NHS
Whittington Health
NHS Trust

Whittington Health

2022 / 2023

Public Sector Equality Duty Compliance Report

Diversity & Inclusion

Contents

Item	Page Number
Purpose of the Report	2
The Protected Characteristics	3
About Whittington Health	5
B: Patient and Service Users	14
C: Workforce	37
D: Equality Objectives	85
Appendix A Equality Objectives	86

A. Context of the report

1. Purpose of the Report

1.1 This report presents equality information about the Trust's workforce, patients and service users. It relates to the protected characteristics set out in the Equality Act 2010, which requires publically funded bodies to demonstrate how they are meeting the general and specific duties of the Public Sector Equality Duty (PSED) in line with the statutory requirements.

1.2 The report uses data between 1 April 2022 and 31 March 2023; some datasets require a single snapshot date of 31 March 2023.

1.3 The report is split into four main Sections: 'A. Context of the report'; 'B. Patients and Service Users'; 'C. Workforce' and 'D: Equality Objectives. Information in each section is presented mainly in headings related to the nine protected characteristics. Some sections contain significantly less information than others, reflecting the challenges and limitations of collecting information and individuals' right to choose what to disclose.

Where there is limited information, these come with the caveat that it is hard to conclude except to give an opinion in places.

1.4 The Equality Act 2010 (the Act) replaced previous anti-discrimination legislation. It simplified the law, removing inconsistencies to make it easier for people to understand and comply. The Public Sector Equality Duty (section 149 of the Act) came into force on 5 April 2011.

1.5 The Equality Duty applies to public bodies and others carrying out public functions. It supports good decision-making by ensuring public bodies consider how different people will be affected by their activities, helping them to deliver policies and services that are efficient and effective, accessible to all, and meet different people's needs.

1.6 The specific duties in the regulations strengthen the Equality Duty. The specific duties require public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty and to set specific, measurable equality objectives.

1.7 The information published should demonstrate the Trust's regard and support for the achievement of the three aims of the Equality Duty:

- Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristic and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not.

1.8 The nine protected characteristics covered by the Equality Duty are:

i. Age
ii. Disability
iii. Gender reassignment
iv. Marriage and civil partnership (elimination of unlawful discrimination only)
v. Pregnancy and maternity
vi. Race (this includes ethnic or national origins, colour or nationality)
vii. Religion or belief (this includes lack of belief)
viii. Sex
ix. Sexual orientation

2. The Protected Characteristics

2.1 **Age** – This refers to a person or persons belonging to a particular age group. An age group includes people of the same age and people of a particular range of ages. People in the same age group share the protected characteristic of age.

2.2 **Disability** – In the Act, a person has a disability if they have a physical or mental impairment, which has a substantial and long-term adverse effect on their ability to perform normal day-to-day activities. For the purposes of the Act, these words have the following meanings:

- *substantial* means more than minor or trivial
- *long-term* means that the effect of the impairment has lasted or is likely to last for at least twelve months or till the end of life (there are special rules covering recurring or fluctuating conditions)
- *normal day-to-day activities* include everyday things like eating, washing, walking and going shopping

There are additional provisions relating to people with progressive conditions. The Act protects people with HIV, cancer or multiple sclerosis from the point of diagnosis. The Act considers people with some visual impairments automatically to be disabled. People with the same disability share the protected characteristic of disability.

2.3 **Gender reassignment** – For the purposes of the Act, where a person has proposed, started or completed a process to change their sex. A person who has just started the process of changing their sex and another who has completed the process share the characteristic of gender reassignment.

2.4 **Marriage and Civil Partnership** – This refers to people with the protected characteristic of being married or civil partners. A person engaged to be married, is not married and, therefore, does not have this protected characteristic. A divorcee or a person in a dissolved civil partnership is not married or in a civil partnership and therefore, does not have this protected characteristic.

2.5 **Pregnancy and maternity** – A woman remains protected in their employment during pregnancy and any statutory maternity leave to which they are entitled. This provision is now separate from protection on the grounds of sex, which is not available to a woman during pregnancy and maternity. It is unlawful to take into account an employee's period of absence due to pregnancy-related illness when making decisions about their employment.

2.6 **Race** – For the purposes of the Act, 'race' includes colour, nationality and ethnic or national origins. People with or share characteristics of colour, nationality or ethnic or national origins may belong to a particular racial group. Examples: colour includes being black or white, and nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be 'Black Britons,' which would encompass those people who are both Black and British citizens.

2.7 **Religion or belief** – This covers people with religious or philosophical beliefs. To be considered a religion within the meaning of the Act, it must have a clear structure and belief system. The Act includes the following examples: The Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism. To be considered a philosophical belief for the purposes of the Act, it must be:

- genuinely held

- be a belief and not an opinion or viewpoint
- be a belief as to a weighty and substantial aspect of human life and behaviour
- attain a certain level of cogency, seriousness, cohesion and importance
- be worthy of respect in a democratic society, compatible with human dignity and not conflict with the fundamental rights of others

The Act cites humanism and atheism as examples of philosophical beliefs. Adherence to a particular football team would not be a religion or belief. A cult involved in illegal activities would not satisfy these criteria. People of the same or different religions or beliefs share the protected characteristic of religion or belief.

The Act also protects people who do not have a religion or belief (non-belief).

2.8 **Sex** – For the purposes of the Act, sex means being a man or a woman.

2.9 **Sexual Orientation** – The Act defines a person's sexual orientation towards:

- People of the same sex as them (a person is a gay man, gay woman or a lesbian).
- People of the opposite sex from them (the person is heterosexual).
- People of both sexes (the person is bisexual).

People sharing a sexual orientation means they are of the same sexual orientation and therefore, share the characteristic of sexual orientation.

3. About Whittington Health

3.1 Whittington Health provides hospital and community care services to over half a million people living in Islington and Haringey and those living in Barnet, Enfield, Camden and Hackney.

3.2 We provided over 40 acute and 60 community health services in 2022/23. This is in addition to providing dental services in 10 London boroughs.

3.3 Every day, we aim to provide high-quality and safe healthcare to people in our hospital, in their homes or in nearby clinics. We are here to support our patients throughout their healthcare journey – this is what makes us an integrated care organisation.

3.4 We have an excellent reputation for being innovative, responsive and flexible to the changing clinical needs of the local population and for leading the way in providing integrated community and hospital services.

3.5 We are treating more patients than ever before and are dedicated to improving services to deliver the best care for our patients, with a clear focus on integrating care for women, children, and the adult frail.

3.6 Our 2019/24 strategy has four main objectives:

- Deliver outstanding safe, compassionate care in partnership with patients.
- Empower, support and develop an engaged staff community.
- Integrate care with partners and promote health and wellbeing.
- Transform and deliver innovative, financially sustainable services.

3.7 The Trust's ICARE values were developed through staff engagement and consultation and continue to be fundamental to everything we do at Whittington Health. An overarching equity value underpins them and forms the basis of expected staff behaviours.

3.8 Our service priorities are focussed on our population needs: integrating care in all settings with emphasis on women, children and frail adult patients and residents.

3.9 Our priority is to deliver the right care, at the right time, and in the right place for our patients. We provide an extensive range of services from our main hospital site and run services from over 30 community locations in Islington and Haringey, and our dental services are run from sites across 10 boroughs.

3.10 As an integrated care organisation, we bring safe and high-quality services closer to home and speed up communication between community and hospital services, improving our patients' experience, reducing admissions and speeding up discharge. Key to our approach is partnering with patients, carers, GPs, social care, mental health and other healthcare providers.

3.11 Our organisation has a highly regarded educational role. We teach undergraduate medical students (as part of University College London Medical School) and nurses and therapists throughout the year, alongside providing a range of

educational packages for postgraduate doctors and other healthcare professionals. We also have a growing research arm which is exceeding Clinical Research Network targets.

3.1 Other relevant reports and data

3.1.1 This report feeds into another range of statutory and NHS standards, which look at their subject areas in greater detail than this document.

These include:

- Workforce Disability Equality Standard
- Workforce Race Equality Standard
- Gender Pay Gap reporting.

The Workforce Disability and Equality Standard is available on the Trust's website. The Trust's statutory Gender Pay Gap report is available on the GPG Reporting Service.

3.1.2 When writing this report, data about the local population has been taken from the 2021 census. The latest census provides an up-to-date and comprehensive overview of the local population, including sexual orientation and gender identity.

3.2 Trustwide equality, diversity and inclusion related Achievements during 2022/23

Whittington Health Trust maintains its commitment to ensuring equity is a goal and decisive factor in delivering excellent patient care and creating a workplace environment that is considerate of our celebrated and diverse workforce. Equity ensures that patients and staff have adequate and appropriate support to enable them to utilise and provide Trust services.

Equality and equity are two very separate ideas. Some people mistakenly use the terms interchangeably. Equality is about providing the same resources to people in the hope that it will reduce discrimination or unfavourable treatment and is sometimes seen as a 'one-size fits all' approach. Whereas equity aims to provide targeted support depending on the needs of the individual.

The Trust has adopted various initiatives and projects, including:

3.2.1 Supported Internships

Supported internships are a one-year work-based study programme where young people spend most of their time-based at an employer.

They provide an important step on the employment journey, helping young people aged 16 to 24 with an Education, Health and Care plan (EHCP) or another form of Special Educational Needs (SEN) support to get the skills they need for work so that they can get into a job.

Using the Project Search model, Ambitious College and Care Trade works with the Whittington Hospital to support interns in developing workplace skills. The programme runs from September for one academic year, with interns based at the Whittington five days a week.

Job outcomes:

- 2019/20 – 2 out of 3 interns in paid work (the COVID-19 pandemic impacted the scheme)
- 2020/21 – 5 interns off-site; the COVID-19 pandemic impacted the scheme (all interns were granted extensions in 2021/22)
- 2021/22- 9 interns (4 returners) – this was our first full year on-site post Covid, and 6 out of 9 young people entered paid employment.
- 2022/23 - 10 interns working across multiple hospital departments in various roles, including administration, portering, stores, estates, pharmacy, Whittington Education Centre, patient dining and the play team. Two have already secured employment.

3.2.2 Disability Confident – Level 3

In December 2021, NHS England and Improvement (NHS E/I) accepted Whittington Health onto a national pilot run by the Nursing Directorate at NHS E/I. The Trust formalised this arrangement with NHS E/I through a Memorandum of Understanding in November 2021.

The focus was on the Disability Confident scheme to encourage employers to think differently about disability and to take action to make improvements to how they recruit, retain and develop people with disabilities.

There were two elements to the pilot. First, NHS organisations assessed current policies, procedures and practices and provided evidence for level three Disability Confident status. An external disability charity, the Shaw Trust, then validates the assessment.

As part of the Trust's submission, we provided a range of information to be validated, including the Recruitment and selection policy, WhitAbility terms of reference (disabled staff network) and the North Central London Apprenticeship policy.

The second element focussed on employability to ensure disabled people secure more paid fixed-term or permanent opportunities.

Whittington Health was successfully awarded level 3 status as a Disability Confident Leader and looks forward to continuing its excellent partnership with two external, third-sector bodies – Ambitious About Autism and the Autism Project – to host internship placements and to help attract and retain disabled people in our workforce.

3.2.3 Inclusion Team

The team consists of 3.2 whole-time equivalent (WTE) staff. A 1.2 WTE joint director role, an EDI manager, and a staff engagement officer. The joint directors are non-voting Board Members and give assurance to the Board and respective governance structures, including staff networks, on compliance with the Equality Act 2010 and other key performance indicators as listed:

- Disability Confident
- Gender Pay Gap
- Workforce Disability Equality Standard (WDES)
- Workforce Race Equality Standard (WRES)
- Medical Workforce Race Equality Standard
- Bank Workforce Race Equality Standard

The Trust has an Executive Director Lead for inclusion and a Non-Executive Lead (Glennys Thornton), with remits to support actions and ambition around cultural change, which ensures we are inclusive for all employees, including in areas of access and experience of all our patients, carers, visitors, volunteers, and goals for improving health outcomes.

Staff engagement has been pivotal for achieving our goals. As part of our work in this area, the staff networks continue to act as a method of consultation to help deliver equity within Trust policies, guidance, and staff engagement. We have developed a network and staff mission statement to enable staff to connect with our Trust values. It conveys a message of supporting belonging and influencing team cohesiveness and inclusion in the organisation.

Some of the key activities supporting our EDI goals and ambition includes:

3.2.3.1 Supporting our Integrated Clinical Service Units (ICSU) and Departments

The Inclusion Team contributes to ICSU and department away days to provide information

about improving equity and inclusion within their workforces. The Inclusion Team have also been invited to ICSU Board meetings to present data from the Workforce Race and Disability Equality Standards, these session inform ICSU management on the existing state of inclusion and improvements that could be made.

These activities promote a meaningful form of engagement, that further's the ICSU or department's accountability through sharing their data, action plans and monitoring progress and highlighlighting how all of this impacts the overall Trust performance on inclusion.

3.2.3.2 Staff Open Forum

The forum is run quarterly and provides engagement opportunities for all staff to hear about developments related to equality, diversity, and inclusion that are being delivered, and gives those who attend space to provide feedback.

Whilst the Inclusion Team leads this meeting, updates from departments or Integrated Clinical Service Units (ICSU) about work they undertake to further inclusion within their areas are particularly welcome.

During 2022/23, several topics were discussed that include:

- Findings and outcomes from WRES and WDES reports
- Experiences from attendees from the Black and Minority Ethnic (BME) Band 2-7 Development Programme
- Work within our Adult and Community Health Services ICSU to improve race equity within their workforce.

3.2.3.3 Staff Engagement and Awareness Events

The Inclusion Team has run and supported the staff networks to run events to increase awareness of inclusion within the Trust. These events also provide opportunities to engage staff and encourage their participation in the EDI agenda.

During 2022/23, a number of Trustwide events (supported by the Inclusion Team), including:

- National Day for Staff Networks
- South Asian Heritage Month
- Black History Month
- UK Disability History Month
- Lesbian, Gay, Bisexual and Transgender (LGBT) History Month
- Race Equality Week (see below)
- International Women's Day

3.2.3.4 Race Equality Week

The Trust participated in Race Equality Week between 6–12 February 2023. The week is designed to unite organisations and staff in workplace activities addressing race equality barriers. This event is the Trust's second time running Race Equality Week.

The theme for this year was 'It's Everyone's Business', and sessions explored important topics such as the new career development pathways for Allied Health Professionals and healthcare support workers, career development and opportunities for BME staff, how Freedom to Speak Up contributes to race equity, hearing from other NHS organisations about their adoption of the See Me First initiative, and the impact on medical staff.

3.2.3.5 Medical Workforce Race Equality Standard

The Medical Workforce Race Equality Standard (MWRES) and 11 indicators were introduced in September 2020 to recognise how the medical workforce differs from the rest of the NHS workforce.

The first MWRES report was published in July 2021. In response, the Trust has created the post of MWRES Leads. The Trust is one of the first to introduce the MWRES lead role. One core focus of the MWRES Lead role is improving the Trust support and development of International Medical Graduates (IMG). A programme and handbook have been produced to support the newly appointed

IMGs settle into UK, understand the workplace cultural expectations of a UK workforce and meet their professional and regulatory requirements.

3.2.3.6 External Mentoring

The introduction of external mentoring with a working title of 'Whittington Health – Mentorship for Black, Asian & Ethnic Minority staff programme from senior BME colleagues working in other North Central London sectors to support mentoring support and career progression to staff from BME who might benefit. Since its introduction in May 2022, there have been fourteen requests from BME staff band seven and above, with two gained promotions.

3.2.3.7 Development of the Reasonable Adjustments Guidelines and Health Passport

Working with the WhitAbility staff network, the Inclusion Team drafted the Reasonable Adjustment Guidelines. The guidelines will support staff with disabilities and long-term health conditions to secure reasonable adjustments.

After consultation with Anna Knight, Yvonne Barrett, Andi King, Sandra Glynn and Ophelia Ponteen from the WhitAbility staff network, a specific pathway for staff with neurodivergent issues was developed.

To complement these guidelines, a health passport has also been developed using feedback from staff with disabilities and long-term health conditions. The Health Passport is a tool that will ensure a member of staff and their manager is as comprehensive as possible and encourages regular review.

To prepare the Trust's managers for the launch of these documents, training on disability, the health passport and reasonable adjustments is currently being delivered.

3.2.3.8 Training Activity

The Inclusion Team participated in several training programmes to help improve the awareness of inclusion issues among staff and managers. Some of these training activities include:

- Corporate induction
- Disability and Reasonable Adjustments
- Building Inclusive and Compassionate Cultures
- Preceptorship programme
- Participation in the Allied Health Leadership Fellowship
- By request to different teams and service units

3.2.3.9 Inclusion Calendar

To assist with services better delivering tailored healthcare to their patients and better supporting the workforce, the Inclusion Team have launched the Inclusion Calendar.

The calendar highlights the important dates related to Religious, spiritual or belief-based festivals and inclusion dates/awareness events throughout the year.

To complement this, the Communication Team promote the calendar highlighting the main festivals or events for that month. The Library Team have been producing monthly newsletters with resources for staff relating to one of the month's key events, e.g. providing care for patients with learning disabilities for Learning Disabilities Week.

3.2.4 Organisational Development

3.2.4.1 Workforce Culture and "Caring for those Who Care".

The Trust's work to support good working relationships, and to promote compassion and inclusion throughout the Whittington Health culture, has continued, alongside a focus on providing staff with rest and respite in short lunchtime sessions. Many initiatives

are detailed below and in the following sections on health and wellbeing.

Below are some main changes, programmes, and campaigns to enhance culture and workplace relationships and environments.

- The range of services offered under the branded 'Caring for Those Who Care' or "#CFTWC" logo has been continuously augmented, with a range of new programmes and services offered in-house, within the North Central London (NCL) integrated care system (ICS), and nationally, to provide staff with the widest choice of supportive opportunities.
- A new Financial Wellbeing Hub was created under CFTWC to support staff through the cost-of-living crisis and various listening events held in the organisation.
- Patient behaviour and staff safety have also been added to the CFTWC hub with a new policy, guidelines and training piloted on Managing Violence and Aggression at Work policy.
- 'Disability in the Workplace' provides employees with an understanding of staff experience and invites people to be more inclusive in their behaviours.
- The organisation launched the Restorative Just Culture programme, which included revised policies and training for managers to support restorative conversations.

3.2.4.2 Staff Health and Wellbeing

2022/23 saw the various organisational groups overseeing staff health and wellbeing working even more closely together, within the Trust and the NCL ICS, to coordinate health and wellbeing support, including financial wellbeing. The Trust focused efforts on both practical staff support and psychological support. Additionally, the organisation has designed a new Staff Wellbeing and Engagement Model, which is being implemented:

From internal staff, these included:

- Mental Health First Aiders received refresher training to continue offering a listening ear and signpost professional support where required.
- Intercultural therapy is available to staff from Black, Asian, and Minority Ethnic backgrounds.
- The increased cohort of mediators responds to mediation requests.
- The 'Check-in and Check-out' toolkit for managers to look after their staff continues to be promoted for use at the start and end of team meetings.
- A resilience workbook that highlights the importance of rest as a cornerstone.
- To support this, several sleep sessions were provided to staff struggling to rest and learn techniques to use at home, and they proved very popular.
- Seated yoga lunchtime sessions are on continuous offer to ensure people's physical health supported their mental health, and again, were booked out.
- From the in-house Employee Assistance Programme, 'People at Work', confidential direct access to counselling continues to be offered.
- Critical Incident Stress Debriefing.

External routes of support include:

- Keeping Well North Central London Hub, national NHS, and specialist provisions such as the Tavistock and Portman NHS Foundation Trust offered a range of counselling and supportive psychological sessions, including intercultural therapy.
- Two local organisations offered counselling to targeted groups.
- National and regional websites and online resources, from advice to chat rooms, provided a range of support, including information.
- Workbooks and worksheets were provided to help people assess their needs.

3.4.2.3 Staff development

Whittington Health places great value on developing staff through courses and development opportunities. Since 2022, we have taken a blended learning approach to our training and development. In the last year, the following was delivered by in-house staff and partners:

- British Sign Language, both tasters and qualification courses from external providers
- Advanced Presentation Skills for those who want to progress their careers or become confident in presenting for audiences.
- Emerging Clinical Leaders programme from King's Fund to develop staff leadership skills for career development.
- Allied Health Professionals Leadership Fellowship Programme, which also promotes inclusion and creating a diverse AHP workforce
- I.CARE Career to support career development, for which a workbook is available.
- I.CARE Leadership Development programme for all managers, including a session on building inclusive cultures.
- Coaching is available for individuals to support career development and working relationships.
- Designed a Reciprocal Mentoring programme for staff with lived experience from all protected characteristics and backgrounds.
- The Reverse Mentoring Programme. The goal of this is to help promote a culture equity of opportunity and progression to improve the experience of BME nurses and midwives working in the organisation and ensure that this is in line with our goals and values. 360-degree feedback for individuals to understand how they impact othe
- rs and to support career development.
- Advanced Leadership and Management Diploma Level 6 from Middlesex University, designed to support staff from underprivileged backgrounds access to higher education qualifications, and participants were over 90% from Black, Asian and Minority Ethnic Backgrounds.
- Bands 2-7 BME Career Development programme was marked by a huge success, with 45% of participants getting promoted.
- Various apprenticeships in both clinical and non-clinical areas to support staff development and progression.
- Functional skills courses are available for staff, particularly those who have not completed GCSEs or Functional Skills, to enable them to progress onto apprenticeship programmes.

3.2.5 Staff Networks

The Trust's staff networks are essential in engaging staff from different protected groups with the inclusion agenda and acting as critical friends.

The networks also provide a forum where like-minded people and their allies can meet to discuss issues and developments that particularly impact them and their community. The networks also offer peer support and provide a route to escalate issues impacting their members.

The staff networks are members of the Staff Inclusion Group meeting where they can highlight their successes, current issues highlighted by their members and any issues they need support or require escalation.

At present, there are four staff networks, which include:

- Lesbian, Gay, Bisexual, Transgender, Queer Plus Network (LGBTQ+) – during 22/23, the network campaigned for the option of pronouns to be added to the 'Hello, my name is' badges, requested the NHS England LGBTQ+ training module to be added to the Trust's learning offers and ran well-attended events for LGBT History Month.
- Staff Race Equity and Nationality Network (SRENN) during 22/23, the

network ran events to promote awareness and celebrate our diverse populations, including Black History Month, the Philippines Independence Day and South East Asian History Month.

- WhitAbility Network for staff with disabilities, long-term health conditions, and allies. During 22/23, the network work supported creating the Trust's reasonable adjustment guidelines and health passport. The network supported the Inclusion Team with events to mark UK Disability History Month.
- Women's Network: During 22/23, the network supported the Menopause Awareness Events run by the Trust's maternity services and ran a week of events to celebrate International Women's Day.

3.2.6 Update from the Children and Young People Integrated Care Service Unit

The Children and Young People (CYP) ICSU has established an Equality, Diversity and Inclusion (EDI) working group with membership across CYP services. The group is focused on the following areas:

1. Diversity in the workforce
2. Career development
3. Inclusive culture
4. CYP and family's access to services
5. Culturally appropriate assessment tools

Inclusion activities across all services are being collated, shared and expanded. CYP is also expanding the scope of the BME monthly newsletter that was started by the Islington Additional Needs and Disability Service Team; it now covers the whole ICSU and includes updates on work from the CYP EDI working group.

In Islington Child and Adolescent Mental Health Service (CAMHS), there have been several achievements that promoted inclusion during 2022/23, including:

- Establishment of a one-day management EDI Lead post. The post supports the senior management team in delivering sustainable change and improvements in EDI across Community CAMHS, Simmons House and the Paediatric Mental Health Team. The EDI Lead post has been recruited to.
- Raising awareness for staff who may have undeclared neurodiversity, including workplace adjustments (part of the Workforce Disability Equality Standard)
- A BME reflective practice group has continued
- A Jewish reflective practice group has been established
- EDI Forum has started to open up conversations in CAMHS about race, culture, LGBTQ+, other differences and social graces with each other to benefit our young people and families. Brave conversations amongst all staff through EDI forums and within teams, supervision sessions and sharing with multi-agency colleagues
- The recruitment steering group has started revamping current systems to develop an inclusive recruitment strategy in CAMHS to cover all stages of the recruitment process, including equitable work experience programmes, job advertisements, job descriptions, and the interview and induction processes.
- Increasing availability of translated resources for children, young people and families joined up across North Central London.

3.2.7 See Me First

See ME First is an initiative to promote a more respectful, civil, and inclusive culture within Organisations to give staff a sense of belonging.

As See ME First approaches its third anniversary on 29th October 2023 and EQUITY now underpins the Whittington Health NHS Trust ICARE values, the message that "…. people should not be judged by the colour of their skin but by the

content of their character….” is even stronger.

Over 2,000 staff have pledged, and over 30 other NHS organisations are ‘following our lead’ and have either adopted or are looking to adopt the initiative. Islington Council – Social Care is the first Organisation outside the NHS, launched in October 2022.

As a testament to the effect of See ME First, we are now also receiving See ME First Impact Testimonials from staff who have made their pledge and want to share their experiences and the tangible changes that have occurred.

One See ME First Impact Testimonials reads,

“See ME First is a platform that allows for

open and honest discussions even when the topics are difficult, it has particularly given me a voice and has empowered me to help others”.

As an entirely staff-led initiative to help raise awareness, raise the profile and support and facilitate those opening dialogues, we now have See ME First Ambassadors, staff who are actively engaging with other staff across the ICO and spreading the message that a change is long overdue.

B. Patients and Service Users

4. Patient Equality Information

4.1 There are two sets of patient equality information that are available. First, data about who uses our services; secondly, data about the patient experience while under our care. Some data is unavailable for analysis as it is not routinely collected via Medway or Rio, our patient management systems. This information could be held in patients' written medical or nursing notes. The Chief Nursing Information Officer is working on this as part of our ongoing work to digitalise patient records.

The available data shows service usage for patients that were outpatients, inpatients, and using emergency services and community services during 2022/23.

4.2 Age

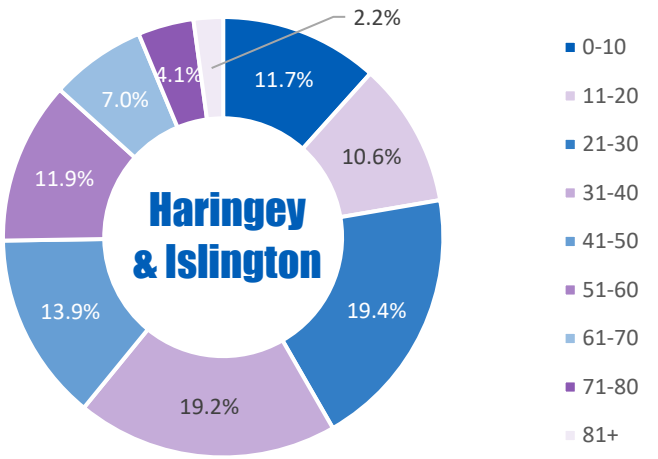


Chart B1 (left) shows the representation of the local population of Haringey and Islington broken down by age group. The local breakdown of the local population helps provide a point of comparison when looking at patient and service use data.

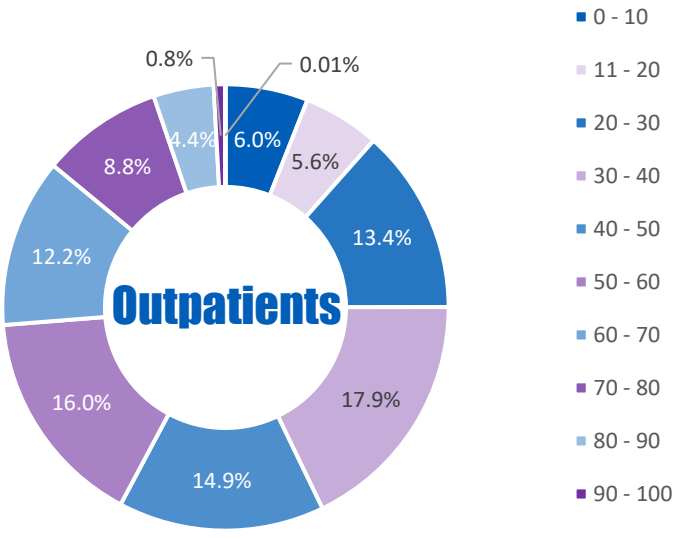
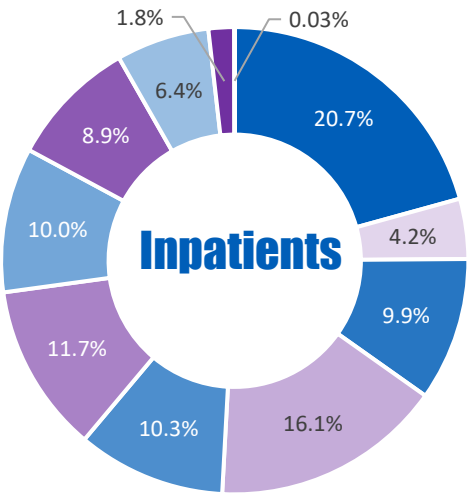


Chart B2 (left) represents outpatient service use by age group. In outpatient services, most patients are 20-70 years of age.

Comparing service use to the age demographic of Haringey and Islington, there is a lower-than-expected representation of patients and service users aged 0-40 and a higher-than-expected representation for those aged 40+.



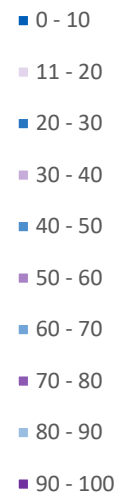
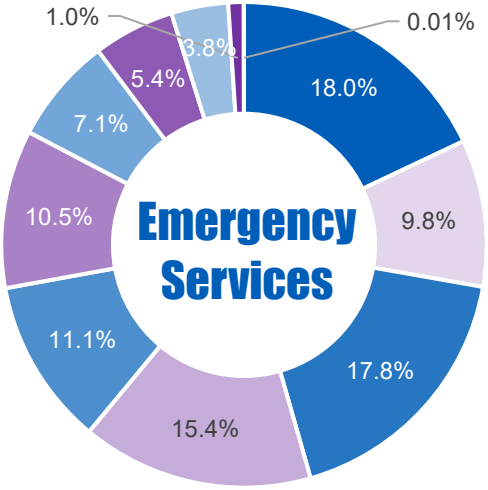


Chart B3 (left) represents inpatient service use by age group. In inpatient services, most service usage is from patients aged 0-10 and 30-70.

Comparing service use to the age demographic of Haringey and Islington, there is a lower-than-expected representation of patients and service users aged 11-60 and a higher-than-expected representation for those aged 0-10 and 60+.



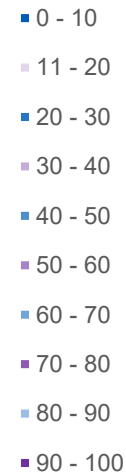
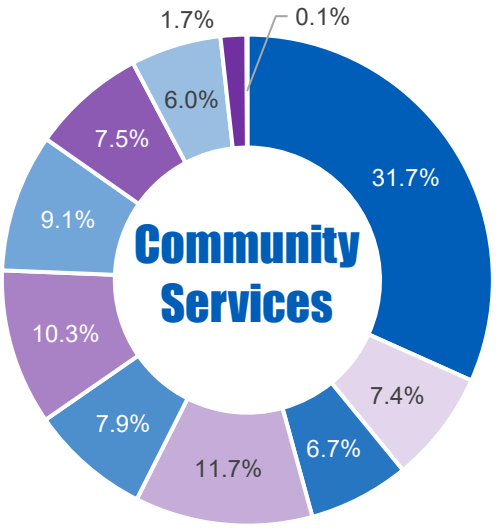


Chart B4 (left) represents patient use of emergency services by age groups. For these services, most service usage is from patients aged 0-60.

Comparing service use to the age demographic of Haringey and Islington, there is a lower-than-expected representation of patients and service users aged 11-60 and a higher-than-expected representation for those aged 0-10 and 60+.



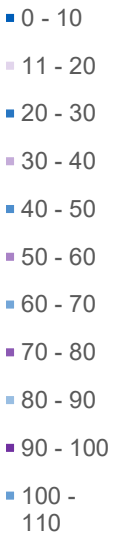


Chart B5 (left) represents patient use of community services by age group. The groups with the greatest representation in community services are 0-10, 30-40 and 50-60.

Comparing service use to the age demographic of Haringey and Islington, there is a lower-than-expected representation of patients and service users aged 11-60 and a higher-than-expected representation for those aged 0-10 and 60+.

4.3 Disability

This information is not routinely collected through Medway or Rio, our patient information management systems.

4.4 Gender Reassignment

This information is not routinely collected through Medway or Rio, our patient information management systems.

4.5 Marriage and Civil Partnership

This section reviews patient attendance data by marital status who attended emergency services or were inpatients and outpatients. Information for community services is not included as over 97% of the patient's relationship status is 'unknown.'

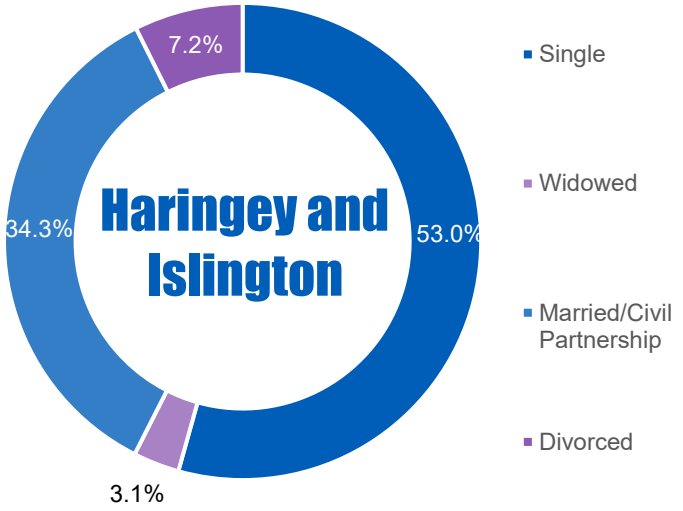


Chart B6 (left) represents the local population of Haringey and Islington broken down by marital status. The breakdown helps provide a point of comparison when looking at patient and service use data.

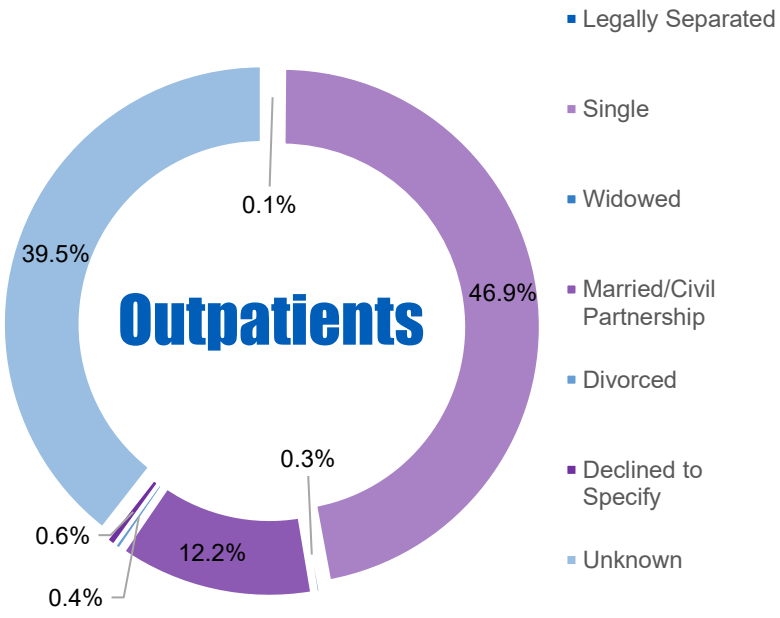


Chart B7 (left) represents patients who attended outpatient services broken down by marital status. Overall, the largest groups to have attended outpatient services are single and patients whose status is unknown.

Compared to Haringey and Islington's local population, there is a much lower representation of patients who are either married or in a civil partnership attending outpatient services. However, it should be noted that nearly 40% of patients' marital status is unknown; the true reflection of the patient demographic for marriage and civil partnership using outpatient services cannot be seen until this improves.

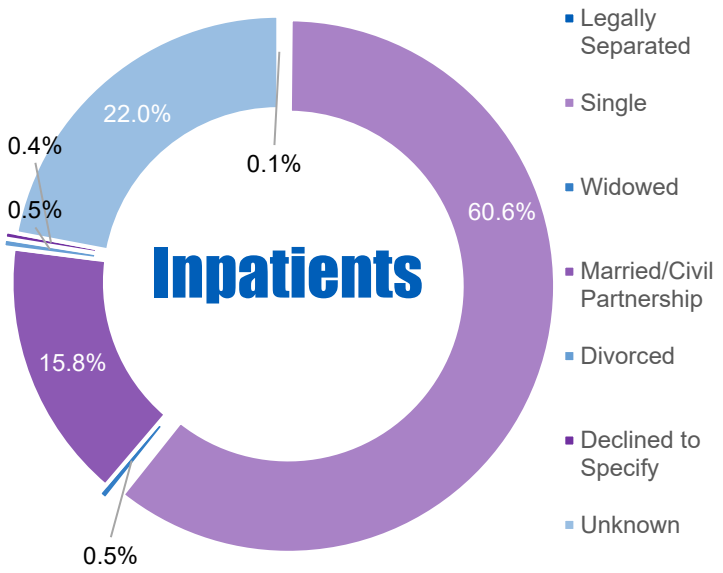


Chart B8 (left) represents patients who attended inpatient services broken down by marital status. Overall, the largest groups to have attended inpatient services are single patients whose status is unknown, followed by those married or in a civil partnership.

Compared to Haringey and Islington's local population, there is a much lower representation of patients who are either married or in a civil partnership attending inpatient services. However, it should be noted that over a fifth of the patient's marital status is unknown; the true reflection of the patient demographic for marriage and civil partnership using inpatient services cannot be seen until this improves.

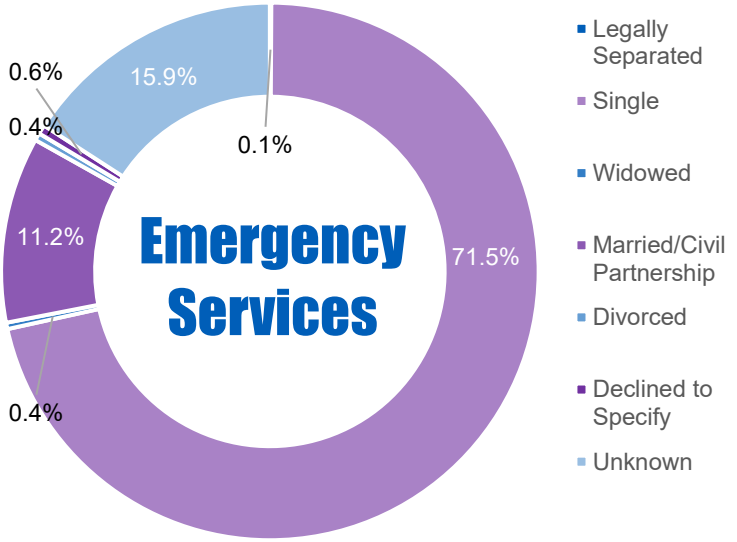


Chart B9 (left) represents patients who attended emergency services broken down by marital status. Overall, the largest groups to have attended emergency services are single patients whose status is unknown, followed by those married or in a civil partnership.

Compared to the local population of Haringey and Islington, nearly all groups have a much lower representation (except single patients).

4.6 Pregnancy and Maternity

This information is not routinely collected through Medway or Rio, our patient information management systems.

4.7 Race (this includes ethnic or national origins, colour or nationality)

For all areas, the predominant race is White British, and the proportion of white patients using Trust services is lower than that of the local population.

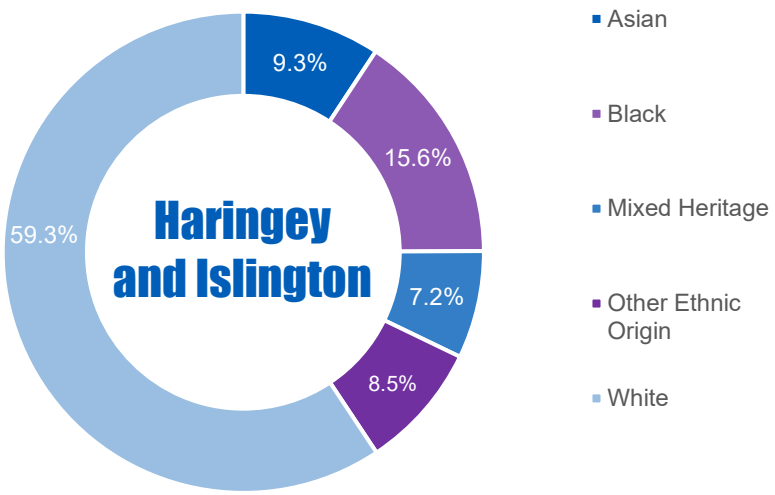


Chart B10 (left) shows the representation of ethnic categories in the local population of Haringey and Islington. The local demographic data will help aid comparison when looking at the use of Trust services by patients.

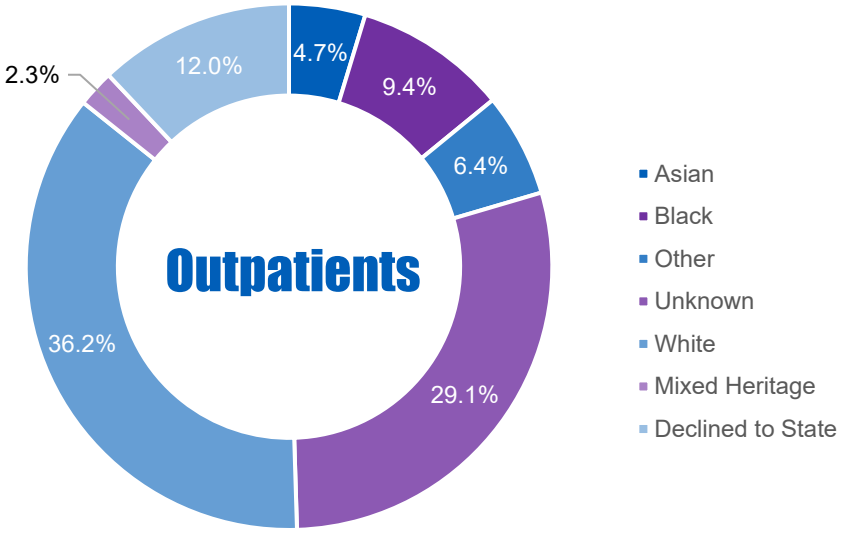


Chart B11 (left) represents patients who attended outpatient services broken down by ethnic categories. Overall, the largest groups to have attended inpatient services are White, followed by patients whose ethnic category is unknown.

When comparing to the local population of Haringey and Islington, there is a lower representation in most groups using outpatient services.

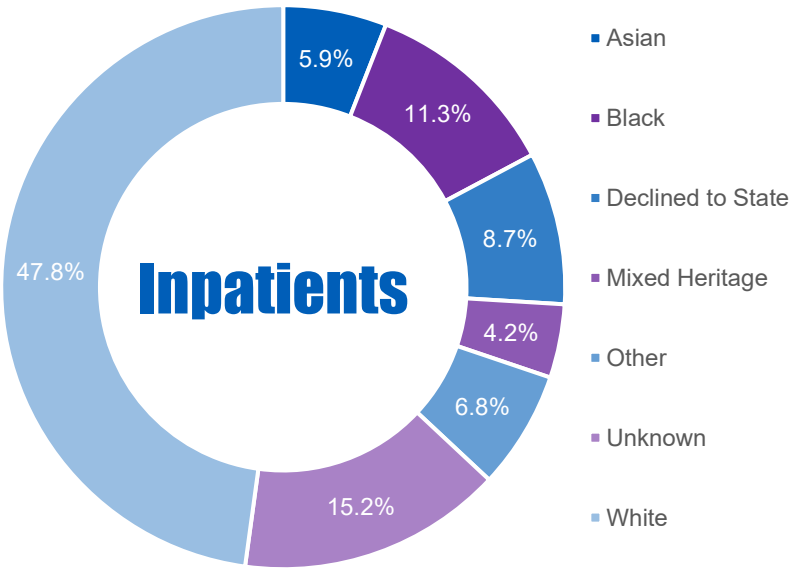


Chart B12 (left) represents patients who attended inpatient services broken down by ethnic categories. The largest groups to use inpatient services are White and patients whose ethnicity is unknown.

Compared to the local population of Haringey and Islington, most groups have a lower representation of all groups in inpatient services.

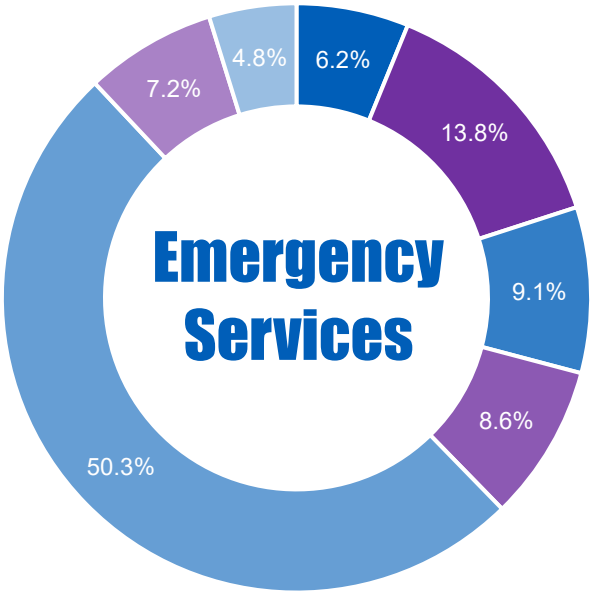


Chart B13 (left) represents patients using emergency services at the Trust. The largest groups to use these services are White and Black patients.

Compared to the local population, most groups have a lower representation; the exception is patients in the 'other' category, where there is a greater representation.

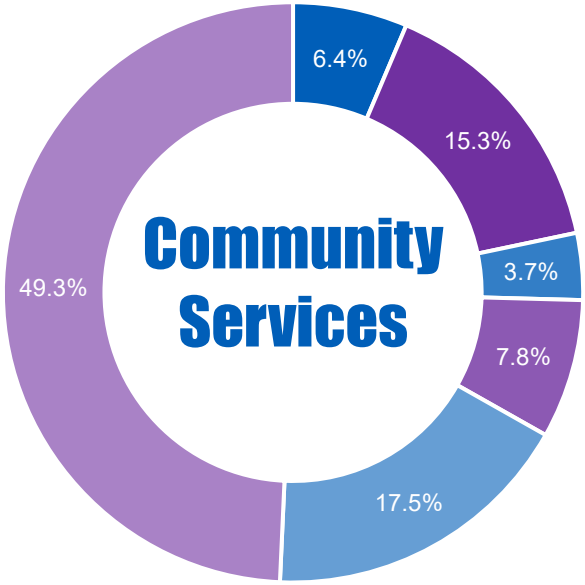


Chart B14 (left) represents patients using community services at the Trust. Overall, the largest groups to use these services are White, Black, and patients whose ethnic category is unknown.

Compared to the local population, most groups have a lower representation; the exception is for Black patients who are broadly in line.

4.8 Religion or belief

It is difficult to comment accurately on patients' religion or belief representation, as over 50% of patients' demographic data in all services is unknown. Where religion or belief is known, 10-20% register as having no religion, and 11-17.5% are Christian or of a Christian denomination. Patients with 50 different religions or beliefs attended Whittington Health last year. Religion or belief information is not routinely collected on Rio, the system used in community services.

Table BT1 (below) shows the limited data available from the service use of patients at the Trust. Items highlighted in purple identify a greater representation than the local population.

Religion	Haringey and Islington	Outpatients	Inpatients	Emergency Services
Buddhist	0.9%			
Christian	37.2%	11.5%	17.0%	13.6%
Declined to specify	7.9%	2.2%	2.1%	2.5%
Hindu	1.2%			
Jewish	2.5%		1.3%	
Muslim	12.3%	4.4%	5.3%	5.9%
No Religion	35.8%	9.3%	12.2%	20.3%
Other	1.9%	3.3%	2.3%	2.7%
Sikh	0.3%			
Unknown		69.3%	59.9%	55.0%

4.9 Sex

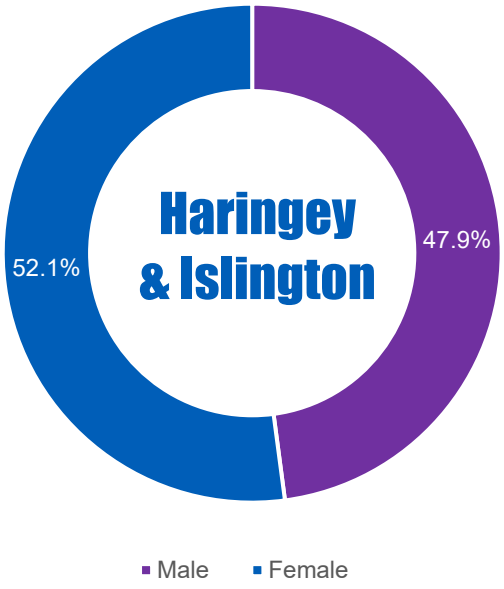


Chart B15 (left) shows the representation of sex in the local population of Haringey and Islington.

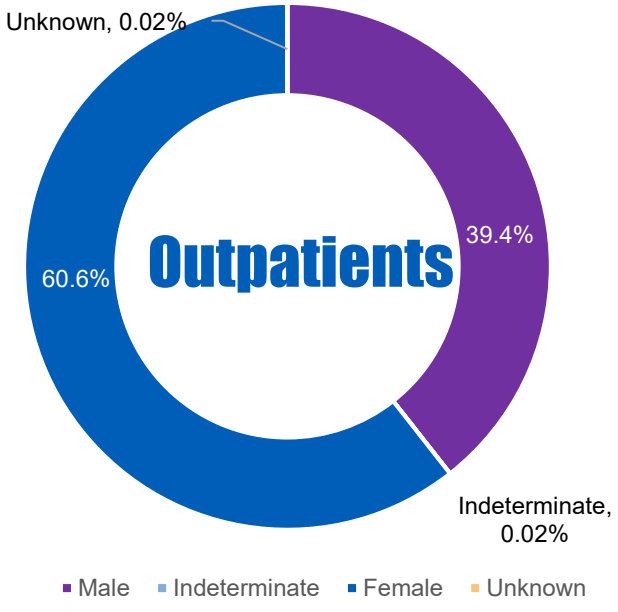


Chart B16 (left) represents the sex of patients using outpatient services. Overall, there are more women than men who have attended outpatient appointments.

Compared to Haringey and Islington's local population, more women and fewer men attend outpatient services.

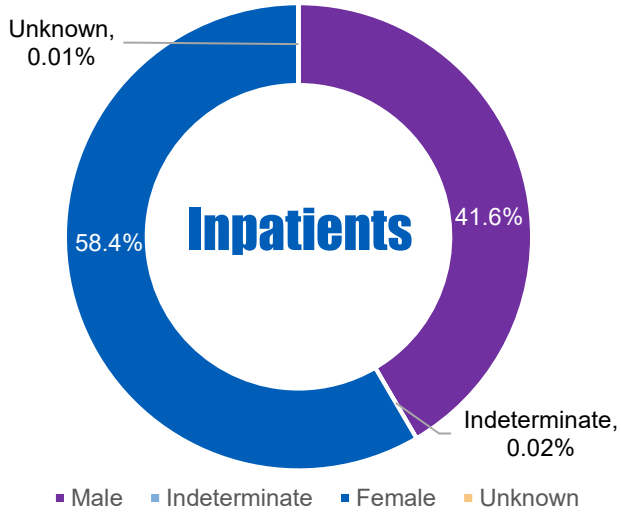


Chart B17 (left) represents the sex breakdown in patients attending inpatient services at the Trust.

Compared to Haringey and Islington's local population, more women and fewer men attend outpatient services.

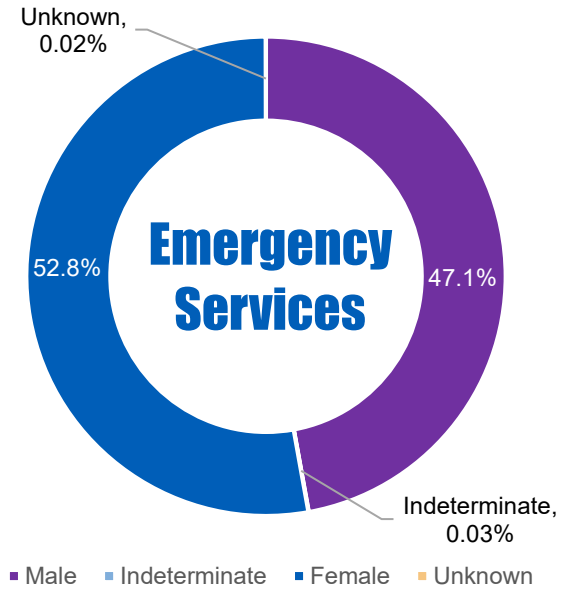


Chart B18 (left) represents the sex breakdown in patients attending emergency services at the Trust.

Compared to the local population of Haringey and Islington, the representation is broadly similar for male and female patients.

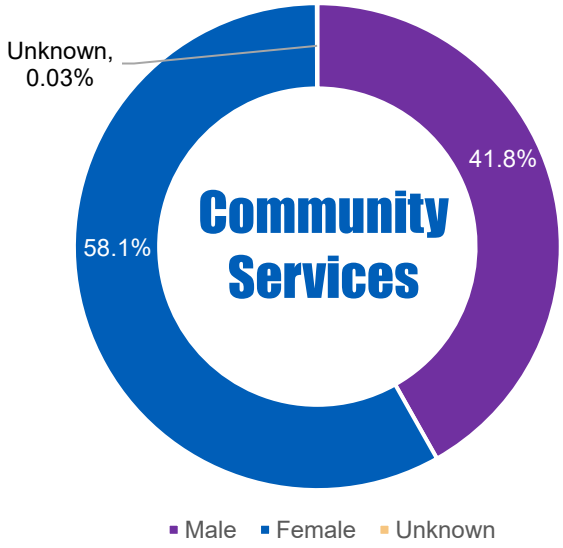


Chart B19 (left) represents the sex breakdown in patients attending community services at the Trust.

Compared to the local population of Haringey and Islington, the representation there is proportionally more female and fewer male patients.

4.10 Sexual orientation

This information is not routinely collected through Medway or Rio, our patient information management systems.

5. Friends and Family Test

The Friends and Family Test measures patient satisfaction with their experiences of using our services. The survey explores different aspects of patients' experience of using Trust services. At present, it is not possible to break down the responses to questions by protected characteristics. Still, it is possible to provide a profile for overall responses.

5.1 Community Services

A total of 2,973 responses were received during 2022/23 that relate to patients' experiences of community services for question one (patients do not have to answer all the questions).

Q1. Overall, how was your experience of our service?

- 2,294 patients said it was very good
- 519 patients said it was good
- 72 patients said it was neither good nor poor
- 42 patients said it was poor
- 46 patients said it was very poor

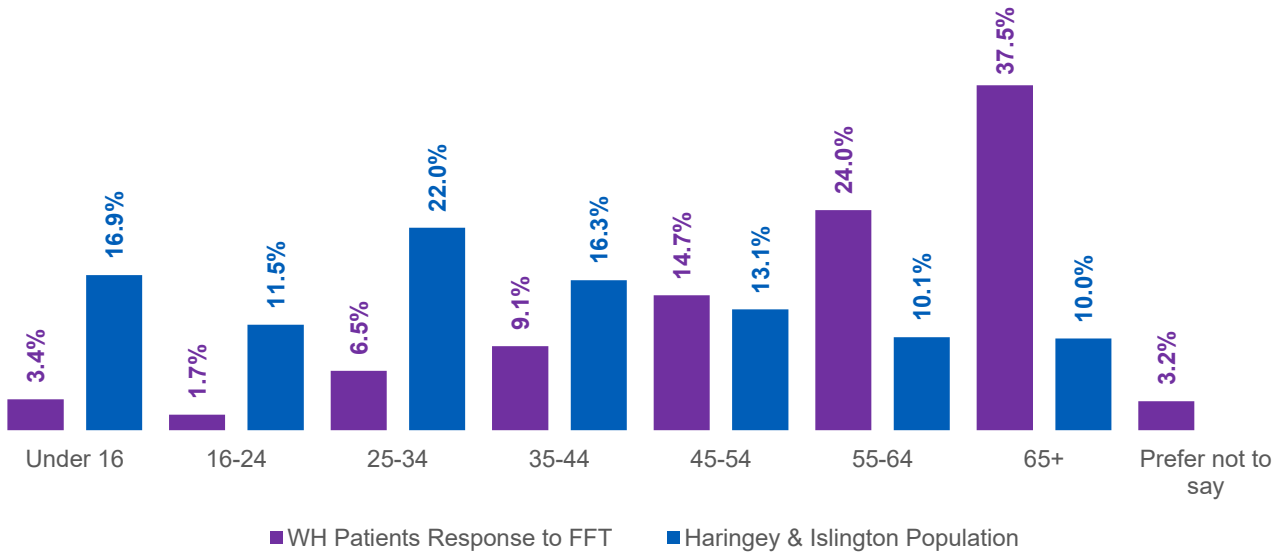
Table BT2 (below) shows the breakdown of questions in the FFT for community services.

Questions	Yes	No
Q2. Was I, or my carer, involved as much as we wanted to be in the decision about my or my child's care/treatment?	2,336	123
Q3. I felt I was treated with kindness and compassion.	2,669	61
Q4. I have confidence and trust in the staff treating/caring for me or my child.	2,597	77
Q5. I was given enough information about the service and/or who to contact if I needed to	2,494	157

Demographic Breakdown of patients who answered the survey:

Age:

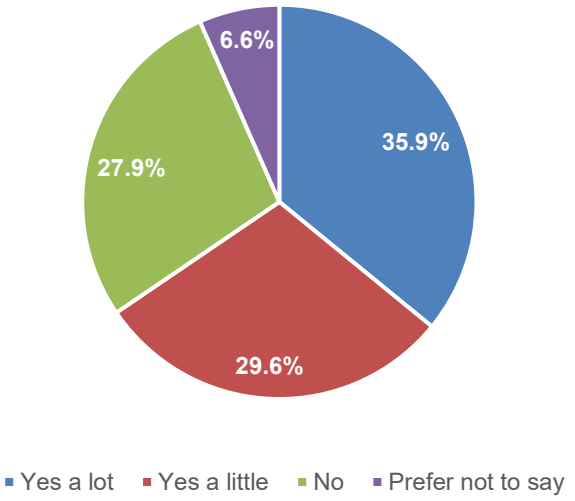
Chart B20 – represents responses to the FFT Survey compared to the local population by age.



Disability:

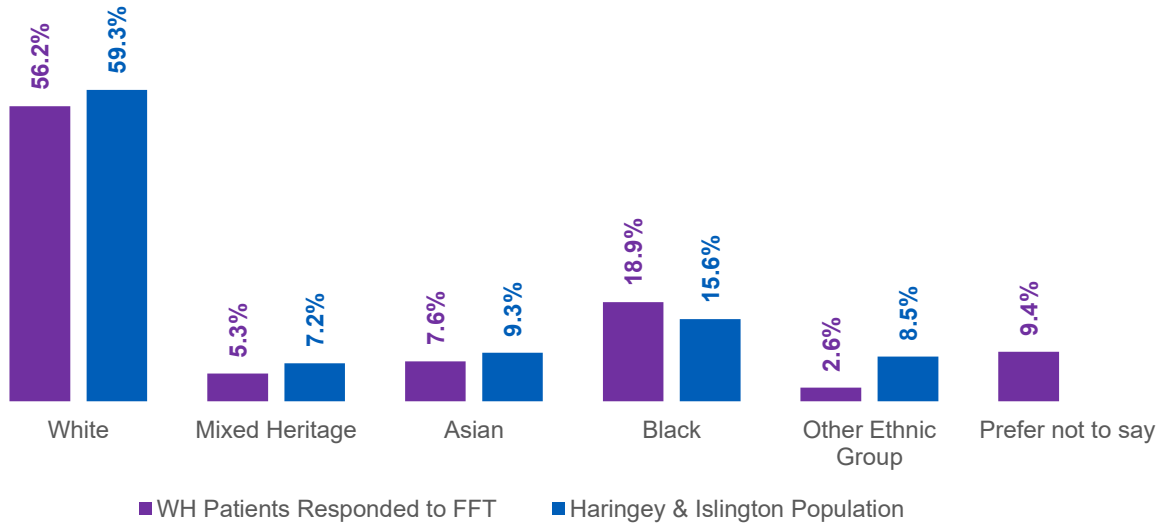
The question asked is, Are your day-to-day activities limited because of a health problem or disability that has lasted, or is expected to last, at least 12 months?' This question aligns with the 2011 Census. With the change to the disability question in the 2021 Census, it is not possible to provide an accurate comparison with the data from the FFT.

Chart B21 – represents responses to the FFT Survey by disability.



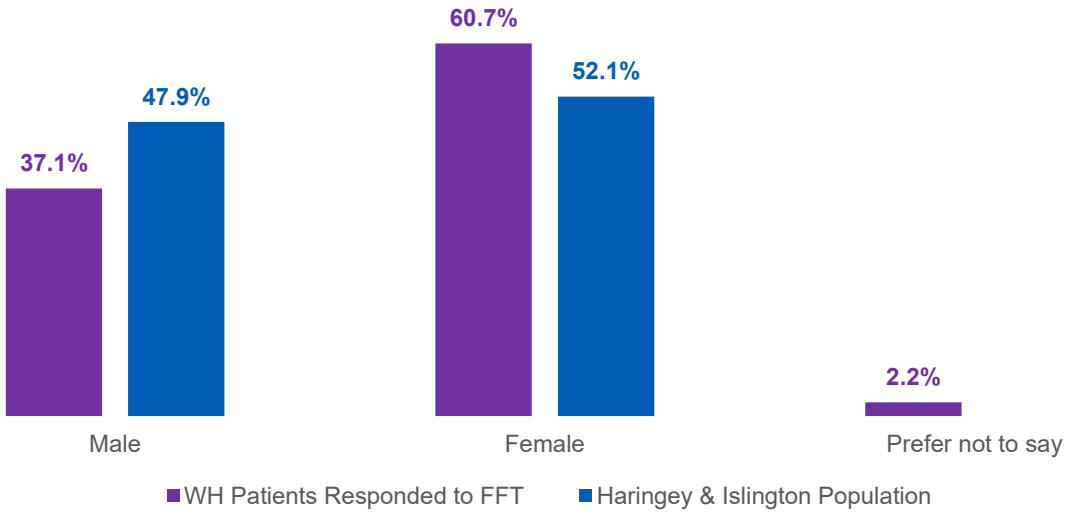
Ethnicity:

Chart B22 – represents responses to the FFT Survey compared to the local population by ethnicity.



Sex:

Chart B23 – represents responses to the FFT Survey compared to the local population by sex.



5.2 Inpatient Services

A total of 3,799 responses were received during 2022/23 that relate to patients' experiences of inpatient services for question one (patients do not have to answer all the questions).

Q1. Overall, how was your experience of our service?

- 3001 patients said it was very good
- 660 patients said it was good
- 89 patients said it was neither good nor poor
- 13 patients said it was poor
- 16 patients said it was very poor
- 20 patients said they didn't know

Table BT3 – breakdown of answers to questions for the FFT Survey in inpatient surveys.

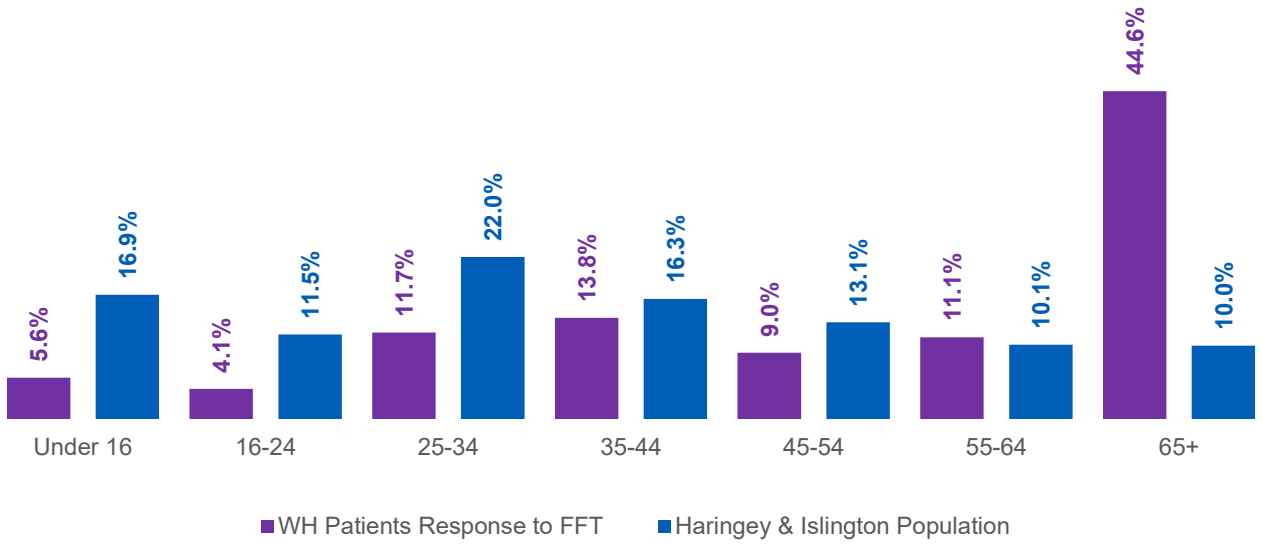
Questions	Strongly Agree	Agree	Disagree	Strongly Disagree
Q2. I feel I was treated with kindness and compassion	686	298	1	0
Q3. I was involved as much as I wanted to be in decisions about my care	681	290	9	1
Q4. I feel I was given enough privacy when discussing my condition and treatment	689	291	2	0
Q5. My medicines and possible side effects were explained to me	652	317	8	2
Q6. Doctors talked in front of me as if I was not there	18	35	264	655
Q7. Nurses talked in front of me as if I was not there	23	39	251	636
Q8. I had confidence and trust in the doctors treating me	704	276	3	3
Q9. I had confidence and trust in the nurses treating me	690	289	6	1

Q10. I was able to find somebody to talk to about my worries and fears	656	305	12	1
Q11. The nurses provided answers to my questions that I was able to understand	649	313	8	1
Q12. I have been given the name of a person to contact if I am worried or have a problem after leaving the ward	Yes: 866 No: 51			
Q13. I was given enough help to eat my meals	623	303	11	5
Q14. I was happy with the quality and choice of food	903	634	118	41
Q15. I was bothered by noise at night	73	323	763	532
Q16. Was the noise at night from	• Staff: 13 • Patients: 97 • Others: 66			
Q17. Please rate the cleanliness of the ward	• Excellent: 754 • Good: 210 • Fair: 21 • Poor: 2 • Very Poor: 1			
Q18. During my appointment/stay, I feel I was unfairly treated for any of the following	• None: 824 • Don't know: 42 • Gender: 4 • Another reason: 3 • Racial/Ethnic Background: 2			

Demographic Breakdown of patients who answered the survey:

Age:

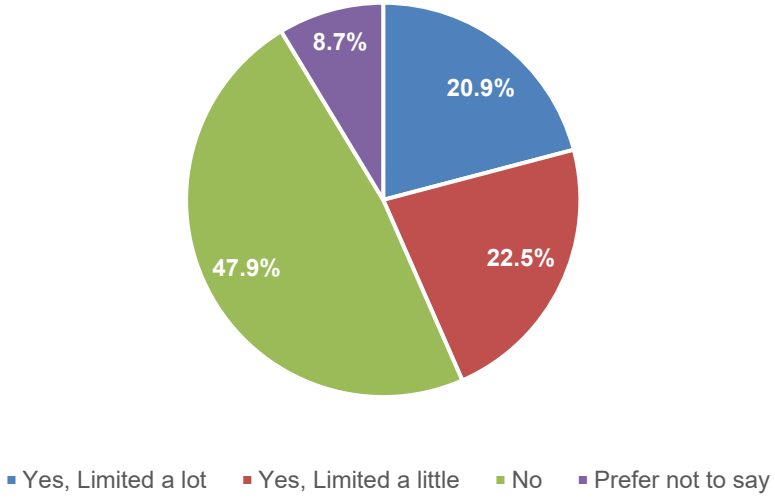
Chart B24 – represents responses to the FFT Survey compared to the local population by age.



Disability:

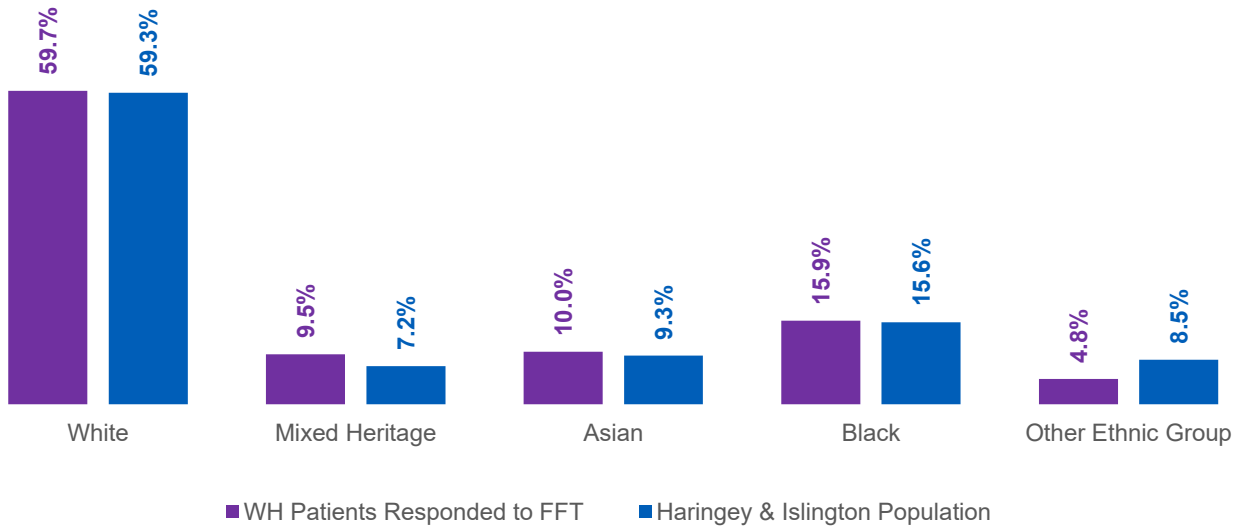
The question asked is, ‘Are your day-to-day activities limited because of a health problem or disability that has lasted, or is expected to last, at least 12 months?’ This question aligns with the 2011 Census. With the change to the disability question in the 2021 Census, it is not possible to provide an accurate comparison with the data from the FFT.

Chart B25 – represents responses to the FFT Survey by disability.



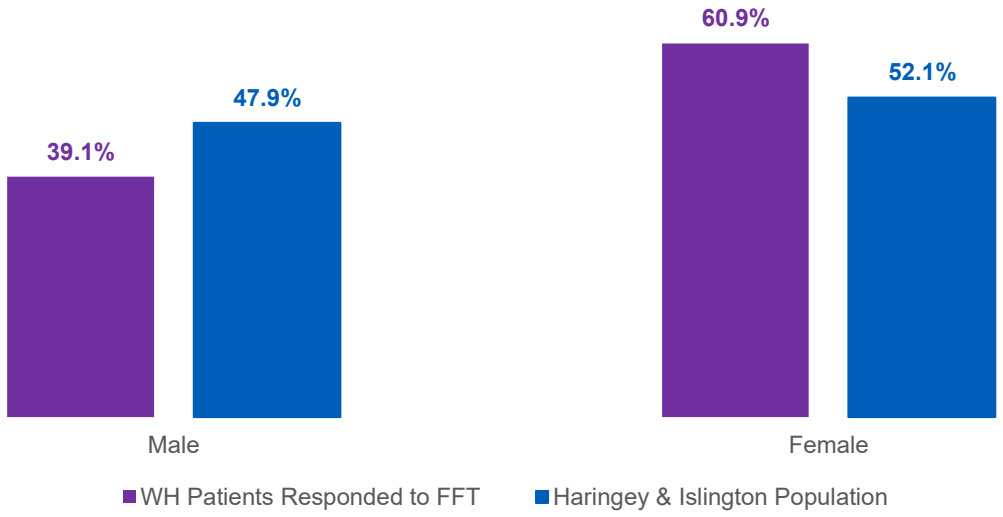
Ethnicity:

Chart B26 – represents responses to the FFT Survey compared to the local population by ethnicity.



Sex:

Chart B27 – represents responses to the FFT Survey compared to the local population by sex.



5.3 Outpatient Services

A total of 3,799 responses were received during 2022/23 that relate to patients' experiences of inpatient services for question one (patients do not have to answer all the questions).

Q1. Overall, how was your experience of our service?

- 619 patients said it was very good
- 96 patients said it was good
- 15 patients said it was neither good nor poor
- 33 patients said it was poor
- 43 patients said it was very poor

Table BT4 – breakdown of responses from FFT Survey in outpatient services.

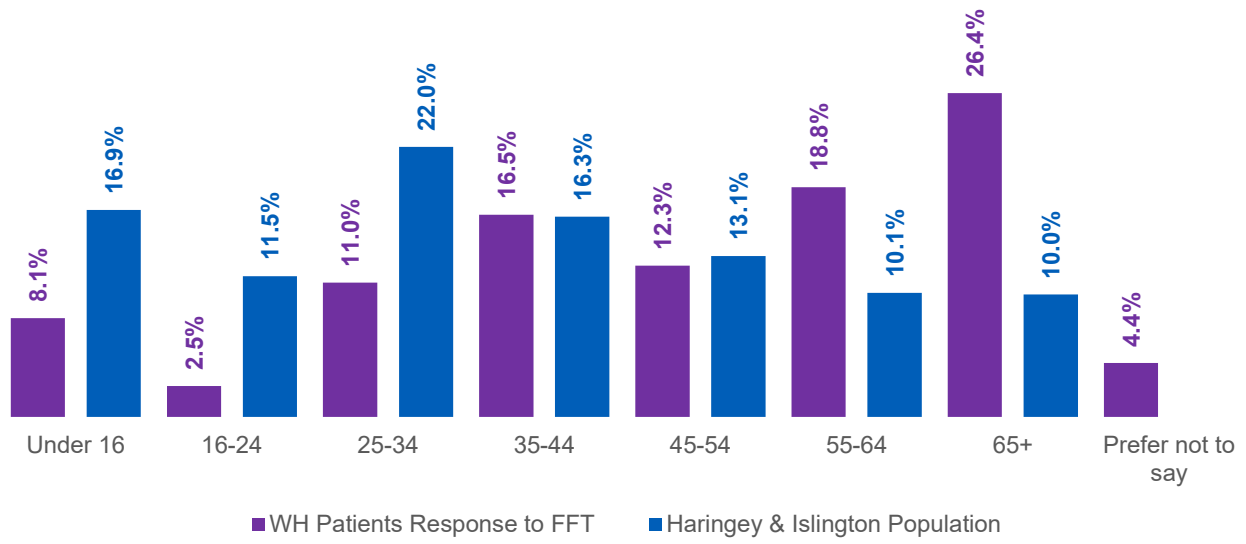
Q2. When you arrived at the Outpatients Department, how would you rate the courtesy of the Receptionist?	• Excellent: 237 • Good: 124 • Fair: 34 • Poor: 5 • Very poor: 8
Q3. Were you told how long you would have to wait?	• Yes, but the wait was shorter: 101 • Yes, and I had to wait about as long as I was told: 59 • Yes, but the wait was longer: 8 • No, I was not told: 201
Q4. In your opinion, how clean was the Outpatients Department?	• Very clean: 258 • Fairly clean: 120 • Not very clean: 13 • Not at all clean: 7
Q5. Did the doctor explain the reasons for any treatment or action in a way that you could understand?	• Yes, completely: 303 • Yes, to some extent: 31 • No: 13
Q6. If you requested an interpreter for your appointment in the Outpatients Department,	• Yes, face-to-face: 18 • Yes, a telephone interpreter: 1

was there someone who could interpret for you?	• No: 36
Q7. Were you given enough privacy when being examined or treated?	• Yes, definitely: 333 • Yes, to some extent: 53 • No: 9
Q8. Were you involved as much as you wanted to be in decisions about your care and treatment?	• Yes, definitely: 335 • Yes, to some extent: 45 • No: 28
Q9. Before you left the Outpatients Department, were you told what would happen next (e.g., whether you needed another outpatient appointment to see your GP, etc.)?	• Yes: 348 • No: 36
Q10. Overall, did you feel you were treated with respect and dignity while you were at the Outpatients Department?	• Yes, all of the time: 360 • Yes, some of the time: 29 • No: 13

Demographic Breakdown of patients who answered the survey:

Age:

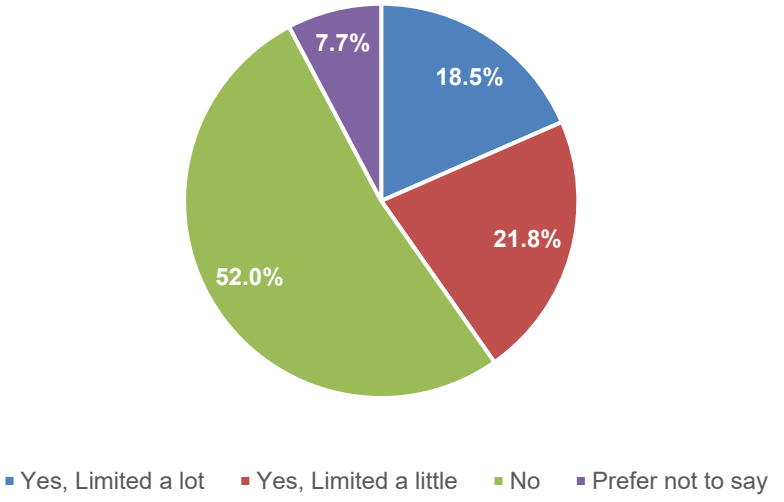
Chart B28 – represents responses to the FFT Survey compared to the local population by age.



Disability:

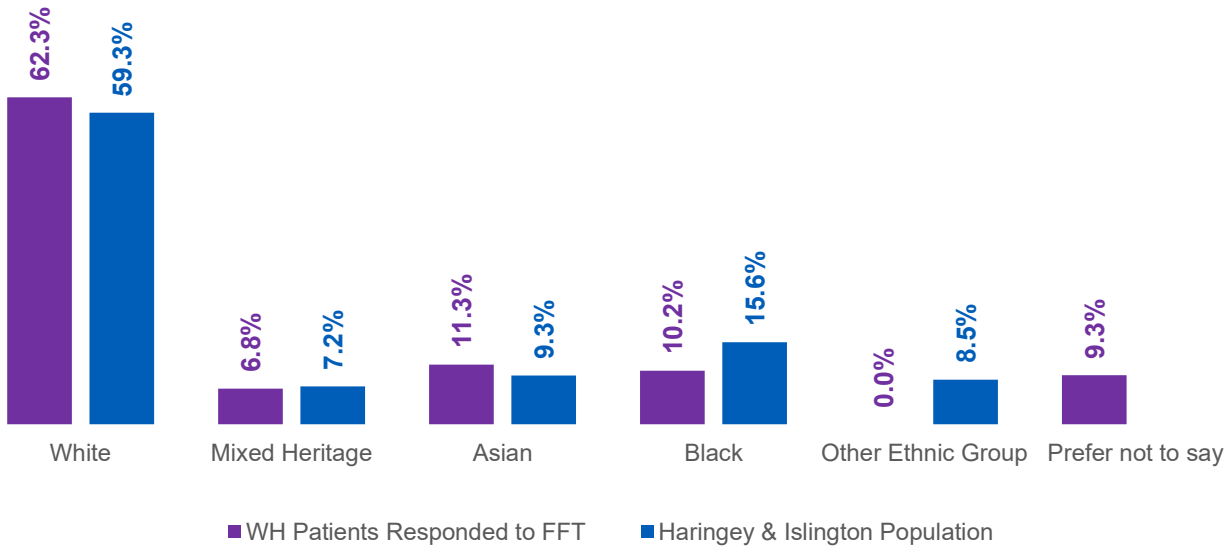
The question asked is, 'Are your day-to-day activities limited because of a health problem or disability that has lasted, or is expected to last, at least 12 months?' This question aligns with the 2011 Census. With the change to the disability question in the 2021 Census, it is not possible to provide an accurate comparison with the data from the FFT.

Chart B29 – represents responses to the FFT Survey by disability.



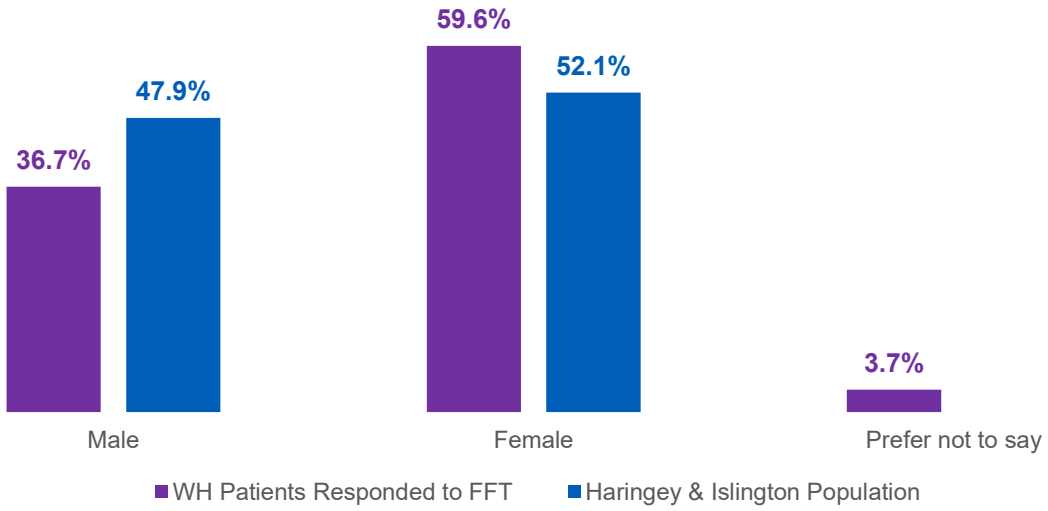
Ethnicity:

Chart B30 – represents responses to the FFT Survey compared to the local population by ethnicity.



Sex:

Chart B31 – represents responses to the FFT Survey compared to the local population by sex.

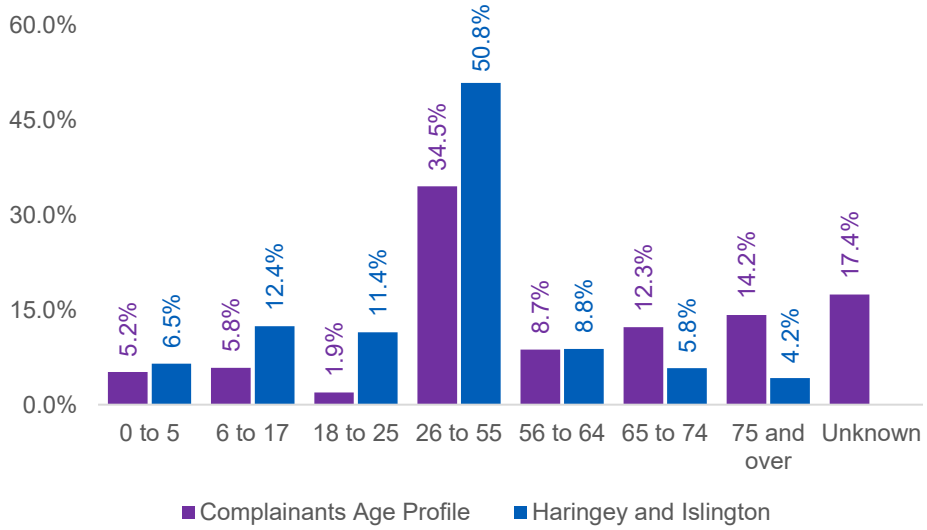


6. Complaints and Concerns Raised with Patient Advice and Liaison Service

Complaints and concerns are essential types of feedback that allow the Trust to make improvements for individual patients and our services. We can only provide a demographical breakdown for age, ethnicity, and sex; there are too many unknown disability statuses to provide useful analysis.

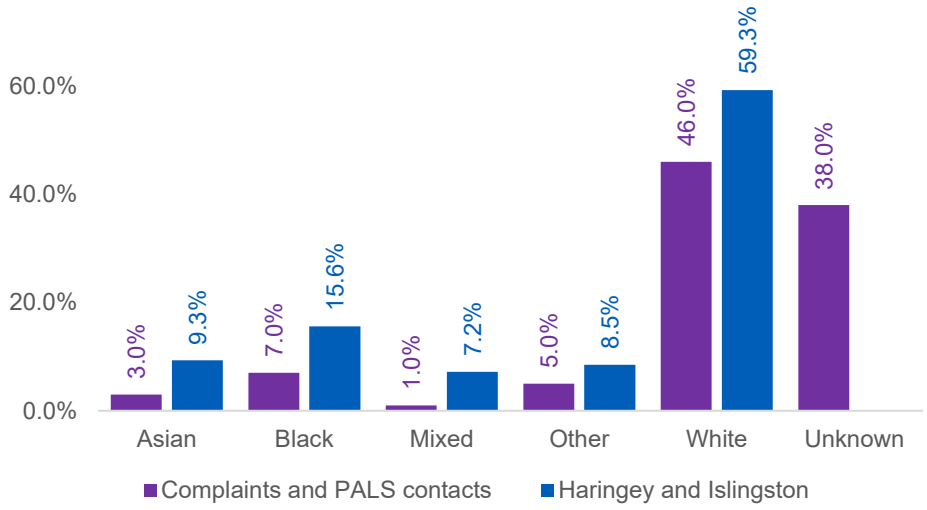
6.1 Age

Chart B32 – represents the age profile of complainants compared to the local population.



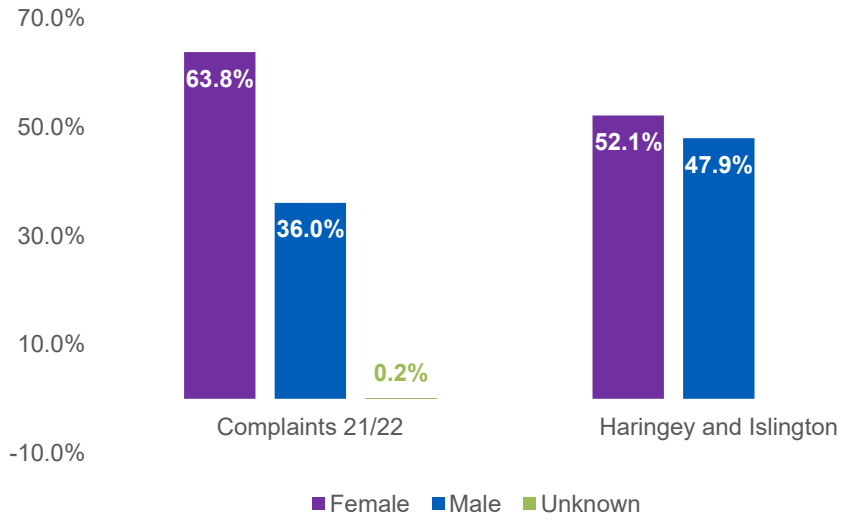
6.2 Race (this includes ethnic or national origins, colour or nationality)

Chart B33 – represents the ethnicity profile of complainants compared to the local population.



6.3 Sex

Chart B34 – represents the sex profile of complainants compared to the local population.



7. Patient language and communication services

The trust uses interpreter and translation services to meet our diverse patient base's language and communication needs across all sites. The Trust has access to a range of in-house interpreters that meet most of the interpreting requests. Where the in-house interpreters cannot meet a request, requests are sent to the external provider, The Big Word, to meet.

During 2022/23, the top ten languages used throughout our acute and community services were:

1. Turkish
2. Spanish
3. Arabic
4. Bengali
5. Albanian
6. Somali
7. Polish
8. Portuguese
9. Farsi
10. BSL

8. Summary of observations from patient data

8.1 Age

For most of our services, the greatest representation is from patients aged 0-10 and 20-70; in outpatient services, the greatest representation is from patients aged 20-70. Compared to the local demographics, there is a greater presentation of patients aged 40+; for inpatient, emergency and community services, there is a greater representation of patients aged 0-10 and 60+.

As the patient satisfaction data is not broken down by protected characteristics (just an overall picture of those who have responded), it is impossible to identify experiential trends by age group.

In community services, there is a staggered increase of respondents to the Friends and Family Test (FFT) survey from patients aged 25+. However, most of the feedback has been received from patients aged 55+. Compared to the local demographic, there are proportionally more responses from patients aged 45+.

In inpatient services, most patient feedback to the FFT is from patients aged 55+; compared to the local demographic, there is a broadly equal representation from respondents aged between 35-64 but greater in patients aged 65+.

In outpatient services, there is a staggered increase in patients aged 35+ who responded to the FFT survey. The group that provided the most feedback are aged 65+, and the majority of feedback was received from patients aged 35+. Compared to the local demographic, there is a broadly equal representation of patients aged 35-54 and a greater representation of patients aged 55+.

There is a staggered increase in complaints received from patients in groups aged 56+; however, most of the complaints received are from patients aged 26-55. Compared to the local demographics, complainants aged 55+ are represented in the complaints process in equal or greater proportion.

8.2 Disability

Data collection appears not to be routinely collected in many factors that relate to the patient journey in all Trust services.

Responses to questions relating to the Friends and Family Test (FFT) survey are not broken down by disability status; it is, therefore, impossible to provide any analysis of the experiences of disabled patients. However, the FFT can be broken down by the overall responses to the FFT survey by disability.

The questions on the FFT about disability status are based on the 2011 Census and, therefore, not directly compatible with the 2021 Census. Some people in the 'Yes, a little' category may be disabled, but there is no way of identifying the appropriate proportion. So only those who stated 'Yes, a lot' are considered disabled for this analysis.

In community services, a greater proportion of patients who are disabled responded to the FFT survey compared to the local demographic (over twice as many).

In inpatient and outpatient services, there is a slightly higher proportion of disabled patients who have responded to the FFT survey compared to the local demographics.

There is no data relating to the disability status of patients that raised concerns and complaints.

8.3 Gender Reassignment

Data is not collected for this protected characteristic related to the patient journey in all Trust services.

8.4 Marriage and Civil Partnership

In inpatient and emergency services, there is a greater representation of patients who are married or in a civil partnership using Trust services than the local demographic. In outpatient services, there is a slightly lower proportion.

The Friends and Family Test survey and complaints data are not broken down by marriage and civil partnership; as such, it is not possible to provide any analysis for this protected characteristic.

8.5 Pregnancy and Maternity

Due to the lack of data collected for this protected characteristic, it is not possible to provide commentary on service use for this group.

8.6 Race (this includes ethnic or national origins, colour or nationality)

Most Trust patients who use services are white, followed by Black and those whose ethnicity is unknown. Compared to the local demographic, most ethnic groups are underrepresented in service use data. However, in emergency services, there is a greater representation of patients from 'other' ethnic groups and Black in community services.

Friends and Family Test (FFT) survey responses are not broken down by ethnicity groups, so it is impossible to analyse patients' experiences by ethnicity groups. However, the number of responses does record the patient's ethnicity. Information about ethnicity has now been expanded to include White or White British Mixed, Asian or Asian British, Black or Black British, Chinese or

other ethnic groups and prefer not to say, which will be available in the next Public Sector Equality Duty Report.

In community services, most responses to the FFT survey are from White and Black patients. Compared to the local demographic, there is a higher proportion of Black patients responding to the FFT, a broadly equal of white and lower of all other known ethnicity categories.

In inpatient services, most respondents to the FFT survey were white patients. Compared to the local demographic, there is a greater representation of mixed heritage patients responding to the survey, a lower of patients from the 'other' group and broadly equal from all remaining groups.

In outpatient services, most responses from the FFT survey were from white patients. Comparing the FFT survey responses to the local demographic, there is a greater representation of white and Asian patients, a broadly equal or mixed heritage and a lower of Black and 'other' groups.

White patients and patients whose ethnicity is unknown are most likely to make a complaint. Compared to the local demographic, this is a lower representation of all ethnic groups in the complaints process. Still, nearly 40% of patients' ethnicity is unknown, which masks the actual levels of representation of ethnicity in the complaints process.

8.7 Religion or Belief

The level of patients where religion or belief is unknown is exceptionally high in all services (circa 60%); providing a meaningful representation analysis is impossible.

Religion or beliefs are not collected or monitored in the Friends and Family Test survey responses and the complaints process.

8.8 Sex

Female patients are the main users of Trust patient services compared to the local demographic; in inpatient, emergency and community services, there is a broadly equal representation of men/women patients using those services and a slightly lower representation of males and slightly higher of females in outpatient services.

In the Friends and Family Test survey (all services) and complaints process, female patients are more represented than male patients. Compared to the local demographic, female patients are more represented than males in Trust processes.

8.9 Sexual Orientation

Data is not collected for this protected characteristic related to the patient journey in all Trust services.

8.10 Actions to Improve Equity for Patients

Table BT5 – Summary of actions to help improve equity for patients

Number	Action	Responsibility	Completion
1	Through the Data Quality and Business Intelligence Group (DQBIG), the Information Team will help surface data quality issues related to inclusion within the clinical systems. The Information Team will also further develop the Data Quality Dashboard to monitor the data quality used for equality monitoring.	Information Team	January 2024
2	The Trust's Information Team will continue to support related ad-hoc requests and offer analysis and insights aimed at improving inclusion for our patient population.	Information Team	Ongoing
3	As part of the Power Business Intelligence Development Project, the Information Team is developing, alongside several dashboards, an Equality/Equity Dashboard that will aim to cover the majority of requirements around inclusion reporting.	Information Team	January 2024
4	Our Patient Systems Team continues to work with system partners to include any missing required sections that would allow the capture of equality related data.	Patient Systems Team	Ongoing
5	Challenges around data quality of equality data will be raised, and possible solutions will be discussed at the Data Quality and Business Intelligence Group.	Data Quality and Business Intelligence Group	Ongoing

C. Workforce

9. Workforce Representation

The following information is displayed in order of protected characteristics.

9.1 Age

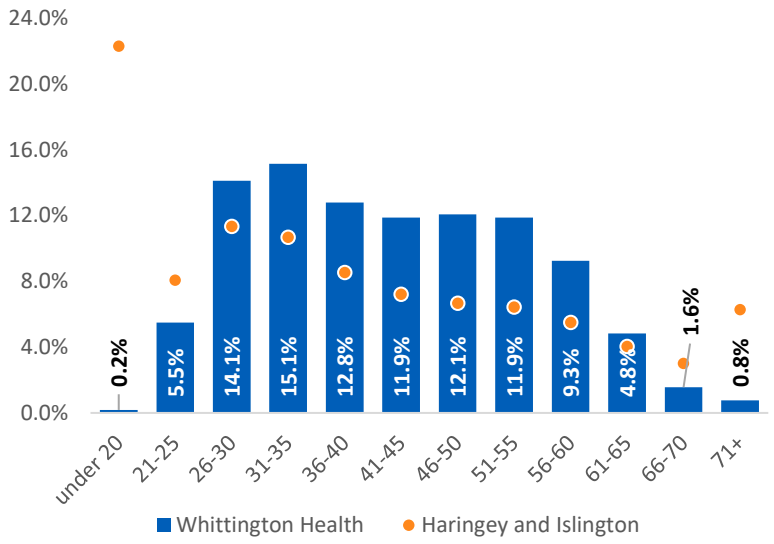
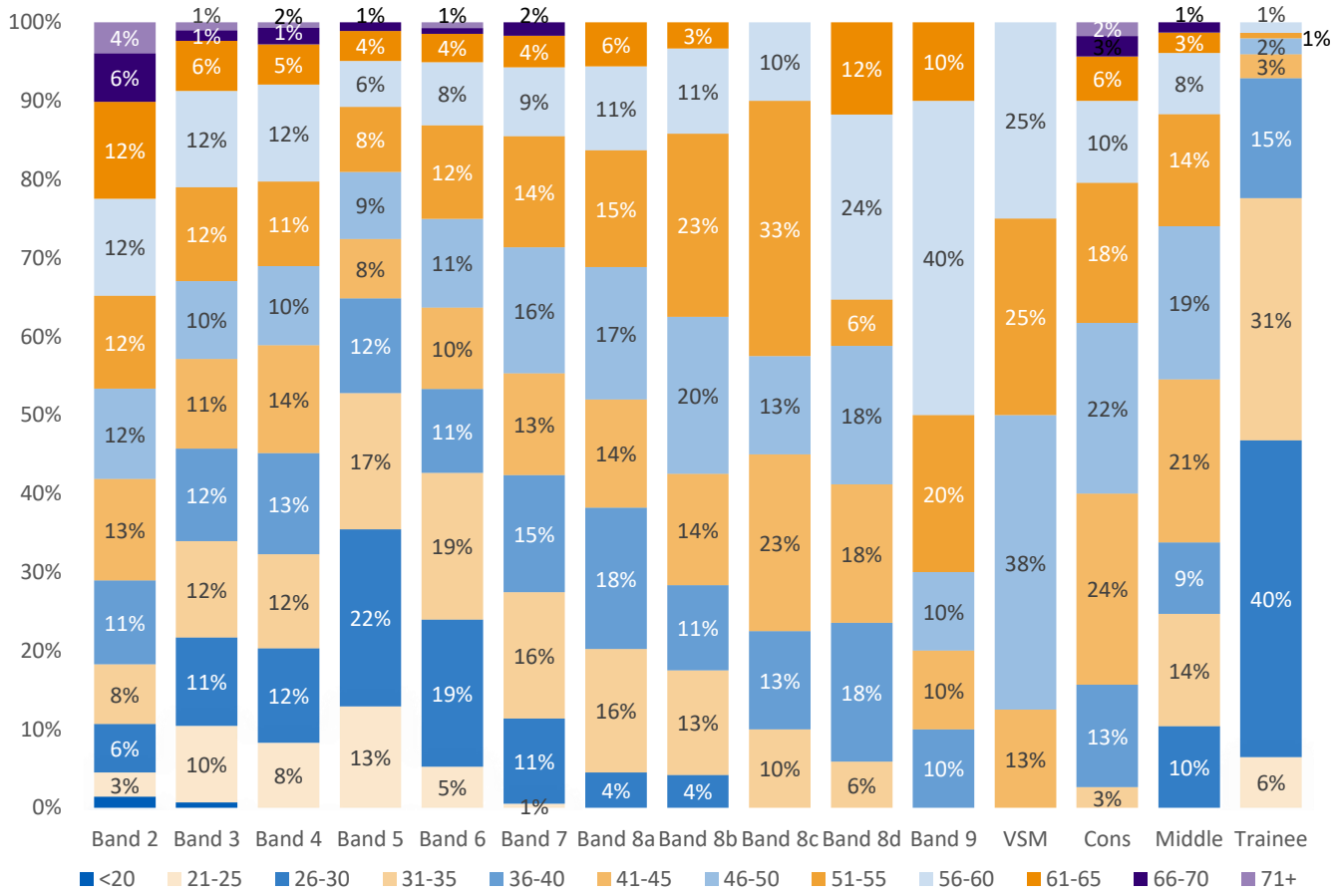


Chart C1 (left) shows the age profile of the Trust's workforce and the profile of residents of Haringey and Islington.

The chart shows the biggest proportion of the workforce is aged between 26-55; each category represents 12-15% of staff. The chart also demonstrates that the Trust has a good representation of staff aged 26-65 compared to the local population. There is also a lower representation of staff aged 21-25 and 66+ compared to the local population.

Chart C2 (below) shows the breakdown by pay band of the Trust's workforce by age.



Pay band or grade.	*Age groups that have the highest representation in pay band or grade*
Band 2	*36-65*
Band 3	*26-60*
Band 4	*26-60*
Band 5	*21-40*
Band 6	*26-55*
Band 7	*31-55*
Band 8a	*31-55*
Band 8b	*41-55*
Band 8c	*41-55*
Band 8d	*36-50 and 56-60*
Band 9	*51-60*
VSM	*46-60*
Medical – consultants	*41-55*
Medical – middle grade	*41-55*
Medical - trainee	*26-35*

Table CT1 (left) highlights what age groups have the greatest representation of pay bands and grades.

Typically, we will see the greatest concentration of younger workers in bands 2-6 and medical trainee roles.

Older workers have high levels of representation in bands 2-7, some senior roles (8d and 9), and there is also fair representation in medical consultant roles.

Table CT2 (below) compares the representation of the age group in the workforce to the actual representation in the band/grade. Higher means greater than workforce representation, lower representation is lower than workforce representation, and equal representation is equal to workforce representation.

Age group	*Higher or Equal representation*	*Lower representation*	*No representation*
<20	Bands 2 and 3		All other bands and grades
21-25	Bands 3-6, medical- trainee	Bands 2 and 7	Bands 8a-9, VSM and medical consultants/middle
26-30	Bands 5-6, medical middle and other	Bands 2-4, 7-8b.	Bands 8c-9, VSM and medical consultants
31-35	Bands 5-8a and medical trainee	Bands 2-4, 8b-d and medical consultants/middle	Band 9 and VSM
36-40	Bands 7-8a, 8d and all medical consultants/trainees	Bands 3, 5 and 6	VSM
41-45	Bands 2, 4, 7-8d, VSM medical consultant/middle	Bands 3, 5, 6, 9 and medical trainee	
46-50	Bands 7-8d, VSM and medical consultants/middle	Bands 2-6, 9 and medical trainee	
51-55	Bands 2-3, 6-8c, 9, VSM, medical consultants/middle	Bands 4-5, 8d and medical trainee	
56-60	Bands 2-4, 8a-9, VSM and medical consultants	Bands 5-7 and medical middle/trainee	
61-65	Bands 2-4, 8a, 8d-9 and medical consultants	Bands 5-8b and medical - other	VSM and medical trainee
66-70	Bands 2, 4, 7 and medical consultants	Bands 3, 5-6 and medical middle.	Bands 8a-9, VSM and medical trainee
71+	Bands 2-3 and medical consultants	Bands 4 and 6	All other bands and grades

9.2 Disability

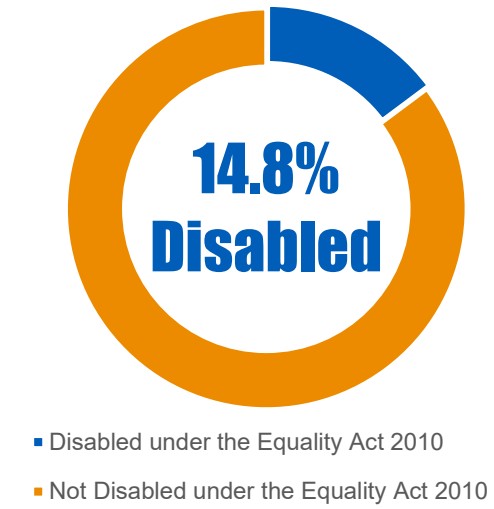


Chart C3 (left) represents the local population of Haringey and Islington by disability taken from the 2021 census.

14.8% of the population have a disability.

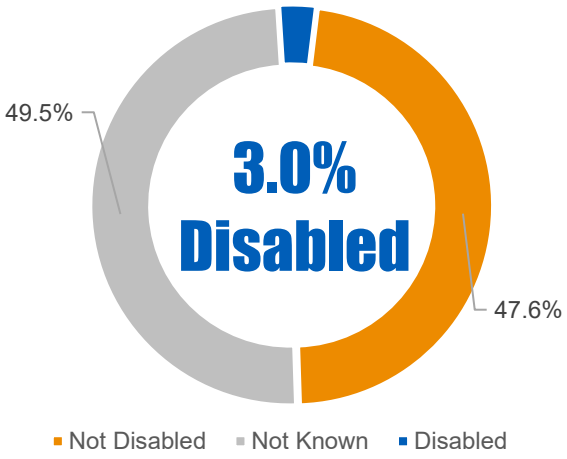


Chart C4 (left) represents the Trust's workforce. 3.0% of staff have declared a disability; this has increased by 0.5% since last year. One of the Trust's priorities is to improve the data on the Electronic Staff Records system about diversity data, as 49.5% of the workforce's disability status is unknown.

In the 2022 NHS Staff Survey, 18.6% of respondents highlighted that they have a disability. This means there is a 15.6% difference between the NHS Staff Survey and local ESR data.

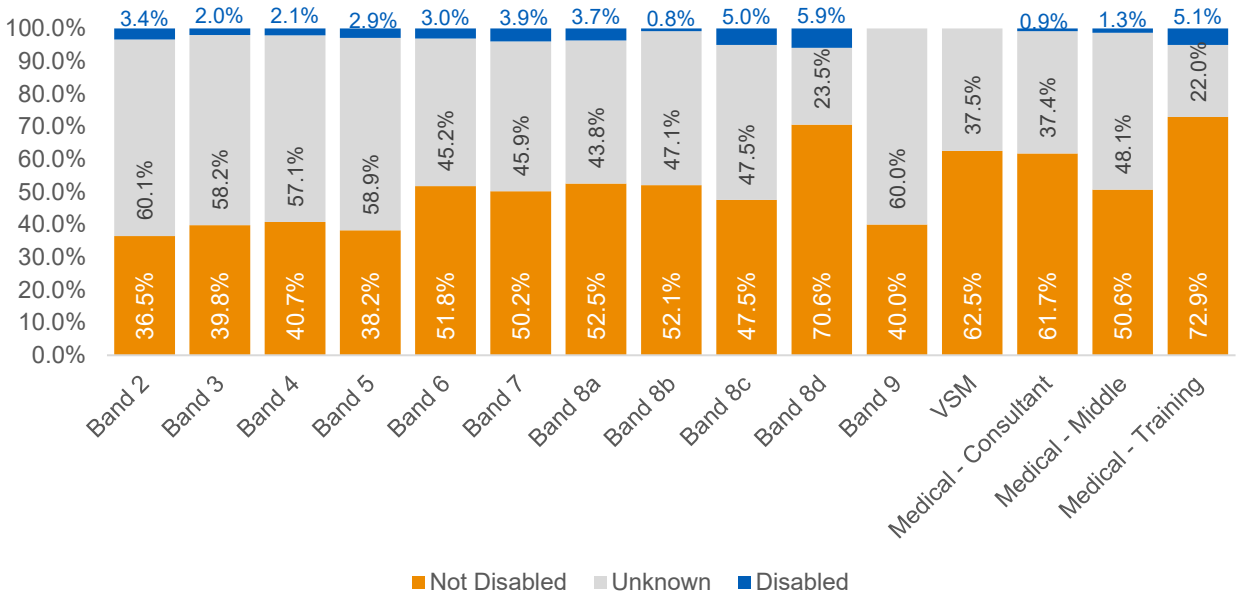


Chart C5 (above) shows the pay bands and grades broken down by disability status. There needs to be more disclosed data to draw firm and accurate conclusions.

However, from the available data, when comparing disabled staff in pay bands and groups compared to overall workforce representation, we can see that:

- In bands 3, 4, 5, 8b and medical consultants and middle grades, there is a lower-than-expected representation of staff with disabilities.
- In bands 2, 6, 7, 8a, 8c, 8d and medical training grades, there is a higher-than-expected representation of staff with disabilities.
- There is no representation of staff with disabilities in band 9 and VSM grades.
- There is a high level of staff whose disability status is either unknown or elected not to share their status throughout the pay bands and grades.

9.3 Gender Reassignment

In Haringey and Islington, 1.1% of the population identified that they are from transgender/trans communities in the 2021 census; this equates to 4,428 people.

Nationally, it is impossible to record gender reassignment/identity on Electronic Staff Records; this is currently under review. Until national updates are made to the ESR system, reporting on this protected characteristic will not be possible.

9.4 Marriage and civil partnership

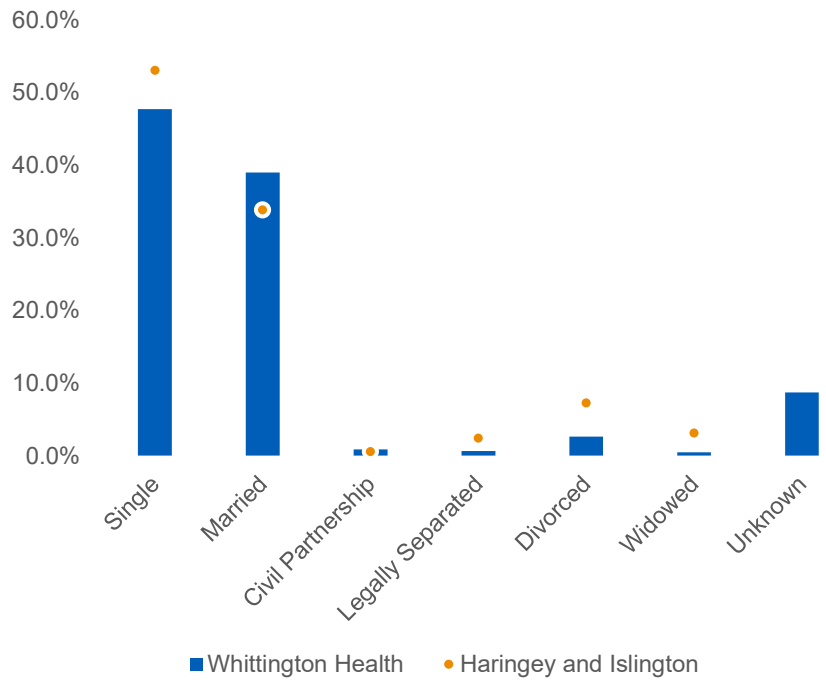


Chart C6 (left) shows the Trust's workforce broken down by marital status compared to the residents of Haringey and Islington.

The Trust's workforce has proportionally more staff that are married or in a civil partnership than the local population. All other categories (except unknown) have a greater representation in the local community than in the workforce.

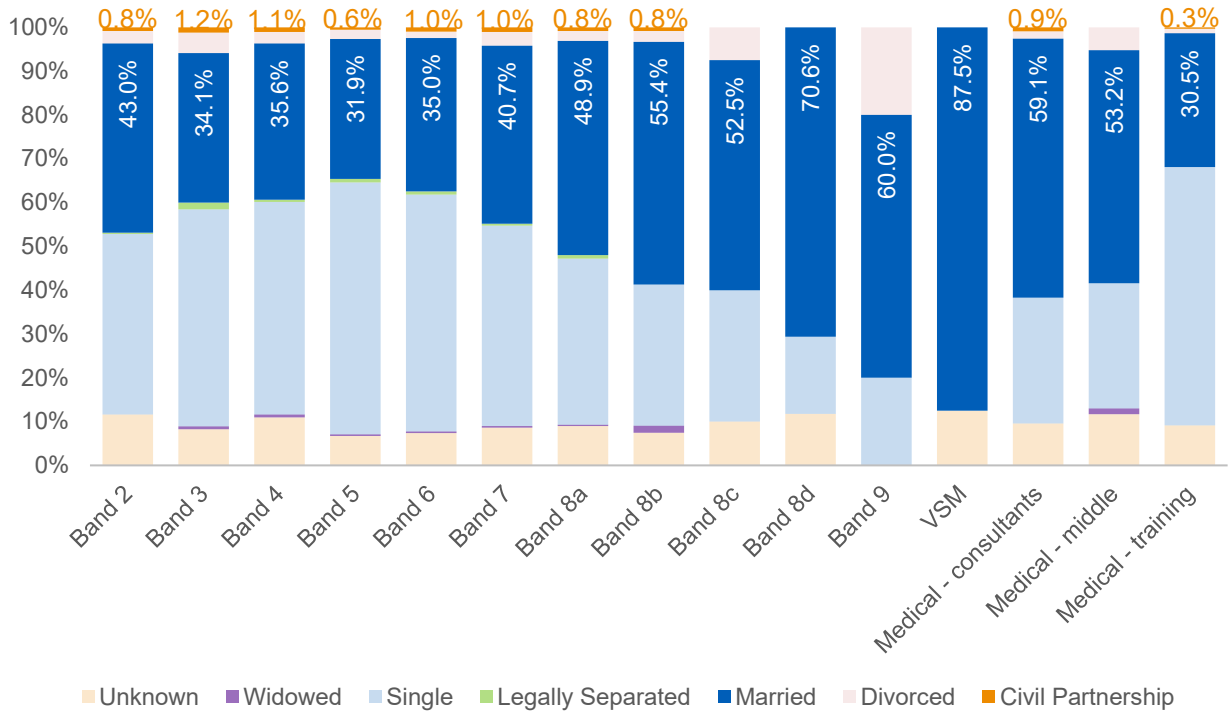


Chart C7 (above) shows pay bands and grades by marital status. Please note only the categories married and civil partnership have been labelled and will be commented on.

When comparing the breakdown provided in Chart C7 (above) to the overall workforce representation:

- For the characteristic of marriage, there is a greater than expected representation in bands 2, 7-9, VSM and all medical consultants and middle grade. There is a lower-than-expected representation in bands 3-6 and medical trainees.
- There is a greater-than-expected representation in bands 3, 4, 6, and 7 for the characteristic of civil partnership. There is a broadly equal representation in bands 2, 8a, 8b and medical consultants. All other bands have either a lower-than-expected representation or no representation.

9.5 Pregnancy and maternity

One hundred forty-three women were recorded on ESR as being on maternity leave as a snapshot on 31st March 2023. This represents just 3.75% of the female population of the Trust's workforce. It is impossible to know the number of pregnant women in the Trust because there is no requirement to record it until the Maternity Certificate can be issued after 20 weeks of pregnancy. ESR will only record those who have completed and submitted their certificates.

9.6 Race (this includes ethnic or national origins, colour or nationality)

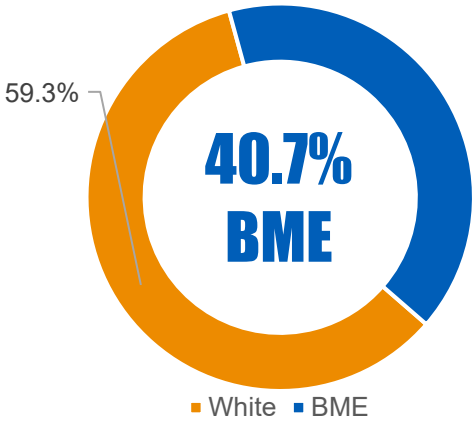


Chart C8 shows the representation of the population of Haringey and Islington broken down by ethnicity.

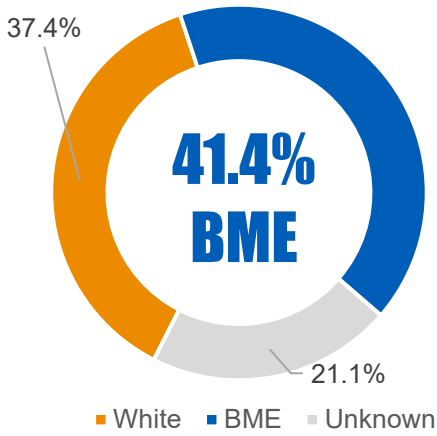


Chart C9 (left) represents the Trust's workforce by ethnicity.

Compared to the local population (chart C8), there is a broadly proportional representation of BME staff and fewer white staff; however, just over a fifth of the workforce's ethnicity is unknown.

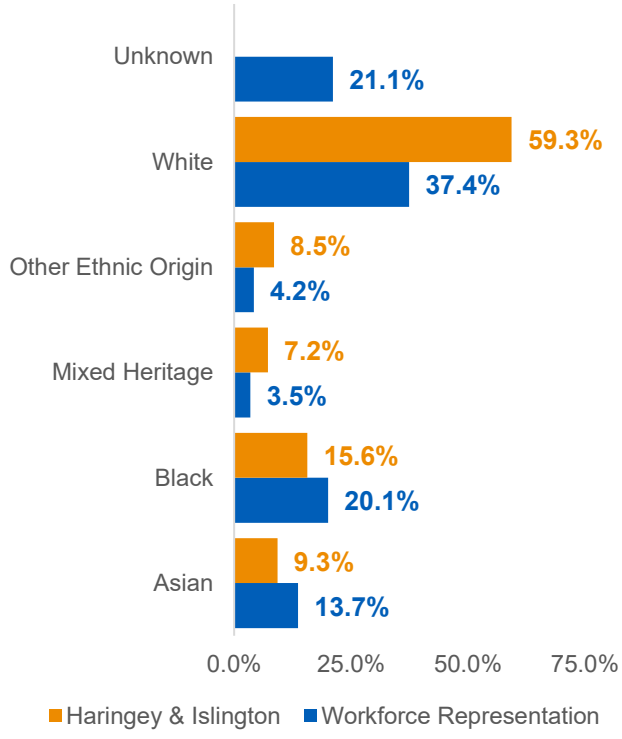


Chart C10 (left) breaks down the representation of the BME category into smaller ethnic groups for the Trust workforce and Haringey and Islington's local population.

Compared to the local population, the workforce has a higher-than-expected representation of Asian and Black staff and a lower-than-expected representation of mixed heritage, other ethnic groups and White staff.

Just over a fifth of the workforce's ethnicity is unknown; the available data may not represent an accurate picture of the racial demographic breakdown of the workforce.

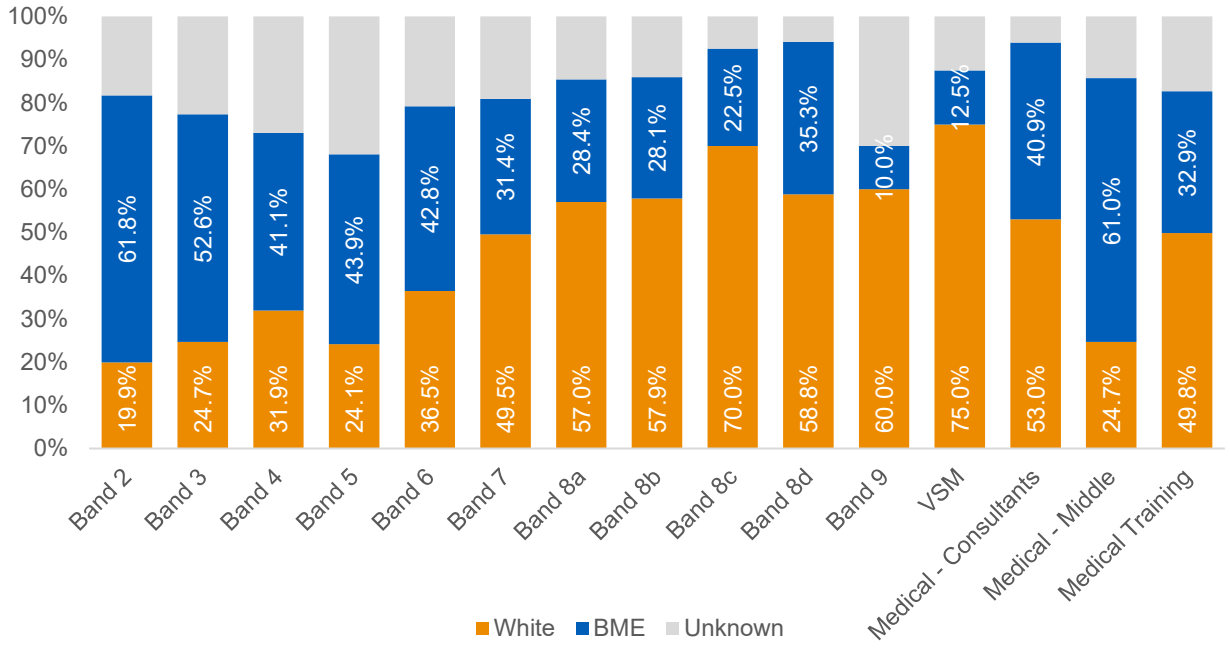


Chart C11 (above) shows the breakdown by pay band of the Trust's workforce by ethnicity. Although there is a 4% difference in the number of BME to white staff, the career path is notably different, with most BME staff represented up to Band 6 and in medical roles. White staff have a much higher-than-expected representation in band seven upwards and in medical roles.

Most notably, there is a lower-than-expected representation of BME staff from bands 7-9, VSM and medical training grades. BME staff have a greater representation than expected in bands 1-6 and medical-middle.

However, nearly a fifth of staff have not declared their ethnicity, so the accurate picture of representation throughout the bands and grades will be known once the declaration rate improves.

9.7 Religion or belief

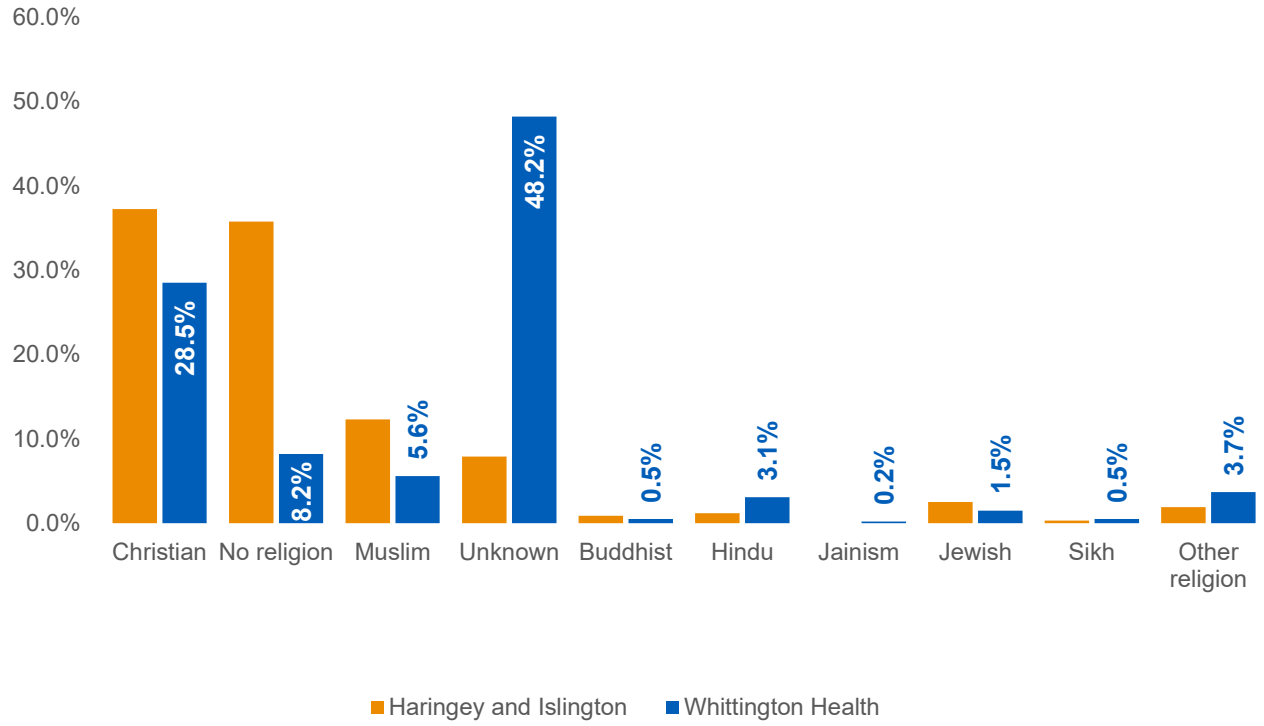


Chart C13 (above) shows the representation of religion and belief of the population of Haringey and Islington and the Trust's workforce. Within the Trust, the greatest representation is for staff whose religion or belief is unknown/staff have elected not to share that information; the second largest group is Christian, and the third largest group are staff with no religion or belief.

When comparing the workforce to the local population, most groups have a lower representation within the Trust's workforce except for Hindus, Sikhs and those of 'other' religions or beliefs. Jainism is not recorded as a separate religion in the 2021 Census.

Table CT3 (below) represents the religion or belief broken down by pay band or grade; the items highlighted in orange illustrate a higher-than-expected representation compared to the overall workforce.

	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9
Atheism	0.6%	4.0%	5.1%	4.9%	6.9%	**10.6%**	**12.4%**	**11.6%**	**10.0%**	**11.8%**	**30.0%**
Buddhism	0.3%	**1.3%**	0.2%	0.3%	**0.7%**	0.3%	0.3%				
Christianity	**29.2%**	**32.8%**	26.8%	**29.8%**	**31.6%**	27.3%	**30.1%**	**29.8%**	27.5%	**47.1%**	**30.0%**
Hinduism	1.4%	3.0%	2.3%	2.0%	1.3%	2.6%	**4.2%**	1.7%			**10.0%**
Islam	**5.6%**	**7.9%**	4.2%	**6.7%**	4.6%	3.7%	1.7%	4.1%	**7.5%**		
Jainism	**0.3%**	**0.2%**	**0.2%**		**0.4%**	0.1%					
Judaism		0.2%	0.4%	0.7%	**1.6%**	**1.7%**	**2.2%**	**1.7%**			
Other	1.7%	**4.0%**	**4.9%**	3.5%	2.6%	**4.4%**	**4.5%**	**6.6%**	**5.0%**	**5.9%**	
Sikhism	0.3%	0.2%	0.4%	0.1%	0.4%	**0.5%**	**0.6%**		**5.0%**	**5.9%**	
Unknown	**60.7%**	46.4%	**55.6%**	**52.0%**	**49.9%**	**48.8%**	44.1%	44.6%	45.0%	29.4%	30.0%

	VSM	Medical - Consultant	Medical – Middle	Medical - Trainee
Atheism	**25.0%**	**12.6%**	2.6%	**27.5%**
Buddhism		**1.7%**		**1.0%**
Christianity	**37.5%**	21.7%	14.3%	19.3%
Hinduism		**8.3%**	**10.4%**	**8.8%**
Islam		**7.4%**	**18.2%**	**9.2%**
Jainism		**0.4%**		
Judaism		**4.3%**	**5.2%**	**5.8%**
Other		1.3%	2.6%	**5.4%**
Sikhism		**1.3%**	**1.3%**	**0.7%**
Unknown	37.5%	40.9%	45.5%	22.4%

Table CT3 shows that:

- Atheists have a higher-than-expected representation in bands 7-9, VSM and medical consultant and trainee roles. A lower-than-expected representation exists in bands 2-6 and medical middle-grade doctors.
- Buddhists have a higher-than-expected representation in bands 3 and 6; medical consultants and trainees have a lower-than-expected representation in bands 2, 4-5, and 7-8a. There is no representation from 8b-9, VSM or middle-grade doctors.
- Christians are generally well represented through AfC pay bands; there is a lower-than-expected representation in bands 4, 7 and 8c and all medical roles.
- Hindus have a generally lower-than-expected representation in most pay bands/grades; there is a higher-than-expected representation in bands 8a and 9 and all medical roles, and there is no representation in 8c-d and VSM roles.
- Muslims have a higher-than-expected representation in bands 2-3, 5, 8c and all medical roles, a lower-than-expected representation in 4 and 6-8b and no representation in 8d-9 and VSM roles.
- Jains have a higher-than-expected representation in bands 2-4, 6 and medical consultants; a lower-than-expected representation in band 7, and no representation in 5, 8a-9, VSM and medical middle/trainee grades.
- Jewish staff have a higher-than-expected representation in bands 6-8b and all medical roles, a lower-than-expected representation in 3-5 and no representation in 2, 8c-9 and VSM roles.
- Staff from any other religion/belief have a higher-than-expected representation in bands 3-4, 7-8d and medical trainee roles, a lower-than-expected representation in 2. 5-6 and medical consultant/middle grades and no representation in 9 and VSM.
- Sikhs have a higher-than-expected representation in bands 7, 8a and all medical roles, a lower-than-expected representation in 2-6 and no representation in 8b, 9 and VSM.
- Many staff have either not shared their religion or belief or have chosen not to across all bands and grades. This high non-declaration masks the accurate picture of religion or belief representation across the pay bands.

9.8 Sex

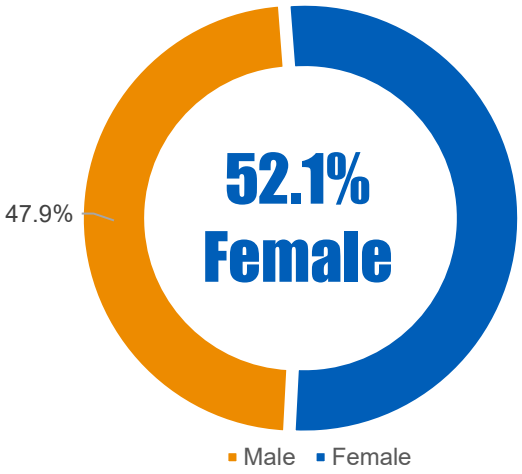


Chart C14 (left) shows the breakdown of the population of Haringey and Islington by sex. 47.9% of the population is male, and 52.1% is female.

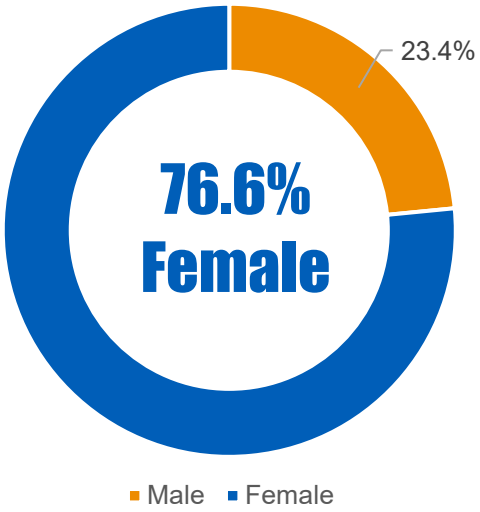


Chart C15 (left) shows the breakdown of the Trust's workforce by sex. Whilst the representation in the Trust does not reflect the local population, it does mirror the national NHS pattern of 77% female and 23% male.

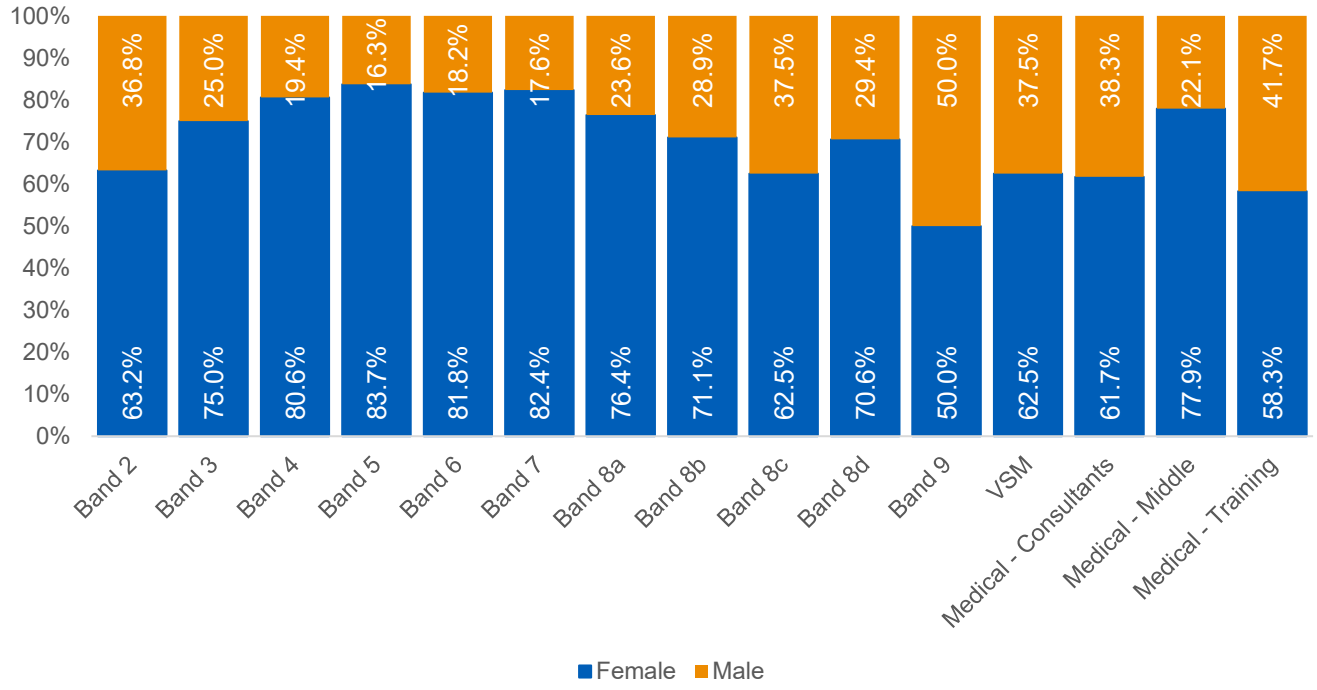


Chart C16 (above) shows the breakdown of pay bands and grades by sex; male and female staff are well represented across all bands and grades.

Compared to the workforce representation, women have a lower-than-expected representation in senior and very senior manager roles and medical consultant and training roles. Women also have a higher-than-expected representation in bands 4-7. Male staff have a higher-than-expected representation in consultant and training medical roles, VSM and bands 8a-9; however, there is a lower-than-expected representation in bands 3-7 and middle medical roles.

9.9 Sexual orientation

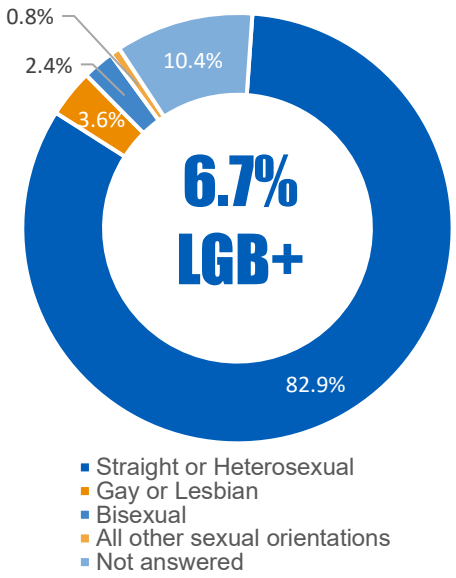


Chart C17 shows the representation of sexual orientation in Haringey and Islington taken from the 2021 Census. 82.9% of the population identify as heterosexual, 6.7% as non-heterosexual (3.6% lesbian or gay, 2.4% bisexual and 0.8% as all other sexual orientations).

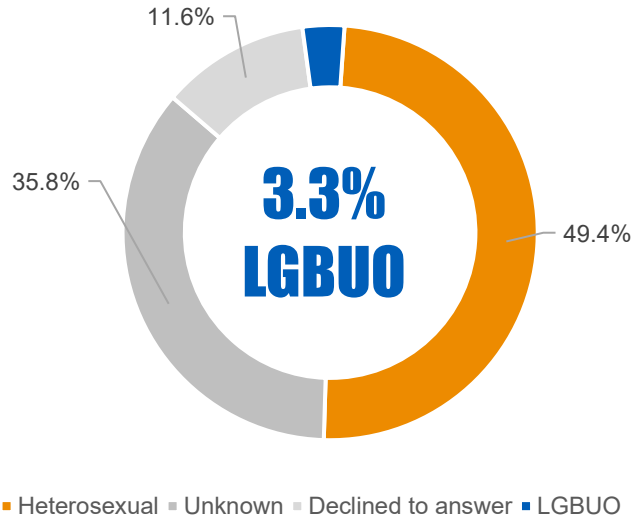


Chart C18 (left) represents the Trust's workforce by sexual orientation. In the 2021 Census, data about sexual orientation was not collected.

Because the level of declaration for sexual orientation is very low throughout the organisation, Lesbian, Gay, Bisexual, Undecided and Other Sexual Orientation Not Listed categories have been aggregated (LGBUO). However, as the declaration rates are so low, it is impossible to draw meaningful conclusions. Still, there has been an increase of 0.8% of staff identifying as LGBUO since 21/22.

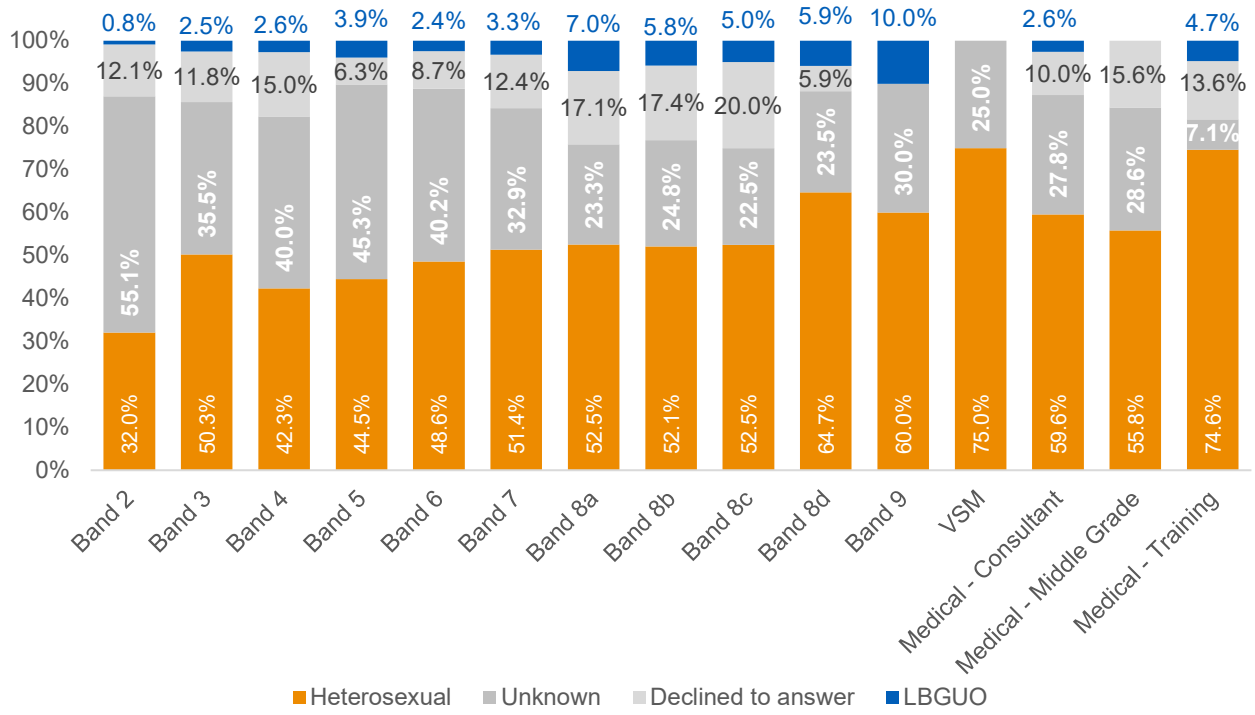


Chart C19 (above) shows the workforce broken down by pay band/grade and sexual orientation.

Many staff have either declined to provide their sexual orientation or that it is simply unknown.

Comparing the representation in pay bands and grades to the overall workforce. LGBUO staff have good (higher-than-expected) representation in bands 5, 7-9, medical training; lower-than-expected representation in bands 2-4, 6 and medical consultants; and no representation in VSM and Medical middle grade. Compared to the previous year, nearly every band has seen an increase in representation in every band/grade, except band 8d and medical middle grade, which reduced. VSM, which remains as having no representation.

Heterosexual staff are well represented throughout most pay bands and grades; in most cases, they have a greater representation in the band/grade compared to the overall representation in the workforce. The bands and grades with a lower-than-expected representation are bands 2 and 4-6.

10. Recruitment

This section reviews recruitment data from 2022/23; it breaks down the representation of protected characteristics through three stages of recruitment – application, shortlisting, and appointment. To aid comparison, data relating to workforce representation is also included.

During 2022/23, there were:

- 17,829 applications received
- 3,449 applicants that were shortlisted to progress to interview
- 771 applicants were appointed

Due to a technical issue with the Trust's recruitment system (TRAC), only data relating to age, disability, and race are available within this reporting period.

10.1 Age

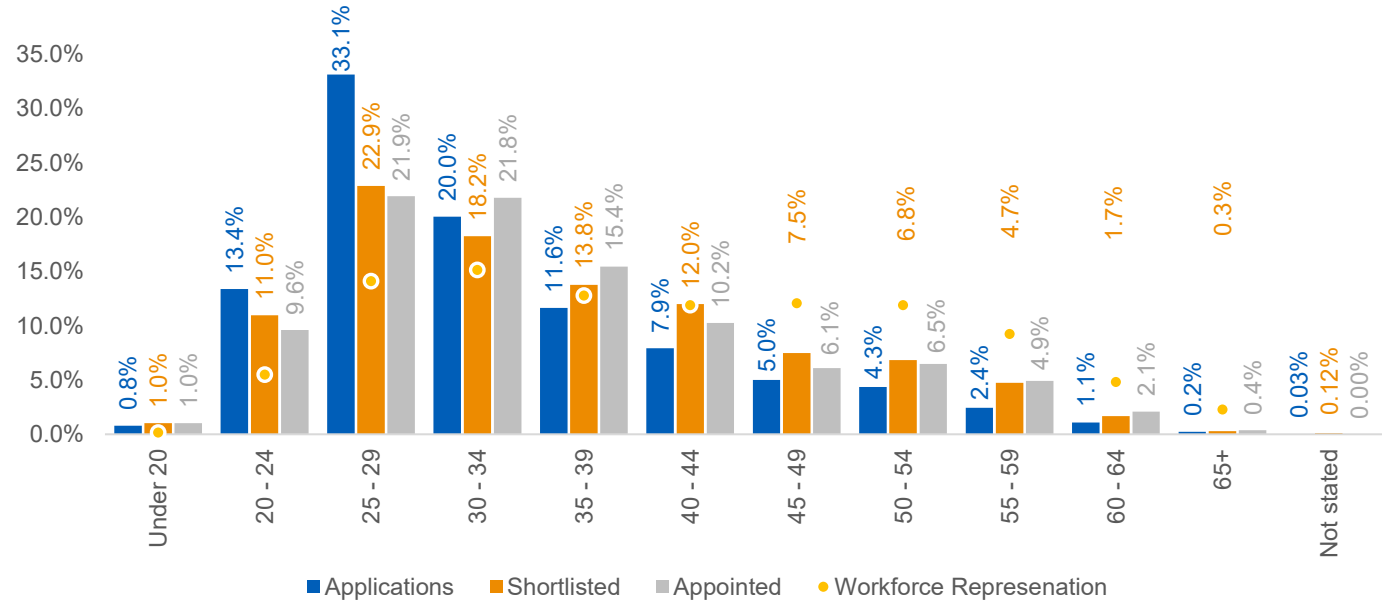


Chart C20 (above) shows the representation throughout the recruitment stages broken down by age; the workforce representation data has also been included to aid comparison.

Compared to the overall workforce representation, there is a greater proportion of applicants aged 20-39 in the recruitment processes; conversely, there is a broadly lower-than-expected representation for those under 20 and 40+.

There is an overall trend of applicants aged 40+ having a greater proportional representation when progressing from the application to the shortlisting stage but a lower or broadly equal representation from shortlisting to the appointment stage. In all cases, the representation at the appointment stage is greater than at the application stage.

For applicants aged 20-34, in all cases, when progressing from the application to the shortlisting stage, there is a lower proportional representation; for applicants aged 20-29, there is a broadly equal representation when progressing from shortlisting to appointment, and for applicants 30-39 there is a greater proportional representation.

10.2 Disability

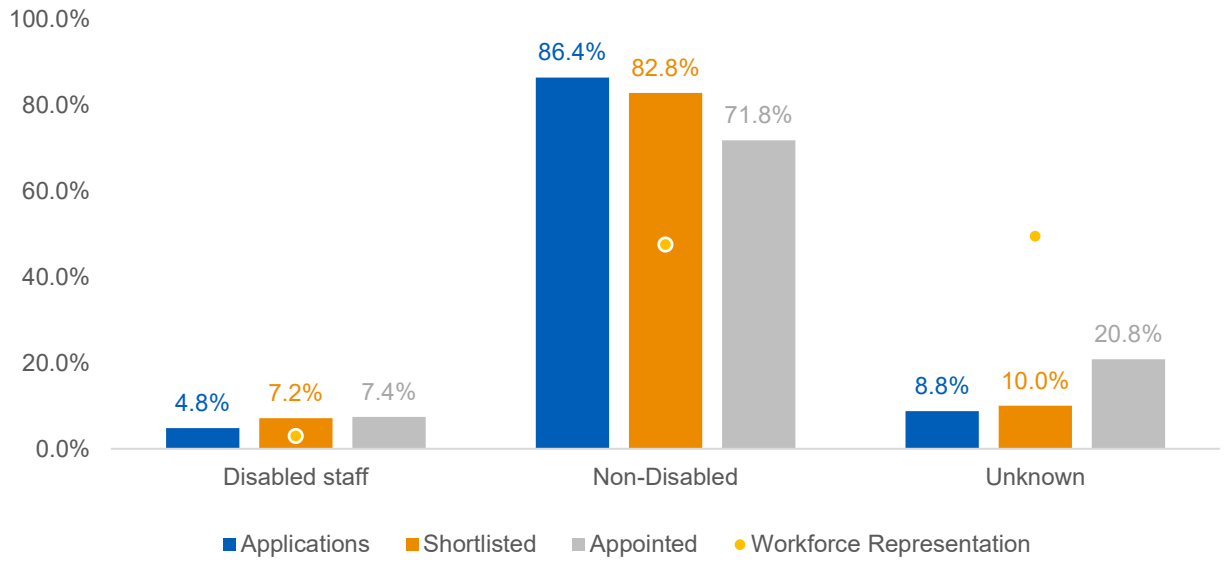


Chart C21 (above) shows the representation throughout the recruitment stages broken down by disability; the workforce representation data has also been included to aid comparison.

Compared to the overall workforce representation, there is a greater proportion of disabled and non-disabled applicants in the recruitment processes; conversely, there is a proportionally lower representation where the applicant's disability status is unknown. Should the trend of representation of disabled applicants continue, the Trust should ultimately see a greater representation of disabled staff in the workforce.

Overall, there is an increase in disabled applicants as they progress through the recruitment stages.

10.3 Race (this includes ethnic or national origins, nationality, or colour)

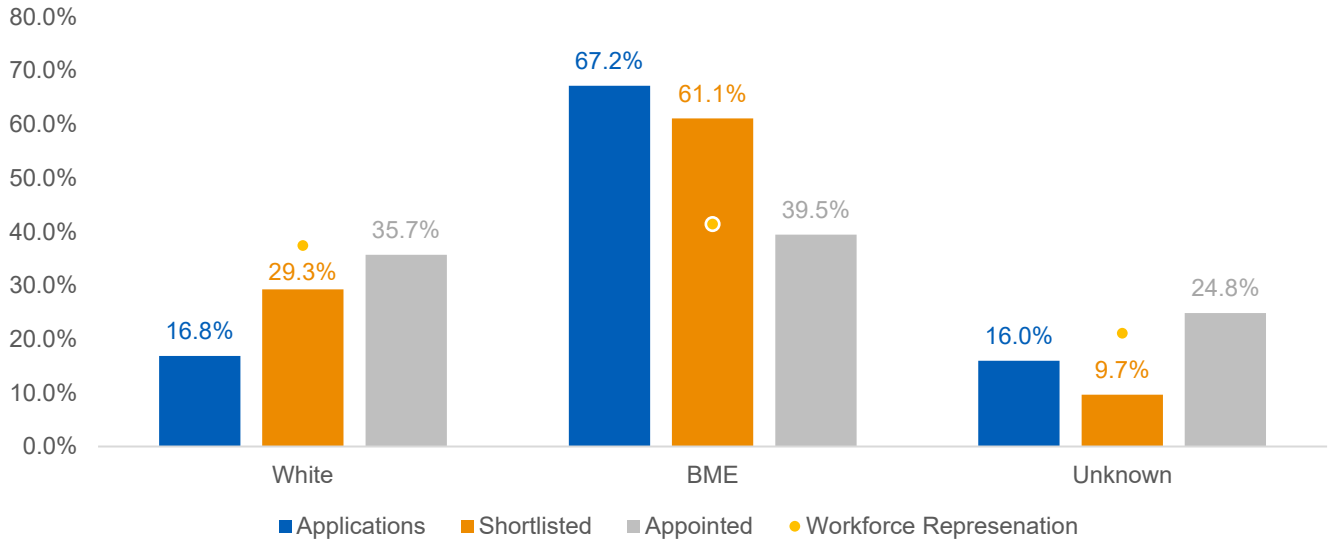


Chart C22 (above) shows the representation throughout the recruitment stages broken down by the applicants' race; the workforce representation data has also been included to aid comparison.

Compared to the overall workforce representation, BME applicants have a greater proportional representation at all stages of recruitment. However, when progressing throughout the stages of recruitment, the representation of BME applicants reduces at each stage. However, there is a lower proportional representation of BME applicants appointed compared to the application stage.

Compared to the overall workforce, there is a lower representation of white applicants at the application and shortlisted stages but a greater representation at the appointment stage. When progressing throughout the three stages, the representation of white applicants increases, and there is a greater representation of white applicants appointed than in the application stage.

11. Employee Relations Processes

During 2022/23, there were 14 disciplinary cases and 4 capability cases.

The following sections review the demographical breakdown in representation compared to the workforce. Not all the data related to employee relations cases was available when writing this report.

11.1 Disability

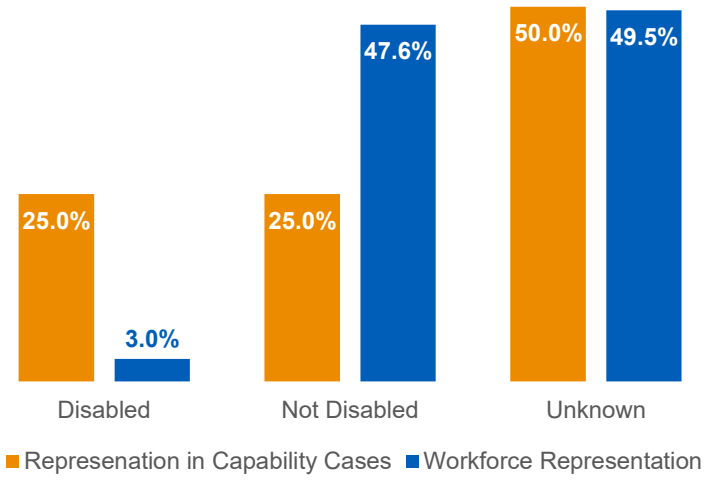


Chart C23 (left) shows the representation within disciplinary procedures compared to the representation in the overall workforce.

While the data indicate a disproportionate number of disabled staff entering into capability procedures, it should be noted that there were only 4 cases during 22/23. With a low number of cases, even a small number could suggest a disproportionate impact.

11.2 Race (this includes ethnic or national origins, colour or nationality)

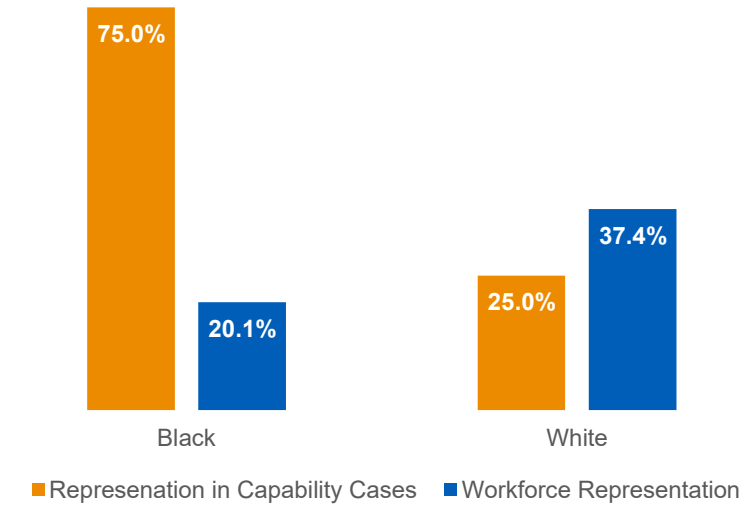


Chart C24 (left) shows the representation in the capability procedures by ethnicity; workforce representation is also included for comparison.

The chart suggests a big overrepresentation of black staff undergoing this process. However, it should be noted that there were only four cases during 22/23.

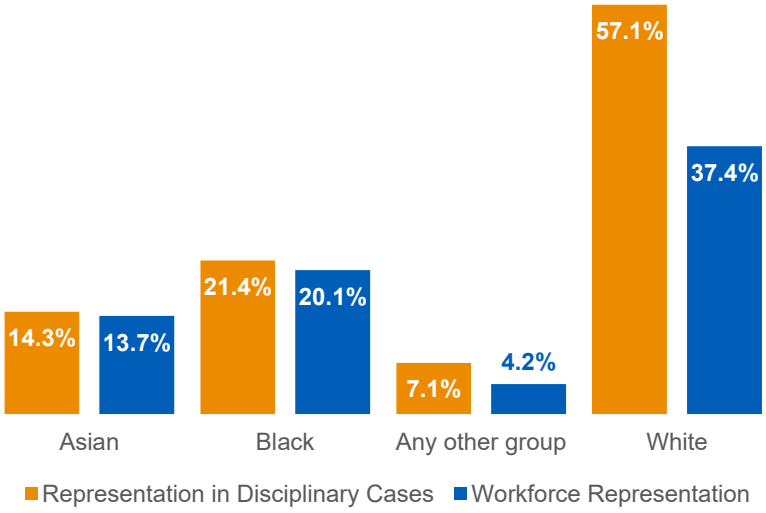


Chart C25 (left) further breaks down the ethnicity categories in the representation in the disciplinary procedures; workforce representation is included for comparison.

Staff from Asian and Black backgrounds have a broadly equal representation compared to the workforce. White staff and those from any other group have a greater representation in disciplinaries compared to their representation in the workforce.

12. Non-Mandatory Training and Continued Professional Development (CPD)

Opportunities for non-mandatory training and CPD can lead to staff career development and play an important metric when measuring inclusion.

During 2022/23, 1,222 staff undertook training that was either non-mandatory or related to continued professional development. The data covers training activities offered by Learning and Development and Organisational Development; ongoing work to work with other departments, e.g., medical and dental, nursing, etc., to improve data coverage. This section will review the demographic breakdown of the staff that undertook training.

12.1 Age

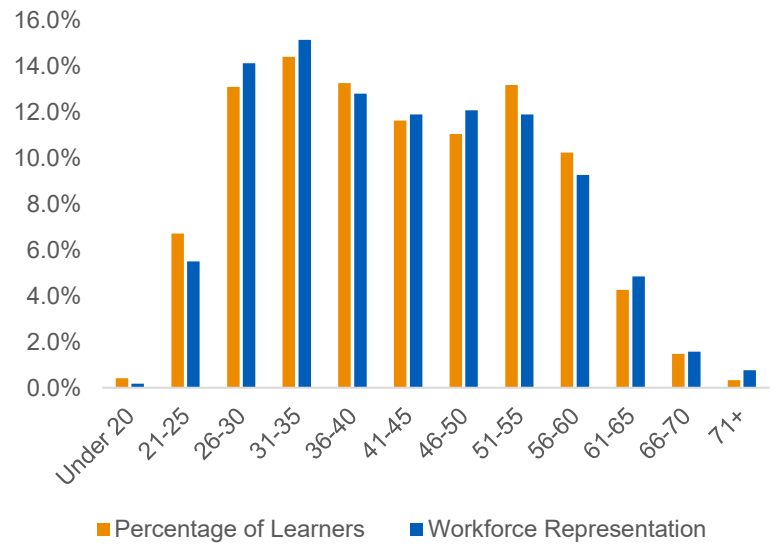


Chart C26 (left) shows the breakdown of staff that access non-mandatory training or CPD by age groups; the overall representation of the workforce by age has been included to aid comparison.

Overall, the representation in training activities broadly aligns with the workforce representation. However, there is a slightly higher workforce representation in age groups <20-25 and 51-60; all other groups have a slightly lower representation.

12.2 Disability

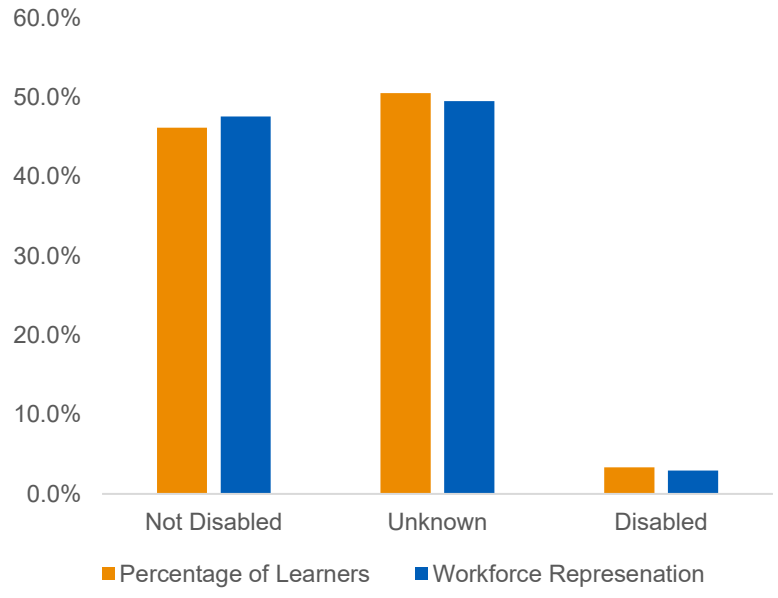


Chart C27 (left) shows the breakdown of staff that access non-mandatory training or CPD by disability status; the overall representation of the workforce by age has been included to aid comparison.

Overall, the representation in training activities broadly aligns with the workforce representation. However, there is a slightly lower representation of disabled staff accessing training than the workforce. Still, a high level of staff has not shared their disability status, which may be masking the accurate level of representation.

12.3 Marriage and civil partnership

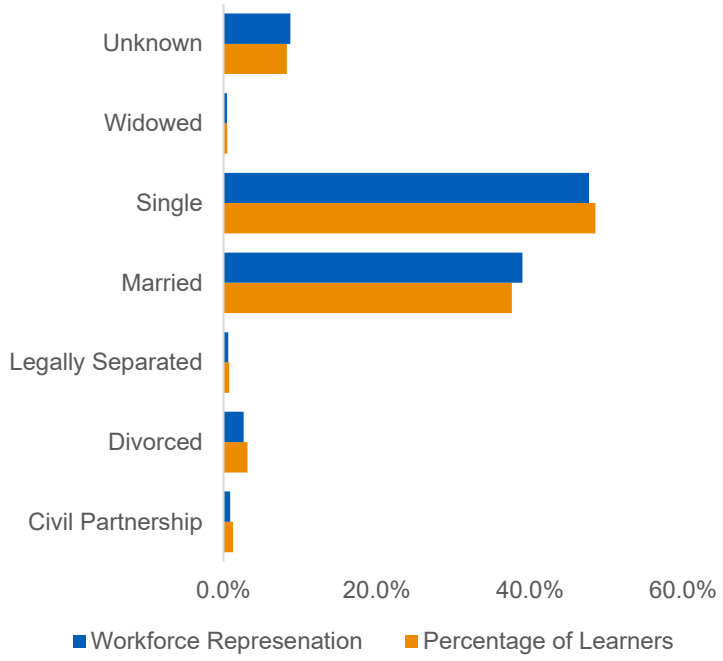


Chart C28 (left) shows the breakdown of staff that access non-mandatory training or CPD by marriage and civil partnership; the overall representation of the workforce has been included to aid comparison.

Overall, the representation in training activities broadly aligns with the workforce representation. However, there is a slightly lower representation of married staff accessing training than the workforce and a higher of staff in a civil partnership.

12.4 Race (this includes ethnic or national origins, colour or nationality)

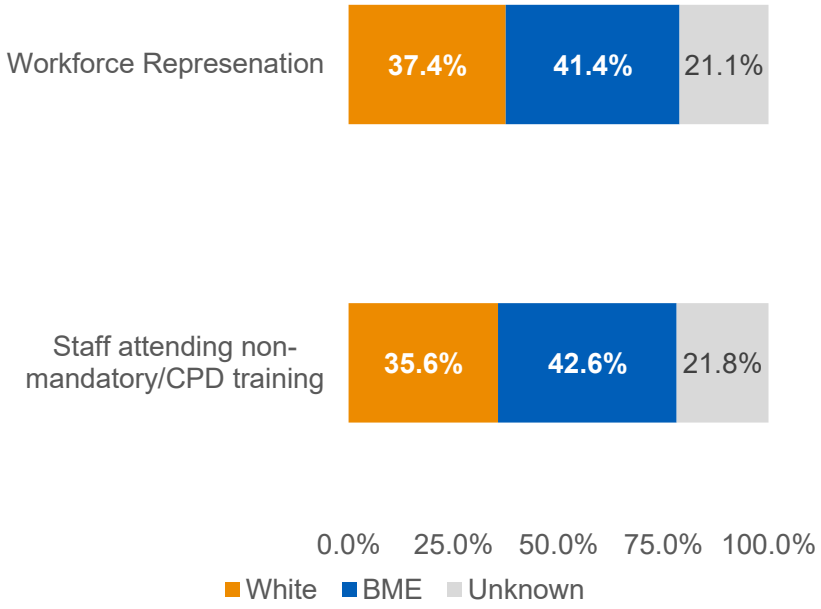
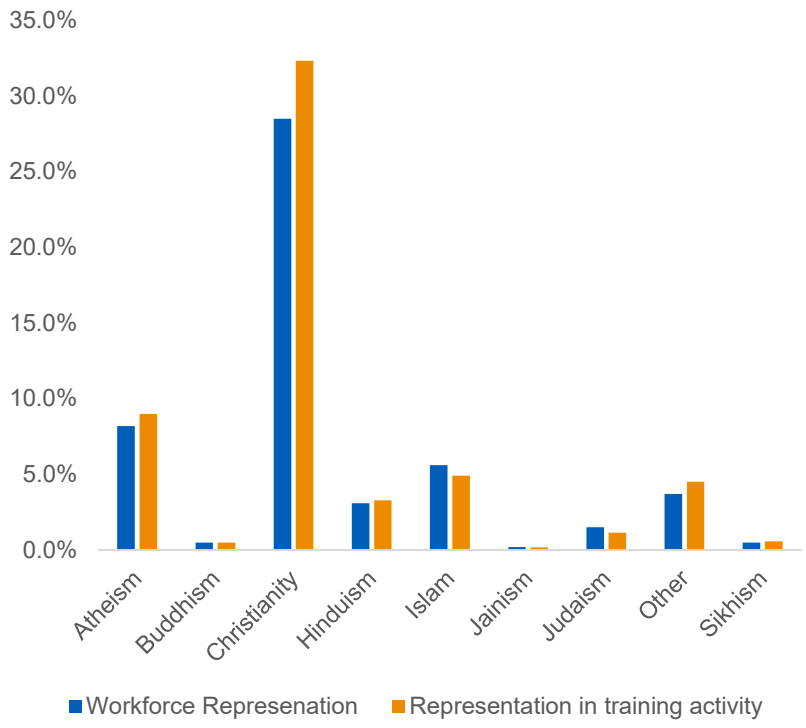


Chart C29 (left) shows the breakdown of staff that accessed non-mandatory training or CPD by race; overall workforce representation has been included to aid comparison.

Overall, the representation in training activity is broadly proportional to the workforce. There is a slightly higher-than-expected representation of BME staff and a slightly lower white staff.



12.5 Religion or Belief

Chart C30 (left) shows the breakdown of staff that accessed non-mandatory training or CPD by religion or belief; the workforce representation has been included to aid comparison.

Compared to the workforce representation, all groups that undertook this type of training are broadly in line. Most groups have a higher-than-expected representation in training activity compared to the overall workforce, except staff that are Muslim, Jewish or unknown (excluded from the chart – 43.6% in training activity and 48.2% in the overall workforce).

12.6 Sex

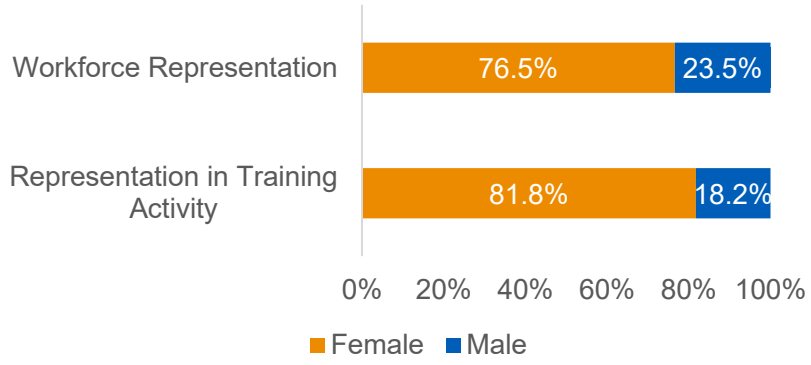


Chart C31 (left) shows the breakdown of staff that accessed non-mandatory training or CPD by sex; the workforce representation has been included to aid comparison.

Compared to the workforce representation, more women and fewer men are accessing non-mandatory or CPD training.

12.7 Sexual Orientation

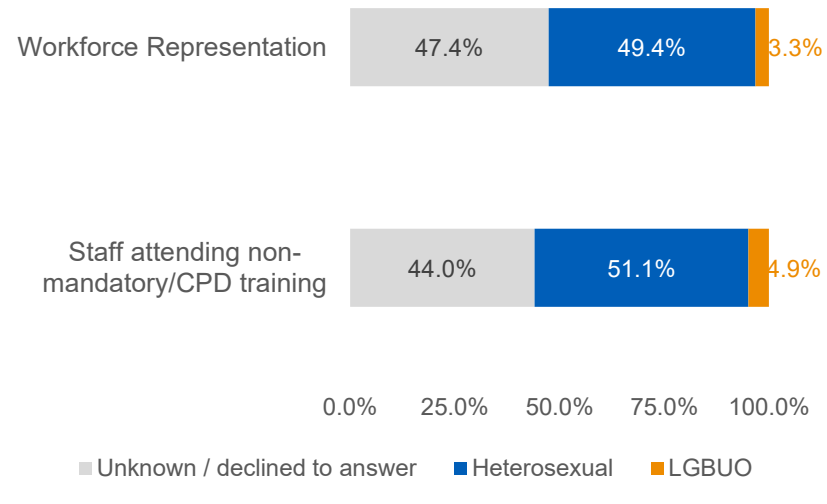


Chart C32 (left) shows the breakdown of staff that accessed non-mandatory training or CPD by sexual orientation; the workforce representation has been included to aid comparison. Due to the low numbers, Lesbian, gay, bisexual, undecided and others have been combined to create an LGBUO category.

Compared to the overall workforce representation, there is a higher proportion of LGBUO staff accessing training.

13. Flexible Working

The Trust has many staff that benefit from flexible working, which helps staff balance the needs of their work and personal lives. Currently, flexible working requests are dealt with on a departmental basis, and information about those who have applied and been accepted for flexible working is not centrally recorded.

In the future, the Trust is investigating utilising Electronic Staff Records (integrated Human Resources and Payroll system) to enable reporting on flexible working arrangements.

14. Leavers

During 2022/23, a total of 979 staff left the organisation. This section will review the demographic breakdown of staff that left the Trust in greater detail.

14.1 Age

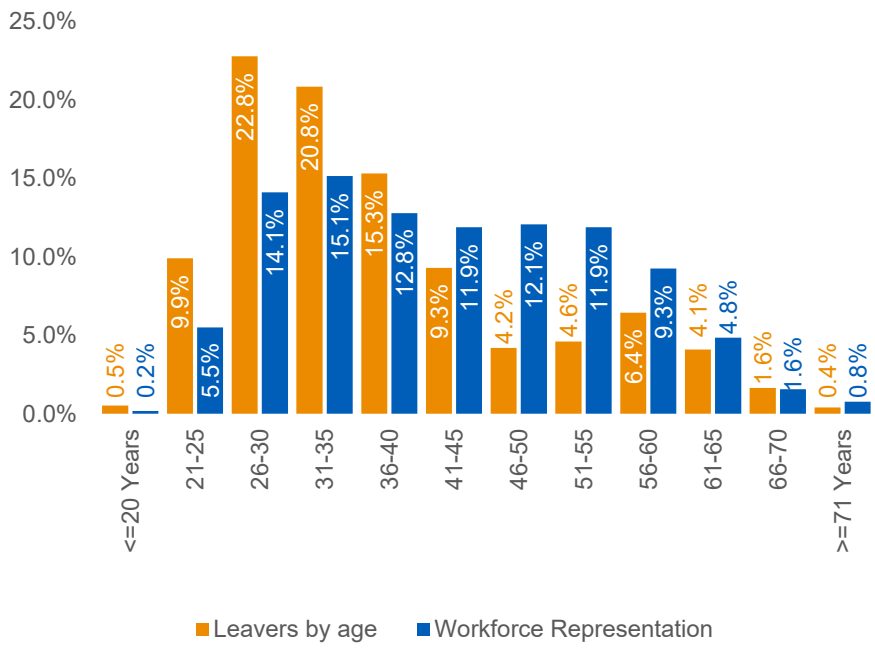


Chart C33 (left) shows the representation of staff that have left Whittington Health by age; the overall workforce representation has been included to aid comparison.

Most staff that have left the Trust are aged between 21 and 40.

Compared to the overall workforce representation, there is a higher-than-expected representation of leavers aged under 20 to 40; all other age groups have a lower-than-expected representation.

14.2 Disability

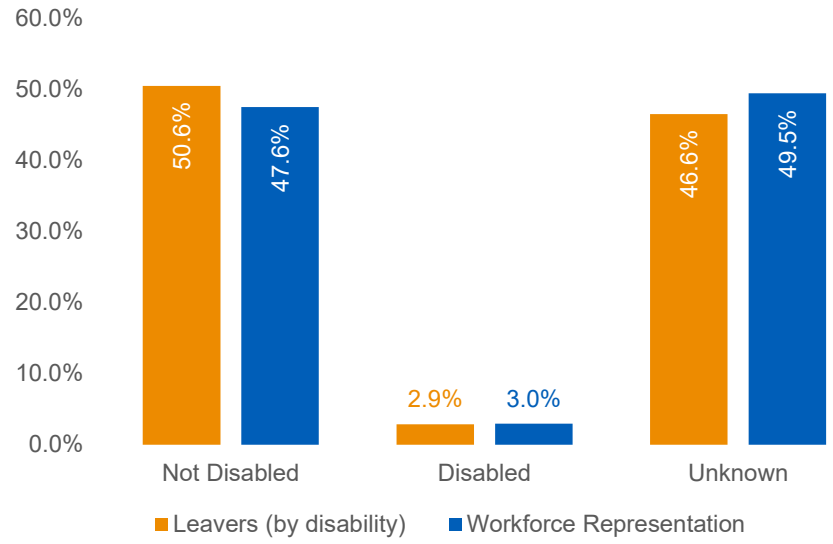


Chart C34 (left) shows the representation of staff that have left the Trust by disability status; the overall workforce representation has been included to aid with comparison.

Compared to the overall workforce, a slightly lower proportion of disabled and unknown and a higher proportion of non-disabled staff have left the organisation.

14.3 Marriage civil partnership

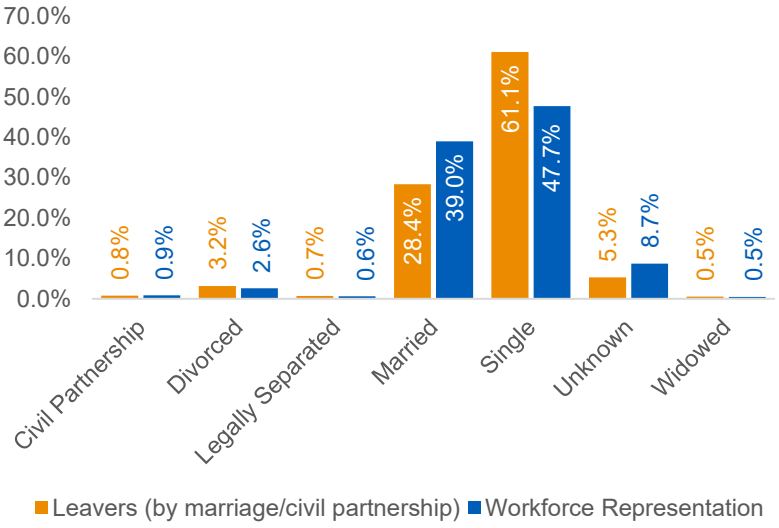


Chart C35 (left) shows the breakdown of staff that have left the organisation by marriage and civil partnership; workforce representation data have been included to aid comparison.

Compared to the overall workforce, fewer staff in civil partnerships and marriage have left the organisation.

14.4 Race (this includes ethnic or national origins, colour, or nationality)

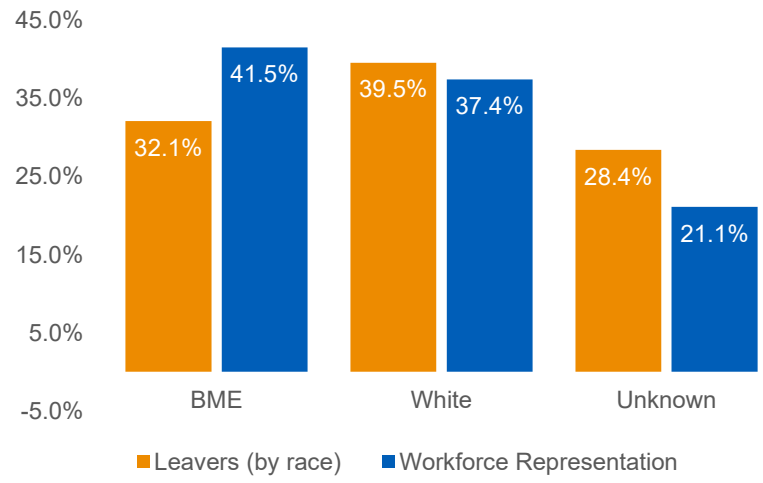


Chart C36 (left) shows the representation of ethnicity of staff that have left the Trust by ethnic group; overall workforce representation has been included to aid comparison.

Compared to the overall workforce, a lower-than-expected proportion of Black and Minority Ethnic (BME) staff have left the organisation. Still, a greater-than-expected proportion of white staff with unknown ethnicity has left the Trust.

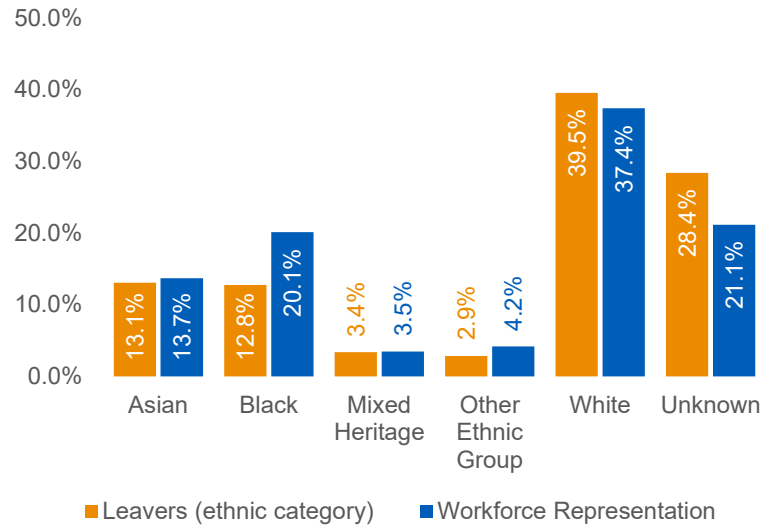


Chart C37 (left) breaks down the BME Category above into main ethnicity categories. Broadly, a proportional number of Asian and Mixed Heritage staff has left the organisation compared to the workforce representation.

A lower proportion of Black and Other Ethnic Group staff and a higher proportion of white and unknown have left the Trust compared to the overall workforce representation.

14.5 Religion or Belief

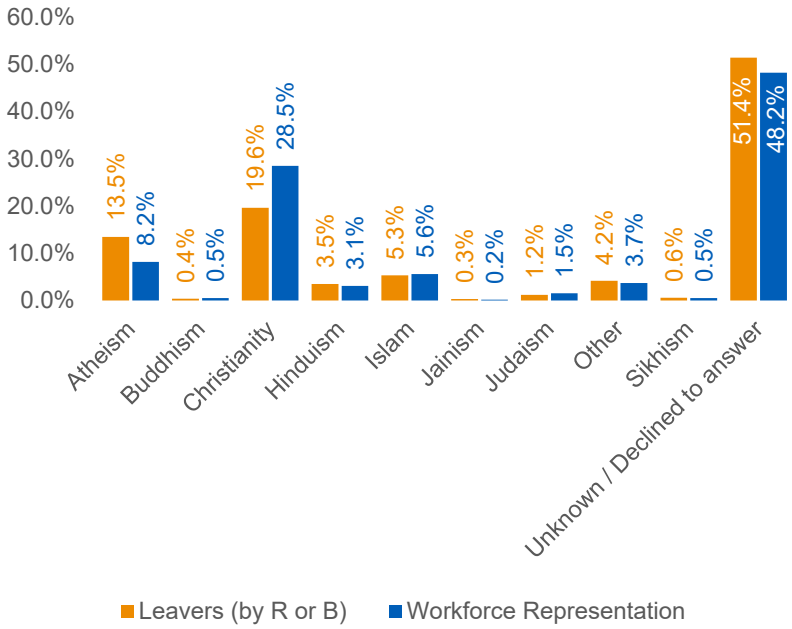


Chart C38 (left) shows the breakdown of leavers by religion or belief; overall workforce representation has been included to aid comparison.

Compared to the workforce, there is a greater than expected representation of atheists, Hindus, Jains, Other religions, Sikhs and staff members whose religion or belief is unknown or they have elected not to share. There is a lower-than-expected representation of Buddhists, Christians, Muslims and Jewish staff.

14.6 Sex

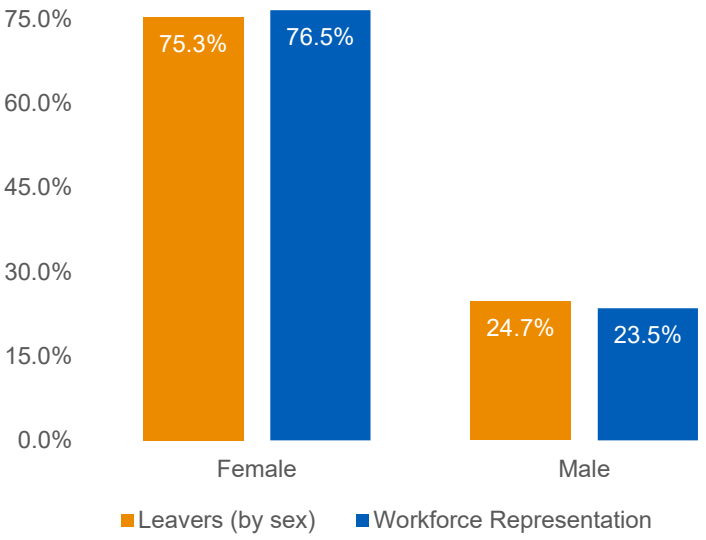


Chart C39 (left) shows the breakdown of leavers by sex; the overall workforce representation has been included to aid in comparison.

Compared to the workforce representation, slightly fewer women are represented in leavers data and slightly more men.

14.7 Sexual Orientation

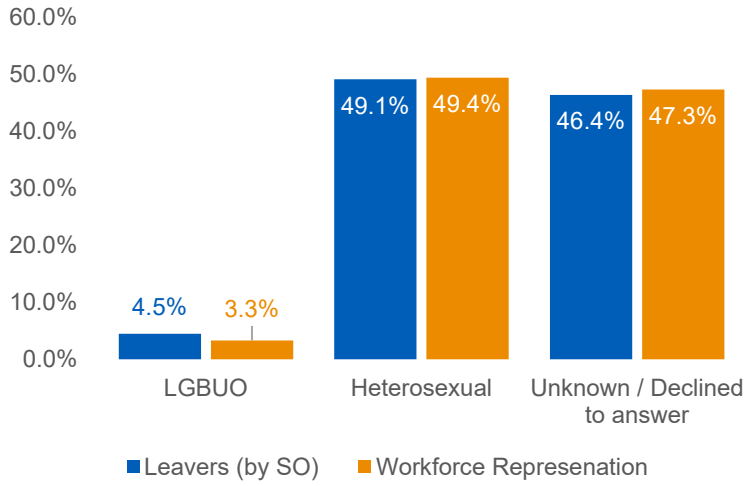


Chart C40 (left) shows a breakdown of leavers by sexual orientation; the overall workforce representation has been included to aid comparison.

Heterosexual staff and where sexual orientation is unknown are represented in line with the workforce representation. However, Lesbian, Gay, Bisexual, Undecided and Others (LGBUO) staff appear to be slightly overrepresented in staff that have left the Trust.

15. NHS Staff Survey

The annual NHS Staff Survey provides insight into staff satisfaction with the organisation and their work. The survey looks at a range of issues related to inclusion, which can be broken down by (most) protected characteristics; this section will explore those issues.

The data explores the average scores for the national acute average for Trusts (124 Trusts), Whittington Health's average score for the question and a breakdown of the protected characteristic.

Where the Whittington Health score is in red, it indicates worse performance compared to the national acute average. Where it is green, it indicates better performance.

In the columns breaking down the scores for individual groups within the protected characteristics, a red score would indicate worse performance than the Whittington average; an amber score is broadly in line; and a green score would indicate better.

A red score in the ‘Whittington Health Average’ indicates worse performance than the average for acute/acute and community trusts; a green score indicates better performance.

15.1 Age

Table CT4 (below) shows the breakdown of staff survey questions by age.

	21-30	31-40	41-50	51-65	66+	Whittington Health Average	Acute Average
q.4b - The organisation values my work	48.9%	41.9%	44.9%	40.6%	39.0%	**41.9%**	41.1%
q.9e - Feels their manager values their work	79.6%	72.1%	75.9%	71.3%	73.8%	**72.8%**	70.2%
q.7h - Feels valued by my team	76.8%	69.8%	70.9%	70.5%	73.8%	**69.4%**	68.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	57.9%	51.8%	47.7%	45.5%	32.5%	**48.3%**	55.6%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	34.8%	36.0%	27.3%	24.7%	19.0%	**30.2%**	28.1%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	9.8%	13.9%	13.8%	14.7%	7.3%	**14.5%**	11.6%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	17.8%	20.1%	18.5%	18.9%	14.3%	**20.8%**	20.0%
q.14d - The last time bullying, harassment, and abuse experience was reported	48.3%	48.3%	49.9%	47.1%	25.0%	**47.5%**	47.4%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	13.2%	13.8%	12.9%	8.9%	7.1%	**12.8%**	7.8%
q.16b - Experienced discrimination from staff in the last 12 months	8.2%	13.2%	13.8%	12.0%	7.1%	**12.9%**	8.7%
q.16c(6) - Age was the cause of the discrimination	28.3%	14.3%	7.8%	26.0%		**17.4%**	18.1%

15.2 Disability

Table CT5 (below) shows the breakdown of staff survey questions by disability.

	Staff with Disabilities	Staff without Disabilities	Whittington Health Average	Acute Average
q.4b - The organisation values my work	34.7%	45.6%	**41.9%**	41.1%
q.9e - Feels their manager values their work	64.2%	76.5%	**72.8%**	70.2%
q.7h - Feels valued by my team	62.1%	73.4%	**69.4%**	68.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	40.1%	51.8%	**48.3%**	55.6%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	37.4%	28.0%	**30.2%**	28.1%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	22.3%	11.2%	**14.5%**	11.6%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	26.5%	17.3%	**20.8%**	20.0%
q.14d - The last time bullying, harassment, and abuse experience was reported	47.1%	48.9%	**47.5%**	47.4%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	12.3%	11.7%	**12.8%**	7.8%
q.16b - Experienced discrimination from staff in the last 12 months	20.1%	10.3%	**12.9%**	8.7%
q.16c(5) - Disability was the cause of the discrimination	35.4%	0.7%	**9.1%**	8.7%
q.30b – Disabled staff that have reasonable adjustments to enable them to carry out their work.	64.7%			71.8%

15.3 Race

Table CT6 (below) shows the breakdown of staff survey questions by race/ethnicity.

	BME Staff	White Staff	Whittington Health Average	Acute Average
q.4b – The organisation values my work	41.7%	45.2%	**41.9%**	41.1%
q.9e - Feels their manager values their work	72.1%	76.3%	**72.8%**	70.2%
q.7h - Feels valued by my team	66.8%	75.8%	**69.4%**	68.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	41.2%	57.5%	**48.3%**	55.6%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	29.3%	30.4%	**30.2%**	28.1%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	14.2%	12.3%	**14.5%**	11.6%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	18.7%	19.1%	**20.8%**	20.0%
q.14d - The last time bullying, harassment, and abuse experience was reported	50.0%	48.3%	**47.5%**	47.4%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	17.4%	6.9%	**12.8%**	7.8%
q.16b - Experienced discrimination from staff in the last 12 months	15.0%	9.4%	**12.9%**	8.7%
q.16c(1) – Ethnic background was the cause of the discrimination	81.0%	35.2%	**63.2%**	48.5%

15.4 Religion or Belief

Table CT7 (below) shows the breakdown of staff survey questions by religion or belief.

	Atheist	Christian	**Buddhist**	Hindu	Judaism	Muslim	Other religion	**I prefer not to say**	Whittington Health Average	Acute Average
q.4b – The organisation values my work	46.4%	43.0%	43.5%	50.0%	53.3%	48.8%	50.0%	24.7%	**41.9%**	41.1%
q.9e - Feels their manager values their work	76.3%	74.0%	65.2%	79.4%	82.2%	79.8%	79.5%	57.9%	**72.8%**	70.2%
q.7h - Feels valued by my team	76.9%	70.8%	47.8%	70.4%	77.8%	73.6%	68.2%	56.7%	**69.4%**	68.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristics	54.7%	50.1%	45.5%	47.9%	71.1%	45.7%	59.5%	27.3%	**48.3%**	55.6%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	29.0%	30.6%	39.1%	21.4%	42.2%	21.1%	34.9%	33.9%	**30.2%**	28.1%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	11.6%	13.7%	27.3%	7.2%	13.3%	5.5%	16.3%	24.6%	**14.5%**	11.6%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	15.4%	21.1%	43.5%	12.5%	13.6%	16.5%	23.3%	23.8%	**20.8%**	20.0%
q.14d - The last time bullying, harassment, and abuse experience was reported	46.2%	52.3%	61.5%	46.2%	58.8%	44.1%	56.3%	38.6%	**47.5%**	47.4%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	6.5%	14.3%	18.2%	10.2%	4.5%	11.7%	20.9%	16.9%	**12.8%**	7.8%
q.16b - Experienced discrimination from staff in the last 12 months	8.0%	12.7%	31.8%	10.3%	13.3%	11.0%	16.3%	21.0%	**12.9%**	8.7%
q.16c(3) - Religion was the cause of the discrimination	1.4%	2.6%		6.7%		54.2%	0.0%	7.5%	**7.0%**	4.3%

15.6 Sex

Table CT8 (below) shows the breakdown of staff survey questions by sex.

	Female	Male	**Prefer not to say**	Whittington Health Average	Acute Average
q.4b – The organisation values my work	42.8%	49.7%	24.2%	**41.9%**	41.1%
q.9e - Feels their manager values their work	74.7%	75.4%	56.8%	**72.8%**	70.2%
q.7h - Feels valued by my team	71.8%	74.1%	49.5%	**69.4%**	68.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	50.3%	54.7%	17.9%	**48.3%**	55.6%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	31.1%	25.5%	31.5%	**30.2%**	28.1%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	13.3%	12.2%	26.0%	**14.5%**	11.6%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	19.8%	14.1%	31.5%	**20.8%**	20.0%
q.14d - The last time bullying, harassment, and abuse experience was reported	49.7%	48.9%	36.2%	**47.5%**	47.4%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	11.6%	11.3%	17.2%	**12.8%**	7.8%
q.16b - Experienced discrimination from staff in the last 12 months	12.6%	8.0%	25.8%	**12.9%**	8.7%
q.16c(2) - Sex was the cause of the discrimination	17.2%	22.1%	6.7%	**17.0%**	20.3%

15.7 Sexual Orientation

Table CT9 (below) shows the breakdown of staff survey questions by sexual orientation.

	Heterosexual	Gay or Lesbian	**I prefer not to say**	Bisexual	**Other**	Whittington Health Average	Acute Average
q.4b – The organisation values my work	44.5%	46.4%	26.8%	57.5%	41.2%	**41.9%**	41.1%
q.9e - Feels their manager values their work	75.5%	81.0%	57.7%	72.5%	58.8%	**72.8%**	70.2%
q.7h - Feels valued by my team	72.0%	82.1%	57.3%	82.5%	58.8%	**69.4%**	68.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	51.3%	67.5%	23.2%	51.3%	29.4%	**48.3%**	55.6%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	28.6%	34.5%	35.9%	47.5%	29.4%	**30.2%**	28.1%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	12.7%	13.4%	20.1%	5.0%	29.4%	**14.5%**	11.6%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	18.6%	19.8%	23.3%	15.4%	25.0%	**20.8%**	20.0%
q.14d - The last time bullying, harassment, and abuse experience was reported	50.2%	42.4%	41.9%	36.8%		**47.5%**	47.4%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	11.9%	13.1%	11.0%	7.5%	17.6%	**12.8%**	7.8%
q.16b - Experienced discrimination from staff in the last 12 months	12.0%	9.5%	15.8%	0.0%	23.5%	**12.9%**	8.7%
q.16c(4) - Sexual orientation was the cause of the discrimination	1.5%	57.1%				**4.3%**	3.9%

16. Other Standards and Reporting to Measure Inclusion

This section will focus on other standards and reporting the Trust participates in that provide a different perspective on equity within the workforce.

16.1 Summary of the Gender Pay Gap 2023

Table CT10 (below) highlights the 2022/23 Gender Pay Gap Report; the report is available on the Gender Pay Gap Reporting Service. Lower representation in senior manager bands and medical grades may impact the gender pay gap at the Trust.

The gender pay gap presents pay information using mean and median averages; when discussing gender pay gaps, it is usually the median average used. This is because extremes of pay do not impact the median average.

GPG Factor	Observation
Women's hourly pay	• Median hourly pay is 1.7% lower than men's • Mean hourly pay is 6.3% lower than men's
Pay quarters – female representation	• Lowest quarter – 74.3% (-1.7% from 21/22) • Lower middle quarter – 79.3% (-0.6% from 21/22) • Upper middle quarter – 80.4% (+1.6 from 21/22) • Upper quarter – 71.3% (+0.1 from 21/22)
Women's bonus pay	• Median bonus pay is 35.7% lower than men's (+3.2% from 21/22) • Mean bonus pay is 28.7 higher than men's (+30.9% from 21/22) • 1.2% of women (-0.4 from 21/22) and 2.3% of men (-0.4 from 21/22) received bonus payments

Overall, women are paid 1.7% less than men, which means for every 98p a woman earns an hour, a man earns £1.00. The mean average is 6.3% lower for women compared to men.

When looking at the pay quartiles, there is a lower-than-expected representation of women in the lowest and upper quarters and a higher-than-expected representation in the lower-middle and upper middle. Compared to the previous year, representation was slightly increased within the upper middle and upper quarters.

The bonuses at Whittington Health relate to the Clinical Excellence Awards for our medical staff. The bonuses for the last two years have been shared among eligible staff.

Overall, women's bonus payments are 35.7% lower than men's. However, the mean average shows that women's bonuses are 28.7% higher than men's.

16.2 Ethnicity Pay Gap 2023

The Ethnicity pay gap enables organisations to compare the average pay rates and bonus amounts of different ethnic groups to help understand if there are disparities in either pay or bonus amounts received.

New guidelines from the government issued in April 2023 encourage organisations to undertake an ethnicity pay gap to help improve the understanding of equity within their pay and bonus structures. This is the first year the Trust has undertaken an ethnicity pay gap.

Representation in the overall workforce:

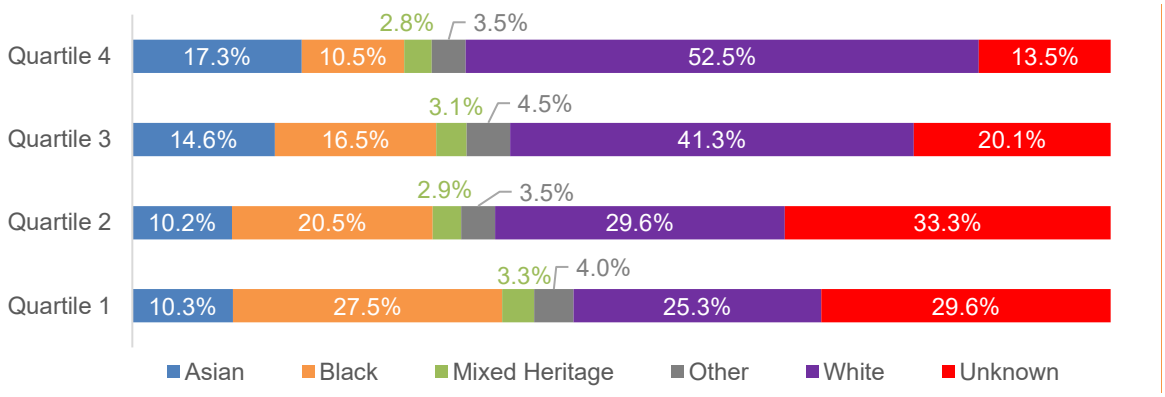
Chart C11 (above) provides an overview of the workforce's ethnicity.

Representation in quartiles:

In order to understand how pay differs for different groups, the overall workforce is split into four groups based on hourly pay. The four groups are broadly equal in size (based on the size of the workforce), which represent:

- Quartile 1 – the lower quarter of pay
- Quartile 2 – the lower middle quarter of pay
- Quartile 3 – the upper middle quarter of pay
- Quartile 4 – the upper quarter of pay

Chart C41 (below) shows a breakdown of the quartiles by ethnicity.



For Asian staff, there is a lower-than-expected representation of staff in quartiles 1 and 2 and a greater-than-expected representation in quartiles 3 and 4.

For Black staff, there is a higher-than-expected representation of staff in quartiles 1 and 2 and a lower-than-expected representation in quartiles 3 and 4.

For mixed heritage and other ethnic groups staff, there is a broadly equal representation throughout the quartiles compared to the overall representation in the workforce.

For white staff, there is a lower-than-expected representation of staff in quartiles 1 and 2 and a greater-than-expected representation in quartiles 3 and 4.

The mean average of pay:

Table CT11 (below) shows the mean average hourly pay for ethnic groups.

	Mean Average hourly pay rates	
Asian	£	25.16
Black	£	19.51
Mixed Heritage	£	22.34
Other	£	22.50
White	£	25.42
Unknown	£	19.76

Table CT12 (below) shows the difference (mean average) in hourly pay for ethnic groups.

Ethnic Origin	Mixed (2)	Asian (2)	Black (2)	Other (2)
White (1)	£3.08	£0.26	£5.91	£2.92
Mixed (1)		-£2.82	£2.83	-£0.16
Asian (1)			£5.65	£2.66
Black (1)				-£2.99

The amounts are expressed as a difference from group 1 (left column) to group 2 (top of the table). So, in this case, white staff, on average, receive £3.08 per hour more than staff from a mixed heritage background. A minus figure would highlight that group 1 receives less than group 2, e.g., staff from a mixed heritage background, on average, receive £2.82 per hour less than Asian staff.

Table CT13 (below) shows the difference (mean average) as a percentage of hourly pay for ethnic groups.

Ethnic Origin	Mixed (2)	Asian (2)	Black (2)	Other (2)
White (1)	12.1%	1.0%	23.2%	11.5%
Mixed (1)		-12.6%	12.7%	-0.7%
Asian (1)			22.5%	10.6%
Black (1)				-15.3%

This table is interpreted in the same way as described above. Another way of expressing this data in this table is that for every £1 a white member of staff earns, a mixed heritage member of staff earns 88p, or for every £1 a mixed heritage member of staff earns, an Asian member of staff earns £1.13.

White staff have the highest mean average pay, followed by Asian, Other, mixed heritage and Black staff. Compared to black staff, white staff earn 23.3% more per hour.

The median average pay

Median averages are often used as reported figures for pay gaps, as extremes do not impact them and take the middle figure for the group that is being analysed.

Table CT15 (below) shows the median average for hourly pay for ethnic groups.

	Median Average hourly pay rates	
Asian	£	23.59
Black	£	17.05
Mixed Heritage	£	20.02
Other	£	20.98
White	£	23.94
Unknown	£	18.13

Table CT14 (below) shows the difference (median average) in hourly pay for ethnic groups.

Ethnic Origin	Mixed (2)	Asian (2)	Black (2)	Other (2)
White (1)	£3.92	£0.35	£6.89	£2.97
Mixed (1)		-£3.57	£2.97	£0.96
Asian (1)			£6.54	£2.61
Black (1)				-£3.93

This table is interpreted in the same way as the previous tables.

Table CT15 (below) shows the difference (median average) as a percentage of hourly pay for ethnic groups.

Ethnic Origin	Mixed (2)	Asian (2)	Black (2)	Other (2)
White (1)	16.4%	1.5%	28.8%	12.4%
Mixed (1)		-17.9%	14.8%	4.8%
Asian (1)			27.7%	11.1%
Black (1)				-23.0%

This table is interpreted in the same way as the previous tables.

White staff have the highest mean average pay, followed by Asian, Other, mixed heritage and Black staff. Compared to black staff, white staff earn 28.8% more per hour.

Bonus Pay Gaps

The number of staff receiving a bonus by ethnic group compared to the representation of that ethnic group within the workforce.

- 2.3% of Asian staff received a bonus payment
- 0.5% of Black staff received a bonus payment
- No staff from a mixed heritage background received a bonus payment
- 0.6% of staff from 'other ethnic groups received a bonus payment
- 2.9% of white staff received a bonus payment

- 0.2% of staff whose ethnic origin is unknown received a bonus payment.

Mean bonus payments

Table CT16 (below) shows the mean average bonus pay for ethnic groups.

	Mean Average hourly pay rates
Asian	£8,081.08
Black	£11,350.74
Other	£19,604.04
White	£10,331.96
Unknown	£6,803.05

Table CT17 (below) shows the difference (mean average) in bonus pay for ethnic groups.

Ethnic Origin	Asian (2)	Black (2)	Other (2)
White (1)	£2,250.87	-£1,018.78	-£9,272.08
Asian (1)		-£3,269.66	-£11,522.96
Black (1)			-£8,253.30

This table is interpreted in the same way as the previous tables.

Table CT18 (below) shows the difference (mean average) as a percentage of bonus pay for ethnic groups.

Ethnic Origin	Asian (2)	Black (2)	Other (2)
White (1)	21.8%	-9.9%	-89.7%
Asian (1)		-40.5%	-142.6%
Black (1)			-72.7%

This table is interpreted in the same way as the previous tables.

Median bonus payments

Table CT19 (below) shows the median average bonus pay for ethnic groups.

	Median Average hourly pay rates
Asian	£3,015.97
Black	£8,375.46
Other	£19,604.04
White	£6,032.04

Unknown	£6,803.05

Table CT20 (below) shows the difference (mean average) in bonus pay for ethnic groups.

Ethnic Origin	Asian (2)	Black (2)	Other (2)
White (1)	£3,016.07	-£2,343.42	-£13,572.00
Asian (1)		-£5,359.49	-£16,588.07
Black (1)			-£11,228.58

This table is interpreted in the same way as the previous tables.

Table CT21 (below) shows the difference (mean average) as a percentage of bonus pay for ethnic groups.

Ethnic Origin	Asian (2)	Black (2)	Other (2)
White (1)	50.0%	-38.8%	-225.0%
Asian (1)		-177.7%	-550.0%
Black (1)			-134.1%

This table is interpreted in the same way as the previous tables.

Overall, the averages for the other group are affected by there being a relatively small number of high-value bonus payments. However, from the information available, the highest mean average hour pay is other, followed by white, Black and Asian. The highest median pay is other, Black, White and Asian.

On investigating the hourly pay rates for Black staff, it should be noted that nearly 65% of this group occupy roles in bands 2-5, and representation in bands seven onwards is generally relatively very low.

16.3 Summary of the Workforce Disability Equality Standard 2023

The population of staff that had declared a disability increased to 3% from 2.5% in the previous year.

Table CT22 (below) summarises the scores for disabled staff against the metrics.

Metric Number	Metric Description	2022	2023	2023 vs. 2022 performance
2	Relative likelihood of non-disabled applicants compared to Disabled applicants being appointed from shortlisting across all posts.	0.84	1.18	Declined
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process.	2.44	5.37*	Declined
4a (i)	Percentage of staff experiencing harassment and bullying from patients & public	33.4%	37.4%	Declined
4a (ii)	Percentage of staff experiencing harassment and bullying from their managers	22.7%	22.3%	Improved
4a (iii)	Percentage of staff experiencing harassment and bullying from other colleagues	27.7%	26.5%	Improved
4b	Percentage of staff that reported harassment and bullying when they experienced it	44.7%	47.1%	Improved
5	Percentage of staff believing there are equal opportunities for career development	38.5%	40.1%	Improved
6	Experience of feeling pressure from manager to work when not well	28.5%	29.5%	Declined
7	Percentage of staff saying they are satisfied with how the extent to which the Trust values their work	33.8%	34.7%	Improved
8	Percentage of staff saying employer made reasonable adjustments	62.3%	64.7%	Improved
9a	The staff engagement score for Disabled staff	6.5	6.3	Declined
10	Board Representation	5.9%	6.7%	Improved

* This metric is based on an average of cases over two years - There are a low proportion of cases that are capability and a low declaration rate of disability; even a small number of cases may indicate a disproportionate impact. Over two years, this indicator was worked out using an average of 4 cases, with one involving a disabled staff member.

You can find full Workforce Disability Equality Standard reports on the Trust's website in the Equality, Diversity and Inclusion Section.

16.4 Summary of the Workforce Race Equality Standard 2023

The population of staff that are from BME backgrounds increased to 41.5% from 38.2% in the previous year.

Table CT23 (below) shows a summary of scores for BME staff against the indicators.

Indicator Number	Indicator Description	2022	2023	2023 vs. 2022 performance
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants.	1.42	1.51	Declined
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.	3.75	0.68	Improved
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development compared to BME	1.01	0.93	Improved
5	Percentage of staff experiencing harassment, bullying or abuse from the public in the last 12 months	28.6%	29.3%	Declined
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	27.7%	25.4%	Improved
7	Percentage of staff who believe that trust provides equal access to career progression or promotion	39.9%	41.2%	Improved
8	Percentage of staff who experience discrimination at work from a manager or other colleagues	15.2%	15.0%	Improved
9	Board representation	17.6%	26.7%	Improved

You can find full Workforce Disability Equality Standard reports on the Trust's website in the Equality, Diversity and Inclusion Section.

17. Summary of observations from workforce data

17.1 Age

Compared to the local population, the Trust's ***workforce representation*** has:

- Lower-than-expected representation of staff aged <20-25 and 66+
- Broadly equal representation of staff aged 61-65
- Higher-than-expected representation of staff aged 26-60

Pay Trends:

- Staff under 20 are only represented in bands 2 and 3
- Staff aged 21-30 are mainly represented in bands 3-6, and medical trainee grades
- Staff aged 31-50 are mainly in bands 3-8a; this group is also well represented in bands 8b-8c and most medical grades.
- Staff aged 51-65 are mainly represented in bands 2-7 but are also well represented in bands 8a onwards and medical and dental middle and consultant grades. Most of the VSMs are in this age group.
- Staff aged 66+ are mainly represented in bands 2-4 and medical and dental consultant grades. There is very low representation in 8a-9 (with only one person in 8b).

Within the Trust's ***recruitment processes***, most age groups broadly see an increase from application to shortlisting stages but are broadly equally represented from shortlisting to appointment stages. For applicants aged 20-29, representation decreases while progressing through the stages of recruitment; those aged 35-39 conversely see an increase in representation when progressing through the stages of recruitment.

Due to limited data availability on the Trust's ***employee relations*** process broken down by protected characteristics, it is impossible to provide commentary for this group.

More work is needed to capture all ***non-mandatory and continued professional development (CPD) training*** on the Trust's Learning Management System (Elev8). The training data currently reports on data offered by the Learning and Development Department and does not include non-mandatory/CPD offers for medics, nurses, etc. From the data that is available, we can see:

- Compared to the overall workforce, a greater proportion of staff aged <20-25 and 51-60 accessed non-mandatory/CPD training. All other groups, whilst lower, have a broadly equal representation in accessing this type of training.

In the Trust's ***leavers data***, compared to the workforce representation, a greater proportion of staff under 40 leave the Trust; all other age groups have a lower representation.

When reviewing the ***NHS Staff Survey***, it is notable that the majority of age groups have experiences that are broadly equal or much better compared to the Trust's average performance. However, some groups have highlighted a much poorer experience compared to the Trust average; these include:

- A lower proportion of staff aged 66+ (32.5%) believes that the Trust acts fairly regarding equal opportunities for progression or promotion.

- A higher proportion (36.0%) of staff aged 31-40 experiencing bullying, harassment or abuse from patients, service users or visitors; it should be noted that while staff age group 21-30 (34.8%) is broadly in line with the Trust average, it is very close to being disproportionate. Comparing the response rate for this question to the workforce representation, the overall number of respondents to the NHS Staff Survey for these age groups suggests a bigger proportion of staff than the base representation experience this behaviour.
- A lower proportion of staff aged 66+ (25%) are reporting their experience of bullying, harassment and abuse than the Trust average.

17.2 Disability

Compared to the local population, there is a much lower ***workforce representation*** of staff declaring that they have a disability. However, nearly half of the workforce has not declared their disability status. There is also a disparity of nearly 16% of staff that have declared a disability on the NHS Staff Survey and the Trust's local data.

As the declaration rate is so low, the ***payband data*** will likely not truly reflect the actual representation of disability status in the Trust's pay structure. However, from the available information:

- There is a fair representation of disabled staff within bands 2-8a
- A low representation in band 8b and medical middle and consultant grades.
- There is a higher-than-expected representation of disabled staff in bands 8c, 8d and medical trainees.
- There is no representation in band 9 and within the VSMs.

Within the Trust's ***recruitment processes***, there is a higher representation of disabled applicants than in the workforce. Disabled applicants appear to fare well in the Trust's recruitment processes as their representation increases through the different stages of recruitment. The opposite is true for non-disabled applicants.

Only data relating to capability by disability was available when writing this report for ***employee relations*** during the reporting period. There were four cases during 22/23, one of which involved a member of staff who declared they had a disability. This level of representation would suggest an overrepresentation compared to the overall workforce. However, in 2 cases (50%), the disability status was unknown, and the remaining case involved a staff member without a disability.

More work is needed to capture all ***non-mandatory and continued professional development (CPD) training*** on the Trust's Learning Management System (Elev8). The training data currently reports on data offered by the Learning and Development Department and does not include non-mandatory/CPD offers for medics, nurses, etc. From the data that is available, we can see:

- All groups access non-mandatory/CPD training in broadly equal representation as their workforce representation.

In the Trust's ***leavers data***, all groups have broadly proportional representation compared to the overall workforce representation.

In the ***NHS Staff Survey***, in every question, staff with disability have identified that they have a poorer experience than non-disabled staff, the average for the Trust and the overall representation of disabled respondents (18.6%) to the NHS Staff Survey.

It should be noted while slightly poorer, there are two areas where the experience of staff with disabilities is broadly in line with the Trust average. These are:

- Staff with disabilities reporting incidents of bullying, harassment and abuse (47.1%)
- Experience of staff with disabilities receiving discriminatory behaviour from patients (12.3%).

Other notable areas of interest include:

- 35.4% of staff with disabilities stated they experienced discrimination because of their disability
- 64.7% of staff with disabilities stated they have adequate, reasonable adjustments.

Please see the Workforce Disability Equality Standard section for further information about the standard and links to recent reports.

17.3 Gender Identity

Data on gender identity is not collected on ESR; it is impossible to provide commentary on the overall ***workforce and pay structure representation***.

Due to an error with the TRAC data for this reporting period, data is unavailable for this protected characteristic on the representation within Trust ***recruitment processes***.

Due to limited data availability on the Trust's ***employee relations*** process broken down by protected characteristics, it is impossible to provide commentary for this group.

Data about accessing ***non-mandatory/continued professional development (CPD) training*** for this protected characteristic is not collected.

Data about gender identity and ***leavers*** is not available.

Whilst data on data identity is collected in the ***NHS Staff Survey***, the response rate is extremely low to provide any meaningful findings.

17.4 Marriage and Civil Partnership

Compared to the local population, there is a lower-than-expected ***workforce representation*** of married staff but a higher-than-expected representation of staff in a civil partnership.

Overall ***pay trends*** for marriage and civil partnership:

- Staff in a civil partnership are well represented in bands 2-8b and medical consultants; have a lower-than-expected representation in medical trainee grade roles; and no representation in 8c-VSM and medical middle-grade roles.

- Staff that are married have a good representation throughout all bands/grades. They also have a higher-than-expected representation in senior manager roles, VSM, medical consultant, and middle-grade roles.

Due to an error with the TRAC data for this reporting period, data is unavailable for this protected characteristic on the representation within Trust ***recruitment processes***.

Due to limited data availability on the Trust's ***employee relations*** process broken down by protected characteristics, it is impossible to provide commentary for this group.

More work is needed to capture all ***non-mandatory and continued professional development (CPD) training*** on the Trust's Learning Management System (Elev8). The training data currently reports on data offered by the Learning and Development Department and does not include non-mandatory/CPD offers for medics, nurses, etc. From the data that is available, we can see:

- Compared to the overall workforce, a slightly lower proportion of married staff and a slightly higher proportion of staff in a civil partnership accessed non-mandatory/CPD training.

In the Trust's ***leavers data***, compared to the overall workforce representation, fewer married staff and a broadly equal representation of staff in a civil partnership leaving the Trust.

Marriage and civil partnership status is not collected within the ***NHS Staff Survey***.

17.5 Maternity and pregnancy

Reporting on staff that are either pregnant or on maternity leave is not available.

17.6 Race (this includes ethnic or national origins, colour or nationality)

Compared to the local population, the Trust ***workforce representation*** shows:

- There is a broadly similar representation of Black and Minority Ethnic (BME) staff as an overall group.
    - When breaking down the BME category, most groups have a lower representation than the local population except for Asian and Black staff (which is greater).
- There is a lower-than-expected representation of white staff.
- Over 1/5th of the workforce have not declared their ethnicity, which will likely mask the accurate picture of representation within the Trust's workforce.

In ***pay bands*** in agenda for change and VSM roles, the representation of BME staff drops as seniority increases; this is particularly noticeable from band seven upwards; the opposite occurs for white staff. For medical roles, there is a slightly lower-than-expected representation in trainee grades, a broadly equal representation in consultant grades and a much higher-than-expected representation in middle-grade roles. In medical roles, white staff have a greater-than-expected representation in consultant and training roles but a lower-than-expected representation in middle-grade roles.

In the Trust's ***recruitment processes***, BME applicants see a decrease in representation when progressing through the different stages of recruitment. This trend may suggest a disadvantage for this group within the Trust's recruitment processes. Compared to the Trust's workforce, there is a greater representation of BME candidates at the application and shortlisting stages, but this reduces to a broadly similar level at the appointment stage.

The Trust's ***employee relations*** processes contain information about the disciplinary and capability processes broken down by race; we can see that:

- Of four capability cases during 22/23, 3 involved Black staff members, and one involved white staff members. This representation suggests an overrepresentation of Black staff and an underrepresentation of White staff in capability processes compared to the overall workforce.
- With disciplinary cases compared to the workforce, there is a broadly equal representation of Asian and Black staff and an overrepresentation of white staff from 'any other group'.

More work is needed to capture all ***non-mandatory and continued professional development (CPD) training*** on the Trust's Learning Management System (Elev8). The training data currently reports on data offered by the Learning and Development Department and does not include non-mandatory/CPD offers for medics, nurses, etc. From the data that is available, we can see:

- Compared to the overall workforce, all groups are accessing non-mandatory/CPD training in proportion.

In the Trust's ***leavers data***, compared to the overall workforce representation, there are proportionally fewer BME and more white staff leaving the Trust. When breaking down the BME category, there are broadly equal Asian and mixed heritage staff leaving, and fewer Black and staff from 'other' ethnic groups.

In the ***NHS Staff Survey***, most BME responses demonstrate a broadly similar experience to white staff and the Trust average. There are some areas where BME staff have a poorer experience than white staff, which include:

- BME staff feeling valued by their team (66.8%)
- BME staff feel that the Trust offer equal opportunities for progression and promotion (41.2%)
- All factors relating to discrimination.

There are also areas where BME staff responses demonstrate a poorer experience compared to the Trust average; these include:

- BME staff feel that the Trust offer equal opportunities for progression and promotion
- BME staff that have experienced racial discrimination (81% of BME respondents)

Please see the Ethnicity Pay Gap section for an overview of the findings and analysis.

Please see the Workforce Race Equality Standard section for further information about the standard and links to recent reports.

17.7 Religion or belief

With nearly half of the workforce not declaring a religion or belief, it is impossible to provide accurate commentary on the ***workforce representation*** compared to the local population and pay structures. However, from the limited available information, most groups have a lower-than-expected representation within the workforce; the exception is Hindus and those who have not declared which is greater.

From the limited information available regarding representation within the ***pay bands*** of religion or belief:

- Most minority groups have a fair-to-good representation in lower to middle-banded roles and a good representation in medical roles.
- Staff that are Sikh have a good representation in senior management roles.
- Staff that are Jewish have a good representation in 8a-b roles.
- Christians broadly have a fair-to-good representation in all bands and medical grades.
- Atheists have a good representation in bands 7-9 and medical consultant and trainee roles.
- For VSMs that have declared their religion or belief, they are either Christian or Atheist.
- 48.2% of staff have not declared their religion or belief, which masks the accurate picture of representation.

Due to an error with the TRAC data for this reporting period, data is unavailable for this protected characteristic on the representation of religion or belief within Trust ***recruitment processes***.

Due to limited data availability on the Trust's ***employee relations*** process broken down by protected characteristics, it is impossible to provide commentary for this group.

More work is needed to capture all ***non-mandatory and continued professional development (CPD) training*** on the Trust's Learning Management System (Elev8). The training data currently reports on data offered by the Learning and Development Department and does not include non-mandatory/CPD offers for medics, nurses, etc. From the data that is available, we can see:

- Compared to the overall workforce, all groups access non-mandatory/CPD training in broadly equal proportion. However, a slight underrepresentation of Muslim and Jewish staff accessing this type of training exists.

In the Trust's ***leavers data***, compared to the overall workforce representation, most groups are leaving the Trust in proportion; however, there is a greater representation of Atheist staff and unknown/declines to answer and fewer Christians.

In the NHS Staff Survey, most groups have a broadly equal or better experience than the Trust average.

However, there are groups which demonstrate a much poorer experience compared to the Trust average:

- Staff that are Buddhist in several areas, including bullying, harassment and abuse (all areas), feeling valued by staff and experiencing discrimination
- Staff that are Jewish experiencing bullying, harassment and abuse from patients (42.2%)
- Staff that are Muslim experiencing discrimination because of their religion (54.2%)
- Staff that have other religions regarding experiencing discrimination from patients (20.9%)
- Staff that have selected 'prefer not to say' demonstrate a poor experience in most of the questions.

17.8 Sex

Compared to the local population, there is a greater proportion of female staff and a lower of male staff within the ***Trust's workforce***. However, this follows the national workforce trend for the NHS.

Within the ***pay structure***, female staff are well represented in bands 3-8a and medical middle grades but have a lower-than-expected representation in bands 2, 8b-VSM and medical consultants and middle grades. The opposite of this trend is true for male staff.

Due to limited data availability on the Trust's ***employee relations*** process broken down by protected characteristics, it is impossible to provide commentary for this group.

More work is needed to capture all ***non-mandatory and continued professional development (CPD) training*** on the Trust's Learning Management System (Elev8). The training data currently reports on data offered by the Learning and Development Department and does not include non-mandatory/CPD offers for medics, nurses, etc. From the data that is available, we can see:

- Compared to the overall workforce, there is a slight underrepresentation of males and an overrepresentation of female staff accessing this type of training.

In the Trust's ***leavers data***, compared to the overall workforce representation, there are broadly proportional amounts of male and female staff leaving the Trust.

The ***NHS Staff Survey*** highlights that male and female staff have experiences that are either better or equal to the Trust average. Those who have selected 'prefer not to say' have a demonstrably poorer experience than the Trust average.

Other specific areas of interest:

- Female staff have a slightly poorer experience (compared to the national Trust average) relating to bullying, harassment and abuse from patients (31.1% of female Trust staff that took part in the Staff Survey highlighted this compared to the national Trust average 28.1%)
- Both male and female staff cite experiencing more (compared to the Trust average) discrimination because of their sex.

Please see the Gender Pay Gap section for observations and a link to the full report.

17.9 Sexual Orientation

Compared to the local population, representation within the ***Trust's workforce*** shows about half the amount of Lesbian, Gay, Bisexual, Undecided and Others (LGBUO) staff. However, with over 47% of the workforce either not declaring or choosing not to share their sexual orientation, this masks the accurate picture of representation within the workforce.

Within the Trust's ***pay structure***, there is a higher-than-expected representation of LGBUO staff in bands 5, 8a-9 and medical trainees; no representation in medical middle and VSM grades and a broadly equal to lower representation in all other pay bands.

Due to an error with the TRAC data for this reporting period, data is unavailable for this protected characteristic on the representation within Trust ***recruitment processes***.

Due to limited data availability on the Trust's ***employee relations*** process broken down by protected characteristics, it is impossible to provide commentary for this group.

More work is needed to capture all ***non-mandatory and continued professional development (CPD) training*** on the Trust's Learning Management System (Elev8). The training data currently reports on data offered by the Learning and Development Department and does not include non-mandatory/CPD offers for medics, nurses, etc. From the data that is available, we can see:

- Compared to the overall workforce, there is a broadly equal representation for all groups; it should be noted that there is a slightly greater representation of staff that identify as LGBUO.

In the Trust's ***leavers data***, compared to the overall workforce representation, all groups have a broadly equal representation in leavers data; however, staff that identify as LGBUO are slightly higher.

The ***NHS Staff Survey*** shows:

- Heterosexual staff have a better experience compared to the Trust average.
- Gay or lesbian staff have a broadly better or equal experience than the Trust average. There are some exceptions, which include reporting bullying, harassment and abuse (42.4%) and experiencing discrimination because of sexual orientation (57.1%)
- Bisexual staff broadly have a better or equal experience than the Trust average. The exceptions include experiencing bullying, harassment and abuse from patients (47.5%) and reporting bullying, harassment and abuse (36.8%)
- Staff with an 'other orientation, not listed' broadly have a poorer experience than the Trust average. The exception to this is experiencing bullying, harassment and abuse from patients (29.4%)
- Staff that selected 'prefer not to say' have a broadly worse experience than the Trust average, except for experiencing discrimination from patients (11.0%).

17.10 Actions we are taking to improve equity for the workforce

Table CT24 – Core actions being undertaken to improve equity for staff.

Workstream Name	Detail of Workstream	Measuring for Progress
Improving staff declaration of equality information.	This ongoing programme of work will aim to improve the declaration rates of equality information of the workforce; there will be a strong focus on benefits to staff and why it is important. Different ways of engaging staff are being planned, and Integrated Clinical Service Units and departments are encouraged to provide leadership for their teams.	• Ongoing review of Electronic Staff Records data for declaration rates for staff for the recordable protected characteristics. • Improved declaration rates can be seen in a number of indicators/metrics related to the WRES/WDES, particularly around representation within paybands.
Continued rollout of Just and Restorative Culture work.	This ongoing programme, started in July 22, forms part of the NHS England civility and respect framework and	• Reduction overall of the number of disciplinary and

	supports patient safety and staff wellbeing by moving to a restorative and learning culture when things go wrong.	grievance cases in the Trust. HR have been providing this data brokendown by race and disability to the Workforce Assurance Committee. • Further improvement around disciplinary cases in Trust WRES data.
Diverse and Inclusion Panels	This programme of work is being rolled out in Autumn Winter 23/24 aims to improve equity within the Trust's recruitment processes. The programme places a requirement for recruitment interview panels of posts that are band 7+ to have training on the diverse and inclusion panels process and to have a panel that is reflective of diverse communities.	• Improved performance in recruitment for the Trust's WDES and WRES data. • Overall improved performance for all groups in the Trust's TRAC (recruitment system) data, which is presented in the annual Public Sector Equality Duty Report.
Staff Survey 22/23 Results	Our Organisational Development Team has reviewed the Staff Survey findings and identified five key areas for improvement. Staff are being invited into listening events to provide their experience of the key areas where a workplan will be produced to deliver improvements. The key areas are: • Fairness with career opportunities and progression • Additional unpaid hours • Health and wellbeing • Reasonable Adjustments • Having enough tools/equipment for staff to undertake their roles.	Each key area is attached to specific questions within the NHS Staff Survey, overall improvements will be seen in future publications of the survey results. However, it should be noted that each key area will have a specific workplan attached to them where progress will be monitored.
Continued rollout of Reasonable Adjustments support for staff.	The Inclusion Team launched: • Disability and Reasonable Adjustment Guidelines • Health Passport • Centralised funding for reasonable adjustments These will help ensure that staff with a long-term health condition can be supported in their roles.	Improvements will be seen in the WDES metric related to staff feeling they have adequate reasonable adjustments in place for their role.
BME Band 2-7 Development Programme	Following on from the successful trial cohort of this programme in 21/22 where 47% of attendees are now working in higher roles after attending this programme. A further two cohorts are planned for 23/24, the attendees will be provided with training, coaching and a work placement (at a higher banding than they currently are) to further their experience and exposure within the organisation.	• Improvement within the Trust's WRES data around representation and staff feeling the Trust acts fairly regarding promotion/training opportunities. • The programme also has a standalone evaluation programme highlighting the statistical/experiencial

		benefit the programme has had to staff.
Reciprocal Mentoring	In 23/24 the Trust will launch it's reciprocal mentoring programme. The programme aims to match junior and senior staff together so they can gain a better appreciation of current issues and challenges in the Trust and for its diverse staff. The programme aims to support greatere systemic change for inclusion and active reduction in inequity.	There are a number of key questions where this can be monitored, some of which are part of the WDES and WRES. These include: • Staff feeling there is fairness in development opportunities. • Staff experience of working in the Trust.
Improved sharing of data	The Recruitment and Inclusion teams will work together to ensure better sharing of information about Recruitment activity within the Trust.	Better coverage of inclusion data in future public sector equality duty reports.

D. Equality Objectives

18.0 The Trust's Equality Objectives form part of our statutory duty under the Public Sector Equality Duty to demonstrate our progression with inclusion.

18.1 The Trust's equality objectives are driven by the results of the grading outcomes following discussion with all the stakeholders attending the focus groups using the EDS2. Staff networks supported by senior leaders and non-executive directors have been vocal in suggesting procedure changes and indicating priorities. These are listed below:

- Continuing work on our data systems to maximise the available data, accuracy, and usefulness. For example, the data descriptions need to be aligned, systems must be amended to ensure it is possible to hold data not currently held, and it is important to continue digitalising paper-based records.

- Reviewing recruitment processes from the content of job descriptions and person specifications, advertising roles, preparing interview panels and monitoring their demographic composition, to monitoring the demographics of applicants, interviewees and the outcome of interviews.

- Details of equality objectives can be found in Appendix A

Appendix A – Developing Public Sector Duty Objectives from EDS2 Grading Results

GOAL ONE: BETTER HEALTH OUTCOMES

Outcome	Grading	Draft Objective	Approach
Services are commissioned, procured, designed and delivered to meet the health needs of local communities.	Developing	To successfully implement the national Maternity Transformation programme	Performance is monitored via the maternity dashboard
Individual people's health needs are assessed and met in appropriate and effective ways.	Developing	To improve the Trust PLACE scores for access, privacy and dementia	Scrutiny by CQRG and the Estates and Facilities Team
Transitions from one service to another for people on care pathways are made smoothly, with everyone well-informed.	Developing	To improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services (achieve CQUIN)	Annual scrutiny via QNIC
When people use NHS services, their safety is prioritised, and they are free from mistakes, mistreatment and abuse.	Achieving	To maintain the number of falls at less than 5 per 100 bed days To increase compliance with the falls bundle	Continue with the actions of the Falls Group
Screening, vaccination, and other health promotion services reach and benefit all local communities.	Developing	To increase the rate of screening for tobacco use and support patients to quit using brief advice and onward referral	Continue with actions as part of the NCL STP Prevention Workstream, including setting up a smoking cessation working group with a clinical lead in the Trust.

GOAL TWO: IMPROVED PATIENT ACCESS AND EXPERIENCE

Outcome	Grading	Draft Objective	Approach
People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds.	Developing	To improve the quality of information – increase accessibility	Monitoring performance against the accessible information standard
People are informed and supported to be as involved as they wish to be in decisions about their care.	Developing	To maintain or increase the score for the percentage involved in decisions in the CQC Maternity Survey	Continue to action and monitor via ICSU
People report positive experiences with the NHS	Achieving	To increase the FFT rate of patients recommending treatment in the ED	Patient experience leads in ED to continue to meet with the corporate patient experience team Introduction and implementation of the Religion and Culture Guideline.
People's complaints about services are handled respectfully and efficiently.	Developing	To improve the response rates to complaints	Performance monitored via the Quality Committee

GOAL THREE: A REPRESENTATIVE AND SUPPORTIVE WORKFORCE

Outcome	Grading	Draft Objective	Approach
3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Developing	Achieve recruitment ten-year goals outlined in the London WRES Strategy	Expand the requirement for all interview panels to include a BME representative and continue to report 'close' BME candidates to the Director of Workforce for further scrutiny. Maintain positive action statements in recruitment advertisements. Add compulsory set "inclusion questions" into each interview.
3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Achieving	Eliminate the gender pay gap over the next ten years by reducing year on year.	Continue to report on the gender pay gap; work on reducing the gap through current initiatives, including the Women's network and use the gender pay gap report to help identify specific focus areas.
3.3 Training and development opportunities are taken up and positively evaluated by all staff	Developing	Equal access to non-mandatory training	The WRES data shows 50/50 access; therefore, further scrutiny of the data shows which specific groups in the workforce do not have equal access to training.
3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source	Developing	Year-on-year reduction in reporting of bullying	Continue to develop and deliver the various elements of the #CaringForThoseWhoCare programme. Continuous overall and local monitoring of staff survey results. Encourage staff to report abuse on Datix and monitor quarterly with feedback to ICSU. Reviewing of the Challenging Behaviour policy and public information to include actions that the Trust will consider against the perpetrator of the abuse.
3.5 Flexible working options are available to all staff consistent with the needs of	Developing	Create a process for requesting flexible working arrangements to enable the creation of a reliable database with outcomes.	We currently have a policy that benefits everyone, but we do not have data to show how it is being implemented locally and how much it is being taken up. Creating a request system might be an added process layer, but it will

the service and the way people lead their lives			provide data we currently lack. Then we will be able to assess whether our policy is being consistently applied and is effective.
3.6 Staff report positive experiences of their membership in the workforce	Developing	The year-on-year increase in existing measures, including engagement score, and other measures from the Staff Survey, Staff FFT/Pulsepoint Survey etc	The #CaringForThoseWhoCare programme is designed to improve culture and engagement, the working environment and the staff experience working at Whittington Health. These objectives must be supported wherever possible by existing programmes of work where they align.

GOAL FOUR: INCLUSIVE LEADERSHIP

Outcome	Grading	Draft Objective	Approach
4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Developing	Visibility of ETM and NED and in particular during projects	ETM and NED to do regular walkabout and attend team meetings support major projects, networks and scrutiny of results and outcomes for staff and patients
4.2 Papers that come before the Board and other major Committees identify equality-related impacts, including risks, and say how these risks are to be managed	Developing	A template is created and used to accompany Board, WAC, ETM and TMG reports in the way cover sheets are expected.	Any template must be short, simple and realistic, avoiding jargon and clearly stating the impact and risk to ensure it is used appropriately.
4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	Developing	A reduction in the experience of discrimination and other related measures is reported in the annual staff survey, Pulse survey etc.	This can be achieved through the various workstreams as part of the #CaringForThoseWhoCare programme and leadership programmes. Promote the use of the health passport. Education of staff on reasonable adjustment, policy and health passport Operationalise the Reasonable Adjustment policy.