how this applied in practice within the workplace. Working closely with Occupational Health, a suite of frequently asked questions and guidance were developed.

6.1.5 Sensitive Calls

There has been a rise in calls from distressed staff, and managers seeking advice in dealing with extremely emotional and complex situations, including serious mental ill health. Feedback evidences the positive impact on staff of the service. The focus remains very much on the member of staff when dealing with complex and distressing situations. However, the Advisors also make a conscious effort to support managers and their wellbeing when dealing with such issues.

Due to the rise in these types of calls, partnership working is in place with Occupational Health's Staff Counselling team. A toolkit for

managers is being developed. Pastoral support is in place for the Advisory team to manage their response to distressing calls.

6.1.6 Employee Relations Casework

In the last 12 months, there have been 322 employee relations referrals of allegations or concerns, of which 213 were formally investigated. Just and learning triaging has achieved a 20% reduction in formal casework from the previous year.

The average length of time to close disciplinary cases is 12 weeks which is an increase of 1 week in comparison to the previous year. The main reason is as a result of time constraints caused by the pandemic.

We are driving a cultural shift in the approach to formal casework management, introducing compassionate casework which is person-centred. Our Disciplinary Procedure has been developed to reflect this approach, including triaging, multi-lens decision-making at all points, clear roles and responsibilities for all parties, trained investigators and panellists, and safeguarding of staff health and wellbeing.

Cases of lapsed professional registration make up 20% of all disciplinary issues. There were also a high number of cases relating to social distancing breaches, social media misuse, or failing to engage with absence management processes.

The following table shows the total number of formal investigations closed over the last 2 year period:

Year	**2019/2020**		**2020/2021**	
Case Type	**Number of cases closed**	**Average length of case (weeks)**	**Number of cases closed**	**Average length of case (weeks)**
Disciplinary	258	11	182	13
Dignity at Work	3	23	19	14
Grievance	6	14	12	9
TOTALS	**267**	**11**	**213**	**12**

Maintaining High Professional Standards casework volumes and completion times (medical staff) are set out separately:

Year	**2019/20**		**2020/2021**	
Case Type	**Number of cases closed**	**Average length of case (weeks)**	**Number of cases closed**	**Average length of case (weeks)**
MHPS	2	28	2	30.5

The MHPS cases have been complex and multi-factorial, which combined with pandemic pressures on clinical investigators has drawn out completion times. We are developing a bank of recently retired clinical investigators to address capacity concerns.

Outcomes on all casework are outlined in the table below:

No Case to Answer	50
Informal Action/ Letter of Concern	15
First Written Warning	70
Final Written Warning	27
Dismissal	20
Resigned	17
Grievance - Outcome Informal Resolution	14

There were 21 performance improvement cases, in which 8 achieved improvement objectives, 4 were redeployed, 7 resigned and 2 employments were ended.

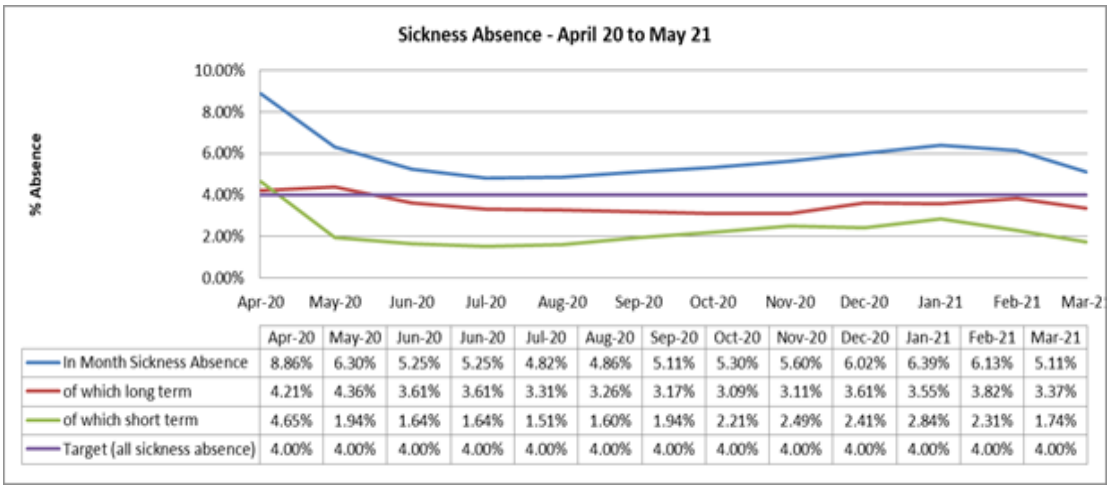
Themes and hot spots are identified, in order to implement education and training, raise awareness of procedural requirements, and embed preventative actions within Divisions.

6.1.7 Employment Tribunal Cases

There were 14 Employment Tribunal cases managed in the last 12 months, either listed during 20/21 or carried forward from the previous year. The Trust successfully defended one case, three cases were settled, two cases were withdrawn and there are currently 10 live cases.

6.1.8 Sickness Absence

In 2020/21, the Trust's annual average sickness absence was 5.80%, an increase of 0.59% from March 2020.



	Apr-20	May-20	Jun-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
In Month Sickness Absence	8.86%	6.30%	5.25%	5.25%	4.82%	4.86%	5.11%	5.30%	5.60%	6.02%	6.39%	6.13%	5.11%
of which long term	4.21%	4.36%	3.61%	3.61%	3.31%	3.26%	3.17%	3.09%	3.11%	3.61%	3.55%	3.82%	3.37%
of which short term	4.65%	1.94%	1.64%	1.64%	1.51%	1.60%	1.94%	2.21%	2.49%	2.41%	2.84%	2.31%	1.74%
Target (all sickness absence)	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%

The top three reasons for sickness absence were:

1. Anxiety/stress
2. Infectious Diseases (Covid-19)
3. Musculoskeletal.

It is acknowledged that the pressures of the Covid-19 pandemic and the infection rate itself has understandably increased the 12-month-rolling figure. At the height of the first peak in April 2020, there were 3,362 staff absent, including 740 staff shielding. In the second and third waves, staff absence did not reach the same levels, peaking at 1,068 Covid-related absences in January 2021, and 141 shielding staff. The reduction of absence between waves can be attributed to:

- Social distancing measures
- Wearing of masks in all areas
- PPE
- Collaborative working with occupational health, infection control, inclusion and wellbeing, and health and safety teams
- Management of risk assessment processes, both environmental risk management and individual risk management
- Introduction of Well-being hubs and psychological support
- Introduction of staff testing and household testing
- Homeworking and flexible working.

Long term sickness continues to be the main cause of absence from work, and has accounted for 3.53% of the total sickness absence for 2020/21 compared to short term absence at 2.27%.

As at March 2021 psychological absence represented 29% of total sickness absence (circa 9,000 WTE days lost). Nursing and Midwifery and Additional Clinical Services are the highest affected staff group.

Over the last 12 months, 434 long term absence cases have been managed, with 83% supported to return to work, either through redeployment, phased return following a long term period of absence or through active interventions such as reasonable adjustments, regular wellbeing meetings and Occupational Health assessments.

There have been 24 mutually agreed terminations where staff made a decision to end their employment on health grounds where they believe there is no prospect of being well enough to return to work.

A comprehensive training and education package is in place to develop managers' confidence and skills in supporting staff who are unwell. Bespoke absence management training is targeted at identified hot-spot areas to ensure tailored support is provided where required.

Extensions to Sick Pay Panels have been established to consider arrangements where staff members have had treatment or procedures delayed as a direct result of the pandemic.

There has been an increased focus on the impact of domestic abuse on attendance and sickness absence. The HR and Occupational Health teams have received specialist training to help identify where matters relating to domestic abuse may be a contributing factor, and are encouraged to ensure that flexibility and discretion is applied.

Staff are able to access or self-refer to health and wellbeing services which include counselling, physiotherapy, mindfulness, chaplaincy support, wellbeing hubs, psychological first aid.

6.1.9 Disability

The Trust takes a proactive approach to supporting staff with a disability, and staff are encouraged to make their managers aware of any disability in order that reasonable adjustments can be considered and appropriate support given. Disability Leave Guidance for Staff and Managers, covering special leave for planned treatment and appointments; developed in conjunction with Occupational Health, Trust staff network leads and the Inclusion team.

6.2 Key priorities 2021/22

6.2.1 Embed the Just and Learning culture throughout the Trust through staff and manager engagement. Improve staff experience of formal processes, with a solutions focussed, people centred and compassionate approach to casework, and through enhanced training for investigators, case managers and panellists.

6.2.2 Build capability and capacity of line Managers undertaking Case Manager and Investigating roles; providing training and guidance

6.2.3 Proactively drive the reduction in absenteeism; using workforce data to target hot spot areas and through strengthened divisional working.

6.2.4 Expand on-demand resources to coach staff and managers in improved employee relations.

7 Workforce Transformation

7.1 Key activity 2020/21

7.1.1 Covid-19 Deployment of Non-Clinical Staff

From Wave 2, we managed the deployment of 44 non-clinical staff in response to growing Covid hospitalisations. Staff to be repurposed were matched to available roles based on transferable skills and experience. Supported areas included vaccine centres, well-being hubs, discharge hubs and Covid marshalling, to name a few.

Responding to feedback from wave 1, steps were taken to ensure

effective communication and support for staff in repurposed roles. Substantive managers played a key ongoing role in alleviating anxieties associated with being repurposed.

Areas that hosted repurposed staff provided positive feedback, specifically praising their work ethic and critical support they provided at such a challenging time.

7.1.2 Reservist Programme

Support was provided to the Reservist Hub, a coordination centre set up at the start of January 2020 to deploy clinical staff in to ITU and to backfill vacancies created by frontline deployments. Suitable staff were identified and either retrained or refreshed to support in these critical roles. At peak, a total of 1,488 staff were deployed, including support from colleagues across the BSol network.

Should this approach be required in the future, a database of successful deployments has been maintained and an SOP developed. Testament to experiences of those involved with the Reservist Hub, a number of transfers to ITU have taken place, and there has been a positive uptake in those working clinically one day per week within ITU to ensure skills and knowledge gained during the pandemic continue to be maintained.

7.1.3 Pandemic Phase 2 Temporary Reconfigurations

The reconfiguration of Solihull Hospital for reinitiating elective surgeries, stood down in March 2020, involved the relocation of numerous wards and necessitated relocation of several services across all UHB sites. From June to August 2020, 32 wards/departments were relocated, with a total of 957 staff affected by these changes.

Whilst the changes did not follow the traditional consultation process due to the speed at which change was necessary, the principles where possible were followed including on-going engagement, staff meetings, and collaboration with our staff-side colleagues. All staff received written confirmation of the temporary changes covering a period of 12-18 months, and were assured of full consultation at a later stage, if the changes were to become permanent. Proactive and transparent engagement increased staff and staff-side buy-in to the changes.

7.1.4 Non-Covid Organisational Change

There were 38 consultations successfully closed; with a further 6 live during this period and on-going into 2021. Of the closed consultations, 11 were in response to changes to shift patterns to better meet service needs, 15 were restructures of which 12 were within Corporate, 4 job description changes, 1 relocation, 4 TUPE transfers and 3 classed as ‘other’.

7.1.5 Dispute

One notable organisational change during this period, which aimed to implement a rotational roster, led to a regrettable dispute with UNISON and Heartlands Hospital porters. On this occasion, after exhausting all other means of resolution, the exceptional decision was taken to engage in collective consultation to seek to reach mutual agreement to the new rotational roster through negotiation. Where no agreement could be reached, we would end the employment and offer immediate reengagement on new terms and conditions. After a long and challenging process, all 77 porters accepted the changes resulting in no dismissals. The new rota was implemented 01 February 2021, with 35 flexible working arrangements accommodated and negotiated terms. We engaged ACAS to conciliate, and they continue to support in helping us and UNISON to undertake an objective review of lessons learned to inform change management for all parties moving forward.

7.1.6 Redundancies

A total of 24 staff were placed at risk during 2020/21, 14 due to organisational change and 10 ending of fixed term contracts. Overall, 12 staff were successfully redeployed, 4 cases are on-going redeployments, and only 8 resulted in redundancy with approval gained from ERG.

7.1.7 Change Management

Training has been developed and delivered to equip managers with tools and confidence to lead organisational change. Leaders are being developed to identify and articulate a clear rationale for change, assessing the benefits and impact, engaging well, consulting meaningfully and supporting individuals in their response to change.

A Workforce Planning Tool and Equality Impact Assessment form have been introduced. Managers leading change are guided through a comprehensive framework of considerations probing for the rationale, scope, expected outcomes, potential impact and equality considerations. Where possible, issues are addressed and either eliminated or minimised to promote equality through all our organisational changes.

7.2 Key priorities 2021/22

7.2.1 Enhance the support provided to both managers and staff in scope for organisational change, reviewing practice and responding to training needs.

7.2.2 Engagement with Divisions and Corporate teams on their respective workforce strategies, looking at different ways of working to respond to workforce challenges within their services.

7.2.3 Follow through on post-implementation Covid Phase 2 reconfigurations

7.2.4 Backlog recovery change programmes.

8 Organisational Development

8.1 Key activity 2020/21

8.1.1 Homeworking

Pre-Covid, plans had been prepared to roll-out a homeworking programme amongst a defined group of Corporate staff. Much of the preparation work undertaken in anticipation of that roll-out was mobilised to support at-scale homeworking necessitated by the pandemic.

For April 2020, a total of 1,505 remote access licenses were enabled. Prior to this, there had typically been 50 staff per day accessing Trust systems remotely, and by the end of March 2021 this had increased exponentially to circa 1,750 remote users.

The large-scale move to homeworking has been a significant cultural shift. Toolkits, videos and procedures were developed for staff and managers in response to a survey on experiences of homeworking:

Managers

- Effective management of homeworkers;
- Holding online team meetings;
- Health and safety requirements;
- Supporting staff wellbeing;
- Domestic Violence Support.

Staff

- Health and safety as a homeworker;
- Looking after mental health and wellbeing;
- Working productively at home.

This period has highlighted the diversity of roles that can deliver work from home successfully, far more than anticipated pre-Covid. Homeworking has created an advantage to successfully fill vacancies in 'hard to recruit to departments'. As an example, the Clinical Coding team reported a 0% vacancy gap for the first time as a direct result of using Homeworking to recruit staff from a wider geographical area.

The Homeworking Procedure has been further updated; changes include removal of the 50% cap on time allowed working from home, and the introduction of permanent homeworking contracts.

8.1.2 Flexible Working

Work has been progressed to support the flexible working requirements of the NHS People Plan. Flexible working options are offered at the

outset of a vacancy being identified for filling, there is visibility in job ads of flexible working options, and guides for applicants on making a request. Enabling and supporting flexible working at UHB will support our staff to have better work-life quality, encourage recruitment of staff from a more diverse background, and help meet the changing requirements of patient expectations and care.

8.1.3 New Starter Engagement

An engagement programme has been piloted to understand the on-boarding experience of staff within their first 100 days at the Trust. This will enable improvements to support new staff and aid their retention. This has been undertaken in collaboration with the Education Department, and feedback has been incorporated into a review of the current Trust Induction, and will inform management guides.

The 100-day engagement sessions will now be rolled out on a monthly basis for the upcoming 12 months. Regular reporting and feedback, along with detailed actions plans, will be developed and implemented to support the continued improvement of the staff experience.

8.1.4 Cultural Reviews

A framework for undertaking cultural reviews in departments has been designed, and fully tested in one area. It has proved effective in crystallising what are often longstanding issues, much of which arises out of post-merger integration but is often much deeper rooted in pre-merger issues. This framework has successfully engaged management and staff. Such reviews will enable all staff to have a voice and be engaged in solutions to address issues in a fair, constructive and restorative way.

8.1.5 Internal Review

The Workforce Directorate is undertaking a period of transformation. To support this, a peer review programme has been developed, based on an appreciative inquiry model. The programme will review each department within the directorate over a 12-month period. The ambition is to develop a model, successfully trialled within the department that may be successfully deployed in other areas of the Trust, as appropriate.

8.2 Key priorities 2021/22

8.2.1 Further develop the flexible working offer, supporting managers to understand the benefits and practicalities of managing a flexible team, making resources available to staff and managers, and looking at Trust wide and local initiatives to help increase the availability and take up of flexible working practices.

8.2.2 A new framework for exit interviews and ‘itchy feet’ conversations has been designed through stakeholder feedback for implementation.

Quantitative data will be gathered via questionnaires, whilst managers will be supported and trained to conduct effective conversations and exit interviews. Analysis of outputs will inform initiatives to target reduction in areas of high turnover.

8.2.3 Implement a Talent Management Framework to enable managers to attract and retain highly skilled staff, whilst ensuring fair and diverse succession plans for future workforce demands.

8.2.4 Proactively identify areas for cultural reviews to improve team dynamics and staff health and wellbeing.

9 Occupational Health

9.1 Key activity 2020/21

9.1.1 Staff Covid Testing

Swabbing of symptomatic staff for Covid-19 commenced in April 2020, before the national roll out. Symptomatic household members were also tested to identify if staff would need to continue isolating. This enabled staff to return to work sooner if they tested negative. All Government guidance was followed for isolation of infected staff and their household. We developed a system for one-day turnaround that involved the Facilities Department delivering swabs through its Transport Service, with the driver waiting and collecting the completed test for same-day return to the Laboratory. Results reported within 24-hours of swabbing.

Using this same proven methodology, we worked collaboratively with our BSol colleagues providing a home swab service to their staff, and we were able to use their drive-through facilities.

A total of 9,276 tests were carried out, with 74% reporting a negative result and enabling 5,252 staff to return to work sooner. 29% of all tests undertaken have been of household members.

Following testing, each individual was contacted by an Occupational Health nurse with their result, health check and advice. These conversations have been challenging and emotional, and many times included issues where there had been a death or critical condition in the family due to Covid-19.

Occupational Health undertook work-related track and trace of staff who had tested positive, in conjunction with Infection Prevention and Control.

Lateral flow tests were distributed to staff in December 2020, and Occupational Health provide confirming tests for staff who test positive.

9.1.2 Shielding and At Risk Groups

At different times in the last year the Government issued advice to

Clinically Extremely Vulnerable (CEV) staff to shield from social contact. Staff worked from home where possible, either in their own role or providing support to other work areas remotely. This was a difficult time for some staff and they were extremely anxious about their health and that of their family, and Occupational Health supported staff through that.

Staff who were not CEV, but had underlying health conditions and wanted specific guidance on their own underlying health conditions also sought advice from Occupational Health on workplace risks of exposure. There were approximately 5,000 such risk-related queries.

9.1.3 Covid-19 Staff Risk Assessments

Occupational Health, in conjunction with HR, developed a Covid-19 risk assessment procedure including a standardised risk matrix for all staff, and "Occupational Health Guidance on health conditions and remaining at work during the COVID-19 pandemic". These were ratified through the Medical and Scientific Advisory Group (MSAG) which the Occupational Health Clinical Service Lead is a member of.

Occupational Health advised on the wearing of face coverings for all individuals visiting or working in the Trust, prior to Government directive.

A risk review panel was established from April 2020 to assess complex cases or cases where local arrangements had not been resolved. The multi-disciplinary panel remains in place and comprises:

- Cathi Shovlin, Director of Workforce
- Dr Alastair Robertson, Clinical Service Lead Occupational Health
- Dr Javid Kayani, Deputy Medical Director
- and a Deputy Director of Nursing.

Panels were held twice a week initially, and then weekly from September 2020. The panel has reviewed and reported on 2,084 cases. All decisions were taken with serious deliberation of the facts, and with a view to fair and equitable outcomes. The Panel has also undertaken generic risk assessments for matters such as Ramadan, pregnancy, menopause and diabetes. These have informed the published Occupational Health guidance.

Concerns about increasing evidence on risk to the BAME population were considered by the panel and reflected in the risk matrix, affording this staff population a higher level of protection.

UHB also provided BSol provision of specialist Covid-19 risk assessment advice for health care students working in the BSol area, with the University of Birmingham, Birmingham City University and University of Central Bingham. A risk panel was chaired by the UHB Clinical Service Lead for Occupational Health, and is ongoing.

9.1.4 Other Covid-19 related case work

9.1.4.1 Travel issues

As travel restrictions continually change, advice was sought on newly arriving staff from abroad, staff wishing to visit sick relatives abroad and staff wishing to go on holiday.

9.1.4.2 Skin Issues

Frequent use of hand gel and the prolonged wearing of PPE all resulted in a significant increase in staff presenting with both allergic and irritant dermatitis. Guidance on dermatitis was published. Occupational Health worked closely with the Dermatology department on severe cases.

9.1.4.3 PPE issues

As well as dermatological problems, there were also concerns about the wearing of PPE. These included staff with underlying respiratory problems as well as occupational asthma and vocal cord issues related to mask allergy.

9.1.4.4 Issues around pregnancy and work

Pregnant staff have had individual risk assessments as well as risk management of the work environment.

9.1.4.5 Post Covid (Long Covid)

As of March 2021, there were 124 staff absent due to Long Covid symptoms. A supportive resource pack for managers and staff has been developed to allow flexibility and fluctuations in the Covid-19 recovery process. The Trust also has the ability to refer staff to the Long Covid clinics.

9.1.5 Mental health

Many staff had extreme anxieties about contracting Covid-19 at work, as well as emotional issues and mental trauma arising from pandemic-pressures, which has required significant mental health support. In addition to an in-house Consultant Psychiatrist for fast-track high-need referrals and assessments, Occupational Health has an established team of in-house counsellors who work to a strengths-based model utilising a solutions-focused therapeutic programme.

To ensure a holistic programme of mental health support has been available for staff at the point and level of need, the counselling team have maintained collaborative working relationships with the Occupational Health Service Psychiatrist, the Wellbeing Team, Psychologists, Junior Doctors, Chaplains and external agencies such as

Cruse. Mental health support has been provided to newly qualified staff as well as support for managers, when needed.

We recruited three additional bank counsellors to meet peaks in demand. Delivery modes included telephone and video counselling to ensure continuity of access during social distancing restrictions and accessibility for those shielding, home working or taking carers' leave. Access to the extended service and a return to face to face counselling has been positively received by staff.

Challenges posed by remote counselling where vital indicators of risk might be missed through distanced work were mitigated in a Risk and Suicide SOP for the Counselling service, as well as focused supervision.

The number of new counselling clients continues to increase. In excess of 950 clients have accessed the service in the past 12 months, facing an average wait of 18 days for an appointment and requiring an average of 2 sessions. Mental health needs for counselling have mainly been for anxiety, work and personal relationships, bereavement and trauma. Tests administered show a large change in the perspective of clients to the difficulties that beset them. Recovery periods in the pandemic have exposed long existing difficulties in coping.

There has been a marked increase in self-referrals from BAME staff, but referrals from those identified as women still outnumber those identified as men four to one. Numbers of staff from 21-35 age group has also increased. By far the largest staff group accessing the service have been Nursing.

9.1.6 <u>Service impact and recovery</u>

There has expectedly been an exponential increase in the demand for Occupational Health guidance and intervention through the pandemic. This necessitated reconfiguring from a 5-day 37.5-hour service to a 7-day 84 hour service of 12-hour shifts. Normal work patterns resumed in February 2021 but with higher than pre-pandemic demand.

Safety-critical tasks such as managing inoculation injuries and skin assessments continued as normal. Additional resourcing was provided through repurposed clinical and non-clinical staff and through UHB+.

Clinics for immunisations and vaccinations were scaled back to prioritise Covid-19 activity. All roles were risk assessed, ensuring safety-critical work was carried out such as screening of staff who undertake exposure prone procedures. Additional clinic sessions are planned to address the backlog of appointments, and in the meantime we are assured that PPE provides staff and patient appropriate levels of protection.

Sickness absence consultations were adapted to a robust triage, providing managers with advice to support their staff. Most referrals were Covid-19 related and these consultations did take place.

Despite the Covid impact, Occupational Health maintained its service accreditation from the Faculty of Occupational Medicine for a Safe Effective Quality Occupational Health Service (SEQOHS). Assessment noted in January 2021: "The Occupational Health Service has continued to maintain the standards to meet the annual re-accreditation requirements. The provision of audit information covered a range of topics and the Service maintains a comprehensive array of clinical policies, procedures and protocols. The scope and frequency of audit is impressive, particularly in light of the COVID-19 work pressures in the hospital setting, and the Service has maintained its clinical governance arrangements."

9.2 Key priorities 2021/22

9.2.1 Provide an enhanced service and rehabilitation programme for staff with Post Covid (Long Covid) symptoms, in conjunction with the UHB Long Covid Clinical Team.

9.2.2 Redesign the service to provide an holistic programme of Occupational Health that can meet current demands and predict future needs, including a review of mental health provision.

9.2.3 Succession plan for all levels of Occupational Health including the Head of Occupational Health and Clinical Service Lead Consultant Occupational Health Physician.

9.2.4 Engagement plan to increase male access to mental health support.

10 Covid Vaccination Programme

10.1 Key activity 2020/21

10.1.1 UHB was the Lead Employer for the Birmingham and Solihull Covid Vaccination Programme. We set up an Employment Bureau in November 2020 specifically to support this programme. Between November 2020 and March 2021 we successfully recruited 6,390 staff to the Covid Vaccine Bank, of which 4,345 were new recruits not on existing bank systems. We worked closely with Redundancy Task Forces within local authorities, Job Centres, Birmingham Airport and airlines. We also attracted recently retired UHB staff, clinical and non-clinical.

10.1.2 We have filled 100% of shifts 100% of the time.

10.1.3 Management training was delivered to Workforce Leads in Vaccination Centres on how to build a culture of fairness and welfare; there have been no formal employee relations issues within this workforce.

10.1.4 We have engaged with the workforce to promote career and employment opportunities. We have held Career Conversation webinars to audiences

of more than 450, and we have seen 180 vaccine bank staff secure employment in permanent or UHB+ roles across the Trust.

10.1.5 We have also been working with the BSol ICS to make available this workforce to the wider system.

10.2 Key priorities 2021/22

10.2.1 Winter workforce planning for community and staff vaccinations for flu vaccination campaign and Covid booster vaccine, including retention of required workforce and/or renewed recruitment drive.

10.2.2 Engagement strategies to facilitate the employment progression for covid vaccine workforce.

11 Recommendations

The Board of Directors is asked to:

Receive the 2021/21 Annual Workforce Report
Accept the workforce priorities for 2021/22
Approve the publication of the Annual Workforce Report.

Cathi Shovlin
Director of Workforce
21 July 2021

APPENDIX 1

Workforce Key Performance Indicators – Trust wide

Workforce Demographics at 31st March 2021

Staff Group*	Number of Staff	FTE
Additional Professional Scientific and Technical	757	676.58
Additional Clinical Services	3966	3438.24
Administrative and Clerical	4321	3844.02
Allied Health Professionals	1323	1139.31
Estates and Ancillary	1938	1507.54
Healthcare Scientists	737	672.04
Medical and Dental	2638	2517.36
Nursing and Midwifery Registered	6204	5428.34
Students (of Nursing and Midwifery)	128	123.20
Total	**22,012**	**19346.63**

Ethnicity*	Number of Staff	%
White - British	12618	57.32%
White - Irish	292	1.33%
White - Any other White background	876	3.98%
Mixed - White & Black Caribbean	241	1.09%
Mixed - White & Black African	35	0.16%
Mixed - White & Asian	114	0.52%
Mixed - Any other mixed background	189	0.86%
Asian or Asian British - Indian	1613	7.33%
Asian or Asian British - Pakistani	1227	5.57%
Asian or Asian British - Bangladeshi	217	0.99%
Asian or Asian British - Any other Asian background	767	3.48%
Black or Black British - Caribbean	809	3.68%
Black or Black British - African	732	3.33%
Black or Black British - Any other Black background	516	2.34%
Chinese	144	0.65%
Any Other Ethnic Group	774	3.52%
Not Stated	848	3.85%
Total	**22,012**	**100.00%**

Disability%	Number of Staff	%
No	17350	78.82%
Not Declared	4052	18.41%
Prefer Not To Answer	11	0.05%
Yes	599	2.72%
Grand Total	**22,012**	**100.00%**

Age Band*	Number of Staff	%
<=20 Years	156	0.71%
21-25	1864	8.47%
26-30	3026	13.75%
31-35	2940	13.36%
36-40	2476	11.25%
41-45	2517	11.43%
46-50	2580	11.72%
51-55	2700	12.27%
56-60	2127	9.66%
61-65	1198	5.44%
65 +	428	1.94%
Total	**22,012**	**100.00%**

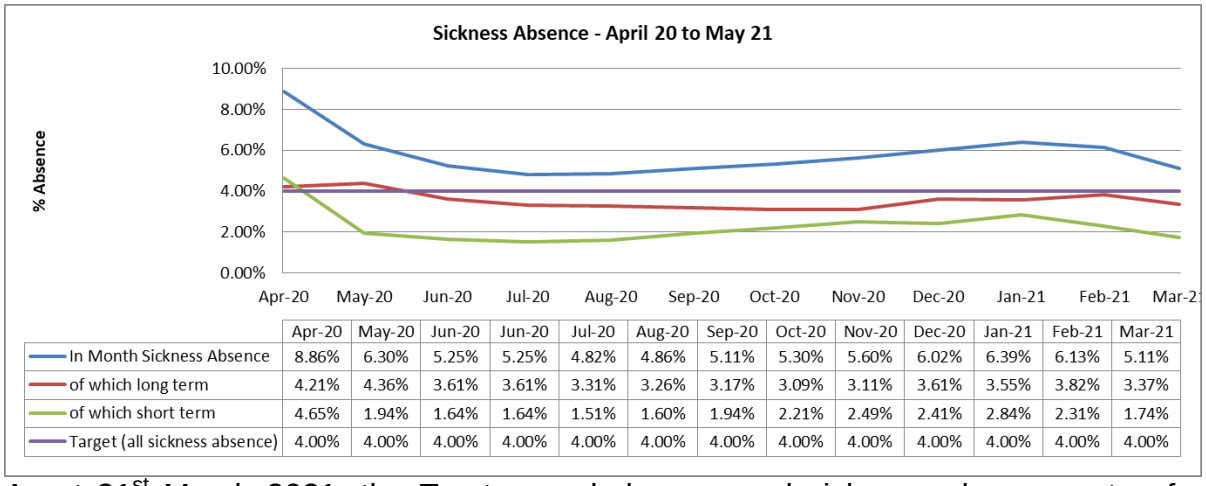
Gender*	Number of Staff	%
Female	16743	76.06%
Male	5269	23.94%
Total	**22,012**	**100.00%**

Sexual Orientation*	Number of Staff	%
Bisexual	158	0.72%
Gay or Lesbian	287	1.30%
Heterosexual or Straight	15547	70.63%
Not stated (person asked but declined to provide a response)	5988	27.20%
Other sexual orientation not listed	12	0.05%
Undecided	20	0.09%
Total	**22,012**	**100.00%**

Religious Belief*	Number of Staff	%
Atheism	1963	8.92%
Buddhism	90	0.41%
Christianity	8571	38.94%
Hinduism	515	2.34%
I do not wish to disclose my religion/belief	6842	31.08%
Islam	1952	8.87%
Jainism	7	0.03%
Judaism	14	0.06%
Other	1559	7.08%
Sikhism	433	1.97%
Unspecified	66	0.30%
Total	**22,012**	**100.00%**

* Categories taken from the national Electronic Staff Record system

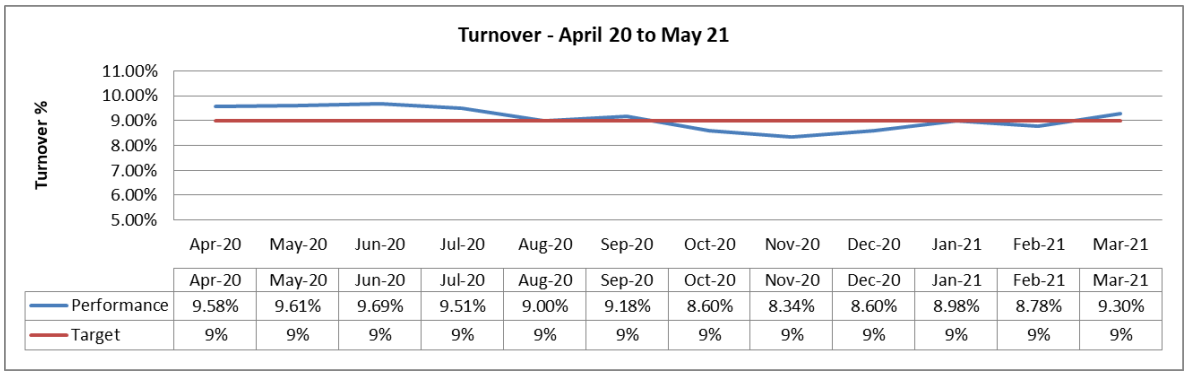
Sickness / Absence



	Apr-20	May-20	Jun-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
In Month Sickness Absence	8.86%	6.30%	5.25%	5.25%	4.82%	4.86%	5.11%	5.30%	5.60%	6.02%	6.39%	6.13%	5.11%
of which long term	4.21%	4.36%	3.61%	3.61%	3.31%	3.26%	3.17%	3.09%	3.11%	3.61%	3.55%	3.82%	3.37%
of which short term	4.65%	1.94%	1.64%	1.64%	1.51%	1.60%	1.94%	2.21%	2.49%	2.41%	2.84%	2.31%	1.74%
Target (all sickness absence)	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%

As at 31st March 2021, the Trust recorded an annual sickness absence rate of 5.80%, an increase of 0.59% from 5.21% in March 2020.

Staff turnover



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Performance	9.58%	9.61%	9.69%	9.51%	9.00%	9.18%	8.60%	8.34%	8.60%	8.98%	8.78%	9.30%
Target	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%

During the year, staff groups with the highest levels of turnover were:

Additional Professional Scientific and Technical **17.06%**
This staff group includes: Pharmacists, Operating Department Practitioners, Physician Associates and Chaplains.

Allied Health Professionals **11.62%**
This staff group includes Physiotherapists, Dietitians, Occupational Therapists, Radiographers, Speech and Language Therapists and Podiatrists

Additional Clinical Services **10.00%**
This staff group includes Healthcare Assistants, Nursing Associates (registered and trainee), Theatre Support Workers, Pharmacy Support Staff, Phlebotomists, Therapy Support Workers.

The top three reasons for leaving were:

1. Work-life balance;
2. Retirement;
3. Relocation.

Turnover (as at 31st March each year)

Staff Group	2020	2021	Grand Total	Average	Total Leavers	Turnover %
Add Prof Scientific and Technic	778	734	1512	756	129	17.06%
Additional Clinical Services	3791	3745	7536	3768	377	10.00%
Administrative and Clerical	4207	4002	8209	4104.5	348	8.48%
Allied Health Professionals	1254	1293	2547	1273.5	148	11.62%
Estates and Ancillary	1956	1911	3867	1933.5	151	7.81%
Healthcare Scientists	691	707	1398	699	50	7.15%
Medical and Dental (Exc Jnr Medics)	1181	1160	2341	1170.5	60	5.13%
Nursing and Midwifery Registered	6097	6095	12192	6096	579	9.50%
Total	**19955**	**19647**	**39602**	**19801**	**1842**	**9.30%**

Gender	Total Leavers	% of Leavers
Female	1458	79.15
Male	384	20.85
Total	**1842**	

Disabled	Total Leavers	% of Leavers
Yes	35	1.90%
No	767	41.64%
Not Declared	1040	56.46%
Total	**1842**	

Ethnicity	Number of Leavers	Percentage of all Leavers
A White - British	1054	57.22%
B White - Irish	31	1.68%
C White - Any other White background	151	8.20%
D Mixed - White & Black Caribbean	22	1.19%
E Mixed - White & Black African	4	0.22%
F Mixed - White & Asian	8	0.43%
G Mixed - Any other mixed background	19	1.03%
H Asian or Asian British - Indian	91	4.94%
J Asian or Asian British - Pakistani	103	5.59%
K Asian or Asian British - Bangladeshi	15	0.81%
L Asian or Asian British - Any other Asian background	58	3.15%

M Black or Black British - Caribbean	73	3.96%
N Black or Black British - African	68	3.69%
P Black or Black British - Any other Black background	35	1.90%
R Chinese	4	0.22%
S Any Other Ethnic Group	22	1.19%
Z Not Stated	84	4.56%
Grand Total	**1842**	