University Hospitals Bristol and Weston NHS Foundation Trust

UHBW Diversity, Equity and Inclusion Data Report 2025

Report Authors

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Workforce Disability Equality Standards (WDES)/ Workforce Race Equality Standards (WRES), including race disparity ratio/ Model Employer:

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Gender Pay Gap

Contents

1. Introduction

The purpose of this report is to provide a data set baseline position for all Diversity Equity & Inclusion (DEI) Key Performance Indicators (KPIs) at the beginning of the first quarter of the year 2025/2026 and draw a comparison with the last two year's data, in order to inform the actions required to achieve the ambition to be a fully inclusive employer and deliver our Pro-equity promise.

Context

At UHBW, we exist to make a difference that matters to the lives we touch. We do this with full-hearted care, every day. There is no place for discrimination of any kind at UHBW, but we know it does exist in our organisation and that's unacceptable.

In summer 2024 we took the learning from the Board development, Bridges, and Respecting Everyone to launch our Pro-equity approach and our commitment to becoming an anti-racist organisation. Pro-equity means building a place where everyone feels truly safe to be themselves and can expect equity of opportunity and equality of outcome and experience. To be pro-equity we must be against that which prevents it. We are anti-racist, anti-ableist, anti-sexist, anti-homophobic. We are actively against all forms of discrimination. Being pro-equity isn't a quick fix or easy to do. We have much work to do to at UHBW to change the unfair systems that perpetuate division and inequity within our hospitals and the wider population that we serve.

We started this work from within, listening to our colleagues' experiences, views and ideas about how we can make UHBW a fair, equitable place to work. This included hosting sexual safety, anti-racism and anti-ableism listening events, co-facilitated by clinical psychology colleagues and those with lived experience to ensure we were following trauma informed practice. In total we held 29 listening events with 212 colleagues participating, including colleagues with lived experience of racism and ableism. Representation of Black, Asian, Multiple Heritage, Global Majority and other ethnically minoritised global majority colleagues at the anti-racism workshops was higher than that of our staff population (36.0% of workshop attendees compared to 25.4% of all staff). Representation of disabled colleagues at the anti-ableism workshops was higher than that of our staff population (40.3% of workshop attendees compared to 4.0% of all staff).

The first output of the listening events was our anti-racism community commitment. The words in this statement come directly from UHBW colleagues, setting out the changes we know we must make for our Black, Asian, Multiple Heritage, and other ethnically minoritised, global majority colleagues, patients and communities.

We have also developed our Pro-equity Action Plan to help us start tackling the systemic causes of discrimination in our organisation and to support our colleagues who experience any form of discriminatory behaviour whilst at work. It has been created from the experiences, ideas and feedback of colleagues across our organisation who took part in the Sexual Safety, Anti-racism and Anti-ableism workshops as well as our WRES, WDES and

People Promise DEI Data. The plan also incorporates the NHS England EDI High Impact Actions (appendix 3) Our pro-equity action plan focuses on 11 key priority areas for change and improvement:

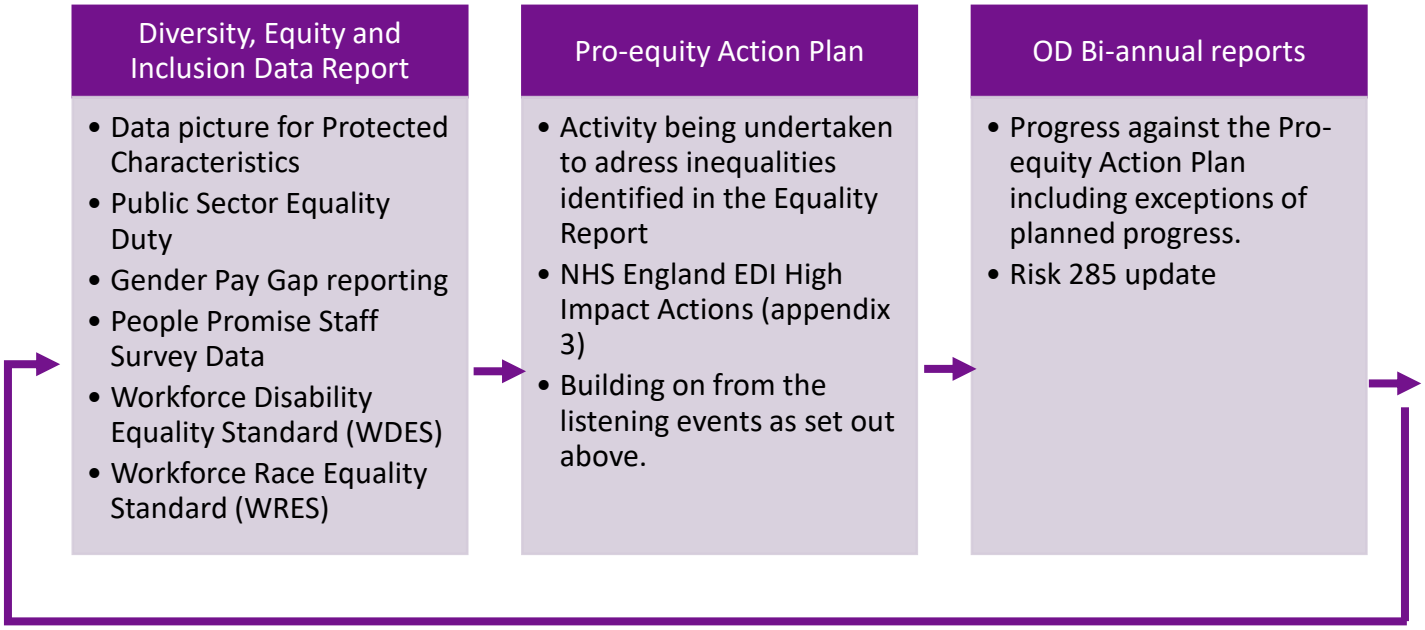
Both the anti-racism community commitment and pro-equity action plan are available on our diversity, equity and inclusion webpage.

The UHBW People Strategy and DEI Strategic Framework concluded at the end of March 2025. We are adopting a data-driven, patient first approach to inform the creation of a Group People Strategy in collaboration with North Bristol Trust, as part of our developing 'Group Model' partnership.

Monitoring process

At the end of each fiscal year, Gender Pay Gap (GPG), Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) data are submitted to NHS England. Alongside this return data, the Model Employer and Race Disparity Ratio (RDR) are utilised to further understand the Trust's benchmarked position. The descriptors for each of the data sets and their requirements can be found in Appendix 1.

The Diversity, Equity and Inclusion Data Report (previously the Equality Report) is one part of the three step DEI monitoring process: Diversity, Equity and Inclusion Data Report, Pro-equity action plan and Organisational Development (OD) Bi-annual Reporting. This is a data driven process, where action is informed by hotspots identified in the annual report data. As each part of the process has a specific purpose, to avoid duplication there will not detailed explanations of planned activity within this report, that is the role of the Pro-equity action plan, a high-level summary of which can be found in appendix 2.



2. Trust Overview

Introduction

This section of the report will use our Electronic Staff Record (ESR) data to show the demographic breakdown of protected characteristics. Previously this section of the report solely focussed on three protected characteristics: Sex, Disability and Ethnicity. For each there is a whole Trust demographic breakdown for the last three years, and a pay band breakdown for 31st March 2025.

In previous years other protected characteristics were included in the Trust's annual report but not in this report. However, this year we have extended the data report to include reportable protected characteristics, in line with the annual report, as follows:

- age
- religion and belief
- sexual orientation

As this is the first-year reporting in this way, the 3-year comparison data is not available for these protected characteristics.

Whole Trust breakdown – Sex

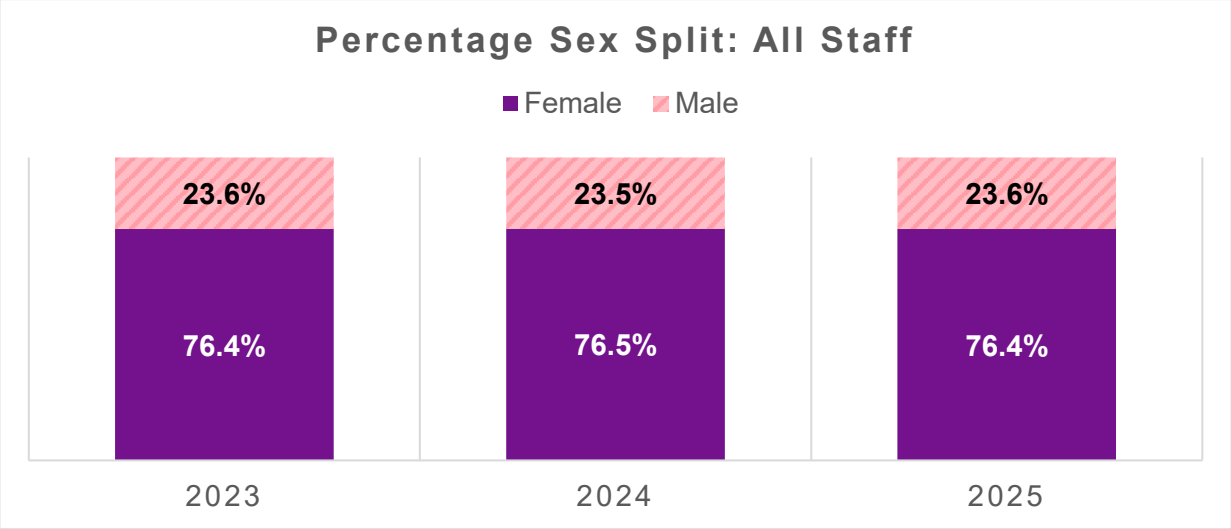
Sex refers to the biological aspects of an individual as determined by their anatomy, which is produced by their chromosomes, hormones and their interactions. Gender refers to a social construction relating to behaviours and attributes based on labels of masculinity and femininity; gender identity is a personal, internal perception of oneself and so the gender category someone identifies with may not match the sex they were assigned at birth. Within ESR we have Sex data available but not a person's gender identity.

Table 1

Sex	2023		2024		2025	
	Headcount	%	Headcount	%	Headcount	%
Female	9688	76.4%	10472	76.4%	10714	76.4%
Male	2990	23.6%	3224	23.6%	3354	23.6%

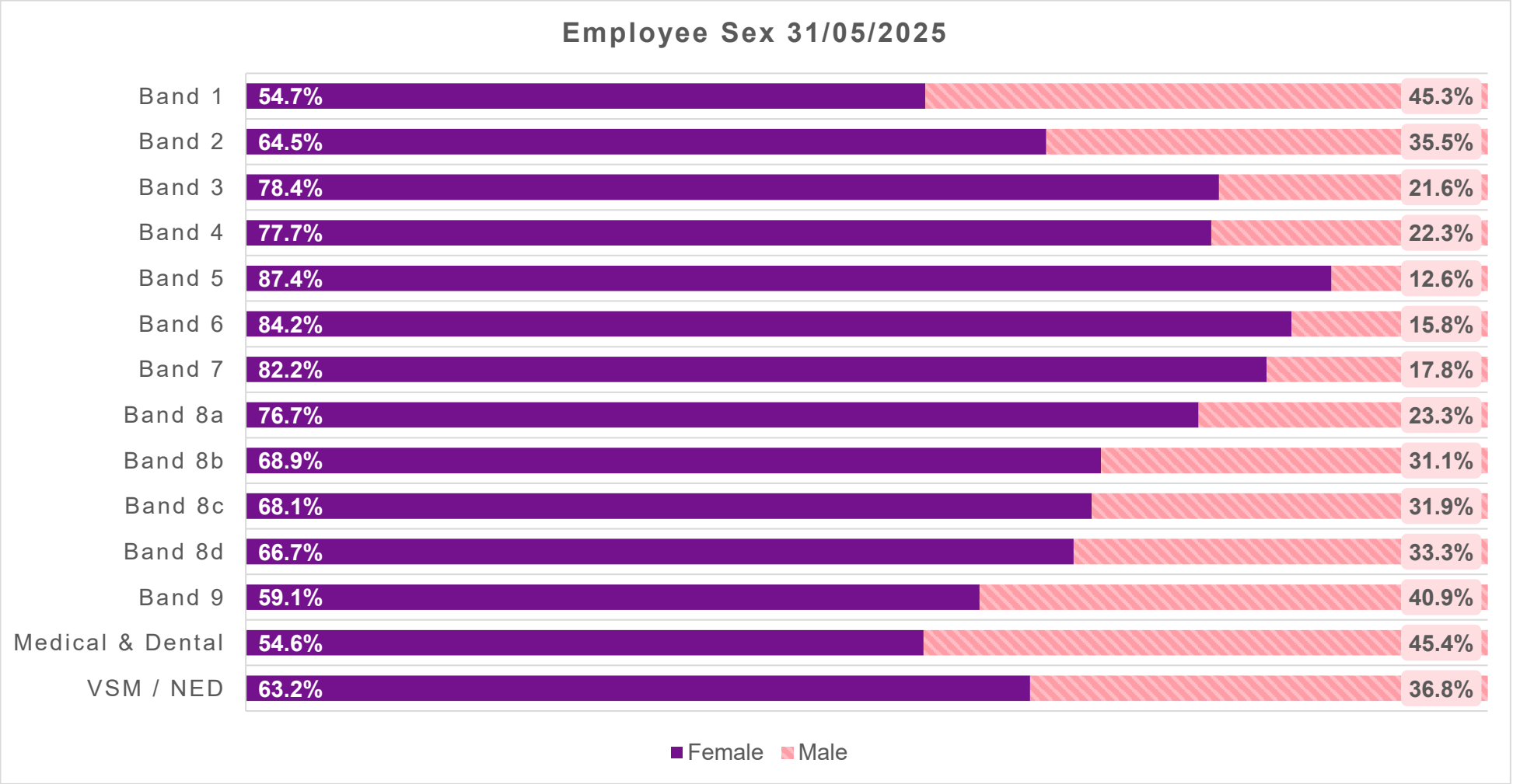
**This represents substantive staff only, not including colleagues who work solely on the bank.

Graph 1



Graph 1 shows the sex split of all staff within the Trust. Like the majority of NHS Trusts, UHBW has a predominantly female workforce, with **76.2%** being female and **23.8%** being male.

Graph 2



Graph 2 shows the sex split by band. The increase in male representation in the lower bands (1 and 2) and higher bands can be clearly seen, with all bands in the highest bands (8b+) being above the overall Trust proportion of male employees.

Whole Trust breakdown – Disabled Status

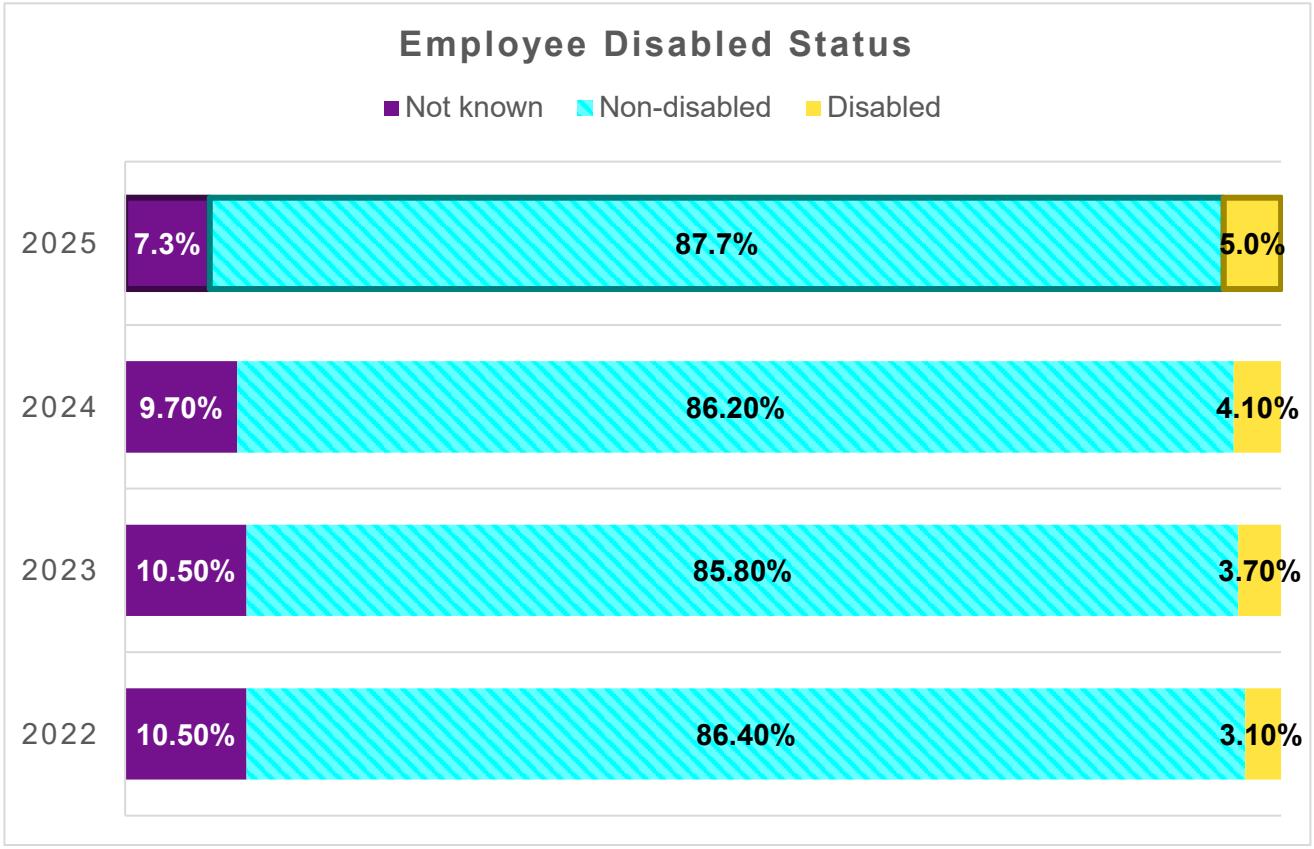
Table 2

Disabled status	2023		2024		2025	
	Headcount	%	Headcount	%	Headcount	%
Disabled	469	3.7%*	565	4.1%	698	5.0%
Non-disabled	10880	85.8%*	11804	86.2%	12340	87.7%

*Where percentages do not add up to 100% this is due to missing data recorded as undeclared or unknown.

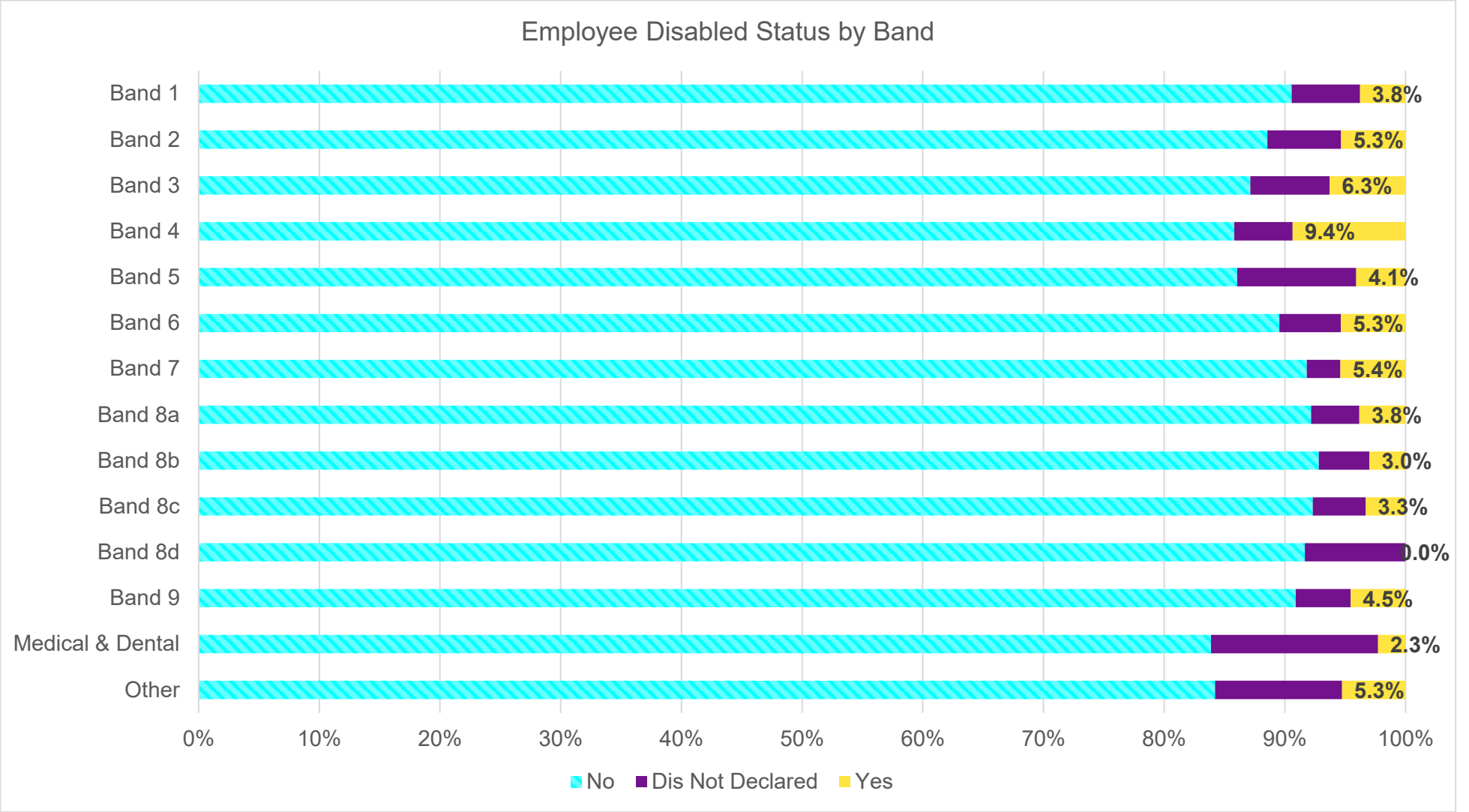
**This represents substantive staff only, not including colleagues who work solely on the bank.

Graph 3



Graph 3 shows the disability percentage split between all staff in UHBW. The percentage of disabled staff in these data extracted from the Electronic Staff Records (ESR) is significantly lower (5.0%) than the percentage of staff who self-declared a disability in the 2024 staff survey (21.9%).

Graph 4



Graph 4 shows the percentage of disabled staff split by band. It demonstrates the highest proportion of colleagues who identify as disabled are at bands 3 and 4.

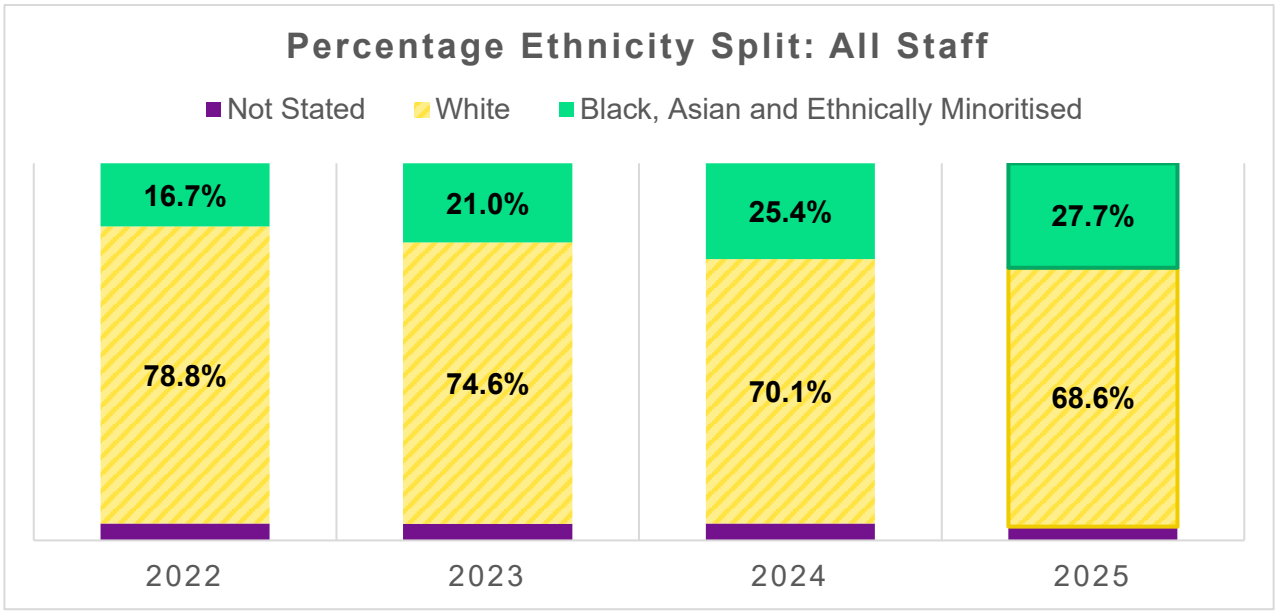
Whole Trust breakdown – Ethnicity

Global Majority: For 2025 we have shifted to using the term Global Majority to refer to colleagues who identify as Black, Asian, Multiple Heritage, GRT (Gypsy, Roma, Traveller), indigenous to the global south, and or have been racialised as 'ethnic minorities'. We have made this move as 'ethnic minority' and 'ethnically minoritised' have negative connotations and imply that colleagues not racialised as white are in the minority, which is a Eurocentric view. There are incidences where 'BME' is used, but this is when quoting NHS England WRES titles for reference.

Table 3

Ethnicity Grouping	2023		2024		2025	
	Headcount	%	Headcount	%	Headcount	%
Global Majority	2667	21.0%*	3479	25.4%	3897	27.7%
White	9462	74.6%*	9599	70.1%	9656	68.6%

Graph 5



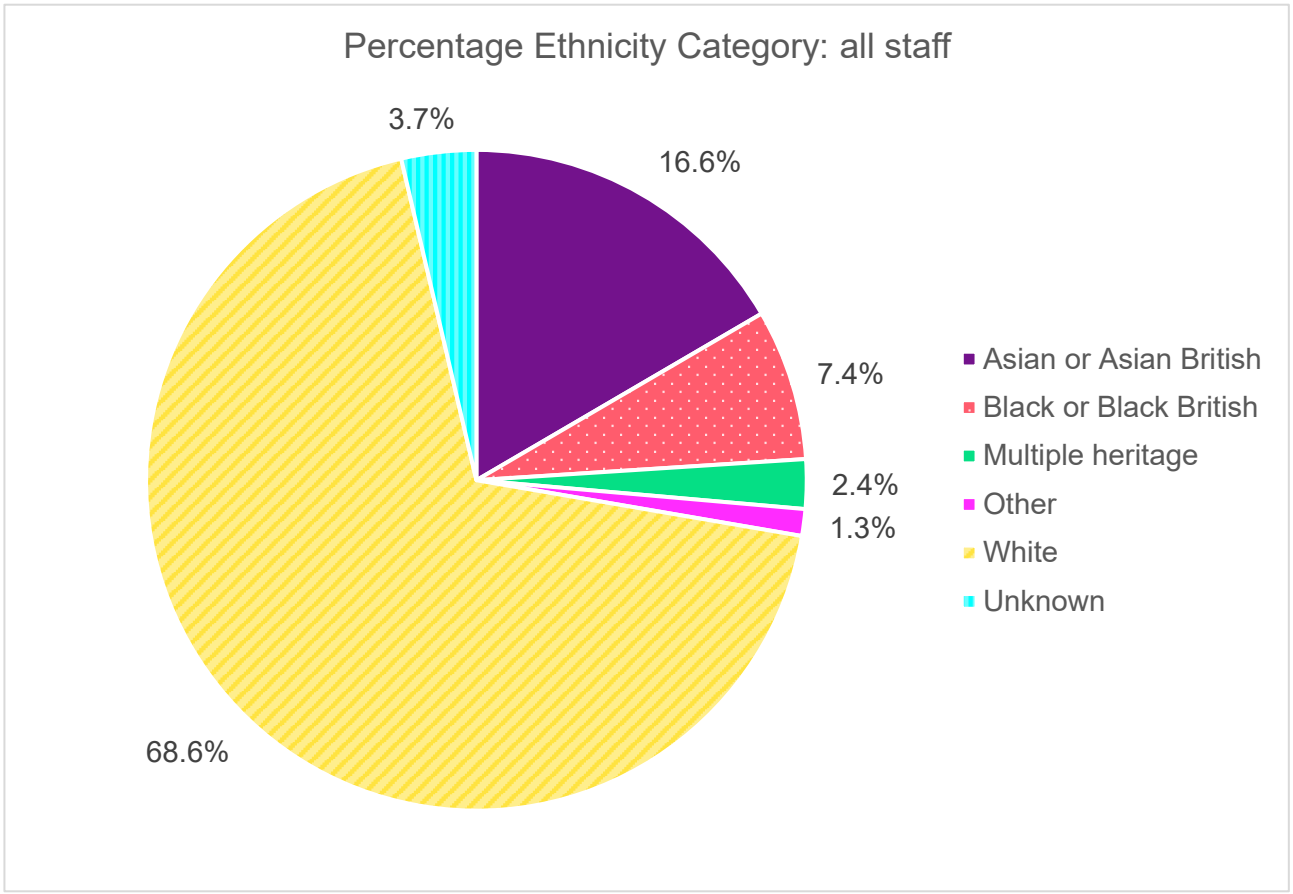
Graph 5 shows the ethnicity percentage split between white and Black, Asian, Multiple Heritage and other Minority Ethnic colleagues (Global Majority) staff in UHBW. The percentage of ethnically minoritised staff in the Trust has increased by 2.3 percentage points from 2024.

The 2021 census also shows an increase in the ethnically minoritised population in Bristol, which now sits at 18.9%, so the Trust has 8.8 percentage point higher representation than the Bristol population. It is important to note that in the 2021 census also showed that Weston Super Mare has a 5.3% Global Majority population in its demographic.

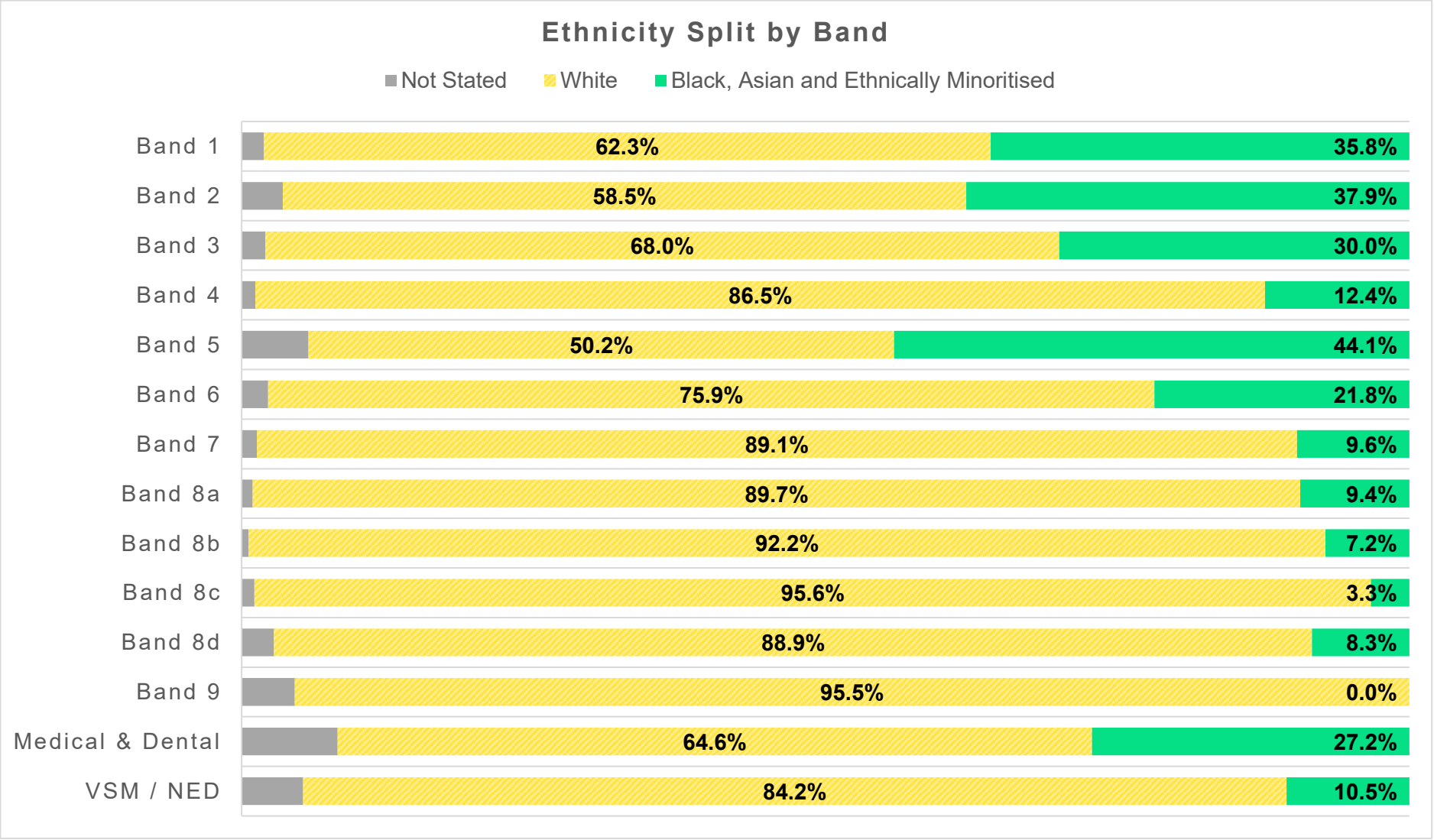
Improving data reporting

We acknowledge and understand that grouping colleagues who are not racialised as white into one category homogenises the experiences of colleagues racialised as Black, Asian, multiple heritage or other global majority identities, when realistically even within one racialised identity there is a vast array of cultures and experiences. As our data reporting capability improves, we will move towards using more data categories for ethnicity.

Graph 6



Graph 7



Graph 7 shows the ethnicity split by band. This data will be explored in more detail in the Model Employer section below.

Age

Table 4

Age Band	Total employees	%
<=20 Years	167	1.2%
21-25	1118	7.9%
26-30	2100	14.9%
31-35	2314	16.4%
36-40	2018	14.3%
41-45	1654	11.8%
46-50	1406	10.0%
51-55	1247	8.9%
56-60	1100	7.8%
61-65	736	5.2%
66-70	156	1.1%
>=71 Years	52	0.4%

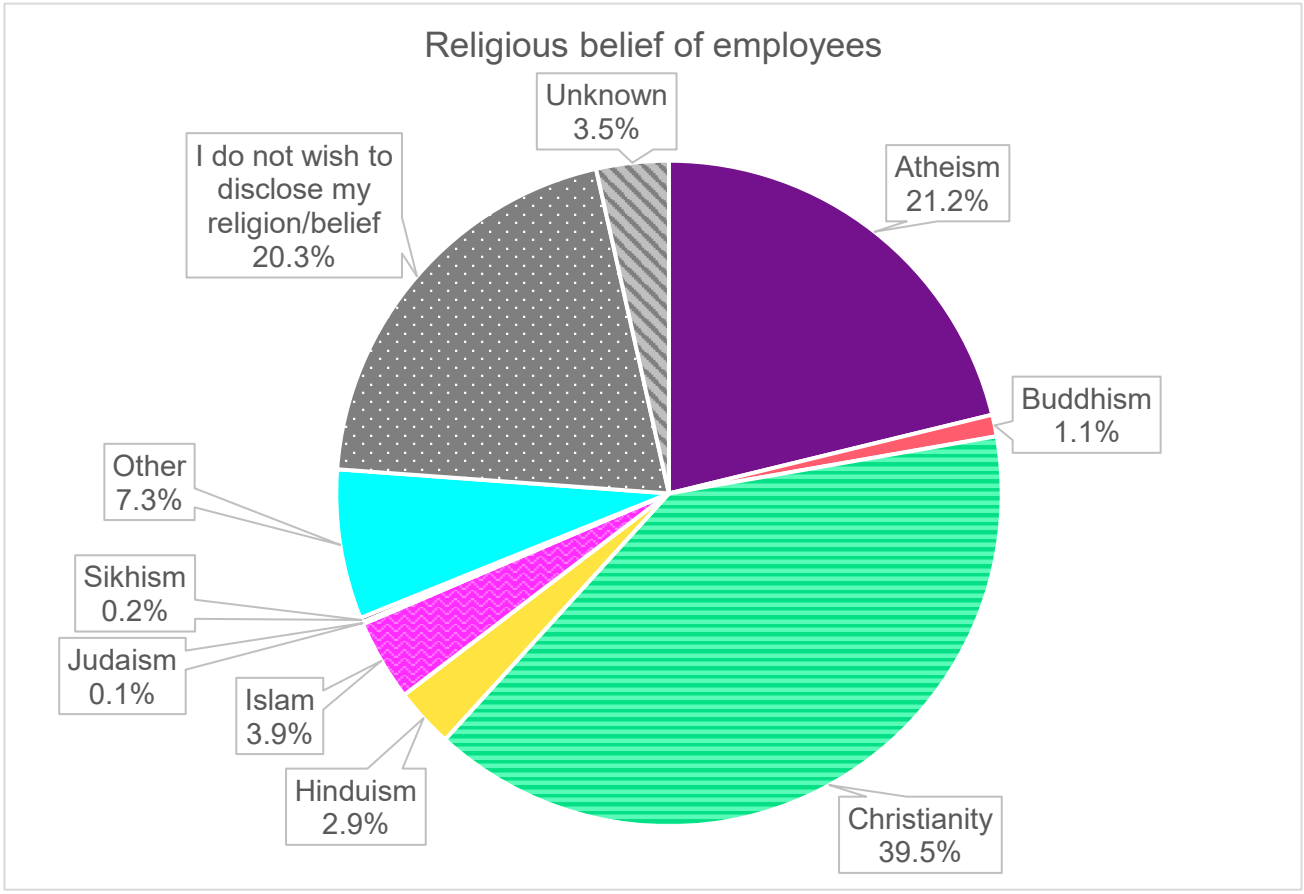
- The highest representation of colleagues is within the 31-35 age band (16.4%).
- 6.7% of colleagues are in the 61 and above age group.

Religion and belief

Table 5

Religious Belief	Total employees	%
Atheism	2982	21.2%
Buddhism	148	1.1%
Christianity	5557	39.5%
Hinduism	408	2.9%
Islam	552	3.9%
Judaism	15	0.1%
Sikhism	31	0.2%
Other	1021	7.3%
I do not wish to disclose my religion/belief	2859	20.3%
Unknown	495	3.5%

Graph 8

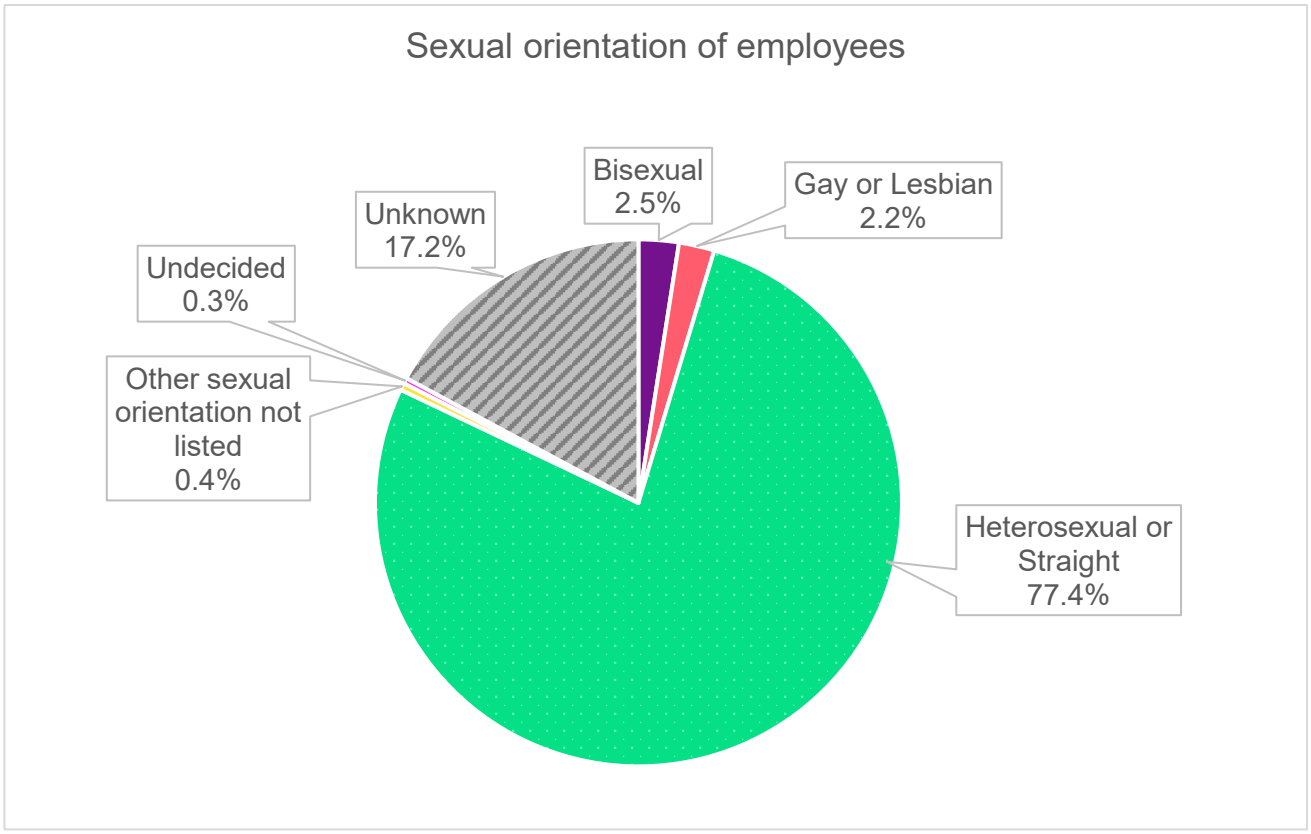


Sexual orientation

Table 6

Sexual Orientation	Total employees	%
Bisexual	347	2.5%
Gay or Lesbian	307	2.2%
Heterosexual or Straight	10891	77.4%
Other sexual orientation not listed	62	0.4%
Undecided	48	0.3%
Unknown	2413	17.2%

Graph 9



Demographic Summary

In summary, the above data shows that UHBW has:

Sex: Over 3 times more female than male employees, this has remained unchanged from 2023.

Disabled Status: 5.0% of staff identified as disabled on the electronic staff records, which is a slight increase from 2023, when it was 4.1%, but still significantly lower than the number of staff who self-declare as having a disability in the staff survey and the Bristol working age population (16.0%).

Ethnicicty: 27.7% of staff are Global Majority, this is an increase from 2024, when the figure was 25.4%. Asian colleagues have the highest representation within the Global Majority community (16.6% of UHBW colleagues).

Age: The Trust has a workforce diverse in age.

The highest representation of colleagues is within the 31-35 age band (16.4%).

6.7% of colleagues are in the 61 and above age group.

Religion and Belief: We have a diverse community of religious belief and faith with the three largest representations being: Christianity 39.5%, Atheism 21.2%, other religions and beliefs making up 7.3%.

Sexual Orientation: 77.4% of colleagues identified as Heterosexual or Straight with 17.2% of colleagues not disclosing their sexual orientation or us not having their data. LGBTQIA+ identities made up 5.1% of colleagues with Bisexual being the highest representation for this group (2.5%).

3. Gender Pay Gap

Introduction

Organisations with 250 or more employees are mandated by the government to report annually on their gender pay gap. The requirements of the mandate within the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 are to publish information relating to pay for six specific measures, as detailed in this report.

The gender pay gap is the difference between the average hourly earnings of men and women. This is not the same as equal pay, which is concerned with men and women earning equal pay for the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because of gender. Instead, the gender pay gap highlights any imbalance of average pay across an organisation. For example, if an organisation's workforce is predominantly female yet the majority of senior positions are held by men, the average female salary would be lower than the average male salary. UHBW is required to report on a 'mean' and a 'median' gender pay gap.

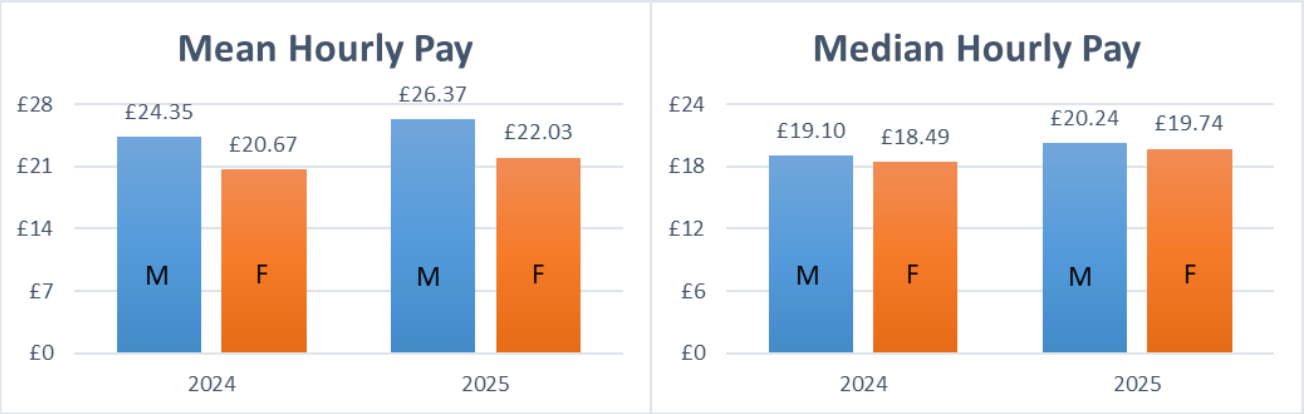
AT UHBW and within the NHS, our pay structure and reward terms and conditions are linked to time served. Pay increases after certain milestones of length of service are met.

Mean and Median Pay Gap

The **mean pay gap** is the difference between the pay of all male and all female employees when added up separately and divided respectively by the total number of males, and the total number of females in the workforce. It is calculated for all employees who have been paid at their full basic pay during the relevant pay period. The mean pay gap percentage is based on a calculation of the hourly rate of pay for each employee, a calculation of the mean hourly rate by gender and then a calculation of the difference between the mean hourly rate between males and females.

The **median pay gap** is the difference between the pay of the middle male and the middle female when all male employees and then all female employees are listed from the highest to the lowest paid. The median pay gap percentage is based on a calculation of the hourly rate for each employee, which is then sorted by gender and hourly rate then finding the mid-point in the list for each gender. The difference between the middle values is calculated and this difference is divided by the male middle value.

Graph 10



Graph 10 shows the mean and median pay rates on which the pay gap calculation is based:

- UHBW's Mean Gender Pay Gap for 2025 is 16.47% in favour of male employees.
- UHBW's Median Gender Pay Gap for 2025 is 2.46% in favour of male employees.

There is a significant difference between the mean and median pay gaps. The mean average takes into account the absolute salary values of all staff, whereas the median takes the actual value of the salary in the middle of the range. By controlling for the effect of a relatively small number of the highest earners, the median can be expected to offer a more accurate average of relative pay levels across the organisation.

As expected, the mean hourly pay rate has increased slightly for both males and female staff, primarily reflecting the 2024/25 AfC pay award. The mean pay gap of 16.47% is a modest increase on the 2024 gap of 15.11%.

The significant gender gap in mean hourly rate is largely attributable to the difference in gender profile across roles in the organisation. A greater proportion of male employees in the Trust occupy senior or medical roles. Female employees make up a disproportionate amount of nursing roles in particular, lowering the mean hourly earnings in comparison. The fact of such a range of heterogeneous roles means that any headline average is of limited value.

The median GPG has reduced further from 3.19% in 2024 to 2.46%, the lowest rate since before the 2020 merger. This is a testament to the robust pay controls in place at the organisation, minimising the use of individual management allowances, recruitment and retention premia (RRPs), or any other irregular changes to earnings.

Most elements of remuneration are set by a process of national collective bargaining. However, as a Foundation Trust, UHBW retains the right to deviate from national terms, as necessary. The Trust's Pay Assurance Group (TPAG) is the Executive body responsible for determining such deviations, and all requests to apply local terms must be approved by TPAG. In doing so, this ensures central oversight of pay arrangements, and provides assurance that any deviation from consistent terms of remuneration are based on robust statements of case and business need. The Joint Union Committee Chair sits on TPAG in an advisory capacity to offer challenge and ensure transparency of decisions.

The remainder of the median pay gap likely arises from the gender profile of roles across the organisation, as explained above. The median male employee is at AfC band 6, on the intermediate pay point. The median female employee is also at band 6, but at the entry pay point. In isolation, it is not possible to infer purely from the median that there is a systemic bias (e.g. women being overlooked for promotion in favour of men).

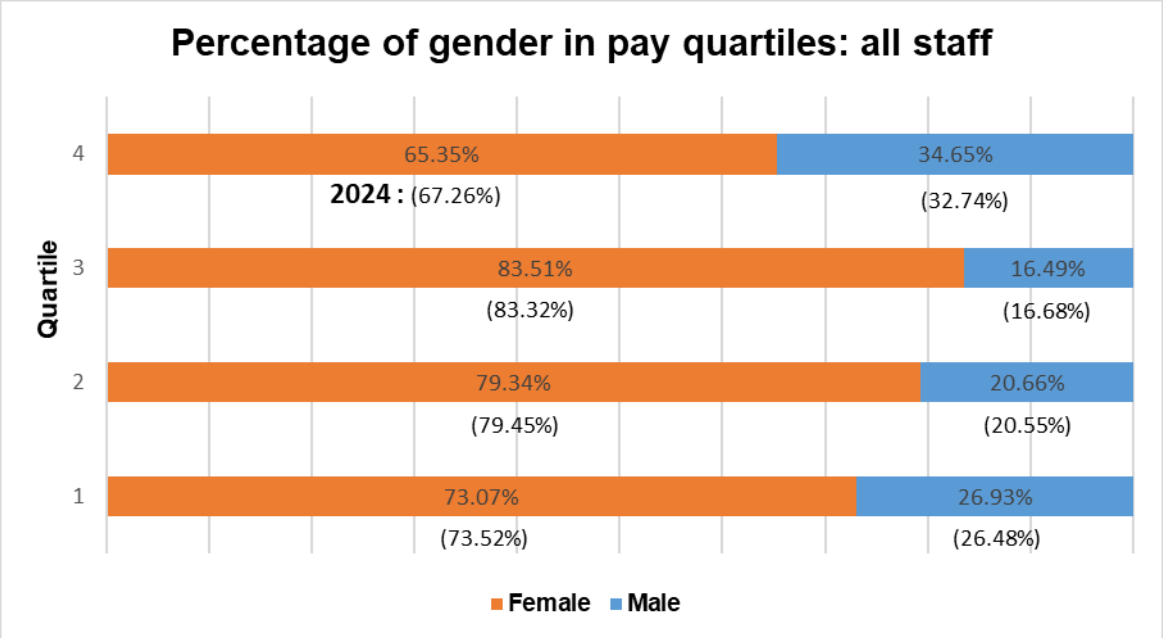
Pay Quartiles

The Gender Pay Gap reporting also requires a split of the workforce by pay, into quartiles and show the proportion of males and females in each quartile. The results of this split are shown in Graph 11. In broad terms this shows that compared to the position across the workforce as a whole, where males represent 23.8%, there are proportionally more males in the highest pay quartile (34.65%).

Again, this is not unexpected given the stratification of gender in roles across the organisation and is a modest increase on the 2024 figure (32.74%).

Quartile 4 is the highest pay quartile.

Graph 11



Medical and Dental

As shown in Table 7, the mean gender pay gap becomes 3.7% in favour of female staff when medical and dental staff are removed. This is because among AfC staff, men are more likely to be in estates and facilities roles, as shown by the greater male representation in the lowest pay quartile.

Table 7

Staff Group	Male Average Hourly Pay	Female Average Hourly Pay	Difference	Mean Pay Gap
Medical and Dental staff	£45.16	£42.69	£2.47	5.5%
All other staff	£18.98	£19.68	-£0.70	-3.7%

The mean pay gap for medical and dental staff of 5.5% is a moderate reduction from the 2024 figure of 7.16%.

Agenda for Change pay bands

Table 8 shows the mean rate of male and female staff in the different AfC pay bands, plus very senior managers (VSM). The mean is a more valid average here than elsewhere, as individual bands rarely have outliers.

This reiterates the quartile data, which showed male staff populating more of the lowest and highest roles in the Trust, with female staff earning more in the middle bands, most notably at bands 5 and 6. This is because female staff at these bands are more likely to be nurses and work a higher proportion of unsocial hours, while male staff are more likely to hold non-clinical roles, or other clinical roles involving fewer unsocial hours than nursing.

Band 1 is closed to new recruitment. The pay rates shown here are higher than band 4 owing to a quirk in national unsocial hours rates, where Sundays and Bank Holidays have a higher multiplier for band 1 than other bands. The gender pay difference here will be owing to female Healthcare Assistants working more unsocial hours than their male colleagues.

The only pay band with a significant gender pay gap is among VSMs, but this arises from a small sample, and the specific roles held within that group.

Table 8

Mean Hourly Pay Rate by AfC Band (& VSM)							
Band	**Headcount Male**	**Headcount Female**	**Male Mean Hourly Rate**	**Female Mean Hourly Rate**	**Difference**	**Gap**	**2024**
Band 1	23	22	14.61	16.82	-£2.21	-15.1%	-14.6%
Band 2	534	989	13.55	13.54	£0.01	0.1%	1.6%
Band 3	450	1879	13.95	13.88	£0.07	0.5%	-0.5%
Band 4	203	853	14.75	14.48	£0.27	1.8%	1.1%
Band 5	370	2185	18.54	19.32	-£0.78	-4.2%	-5.7%
Band 6	332	1732	21.42	21.95	-£0.53	-2.5%	-3.3%
Band 7	267	1191	25.66	25.95	-£0.29	-1.1%	-1.6%
Band 8	224	631	32.58	32.09	£0.49	1.5%	-0.3%
Band 9	9	13	59.95	58.34	£1.61	2.7%	-2.5%
VSM	4	5	95.06	86.18	£8.88	9.3%	12.5%

Table 9 displays the same breakdown of this data into medical grades.

Table 9

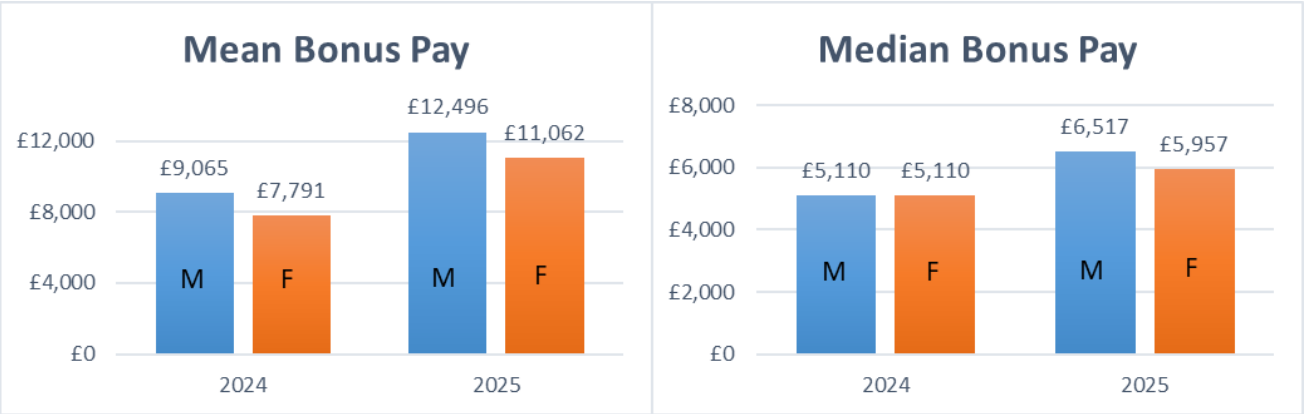
Mean Hourly Pay Rate by Medical grade							
Grade	**Headcount Male**	**Headcount Female**	**Male Mean Hourly Rate**	**Female Mean Hourly Rate**	**Difference**	**Gap**	**2024**
Foundation Y1	24	47	£19.59	£19.59	£0.00	0.0%	-1.8%
Foundation Y2	21	47	£23.44	£22.93	£0.51	2.2%	1.3%
Trust Grade Docs	176	178	£33.41	£32.69	£0.72	2.2%	0.4%
Specialty Registrar	228	266	£34.67	£34.69	-£0.02	-0.1%	0.5%
Specialty Doc/ Associate Specialist	51	66	£42.76	£45.93	-£3.17	-7.4%	-5.3%
Consultant	338	326	£61.61	£60.50	£1.11	1.8%	1.6%

Bonus Pay

We are also required to report on gender pay gap in bonus pay. The only payments that qualify as bonus pay are Clinical Excellence Awards, which are paid at both a local and national level.

The bonus pay gap is calculated by isolating bonuses paid in the previous 12 months, to staff who were still employed at the snapshot date of 31 March, with the difference by gender again expressed in both mean and median. Staff who received no bonus pay are therefore not included in this dataset.

Graph 12



Graph 12 shows the mean and median bonus pay. The mean bonus pay gap in 2025 is 11.48%, a moderate reduction from 14.05% in 2024. The median gap is 8.60%, up from 0% in 2024.

In previous years, the Trust had been required to spend on Local Clinical Excellence Awards (LCEAs) a nationally agreed sum per consultant whole time equivalent. Since the pandemic, the available funding had been split equally between all consultants rather than via an application process.

As part of the consultant pay award agreed in April 2024, most LCEAs ceased to be paid, with only pre-2018 LCEAs continuing. These are paid on a long-term basis and in most cases only lost upon retirement.

National awards are also paid on a long-term basis for clinical excellence, but these are not administered by the Trust.

The Trust therefore has no local control over its bonus pay gap, and as expected the cessation of the all-consultant LCEA payments has reintroduced a gender gap primarily reflecting the pre-2018 LCEAs. As recipients of pre-2018 awards retire, the mean bonus pay gap has reduced over time as these historic payments are lost, and this is expected to continue in the coming years.

Historical gender pay gap data

This is included for reference. Before 2021 the data would be for UHBristol rather than UHBW, so is not comparable and is not included.

Table 10

Year	Mean pay gap	Median pay gap	Mean bonus gap	Median bonus gap
2021	18.30%	4.22%	20.02%	33.33%
2022	19.03%	10.89%	21.04%	0%
2023	16.20%	4.34%	14.04%	0%
2024	15.11%	3.19%	14.05%	0%
2025	16.47%	2.46%	11.48%	8.60%

Summary

The positive movement of the median gender pay gap to its lowest figure since before the Bristol and Weston merger speaks to the continued strength of pay controls at UHBW that minimise the likelihood of outlying rates of pay.

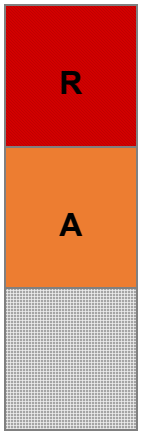
4. Workforce Disability Equality Standards (WDES)

Introduction

This section of the report will summarise the WDES indicators. There is a summary report for high level information, followed by a detailed breakdown of each indicator.

WDES Summary report

Key



Red: Repeat year on year increase in gap of experience or a gap of 5 percentage points or greater.

Amber: First year on year increase in gap of experience or a gap of 1.5 to 4.9 percentage points. Indicator has improved since previous year but still needs improvement. Gap reducing but action still needed.

Non-priority: Gap is smaller than 1.1 or relative likelihood ratio is between 0.9 and 1.1. Specific DEI action not needed at a Trust level but might be needed at a division level.

pp: percentage point

WDES Measure		Performance Summary			
Measure	**Description**	**Current position**	**Performance year on year**	**Position since previous year**	**Executive Summary**
WDES Indicator 1	Percentage of staff in Agenda for Change (AfC) pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.	5.0% of colleagues identify as disabled • 6.7% non-clinical • 4.9% clinical • 2.3% medical and dental	↑ by 0.8pp	R	Disabled colleague representation remains low compared to the Bristol working age population, with high levels of non-disclosure. Representation has only increased by 1.9 percentage points since 2022. Remains red.
WDES Indicator 2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	Non-Disabled candidates are 1.08 times more likely to be appointed than Disabled candidates from shortlist. 30.3% of Non-Disabled Colleagues compared to 28.0% of Disabled colleagues (2.3pp gap)	↔ no change in Relative likelihood		The gap in the likelihood of non-disabled colleagues being appointed from shortlisting compared to disabled colleagues is minimal for the second year in a row. Remains non-priority.

WDES Measure		Performance Summary			
Measure	**Description**	**Current position**	**Performance year on year**	**Position since previous year**	**Executive Summary**
WDES Indicator 3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance, as measured by entry into the formal capability procedure.	Disabled colleagues are 1.30 times more likely to enter the formal capability process than non-disabled colleagues. 0.14% of Disabled Colleagues enter the formal capability process compared to 0.11% of non-disabled colleagues (0.03pp gap)	Relative likelihood ↓ by 1.43		Disabled colleagues are 1.3 times more likely to enter the formal capability progress than non-disabled colleagues (target 1.0). This has reduced since 2022 and now there is a marginal gap. Deescalated from amber to non-priority.
WDES Indicator 4a	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse	11.3% of Disabled Colleagues experiencing harassment, bullying or abuse from managers compared to 5.1% of non-disabled colleagues (6.2pp gap) 22.2% of Disabled Colleagues experiencing harassment, bullying or abuse from other colleagues compared to 14.5% of non-disabled colleagues (7.7pp gap) 28.0% of Disabled Colleagues experiencing harassment, bullying or abuse from patients/service users compared to 21.0% of non-disabled colleagues (7.0pp gap)	From managers gap ↑ by 0.8pp From other colleagues gap ↓ by 2.8pp From patents/service users ↓1.5pp	**R**	The gap in experience of harassment, bullying or abuse for Disabled Colleagues compared to non-disabled colleagues continues to be high in all measures. Remains red.

WDES Measure		Performance Summary			
Measure	**Description**	**Current position**	**Performance year on year**	**Position since previous year**	**Executive Summary**
WDES Indicator 4b	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	58.0% of Disabled Colleagues compared to 55.0% of non-disabled colleagues (3.0pp gap)	Gap ↑ by 0.3pp		The gap of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it remains low. Remains non-priority.
WDES Indicator 5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	53.6% of Disabled Colleagues compared to 59.1% of non-disabled colleagues (5.5pp gap)	Gap ↓ by 0.2pp	**R**	Disabled colleagues have a lower belief that the Trust provides equal opportunities for career progression or promotion. The gap remains large. Remains red.
WDES Indicator 6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	19.3% of Disabled Colleagues compared to 13.0% of non-disabled colleagues (6.2pp gap)	Gap ↑ by 0.2pp	**R**	Disabled colleagues have felt more pressure from their manager to come to work, despite not feeling well enough to perform their duties. The gap has remained consistent over 4 years so escalating to red.

WDES Measure		Performance Summary			
Measure	**Description**	**Current position**	**Performance year on year**	**Position since previous year**	**Executive Summary**
WDES Indicator 7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	38.6% of Disabled Colleagues compared to 51.1% of non-disabled colleagues (12.5pp gap)	Gap ↑ by 1.9pp	**R**	Disabled colleagues feel much less valued than non-disabled colleagues and this gap is increasing year on year. Remains red.
WDES Indicator 8	Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.	81.3% of Disabled Colleagues	↑ by 1.9pp	**A**	Reasonable adjustment implementation is the highest it has been in 4 years but could increase. Remains Amber.
WDES Indicator 9	The staff engagement score for Disabled staff, compared to non-disabled staff.	6.6 for disabled colleagues compared to 7.2 for non-disabled colleagues (0.6 gap)	Gap ↑ by 0.1	**R**	Disabled staff have a 0.6 lower engagement score compared to non-disabled colleagues. This gap is slowly increasing year on year. Remains Red.
WDES Indicator 10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated.	5.3% of the Board are disabled	Representation ↑ by 5.3pp	**A**	Board representation has increased to match the staff population but not the Bristol working age population. Deescalating to amber.

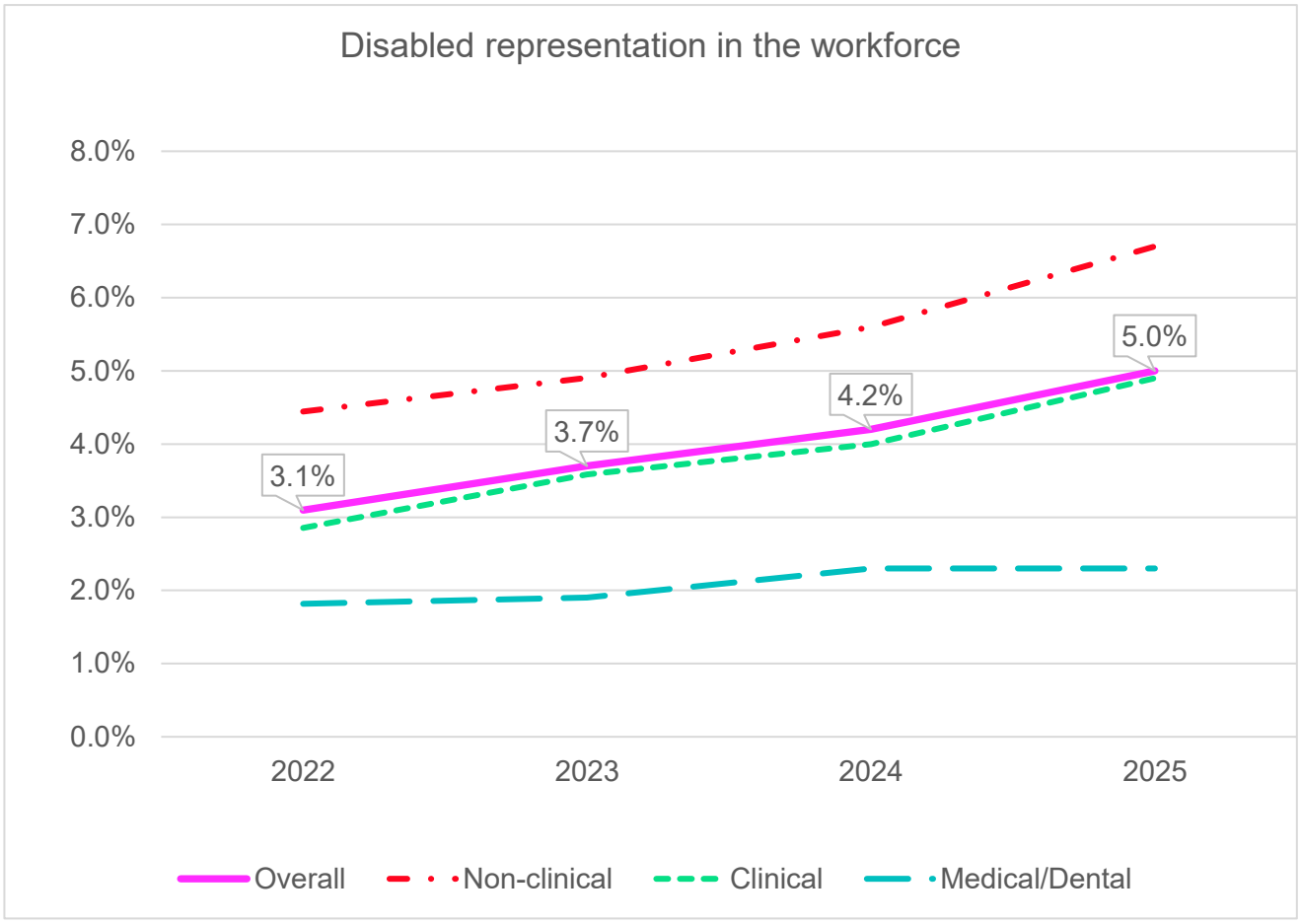
WDES Indicator 1

Percentage of staff in Agenda for Change (AfC) pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

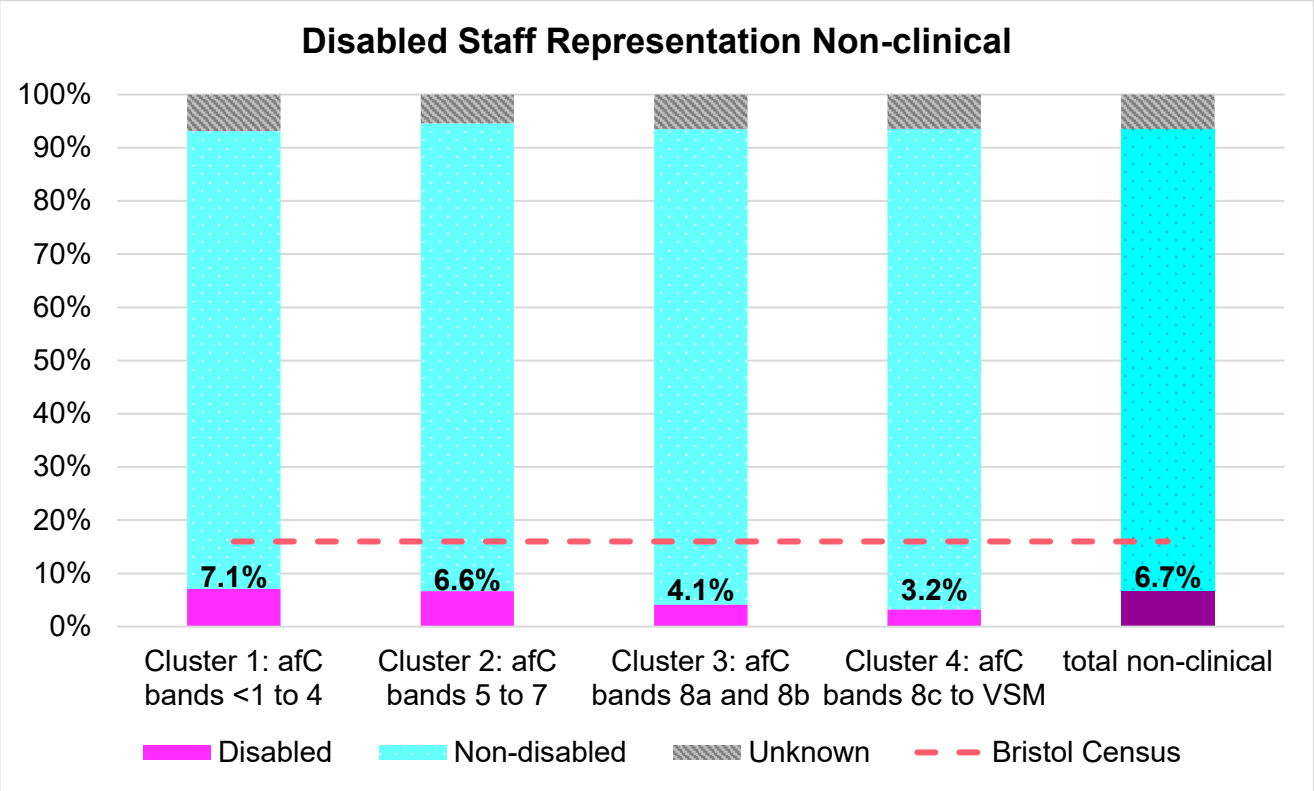
Across all AfC bands for Non-Clinical, Clinical (non-medical) and Medical / Dental the Trust has low representation of Disabled colleagues, with 5.0% of the overall workforce identifying as Disabled. This is increasing year on year (1.9 percentage points since 2022) however, UHBW still has low representation of disabled colleagues compared to the Bristol census 2021 where "people who have long-term physical or mental health conditions or illness whose day-to-day activities are limited" made up 16.0% of the working age (16 – 64) population.

Within Medical and Dental there is a high proportion of colleagues where their disability status is 'unknown' either because we do not have their data or they did not wish to disclose, which could be potentially masking disabled colleague representation.

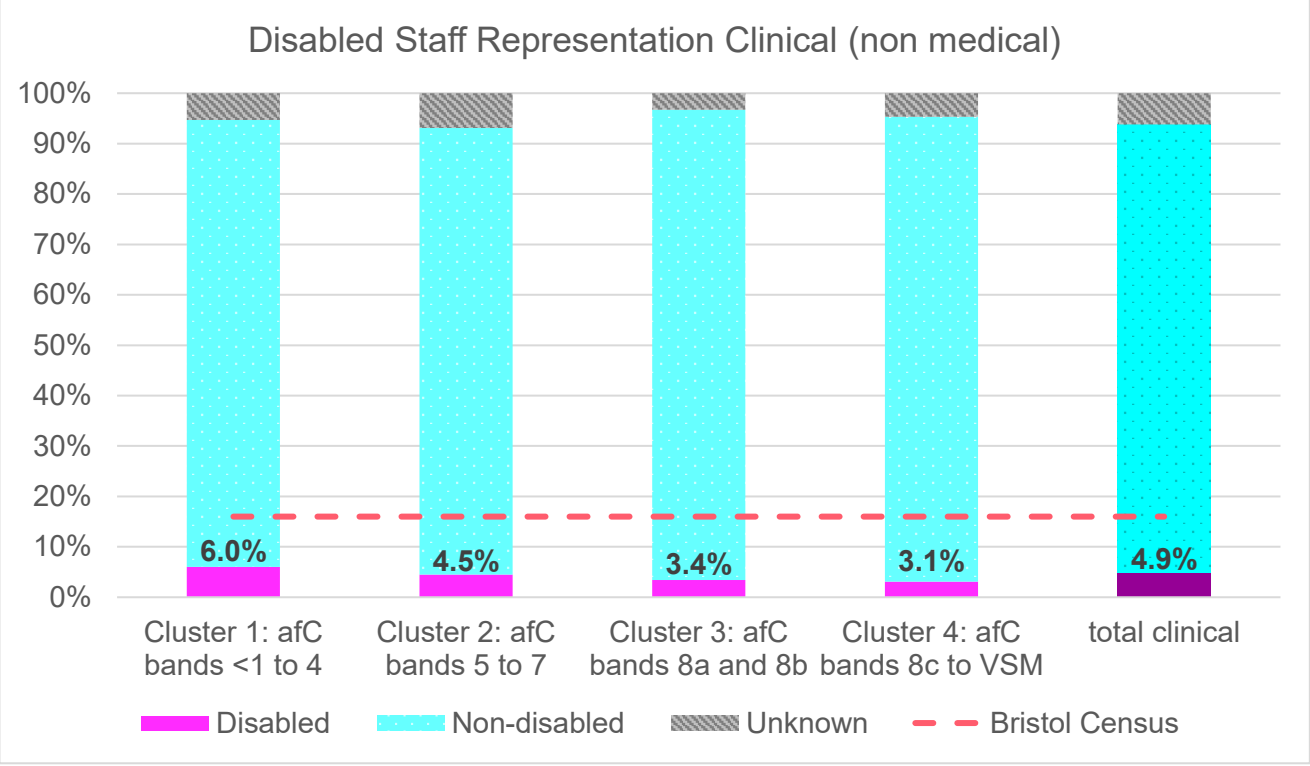
Graph 13 Total workforce



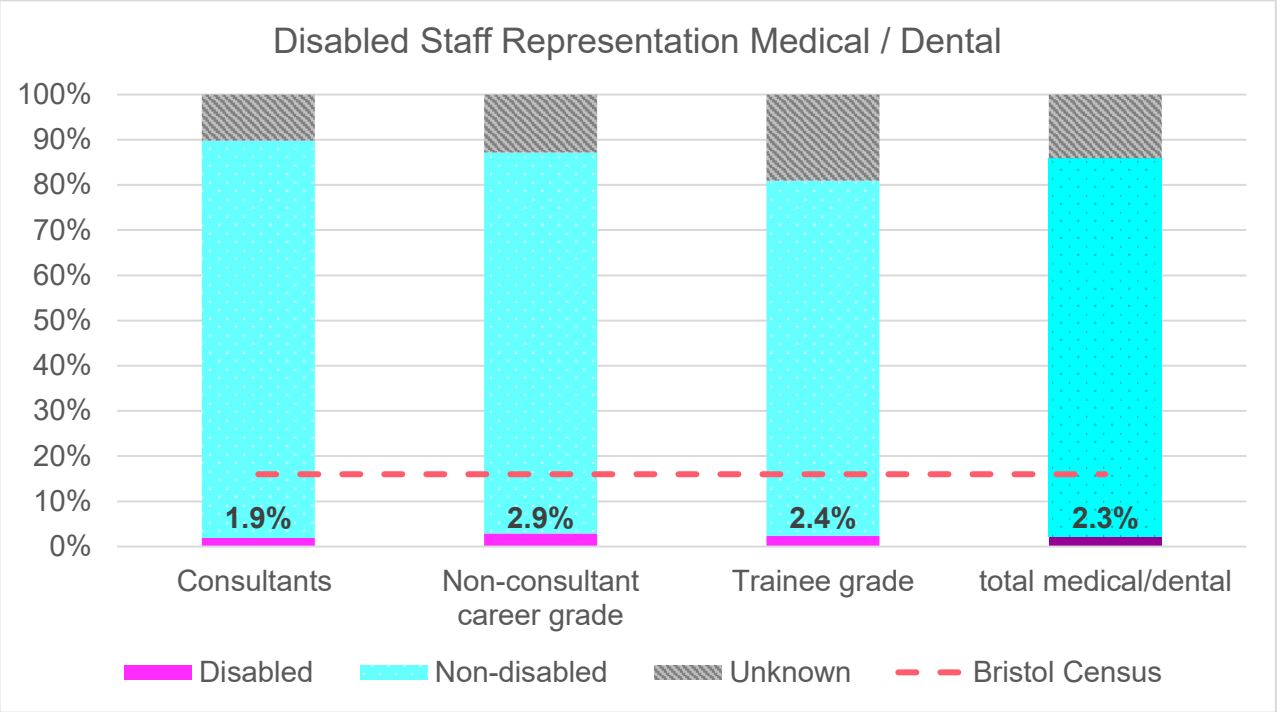
Graph 14 Non-clinical



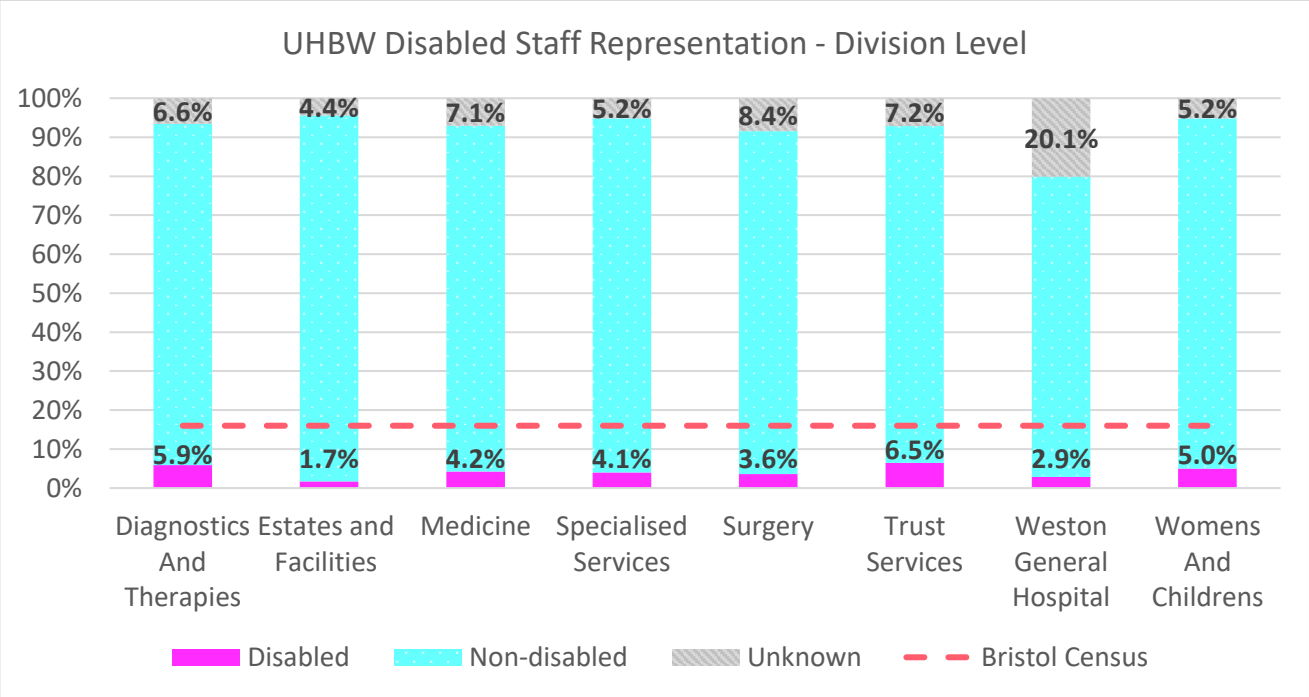
Graph 15 Clinical (non-medical)



Graph 16 Medical / Dental



Graph 17 Division Level



All divisions have low representation of disabled colleagues, however the lowest are:

- Estates and Facilities 1.7% (4.4% did not disclose)
- Weston General Hospital 2.9% (20.1% did not disclose)
- Surgery 3.6% (8.4% did not disclose)

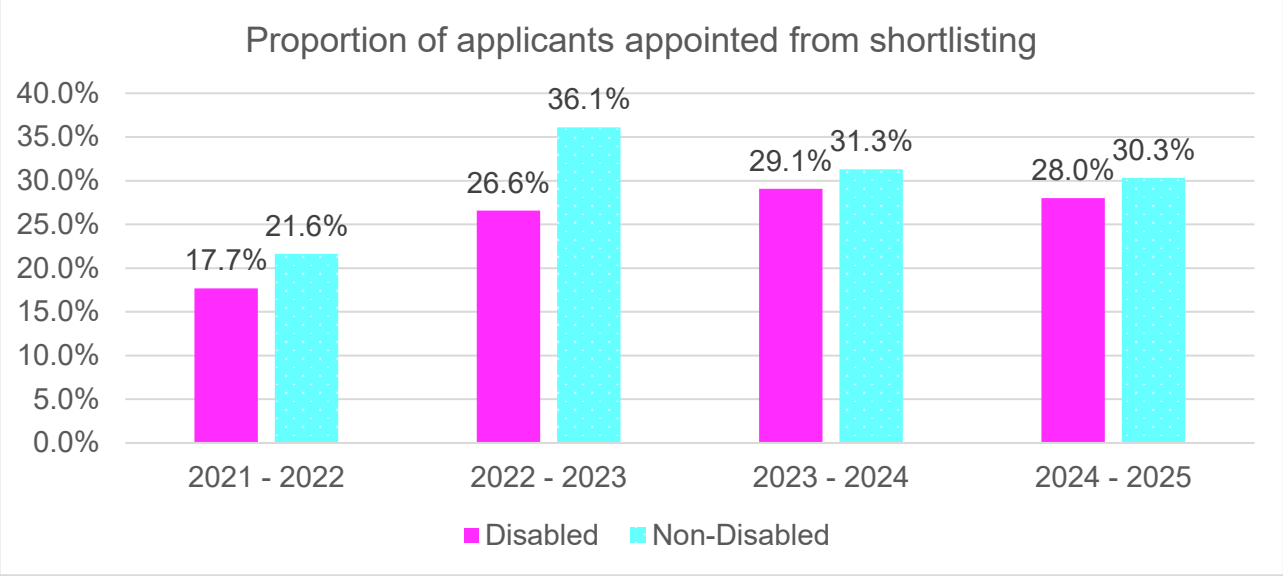
WDES Indicator 2

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

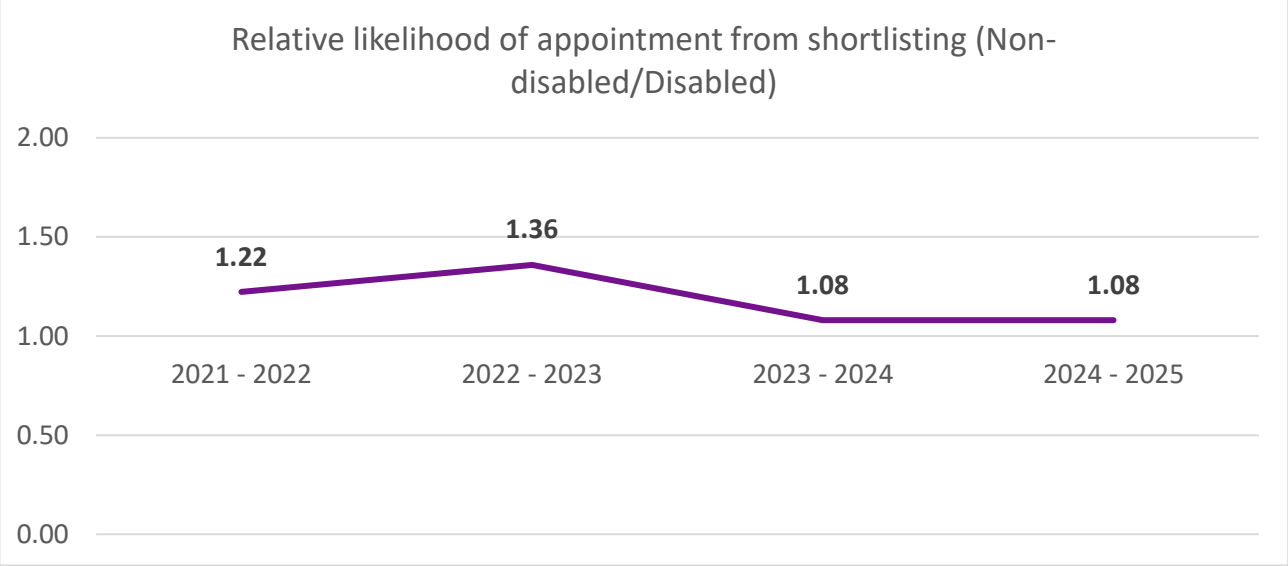
The relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts remains at 1.08, with only a 2.3 percentage point gap in the proportion of disabled candidates appointed form shortlist (28.0%) compared to the proportion of non-disabled applicants (30.3%).

A relative likelihood value of 1.0 would mean an equal proportion of disabled candidates were appointed from shortlist compared to non-disabled candidates. Whereas a value above 1.0 means proportionately less disabled candidates are shortlisted compared to non-disabled candidates.

Graph 18



Graph 19



WDES Indicator 3

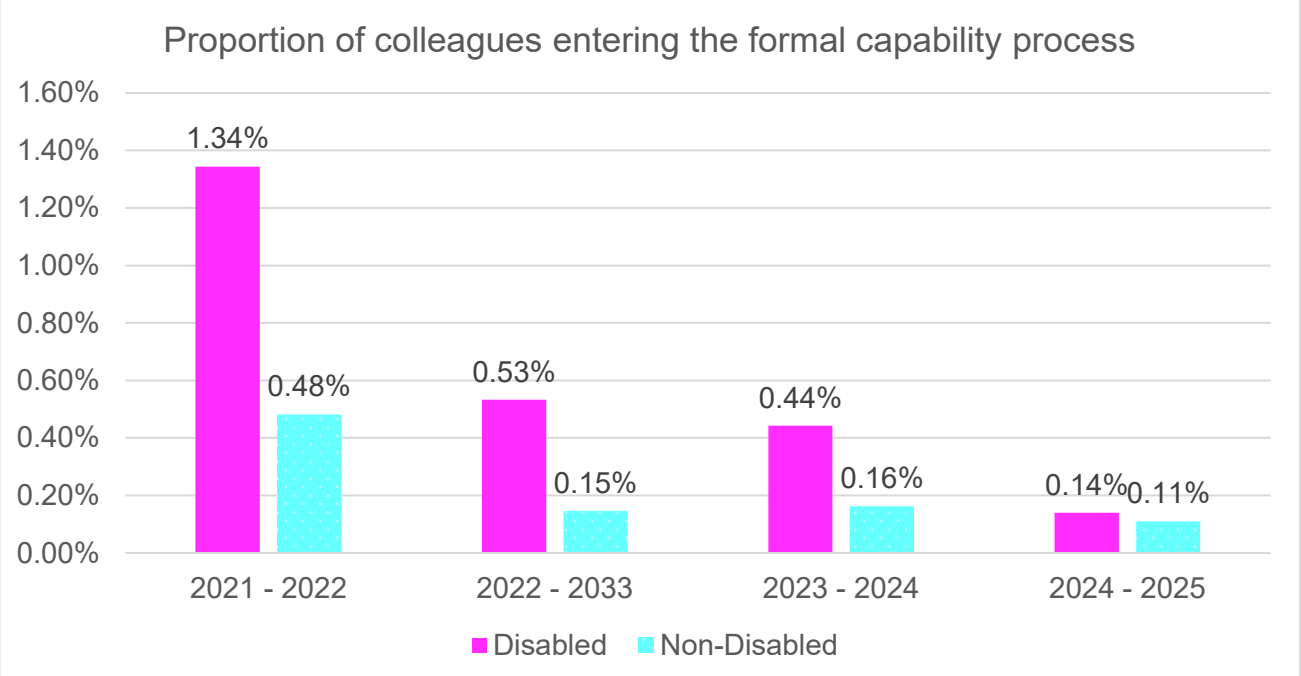
Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance, as measured by entry into the formal capability procedure.

The proportion of non-disabled colleagues entering the formal capability process has reduced from 0.44% to 0.14%. This has resulted in the relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff reducing to 1.3 times as likely. A value of 1.0 would mean an equal proportion of disabled colleagues went through the formal capability process compared to non-disabled colleagues, meaning we are very close to the target.

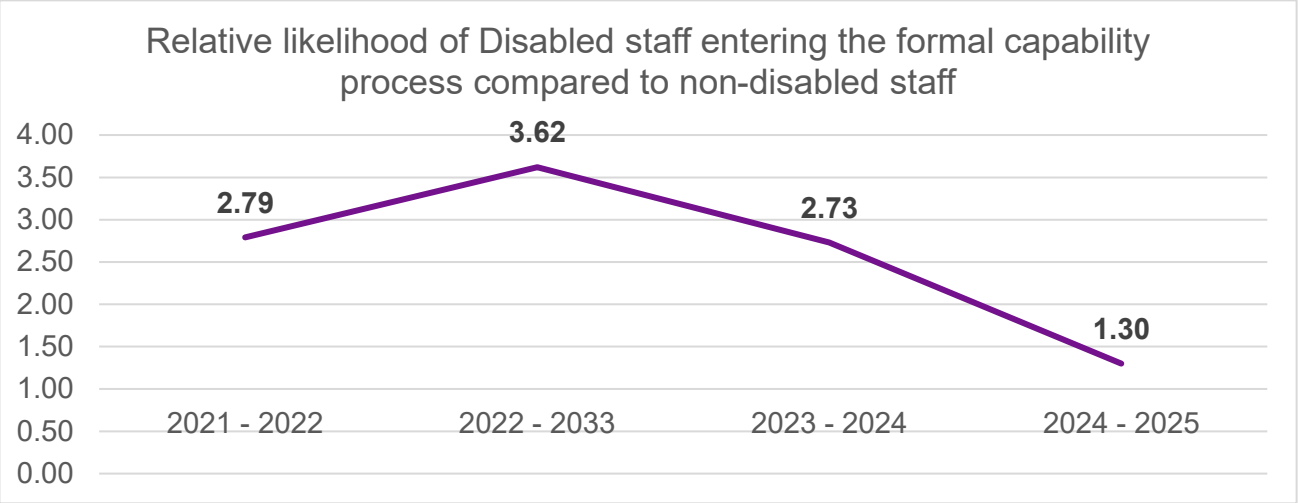
Following the launch of Respecting Everyone, a full review of the Health and Wellness at Work Policy took place. Two significant changes to the support and management of colleagues with disabilities occurred as a result of these policy changes. The introduction of Early Resolution when capability concerns arose which focussed on understanding the employee voice and using improvement plans to resolve concerns early and informally and a renewed emphasis on workplace adjustments and supportive management of colleagues with disabilities.

Using the policies outlined above to support colleagues who have disabilities and performance concerns means that adjustments and informal improvement interventions are considered and exhausted before any formal capability process commences and this has significantly reduced the number of formal capability processes across UHBW year on year. This has also greatly reduced the number of disabled colleagues entering a formal capability process.

Graph 20



Graph 21



WDES Indicator 4

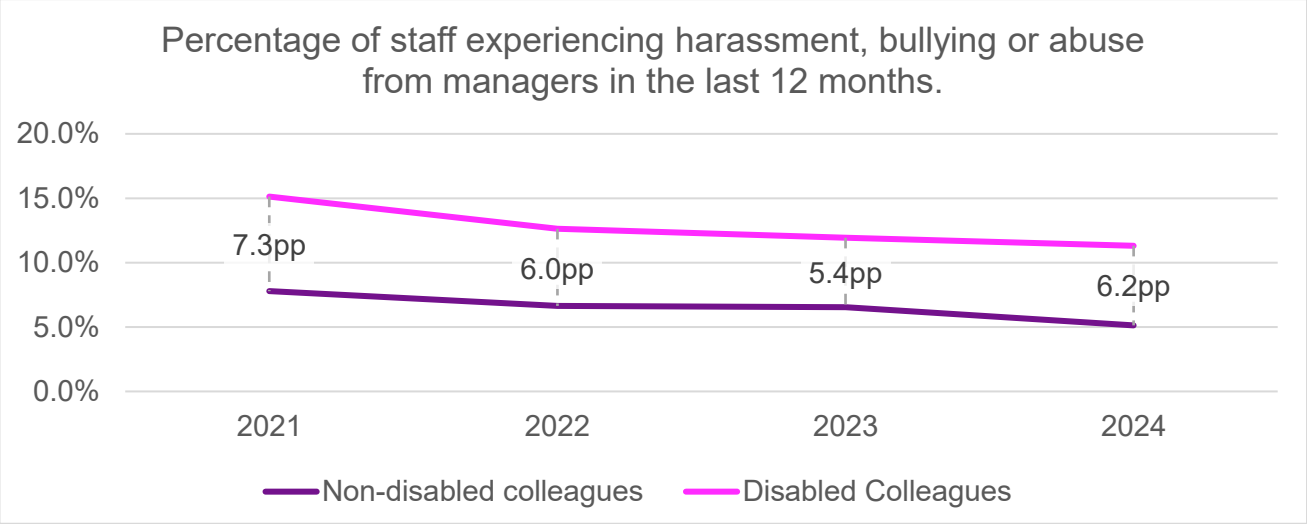
4a. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse.

The gap in experience of staff experiencing harassment, bullying or abuse from managers has slightly increased to 6.2 percentage points where disabled colleagues experience a higher rate.

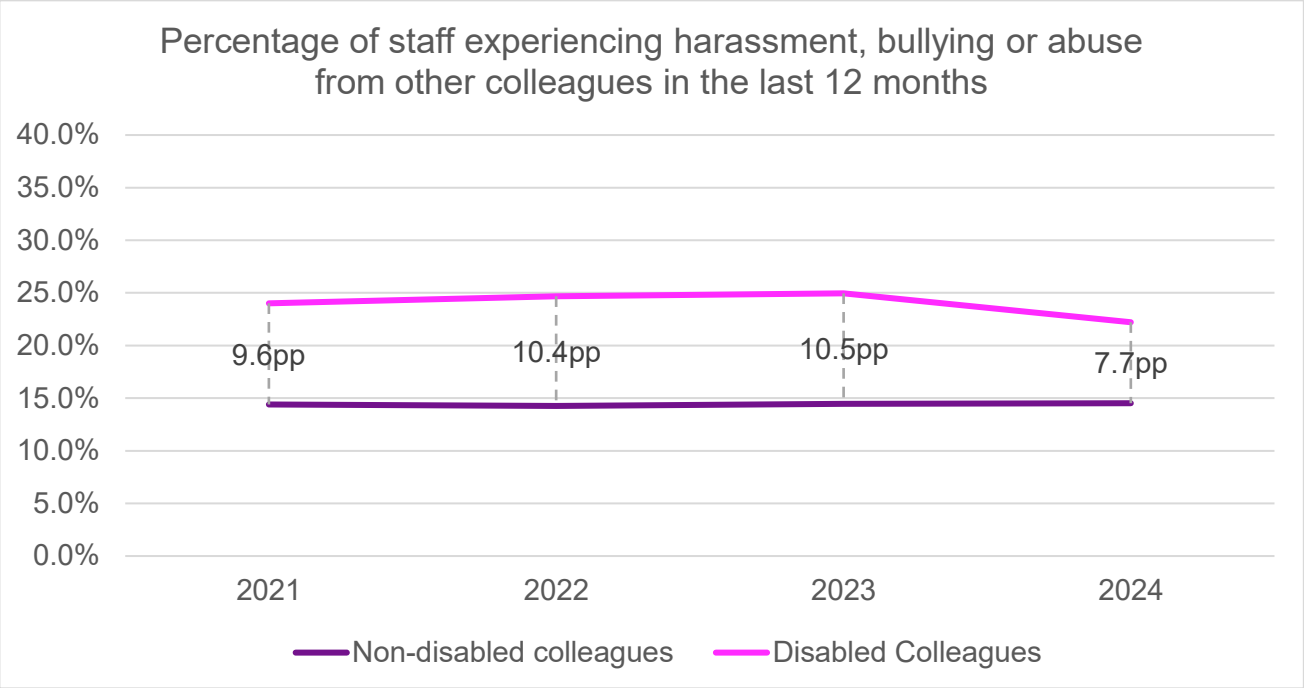
The gap in experience of staff experiencing harassment, bullying or abuse from other colleagues has reduced by 2.8 percentage points and is the lowest proportion of disabled colleagues experiencing bullying harassment and abuse from other colleagues in four years. The gap is large where disabled colleagues experience a higher rate.

The gap in experience of staff experiencing harassment, bullying or abuse from patients/service has reduced by 1.5 percentage points since 2023. However, the gap is still large where disabled colleagues experience a higher rate.

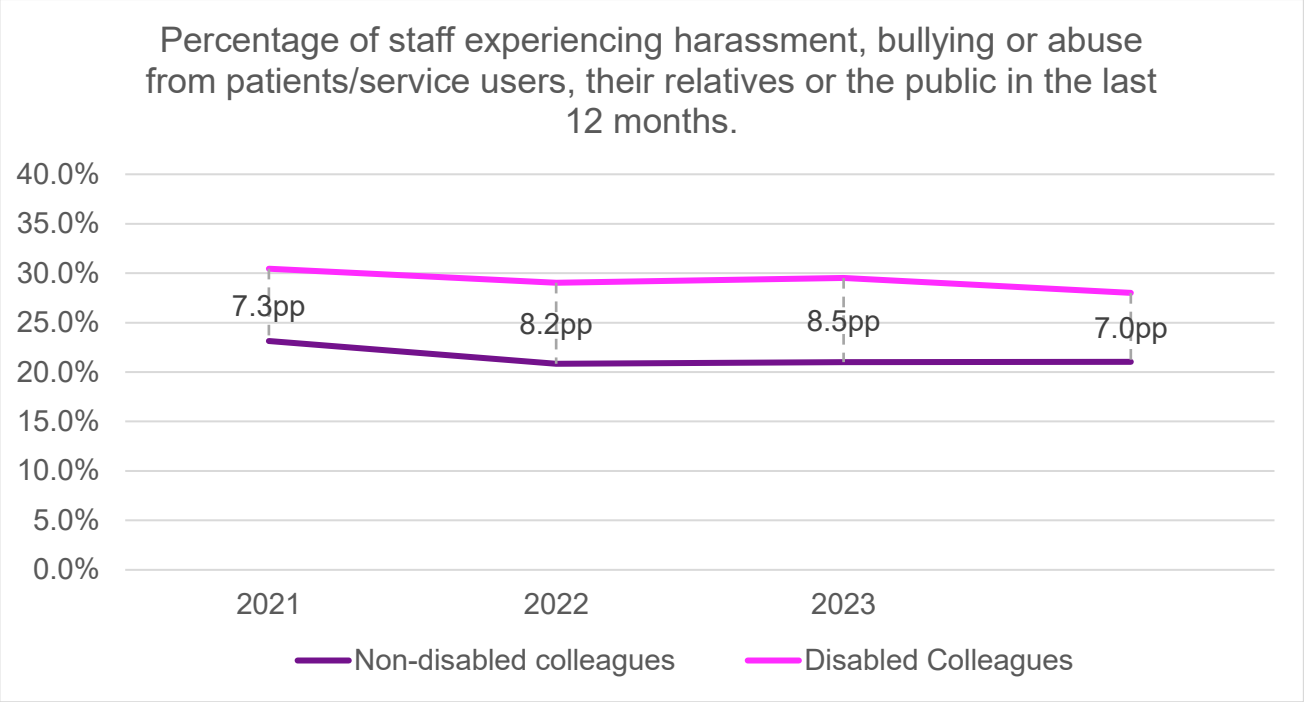
Graph 22



Graph 23



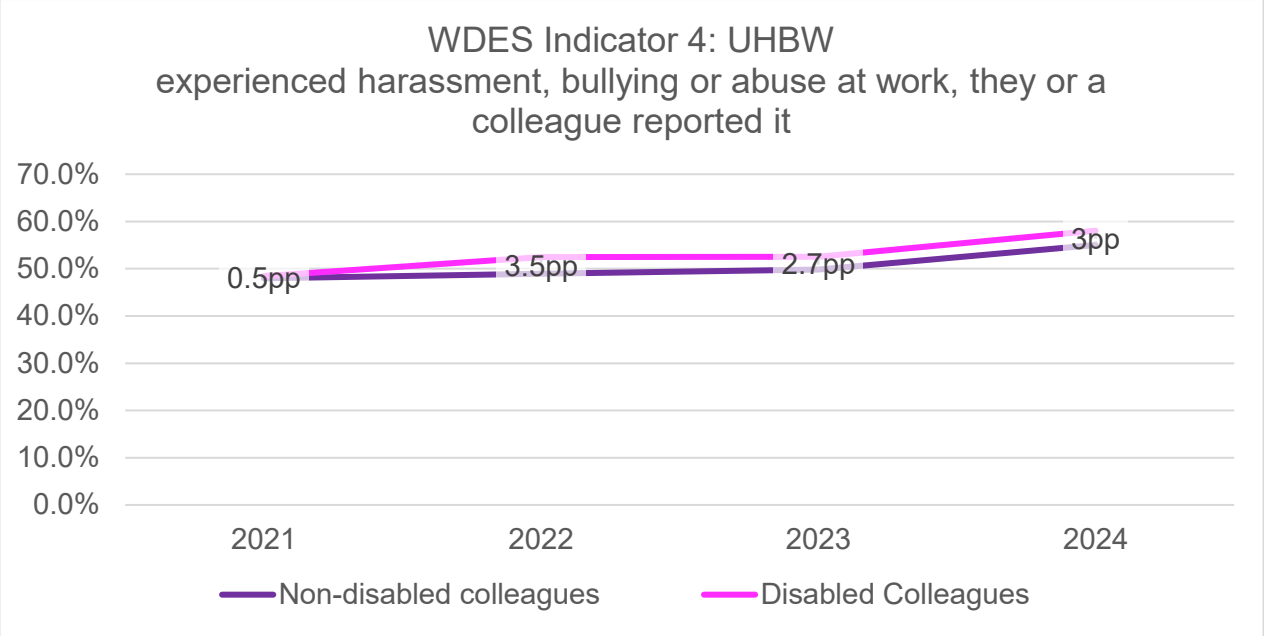
Graph 24



4b. Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

The proportion of disabled and non-disabled colleagues saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it both increased with the gap in reporting slightly reducing by 0.3 percentage points to 3 percentage points.

Graph 25

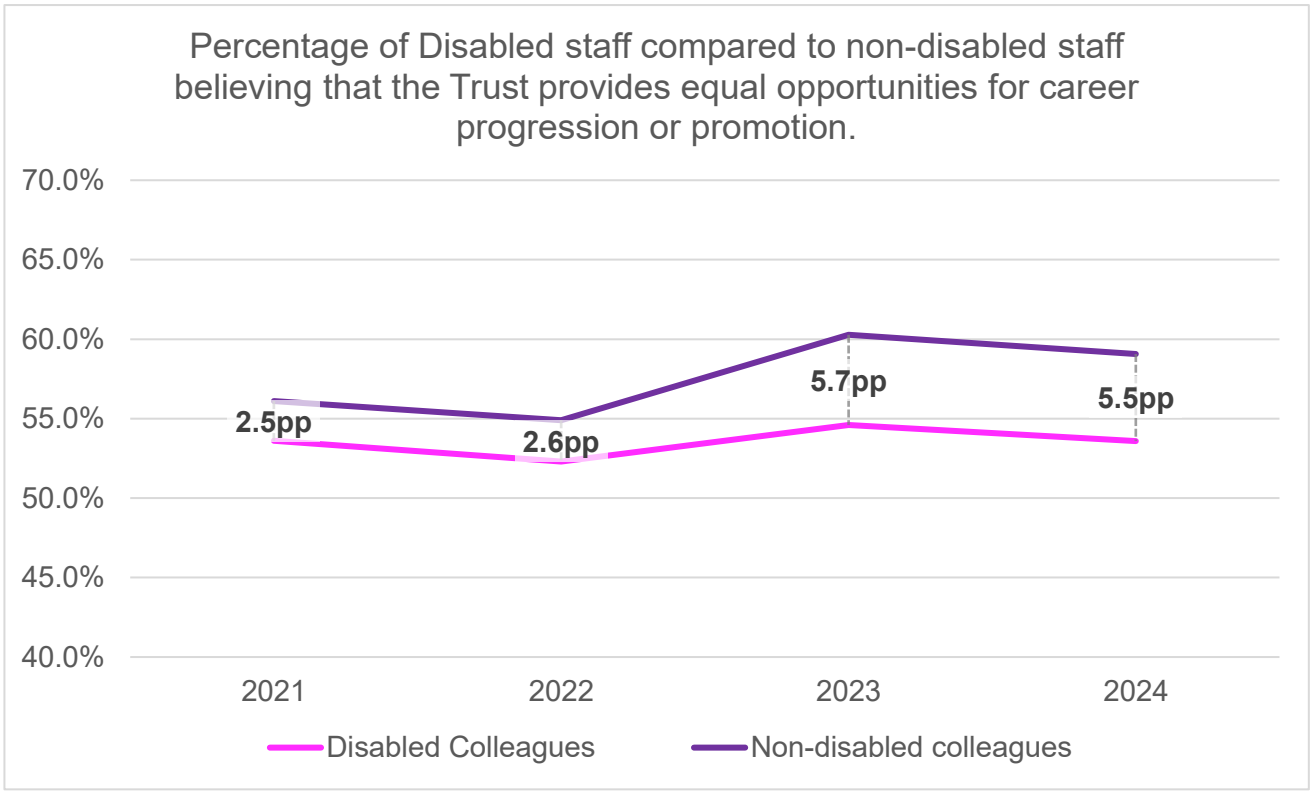


WDES Indicator 5

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

The proportion of both disabled colleagues and non-disabled colleagues believing that the Trust provides equal opportunities for career progression or promotion has decreased (which is worse than in 2023), with the gap in experience only narrowing slightly by 0.2 percentage points. The gap is still large.

Graph 26

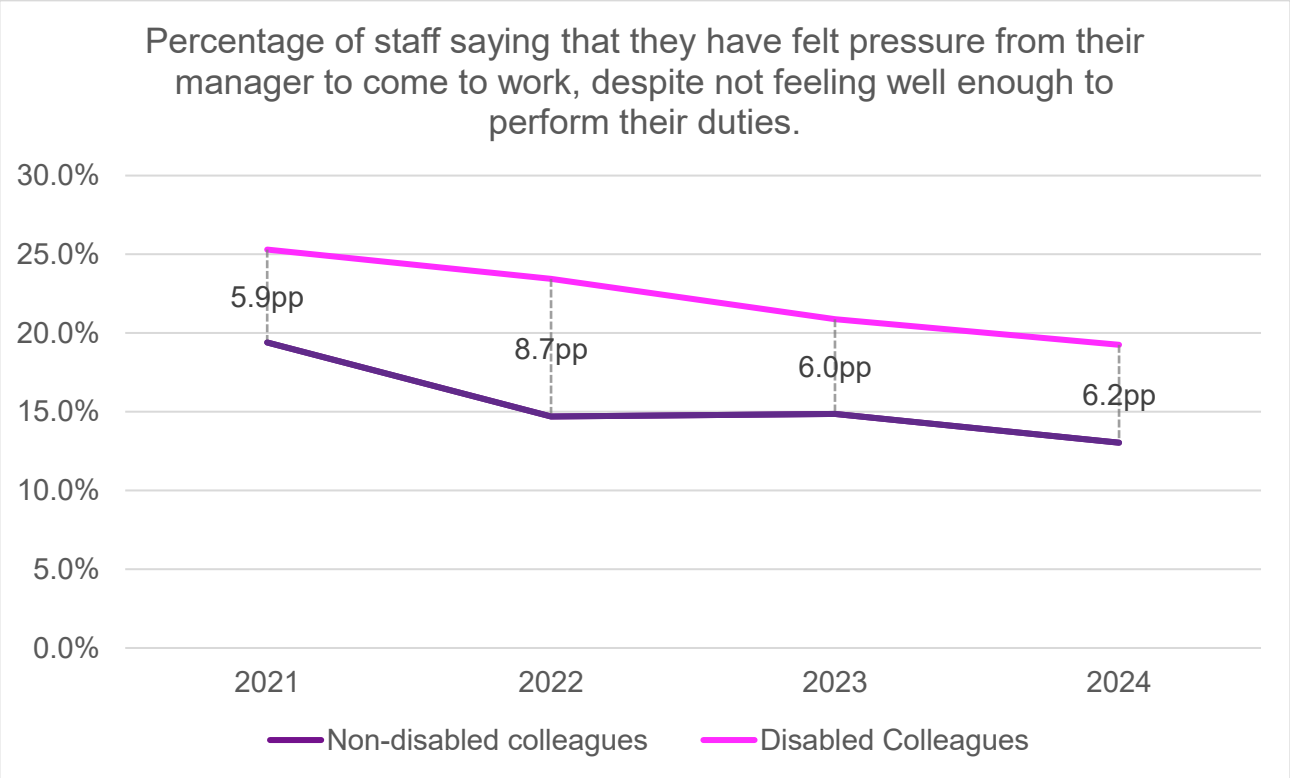


WDES Indicator 6

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

The proportion of disabled colleagues saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties, is higher than non-disabled colleagues. There is a downward trend of colleagues experiencing presenteeism but the gap from 2021 to 2024 remains roughly the same.

Graph 27

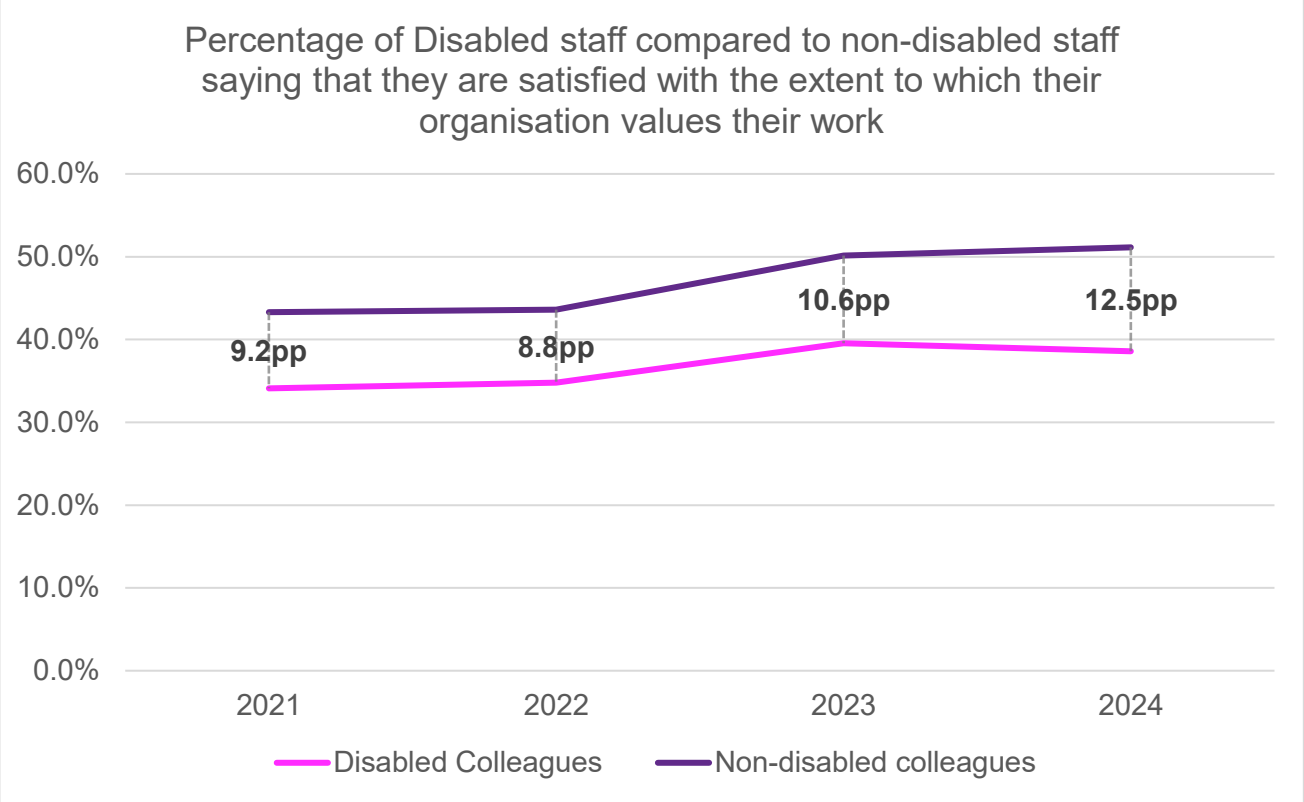


WDES Indicator 7

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

The proportion of disabled colleagues satisfied with the extent to which their organisation values their work has increased whereas the satisfaction of non-disabled staff has remained the same, widening the gap in experience for a third year in a row.

Graph 28



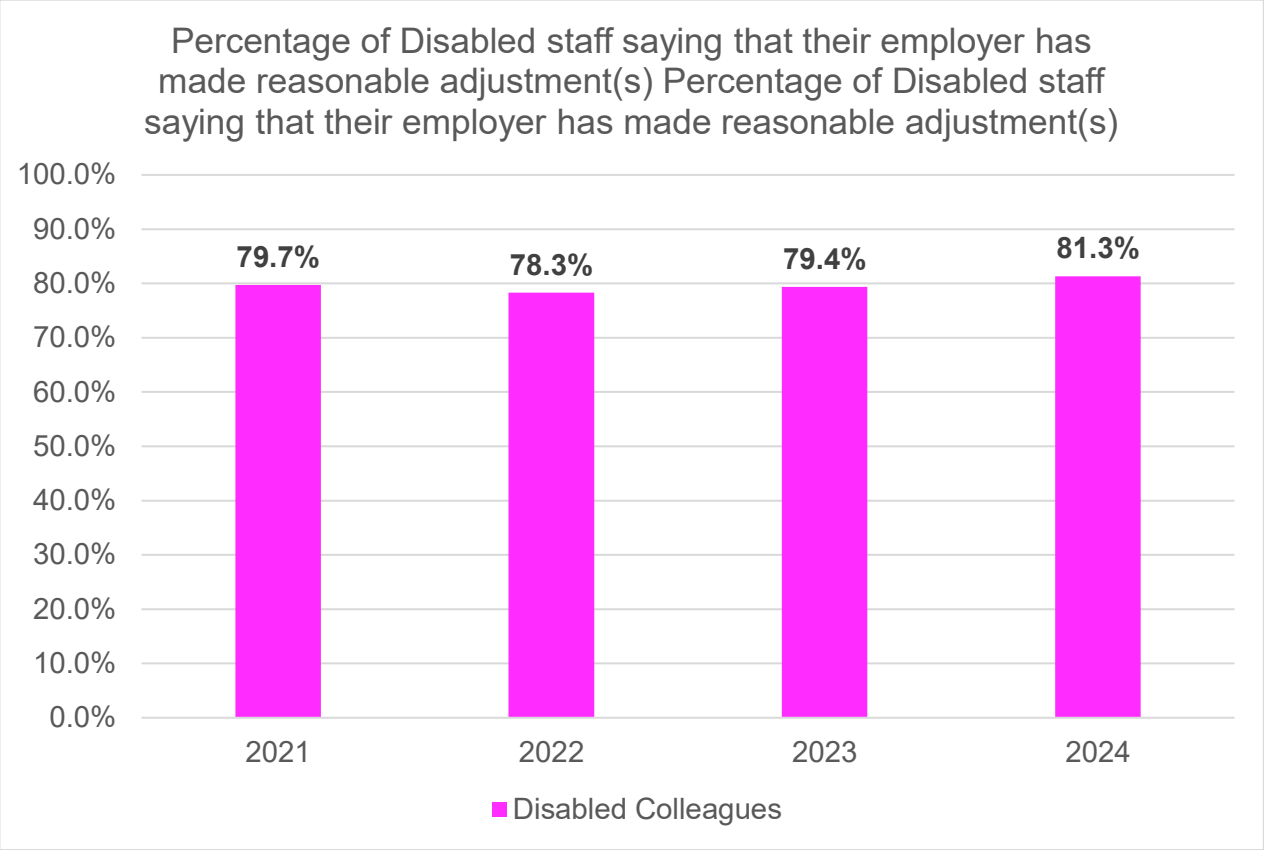
WDES Indicator 8

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

The proportion of disabled colleagues saying that their employer has made reasonable adjustment(s) to enable them to carry out their work is at the highest proportion is has been for the last 4 years, increasing by 1.9 percentage points to 81.3%. Ideally this would be closer to 100% and show a greater increase in percentage each year.

We know from the Pro-equity anti-ableism listening events that reasonable adjustments were the main priority for colleagues to improve the experience of disabled colleagues therefore it is pleasing to see an increase in this indicator.

Graph 29

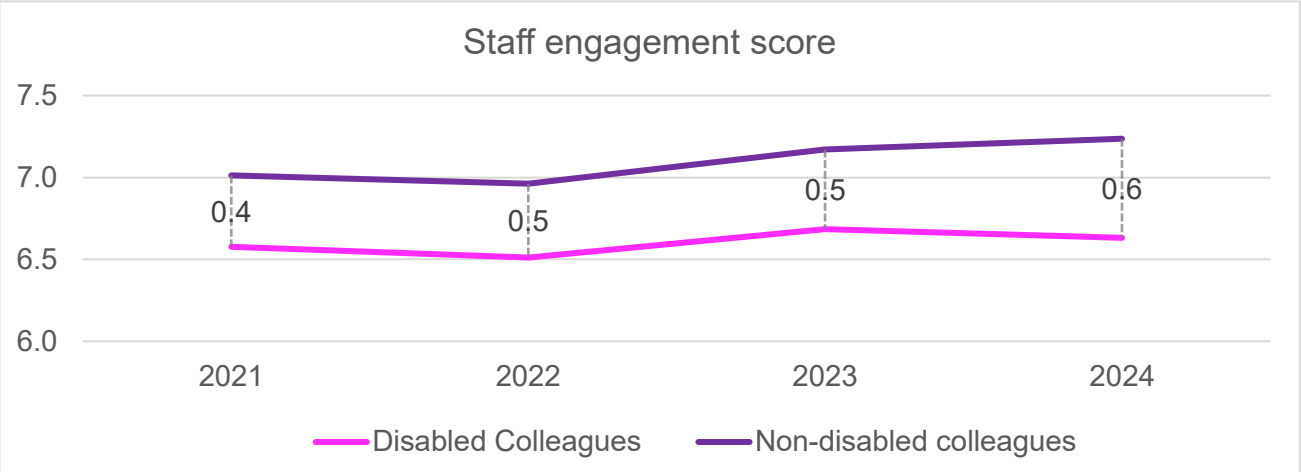


WDES Indicator 9

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

Disabled colleagues have a 0.6 lower engagement score compared to non-disabled colleagues. This gap has increased by 0.2 over 4 years from o.4 to 0.6, a gap of 0.5 or greater shows a significant gap in experience.

Graph 30



WDES Indicator 10

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated.

5.3% of the Board identified as disabled within the electronic staff record, increasing since the previous year where no Board members identified as disabled. There is a high rate of Board members where it is 'unknown' whether they are disabled either because we do not have their data or that they did not wish to disclose.

Table 11

	All Board Members		
	Disabled	Non-Disabled	Unknown
March 2022	7.7%	76.9%	15.4%
March 2023	6.3%	81.3%	12.5%
March 2024	0.0%	80.0%	20.0%
March 2025	5.3%	84.2%	10.5%

Summary

From our data in the summary report, we can see that disabled colleagues have a significantly worse experience than non-disabled colleagues, however the picture is improving year on year with:

- Six indicators being flagged as red (compared to six last year)
- Two as amber (compared to three last year)
- Three as a non-DEI priority (compared to two last year).

Changes from the 2024 Equality report


Indicator 6, focussing on presenteeism, was escalated from Amber to red.


Indicator 10, Board representation, was deescalated from red to amber.


Indicator 3, formal capability was deescalated from amber to non-priority, highlighting the success of the respecting everyone programme.

Addressing WDES areas of inequality: 2025-26 Priorities from the Pro-equity Action plan to address identified areas of concern

As mentioned in the introduction section of the report, our Pro-equity Action Plan will help us start tackling the systemic causes of discrimination in our organisation and to support our colleagues who experience any form of discriminatory behaviour whilst at work. It has been created from the experiences, ideas and feedback of colleagues across our organisation.

Below are the actions specifically linked to supporting disabled colleagues and addressing ableism in the 2025-2026 year. For further details please see either the high-level summary of the plan in appendix 2 or the detailed version available on our DEI webpage.

Quarter 1 April – June 2025

- Review the staff conduct policy so that expectations are clear for all and that it specifically talks to addressing incivility, racism, ableism, sexual safety and other forms of harassment and aligns with full hearted care and the NHS E national code of practice / Leadership and development framework.
- Design Pro-equity and trauma informed e-learning including anti-ableism module.
- Identify existing National and other related training programmes and resources to build into the Pro-equity training and resource package (e.g. active bystander / SSHINE / Suzy Lamplugh / civility saves lives).
- Share pro-equity approach to allyship and community at the joint staff network day celebration event.
- Update current induction and resources to embed pro-equity approach.

- Supporting candidates through the application and interview process. Interview themes to be provided to all shortlisted candidates. Launching training sessions for staff on best practice when applying and interviewing. Creation of bitesized videos for external candidates.
- Resourcing team Internal Training on reasonable adjustments in the recruitment process, Disability Confident Employer and enhanced candidate support.

Quarter 2 July – September 2025

- Launch Pro-equity and TI training framework.
- Design development programme and resources for facilitators to embed inclusive practice into learning interventions.
- Replicate the reporting framework relating to sexual safety to enable reporting of racism, ableism, and other forms of harassment in the workplace and launch.
- Breaking down the bias in recruitment. Pilot the creation of a bank of interview panel members from protected characteristics/pro-equity advocates. Introduce an independent panel member for internal interviews and external interviews when there is a conflict of interest. Research how to anonymise more information on application forms e.g. location of qualifications.
- Neurodiversity understanding and awareness. Provide Trust wide access to information and resources to support learners and colleagues with neurodiversity in the workplace. Design / source neurodiversity train the trainer programme for facilitators.
- Embedding reasonable adjustments into current practice: Review and refresh resources currently available and incorporate reasonable adjustment sessions and advice sessions into People Services implementation plan.

October – December 2025

- Deliver senior leadership anti-ableism development programme, using learning from the Board anti-racism development.
- Transparency in Recruitment Communications including Increase promotion of reasonable adjustments in recruitment webpage.
- Deliver building capability programme for people teams (phase 2) including: Trauma informed training for people services and HRBPs and Disability awareness training including language and the social model of disability.

January – March 2026

- Develop central L&D hub for inclusive resources for learners.
- Develop content and resources to support staff to manage conflict and difficult conversations and integrate this into existing programmes (e.g. Preceptorship and Healthcare Support worker programme).
- Recruitment quality assurance. Include questions about the Disability Confident Scheme in candidate feedback questionnaire, introduce random interview audits,

introduce random shortlisting audits and undertake thorough investigations / learning (Speak up/People team/Resourcing).

- Commitment to the community. Presence at local career events link with Job Centre Plus (Link with Education outreach work).
- Aligning career development support across the Trust. Identify career development (including talent pools) support across Resourcing, HRBPs and L&D and align, integrate and identify gaps to deliver offer to colleagues with protected characteristics.
- Create a central repository for reasonable adjustment passports.
- Resources and training for managers on how to support colleagues and resources for disabled colleagues on how to approach the conversation of reasonable adjustments and access the support they need.
- Ensure barriers to reasonable adjustments for hot desking, accessing relevant equipment and safe and supportive office environments are reduced.

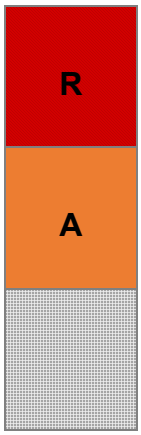
5. NHS Workforce Race Equality Standard (WRES): UHBW Report April 2023 - March 2024

Introduction

This section of the report will summarise the WRES indicators. There is a summary report for high level information, followed by a detailed breakdown of each indicator.

WRES Summary report

Key



Red: Repeat year on year increase in gap of experience or a gap of 5 percentage points or greater.

Amber: First year on year increase in gap of experience or a gap of 1.5 to 4.9 percentage points. Indicator has improved since previous year but still needs improvement. Gap reducing but action still needed.

Non-priority: Gap is smaller than 1.1 or relative likelihood ratio is between 0.9 and 1.1. Specific DEI action not needed at a Trust level but might be needed at a division level.

pp: percentage point

Global Majority: For 2025 we have shifted to using the term Global Majority to refer to colleagues who identify as Black, Asian, Multiple Heritage, GRT (Gypsy, Roma, Traveller), indigenous to the global south, and or have been racialised as 'ethnic minorities'. We have made this move as ‘ethnic minority’ and ‘ethnically minoritised’ have negative connotations and imply that colleagues not racialised as white are in the minority, which is a Eurocentric view. There are incidences where ‘BME’ is used, but this is when quoting NHS England WRES titles for reference.

WRES Measure		Performance Summary			
Measure	**Description**	**Current position**	**Position since previous year**	**Performance year on year**	**Executive Summary**
WRES Indicator 1	Percentage and number of staff in NHS Trusts by ethnicity. This includes the race disparity ratio and model employer data.	Race disparity ratio (RDR): Global majority staff have a 6.44 times greater gap between the proportion of staff at lower bands compared to upper bands than White staff.	RDR lower to upper ↓ 0.44	**A**	The Race Disparity ratio has narrowed slightly however, this is due to increased representation of ethnically minoritised colleagues at AfC bands 1-6, while representation at higher bands remains the same. To reduce this gap, we need to increase representation at higher AfC bands.
WRES Indicator 2	The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants.	White candidates are 1.90 times more likely to be appointed than Ethnically Minoritised candidates from shortlist. 20.4% of Global Majority Colleagues compared to 38.8% of white colleagues (18.4pp gap)	Relative likelihood ↓ by 0.2	**R**	The gap in the likelihood of white colleagues being appointed from shortlisting compared to ethnically minoritised colleagues remains large and constant.

WRES Measure		Performance Summary			
Measure	**Description**	**Current position**	**Position since previous year**	**Performance year on year**	**Executive Summary**
WRES Indicator 3	The relative likelihood of BME staff entering the formal disciplinary process compared to white staff	0.63% of Global Majority Colleagues enter the formal disciplinary process compared to 0.37% of white colleagues (0.26pp gap)	Relative likelihood ↑ by 0.12	**R**	Global Majority colleagues are 1.71 times more likely to enter the formal disciplinary progress than white colleagues. The gap of experience is widening year on year.
WRES Indicator 4	The relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff	76.1% of Global Majority Colleagues have accessed non-mandatory training and CPD compared to 71.1% of white colleagues (5.0pp gap)	Relative likelihood moved 0.16 closer to target of 1.0 (equal experience)		Global Majority colleagues are more likely to access non-mandatory training and CPD compared to white colleagues however the gap in experience has reduced. This could be due to the induction process of internationally recruited colleagues as well as the Bridges programme positively skewing the data.
WRES Indicator 5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.	24.8% of Global Majority Colleagues compared to 21.9% of white colleagues (2.9pp gap)	Gap ↑ by 1.4pp	**A**	The gap in experience of bullying and harassment from patients / service users, their relatives, or the public for Ethnically Minoritised Colleagues compared to White colleagues remains low, although has slightly increased since 2023.

WRES Measure		Performance Summary			
Measure	**Description**	**Current position**	**Position since previous year**	**Performance year on year**	**Executive Summary**
WRES Indicator 6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	21.3% of Global Majority Colleagues compared to 18.2% of white colleagues (3.1pp gap)	Gap ↑ by 2.3pp	**A**	The gap in experience for Global majority colleagues compared to White colleagues has increased back to the same level as in 2022. Levels overall remain high for all colleagues.
WRES Indicator 7	Percentage of staff believing that Trust provides equal opportunities for career progression or promotion	51.9% of Ethnically Minoritised Colleagues compared to 60.0% of white colleagues (8.1pp gap)	Gap ↑ by 3.9pp	**R**	The gap in experience of the percentage of staff believing that Trust provides equal opportunities for career progression or promotion for Ethnically Minoritised Colleagues compared to White colleagues has almost doubled in the year last year.
WRES Indicator 8	Percentage of staff experiencing discrimination at work from other staff in the last 12 months	12.9% of Global Majority Colleagues compared to 5.5% of white colleagues (7.4pp gap)	Gap ↑ by 1.0pp	**R**	Global Majority colleagues continue to face higher levels of discrimination at work. The gap in experience is large and consistent.
WRES Indicator 9	The representation of BME people amongst Board members	10.5% of the Board are Global Majority colleagues.	Representation ↓ by 9.5pp	**A**	The Board representation is lower than the Bristol census and reduced for the first time in three years.

WRES Indicator 1

Percentage and number of staff in NHS Trusts by ethnicity

Workforce distribution by ethnicity WRES (Taken on 31st March 2025)

WRES Indicator 1: Trust Level Summary

For non-clinical roles, only cluster 1 mirrors the Bristol 2021 census rate of 18.9% ethnically minoritised colleagues. For clinical roles, only clusters 1 and 2 mirror the Bristol census rate of 18.9% ethnically minoritised colleagues. For medical and dental roles, all are close to the Bristol census rate, with non-consultants career grade having 48.3% Ethnically Minoritised colleague representation.

When looking at model employer data, there has been an increase in the proportion of Global Majority colleagues at the following bands from 2024 to 2025:

- Band 2 and under = 4.9 percentage point increase
- Band 3 = 3.5 percentage point increase
- Band 5 = 3.1 percentage point increase
- Band 6 = 4.0 percentage point increase
- Band 7 = 1.1 percentage point increase
- Band 8a = 2.0 percentage point increase
- Band 8b = 0.6 percentage point increase
- VSM = 0.5 percentage point increase

This shows that at bands 6 and below (apart from band 4) we are seeing a year on year increase in representation at a noticeable rate however, a higher bands, although we are seeing an increase up to band 8b, this is at a slower rate. At bands 8c and Bd we have seen a year-to-year reduction in the proportion of Global Majority colleagues. There was also a significant reduction in the proportion of Global Majority colleagues at Band 4 reducing by 9.8 percentage points. We cannot say whether this is due to promotions or colleagues leaving the Trust at that band.

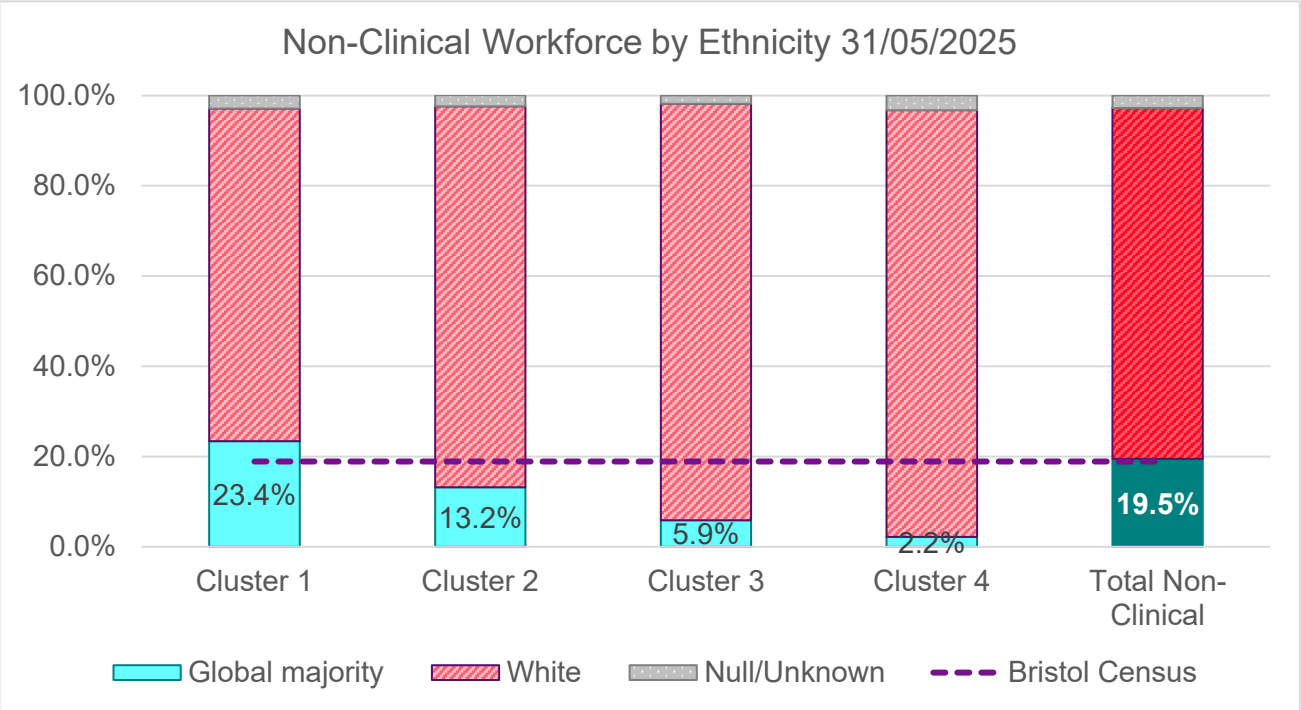
When looking ahead to the work across the Bristol NHS Group it is important to note that this position may not improve in the short to medium term due to internal recruitment practices in place due to the financial position.

Race Disparity Ratio

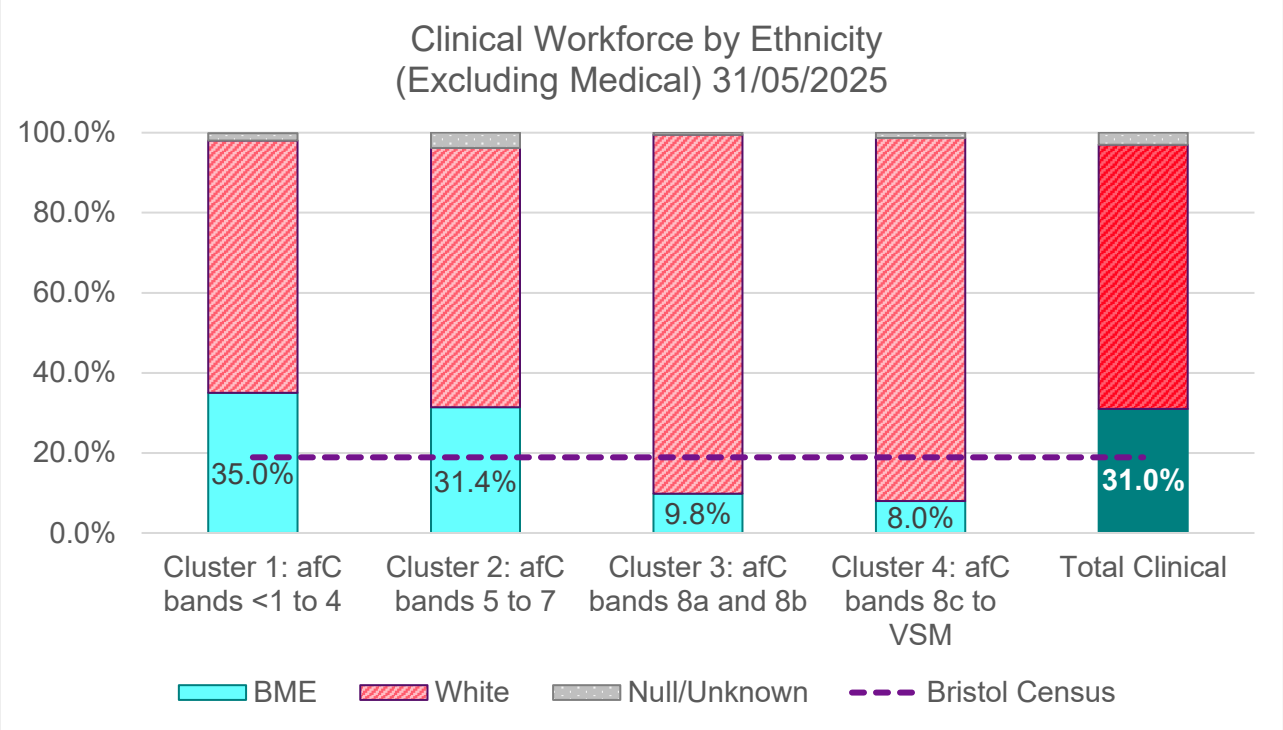
In 2025 Global Majority colleagues have a 6.44 times greater gap between the proportion of colleagues at lower bands compared to upper bands than White colleagues, which has reduced slightly since 2024. However, this is due to the increase in representation of Ethnically Minoritised colleagues in bands 6 and below, meaning we need to work on our staff pipeline to ensure these colleagues progress into higher bands.

WRES Indicator 1: Trust Level Data

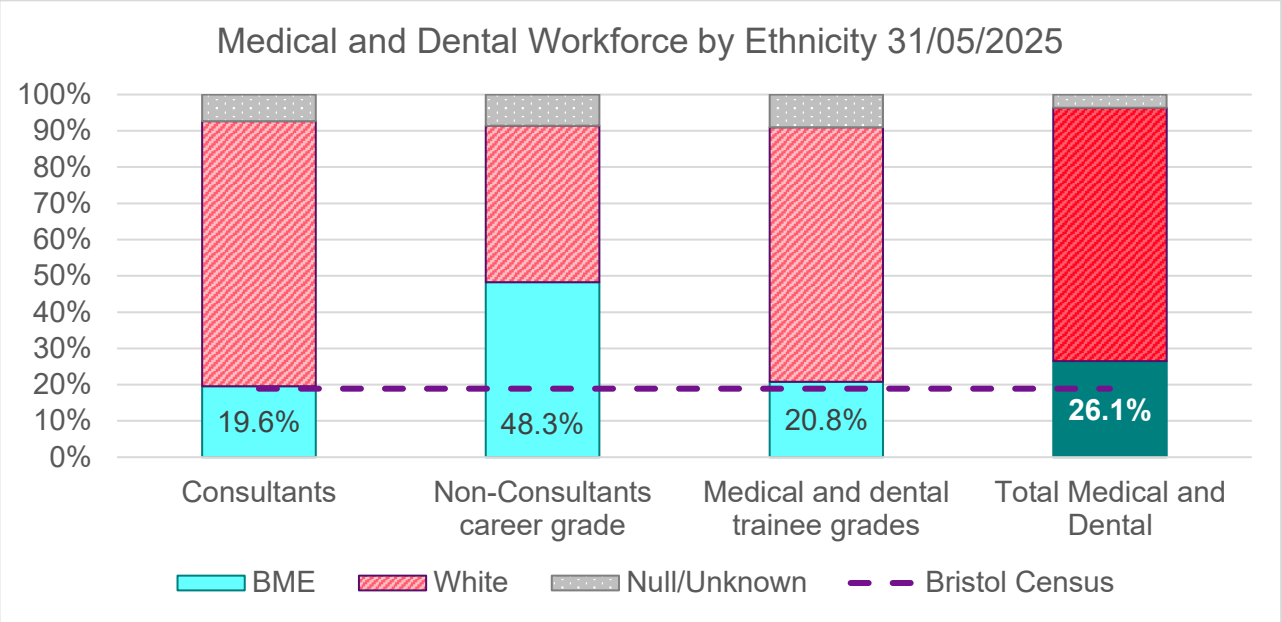
Graph 31



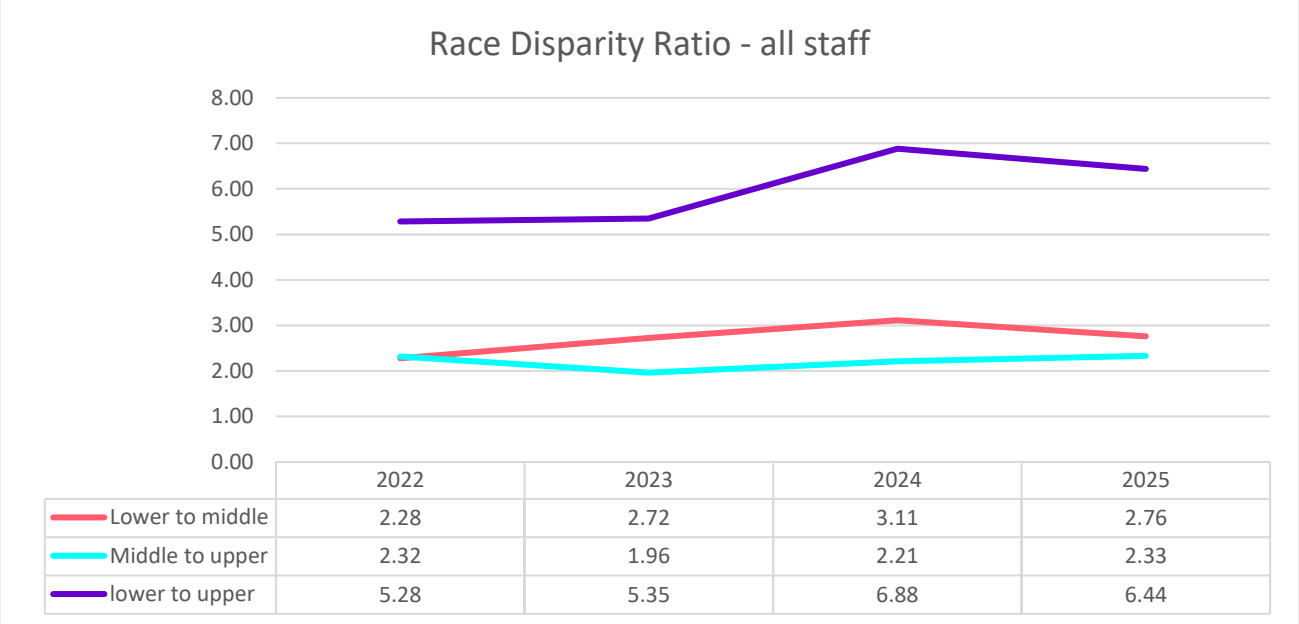
Graph 32



Graph 33

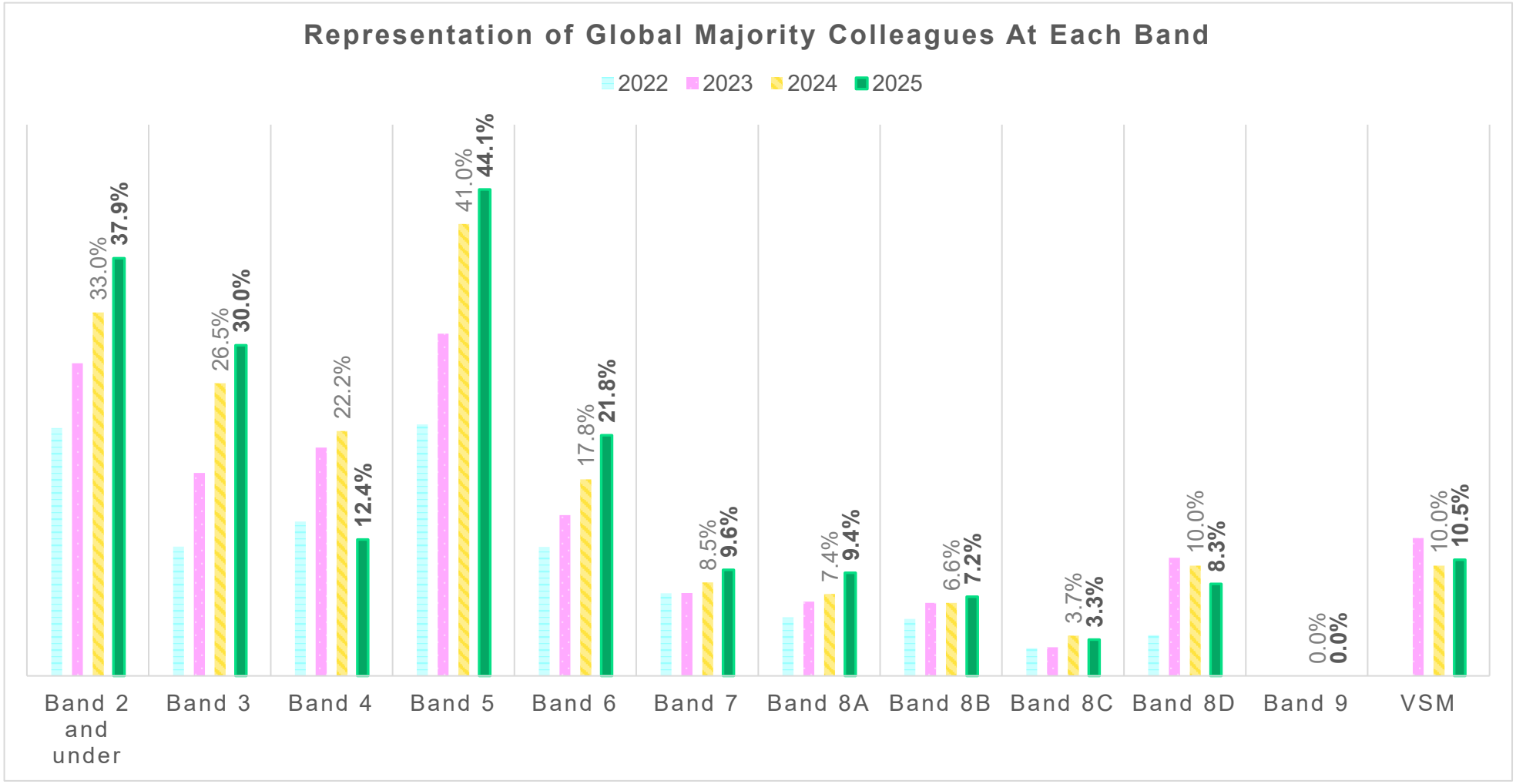


Graph 34



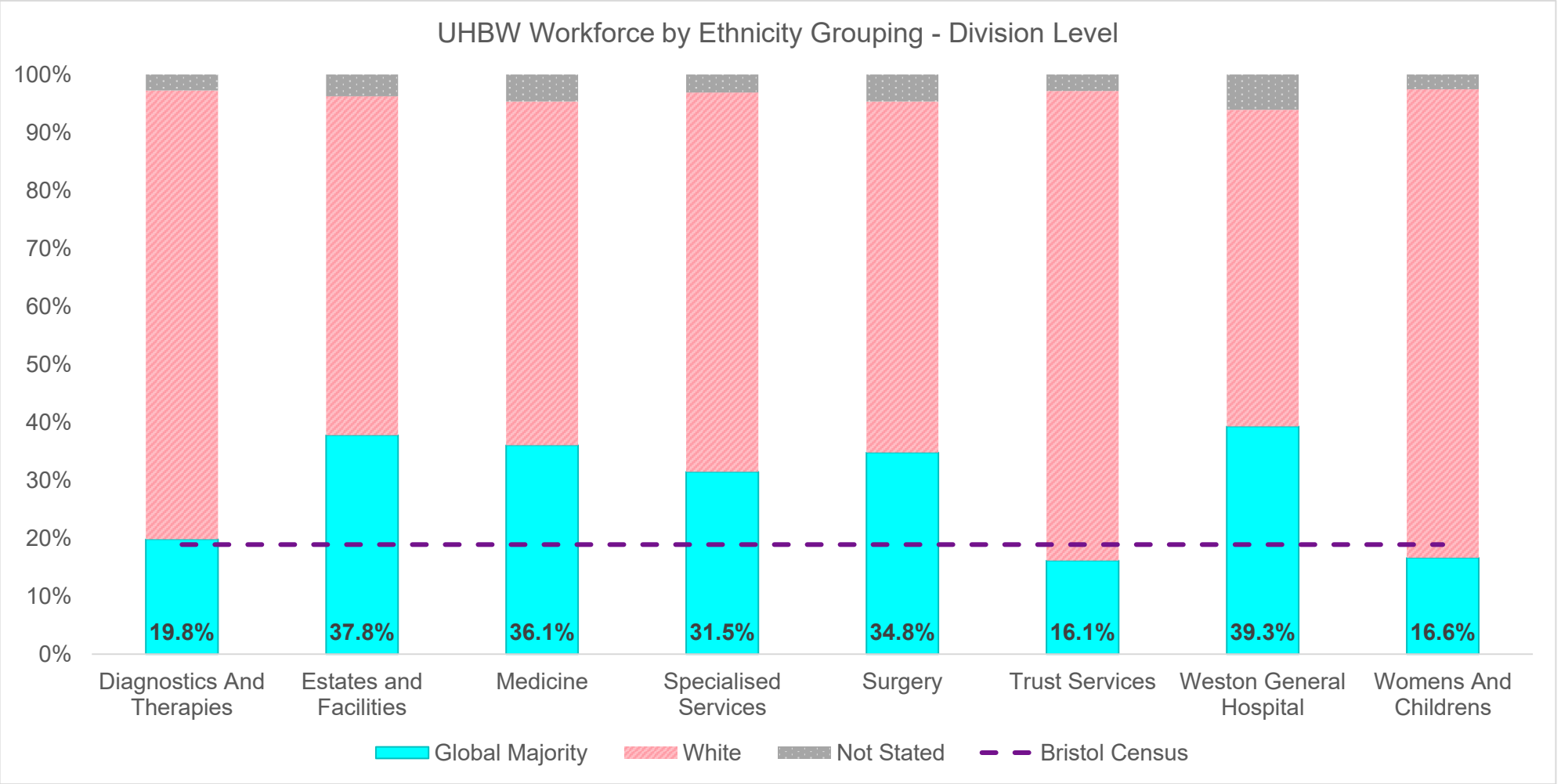
	2022	2023	2024	2025
Lower to middle	2.28	2.72	3.11	2.76
Middle to upper	2.32	1.96	2.21	2.33
lower to upper	5.28	5.35	6.88	6.44

Graph 35


Representation of Global Majority Colleagues At Each Band
2022
2023
2024
2025
33.0%
37.9%
26.5%
30.0%
22.2%
12.4%
41.0%
44.1%
17.8%
21.8%
8.5%
9.6%
7.4%
9.4%
6.6%
7.2%
3.7%
3.3%
10.0%
8.3%
0.0%
0.0%
10.0%
10.5%
Band 2 and under
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8A
Band 8B
Band 8C
Band 8D
Band 9
VSM

WRES Indicator 1: Division Level Data

Graph 36



2021 census: Bristol 18.9% Global Majority population, Weston Super Mare 5.3% Global Majority population.

WRES Indicator 2

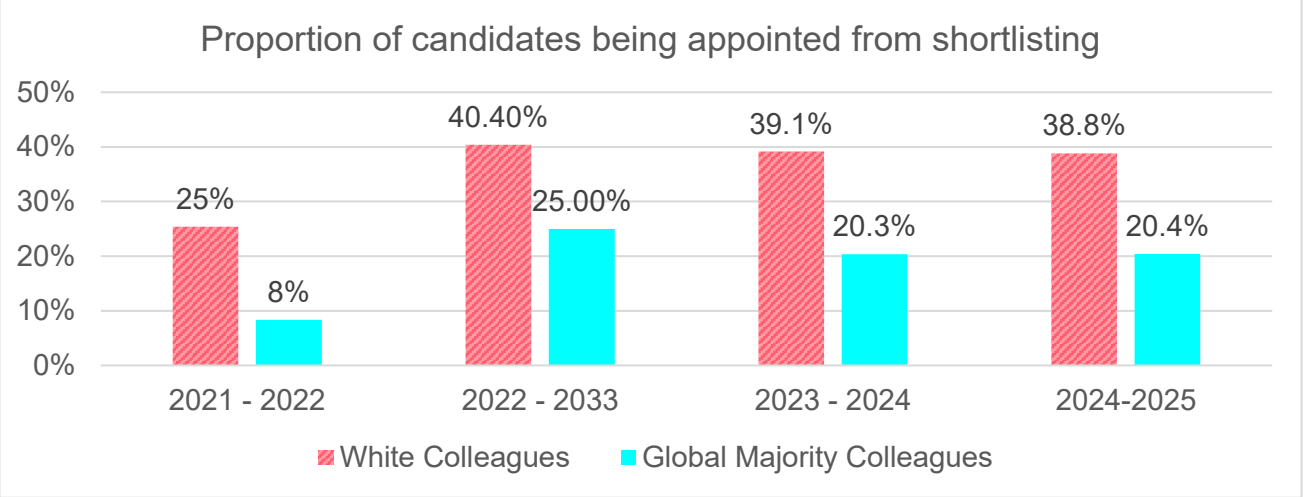
The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants.

There is still a large gap between the proportion of Minority Ethnic Colleagues being appointed from shortlisting compared to White colleagues.

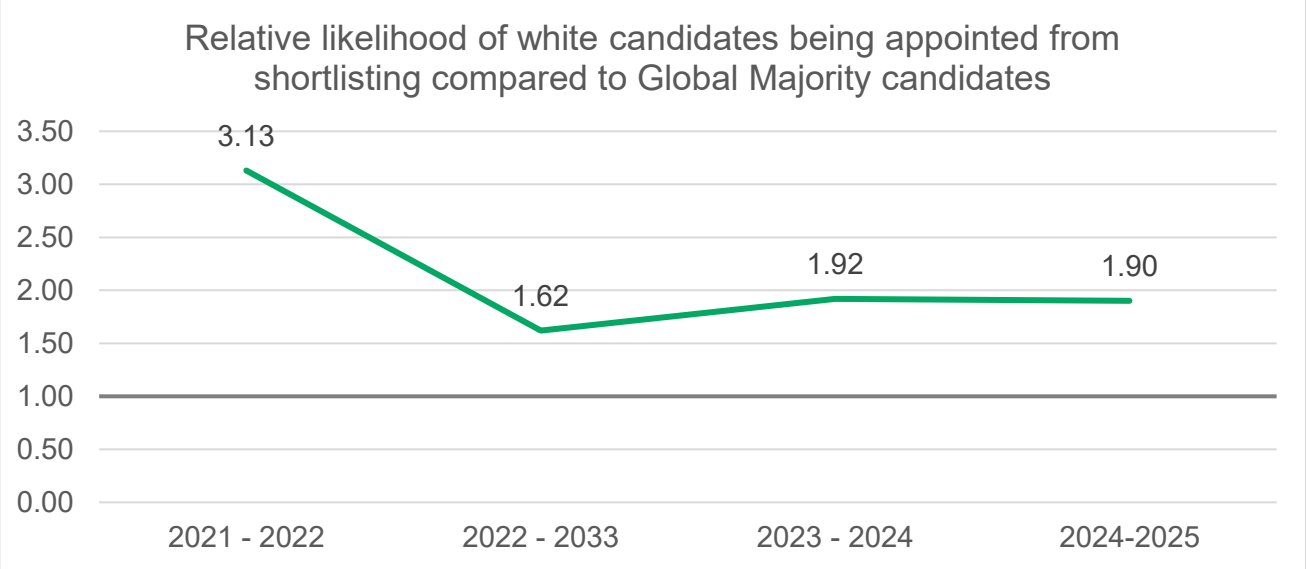
The relative likelihood of white candidates being appointed from shortlisting compared to Ethnically Minoritised candidates has remained roughly the same from 2023 – 2024 (1.92) to 2024-2025 (1.90). Both the proportion how white candidates being appointed form shortlist and global majority candidates being appointed form shortlist also remains the same.

In the WRES summary at the end of this section you will see the extensive planned action around recruitment to address our inequalities.

Graph 37



Graph 38



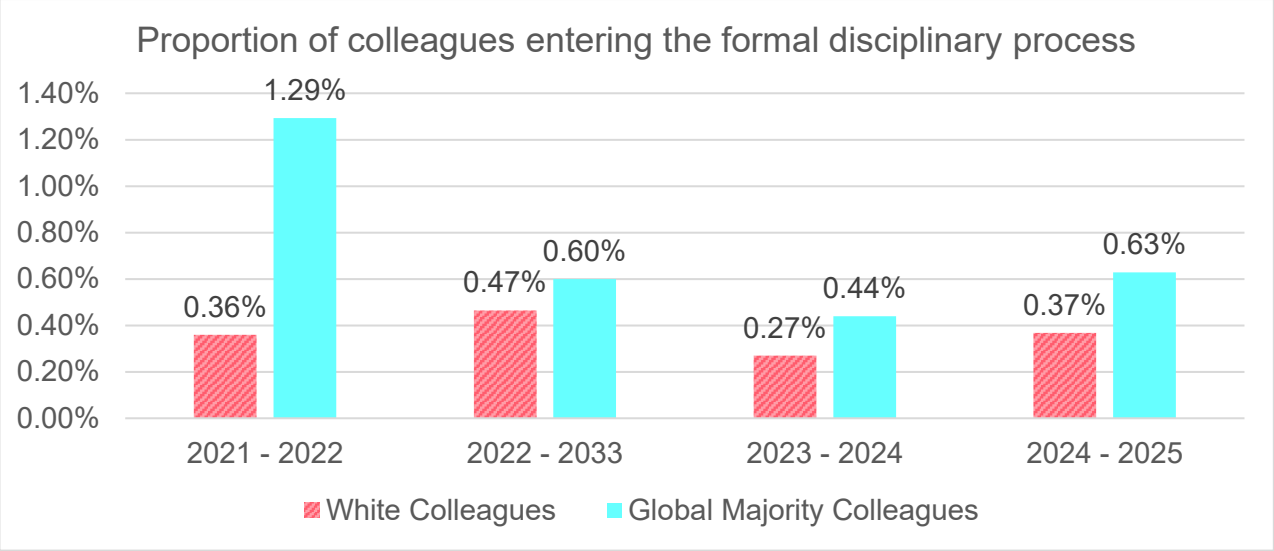
WRES Indicator 3

The relative likelihood of BME staff entering the formal disciplinary process compared to white staff.

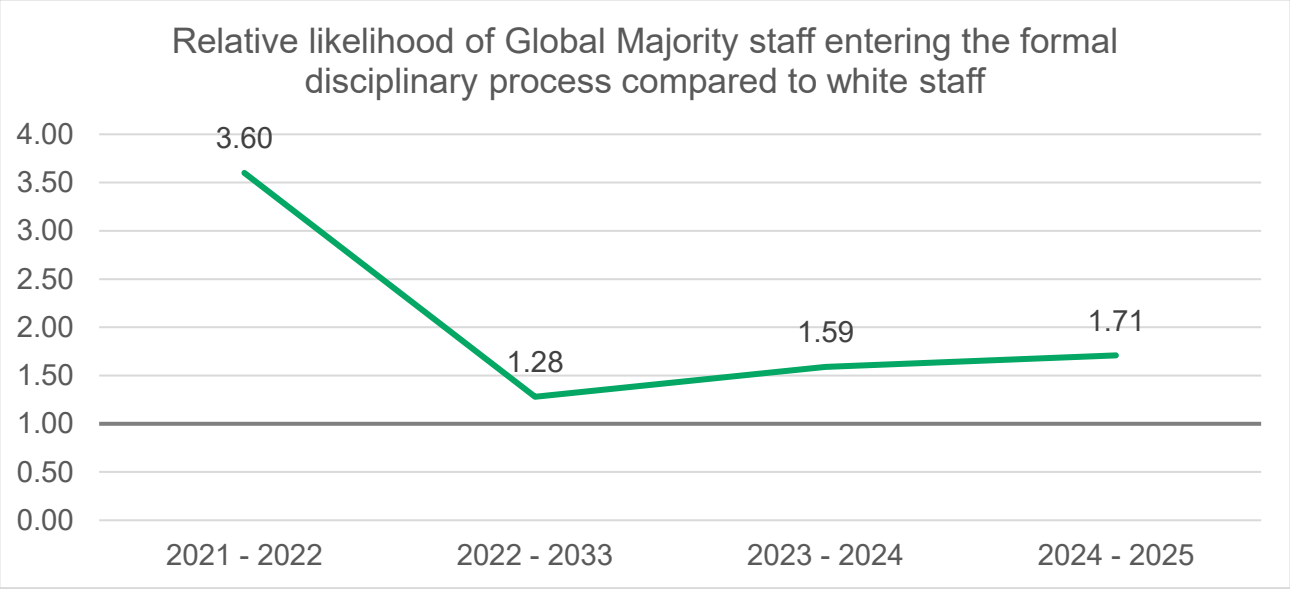
The proportion of both White and Global Majority colleagues entering the formal disciplinary process has increased since 2023-2024, and the gap in experience has widened again, with the relative likelihood of Global Majority colleagues entering the formal disciplinary process being 1.71 times more likely than white colleagues (graph 39).

A value of 1.0 would mean an equal proportion of Global Majority colleagues went through the formal disciplinary process compared to white colleagues. A value above 1.00 would indicate that Global Majority colleagues are more likely than White colleagues to enter the formal disciplinary process.

Graph 39



Graph 40



A positive action approach is being developed to reduce the likelihood of formal disciplinary action and exclusions between white colleagues compared to global majority colleagues across UHBW. This approach will focus on highlighting particular exploratory questions and considerations during the decision-making process for global majority colleagues to try and reduce the likelihood of these colleagues being disproportionately impacted. This work is being developed as part of our Pro-equity action planning and will be launched into the Respecting Everyone resources and guidance.

The Pro-equity Action Plan that will complete this work has now commenced and a new Case Assessment and Decision-Making Process for Global Majority colleagues is being drafted, this is due to be launched in summer 2025. The aim of this work is to bring UHBW's likelihood down to the NHS England target of between 0.8 and 1.25.

WRES Indicator 4

The relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff.

Global Majority colleagues are more likely to access non-mandatory training and CPD than White colleagues (table 17) however, the gap in experience has reduced with white colleagues being 0.94 times as likely to access non-mandatory training compared to global majority colleagues compared to in 2023-2024 when it was 0.78 times as likely.

This could be due to the end of the international colleague recruitment campaign. In the 2024 Equality Report we noted that this was skewing the data, as the induction process counted as non-mandatory training. This data moving forward more accurately reflects the experiences of colleagues.

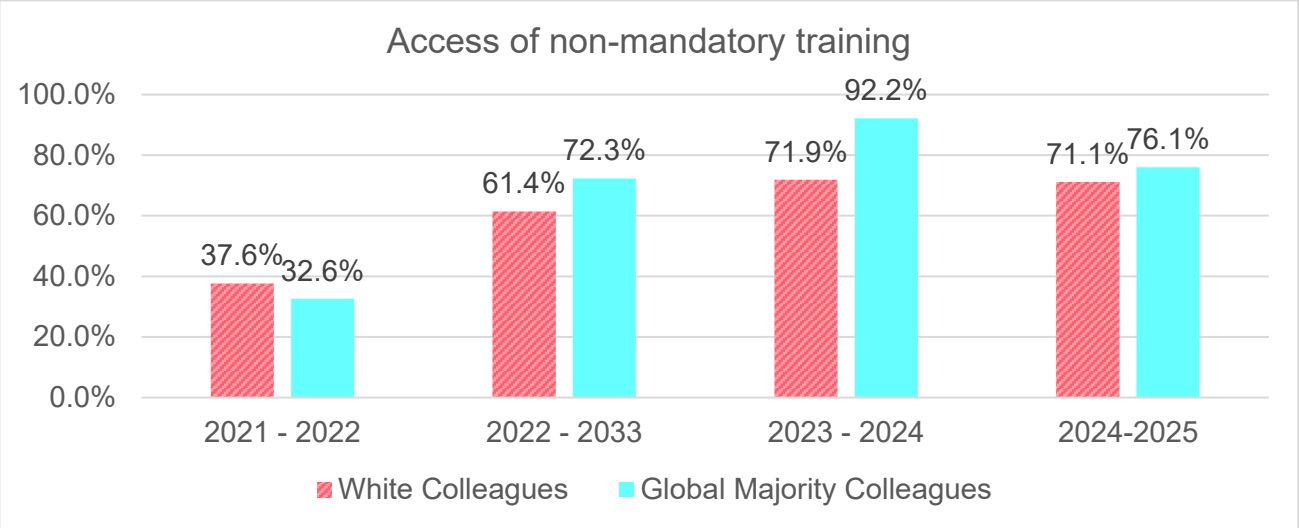
The Trust's positive action programme Bridges might also contribute the gap in experience. The Bridges Talent Management Programme is a Nationally recognised programme which has been created for colleagues working at Bands 1-5, who identify as Black, Asian, Multiple Heritage, GRT (Gypsy, Roma, Traveller), or other Global Majority racially minoritised colleagues.

- The ambition of the Bridges Programme is to work with participants to build their expertise, knowledge, skills and confidence to create equal opportunities for progression.
- Bridges is a positive action programme to support increasing representation of global majority colleagues at bands 6 and above.
- Bridges is featured within the National EDI Repository as an example of best practice for High Impact Action 2: Overhaul recruitment processes and embed talent management processes.

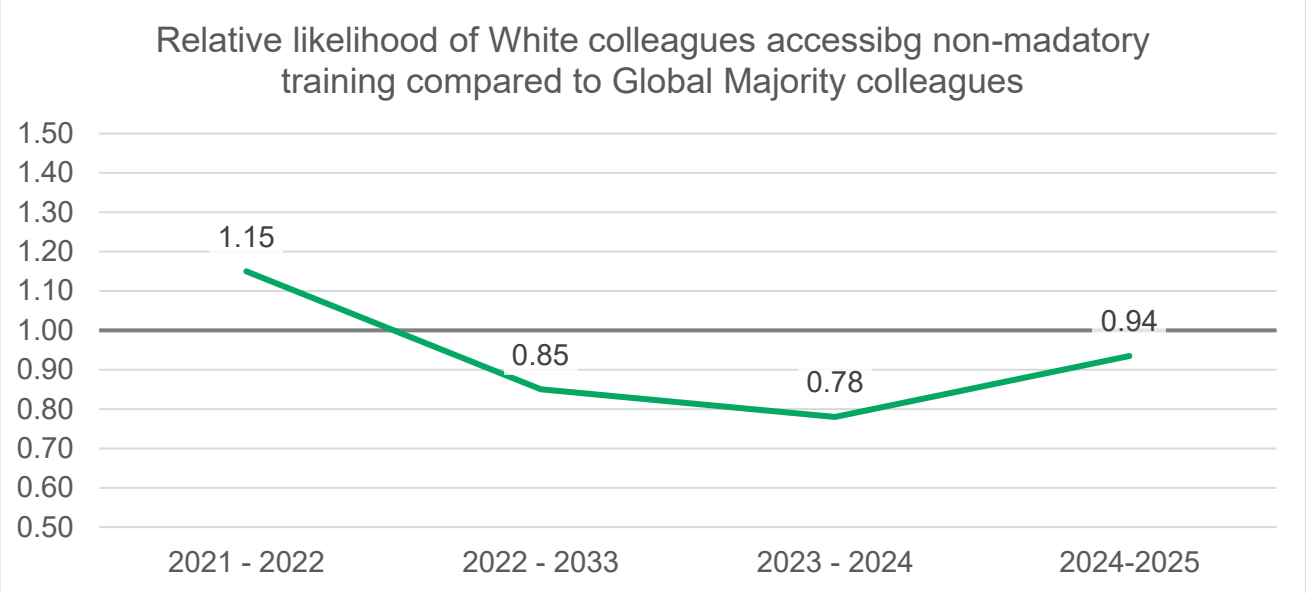
Outcomes of Bridges so far

- On cohort 6 of the programme, recruiting for cohort 7.
- 46 learners have completed the programme.
- 16 Bridges Graduates have been successful in career progression.
- 3 graduates have been accepted onto Nursing Degree Apprenticeships.

Graph 41



Graph 42



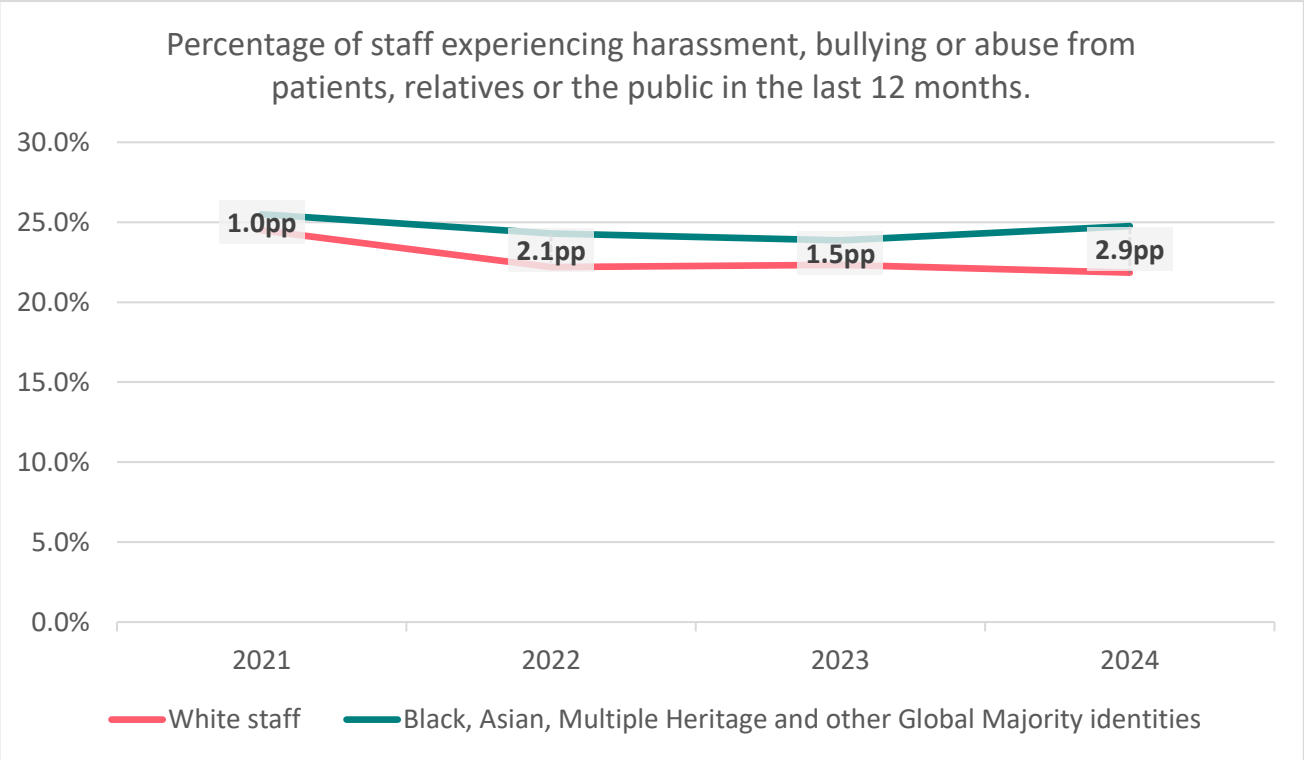
A figure above 1.00 would indicate that White colleagues are more likely than global majority colleagues to access non-mandatory training and CPD. A figure below 1.00 would indicate that Global Majority are more likely than White colleagues to access non-mandatory training and CPD.

WRES Indicator 5

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

The gap in experience of bullying and harassment from patients / service users, their relatives, or the public for Ethnically Minoritised Colleagues compared to White colleagues remains low but has slightly increased by 1.4 percentage points from 1.5 percentage points in 2023 to 2.9 percentage points in 2024.

Graph 43

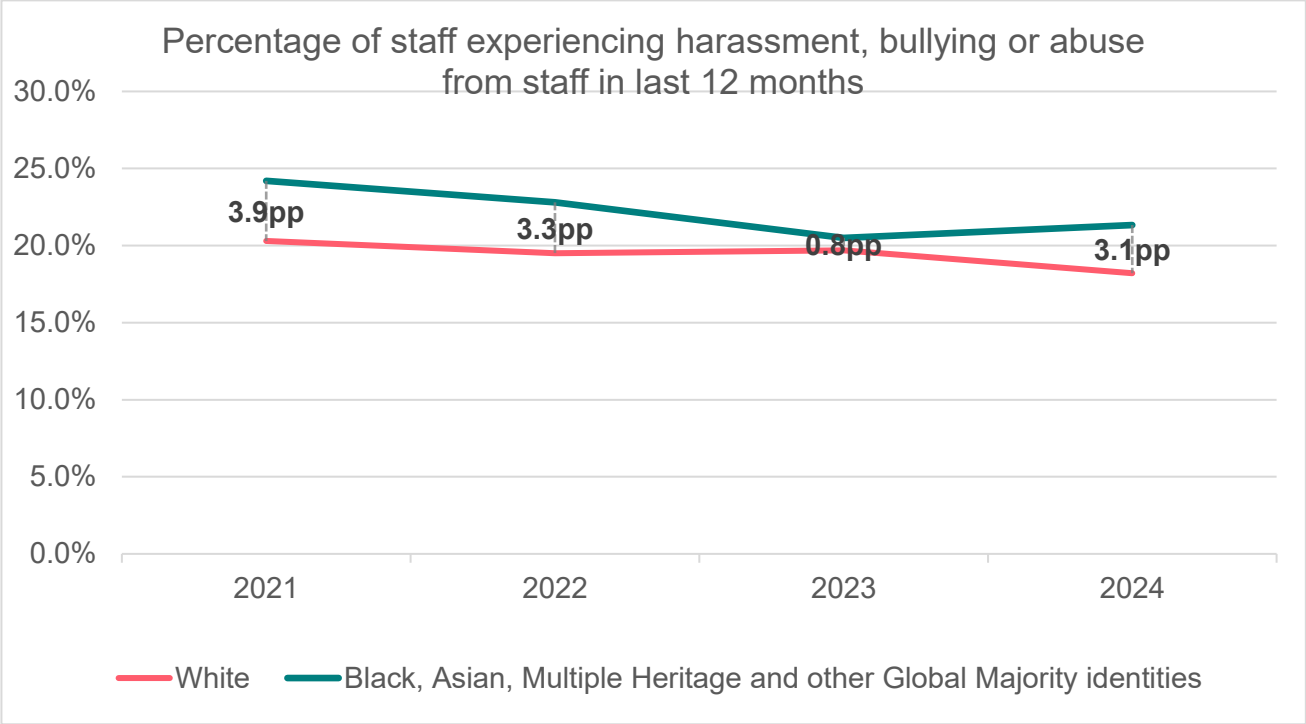


WRES Indicator 6

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

The gap in experience of Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months for Ethnically Minoritised Colleagues compared to White colleagues has increased to 3.1 percentage points. This is because even though the experiences of colleagues racialised as White improved, the experiences of Global Majority colleagues got worse.

Graph 44



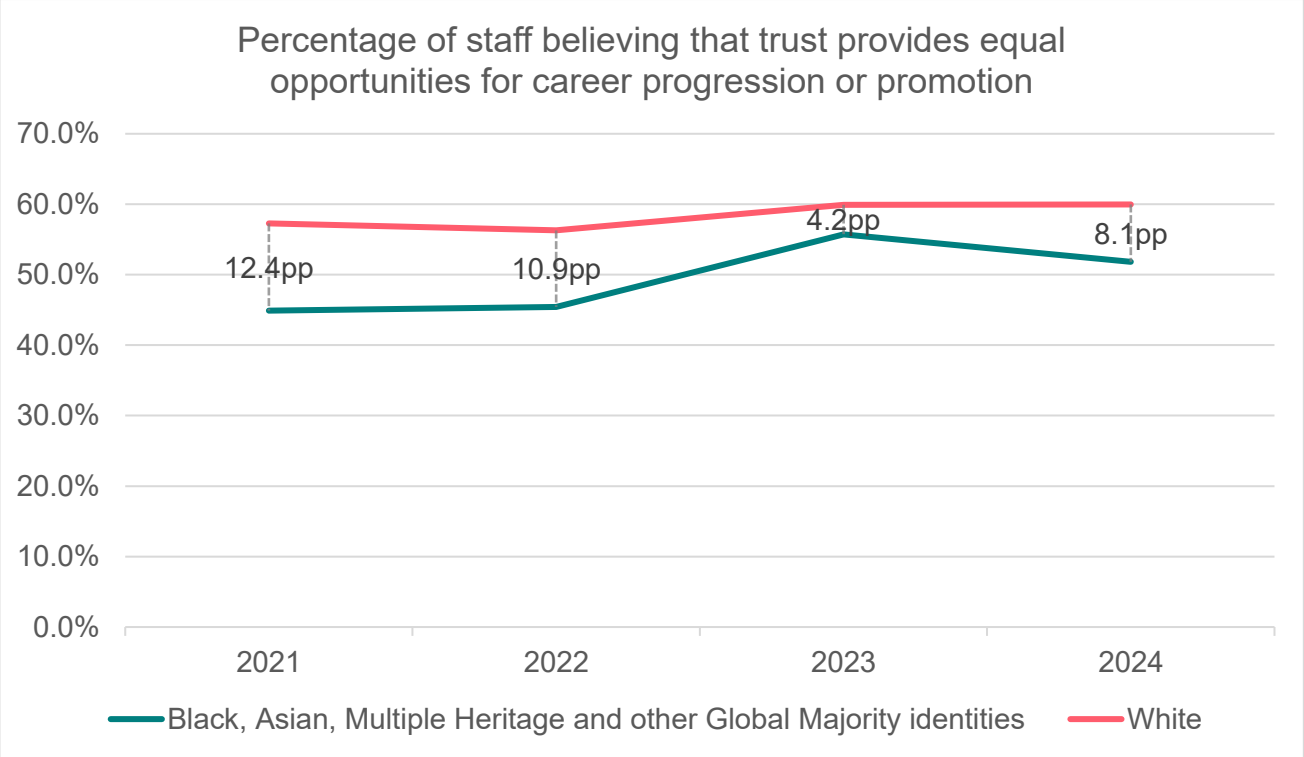
WRES Indicator 7

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

The gap in experience of the percentage of staff believing that Trust provides equal opportunities for career progression or promotion for Ethnically Minoritised Colleagues compared to White colleagues has almost doubled in the year last year (4.2 percentage points in 2023 and 8.1 percentage points in 2024). However, the gap is still lower than two years ago.

Overall, the proportion of Ethnically Minoritised colleagues who feel they have been provided with equal opportunities for career progression has decreased to 51.9%, this is still only slightly more than half of colleagues.

Graph 45



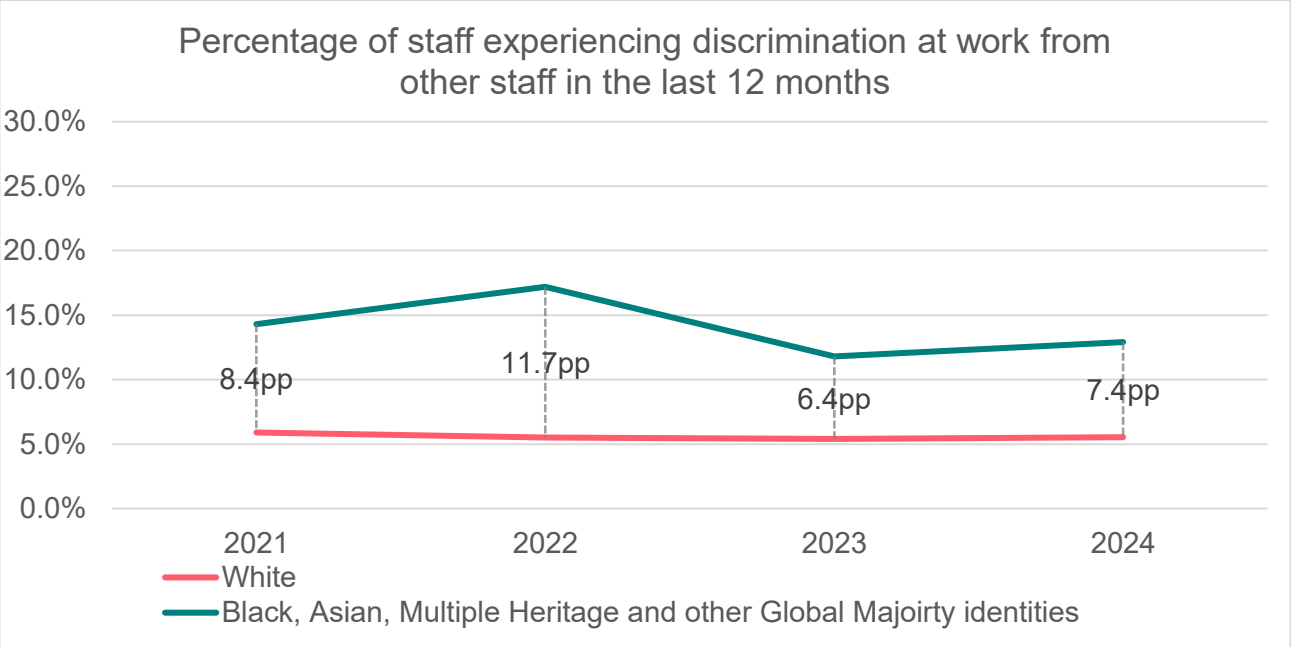
WRES Indicator 8

Percentage of staff experiencing discrimination at work from other staff in the last 12 months

The gap in experience of the percentage of staff experiencing discrimination at work from other staff in the last 12 months for Ethnically Minoritised Colleagues compared to White colleagues has slightly increased by 1.0 percentage points to 7.4 percentage points.

Overall, the proportion of Ethnically Minoritised colleagues who experienced discrimination at work from other staff has increased to 12.9%.

Graph 46



WRES Indicator 9

The representation of BME people amongst Board members

The representation of Global Majority colleagues amongst Board members has reduced for the first time in three years to 10.5%. However, it is important to note due to low numbers of colleagues on the Board, a small change within a role can have a large impact on the demographics. It is also important to note that representation does not necessarily equate to inclusive practices or diversity of thought.

Table 12

	All Board Members		
	White	Global Majority	Unknown
March 2022	100.0%	0.0%	0.0%
March 2023	87.5%	12.5%	0.0%
March 2024	80.0%	20.0%	0.0%
March 2025	84.2%	10.5%	5.3%

Summary

From our data in the summary report, we can see that global majority colleagues have a significantly worse experience than colleagues racialised as White, with:

- Four indicators being flagged as red (compared to two last year)
- Four as amber (compared to three last year)
- One as a non-EDI priority (compared to four last year).

Changes from the 2024 Equality report

☹ Indicator 5, focussing on harassment, bullying or abuse from patients, relatives or the public was escalated from non-priority to amber.

☹ Indicator 6, focussing harassment, bullying or abuse from staff was escalated from non-priority to amber.

☹ Indicator 7 focussing on career progression or promotion was escalated from amber to red.

☹ Indicator 8 focussing on discrimination at work was escalated from amber to red.

☹ Indicator 9 focussing on Board representation was escalated from non-priority to amber.

As part of our Trauma Informed approach, we focussed on raising awareness of racism in 2024-25 through the listening events and anti-racism community commitment. We would therefore expect to see an increased reporting and anticipate our plan will start to see the picture changing in the future.

Addressing WRES areas of inequality: 2025-26 Priorities from the Pro-equity Action plan to address identified areas of concern

As mentioned in the introduction section of the report, our Pro-equity Action Plan will help us start tackling the systemic causes of discrimination in our organisation and to support our colleagues who experience any form of discriminatory behaviour whilst at work. It has been created from the experiences, ideas and feedback of colleagues across our organisation.

Below are the actions specifically linked to supporting global majority colleagues and addressing racism in the 2025-2026 year. For further details please see either the high-level summary of the plan in appendix 2 or the detailed version available on our DEI webpage.

Quarter 1 April – June 2025

- Review the staff conduct policy so that expectations are clear for all and that it specifically talks to addressing incivility, racism, ableism, sexual safety and other forms of harassment and aligns with full hearted care and the NHS E national code of practice / Leadership and development framework.
- Undertake NHSE ITP anti-racism train the trainer programme to design UHBW anti-racism training module.
- Design Pro-equity and trauma informed e-learning including anti-racism module.
- Identify existing National and other related training programmes and resources to build into the Pro-equity training and resource package (e.g. active bystander / SSHINE / Suzy Lamplugh / civility saves lives).
- Share pro-equity approach to allyship and community at the joint staff network day celebration event.
- Update current induction and resources to embed pro-equity approach.
- Supporting candidates through the application and interview process. Interview themes to be provided to all shortlisted candidates. Launching training sessions for staff on best practice when applying and interviewing. Creation of bitesized videos for external candidates.

Quarter 2 July – September 2025

- Launch Pro-equity and TI training framework.
- Design and launch UHBW Anti-racism training.

- Design development programme and resources for facilitators to embed inclusive practice into learning interventions.
- Replicate the reporting framework relating to sexual safety to enable reporting of racism, ableism, and other forms of harassment in the workplace and launch.
- Breaking down the bias in recruitment. Pilot the creation of a bank of interview panel members from protected characteristics/pro-equity advocates. Introduce an independent panel member for internal interviews and external interviews when there is a conflict of interest. Research how to anonymise more information on application forms e.g. location of qualifications.
- Building the Pro-equity knowledge, skills and confidence of the people teams. Including Trauma informed training for people services and HRBPs and identifying and escalating poor decision making relating to cases of racism or other types of discrimination.

October – December 2025

- Deliver building capability programme for people teams (phase 2) including: Trauma informed training for people services and HRBPs and Identifying and escalating poor decision making relating to cases of racism or other types of discrimination.

January – March 2026

- Develop central L&D hub for inclusive resources for learners.
- Develop content and resources to support staff to manage conflict and difficult conversations and integrate this into existing programmes (e.g. Preceptorship and Healthcare Support worker programme).
- Recruitment quality assurance. Introduce random interview audits and introduce random shortlisting audits and undertake thorough investigations / learning (Speak up/People team/Resourcing).
- Commitment to the community. Presence at local career events link with Job Centre Plus (Link with Education outreach work).
- Develop bitesize training and drop in sessions targeting managers to equip them with the skills to deal with concerns of racism within their teams appropriately.

6. Other Protected Characteristics

As well as focusing on the GPG, WDES, WRES, Model Employer and RDR data, it is important to be mindful of the other personal characteristics protected under the Equality Act, as it is essential the Trust provides a fully inclusive work environment for all staff.

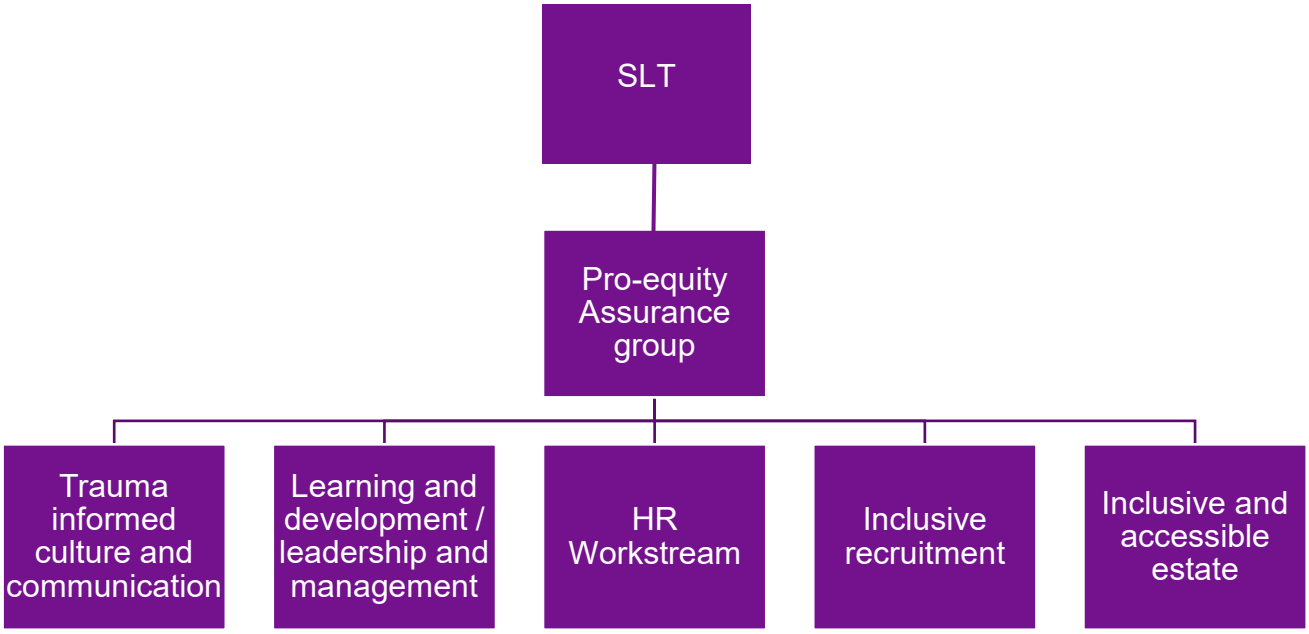
The infographic presents some of the initiatives, groups and individuals in place to offer support to all staff with protected characteristics, with an emphasis on intersectional working.

Although pro-equity has an anti-ableism, anti-racism and sexual safety focus, many actions in the plan are about creating a Pro-equity culture, which means building a place where everyone feels truly safe to be themselves and can expect equity of opportunity and equality of outcome and experience.

Good practice aimed at one protected characteristic often has a positive impact on other minoritised identities. When addressing WRES and WDES inequalities, divisions will also be invited to reflect on inclusive practice that could benefit other protected characteristics.

7. Next Steps

Pro-equity is an 'Important Corporate Project' for the Trust and is managed by the Pro-equity Assurance Group which reports to the Senior Leadership Team. Under the assurance group are five sub-groups that will deliver specific areas of the plan, ensuring Trust wide ownership and collaboration.



To ensure the deliverables of the Pro-equity action plan are embedded, each division has Pro-equity activity within their Culture and People Plans, aligning to their divisional DEI data priorities form the Staff Survey.

In light of this data and our ongoing pro-equity work we will be reviewing our risk scoring to ensure it is reflective of the Trusts current position.

8. Appendix

Appendix 1 Definitions

Agenda for Change (AfC)

The main pay system for staff in the NHS, except doctors, dentists and senior managers. Abbreviated to AfC and also known as NHS Terms and Conditions of Service.

- Cluster 1 (AfC bands <1 to 4)
- Cluster 2 (AfC bands 5 to 7)
- Cluster 3 (AfC bands 8a and 8b),
- Cluster 4 (AfC bands 8c to VSM).

Global Majority (previously Ethnically Minoritised)

This term is used in this report to represent colleagues who identify as Black, Asian, Multiple Heritage, GRT (Gypsy, Roma, Traveller), indigenous to the global south, and or have been racialised as 'ethnic minorities'. We have made this move as ‘ethnic minority’ and ‘ethnically minoritised’ have negative connotations and imply that colleagues not racialised as white are in the minority, which is a Eurocentric view. There are incidences where ‘BME’ is used, but this is when quoting NHS England WRES titles for reference.

Gender Pay Gap (GPG)

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 (the Regulations) require public sector organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31st March each year, and each organisation is duty bound to publish information on their website. This report captures data from 31st March 2023.

UHBW employs 12,678 substantive staff in a number of staff groups, including: administrative; nursing; allied health; and medical and dental roles. All staff, except for medical and dental and Very Senior Managers (VSMs), are on Agenda for Change (AfC) pay-scales.

Workforce Disability Equality Standards (WDES)

The WDES focuses on ten indicators (indicator 4 has two parts, meaning eleven metrics in total) which enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The metrics have an emphasis on issues that are likely to disproportionately impact on staff with disabilities, such as presenteeism and reasonable adjustments. NHS organisations use the metrics data to develop and publish an action plan each year. Year on year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality.

Workforce Race Equality Standards (WRES)

Implementing the Workforce Race Equality Standard is a requirement for NHS commissioners and NHS healthcare providers. NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from Black and minority ethnic backgrounds (ethnically minoritised) have equal access to career opportunities and receive fair treatment in the workplace.

This is important because studies shows that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety.

NHS providers are expected to show progress against nine indicators of workforce equality, including a specific indicator to address the low numbers of Black, Asian and Ethnically Minoritised Board members across organisations.

Model Employer

The 2019 NHSE document “A Model Employer: Increasing Black, Asian, Minority Ethnic Representation at Senior Level across the NHS” outlined the NHS plans, in line with the NHS Long Term Plan (NHSLTP) stating *“NHS England and NHS Improvement, with their partners, are committed to tackling race discrimination and creating an NHS where the talents of all staff are valued and developed – not least for the sake of our patients”.*

The government set a clear goal that NHS leadership should be as diverse as the rest of the workforce, therefore addressing the race disparity ratio; and in particular, we should “…*ensure that BAME representation at senior management matches that across the rest of the NHS workforce within ten years”*.

Race Disparity Ratio

The race disparity ratio is "a reflection of staff distribution in terms of representation through the AfC pay bands, comparing BME staff with white staff. Lower bands refer to band 5 and below, middle bands 6 and 7, higher bands 8a and above. A ratio of 1 reflects parity of progression, and values higher than ‘1’ reflect inequality, with a disadvantage for BME staff." NHS England

To calculate race disparity, first a progression ratio is calculated by comparing the number of Ethnically Minoritised colleagues at one band grouping to another band grouping. The same calculation is made for white colleagues. These two disparity ratios are then compared by dividing the Ethnically Minoritised progression ratio by the white progression ratio.

It is presented at three tiers: 1.bands 5 and below (lower), 2. bands 6 and 7 (middle) and 3. bands 8a and above (upper).

There is no separate target set for race disparity ratio as the overall expectation is to achieve parity with ethnically minoritised and White staff, indicated by a ratio of 1.0.

NHS
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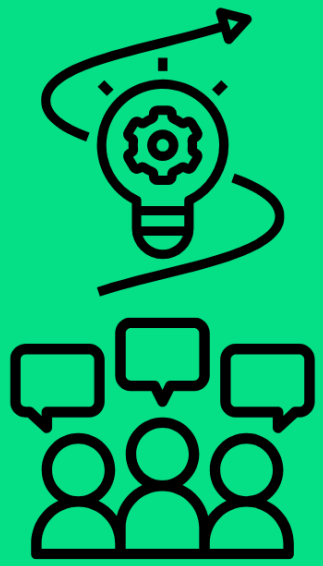
NHS Foundation Trust

Pro-equity Action Plan

High level summary



NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

How we arrived here

Our Pro-equity Action Plan and our commitment to anti-racism have been created from the experiences, ideas and feedback from colleagues across our organisation, setting out the steps we will take to tackle all forms of discrimination at UHBW, not just in words but in action.

We've started this work from within, listening to our colleagues' experiences, views and ideas about how we can make UHBW a fair, equitable place to work where everyone feels truly safe to be themselves. And not just when people are watching.

We have developed an action plan to help us start tackling the systemic causes of discrimination in our organisation and to support our colleagues who experience any form of discriminatory behaviour whilst at work.

Pro-equity Action Plan

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

Pro-equity Action Plan - Activity summary

Leadership accountability

- Support our leaders to understand the experience of Disabled colleagues, the prevalence of ableism within the trust and how to champion anti-ableism as part of Pro-equity.
- Embed compassionate and inclusive leadership behaviours, trauma informed approach and psychological safety into our leadership and management framework.
- Support leaders and managers to have compassionate and inclusive onboarding, 1-1s and supervision with colleagues.
- Make sure our leaders and managers understand their role in promoting an inclusive environment, being accountable and a role model.

Embedding pro-equity in our resources and training

- To ensure our policies and processes support managers and colleagues to utilise a Pro-equity approach in their role.
- Run NHSE Anti-racism training pilot and ensure that all managers are provided with the tools and education to be anti-racist and actively challenge and prevent inappropriate behaviours.
- Create a Pro-equity trauma informed training package and resources to support colleagues (including sexual safety, anti-ableism and anti-racism).
- Support managers and all colleagues to prevent and help protect colleagues from sexual harassment, domestic violence and abuse.
- Create efficient and simple reporting systems for all UHBW colleagues to ensure concerns relating to harassment are reported, heard and actioned.
- Increase understanding of the lived experience of our diverse community, encouraging empathy and compassion of others.
- Increasing the skill, competence and confidence of staff in managing conflict and difficult conversations / situations.

Sharing and celebrating our Pro-equity approach

- Communicate our Pro-equity trauma informed approach to drive a social change movement within the trust.
- Drive culture change at a team level through the Pro-equity advocates.
- Strengthen safe spaces within the trust for colleagues with lived experience.
- Develop training resources to embed pro-equity approach into key learning and development programmes.
- Develop central L&D hub for inclusive resources for learners.

Inclusive recruitment development and accountability

- Full review of the Inclusive Recruitment training.
- Supporting candidates through the application and interview process.
- Breaking down the bias in recruitment with diverse panels and further anonymity at shortlisting.
- Transparency in Recruitment Communications.

Feeling safe at work

- Ensure that all managers have access to the tools that they require to ensure they are robustly risk assessing their workplaces in relation to sexual harassment in line with the Workers Protection Act 2024.
- Promoting support available to enhance safety of lone workers and lone commuters.

Neurodiversity and Disability awareness

- Building on the work of the neuro-diversity steering group, provide trust wide access to information and resources to support learners and colleagues with neuro-diversity in the workplace. Link into the Accessibility Inclusive Comms steering group.
- Design / source neurodiversity train the trainer programme for facilitators.

Positive Action

- Identify career development support across the Trust and align, integrate and identify gaps to deliver offer to colleagues with protected characteristics.
- Continue and expand positive action programmes e.g. Bridges: Develop Bridges plus (Band 6+) programme and talent management programmes for other protected characteristics, aligned with joint work in LMC.

Safe Learning Environment Charter (SLEC)

- Scope how a student council could be developed and aligned to NHSE student ambassadors to capture the learner voice with a pro-equity thread as a core component of the council.
- Datix to include a screening questions to ensure that we are effectively capturing incidents that include Learners - this includes experiencing violence and aggression, including racism and ableism.
- Create and implement process for learners / students to raise concerns.

Reasonable adjustments

- Educate Managers so they are confident to support reasonable adjustments compassionately for their teams.
- Ensure barriers to reasonable adjustments for hot desking, accessing relevant equipment and safe and supportive office environments are reduced.

Training for people teams - Inclusive HR

- Building the Pro-equity knowledge, skills and confidence of the people teams.
- Resourcing team training: - Reasonable Adjustments in the recruitment process; Disability Confident Employer; Enhanced candidate support.
- Design development programme and resources for facilitators to embed inclusive practice into learning interventions.

Inclusive and accessible estate

Plan to come in June 2025

High-impact actions

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap

Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2

Comprehensive Induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff

Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)