



University Hospitals Birmingham
NHS Foundation Trust

Workforce Equality Standards Report 2026

University Hospitals Birmingham
NHS Foundation Trust



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Introduction

NHS England oversees and maintains two national workforce equality data collections that promote equality of career opportunities and fairer treatment in the workplace. Providing an annual report for the Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers through the NHS Standard Contract. Although it is not a requirement, University Hospitals Birmingham NHS Foundation Trust (“the Trust”) took the decision independently to also produce an annual Workforce Women’s Equality Standard (WWES), which reports on the experiences of women at the Trust.

While this combined report demonstrates improvements across several metrics and indicators, the Trust recognises that these improvements may not be experienced consistently by all staff. Individual experiences can vary, and for some colleagues, their day to day experience may not yet reflect the positive progress reported at an organisational level.

This report draws on data from the Electronic Staff Record (ESR), NHS Jobs, and the National Staff Survey (NSS). Due to differences in reporting periods across these data sources, some comparisons are presented between 2025 and 2026, while others compare 2024 and 2025. ESR and NHS Jobs data are based on a snapshot as of 31 March 2026. Therefore, data derived from these sources compare 2026 results with 2025. However, the 2025 NSS data is collected between September and November 2025 and reported to the Trust in March 2026. As a result, NSS findings compare the most recent 2025 survey data with results from the 2024 NSS.

This year, the Trust is producing one equalities report which incorporates the 2026 WDES, WRES and WWES. Reporting in this format will allow the Trust to understand intersectional¹ progress and inequality. The Trust will also develop an intersectional action plan that takes a more inclusive approach to improving the experiences of multiple staff who share multiple identities. This plan will recognise how overlapping inequalities affect staff with multiple protected characteristics identified in this report.

¹Intersectionality (intersectional) refers to how different aspects of a person’s identity overlap and interact (e.g. race, sex, disability, deprivation), shaping their experiences of inequality.

Revisions to National Staff Survey (NSS) Q15 and implications for career progression metrics across WDES, WRES and WWES

Metric 5 of the WDES, Indicator 7 of the WRES, and Metric 7 of the WWES all relate to career progression. NHS England has revised the wording of the associated NSS question (Q15) between the 2024 and 2025 survey cycles to incorporate a broader range of protected characteristics.

The 2024 question asked: 'Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?'

From 2025, the question has been updated to: 'Does your organisation act fairly with regard to career progression/promotion, regardless of e.g. age, disability, ethnic background, gender reassignment, religion, sex or sexual orientation?'

Previous reports have used the 2024 wording, while reports from 2026 onwards will reflect the updated 2025 version. Although the phrasing has changed, the overall concept being measured remains broadly aligned, and the 2025 result should be treated as a baseline, with year-on-year comparison indicative only.

The Culture Transformation Programme

The Culture Transformation Programme sets out the Trust's approach to improving the day-to-day experience of working and training at UHB and provides a central framework to support delivery of the WRES, WDES and WWES action plans. The programme is aligned to the Trust's strategic objectives and is overseen by the Culture Transformation Programme Board. It has six key workstreams:

- Bullying and harassment prevention programme;
- Compassionate leadership;
- Preventing violence and aggression;
- Race improvement programme;
- Sexual safety;
- Stay well programme.

The Staff Networks and the Wise Council play a critical and active role in the Culture Transformation Programme.

Staff Networks

The Trust Staff Networks support the development of a more inclusive and equitable workplace. They provide a safe and supportive space for staff to share experiences, inform organisational understanding of inequality, and contribute to the co-design of policies and initiatives. Through active engagement with senior leadership and governance structures, staff networks help to ensure that diverse perspectives are reflected in decision-making. This contributes to improved staff experience, engagement, and retention. In turn, a more inclusive and supported workforce is better equipped to deliver high-quality, compassionate and culturally responsive care, leading to improved outcomes and experiences for patients.

The Wise Council

The Wise Council is a group of individuals from across the organisation who play an active role in creating a fairer and more inclusive culture. It is open to all colleagues, trainees and volunteers during their time at the Trust. The Wise Council works with the Culture Transformation Programme Board, acting as a critical friend and holding the group to account, and helping to co-design and deliver key initiatives to support cultural transformation at the Trust.

The Trust Strategy

The Culture Transformation Programme Board provides the governance and oversight required to ensure that this work is effectively aligned with, and contributes to, the delivery of the Trust's overarching strategic priorities.

The Trust's strategy and inclusion objectives are agreed until 2029. To align with this timeline, the intersectional action plan outlined in this report will run concurrently from 2026 to 2029 and is also in line with the Culture Transformation Programme.

The Trust's strategy can be found on our [website](#), and the Trust's Inclusion Objectives are below.



Workforce Disability Equality Standard

Summary of Findings

Metric 1: Representation



7.90% of staff shared their disability in 2026, from 5.60% in 2025.

Metric 4: Reporting Bullying and Harassment

54.56% of disabled staff reported harassment and bullying when it occurred from 53.45% in 2024.

Metric 5: Career Progression



46.32% of disabled staff felt that the Trust provides equal access to career progression from 44.23% in 2024.

Metric 6: Pressure at Work



26.87% of disabled staff reported pressure to work when not well enough to do so from 28.25% in 2024.

Metric 7: Feeling Valued



32.09% of disabled staff reported feeling valued from 30.79% in 2024.

Metric 4: Harassment and bullying from staff

Disabled staff are more likely to experience harassment and bullying from managers (15.99%) and colleagues (28.69%).

Metric 8: Adjustments



72.62% of staff reported having the reasonable adjustments in place they need to complete their roles from 71.79% in 2024.

Metric 9: Engagement

The engagement score for disabled staff has increased slightly to 6.12 from 6.10.

Metric 10: Board



8.70% of the overall Board shared a disability in 2026, from 8.00% in 2025.

Metric 2: Shortlisting

The relative likelihood of appointing a disabled candidate has worsened to 1.34 in 2026 from 1.17 in 2025.

Metric 3: Capability

Disabled staff are 2.94 times more likely to enter the formal capability process in 2026, though is based on a small number of staff (4).

Metric 4: Harassment and bullying from patients or public

29.10% of disabled staff reported harassment or bullying from patients, service users or the public from 26.83% in 2024.

■ More than 1% improvement
 ■ Less than 1% difference
 ■ More than 1% decline

Workforce Race Equality Standard

Summary of Findings

Indicator 1: Representation



Representation of ethnic minority staff across all bands increased to **45.40%** in 2026, compared to 43.67% in 2025. This is the highest to date.

Indicator 2: Shortlisting



The relative likelihood of appointing an ethnic minority candidate has moved closer to parity shifting to **1.40** in 2026 from 1.69 in 2025.

Indicator 6: Harassment from staff

26.95%

26.95% of ethnic minority staff reporting harassment and bullying from staff in 2025 decreased from 28.27% in 2024.

Indicator 7: Equal opportunities



45.76% of ethnic minority staff reported equal access to career opportunities in 2025, from 43.78% in 2024.

Indicator 8: Discrimination from staff

15%

15.00% of ethnic minority staff experienced discrimination in 2025 from 17.66% in 2024.

Indicator 3: Disciplinary



Ethnic minority staff are **1.20** times more likely to enter the formal disciplinary process in 2026, from 1.23 in 2025.

Indicator 4: Training



Ethnic minority staff are **0.77** times more likely to access non-mandatory training in 2026, from 0.92 in 2025.

Indicator 5: Harassment



25.07% of ethnic minority staff reported harassment and bullying from the public in 2025, from 23.87% in 2024.

Indicator 9: Board Representation



Representation of ethnic minority staff on the Board has decreased to **34.78%** in 2026, from 36.00% in 2025.

More than 1% improvement

Less than 1% difference

More than 1% decline

Workforce Women's Equality Standard

Summary of Findings

Metric 7: Career Progression



52.71% of women felt that the Trust provides equal access to career progression in 2025, from 51.16% in 2024.

Metric 9: Flexible working



70.70% of women feel that they can talk openly with their line manager about flexible working in 2025, from 67.80% in 2024.

Metric 11: Board



Representation of women on the Board has increased to **39.13%** in 2026, from 32.00% in 2025.

Metric 1: Representation

Representation of women across all bands has decreased slightly to **74.72%** in 2026, from 74.78% in 2025.

Metric 4: Bullying and Harassment

Women are more likely to experience bullying and harassment from the public (**24.56%**), managers (**10.30%**), colleagues (**21.50%**), and more likely to report it when it does occur (**56.18%**) compared to men.

Metric 5: Physical Violence

Women are more likely to experience physical violence from the public (**13.39%**) and colleagues (**2.51%**), slightly less likely to experience it from managers (**0.85%**) and more likely to report it when it does occur (**65.96%**) compared to men.

Metric 2: Shortlisting

The relative likelihood of appointing a woman has moved further away from parity, shifting to **0.83** in 2026 from 0.92 in 2025.

Metric 6: Unwanted behaviour of a sexual nature from colleagues

4.28% of women reported unwanted behaviour of a sexual nature from colleagues from 4.65% in 2024.

Metric 8: Feeling Valued

40.71% of women reported feeling valued in 2025 from 40.41% in 2024.



Metric 10: Engagement

The engagement score for women has decreased to **6.64** in 2025, from 6.66 in 2024.



Metric 6: Unwanted behaviour of a sexual nature from colleagues



9.52% of women reported unwanted behaviour of a sexual nature from patients, service users or the public, from 8.53% in 2024.

Metric 3: Absences related to women's health. This is the first year that data has been reported on this metric, therefore it cannot be compared to provide an indication of progress.

■ More than 1% improvement
 ■ Less than 1% difference
 ■ More than 1% decline

Workforce Equality Standards Action Update 2025–2026

Overview

Over the past 12 months, the Trust has continued to strengthen its approach to improving the experiences of disabled staff, ethnic minority staff, and women. This combined update brings together activity previously reported through the WDES, WRES and WWES providing a more integrated overview of progress and impact.

Workforce Representation and Progression

Disability declaration rates, alongside key ethnicity and gender workforce metrics, are monitored through site-level WDES, WRES and WWES, which are reviewed at People and Culture meetings and supported by Senior Diversity, Equality and Inclusion (DEI) Business Partners. Data has been analysed at site, Clinical Delivery Group (CDG), and specialty level, enabling targeted support, including focused engagement with underperforming specialties, and areas where improvement is required.

For example, where disability declaration rates are lower or where data quality requires improvement, targeted engagement actions have contributed to increased confidence among staff in disclosing disabilities and accessing support. This coordinated approach has improved both data quality and staff confidence in sharing, with Corporate Services becoming the first area to achieve the Trust's 10% target, reaching a disability declaration rate of 10.60% in May 2026. At the same time, Good Hope Hospital (GHH) reported the highest levels of disabled staff receiving the reasonable adjustments they require (76.90%), and the lowest levels of pressure to attend work when unwell. This demonstrates both increased disclosure and improvements in staff experience.

Alongside this, the Trust's Workplace Adjustment Officer actively encourages staff to disclose their disability when requesting support and supports managers to promote this within their teams. This has contributed to measurable improvements in staff experience, including a higher proportion of reasonable adjustments being met and a reduction in pressure to attend work when unwell. Together, this demonstrates the impact of coordinated action in improving transparency and enhancing the lived experience of disabled staff.

To enable a sustained focus and visibility of disability support and disparities, a structured communications plan has been introduced, with a dedicated disability related theme each month. This provides a consistent and coordinated approach to raising awareness, reinforcing key messages about disability, and highlighting available support. Over time, this sustained engagement is expected to improve understanding, reduce stigma, and encourage greater openness, contributing to higher levels of disability declaration and a more inclusive workplace experience.

Ethnic minority representation within the Trust workforce has continued to increase, with staff from ethnic minority backgrounds representing 45.40% of the workforce in 2026, an increase from 43.67% in 2025 reflecting a consistent upward trend over the past five years. This compares with

51.40% of the Birmingham population and 17.80% of the Solihull population, according to the 2021 Census.

At site level, Group Clinical Support Services (GCSS) (57.09%), Birmingham Heartlands Hospital (BHH) (52.81%) and Solihull Hospital (SHH) (48.43%) are more representative than the communities they serve. However, this overall representation is not evenly distributed across the workforce and does not yet translate into equitable representation at senior levels.

A clear reduction in representation is observed across Band 8a and above roles, indicating ongoing disparities in career progression. Ethnic minority representation falls from 22.90% at Band 8a to 5.26% at Band 8d, with VSM representation at 19.15%, all significantly below the overall workforce representation of 45.40%.

Band	Ethnic Minority Head Count	%
Band 8a	191	22.90%
Band 8b	55	18.27%
Band 8c	23	19.83%
Band 8d	3	5.26%
Band 9	3	15.00%
VSM	9	19.15%
Overall	284	20.65%

When the data is disaggregated by pay band, representation reduces at more senior levels. The Trust is therefore undertaking more detailed analysis by both pay band and ethnic group to better understand where disparities exist, identify those groups most affected, and inform targeted action to improve equity in career progression and leadership representation.

Further analysis shows that, although ethnic minority staff make up a larger proportion of the clinical workforce than the non-clinical workforce at senior levels, representation remains broadly similar across both groups. This suggests that higher overall workforce diversity is not yet translating into proportionate representation in senior clinical or non-clinical leadership roles.

Band	Ethnic Minority Head Count	% Ethnic Minority	White Head Count	% White	Unknown Head Count	% Unknown	Total
Non-Clinical Staff							
Band 8a	39	21.7%	135	75.0%	6	3.3%	180
Band 8b	30	20.3%	111	75.0%	7	4.7%	148
Band 8c	13	19.4%	53	79.1%	1	1.5%	67
Band 8d	3	9.1%	30	90.9%	0	0.0%	33
Band 9	2	20.0%	8	80.0%	0	0.0%	10
VSM	7	17.5%	30	75.0%	3	7.5%	40
Clinical Staff							
Band 8a	152	23.24%	489	74.77%	13	1.99%	654
Band 8b	25	16.34%	126	82.35%	2	1.31%	153
Band 8c	10	20.41%	38	77.55%	1	2.04%	49
Band 8d	0	0.00%	23	95.83%	1	4.17%	24
Band 9	1	10.00%	8	80.00%	1	10.00%	10
VSM	2	28.57%	5	71.43%	0	0.00%	7

Ethnicity data has been further disaggregated by Senior DEI Business Partners at site level to provide a more detailed understanding of ethnicity beyond high-level groupings. These insights have been reported to site People and Culture Committee meetings which inform local, targeted actions. For example, at SHH, it was identified that there is a higher proportion of ethnic minority staff working in night-shift roles. It is recognised that night-shift workers can experience reduced visibility in the workplace, which limits their opportunities for career development and engagement with the wider Trust. This insight also supports the Trust's Health Inequalities Strategy, which has a focus on improving health inequalities for ethnic minority staff.

While previous actions have resulted in an overall increase in workforce ethnic diversity, the Trust recognises that this has not yet translated into equitable outcomes across all groups. Targeted action will continue to focus on reducing these disparities and supporting inclusive career progression.

The percentage of women in the overall workforce has decreased slightly to 74.72% from 74.78%, which is broadly in line with other NHS Trusts and has not significantly changed since 2025. However, representation has increased in senior roles, with women in VSM positions rising to 63.83% from 54.97% in 2025, and women in Medical Consultant roles increasing to 34.96% from 33.89%, demonstrating a positive increase in women's representation in senior roles.

Staff survey data relating to equal opportunities for career progression presents a mixed picture compared to last year. While the percentage of disabled staff, ethnic minority and women staff who believe the Trust provides equal access to career progression has increased, non-disabled staff, white staff and men continue to report a better experience (although the disparity gap is different for each group).

Taking ethnicity as an example, through the Race Improvement Programme, the Senior DEI Business Partner and Associate Director of Inclusion have begun targeted engagement with ethnic minority staff at AfC Band 8a and above to understand the factors influencing progression. Early focus group feedback has identified recurring themes, including:

- the impact of sponsorship and advocacy;
- perceived structural barriers within existing systems and processes;
- perceived inequality in how promotion opportunities are shared across teams;
- experiences of being undermined or not fully recognised.

The Trust will build on this pilot by rolling out further focus groups across all hospital sites. Findings will be reported through the Race Improvement Programme and used to shape targeted interventions as part of the wider Cultural Transformation Programme.

Engagement scores are a key insight into how staff experience their day to day working lives. The staff engagement score for women has decreased slightly to 6.64 in 2025 from 6.66 in 2024, while the score for men has increased to 6.66 from 6.59, indicating broadly stable engagement levels overall. For disabled staff at Solihull Hospital (SHH), the engagement score increased to 6.40 in 2025 from 6.20 in 2024, the highest among all sites, demonstrating the impact of sustained local leadership and engagement activity. No engagement score is reported within WRES.

Data

The introduction of site-based equalities reports, which report on the experiences of disabled, ethnic minority and women staff, has significantly strengthened the Trust's ability to understand and respond to inequalities. These reports have provided comparative data across sites, Clinical

Delivery Groups (CDGs) and specialties, enabling more timely and targeted action. Providing this level of insight earlier in the year has enabled site and CDG leads to incorporate equality data directly into annual National Staff Survey (NSS) action planning, supporting more integrated and targeted interventions that benefit multiple staff groups.

This enhanced analytical approach supports the identification of both areas of concern and high-performing services, where inclusive leadership and management practices are positively influencing staff experience. Learning from these areas is being shared to inform wider improvement across the organisation. For example, at the Queen Elizabeth Hospital Birmingham (QEHB), CDG 8B demonstrates consistently strong performance across key WDES indicators, including high levels of reasonable adjustments (84.40%) and above-average engagement scores (6.42). This provides tangible evidence of how local leadership, management practice, and inclusive behaviours are positively influencing staff experience.

Improvements in data quality have also been achieved, particularly in relation to capability and disciplinary processes, where previously high levels of “unknown” demographic data limited the Trust’s ability to fully understand potential disparities. To address this, Associate Directors of People and Senior DEI Business Partners have strengthened data capture processes, ensuring that all staff entering formal HR processes have accurate demographic information recorded. As a result, between 2025 and 2026, there was no unknown data recorded for any individual involved in the formal capability process. This has strengthened the reliability of reporting and supported more accurate identification of disparities and targeted action.

In March 2026, the Trust produced its first combined pay gap report, bringing together disability, ethnicity and gender pay gap analysis. This provides a clearer, evidence-based understanding of disparities in pay, progression and workforce representation across different staff groups. As workforce data quality continues to improve, including declaration rates and demographic recording, the reliability and depth of this analysis will further strengthen, enabling more targeted and proportionate interventions to address structural inequalities, support fairer career progression, and deliver measurable impact across the workforce.

Together, these improvements provide increased assurance in the quality, completeness, and use of workforce equality data. This strengthens the Trust’s ability to identify disparities, target interventions effectively, and monitor progress over time, supporting sustained improvements in staff experience and equity across disability, ethnicity, and gender.

Accessibility

The Inclusive Access Steering Group, chaired by the Associate Director of Estates (and supported by the Associate Director of Inclusion, Staff Network Chairs, and Health and Safety leads), is driving tangible improvements to the working environment by improving accessibility. Over the past 12 months, this has included enhancements to accessible changing and toilet facilities and improved reporting of accessibility concerns.

In addition, the Inclusion team, staff networks and Wise Council have collaboratively refreshed the Trust’s Disability and Neurodivergence Passport, improving accessibility, aligning it more closely with staff needs, and providing clearer, more practical guidance for managers and employees.

Senior DEI Business Partners have worked in partnership with the Education Team to strengthen the disability content within the revised appraisal framework and associated training. This enhanced training places greater emphasis on disability inclusion, including communication preferences and reasonable adjustments. By equipping managers with the skills to hold inclusive, accessible, and

unbiased appraisal conversations, this approach improves the quality and consistency of support provided to disabled staff. It also helps to remove barriers to development and enables more equitable access to progression opportunities.

Following the launch of the Flexible Working Procedure, the Trust is now reporting on flexible working data, including demographic breakdowns. This has enabled detailed analysis to identify key areas of disparity. Working with the Organisational Development Team and the Occupational Health and Wellbeing Team, the DEI Compliance Partner is identifying hotspot areas with the greatest disparity in flexible working requests to support targeted interventions.

Flexible working is key to supporting staff at the Trust to achieve a better work-life balance, enabling the Trust to be a more inclusive and diverse employer, and helping to attract and retain staff to deliver high-quality patient care. This includes offering a range of options such as part-time working, flexible shift patterns, job sharing, and remote or hybrid roles where appropriate.

Line managers have been supported to have open, supportive conversations about flexible working, recognising the impact of caring responsibilities, maternity, and career progression. Monitoring uptake and outcomes for women has helped identify inequities, ensuring that flexible working supports retention, progression, and wellbeing for women across the workforce. Since last year the proportion of women who feel able to speak openly about flexible working has increased from 67.80% to 70.70%. A similar trend has also been seen in men, whose responses have increased to 67.34% from 66.92%.

Acknowledging that flexible working can also help women in the workplace, data has been collected to identify the total number of days lost in a 12 month period due to women's health related absences. However, absence recording is inconsistent meaning the Trust is currently unable to accurately determine the total number of days lost. Women's health related absences are recorded under a broad category of Genitourinary and Gynaecological absences, limiting the accuracy of reporting.

A Women's Health Strategy is being developed to address women's health inequalities within the Trust. A key focus of the strategy is improving the quality of data collected through Trust systems, such as ESR. Enhanced data reporting will enable more accurate analysis of women's health related absences and support the development of evidence based initiatives to improve the experiences of women at the Trust.

The introduction of flexible bank holidays has further supported an inclusive working environment by enabling staff to work on traditional public holidays, such as Easter and Christmas, where these are not personally observed. This allows staff to take time off at a later point to meet individual needs, including childcare responsibilities or to observe other faith and spiritual occasions, such as Eid or Ramadan.

Inclusive Recruitment

Fair Recruitment Experts (FREs) provide independent challenge and assurance for all Agenda for Change (AfC) Band 8a and above appointments. This strengthens transparency and accountability across recruitment processes and supports fairer outcomes for all staff groups. FREs offer impartial guidance throughout the recruitment lifecycle, from advert design to final appointment decisions, strengthening both challenge and accountability. As of May 2026, there are 25 active FREs, with a further 37 scheduled for training. Collectively, they have provided quality assurance across 50 recruitment processes. Further analysis will be undertaken to assess the impact on recruitment outcomes for disabled, ethnic minority, and women staff.

A new fair recruitment training programme has been developed and launched by the DEI Capability Lead, designed as a prerequisite to recruitment and selection training for all hiring managers. The training focuses on embedding bias aware recruitment practices, strengthening compliance with legislative requirements, and improving consistency in decision-making. It uses practical, Trust-specific scenarios, including content on reasonable adjustments, recruitment disparities affecting disabled candidates, and the Trust's commitments as a Disability Confident Leader. By equipping managers with the skills and confidence to recognise and mitigate bias, the training aims to improve equitable access to employment and reduce disparities in recruitment outcomes for disabled applicants. Following a successful pilot in GCSS, the programme was rolled out Trust wide in March 2026.

The Healthcare Careers Development (HCCD) team has established 'Careers Zones' across the Trust, providing accessible, community-facing hubs offering tailored advice and support into NHS employment, helping to reduce barriers for underrepresented groups. Employability programmes also include embedded pastoral support for individuals who are neurodivergent or have mental health conditions, ensuring appropriate support and reasonable adjustments throughout their journey into work.

Together, these interventions are strengthening consistency and fairness in recruitment practices, helping to reduce bias and build confidence that processes are equitable. This is reflected in localised improvements, with BHH achieving recruitment outcomes close to parity (1.01) for disabled staff, SHH demonstrating the most positive recruitment outcome for women (0.66), and CGSS showing the strongest recruitment outcome for ethnic minority staff (1.51). However, there is not yet evidence of sustained improvement across all three areas, disability, ethnicity, and gender within the same site or CDG.

Bullying, Discrimination and Anti-Racism

Across BHH and SHH, targeted work has been undertaken to address bullying and harassment, with DEI Business Partners using NSS data to identify hotspot areas across CDGs. Engagement with hotspot areas has been through 'listen and learn' sessions, where DEI Business Partners have spent time speaking with staff to understand their experiences, challenges, and opportunities. This approach provides valuable qualitative insight alongside the quantitative data to inform locally targeted actions. Following these sessions, a summary of key findings is produced and shared with the senior leadership teams to co-produce actions tailored to the specific site or service. Through co-production, these actions are practical and meaningful, and have included relatively simple but important steps, such as encouraging managers to complete essential training including, 'How We Behave Matters' training, the Welcome to Leadership course and Civility Saves Lives training.

Following engagement with staff across the Trust, several staff fed back that the process for reporting incidents of violence and aggression using Radar was unclear in places. Through the Violence and Aggression Steering Group, a dedicated workstream has been established to review and improve how incidents are logged on the Radar system. Chaired by the Radar Manager, with support from a DEI Business Partner and clinical staff, the workstream has focused on simplifying the reporting process and aligning categories to ensure consistency with other data sources, such as the National Staff Survey.

Improvements to the reporting system will enable staff to report incidents of violence and aggression more effectively using clearly defined categories. This will support the capture and analysis of accurate data, helping to identify hotspots and monitor trends

Through the Trust's Race Improvement Programme, data is now being disaggregated in greater

detail to better understand variation in experience across different ethnicities and staff groups by AfC band. The Race Equality and Cultural Heritage (REACH) Staff Network and the Wise Council play a pivotal role by providing insight and challenge which is grounded in lived experience.

Work to address discrimination has been closely aligned with actions to tackle bullying and harassment, recognising the link between staff experience, culture, and reporting. At site level, greater focus has been placed on identifying areas of concern through NSS data and strengthening local oversight via site People and Culture Committees.

Within the NSS results, for ethnic minority staff there has been an improvement across three sites. Experiences of discrimination have reduced at GHH to 13.30% from 18.70%, at SHH to 14.90% from 17.20% and within corporate services to 15.00% from 17.70%, alongside a small Trust wide reduction to 15.00% from 17.66%.

The Trust has continued to progress work under the RACE Equality Code. A comprehensive evidence base was compiled by the Trust and submitted to the RACE Equality Code team. In addition, two Executive Board development sessions were delivered by the RACE Equality Code team to strengthen understanding of the framework and align leadership priorities with race equity. These sessions have also supported a more structured assessment of governance, leadership, and Trust practices.

The Trust has now received the final report; and is analysing the findings alongside an increased use of disaggregated data to better understand and respond to the experiences of ethnic minority staff across sites. This will inform an 'apply and explain' statement and future actions, to strengthen accountability and embed race equality at a strategic and leadership level. This will be progressed through the Race Improvement Programme.

The Trust has developed its first Anti-Racist Toolkit to help deliver against its Anti-Racist Statement. Based on the Seven Anti-Racism Principles and Briefings of the NHS Race and Health Observatory (NHSRHO), the toolkit provides advice and guidance to leaders and staff to address racism in the moment. The toolkit has been reviewed and updated to ensure it fully incorporates the recommendations and principles set out by the NHSRHO, strengthening its focus on practical action, accountability, and the sustained embedding of anti-racist practice across the organisation.

Faith and race are closely interconnected, as experiences of faith are often shaped by cultural and ethnic backgrounds, influencing how beliefs are practised, expressed, and understood. For many individuals, racial identity and faith are not separate aspects but overlapping parts of their lived experience, meaning that discrimination or exclusion may be experienced simultaneously on both grounds.

Recognising this intersection is important within the Trust, as it helps ensure that policies and support mechanisms are inclusive, culturally sensitive, and responsive to the multiple dimensions of identity that shape staff wellbeing and experience. To strengthen the sense of belonging for ethnic minority staff, the Trust draws on support provided by the Chaplaincy and Multifaith Services team, who offer pastoral, spiritual and religious care to patients and staff. Staff are supported to provide care in line with patient's religious beliefs through the Good Practice Guide which provides guidance on spiritual care for patients.

Antisemitism training is being developed by the Head of Chaplaincy and Multifaith Services with the Campaign Against Antisemitism Charity and other partners including the police. The final training modules will be reviewed by staff network members, the Inclusion Team, and Jewish colleagues before being launched Trust wide in Quarter 3.

The Trust has utilised the Lord Mann Review to ensure strategic alignment with its existing equality, diversity and inclusion programmes, enabling a more coordinated and evidence-based approach to tackling discrimination and improving staff experience. By mapping the review's recommendations against current policies, workforce data, and initiatives, the Trust has been able to identify gaps, duplication, and areas requiring strengthened action.

This approach supports continuous improvement by embedding clear accountability, prioritising targeted interventions, and ensuring that actions are informed by both national guidance and local workforce insights. It also enables the Trust to monitor progress more effectively, ensuring that improvements in staff experience are sustained and aligned across race, faith, and wider inclusion priorities.

Sexual Safety and Domestic Abuse

The Trust signed the NHS Sexual Safety Charter in October 2023, reinforcing its commitment to creating a safe and respectful working environment for all staff. The Charter sets out a series of principles, including clear standards of behaviour, robust policies and procedures, and effective reporting mechanisms.

The Trust is also progressing an application for White Ribbon accreditation, an initiative led by an international organisation dedicated to preventing violence against women and girls. Achieving this accreditation will further strengthen the Trust's safeguarding culture, demonstrating leadership in addressing gender-based violence and building trust with staff, patients, and the wider community.

In November 2024, the Trust launched its Sexual Misconduct Policy to meet its legal and moral responsibilities to prevent sexual harassment. The policy ensures that all staff understand their rights and responsibilities in maintaining a safe working environment and provides clear guidance on recognising and reporting sexual misconduct.

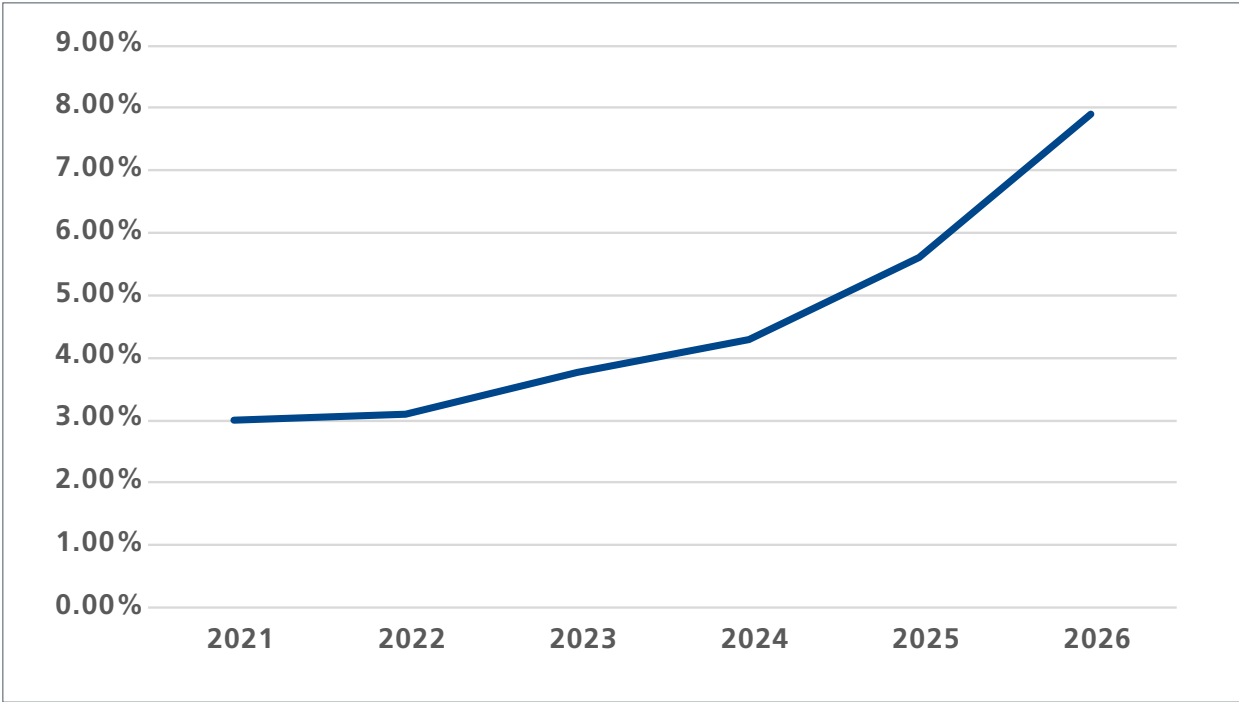
Sexual misconduct training has been implemented across the Trust, with 2,507 staff members completing the programme as of June 2026. This supports the Trust in meeting its legal duty to take all reasonable steps to prevent sexual harassment. In addition, a new reporting tool has been introduced, alongside a dedicated intranet page offering guidance, resources, and information on appropriate behaviours and reporting routes.

The Trust reviewed and updated its Domestic Abuse Policy in April 2025 to reflect changes in legislation. The revised policy ensures that clear support pathways are in place for both staff and patients, within the Trust and across the wider region.

Workforce Disability Equality Standard Metrics

Metric 1: Representation

Percentage of disabled staff in Agenda for Change pay-bands or medical and dental subgroups, and very senior managers (VSM) (including Executive Board members).



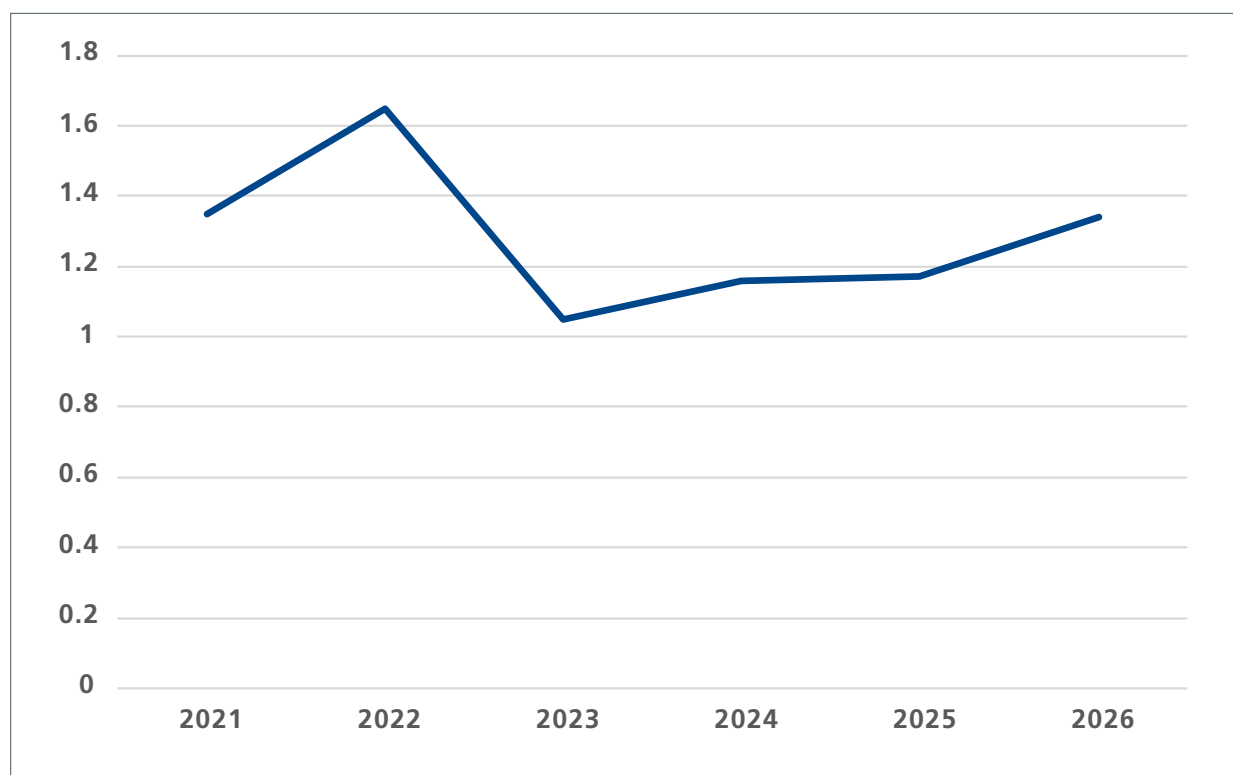
2021	2022	2023	2024	2025	2026
3.00%	3.10%	3.76%	4.29%	5.60%	7.90%

For this metric, a higher number indicates improvement.

The disability declaration rate has shown the largest year on year increase since the Trust started reporting on the WDES, rising to 7.90% from 5.60% in 2025. This has increased in both clinical staff (7.80% from 4.29%) and non clinical staff (11.20% from 7.97%).

Metric 2: Shortlisting

Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.



2021	2022	2023	2024	2025	2026
1.35	1.63	1.05	1.16	1.17	1.34

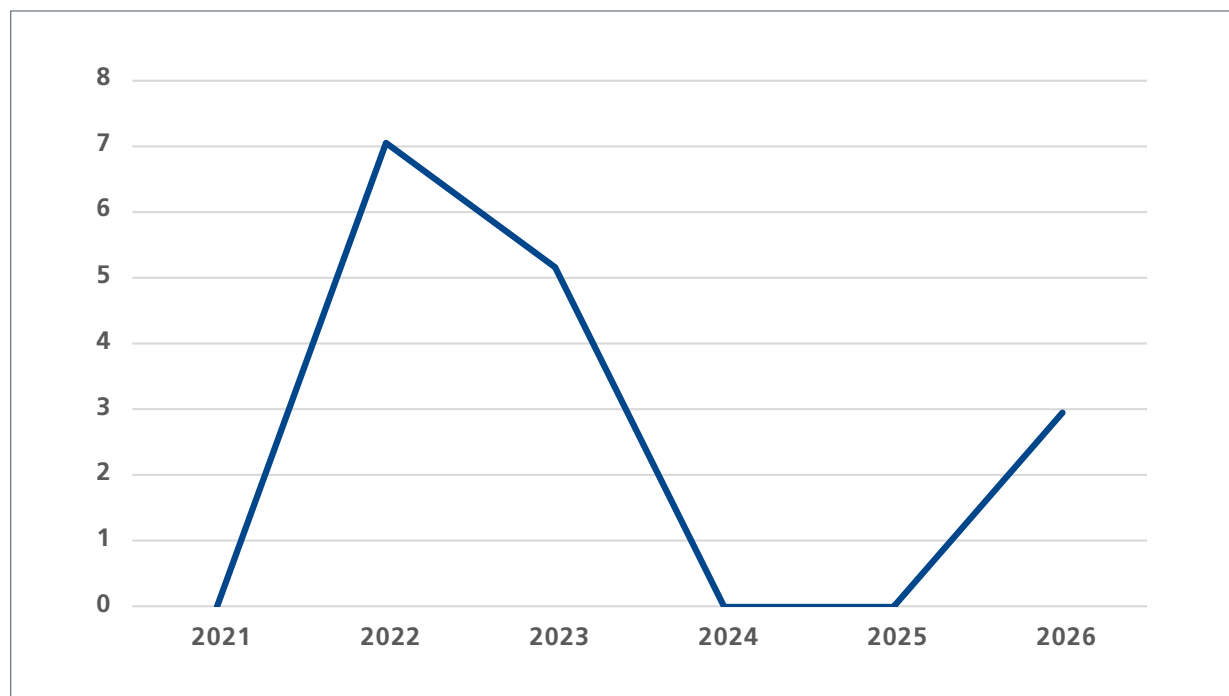
A figure above 1 indicates that disabled staff are less likely than non-disabled staff to be appointed from shortlisting.

In 2026, 24,014 candidates were shortlisted across all roles at the Trust from 01 April 2025 to 31 March 2026. Overall, 58 more candidates were appointed from shortlisting who had declared a disability compared to 2025. However, the relative likelihood of appointing a disabled candidate has worsened to 1.34 in 2026 from 1.17 in 2025.

Total Applicants shortlisted	Shortlisted who declared disability	Appointed who declared disability
24,014	1779	328

Metric 3: Capability

Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance, as measured by entry into the formal capability procedure.



2021	2022	2023	2024	2025	2026
0	7.04	5.15	0	0	2.94

A figure above 1 indicates that disabled staff members are more likely than non disabled staff to enter the formal capability process.

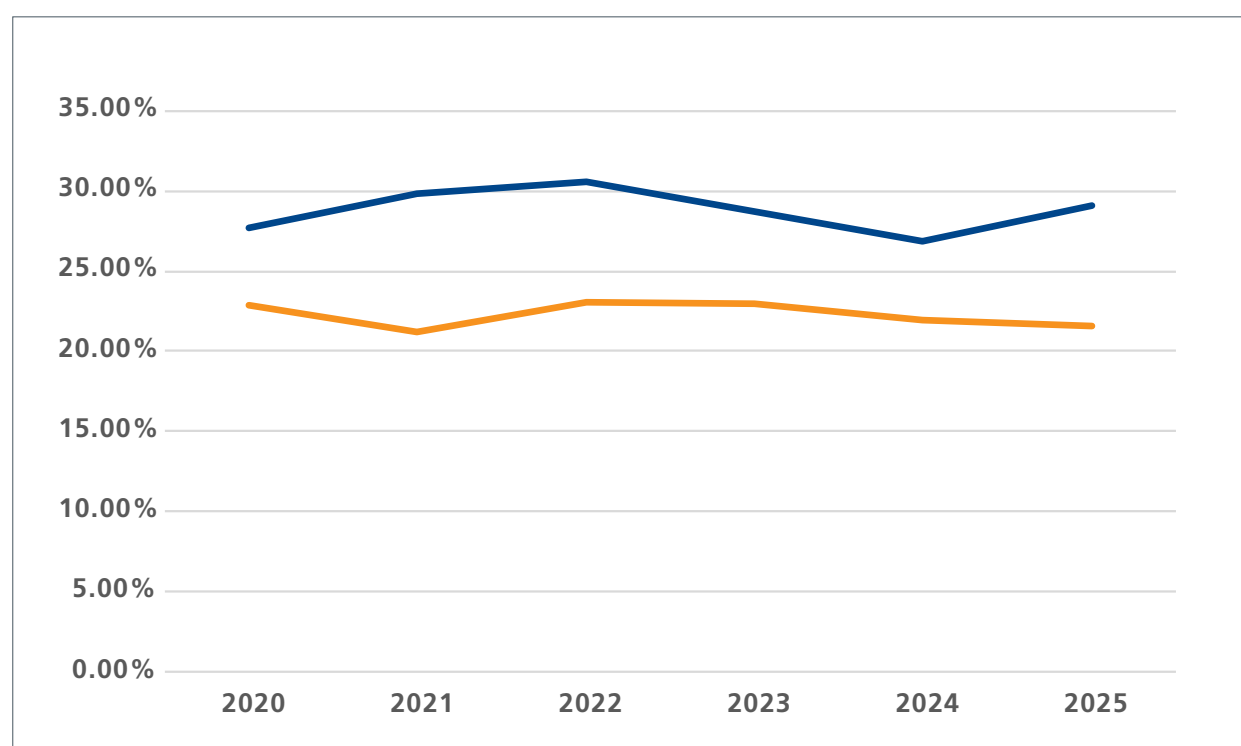
The relative likelihood of disabled staff entering the formal capability process has increased to 2.94 times more likely in 2026 from 0.00 in 2025. Of the 12 staff in this process, 4 had shared a disability and, unlike previous years, there were no staff with an 'unknown' disability status.

Metric 4: Harassment and bullying

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

- 1 Patients/Service users, their relatives or other members of the public
- 2 Managers
- 3 Other colleagues
- 4 Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

1. Harassment, bullying or abuse from patients, service users or the public

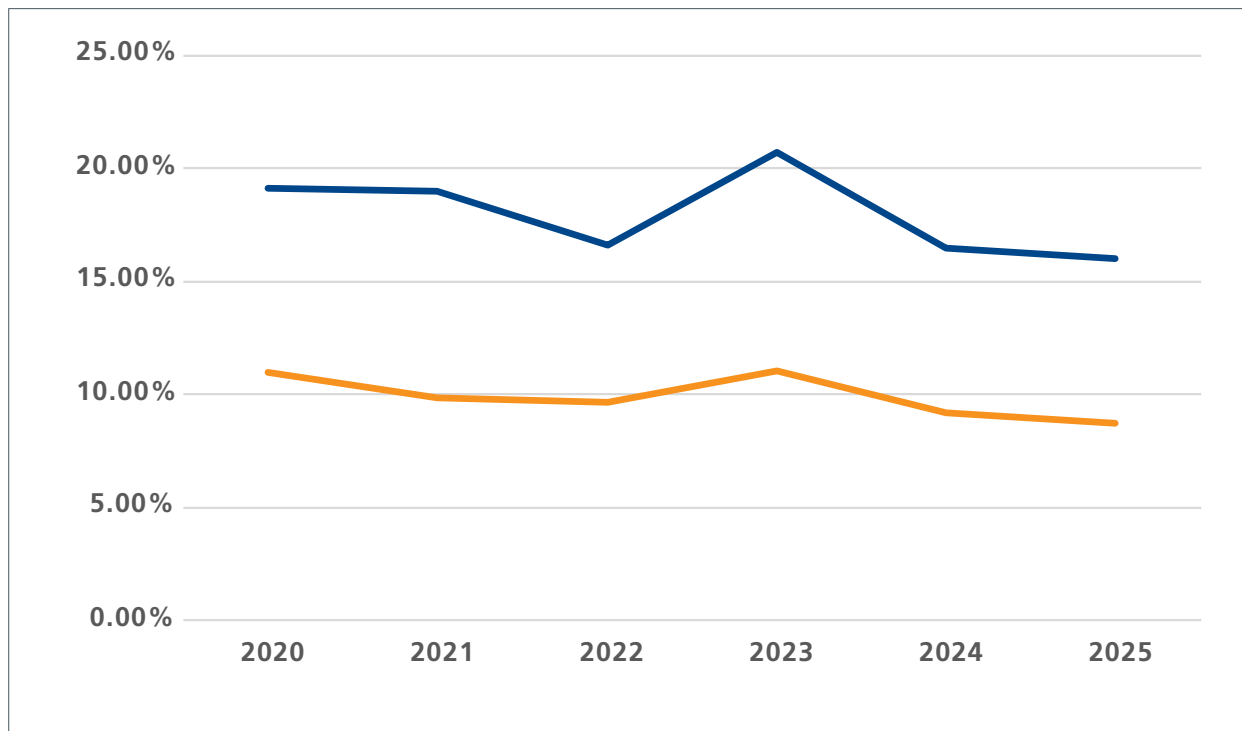


		2020	2021	2022	2023	2024	2025
	Disabled	27.70%	29.85%	30.59%	28.72%	26.83%	29.10%
	Non-Disabled	22.88%	21.25%	23.10%	23.00%	21.92%	21.62%

For this metric, a lower number indicates improvement.

The percentage of disabled staff experiencing harassment, bullying or abuse from patients, service users or the public has increased to 29.10% in 2025 from 26.83% in 2024.

2. Harassment, bullying or abuse from a line manager

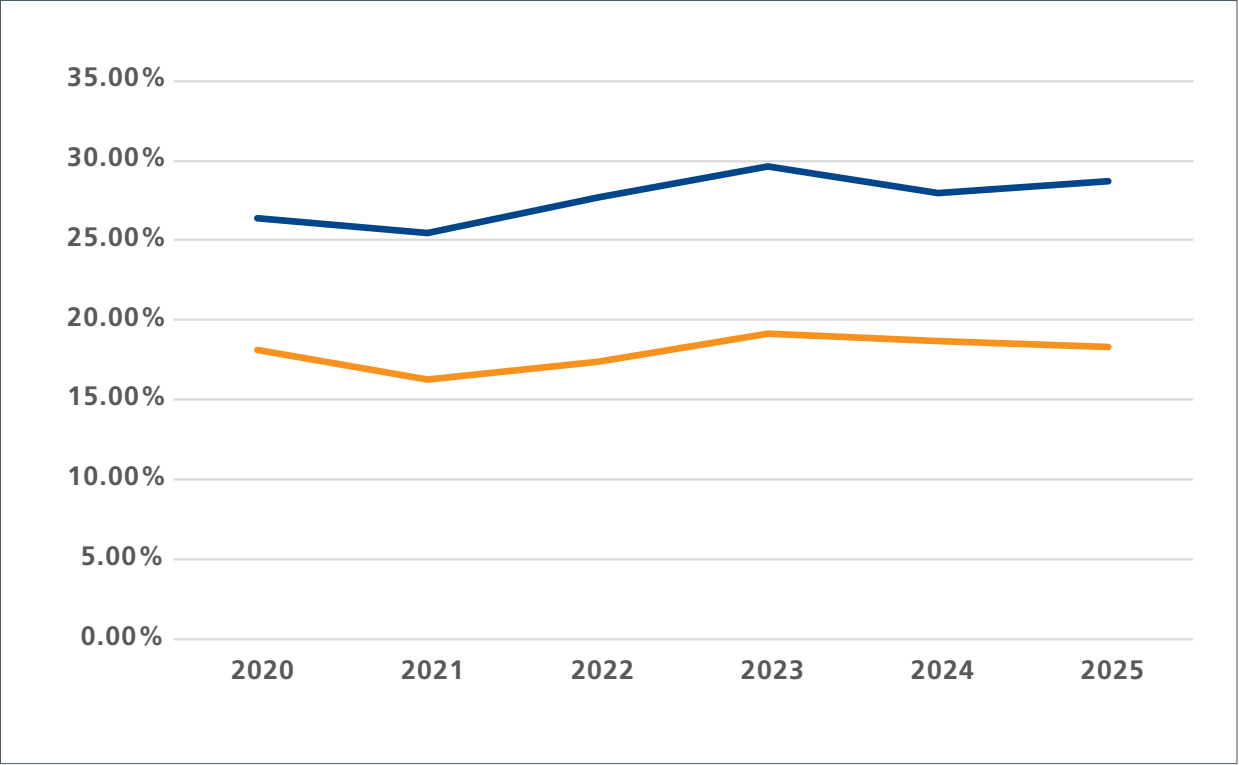


		2020	2021	2022	2023	2024	2025
	Disabled	19.11%	18.99%	16.60%	20.68%	16.43%	15.99%
	Non-Disabled	10.95%	9.81%	9.61%	11.02%	9.19%	8.71%

For this metric, a lower number indicates improvement.

The percentage of disabled staff experiencing harassment, bullying or abuse from line managers has decreased to 15.99% in 2025 from 16.43% in 2024.

3. Harassment, bullying or abuse from other colleagues

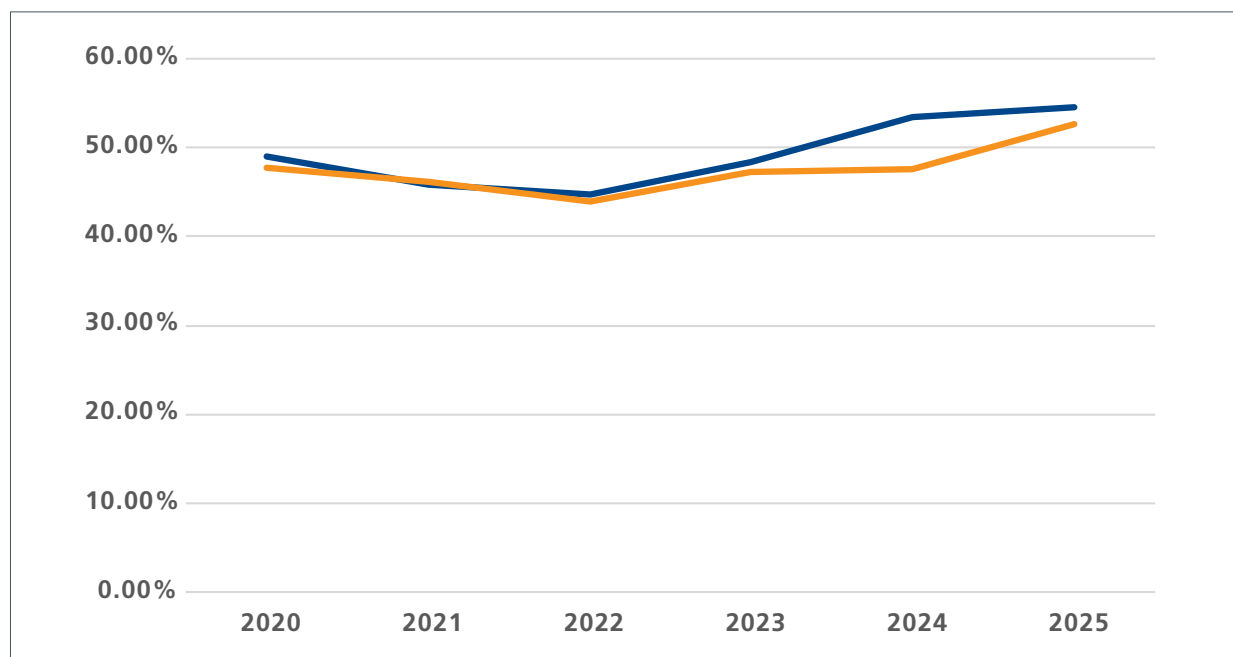


		2020	2021	2022	2023	2024	2025
	Disabled	26.40%	25.42%	27.71%	29.60%	27.92%	28.69%
	Non-Disabled	18.17%	16.24%	17.35%	19.19%	18.68%	18.29%

For this metric, a lower number indicates improvement.

The percentage of disabled staff experiencing harassment, bullying or abuse from colleagues has increased to 28.69% in 2025 from 27.92% in 2024.

4. Percentage of staff saying that the last time that experienced harassment bullying or abuse at work, they or a colleague reported it



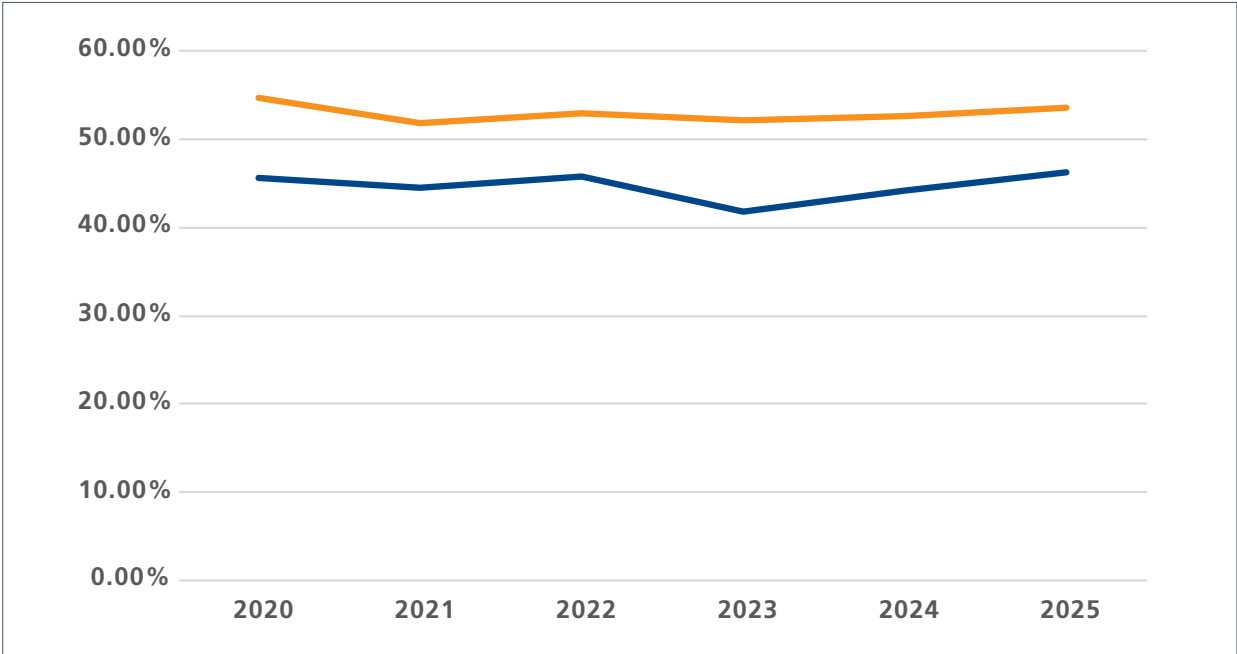
		2020	2021	2022	2023	2024	2025
	Disabled	48.95%	45.85%	44.81%	48.35%	53.45%	54.56%
	Non-Disabled	47.74%	46.09%	43.92%	47.25%	47.59%	52.62%

For this metric, a higher number indicates improvement.

The percentage of disabled staff reporting harassment, bullying or abuse when it does occur, has increased to 54.56% in 2025 from 53.45% in 2024.

Metric 5: Career Progression

Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.



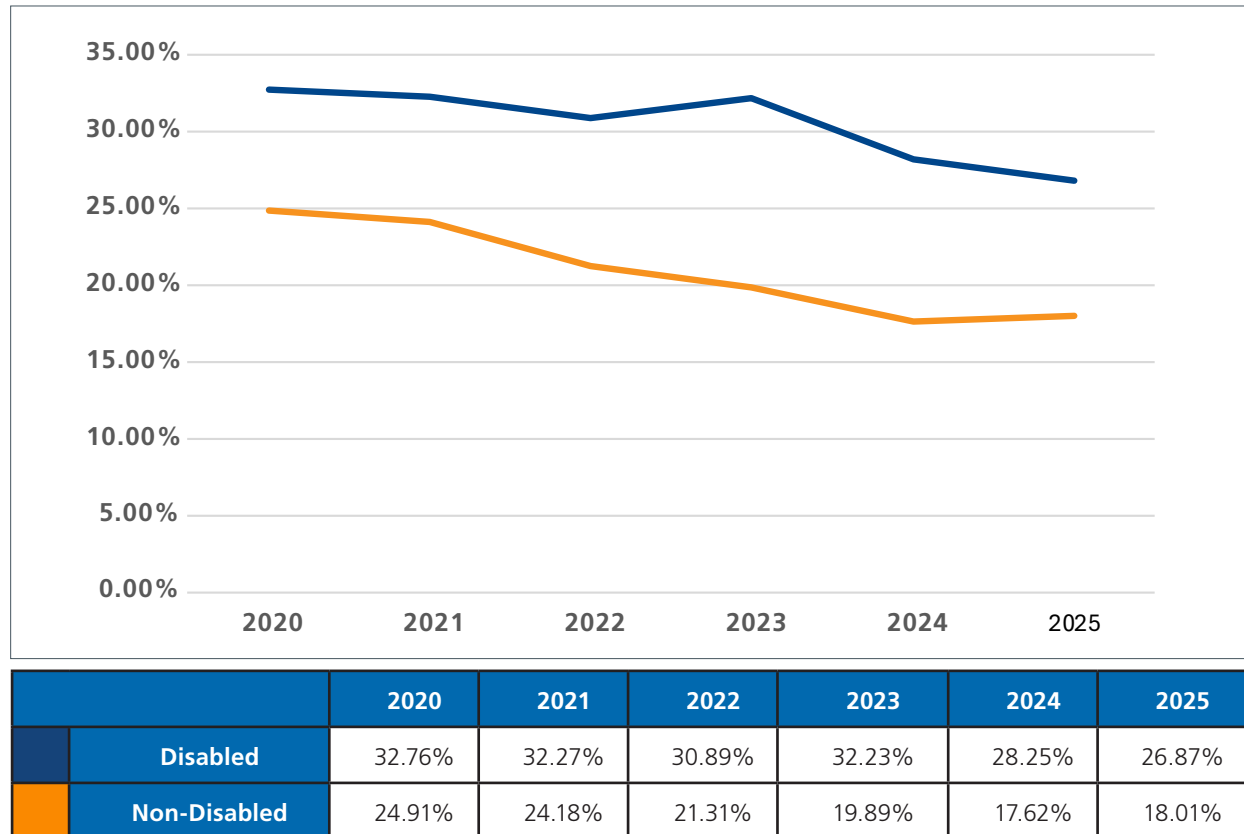
	2020	2021	2022	2023	2024	2025
Disabled	45.63%	44.49%	45.71%	41.87%	44.23%	46.32%
Non-Disabled	54.71%	51.87%	52.96%	52.17%	52.60%	53.64%

For this metric, a higher number indicates improvement.

The percentage of disabled staff who believe the Trust provides equal access to career progression has increased to 46.32% in 2025 from 44.23% in 2024, further reducing the gap between disabled and non disabled staff.

Metric 6: Pressure to work

Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

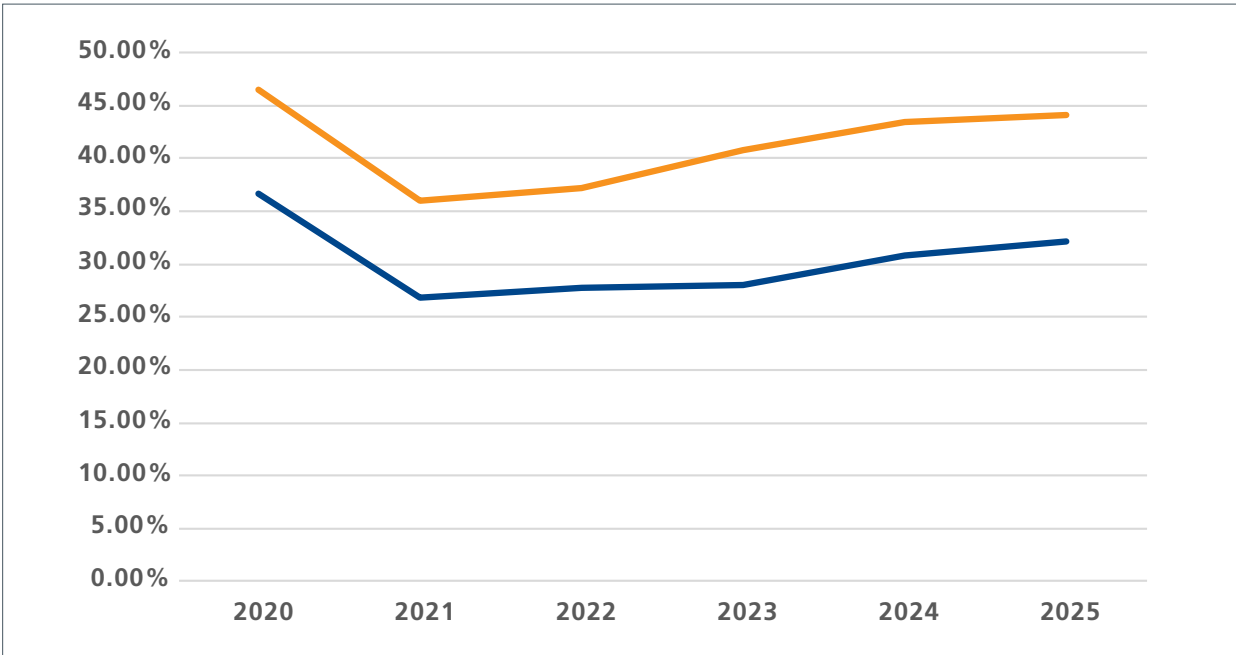


For this metric, a higher number indicates improvement.

The percentage of disabled staff reporting pressure to work has reduced to 26.87% from 28.25% in 2024, reducing the gap between disabled and non disabled staff.

Metric 7: Feeling Valued

Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.



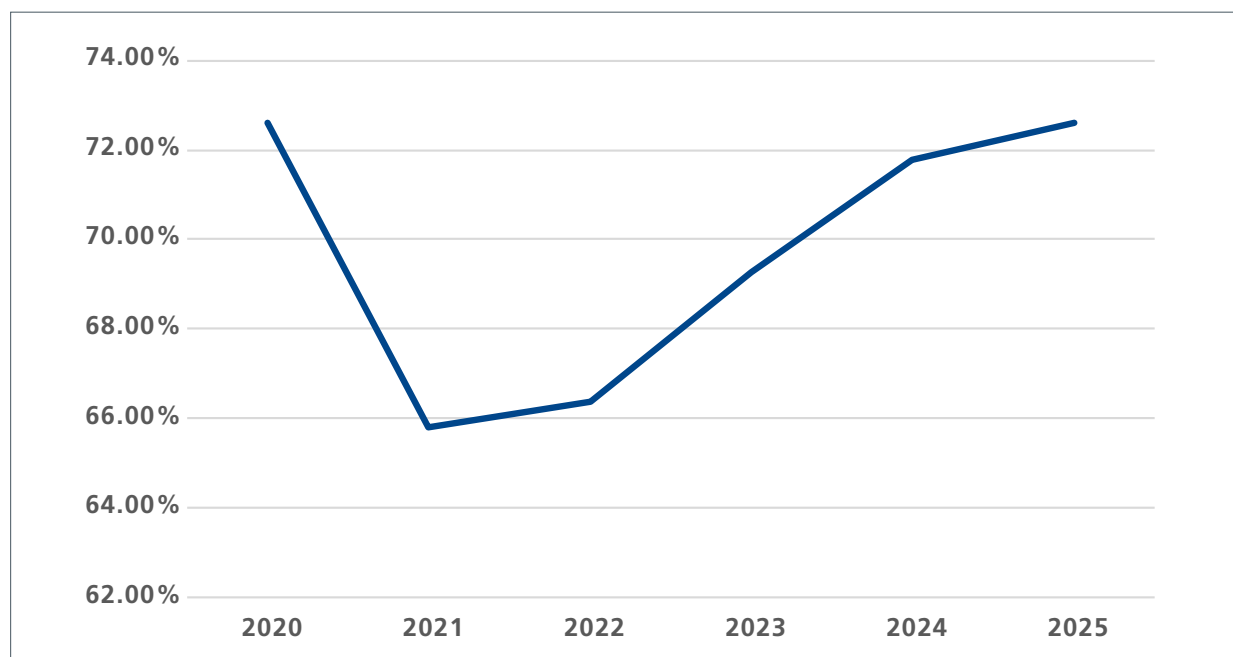
	2020	2021	2022	2023	2024	2025
Disabled	36.66%	26.80%	27.73%	28.06%	30.79%	32.09%
Non-Disabled	46.53%	36.00%	37.15%	40.82%	43.42%	44.05%

For this metric, a higher number indicates improvement.

The percentage of disabled staff reporting feeling valued by the Trust has increased to 32.09% from 30.79% in 2024, reducing the gap between disabled and non disabled staff.

Metric 8: Adjustments

Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.



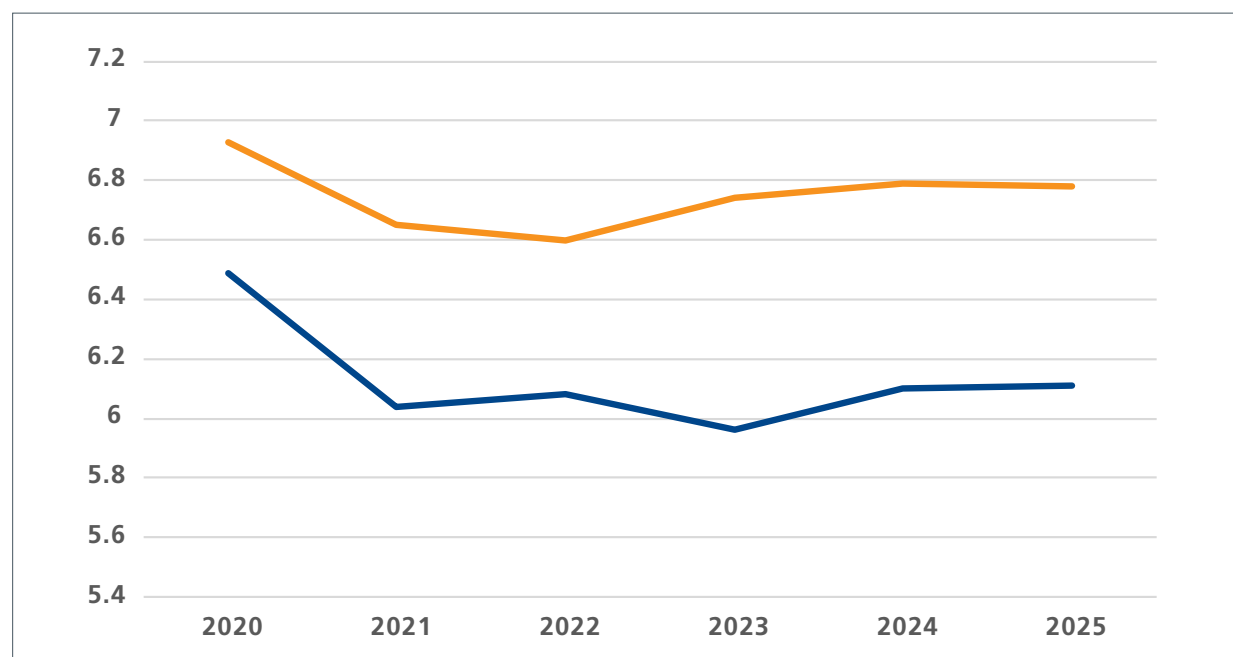
2020	2021	2022	2023	2024	2025
72.60%	65.80%	66.37%	69.27%	71.79%	72.62%

For this metric, a higher number indicates improvement.

The percentage of disabled staff stating they have the reasonable adjustments they require to do their role has risen to the highest level since reporting began, increasing to 72.62% from 71.79% in 2024.

Metric 9: Engagement

■ The staff engagement score for disabled staff, compared to non-disabled staff.



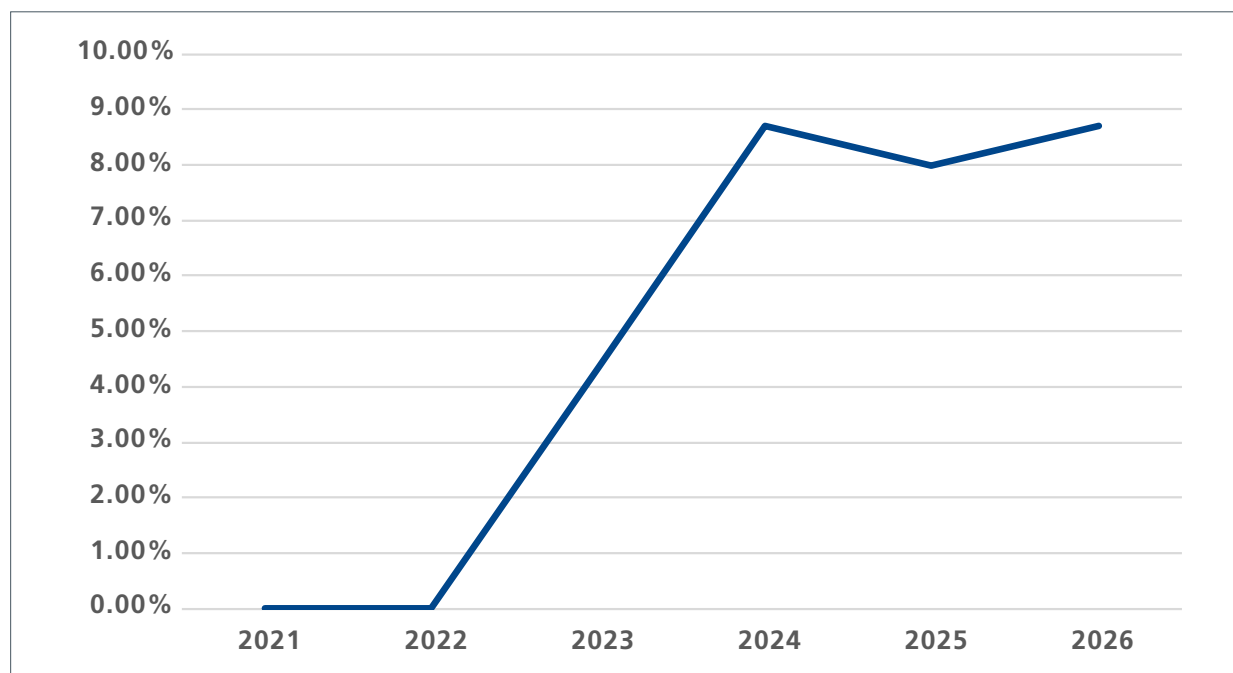
	2020	2021	2022	2023	2024	2025
Disabled	6.49	6.04	6.08	5.96	6.10	6.12
Non-Disabled	6.93	6.65	6.60	6.74	6.79	6.78

For this metric, a higher number indicates improvement.

The engagement score for disabled staff has risen to 6.12 from 6.10, compared to 6.78 for non disabled staff.

Metric 10: Board Representation

■ *Percentage of Board sharing a disability.*



2021	2022	2023	2024	2025	2026
0.00%	0.00%	4.35%	8.70%	8.00%	8.70%

For this metric, a higher number indicates improvement.

The percentage of Board members sharing their disability has increased to 8.70% in 2026 from 8.00% in 2025. Though 35% of the board have an unknown disability status.

*For a detailed breakdown of Board representation, please see Appendix 1

Workforce Disability Equality Standard Metrics Summary

The 2026 WDES data shows clear improvements in the experiences of disabled staff at the Trust. Representation has improved significantly, with the disability declaration rate increasing to 7.90% (the largest year-on-year rise recorded) indicating growing confidence among staff to share their disability status. Disabled staff remain more likely to report harassment and bullying when it occurs (54.56%) and have seen meaningful improvements in pressure to work when unwell (26.87%), feeling valued (32.09%), and access to career progression (46.32%).

No metric has worsened by more than two percentage points. Although disparities remain between the experiences of disabled and non-disabled staff, many of these gaps have reduced when compared to previous data. The relative likelihood of entering the formal capability process has worsened. This is based on small numbers of staff (12), and for the first time there are no “unknown” data points, meaning the reliability of the data has increased significantly when compared to previous years. The relative likelihood of recruiting disabled candidates has also worsened to 1.34 in 2026 from 1.17 in 2025.

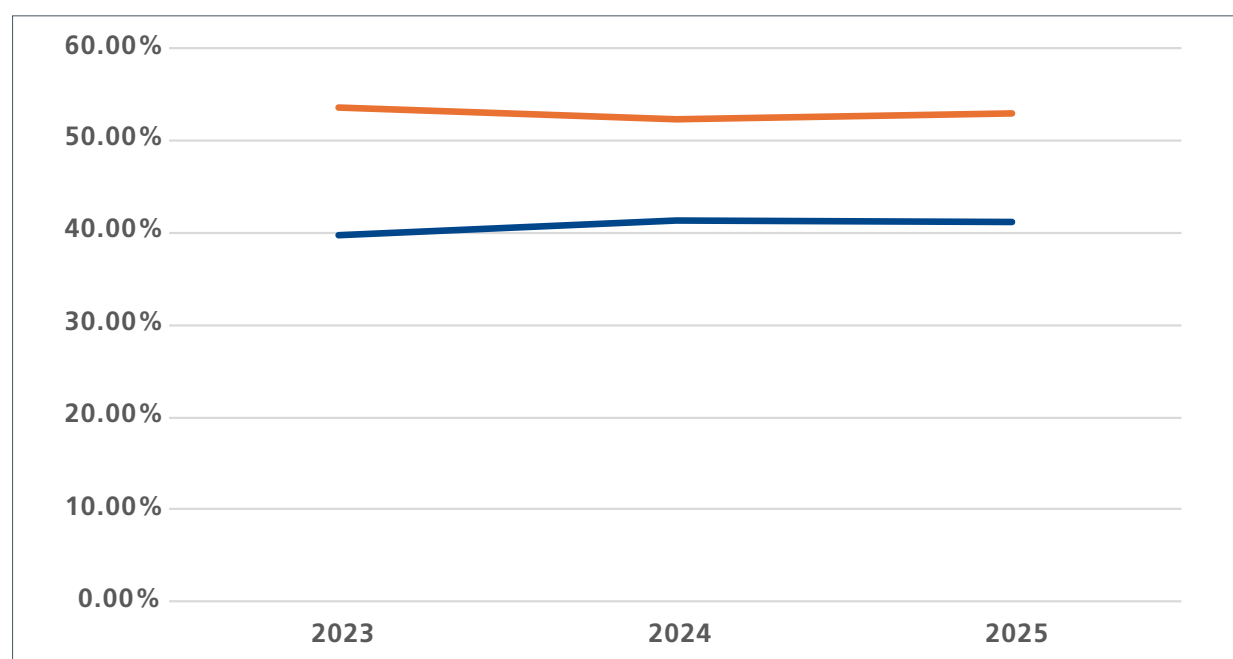
Mental Health and Wellbeing

In April 2025, the Trust achieved Disability Confident Leader status as part of the Government's Disability Confident Scheme. As part of this accreditation, the Trust has committed to publishing additional data on mental health and wellbeing within the NSS, ESR, reports from the Occupational Health and Wellbeing (OHWB) Team.

ESR data indicates that the overall disability declaration rate is 7.90% (2,097 staff). Of those staff, 14.07% (295 staff) have identified a mental health condition, an increase from 13.01% (197 staff) in 2025. However, this increase is likely to be driven by improved disability declaration rates rather than a substantive rise in mental health related disability.

Data from the 2025 NSS provides additional insight into the experiences of disabled staff.

Metric 11: I look forward to going to work

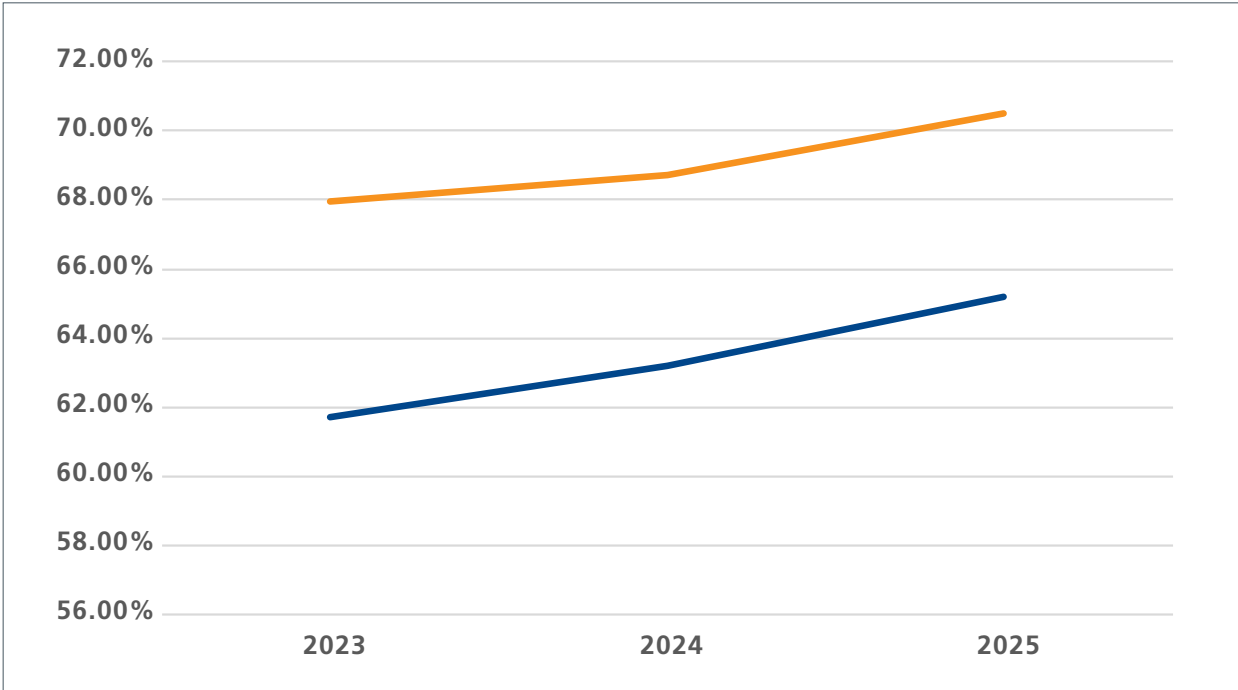


	2023	2024	2025
Disabled	39.79%	41.29%	41.16%
Non-Disabled	53.58%	52.34%	52.94%

For this metric, a higher number indicates improvement.

The percentage of disabled staff reporting they look forward to going to work has decreased slightly to 41.16% and increased slightly for non-disabled staff to 52.94%. These fluctuations represent a broadly stable position for staff reporting they look forward to going to work.

Metric 12: My immediate manager takes a positive interest in my health and wellbeing

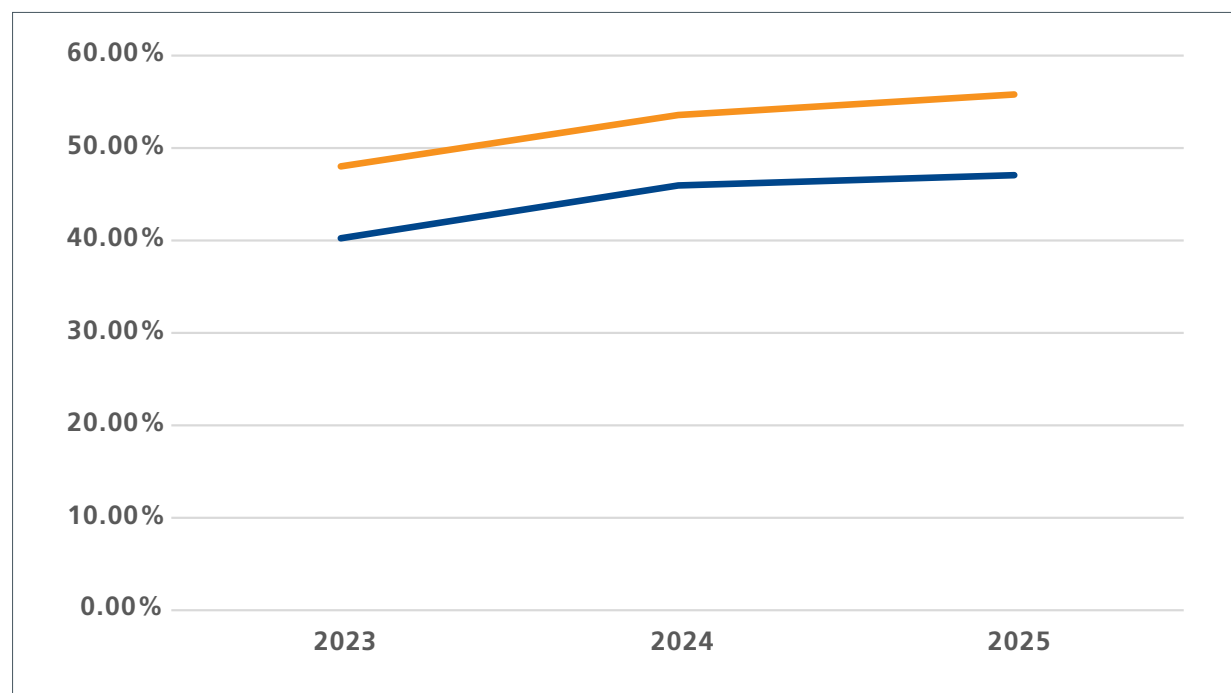


	2023	2024	2025
Disabled	61.72%	63.19%	65.20%
Non-Disabled	67.95%	68.71%	70.52%

For this metric, a higher number indicates improvement.

Disabled staff reporting that their immediate line manager takes a positive interest in health and wellbeing has increased to 65.20% from 63.19% in 2024, with non-disabled staff increasing to 70.52% from 68.71%.

Metric 13: My organisation takes positive action in health and wellbeing

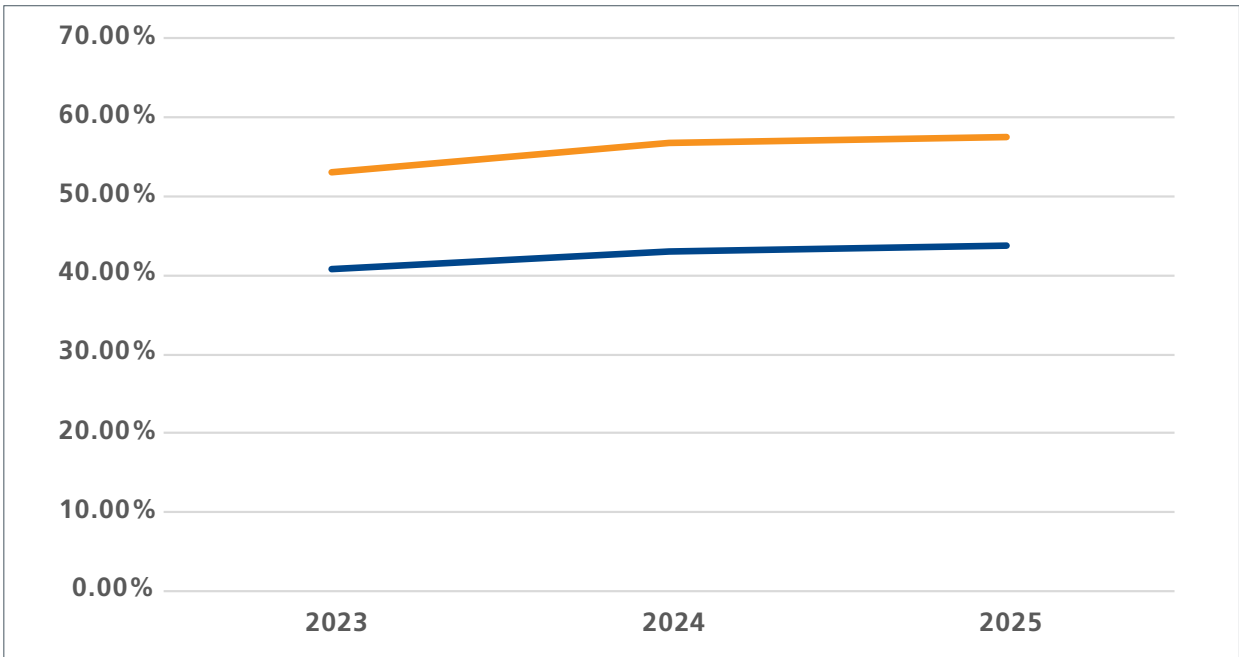


	2023	2024	2025
Disabled	40.31%	46.00%	47.15%
Non-Disabled	48.01%	53.60%	55.80%

For this metric, a higher number indicates improvement.

The percentage of disabled staff reporting that the Trust takes positive action on health and wellbeing has increased to 47.15% from 46.00%, compared to 55.80% of non disabled staff.

Metric 14: I would recommend my organisation as a place to work



	2023	2024	2025
Disabled	40.79%	42.97%	43.79%
Non-Disabled	53.14%	56.87%	57.58%

For this metric, a higher number indicates improvement.

The percentage of disabled staff who would recommend the Trust as a place to work has increased, to 43.79% from 42.97% in 2024.

The Trust’s OHWB Team has a counselling service and psychiatrist to support staff, which plays a pivotal role in supporting those with mental health conditions, helping them to remain well at work, and return to work following periods of absence.

Data for 2025/2026 from OHWB, demonstrates sustained demand for support from the team, with management referrals remaining high. Mental health and musculoskeletal (MSK) conditions continue to be the primary reasons affecting attendance and capability at work, which reflects national trends. Despite increasing demand, waiting times for management referrals have significantly reduced from over 14 weeks to approximately 3 weeks, highlighting the positive impact of service improvements within the department. This supports earlier intervention, more timely workplace adjustments, and reduces the risk of prolonged sickness absence.

Counselling and wellbeing services received 503 new counselling referrals between December 2025 and February 2026 and have 172 staff on the waiting list. Workload and work-related relationships remain the most common reasons for referral. To support earlier access and reduce escalation, a wellbeing call offer has been introduced for staff on the waiting list, delivering 125

early intervention contacts since December 2025 and supporting prioritisation and faster discharge where appropriate. The OHWB team launched Supportive Listening Training in April 2026 to upskill managers in providing first-line mental health support to their teams.

The Trust's Wellbeing Hubs provide visible, and informal routes into support. Between October 2025 and March 2026, the Hubs averaged 5,000 walk-ins per month, engaged with 1,200 staff per month through ward rounds, and delivered at least 600 pre-arranged one-to-one conversations. Staff access support for a wide range of issues, including mental health, bereavement, domestic abuse, disability-related concerns, financial wellbeing, and work-related stress. This model also includes proactive outreach and promotion of the wider OHWB offer, supporting access for staff who may face barriers to formal referral pathways. This is particularly valuable for disabled staff and those with long-term conditions. The Occupational Health Service achieved Safe Effective Quality Occupational Health Service (SEQOHS) reaccreditation in February 2026, providing assurance of high clinical and governance standards. Live dashboards and workforce intelligence now support a more targeted approach, enabling identification of hotspots, risk areas and inequality trends, to strengthen the Trust's ability to address differential experiences and improve outcomes for disabled staff.

The Chaplaincy and Multifaith Services Team (CMST) plays an important role in supporting the mental health and wellbeing of staff across the Trust by offering compassionate, confidential, and non-judgemental pastoral and spiritual care. Chaplains provide a safe space for colleagues to talk through workplace pressures, traumatic incidents, bereavement, moral distress, burnout, and personal challenges. All members of the CMST will have completed Psychological First Aid (PFA) training by 31 July 2026, enabling them to provide immediate emotional support following distressing events, help staff process difficult experiences, and signpost them to appropriate wellbeing and specialist services where required. From March to May 2026 chaplains have supported 431 members of staff through one-to-one support sessions:

- March – 194
- April – 178
- May – 59

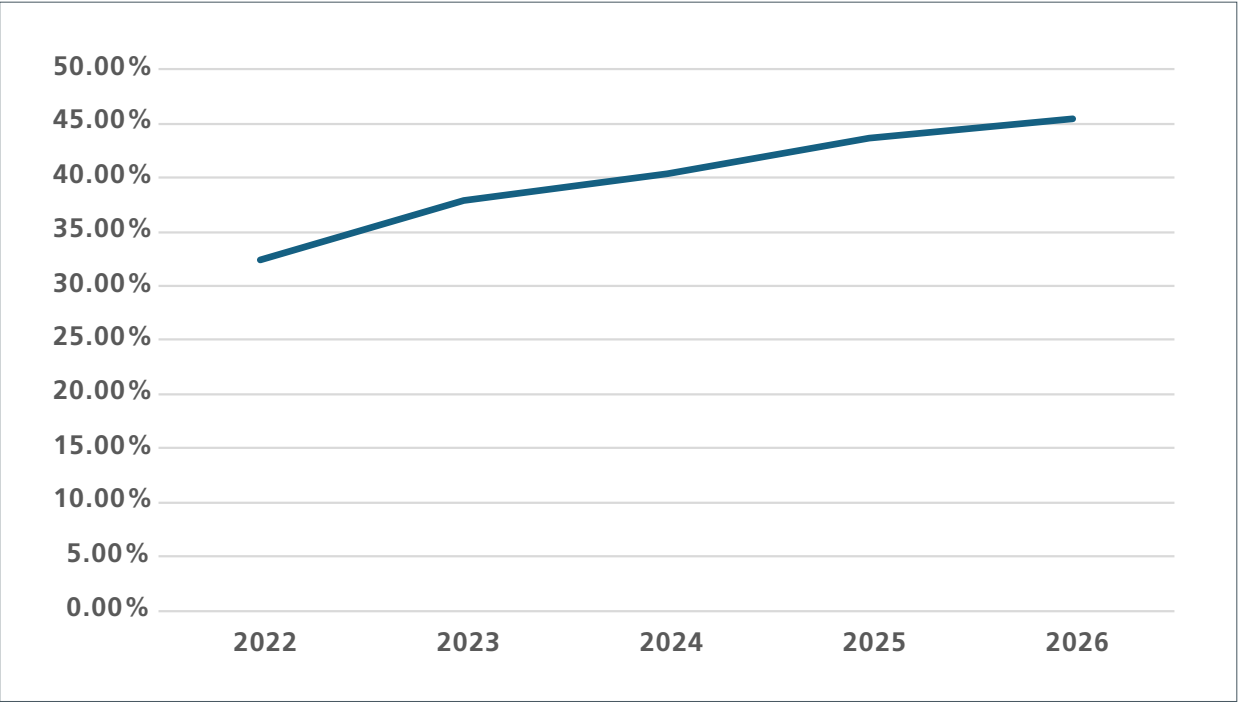
The higher levels of activity recorded in March and April were due to increased demand for support associated with major faith observances, including Lent, Ramadan and Vaisakhi, which took place during this period. Activity in May was more representative of baseline demand.

As part of the Trust's Cultural Transformation Programme, the Director of Occupational Health is leading the Stay Well programme. This programme focuses on supporting staff to remain well at work and reduce sickness absence, with a particular emphasis on mental health, MSK, and women's health. Impact will be measured through sickness absence rates particularly those related to mental health and MSK, alongside NSS wellbeing measures. The programme is aligned to the Trust strategy and will run from 2026 to 2029.

Workforce Race Equality Standard Indicators

Metric 1: Representation

Percentage of staff ethnic minority staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members).



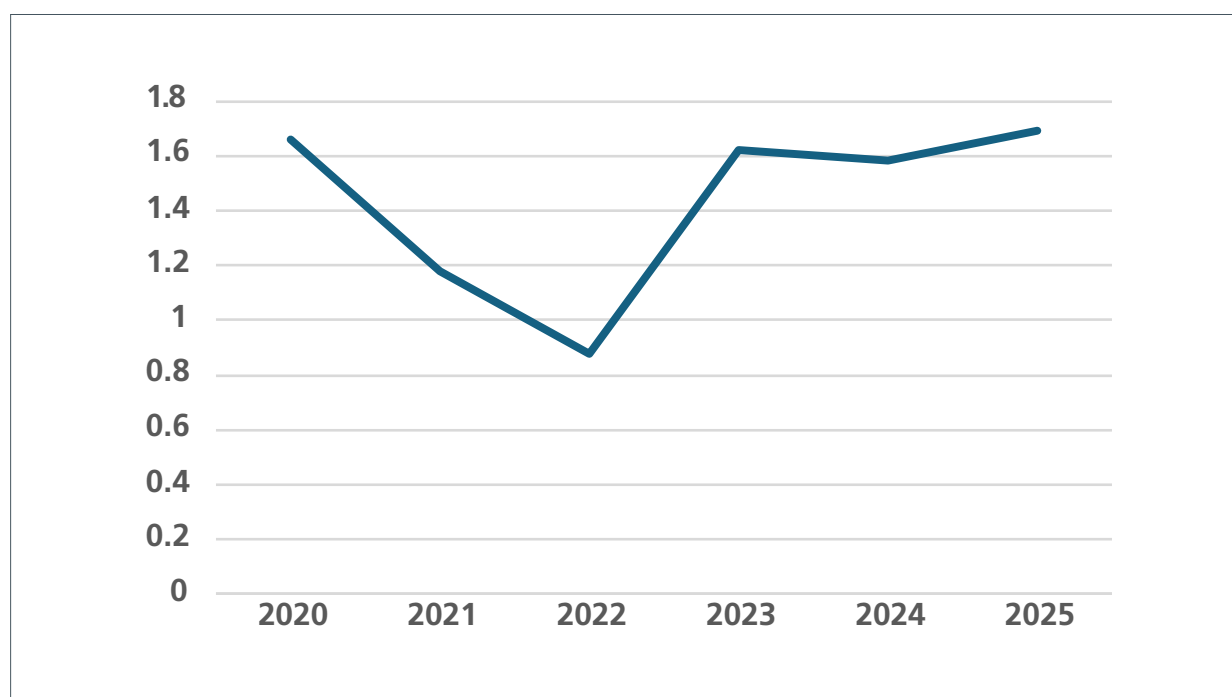
2022	2023	2024	2025	2026
32.40%	37.90%	40.37%	43.67%	45.40%

For this indicator, a higher value reflects improvement.

Representation of ethnic minority staff has increased consistently year on year, rising to 45.40% in 2026 from 43.67% in 2025.

Indicator 2: Shortlisting

■ *Relative likelihood of staff being appointed from shortlisting across all posts.*



2021	2022	2023	2024	2025	2026
1.18	0.88	1.62	1.58	1.69	1.40

A figure above 1 indicates that ethnic minority staff are less likely than white staff to be appointed from shortlisting.

The relative likelihood of appointing an ethnic minority candidate has improved to 1.40 in 2026 from 1.69 in 2025.

In 2026, 24,014 candidates were shortlisted across all roles at the Trust from 01 April 2025 to 31 March 2026.

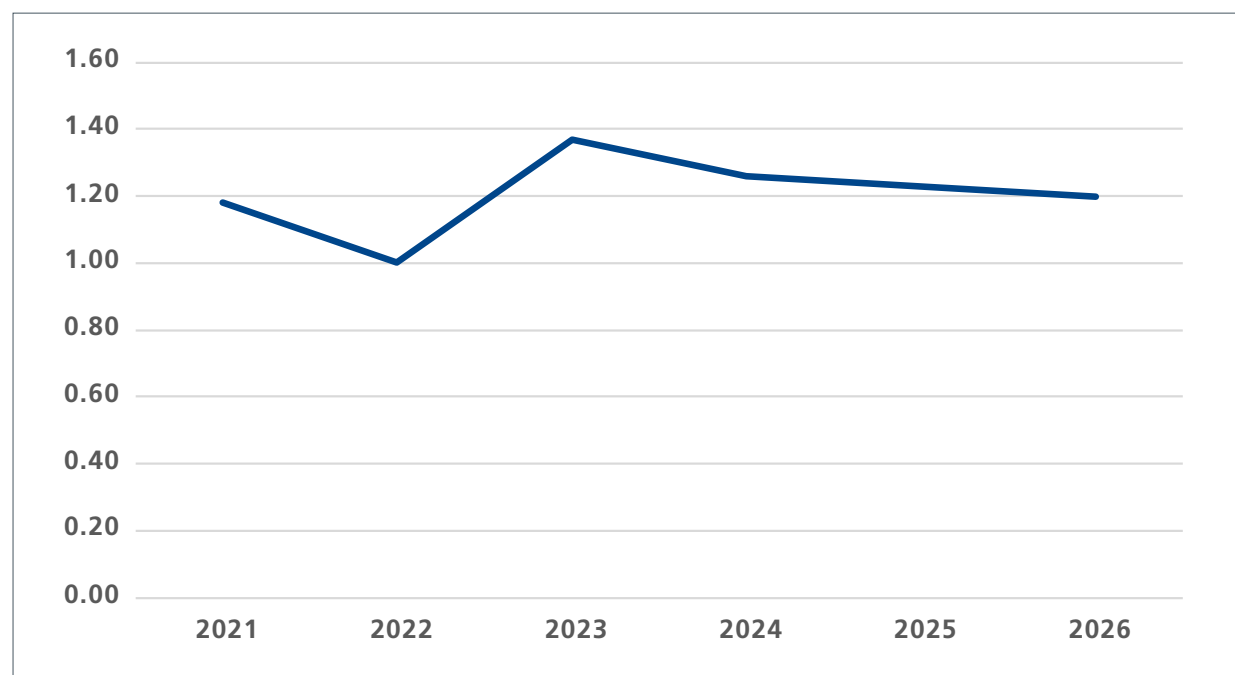
Overall, 17,055 candidates from an ethnic minority background were shortlisted, a decrease of 2,637 compared to 2025. This decline should be viewed in the context of reduced recruitment activity during the reporting period, resulting in fewer recruitment opportunities overall.

Despite this, the number of candidates from an ethnic minority background appointed increased by 784, from 2,975 in 2025 to 3,759 in 2026. In comparison, 6,208 white candidates were shortlisted, of whom 1,922 were appointed.

Total applicants shortlisted	Shortlisted from ethnic minority background	Appointed from ethnic minority background	Shortlisted from white background	Appointed from white background	Unknown ethnicity
24,014	17,055	3,759	6,208	1,922	751

Indicator 3: Disciplinary

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.



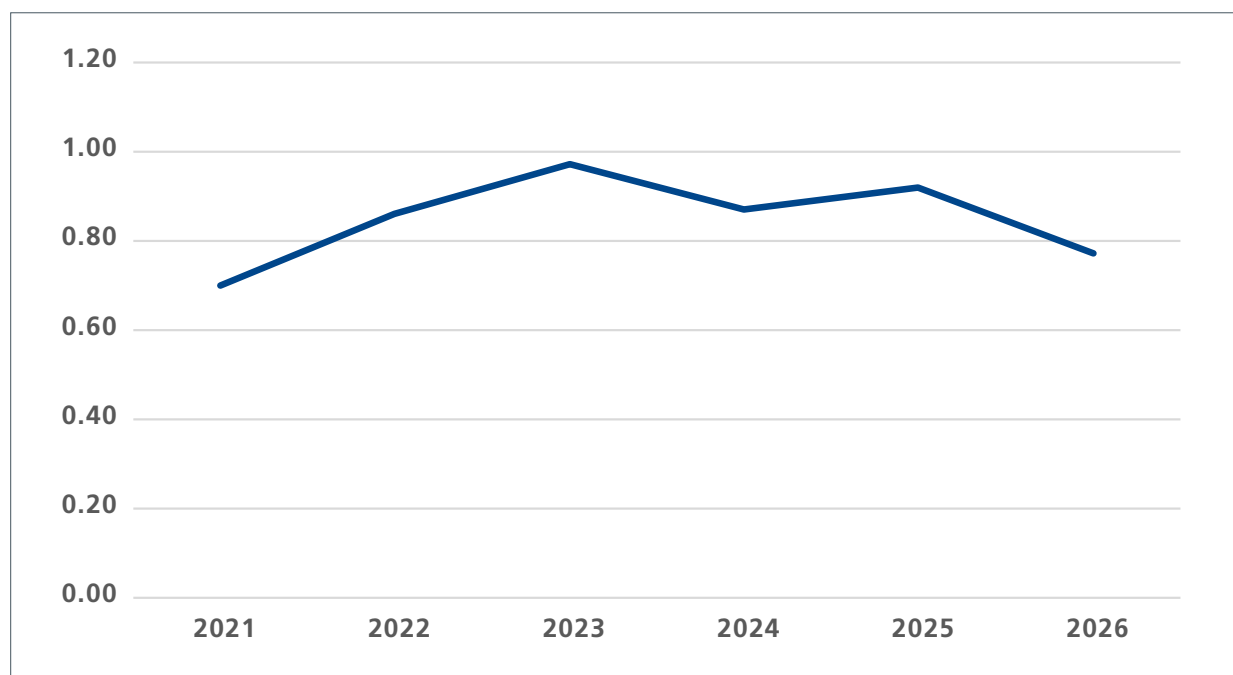
2021	2022	2023	2024	2025	2026
1.18	1.00	1.37	1.26	1.23	1.20

A figure above 1 indicates that ethnic minority staff are more likely than white staff to enter the disciplinary process.

The relative likelihood has decreased to 1.20 in 2026 from 1.23 in 2025, indicating a small improvement.

Indicator 4: Training

Relative likelihood of staff accessing non-mandatory training and Continuous Professional Development (CPD).



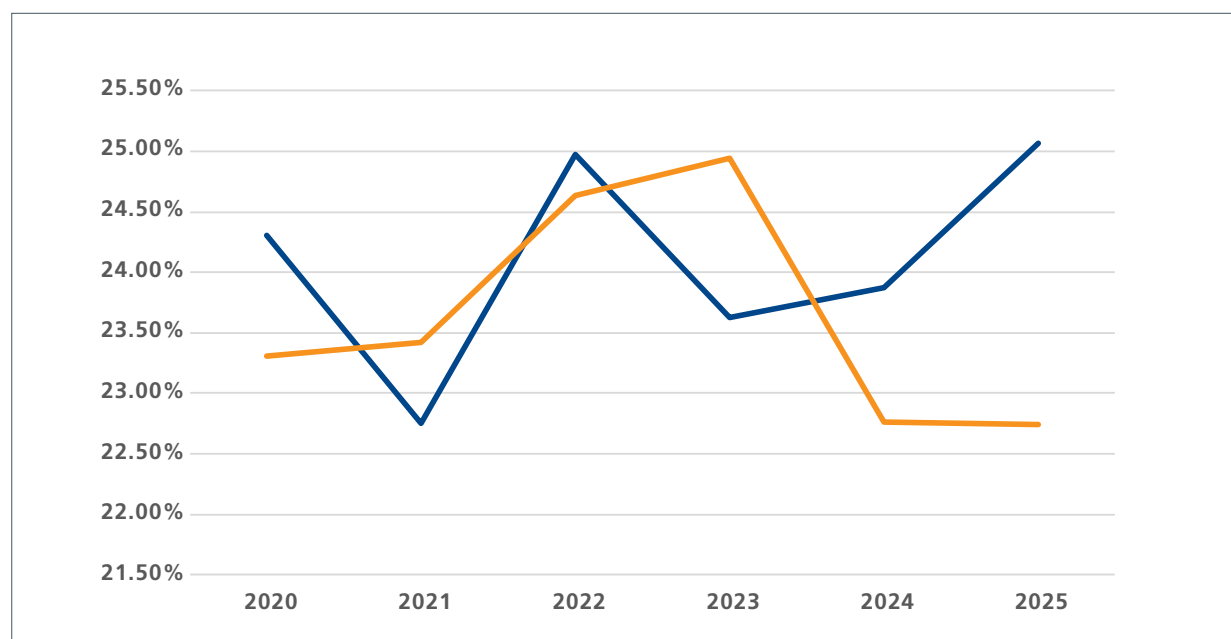
2021	2022	2023	2024	2025	2026
0.70	0.86	0.97	0.87	0.92	0.77

A figure below 1 indicates that ethnic minority staff are more likely than white staff to access non mandatory training.

The relative likelihood has decreased to 0.77 in 2026 from 0.92 in 2025, indicating that ethnic minority staff are now more likely than White staff to access non-mandatory training.

Indicator 5: Bullying and harassment from the public

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months.

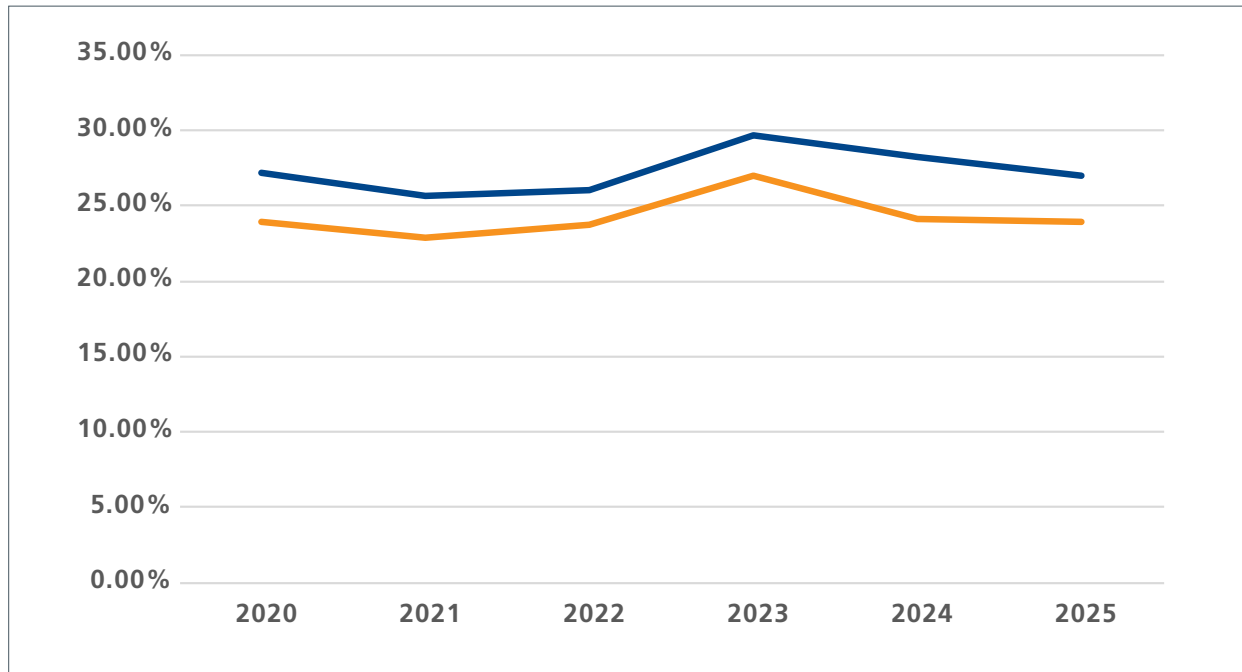


For this indicator, a lower number indicates improvement.

The percentage of ethnic minority staff reporting harassment, bullying or abuse from patients, service users or the public has increased, rising to 25.07% in 2025 from 23.87% in 2024.

Indicator 6: Bullying and harassment from staff

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.



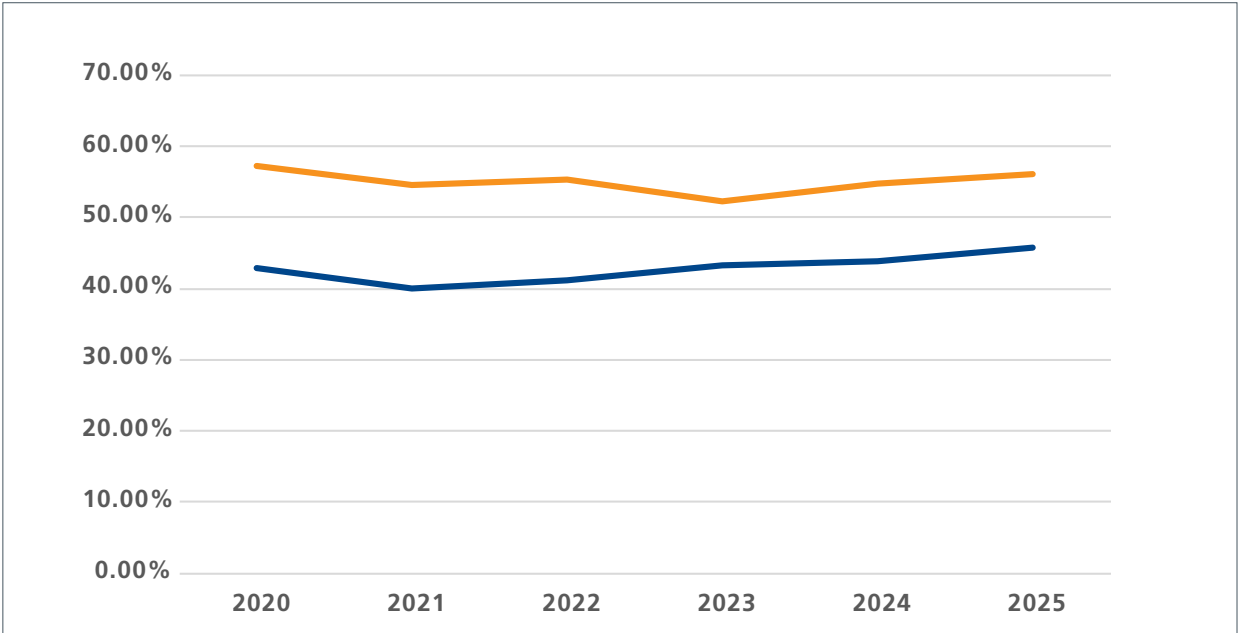
	2020	2021	2022	2023	2024	2025
Ethnic minority	27.22%	25.69%	26.04%	29.66%	28.27%	26.95%
White	23.97%	22.90%	23.75%	27.03%	24.08%	23.96%

For this indicator, a lower number indicates improvement.

The percentage of ethnic minority staff reporting harassment, bullying or abuse from staff has fallen to 26.95% from 28.27% in 2024.

Indicator 7: Equal opportunities

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.



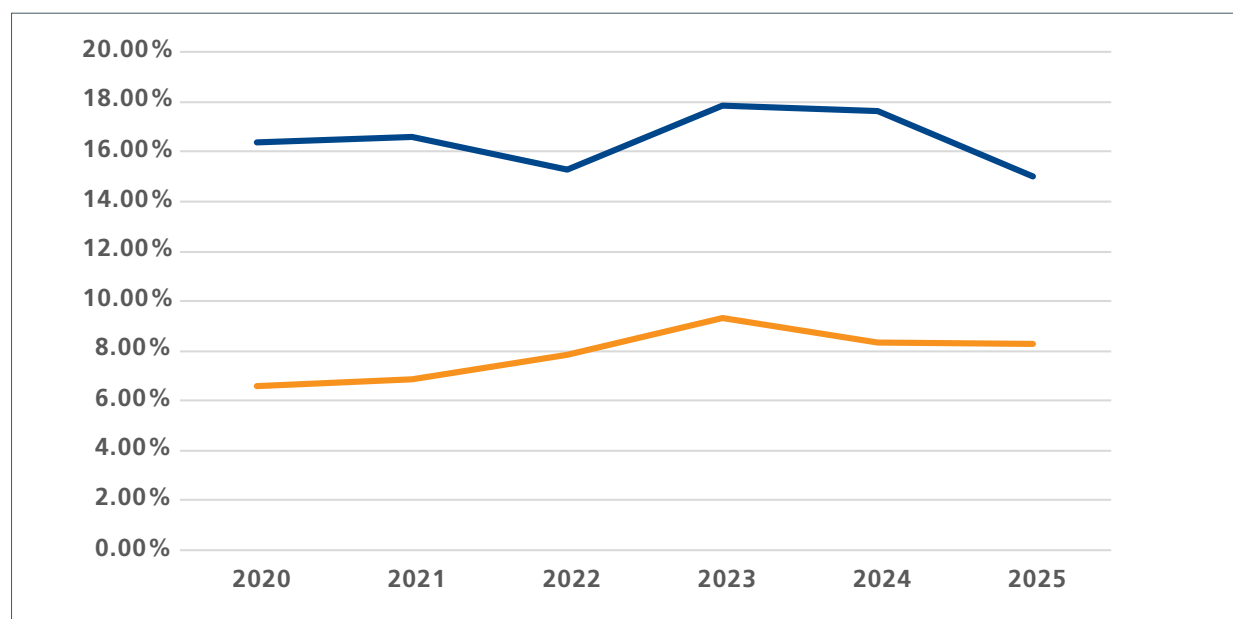
	2020	2021	2022	2023	2024	2025
Ethnic minority	42.94%	40.09%	41.11%	43.23%	43.78%	45.76%
White	57.31%	54.55%	55.34%	52.29%	54.75%	56.12%

For this indicator, a higher number indicates improvement.

The percentage of ethnic minority staff reporting equal access to career opportunities has increased to 45.76% from 43.78% in 2024.

Indicator 8: Discrimination

In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues.



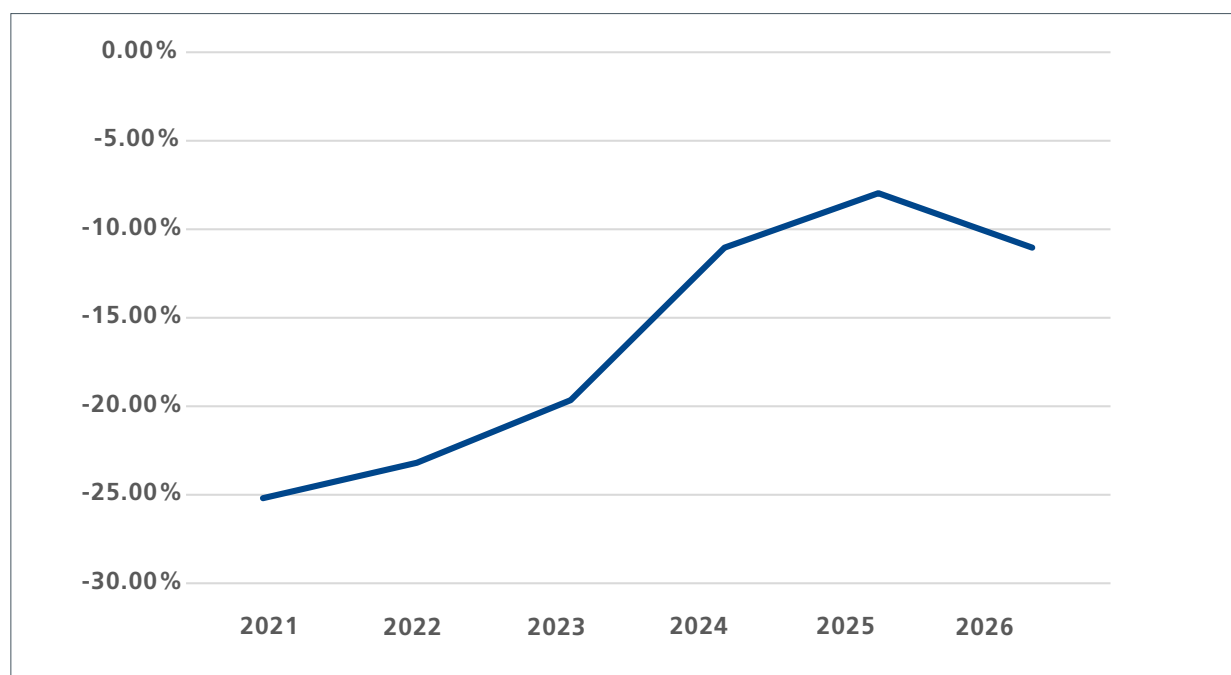
	2020	2021	2022	2023	2024	2025
Ethnic Minority	16.40%	16.60%	15.27%	17.83%	17.66%	15.00%
White	6.57%	6.87%	7.84%	9.30%	8.32%	8.28%

For this indicator, a lower number indicates improvement.

The percentage of ethnic minority staff reporting discrimination has decreased, to 15.00% from 17.66% in 2024.

Indicator 9: Board representation

Percentage difference between the organisations' Board membership and its overall workforce.



2021	2022	2023	2024	2025	2026
8.33%	12.50%	16.67%	34.78%	36.00%	34.78%

For this indicator, a higher number indicates improvement.

Ethnic minority representation on the Board has decreased to 34.78% in 2026 from 36.00% in 2025.

When compared with the overall Trust workforce, ethnic minority staff remain underrepresented at Board level. The representation gap has widened from -7.67% to -10.62% in 2026, showing that Board representation has moved further away from parity.

Please refer to Appendix 2 for the WRES indicator showing the percentage difference.

Workforce Race Equality Standard Indicators Summary

The 2026 WRES data presents the most positive position the Trust has reported to date, with improvement seen across most indicators for ethnic minority staff. Overall representation has increased to 45.40%, continuing the steady year-on-year progress across the Trust.

Improvements are evident across several key areas, including recruitment from shortlisting (1.40), bullying and harassment from staff (26.95%), perceptions of equal opportunities for career progression (45.76%), and discrimination (15.00%). For the first time, more indicators show improvement than deterioration, suggesting that actions taken across the Trust are beginning to translate into more consistent improvements in staff experience.

The likelihood of entering the formal disciplinary process has continued to move closer to parity (1.20), while access to non-mandatory training remains favourable for ethnic minority staff (0.77), indicating continued stability in these areas.

There has been a decline in performance across some areas. Reports of harassment, bullying or abuse from patients, service users and the public have increased to 25.07%, up from 23.87%. In addition, ethnic minority representation at Board level has decreased from 36.00% in 2025 to 34.78% in 2026.

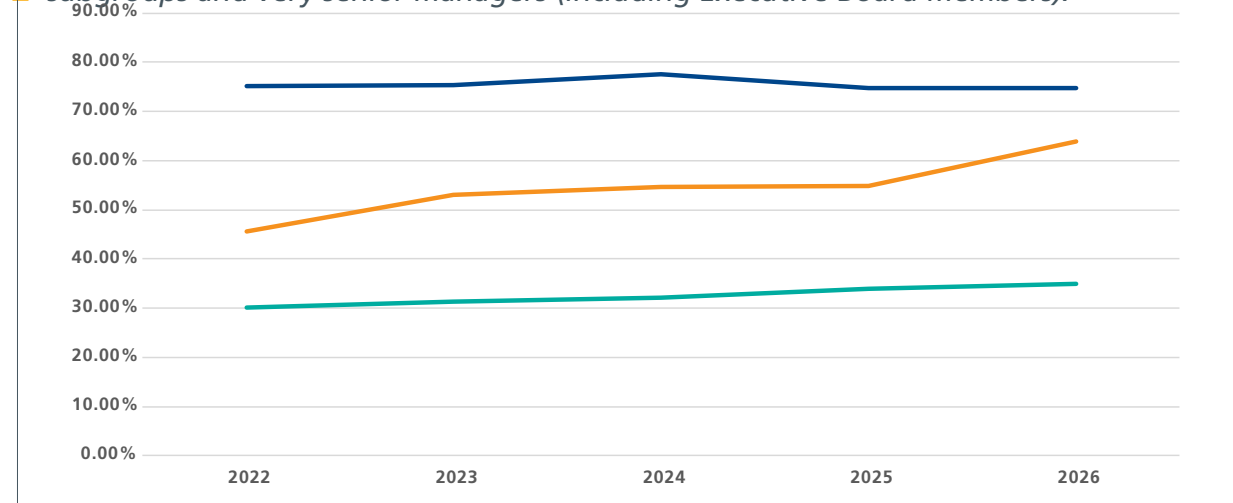
Additionally, although overall workforce representation has improved, the gap between Board and workforce representation has widened at 10.62%, highlighting a continued challenge at senior levels.

Overall, while disparities between ethnic minority and white staff remain, the direction of travel is positive. Most indicators show sustained improvement, and fewer areas have declined compared with previous years, demonstrating encouraging progress across the Trust.

Workforce Women's Equality Standard Metrics

Metric 1: Representation

Percentage of women in Agenda for Change pay-bands or medical and dental subgroups and very senior managers (including Executive Board members).

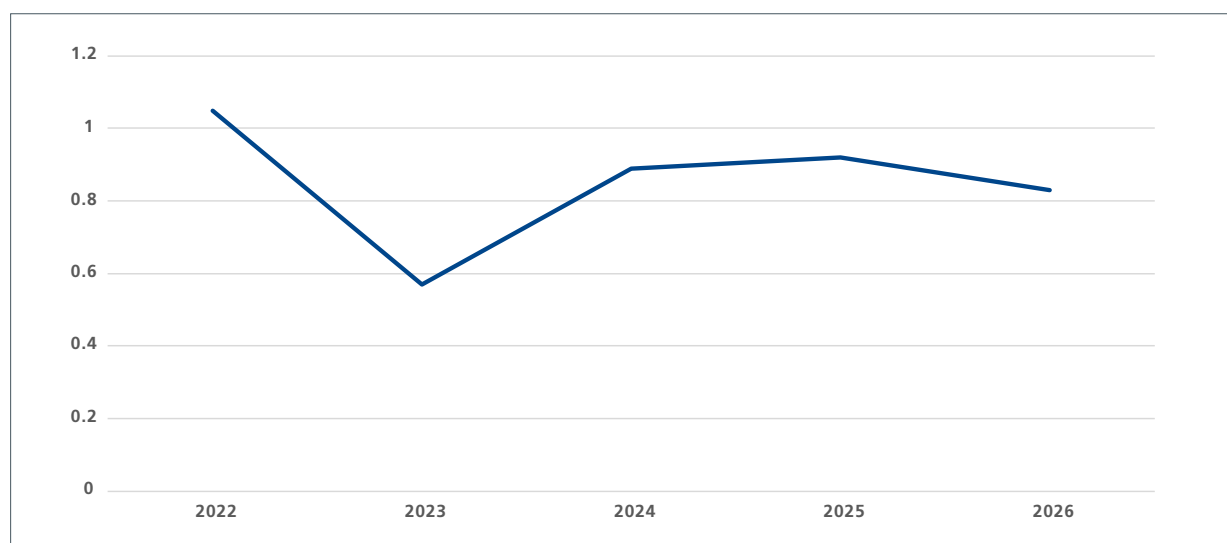


	2022	2023	2024	2025	2026
Overall	75.11%	75.28%	77.56%	74.78%	74.72%
VSM (Exc. Consultants)	45.59%	53.01%	54.68%	54.97%	63.83%
Consultants	30.20%	31.25%	32.17%	33.89%	34.96%

The percentage of women in the overall workforce has decreased slightly to 74.72% from 74.78%. However, representation has increased in senior roles, with women in VSM positions rising to 63.83% from 54.97% in 2025, and women in Consultant roles increasing to 34.96% from 33.89%.

Metric 2: Shortlisting

Relative likelihood of women compared to men being appointed from shortlisting across all posts).



2022	2023	2024	2025	2026
1.05	0.57	0.89	0.92	0.83

A figure below 1 indicates that women are more likely than men to be appointed from shortlisting.

The relative likelihood of appointing a woman has moved further away from parity, shifting to 0.83 in 2026 from 0.92 in 2025.

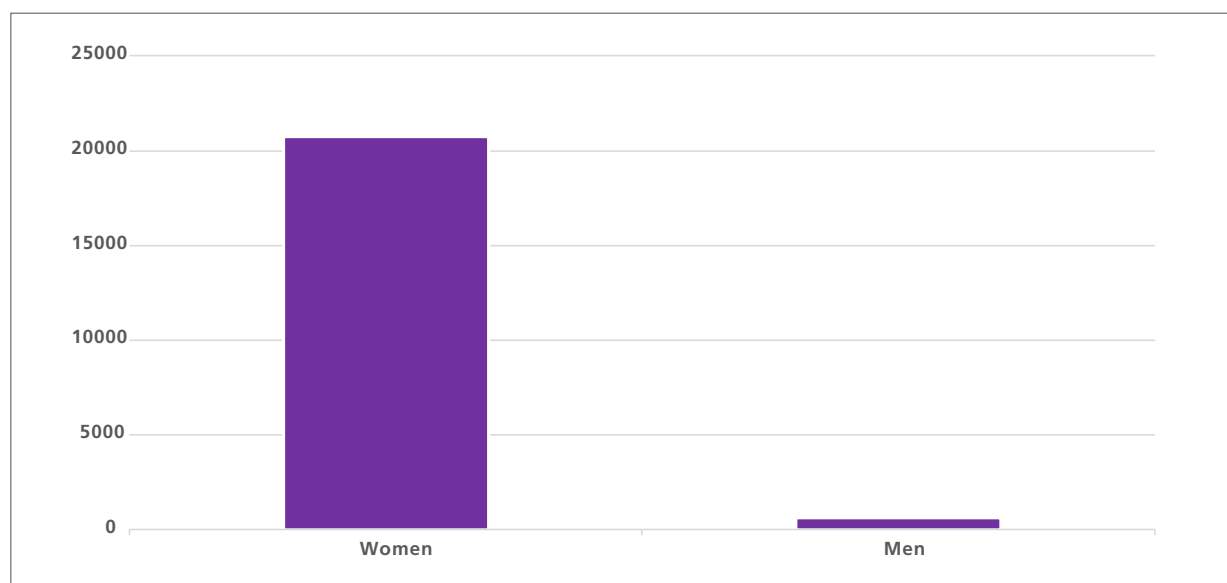
A total of 22,206* candidates were shortlisted across all roles at the Trust from 01 April 2025 to 31 March 2026, of whom 16,296 were women. Of these, 2,465 women were appointed.

Total Applicants shortlisted	Women Shortlisted	Women Appointed
22,206	16,296	2,465

**Data note: Recruitment data is extracted from a live system and may not align exactly with WRES and WDES figures due to differing reporting and extraction dates.*

Metric 3: Absence related to women's health

How many days have been lost due to women's health related issues including gynaecological and menopausal reasons.



Women	Men
20742.63	623.53

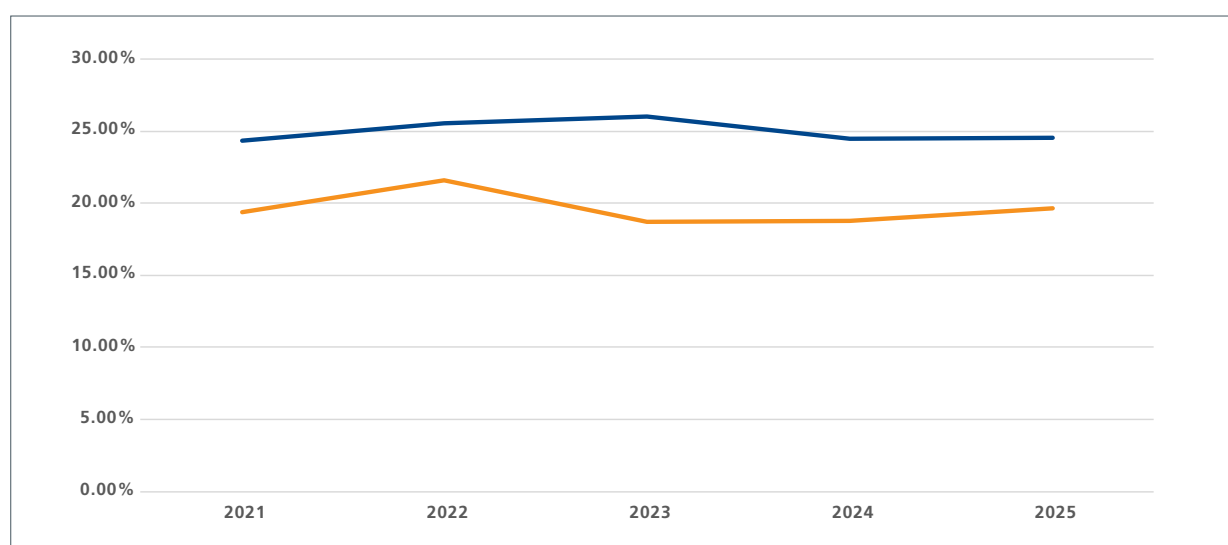
Full Time Equivalent (FTE) days lost due to genitourinary and gynaecological conditions are substantially higher for women (20,742.63) compared with men (623.53). As this is the first year of reporting, a baseline has now been established; however, limitations in recording practices mean the data is likely to underrepresent the full extent of women's health related absence. Improvements in data quality will enable more detailed analysis and trend comparison in future reporting.

Metric 4: Harassment and bullying

Percentage of women compared to men experiencing harassment, bullying or abuse from:

- 1 Patients/Service users, their relatives or other members of the public
- 2 Managers
- 3 Other colleagues
- 4 Percentage of women compared to men saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

1. Harassment, bullying or abuse from patients, service users or the public

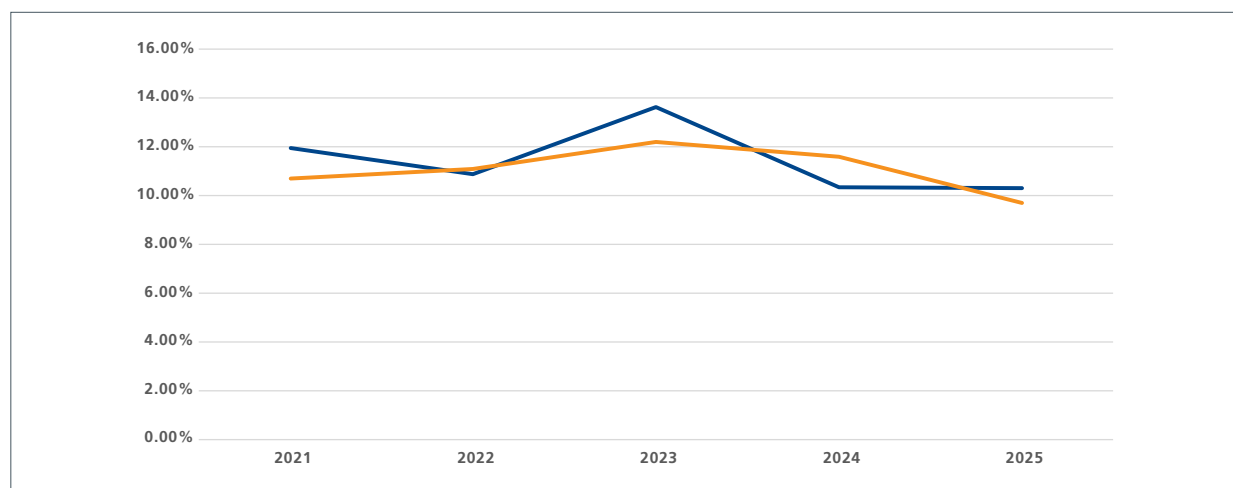


	2021	2022	2023	2024	2025
Women	24.32%	25.56%	26.03%	24.50%	24.56%
Men	19.35%	21.58%	18.68%	18.79%	19.63%

For this metric, a lower number indicates improvement.

The percentage of women experiencing harassment, bullying or abuse from patients, service users or the public has increased to 24.56% in 2025 from 24.50% in 2024.

2. Harassment, bullying, or abuse from a line manager

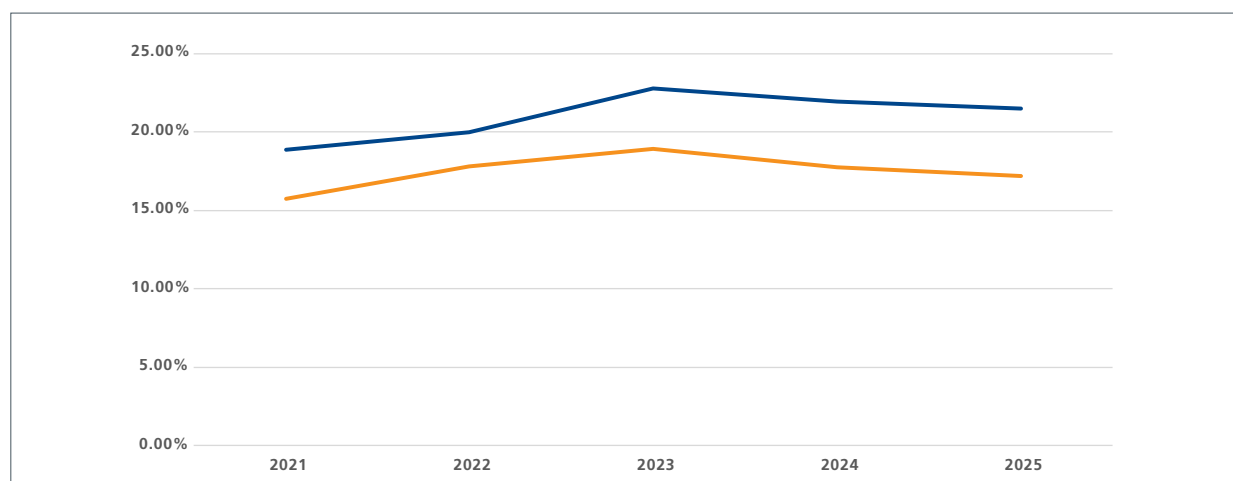


	2021	2022	2023	2024	2025
Women	11.94%	10.88%	13.64%	10.36%	10.30%
Men	10.69%	11.08%	12.20%	11.60%	9.69%

For this metric, a lower number indicates improvement.

The percentage of women experiencing harassment, bullying or abuse from line manager has reduced to 10.30% in 2025 from 10.36% in 2024.

3. Harassment, bullying or abuse from other colleagues

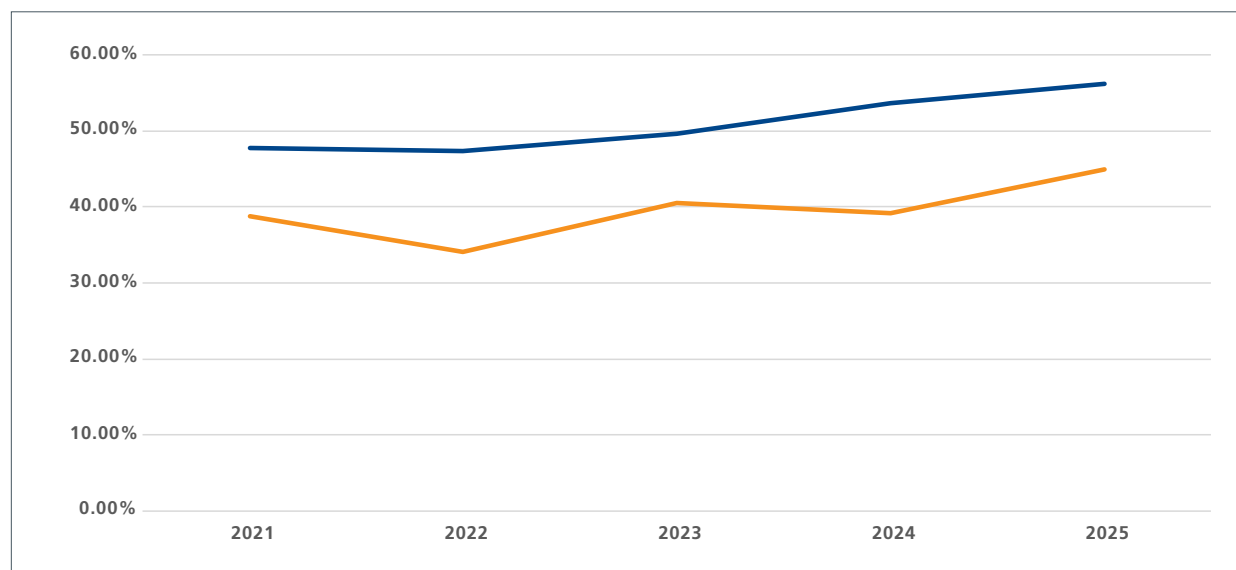


	2021	2022	2023	2024	2025
Women	18.85%	20.01%	22.79%	21.97%	21.50%
Men	15.77%	17.83%	18.94%	17.76%	17.21%

For this metric, a lower number indicates improvement.

The percentage of women experiencing harassment, bullying or abuse from colleagues has reduced to 21.50% in 2025 from 21.97% in 2024.

4. Percentage of staff saying that the last time that experienced harassment bullying or abuse at work, they or a colleague reported it



	2021	2022	2023	2024	2025
Women	47.72%	47.31%	49.67%	53.72%	56.18%
Men	38.84%	34.10%	40.57%	39.24%	44.91%

For this metric, a higher number indicates improvement.

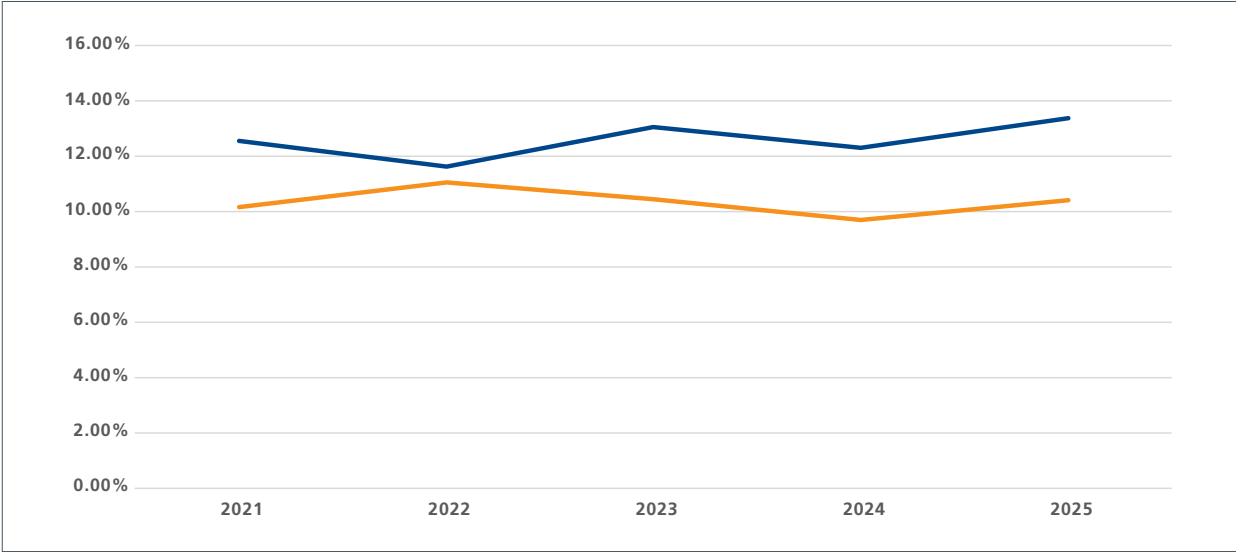
The percentage of women reporting harassment, bullying or abuse when it does occur, has increased to 56.18% in 2025 from 53.72% in 2024.

Metric 5: Physical Violence

Percentage of women compared to men experiencing physical violence in the last 12 months from:

- 1 Patients/Service users, their relatives or other members of the public
- 2 Managers
- 3 Other colleagues
- 4 Percentage of women compared to men saying that the last time they experienced physical violence, they or a colleague reported it.

1. Percentage of women compared to men experiencing physical violence from patient, service user, their relatives or other members of the public.

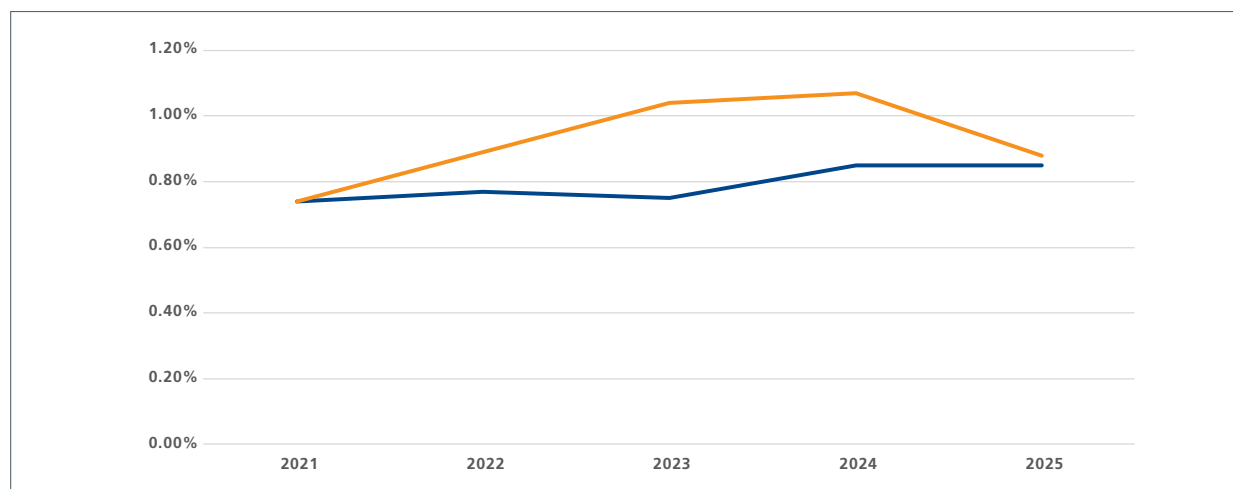


	2021	2022	2023	2024	2025
Women	12.55%	11.63%	13.06%	12.29%	13.39%
Men	10.14%	11.06%	10.43%	9.69%	10.40%

For this metric, a lower number indicates improvement.

The percentage of women experiencing physical violence from patients, service users or the public has increased to 13.39% in 2025 from 12.29% in 2024.

2. Percentage of women compared to men experiencing physical violence from managers.

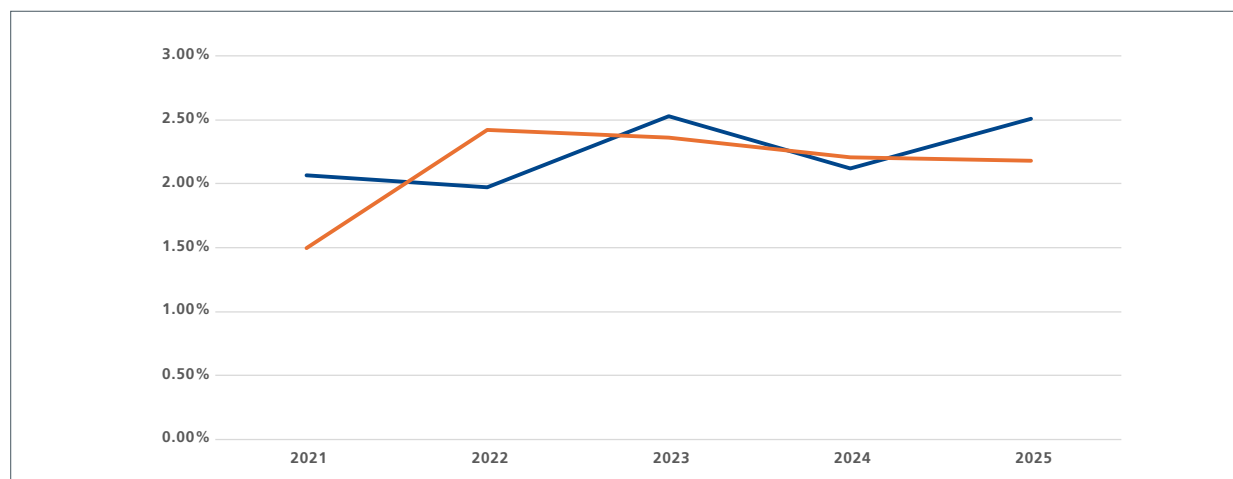


	2021	2022	2023	2024	2025
Women	0.74%	0.77%	0.75%	0.85%	0.85%
Men	0.74%	0.89%	1.04%	1.07%	0.88%

For this metric, a lower number indicates improvement.

The percentage of women experiencing physical violence from managers has remained at 0.85% in 2025.

3. Percentage of women compared to men experiencing physical violence from other colleagues

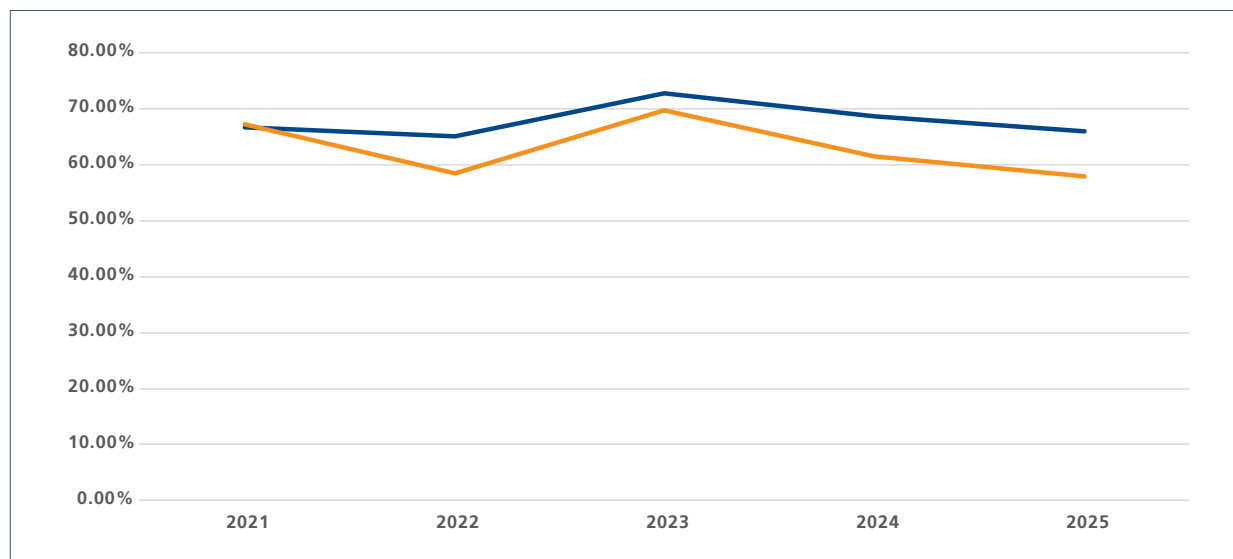


	2021	2022	2023	2024	2025
Women	2.07%	1.97%	2.53%	2.12%	2.51%
Men	1.50%	2.42%	2.36%	2.21%	2.18%

For this metric, a lower number indicates improvement.

The percentage of women experiencing physical violence from other colleagues has increased to 2.51% in 2025 from 2.12% in 2024.

4. Percentage of women compared to men saying that the last time they experienced physical violence at work, they or a colleague reported it.



	2021	2022	2023	2024	2025
Women	66.67%	65.08%	72.66%	68.62%	65.96%
Men	67.12%	58.46%	69.60%	61.50%	57.80%

For this metric, a higher number indicates improvement.

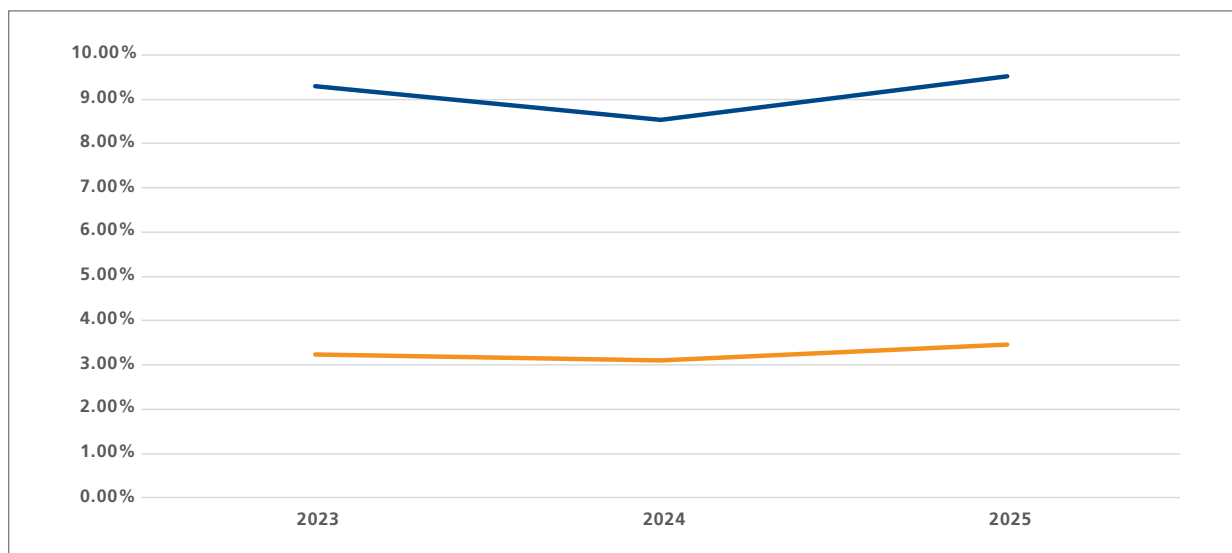
The percentage of women reporting physical violence when it does occur, has decreased to 65.96% in 2025 from 68.62% in 2024.

Metric 6: Unwanted behaviour of a sexual nature

Percentage of women compared to men who have been the target of unwanted behaviour of a sexual nature from:

- 1 Patients/Service users, their relatives or other members of the public
- 2 Colleagues

1. Percentage of women compared to men experiencing physical violence from patient, service user, their relatives or other members of the public.

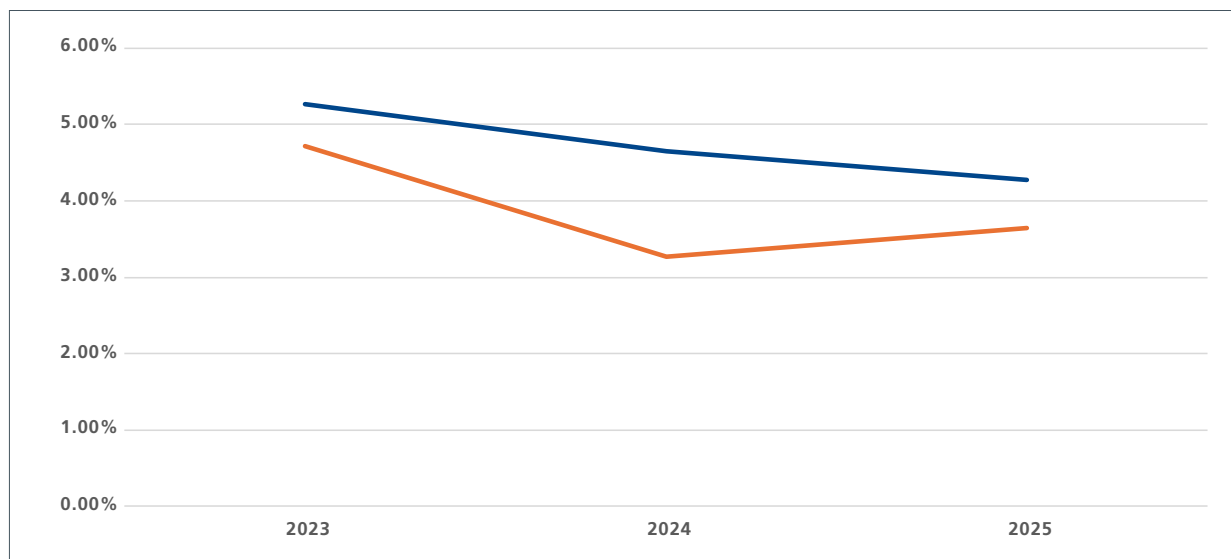


	2023	2024	2025
Women	9.30%	8.53%	9.52%
Men	3.23%	3.11%	3.46%

For this metric, a lower number indicates improvement.

The percentage of women who have been the target of unwanted behaviour of a sexual nature from patients, services users or the public has increased to 9.52% in 2025 from 8.53% in 2024.

2. Percentage of women compared to men who have been the target of unwanted behaviour of a sexual nature from colleagues



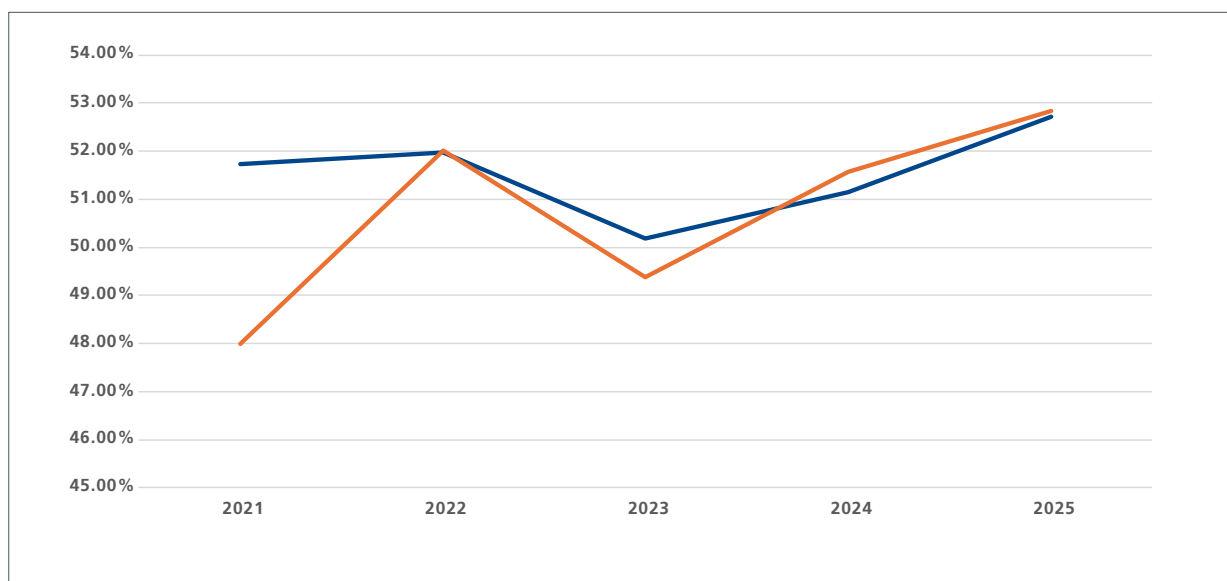
	2023	2024	2025
Women	5.27%	4.65%	4.28%
Men	4.71%	3.27%	3.65%

For this metric, a lower number indicates improvement.

The percentage of women who have been the target of unwanted behaviour of a sexual nature from colleagues has decreased to 4.28% in 2025 from 4.65% in 2024.

Metric 7: Career progression

Percentage of women compared to men believing that the Trust provides equal opportunities for career progression or promotion.



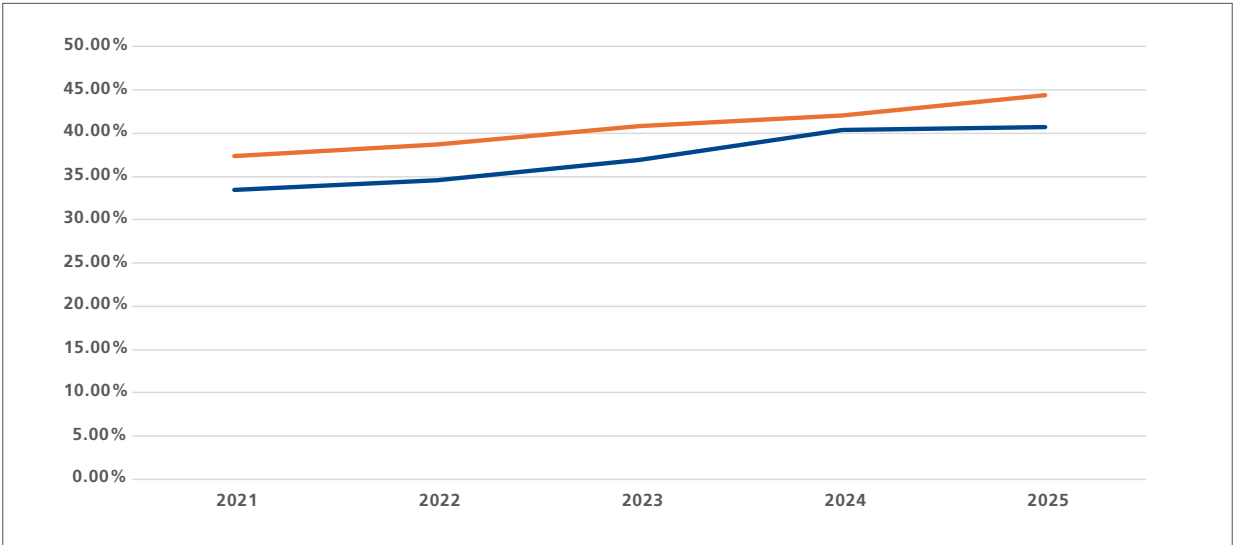
	2021	2022	2023	2024	2025
Women	51.73%	51.97%	50.18%	51.16%	52.71%
Men	48.00%	52.01%	49.39%	51.57%	52.83%

For this metric, a higher number indicates improvement.

Perceptions of equal opportunities for career progression have remained broadly stable between women and men, demonstrating continued progress towards parity in this area.

Metric 8: Feeling valued

Percentage of women compared to men saying that they are satisfied with the extent to which their organisation values their work.



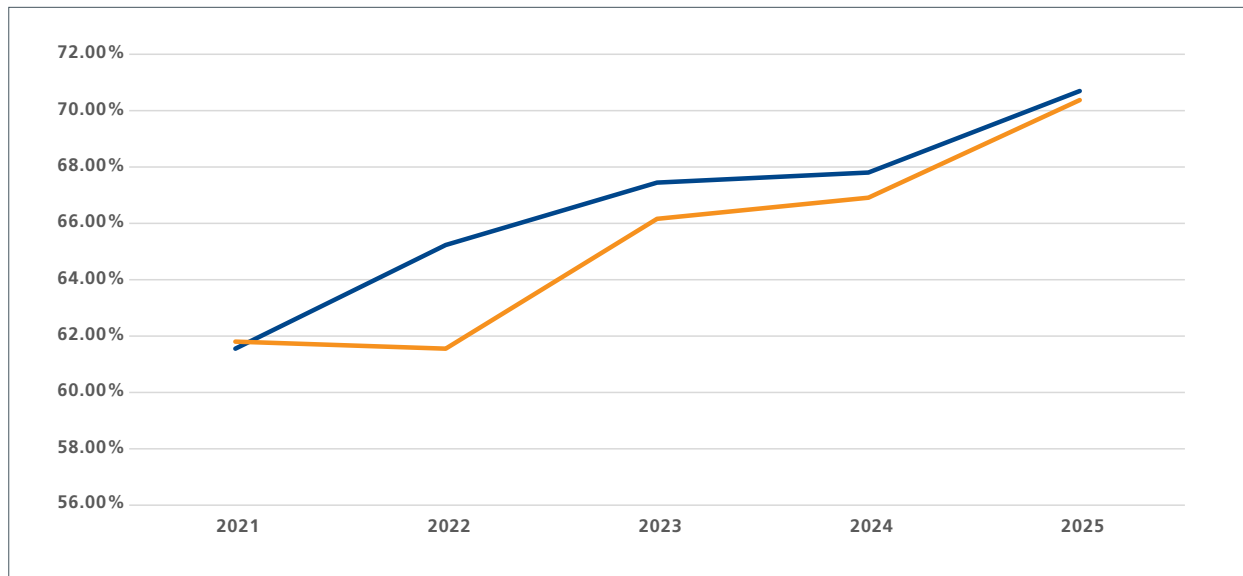
	2021	2022	2023	2024	2025
Women	33.41%	34.61%	36.94%	40.41%	40.71%
Men	37.35%	38.71%	40.86%	41.99%	44.44%

For this metric, a higher number indicates improvement.

The percentage of women reporting that they feel valued has increased slightly to 40.71% from 40.41%, although it remains lower than the percentage reported by men.

Metric 9: Flexible working

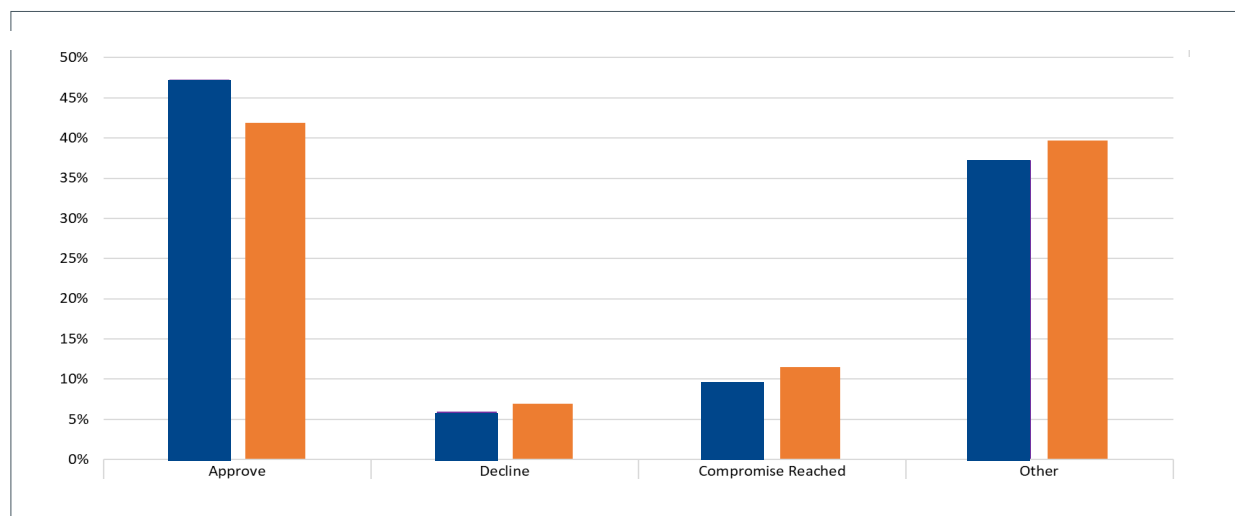
1. Percentage of women compared to men who feel that they can talk openly with their line manager about flexible working.



	2021	2022	2023	2024	2025
Women	61.57%	65.22%	67.46%	67.80%	70.70%
Men	61.81%	61.54%	66.17%	66.92%	70.37%

For this metric, a higher number indicates improvement.

2. Percentage of women compared to men who feel they have the flexibility within their role to manage their home responsibilities, including childcare and caring for family.



Women	47.29%	5.93%	9.53%	37.25%
Men	41.85%	6.92%	11.54%	39.69%

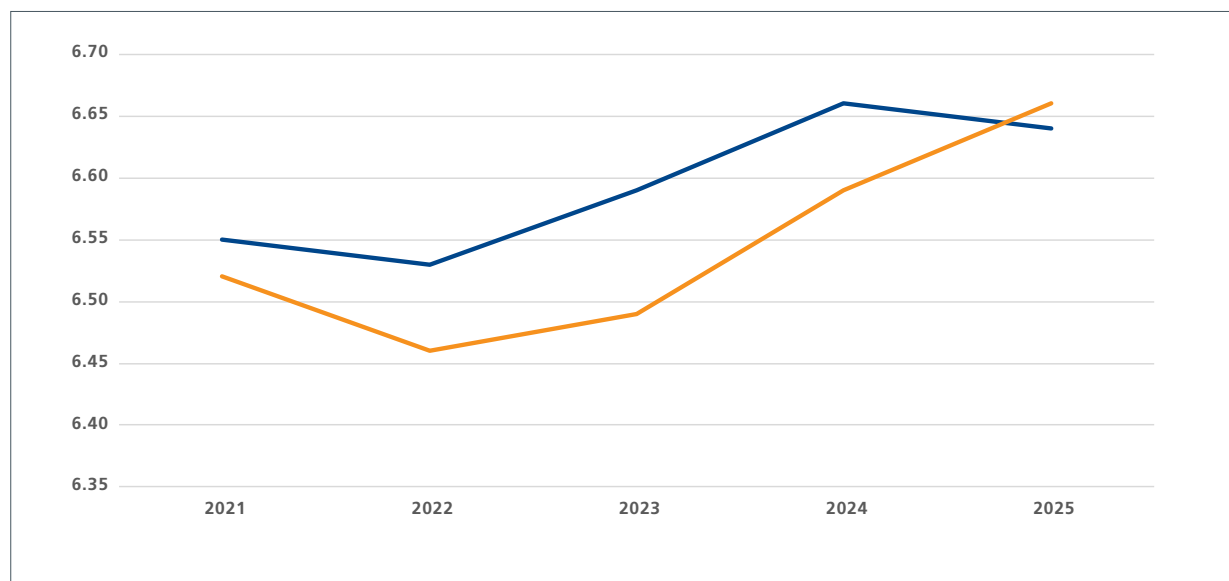
For this metric, a higher number indicates improvement.

The number of women who feel able to speak openly about flexible working has increased from 67.80% to 70.70%. This trend is also seen among men, whose responses have increased to 67.34% from 66.92%.

To understand whether women feel they have sufficient flexibility within their roles to manage home responsibilities, including childcare and caring for family, the flexible working data was reviewed to identify disparities in the outcomes of requests. Women are more likely to have their requests approved (47.29%) and less likely to have their requests declined (5.93%) or resolved through a compromise (9.53%).

Metric 10: Engagement

■ Staff engagement score for women compared to men.



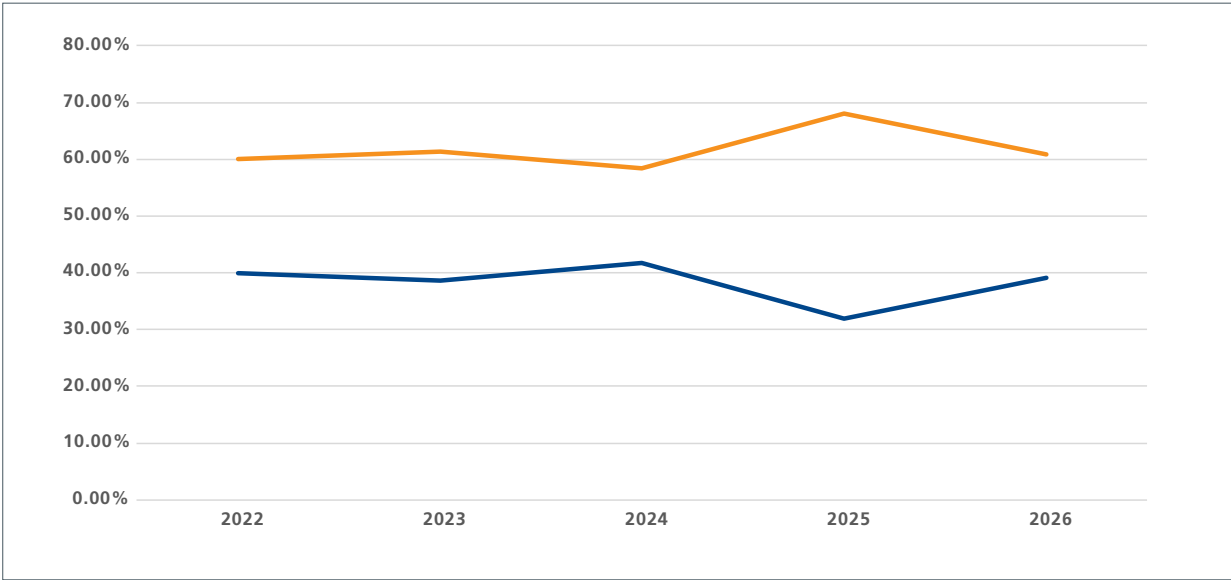
	2021	2022	2023	2024	2025
Women	6.55	6.53	6.59	6.66	6.64
Men	6.52	6.46	6.49	6.59	6.66

For this metric, a higher number indicates improvement.

The staff engagement score for women has decreased slightly to 6.64 in 2025 from 6.66 in 2024, while the score for men has increased to 6.66 from 6.59, indicating broadly stable engagement levels overall.

Metric 11: Board representation

■ *Percentage of men and women as part of the Trust Board.*



	2022	2023	2024	2025	2026
Women	40.00%	38.71%	41.67%	32.00%	39.13%
Men	60.00%	61.29%	58.33%	68.00%	60.87%

For this metric, a higher number indicates improvement.

Women now represent 39.13% of Board members, compared with 32.00% in 2025, demonstrating continued progress towards improved senior representation.

Workforce Women's Equality Standard Metrics Summary

The 2026 Workforce Women's Equality Standard (WWES) data broadly indicates a stabilising position in the experience of women at the Trust. While overall representation remains strong at 74.72%, there has been a continuous incremental progress in senior roles, with women now comprising 39.13% of Board members, 63.83% of VSM roles and 34.96% of Consultant roles. Most indicators remain comparable to the previous year, although some areas show slight deterioration, including shortlisting outcomes (0.83) and engagement (6.64). There has been a positive shift in openness around flexible working, with 70.70% of women reporting they feel able to discuss this with their line manager. The introduction of women's health absence data provides an important baseline for future analysis.

However, harassment, bullying and abuse remain a consistent challenge, with 24.56% of women reporting incidents from patients, 21.50% from colleagues and 10.30% from managers. Additionally, 13.39% reported experiencing physical violence from patients and the public, indicating persistent patterns in staff experience. Unwanted sexual behaviour also remains a concern, increasing to 9.52% from patients, while decreasing to 4.28% from colleagues.

Perceptions of career progression and engagement remain broadly aligned between women and men, although women continue to report feeling valued at lower rates, with 40.71% stating that they feel valued.

Overall, the data suggests that while inequalities remain, the experience of women at the Trust is broadly stable, with fewer significant shifts across metrics and some instances of parity emerging between women and men.

Analysis summary

Metric/Indicator	WDES	WRES	WWES
Representation (WDES 1, WRES 1, WWES 1)	IMPROVED	IMPROVED	IMPROVED
Shortlisting (WDES 2, WRES 2, WWES 2)	DECLINED	IMPROVED	MINIMAL CHANGE
Career Progression/ Equal Opportunities (WDES 5, WRES 7, WWES 7)	IMPROVED	IMPROVED	IMPROVED
Bullying & Harassment Public (WDES 4.1, WRES 5, WWES 4.1)	DECLINED	DECLINED	DECLINED
Bullying & Harassment colleague (WDES 4.3, WRES 6, WWES 4.3)	MINIMAL CHANGE	IMPROVED	MINIMAL CHANGE
Bullying & Harassment Managers (WDES 4.2, WWES 4.2)	MINIMAL CHANGE	Not a WRES indicator	MINIMAL CHANGE
Reporting (WDES 4.4, WWES 4.1)	IMPROVED	Not a WRES indicator	IMPROVED
Feeling Valued (WDES 7, WWES 8)	IMPROVED	Not a WRES indicator	MINIMAL CHANGE
Board Representation (WDES 10, WRES 9, WWES 11)	MINIMAL CHANGE	DECLINED	IMPROVED
Engagement (WDES 9, WWES 10)	IMPROVED	Not a WRES indicator	MINIMAL CHANGE

Note: Improved = more than 1% improvement. / a ratio improvement of more than 0.1

Minimal Change = less than 1% difference / a ratio change of less than 0.1

Declined = more than 1% decline / a ratio decline of more than 0.1

Intersectional Summary

This is the first year the Trust has adopted a combined, intersectional approach across the Workforce Disability, Race and Women's Equality Standards. This approach enables the Trust to better identify areas of disparity and improvement, prioritise targeted interventions, and build on areas of progress.

The review of WDES, WRES and WWES identifies consistent themes across the Trust. Improvements are evident in workforce representation, perceptions of career progression and aspects of staff experience. Representation has improved across all standards, with ethnic minority staff comprising 45.40% of the workforce and disability declaration rates increasing to 7.90%, alongside continued progress in the representation of women at Board level 39.13%.

Staff also report more positive perceptions of career progression, with 46.32% of disabled staff, 45.76% of ethnic minority staff, and 52.71% of women reporting equal access to progression. Improvements in staff experience are reflected through stronger engagement, increased feelings of being valued, improved reporting of inappropriate behaviours and greater openness in relation to flexible working.

Despite these improvements, challenges remain and further work is required. While perceptions of career progression have strengthened, this is not yet reflected in workforce outcomes, with disparities persisting at senior levels (Band 8a and above). This suggests that improvements are not yet translating into proportional representation of disabled, ethnic minority, and women staff in the most senior roles. Recruitment gaps are also evident, with the relative likelihood of appointing disabled candidates moving further away from parity 1.34 in 2026 from 1.17 in 2025, alongside continued inequalities in progression to senior roles and a reduction in ethnic minority Board representation to 34.78% in 2026 from 36.00% in 2025.

Taken together, these findings highlight a disconnect between improved staff perceptions of opportunity and actual progression outcomes, with representation at senior levels remaining disproportionate across all three standards. This is further compounded by widening disparities in experiences of bullying, harassment, and abuse, as well as violence and aggression from the public.

Intersectional Analysis

Intersectional analysis provides a more detailed understanding of how different aspects of staff identity combine to shape workforce experiences and outcomes. Rather than considering disability, ethnicity and sex in isolation, this approach examines where these characteristics overlap and whether staff with multiple protected characteristics experience different or compounded patterns of inequality.

For the Trust, this enables a more comprehensive assessment of representation, progression and staff experience across the workforce. It supports the identification of groups who may be under-represented, particularly in senior roles, and helps ensure that actions are targeted, proportionate and responsive to the experiences of staff considering each protected characteristic in isolation. This approach strengthens the Trust's ability to move beyond single-characteristic analysis and develop more inclusive, evidence-based interventions to address inequality.

Appendix 3 presents an intersectional analysis of staff in Band 8a to VSM roles (excluding Medical and Dental staff group e.g. Consultants), examining the combined impact of disability, ethnicity, and sex. Rather than looking at each protected characteristic in isolation, the table demonstrates the proportion of staff in each pay band who belong to specific combinations of these characteristics. This allows a more detailed understanding of workforce representation at senior levels and helps identify where particular groups may be under-represented or over-represented within the Trust's leadership structure. The analysis supports a deeper assessment of equity in progression and representation by highlighting the experiences and presence of staff with intersecting protected identities.

Based on the intersectional analysis of disability, ethnicity and sex, across bands 8a to VSM, several key patterns emerge. Women are the majority population across all senior pay bands, although the balance between men and women becomes more even at VSM level (31 women and 23 men). White staff make up the largest proportion of the workforce at every band, whilst ethnic minority representation is comparatively lower and decreases noticeably in the more senior bands. For example, ethnic minority staff account for around 22.90% of staff at Band 8a (191 of 834) but fall to around 5.26% at Band 8d (3 of 57) and 15.00% at Band 9 (3 of 20).

The data also highlight relatively low levels of disability declaration rates across all bands. Whilst there are examples of disabled staff in most bands, the numbers are small, particularly among ethnic minority groups. At band 8b, for example, there are no disabled ethnic minority women and only one disabled ethnic minority man. The small numbers make it difficult to draw firm conclusions, but they may indicate either under-representation or under-reporting of disability within senior roles.

There is the very limited representation of ethnic minority men in the most senior bands. There are no ethnic minority men recorded at band 8d and only one at band 9. Ethnic minority women are present at all grades but in much smaller numbers in all bands when compared to white women. This suggests that progression into the most senior leadership roles may be disproportionately affecting ethnic minority staff.

The intersectional analysis indicates that both ethnic minority, disabled women and men are less well represented in senior pay bands than their white disabled counterparts. Whilst white, disabled staff are present across most bands from 8a to VSM, representation for ethnic minority, disabled staff declines markedly at higher bands. Ethnic minority, disabled women are represented at band 8a and VSM only, with no recorded staff in bands 8b, 8c, 8d or band 9. Similarly, ethnic minority, disabled men are present in bands 8a to 8c but are absent from bands 8d, band 9 and VSM.

Disability representation for men in higher bands reduces significantly, with no men in bands 8d to VSM declaring a disability.

Although workforce numbers become increasingly smaller at the most senior levels and should therefore be interpreted with caution, the findings suggest that individuals who have the combined characteristics of ethnicity and disability may face greater barriers to progression into senior leadership positions. The sustained representation of white, disabled staff across the bands contrasts with the limited and inconsistent representation of ethnic minority, disabled staff, highlighting a potential inequality in progression opportunities.

The absence of ethnic minority, disabled, and men across several senior bands, particularly within the transition from band 8a to executive-level roles, represents an important area for further investigation. Targeted actions have been developed to address workforce equality and leadership development and are detailed in the action plan below.

Workforce Equality Standards Intersectional Action Plan 2026-2029

Building on the analysis presented within this report, the following action plan outlines the targeted actions that the Trust will undertake to address identified inequalities, sustain areas of progress, and improve the lived experiences of all staff.

These actions are aligned with the Trust's strategic priorities and will be monitored through established governance arrangements. This approach reflects a focused prioritisation of key areas where targeted interventions are expected to deliver the greatest impact, rather than attempting to address all areas simultaneously.

By adopting this targeted methodology, the Trust aims to deliver meaningful, measurable, and sustainable improvements in staff experience. The Trust will also continue to monitor all indicators through established reporting mechanisms and governance structures, ensuring ongoing oversight, accountability, and continuous improvement.

The actions and timescales presented primarily relate to delivery during 2026 and 2027; however, this action plan will be subject to ongoing review and refinement throughout the three-year reporting period to 2029, ensuring that actions remain responsive, relevant, and aligned to emerging priorities, data insights, and organisational learning.

1. Bullying and Harassment Prevention

Objective: Reduce the incidence of bullying, harassment and abuse from colleagues and managers, and increase reporting and confidence in the Trust's response, with disparity reduction for disabled, ethnic minority and women staff explicit in every intervention.

Standards addressed: WDES 4, 7, 9; WRES 5, 6, 8; WWES 4, 8, 10.

Ref	Intervention	Owner	Milestone	Leading indicators (in-year)
1.1	Hotspot identification triangulating NSS, NETS, Radar and FTSU data at CDG level; 'listen and learn' sessions in all bottom-decile areas; co-produced local action plans with 90-day review cycles.	Senior DEI Business Partners with ADPs	Hotspot list Nov 2026; all plans live Feb 2027	% hotspot areas with live plan; % 90-day reviews held on time; hotspot Radar report volumes (SPC - expected to rise as confidence grows, then fall)
1.2	Embed the unified Resolution Procedure with an early-resolution gateway: a mandatory, recorded reflective assessment (individual vs systemic; informal resolution considered) before any formal Dignity at Work or disciplinary process is opened.	CPO	Gateway live with procedure launch; first compliance audit Apr 2027	% formal cases with completed gateway record; informal-to-formal resolution ratio (quarterly); Dignity at Work case volumes and cycle times
1.3	Behavioural framework cascade: How We Behave Matters, Civility Saves Lives and Welcome to Leadership completion prioritised in hotspot areas; values-based content in induction.	DEI Capability Lead with Leadership Team	Hotspot completion 85% by Mar 2027	Training completion by hotspot CDG vs Trust average; induction content live
1.4	Case quality assurance: sampled QA of Dignity at Work investigation outputs against the Trust QA standard, with themed learning fed back to case managers and investigators.	CPO office / Employment Solicitor	QA sampling framework live Sept 2026	% sampled cases meeting standard; recurring themes logged and actioned

Mechanism of change

Early, recorded triage diverts resolvable matters from formal process, reducing the harm formal processes themselves cause (a known driver of the manager-related harassment measure and of ethnicity disparity in disciplinary entry). Visible, credible local action in hotspots raises reporting confidence before it reduces incidence; reporting measures are therefore expected to rise ahead of experience measures, and the SPC presentation will make that sequence legible.

Outcome measures (lagging)

NSS: bullying/harassment from colleagues 20.67% (2026) to 18.63% (2028); from managers 9.40% (2026) to 6.80% (2028); reporting 55.74% (2026) to 59.60% (2028). Baseline: 2025 NSS.

NETS: not bullied/harassed by other staff 82.66% (2026) to 84.72% (2028); reported when experienced/witnessed 11.19% (2026) to 15.35% (2028).

Values visibility: kind 64.40% to 68.40%; connected 58.40% to 62.40%; bold 50.50% to 54.50% (2026 to 2028).

Disparity measures: gap between disabled/ethnic minority/women staff and comparator groups on colleague, and manager-source measures, reported alongside each headline figure.

Impact

Reducing bullying, harassment and abuse from both colleagues and managers, alongside increasing the proportion of staff who do not experience these behaviours, will support a more respectful, inclusive and psychologically safe working environment. This will strengthen Trust in leadership, improve staff wellbeing, and help create a culture where all staff feel valued and able to belong.

Increasing the reporting of bullying, harassment and abuse enables the Trust to respond more effectively, identify patterns and take targeted action to improve staff experiences. Strengthening reporting will also enhance accountability and support a culture where concerns are raised early and addressed promptly.

Reducing bullying, harassment and abuse identified in hotspot areas will improve local accountability and workplace culture, providing the Trust with a blueprint for improvements in other parts of the Trust. Targeted reductions in manager led bullying, harassment and abuse within these hotspots will strengthen trust in leadership, increase accountability and help create a psychologically safe environment where staff feel able to speak up and be heard.

Embedding the behavioural framework and the Trust values (kind connected and 'bold) will help staff feel valued, respected and supported, contributing to improved wellbeing, stronger team cohesion and increased retention. Over time, this will also support reduced sickness absence and help build a more positive, engaged workforce.

2. Compassionate Leadership

Objective: Build consistent, values-based management capability so that staff experience fair, inclusive and psychologically safe leadership regardless of team, site or profession.

Standards addressed: WDES 5, 7, 9, 12; WRES 4, 5, 6, 7, 8; WWES 7, 8, 10.

Ref	Intervention	Owner	Milestone	Leading indicators (in-year)
2.1	New Leaders' Induction: completion by all leaders, with cohort tracking by site and staff group.	Education Team lead	80% Mar 2027; 100% Mar 2028	Completion % by site (quarterly); new-in-post leaders inducted within 3 months of appointment
2.2	Management Essentials training to 90% of managers, sequenced hotspot-first.	Leadership Team	80% Mar 2027; 90% Mar 2028	Completion % by CDG; hotspot completion vs Trust average
2.3	How We Behave Matters for Consultants, co-sponsored by the Chief Medical Officer, with a published cohort schedule per site.	CMO with Associate Director of Leadership	Cohort schedule Oct 2026; 60% of Consultants by Mar 2028	Consultant completion % by site; NETS free-text themes in Consultant-led areas
2.4	Revised appraisal framework rollout with inclusive-conversation training (including disability, adjustments and communication preferences content already developed).	Senior DEI Business Partners with Education Team	Rollout complete Jun 2027	Appraisal completion %; sampled appraisal quality audit; % appraisals recording development conversation
2.5	Speaking-up culture: quarterly FTSU triangulation reports (themes by site, staff group and protected characteristic) to site People and Culture Committees, with actions tracked.	FTSU Guardian with CPO (FTSU oversight)	First triangulated report Dec 2026	Reports delivered on schedule; % FTSU-derived actions closed within agreed timescale; anonymous reporting proportion (falling proportion indicates rising confidence)

Mechanism of change

Manager capability is the common upstream factor across career progression perception, harassment from managers, and speak-up confidence. Consistent induction and essentials training reduce variation in management practice; the Consultant-specific strand addresses the medical hierarchy dynamics that general programmes miss; FTSU triangulation converts individual speak-up cases into systemic learning and demonstrates response, which is what moves the 'confident the Trust would address concerns' measure.

Outcome measures (lagging)

NSS: line manager shows behaviours in line with Trust values 75.70% (2026) to 79.70% (2028); immediate manager encourages me 70.96% to 73.74%; secure raising clinical concerns 67.86% to 69.23%; safe to speak up 54.03% to 54.65%; confident Trust would address concerns 51.75% to 52.90%. Baseline: 2025 NSS.

NETS: comfortable raising concerns 82.02% to 83.40%; staff welcoming, supportive, friendly 81.93% to 85.93%.

Programme completion: New Leaders' Induction 100% and Management Essentials 90% by 2028.

Impact

Strengthening compassionate leadership will help staff feel supported, valued and encouraged by their line managers, leading to improved engagement, stronger team performance and increased retention, alongside positive impacts on overall staff wellbeing.

Embedding compassionate leadership behaviours among Consultants will improve psychological safety, ensuring staff feel confident to speak up and raise concerns while fostering a more welcoming environment. This will support a more positive culture for staff and contribute to improvements in patient safety.

Ensuring all leaders complete the induction will support a consistent understanding and application of Trust values. This will contribute to improved staff experience, stronger team performance and a more supportive, positive workplace culture.

Increasing completion of Managers' Essentials will build leadership capability and strengthen consistency in people management practices. This will contribute to a more engaged workforce and better staff experiences, ultimately supporting stronger, more effective patient care.

Strengthening the speaking up culture will support staff to feel safe and confident to raise concerns, with greater Trust that these will be heard and acted upon. This will enhance psychological safety, support earlier identification of risks, and contribute to improved staff experience and safer patient care.

3. Preventing Violence and Aggression

Objective: Reduce staff experience of violence and aggression from patients and the public, improve reporting, and ensure every affected member of staff is supported - recognising that women, disabled and ethnic minority staff report disproportionate exposure.

Standards addressed: WWES 5; WDES 4.1; WRES 5.

Ref	Intervention	Owner	Milestone	Leading indicators (in-year)
3.1	Radar reporting redesign: simplified logging, categories aligned to NSS definitions, delivered through the established workstream.	Radar Manager with Senior DEI Business Partner	Revised system live Dec 2026	Report volumes (SPC); % reports with complete demographic and category data; time-to-log
3.2	Post-incident support pathway: documented supportive contact within 72 hours of every reported physical violence incident, with escalation to OHWB where indicated.	Violence and Aggression Steering Group chair	Pathway live Jan 2027	% incidents with documented 72-hour contact; OHWB referral conversion; violence-related sickness absence (ESR)
3.3	Hotspot prevention: environmental, staffing and security reviews in the highest-incident areas identified through improved Radar data, with site-owned prevention plans.	Site ADPs with Hospital Executive Directors	First hotspot reviews Apr 2027	Hotspot incident rates (SPC); % review recommendations implemented
3.4	Demographic disparity reporting: violence and aggression exposure and reporting rates by sex, disability and ethnicity reported quarterly to the Steering Group.	DEI Compliance Partner	First quarterly report Mar 2027	Report delivered; disparity gaps trended

Mechanism of change

Reporting friction currently suppresses the data needed for targeted prevention; fixing Radar is therefore the gateway intervention. Reliable post-incident support changes the experience measure ('supported following incidents') directly and reduces absence; prevention plans then act on the exposure measure. As with bullying and harassment, reported incident volumes are expected to rise before experienced violence falls.

Outcome measures (lagging)

Support: 70% (2026) to 90% (2028) of staff feel supported following incidents. Baseline to be established via the first post-incident pathway audit.

Report: NSS physical violence reporting 67.60% (2026) to 71.92% (2028). Baseline: 2025 NSS 65.96% (women) / all-staff figure to be stated from the 2025 extract.

Prevent: NSS physical violence from patients/public 13.65% (2026) to 12.46% (2028), all staff. Baseline: 2025 NSS all-staff figure to be stated alongside the women's figure (13.39%) so the trajectory is auditable.

Impact

By supporting staff following incidents, staff feel valued by the Trust and are less likely to take periods of sickness absence related to violence and aggression.

Increased reporting enables the Trust to respond to incidents more effectively through trend analysis and targeted interventions.

Reducing incidents of physical violence helps the Trust create an environment where all staff feel safe, supported and able to work without fear of violence and aggression.

4. Race Improvement Programme

Objective: Convert workforce diversity into equitable progression, experience and senior representation - closing the gap between 45.40% overall ethnic minority representation and 20.65% at Band 8a and above.

Standards addressed: WRES 1, 2, 3, 4, 6, 7, 8, 9.

Ref	Intervention	Owner	Milestone	Leading indicators (in-year)
4.1	Complete progression focus groups at Band 8a+ across all sites; publish thematic findings and convert to a targeted intervention set.	Associate Director of Inclusion with DEI Business Partners	All sites complete Nov 2026; interventions agreed Jan 2027	Sessions held per site; themes published; interventions with owners agreed
4.2	Sponsorship programme (distinct from mentorship): senior leaders sponsor ethnic minority staff at Bands 7-8b, with explicit accountability for advocacy into stretch roles, visibility and appointment opportunities.	Associate Director of Inclusion; GET members as sponsors	Cohort 1 (c.30) launched March 2027	Cohort size; sponsor engagement (meetings held); participant applications and appointments to higher-band roles (tracked vs matched comparison)
4.3	Divisional talent boards scrutinising all Band 7 to 8a+ appointments: shortlist diversity reviewed, documented justification required where shortlists lack diversity, outcomes reported quarterly.	ADPs with CDG leadership	Boards operating Jan 2027	% senior campaigns reviewed; % shortlists meeting diversity expectation; internal promotion rates by ethnicity (quarterly SPC)
4.4	Fair Recruitment Expert (FRE) evaluation: pre/post analysis of appointment ratios in FRE-assured vs unassured 8a+ campaigns, using the 50 assured processes already banked.	DEI Compliance Partner; DEI Business Partners with Resourcing	Evaluation reported Dec 2026	Evaluation delivered; FRE coverage % of 8a+ campaigns; FRE numbers trained (62 by Mar 2027)
4.5	RACE Equality Code: publish the 'apply and explain' statement and resulting actions from the final report, through the Race Improvement Programme.	Director of Inclusion, sponsored by Chair/CEO/CPO	Statement published Oct 2026	Statement published; actions integrated into this plan at first annual review
4.6	Band 8a+ representation feasibility model: published arithmetic showing net additional ethnic minority appointments required per year against expected vacancy turnover to reach 24.65% by 2028, reviewed annually.	Workforce analytics with Director of Inclusion	Model published Nov 2026	Actual vs required net appointments (quarterly); vacancy and turnover assumptions reviewed

Mechanism of change

The diagnosis from focus groups - sponsorship, opaque opportunity-sharing, structural barriers - dictates the intervention set. Sponsorship moves appointments where mentorship does not, because sponsors spend capital rather than give advice. Talent-board scrutiny changes panel behaviour at the point of decision, which is where the sector evidence (structured processes, accountable challenge) says the dial moves. The feasibility model converts the representation target from aspiration to commitment: the Trust will know each quarter whether the appointment run-rate is sufficient, rather than discovering a miss in 2028.

Outcome measures (lagging)

Representation at Band 8a+: 20.65% (2026 baseline) to 22.65% (2027) to 24.65% (2028).

NSS fair career progression: all staff 52.58% (2026) to 53.98% (2028); ethnic minority staff 46.46% (2026) to 47.86% (2028). Treated as re-baselined at 2025 owing to the Q15 wording change.

NSS bullying/harassment from staff (ethnic minority) 26.88% (2026) to 24.10% (2028); discrimination from staff (ethnic minority) 13.61% (2026) to 10.83% (2028). Baseline: 2025 NSS (26.95% and 15.00% respectively).

WRES 2 appointment ratio and WRES 3 disciplinary ratio: sustained movement toward parity, monitored via SPC.

Impact

Reducing racism from both colleagues and managers, alongside increasing the proportion of staff who do not experience these behaviours, will support a more respectful, inclusive and psychologically safe working environment. This will strengthen Trust in leadership, improve staff wellbeing, and help create a culture where all staff feel valued and able to belong.

Staff feel that opportunities are equitable and inclusive, which supports engagement, retention and overall confidence in the Trust.

By making recruitment, promotion, talent management and leadership development processes more equitable there will be more equitable career progression opportunities for ethnic minority staff.

By increasing the representation at Band 8a and above there will be Improved representation in senior leadership roles.

The sponsorship programme will increase progression into senior leadership roles and improve the lack of access to influence, visibility and advocacy.

5. Sexual Safety

Objective: Prevent unwanted behaviour of a sexual nature, meet the Trust's Worker Protection Act duty to take all reasonable steps to prevent sexual harassment, and ensure those affected are supported through credible, well-handled processes.

Standards addressed: WWES 6; NHS Sexual Safety Charter commitments.

Ref	Intervention	Owner	Milestone	Leading indicators (in-year)
5.1	Sexual misconduct training: state the target population and complete rollout - all staff in identified hotspot and patient-facing areas first, then Trust-wide. Current completion 2,507 (c.10% of workforce) - the denominator will be reported from now on.	Sexual safety lead with OD Team	Hotspot populations 90% by Jun 2027; Trust-wide 75% by Mar 2028	Completion % against stated denominator (quarterly); hotspot-area completion vs Trust average
5.2	Hotspot interventions: NSS and reporting-tool data triangulated to identify areas of elevated risk; local prevention plans co-produced as per the bullying and harassment model.	Senior DEI Business Partners	Hotspot plans live Apr 2027	Reports via new tool (volume and source, SPC); % hotspot plans on track
5.3	Sexual safety team development: investigation and support standards aligned to the Trust's Dignity at Work QA framework; every investigation offers a named support contact to those affected.	Sexual safety lead with CPO	Standards live Jan 2027	% investigations meeting standard on QA sample; investigation cycle times; % affected staff taking up support offer
5.4	White Ribbon accreditation completed and Domestic Abuse Policy pathways promoted alongside it.	Director of Inclusion	Accreditation submission Dec 2026	Submission made; action plan milestones met

Mechanism of change

The Worker Protection Act duty is evidenced by preventative steps proportionate to risk - which requires knowing the denominator and targeting training where exposure is highest, not counting completions. Credible, supported investigations drive disclosure; disclosure drives the data; the data drives prevention. The reporting measure is therefore expected to rise ahead of the experience measure falling.

Outcome measures (lagging)

NSS: unwanted behaviour of a sexual nature from colleagues 3.86% (2026) to 2.92% (2028), all staff, with the women's figure (4.28% in 2025) reported alongside. Hotspot areas: 0.47pp year-on-year reduction.

Support: 70% (2026) to 90% (2028) of staff feel supported following investigations; baseline to be established through the first QA sample.

Public-source measure (worsened to 9.52% for women in 2025): monitored through this workstream jointly with Violence and Aggression; a specific public-facing prevention approach to be scoped by Jun 2027.

Impact

Reducing incidents of sexual harassment is essential for the Trust to meet its legal duties. It also helps the Trust create a safe and inclusive culture where staff feel confident to speak up and challenge unacceptable behaviours.

6. Stay Well

Objective: Support staff to remain well at work, with adjustments in place before attendance or capability suffers, and close the disability gaps in pressure-to-work and adjustment provision.

Standards addressed: WDES 3, 6, 8, 12, 13; WRES 3, 5, 6; WWES 3, 9.

Ref	Intervention	Owner	Milestone	Leading indicators (in-year)
6.1	Adjustments pathway: end-to-end review of request-to-implementation.	Director of Inclusion and Director of Occupational Health with Workplace Adjustment Officer	Review Dec 2026; business case Mar 2027	Adjustment request volumes and turnaround times; % adjustments implemented within agreed timescale
6.2	GHH positive-deviant exercise: structured learning review of why GHH leads on adjustments (76.90%) and pressure-to-work, with transferable practice adopted at other sites.	Senior DEI Business Partner (GHH) with site ADPs	Review Nov 2026; adoption plan Feb 2027	Practices identified and adopted per site; site-level adjustment and pressure-to-work measures
6.3	Capability gateway: before any formal capability process is opened, a recorded check that required adjustments were in place and working - addressing the 2.94 WDES Metric 3 ratio at its most likely source.	ADPs with Workplace Adjustment Officer	Gateway live with Resolution Procedure	% capability entries with completed adjustment review; capability entries by disability status (counts, given small numbers)
6.4	Targeted MSK and stress prevention in hotspot areas; wellbeing call offer maintained for counselling waiting list; Supportive Listening training rollout to managers.	Director of Occupational Health	Supportive Listening 500 managers by Jun 2027	OH referral waiting times (currently c.3 weeks - maintain); counselling waiting list and time-to-first-contact; managers trained
6.5	Women's Health Strategy: ESR absence coding improved to separate menopausal, menstrual and gynaecological categories so that WWES Metric 3 becomes reliable; strategy launched with data workstream first.	Director of Occupational Health with Workforce Systems	Coding change Apr 2027; re-baseline in 2027 report	Coding completeness on new categories; recorded women's-health absence (expected to rise as recording improves)

Mechanism of change

Adjustments are the single point of leverage across three WDES measures: staff with working adjustments feel less pressure to attend when unwell, are absent less, and should rarely reach capability processes. The capability gateway applies the Trust's just-culture logic to WDES Metric 3: before asking whether an individual is performing, confirm the system gave them the means to.

Outcome measures (lagging)

NSS: Trust takes positive action on health and wellbeing 54.68% (2026) to 57.99% (2028); work-related stress 44.14% to 42.01%; MSK as a result of work 44.25% to 43.25%. Baseline: 2025 NSS.

NETS: able to access help and resources 72.61% (2026) to 75.91% (2028).

WDES: pressure to work (26.87% in 2025) and adjustments in place (72.62% in 2025); continued improvement, gap-to-non-disabled reported alongside; capability entries by disability status reported as counts with the gateway compliance rate.

WWES 3: reliable women's-health absence baseline re-established in the 2027 report following the coding change.

Impact

Taking positive action on health and wellbeing will support staff to feel confident in sharing their disability status with the Trust, thereby increasing disability representation across the workforce. Positive action will also reduce the pressure staff feel to work when they are unwell, helping to promote a healthier and more sustainable working environment.

Reducing MSK related absences will be achieved by ensuring staff receive the workplace adjustments they need to attend work safely and consistently.

Addressing the causes of work-related stress — such as formal people processes, bullying and harassment, and violence and aggression — will improve staff wellbeing and attendance at work.

7. Inclusive Recruitment below Band 8a (new programme)

Objective: Reverse the deterioration in disabled candidates' relative likelihood of appointment (1.17 to 1.34), which arises mainly in high-volume recruitment below Band 8a - outside the reach of the FRE assurance model.

Standards addressed: WDES 2; supports WRES 2 and WWES 2.

Ref	Intervention	Owner	Milestone	Leading indicators (in-year)
7.1	Funnel diagnostic: application-to-shortlist-to-appointment conversion rates by disability status for Bands 2-7, by staff group and site, to locate precisely where disabled candidates fall out.	Director of Inclusion	Diagnostic reported Nov 2026	Diagnostic delivered; funnel conversion rates established as a routine quarterly dataset
7.2	De-identified shortlisting pilot in two high-volume staff groups, with a matched-comparison evaluation of appointment ratios.	Associate Director of Talent	Pilot Jan-Sep 2027; evaluation Dec 2027	Pilot campaign volumes; appointment ratio in pilot vs comparison campaigns
7.3	Interview adjustments guarantee: adjustments proactively offered at invitation stage for every interview, with panel training on providing them; monitored through candidate feedback.	Associate Director of Talent with Workplace Adjustment Officer	Live Feb 2027	% invitations carrying the offer; % requested adjustments provided; disabled candidate feedback scores
7.4	Risk-based assurance sampling of sub-8a campaigns using the FRE methodology, prioritised by the funnel diagnostic findings.	DEI Compliance Partner with FRE cohort	Sampling live Apr 2027	Campaigns sampled per quarter; issues identified and remediated

Mechanism of change

The FRE model assures Band 8a+ appointments, but the aggregate WDES 2 ratio is driven by the volume bands below it, where no control currently operates. The diagnostic locates the leak in the funnel; de-identification and the adjustments guarantee act on the two most evidenced failure points (shift bias and interview accessibility); assurance sampling extends accountability to where the volume is.

Outcome measures (lagging)

WDES 2 appointment ratio: return to no worse than 1.17 by the 2027 report and no worse than 1.10 by 2028 (proposed targets for CPO/GET agreement; to be confirmed against the funnel diagnostic).

Funnel measures: disabled application-to-shortlist and shortlist-to-appointment conversion gaps narrowing year-on-year from the Nov 2026 baseline.

Impact

The Trust will have a clearer, evidence-based understanding of where disabled candidates are being disproportionately lost in the recruitment process.

Recruitment panel capability will increase understanding of reasonable adjustments and inclusive recruitment practices.

8. Board and Senior Representation (new programme)

Objective: Address the widening gap between Board composition and the workforce (WRES 9 gap widened in 2026) and make Board-level disability reporting reliable.

Standards addressed: WRES 9; WDES 10; WWES 11.

Ref	Intervention	Owner	Milestone	Leading indicators (in-year)
8.1	Inclusive succession planning for Board vacancies: with the Chair and, for NED appointments, the Council of Governors - inclusive role specifications, search partners with demonstrable diverse-appointment track records, and diverse long-lists as a stated expectation.	Trust Secretary with Chair; CPO advising	Framework agreed Jan 2027, applied to all subsequent vacancies	% Board campaigns using the framework; long-list and short-list composition per vacancy (reported to Nominations Committee)
8.2	Board-ready development for ethnic minority staff at Bands 8d/9/SM: aligned to the sponsorship programme (4.2), including committee observer placements and Director-style external opportunities.	CPO	Cohort identified Mar 2027	Participants; placements taken up; subsequent senior appointments
8.3	Board declaration completeness: reduce unknown disability status among Board members (currently 8 of 23) to zero, so WDES Metric 10 reports on a complete denominator.	Trust Secretary	Complete by Mar 2027	Unknown-status count (target zero); WDES 10 reported on known-status denominator until then

Mechanism of change

Board composition changes through vacancies, so the intervention point is the appointment process itself - search practice and long-list composition - paired with a credible internal pipeline. Declaration completeness is a precondition for honest reporting: a Board metric with 35% missing data cannot evidence anything. NED appointments rest with the Council of Governors, so this programme influences rather than controls; the plan is explicit about that boundary and reports what the Trust can actually own.

Outcome measures (lagging)

WRES 9: Board-to-workforce representation gap narrowing.

WDES 10: reported on a complete declaration base from 2027.

WWES 11: maintain progress (39.13% women in 2026) with the succession framework applied to all vacancies.

Impact

By increasing representation at senior level, we are strengthening inclusive decision making, and by increasing representation at band 8a and above, we are also creating a pipeline for greater Board level representation.

9. Measurement and Evaluation (cross-cutting)

Objective: Give the Board reporting it can rely on: statistically literate, intersectional where it matters, and honest about what the data can and cannot show.

Standards addressed: All standards; enables every programme above.

Ref	Intervention	Owner	Milestone	Leading indicators (in-year)
9.1	Statistical Process Control (SPC) adoption: WRES, WDES and WWES indicators and programme leading indicators presented to the People and Culture Committee as SPC/run charts per Making Data Count, replacing annual pre/post comparison wherever data frequency permits.	Workforce analytics with DEI Compliance Partner	First SPC pack Dec 2026	Indicators converted; committee feedback
9.2	Classification rubric: separate thresholds for percentages, likelihood ratios and engagement scores applied to all future summary tables.	Director of Inclusion	Applied from Oct 2026	Rubric published within reports
9.3	Intersectional analysis delivered: first cross-tabulations in the 2027 report (Band 8a+ representation by ethnicity and sex, and harassment experience by disability and ethnicity) with ESR/NSS feasibility confirmed by Dec 2026.	Director of Inclusion	Feasibility Dec 2026; analysis in 2027 report	Cross-tabulations produced; small-number suppression rules agreed
9.4	Contribution analysis: annual contribution story per programme to the Culture Transformation Programme Board, forming the evidence spine of the 2027 and 2028 combined reports.	Programme SROs, coordinated by Head of OD	First stories Jun 2027	Stories delivered; NED feedback on assurance quality
9.5	Data quality: NSS response rates and group sizes published per metric; Q15 career progression measures treated as re-baselined at 2025; recruitment funnel data (application stage) built for all three standards for the 2027 report.	Director of Inclusion	2027 report cycle	Response rates published; application-stage data available

Mechanism of change

Every programme above depends on being able to distinguish signal from noise and delivery from drift. SPC does the first; contribution analysis does the second; the corrected rubric and intersectional cross-tabulation make the annual report defensible under NED scrutiny. This workstream is deliberately owned centrally so that measurement discipline is uniform across programmes rather than negotiated within each.

Outcome measures (lagging)

The 2027 combined report is produced with: corrected rubric, SPC presentation, stated response rates and denominators, at least two intersectional cross-tabulations, and a contribution story per programme.

Strategic outcome measure (unchanged): top 25% of Trusts for staff recommending UHB as a place to work in the NSS by 2029.

Governance, reporting and review

Executive sponsor: Chief People Officer. Each programme has a Senior Responsible Owner as identified above.

Reporting rhythm: leading indicators quarterly to the Culture Transformation Programme Board; hotspot and site measures bi-monthly to site People and Culture Committees; SPC indicator pack to the Trust People and Culture Committee from December 2026; annual assurance to the Board through the combined Workforce Equality Standards Report, structured around the contribution stories.

Review points: milestone slippage of more than one quarter on any intervention is reported by exception to the Programme Board with a recovery plan. The full plan is reviewed annually alongside the combined report, at which point trajectories are restated against actual baselines where the 2026 milestones were set without them.

Conclusion

This is the first year that the Trust has produced a combined Workforce Disability, Race, and Women's Equality Report, demonstrating a more integrated and intersectional approach to understanding staff experience and inequality. Bringing WDES, WRES, and WWES together enables the Trust to move beyond individual indicators and identify shared themes and patterns across staff groups.

This intersectional approach enables the Trust to better understand how different aspects of identity and experience combine to shape the working lives of staff and the care experiences of patients. By considering the interplay between identities such as disability, race and sex, the Trust can identify more nuanced inequalities that may not be visible through a single-lens analysis. This supports the development of more targeted and effective interventions, leading to improved staff experience, greater inclusion, and a more equitable working environment. In turn, a more inclusive and supported workforce contributes to the delivery of higher-quality, safer and more compassionate patient care, supporting improved patient outcomes and experience.

The alignment of the 2026–2029 equality action plan to the Trust's Cultural Transformation Programme provides a clear framework for delivering continued improvements, strengthens governance, and ensures equality priorities are embedded within core workstreams. Through its six workstreams, the programme enables coordinated action across key areas such as bullying and harassment, compassionate leadership, violence and aggression, race improvement, sexual safety, and wellbeing.

Overall, the 2026 report demonstrates clear and sustained improvement across the workforce equality standards. The WDES data shows a largely positive picture, with improvements across most metrics. The WRES results reflect the strongest position reported to date with improvements across most indicators, and the WWES data indicates a broadly stable position.

This report forms part of a broader suite of reports used by the Trust to assess and monitor its equality performance. These standards are considered alongside other key sources of assurance, including disability, ethnicity and gender pay gap reports, the Equality Delivery System (EDS), and the Trust's Annual Workforce Diversity Report. Together, these reports provide a comprehensive and triangulated assessment of workforce equality, enabling the Trust to identify areas of progress and persisting inequalities that inform strategic priorities designed to support continuous improvement in staff experience and patient care outcomes.

While some inequalities remain, these are clearly identified and reflected in the targeted action plan. Through sustained delivery of the Cultural Transformation Programme and continued application of an intersectional approach, the Trust is well positioned to build on this progress and further improve outcomes, ensuring that an inclusive culture is embedded across the Trust, where all staff feel a sense of belonging, are able to thrive, recognise their value, and feel valued.

Appendix 1

Trust Board composition

Data is a snapshot taken from ESR on 31 March 2026.

	Voting or non-voting	Total	Demographic Breakdown						
			Disabled	Non-Disabled	Unknown (Disability)	White	Ethnic Minority	Women	Men
Board of Directors	Voting and non-voting	23	2	13	8	15	8	9	14
Executive Directors	Voting	6	1	4	1	5	1	2	4
Executive Team	Non-Voting	6	0	4	2	5	1	2	4
Non-Executive Directors	Voting	11	1	5	5	5	6	5	6

The Executive Directors are;

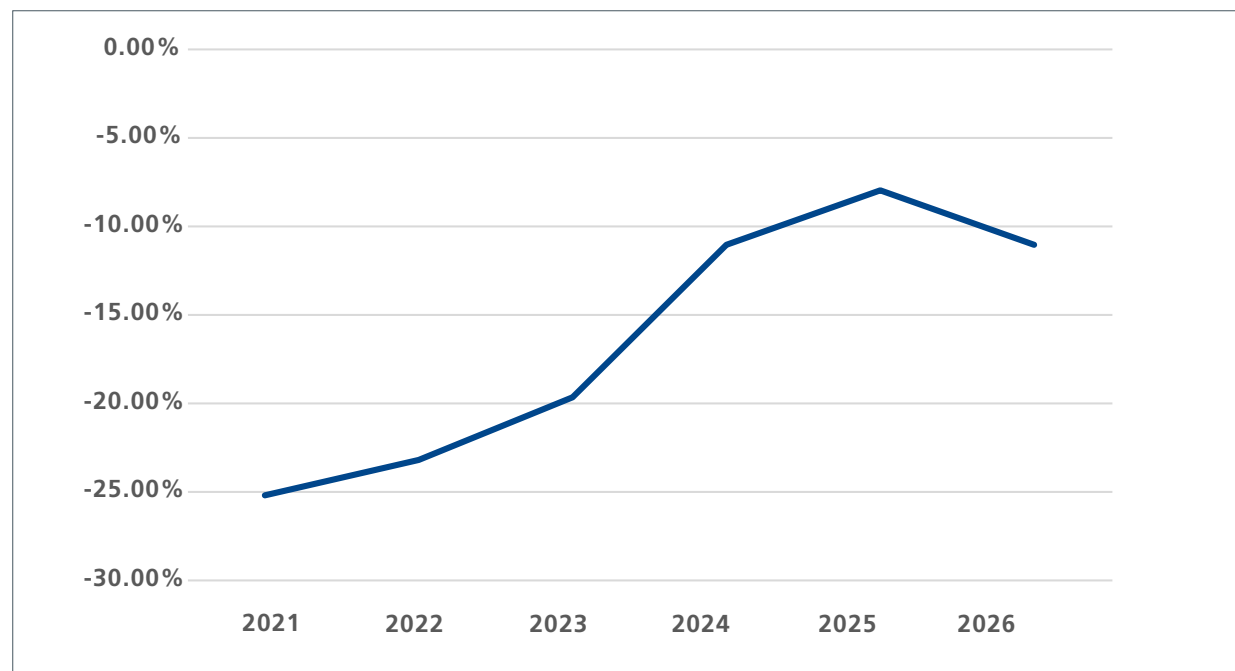
- Chief Executive;
- Chief Financial Officer;
- Chief Operating Officer;
- Chief People Officer;
- Chief Nurse;
- Chief Medical Officer.

The Executive Team are;

- Director of Communications;
- Hospital Executive Director for Good Hope Hospital;
- Hospital Executive Director for Birmingham Heartlands Hospital;
- Hospital Executive Director for Queen Elizabeth Hospital Birmingham;
- Hospital Executive Director for Solihull Hospital;
- Trust Secretary.

Appendix 2

WRES indicator 9 – Board Representation



2021	2022	2023	2024	2025	2026
-25.20%	-23.20%	-19.60%	-11.00%	-7.94%	-10.62%

For this indicator, a value closer to zero reflects stronger alignment between Board and workforce representation.

When compared with the overall Trust workforce, ethnic minority staff remain underrepresented at Board level. The representation gap has widened from 7.67% to 10.62% in 2026, showing that Board representation has moved further away from parity.

The data presented in the table highlights the ethnicity representation gap. This is calculated by subtracting the percentage of ethnic minority Board members (34.78%) from the percentage of ethnic minority staff in the overall workforce (45.40%%). A positive value indicates overrepresentation, whereas a negative value (shown with a minus sign) indicates underrepresentation. In this case, the negative value shows that ethnic minority staff make up a smaller proportion of the Board membership compared with the overall workforce.

Appendix 3

Intersectional analysis by disability, ethnic minority and sex for AfC Band 8a-9 and VSM.

Band 8a							
AfC Pay Band	Sex	Total headcount (sex)	Ethnicity	Total headcount (ethnicity)	Disability	Total headcount (disability)	% of total 8a Pay Band
Total headcount of 8a pay band 834	Female	584	Ethnic Minority	122	No	111	13.31%
					Not Declared	3	0.36%
					Prefer Not To Answer	0	0.00%
					Yes	8	0.96%
			Not Declared	9	No	6	0.72%
					Not Declared	2	0.24%
					Prefer Not To Answer	0	0.00%
					Yes	1	0.12%
			White	453	No	386	46.28%
					Not Declared	30	3.60%
					Prefer Not To Answer	1	0.12%
					Yes	36	4.32%
	Male	250	Ethnic Minority	69	No	63	7.55%
					Not Declared	1	0.12%
					Prefer Not To Answer	0	0.00%
					Yes	5	0.60%
			Not Declared	10	No	8	0.96%
					Not Declared	2	0.24%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			White	171	No	146	17.51%
					Not Declared	8	0.96%
					Prefer Not To Answer	1	0.12%
					Yes	16	1.92%

Band 8b							
AfC Pay Band	Sex	Total headcount (sex)	Ethnicity	Total headcount (ethnicity)	Disability	Total headcount (disability)	% of total 8b Pay Band
Total headcount of 8b pay band 301	Female	204	Ethnic Minority	35	No	35	11.63%
					Not Declared	0	0.00%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			Not Declared	3	No	3	1.00%
					Not Declared	0	0.00%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			White	166	No	147	48.84%
					Not Declared	6	1.99%
					Prefer Not To Answer	0	0.00%
					Yes	13	4.32%
	Male	97	Ethnic Minority	20	No	16	5.32%
					Not Declared	2	0.66%
					Prefer Not To Answer	1	0.33%
					Yes	1	0.33%
			Not Declared	6	No	5	1.66%
					Not Declared	0	0.00%
					Prefer Not To Answer	0	0.00%
					Yes	1	0.33%
			White	71	No	58	19.27%
					Not Declared	6	1.99%
					Prefer Not To Answer	1	0.33%
					Yes	6	1.99%

Band 8c							
AfC Pay Band	Sex	Total headcount (sex)	Ethnicity	Total headcount (ethnicity)	Disability	Total headcount (disability)	% of total 8c Pay Band
Total headcount of 8c pay band 116	Female	69	Ethnic Minority	16	No	13	11.21%
					Not Declared	1	0.86%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			Not Declared	1	No	1	0.86%
					Not Declared	0	0.00%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			White	52	No	43	37.07%
					Not Declared	4	3.45%
					Prefer Not To Answer	0	0.00%
					Yes	5	4.31%
	Male	47	Ethnic Minority	7	No	5	4.31%
					Not Declared	1	0.86%
					Prefer Not To Answer	0	0.00%
					Yes	1	0.86%
			Not Declared	1	No	1	0.86%
					Not Declared	0	0.00%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			White	39	No	29	25.00%
				39	Not Declared	5	4.31%
				39	Prefer Not To Answer	0	0.00%
				39	Yes	5	4.31%

Band 8d							
AfC Pay Band	Sex	Total headcount (sex)	Ethnicity	Total headcount (ethnicity)	Disability	Total headcount (disability)	% of total 8d Pay Band
Total headcount of 8d pay band 57	Female	37	Ethnic Minority	3	No	3	5.26%
					Not Declared	0	0.00%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			Not Declared	0	No	0	0.00%
					Not Declared	0	0.00%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			White	34	No	29	50.88%
					Not Declared	3	5.26%
					Prefer Not To Answer	0	0.00%
					Yes	2	3.51%
	Male	20	Ethnic Minority		No	0	0.00%
					Not Declared	0	0.00%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			Not Declared	1	No	1	1.75%
					Not Declared	0	0.00%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			White	19	No	17	29.82%
					Not Declared	2	3.51%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%

Band 9							
AfC Pay Band	Sex	Total headcount (sex)	Ethnicity	Total headcount (ethnicity)	Disability	Total headcount (disability)	% of total 9 Pay Band
Total headcount of 9 pay band 20	Female	12	Ethnic Minority	2	No	2	10.00%
					Not Declared	0	0.00%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			Not Declared	1	No	1	5.00%
					Not Declared	0	0.00%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			White	9	No	7	35.00%
					Not Declared	2	10.00%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
	Male	8	Ethnic Minority	1	No	1	5.00%
					Not Declared	0	0.00%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			Not Declared	0	No	0	0.00%
					Not Declared	0	0.00%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			White	7	No	6	30.00%
					Not Declared	1	5.00%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%

VSM							
AfC Pay Band	Sex	Total headcount (sex)	Ethnicity	Total headcount (ethnicity)	Disability	Total headcount (disability)	% of total VSM Pay Band
Total headcount of VSM pay band 54	Female	31	Ethnic Minority	7	No	5	9.26%
					Not Declared	0	0.00%
					Prefer Not To Answer	0	0.00%
					Yes	2	3.70%
			Not Declared	2	No	1	1.85%
					Not Declared	1	1.85%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			White	22	No	16	29.63%
					Not Declared	3	5.56%
					Prefer Not To Answer	0	0.00%
					Yes	3	5.56%
	Male	23	Ethnic Minority	3	No	2	3.70%
					Not Declared	1	1.85%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			Not Declared	1	No	1	1.85%
					Not Declared	0	0.00%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%
			White	19	No	17	31.48%
					Not Declared	2	3.70%
					Prefer Not To Answer	0	0.00%
					Yes	0	0.00%

