University Hospitals Bristol and Weston NHS Foundation Trust

UHBW Equality Report 2024

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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

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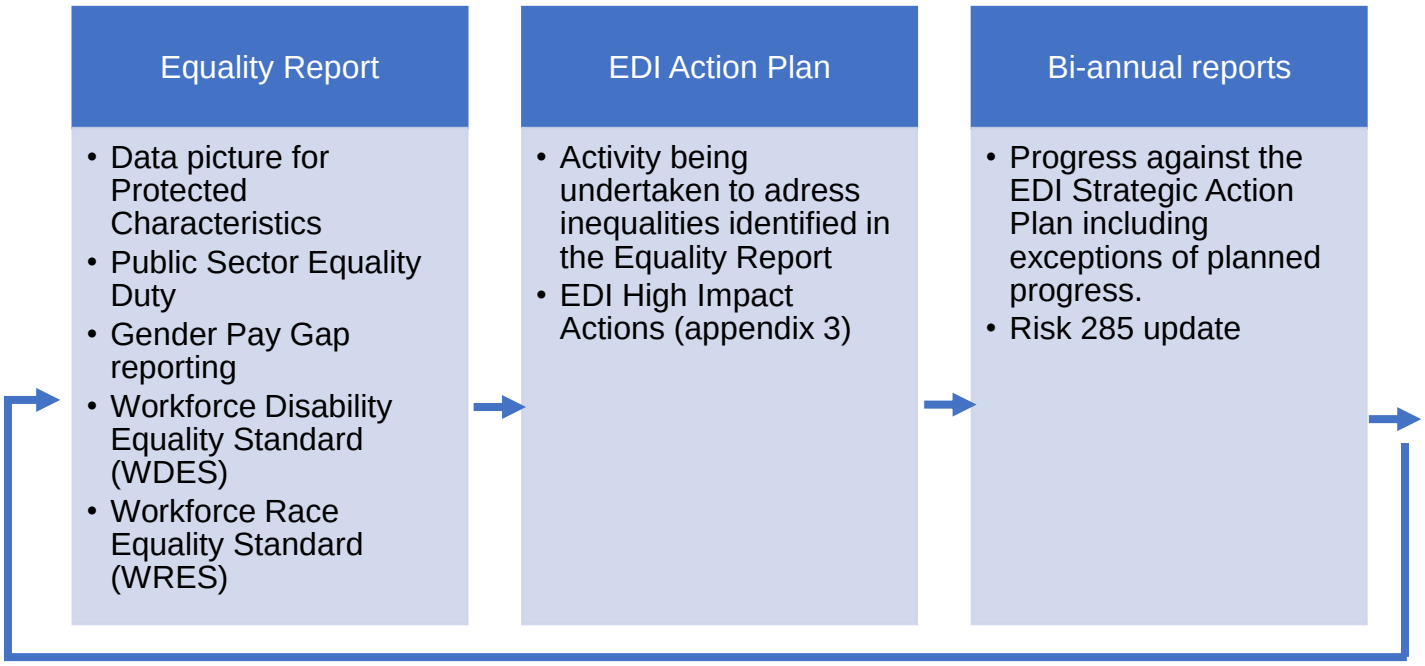
1. Introduction

The purpose of this report is to provide a data set baseline position for all Equality Diversity & Inclusion (EDI) Key Performance Indicators (KPIs) at the beginning of the first quarter of the year 2024/2025 and draw a comparison with last year's data, in order to inform the actions required to achieve the ambition to be a fully inclusive employer. This work aligns to the "Inclusion and Belonging" and "Looking After Our People" pillars of the People Strategy.

UHBW is committed to providing the best possible working environment for our staff, ensuring we are, 'committed to inclusion in everything we do.' This will be delivered through the ambitions set out in the strategic objectives in the Workforce Diversity and Inclusion Strategy 2020-2025 and the overarching UHBW People Strategy. All of which was further endorsed in the NHS People Plan: Our NHS.

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 Equality Report is one part of the three step EDI monitoring process: Equality Report, EDI Action Plan, 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 EDI Action Plan, a copy 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 three protected characteristics this report focusses on: 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 2024.

Table 1 shows the division of staff in UHBW on 31 March 2023 by sex, ethnicity and disability.

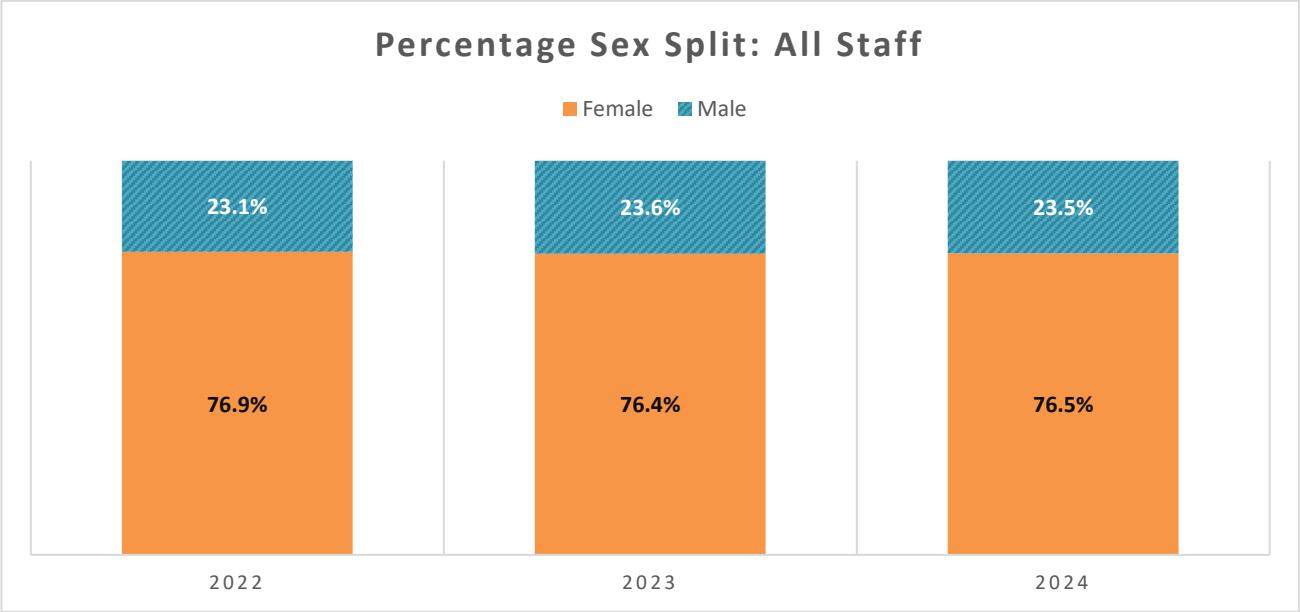
Table 1

UHBW Demographic Group	Total staff 2022: 12,013		Total staff 2023: 12,678**		Total staff 2024: 13 696**	
	Headcount	Percentage of whole workforce	Headcount	Percentage of whole workforce	Headcount	Percentage of whole workforce
Female	9238	76.9%	9688	76.4%	10472	76.5%
Male	2775	23.1%	2990	23.6%	3224	23.5%
Disabled	373	3.1%*	469	3.7%*	565	4.1%
Non-disabled	10378	86.4%*	10880	85.8%*	11804	86.2%
Ethnically Minoritised	2010	16.7%*	2667	21.0%*	3479	25.4%
White	9472	78.8%*	9462	74.6%*	9599	70.1%

*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.

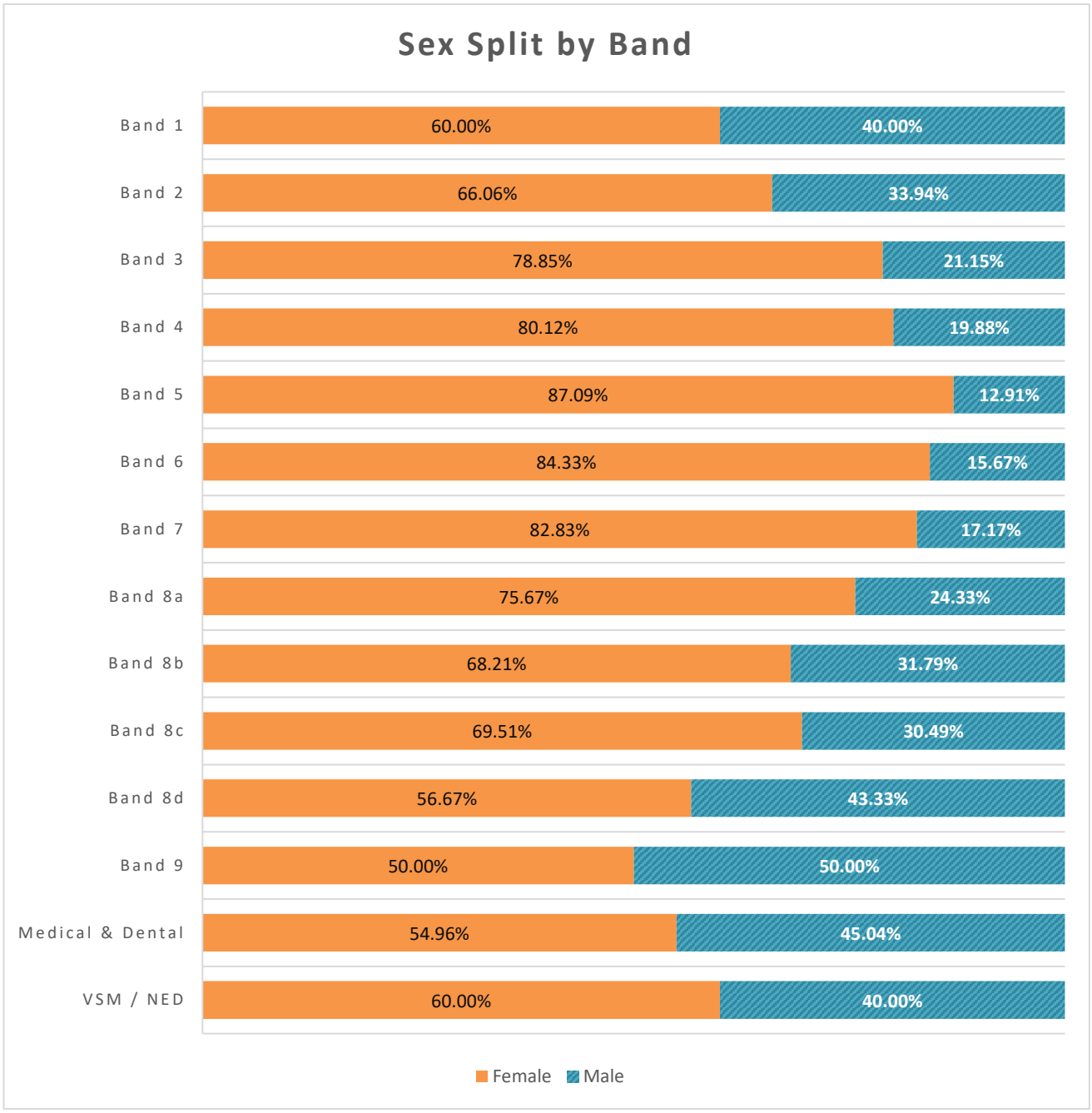
Whole trust breakdown - Sex

Graph one



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 **76.5%** being female and **23.5%** being male.

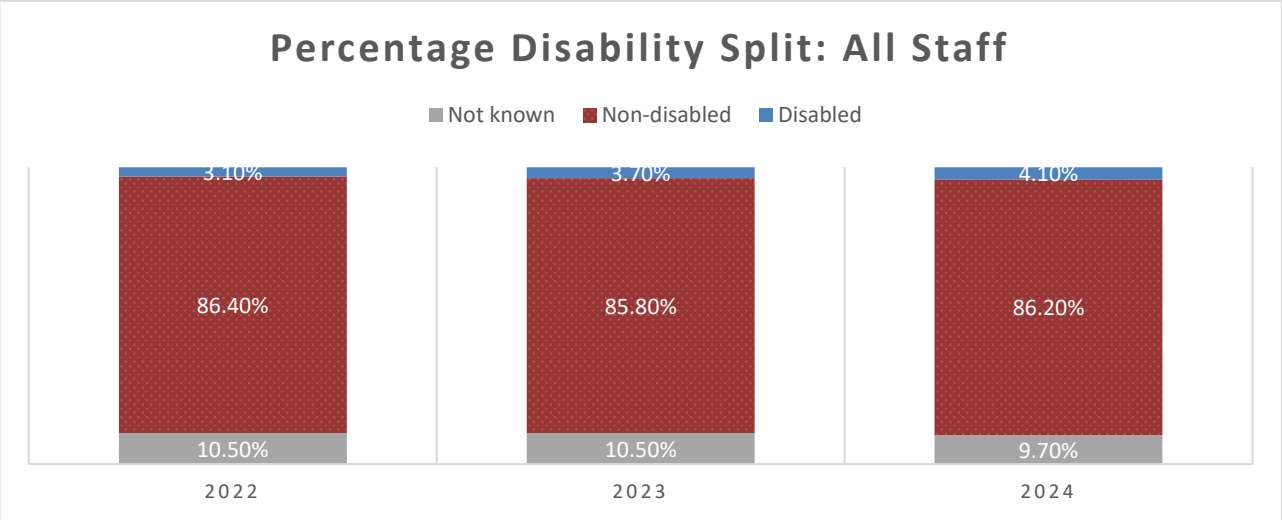
Graph 2



Graph 2 shows the sex split by band and 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 (8a+) being above the overall Trust proportion of male employees.

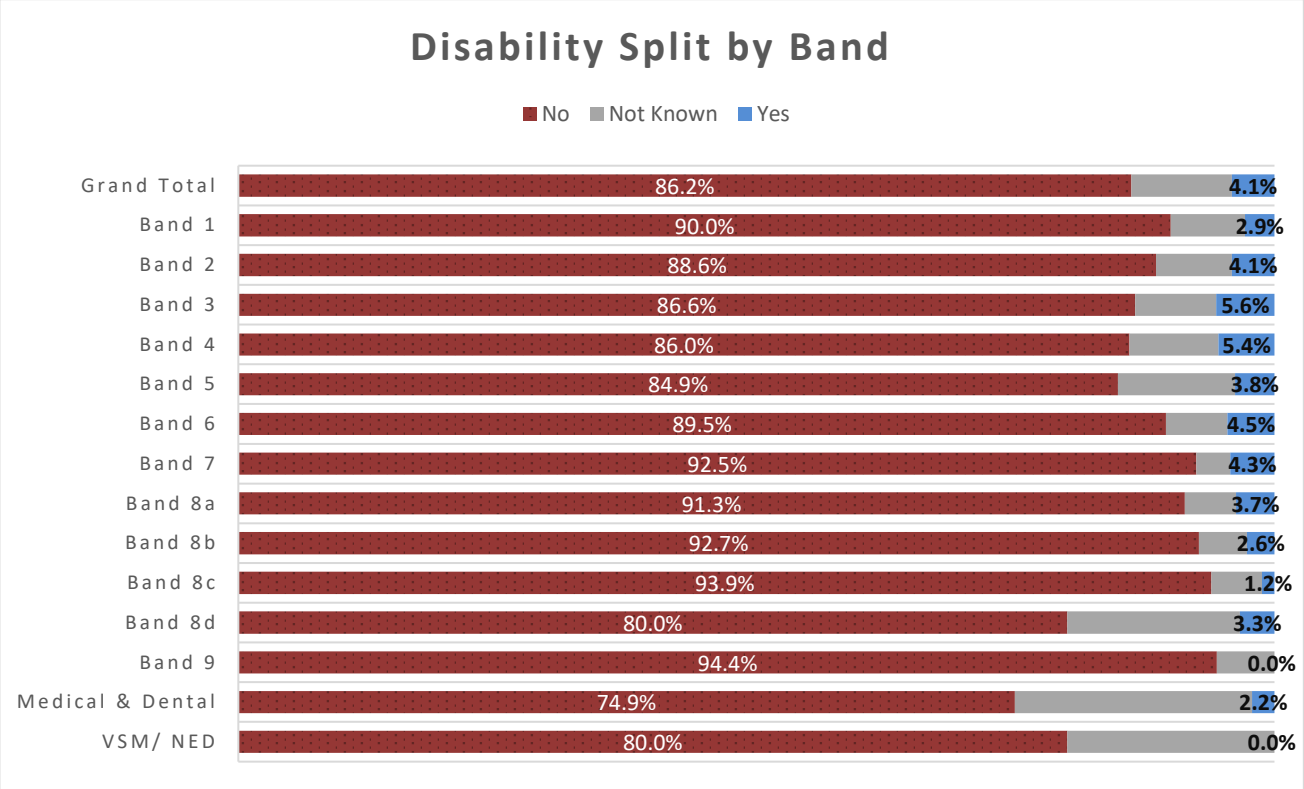
Whole trust breakdown - Disability

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 (4.1%) than the percentage of staff who self-declared a disability in the 2023 staff survey (20.9%).

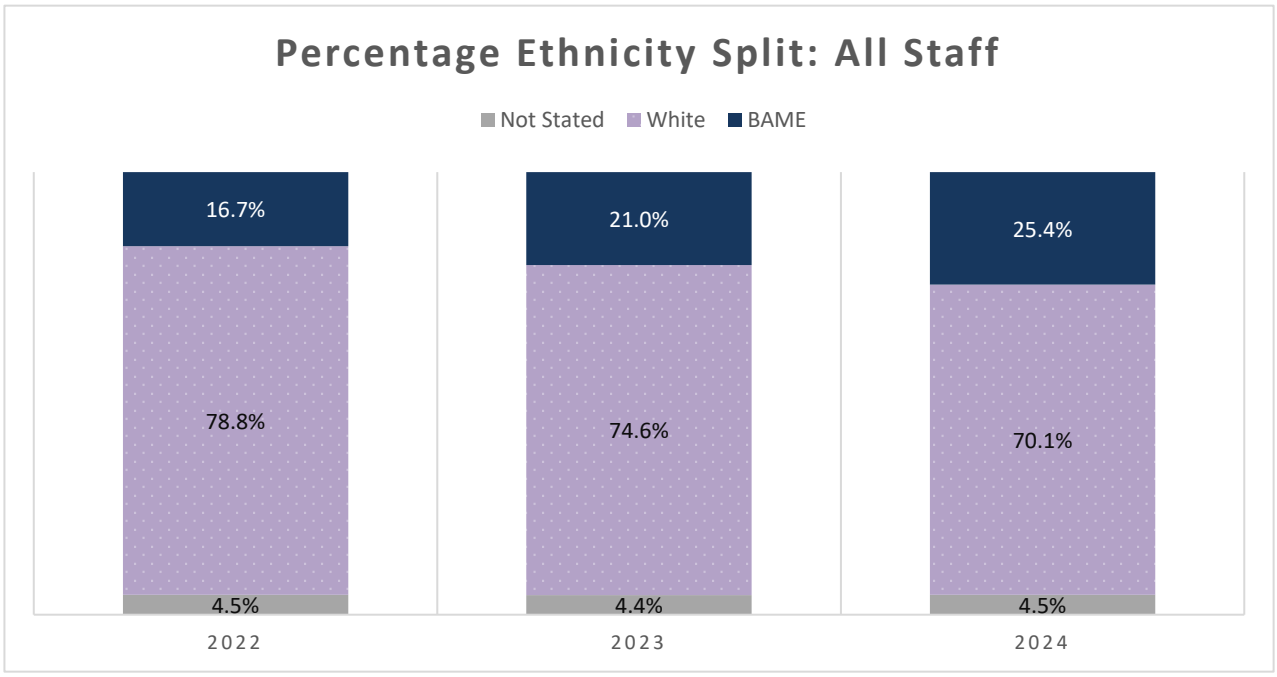
Graph 4



Graph 4 shows the percentage of disabled staff split by band. It demonstrates a decrease in disabled staff at higher bands.

Whole trust breakdown - Ethnicity

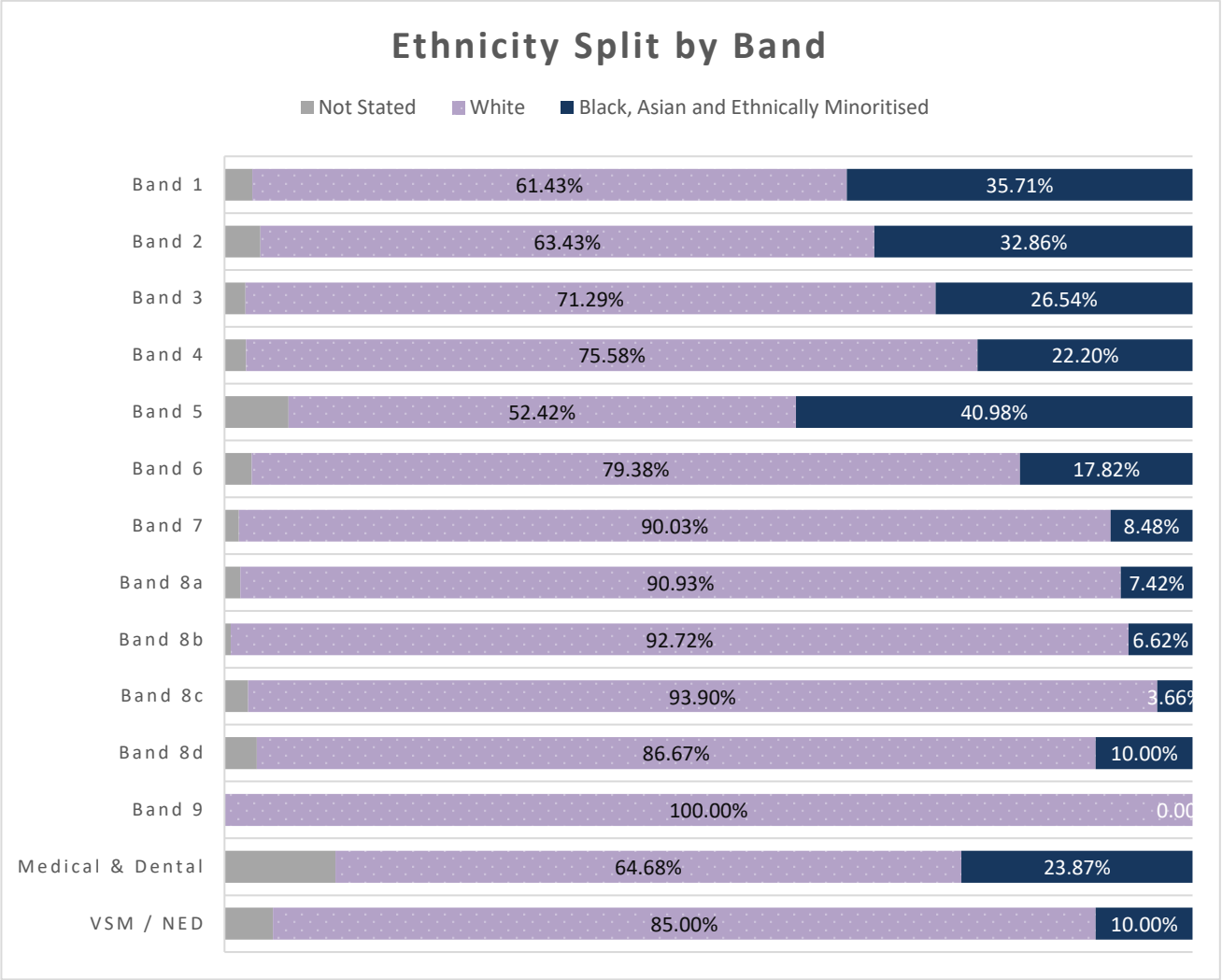
Graph 5



Graph 5 shows the ethnicity percentage split between white and Black, Asian, Multiple Heritage and other Minority Ethnic colleagues (ethnically minoritised) staff in UHBW. The percentage of ethnically minoritised staff in the Trust has increased by 4.4 percentage points from 2023. In 2023-24 we recruited over 470 Internationally Educated Nurses which is one of the main contributing factors to the increased ethnic diversity of our workforce.

The 2021 census also shows an increase in the ethnically minoritised population in Bristol, which now sits at 18.9%, so the Trust has 6.5 percentage point higher representation than the Bristol population. It also has significantly higher representation than Weston Super Mare, which has a 5.3% ethnically minoritised population in its demographic.

Graph 6



Graph 6 shows the ethnicity split by band. This data will be explored in more detail in the Model Employer section below.

Summary

In summary, the above data show that UHBW has:

- Over 3 times more female than male employees, this has remained largely unchanged from 2022, where it was 76.9% female, compared to 76.5% in 2023.
- 4.1% of staff identified as disabled on the electronic staff records, which is a slight increase from 2023, when it was 3.7%, but still significantly lower than the number of staff who self-declare as having a disability in the staff survey.
- 25.4% of staff are Black, Asian or Ethnically Minoritised, this is an increase from 2023, when the figure was 21.0%.

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.

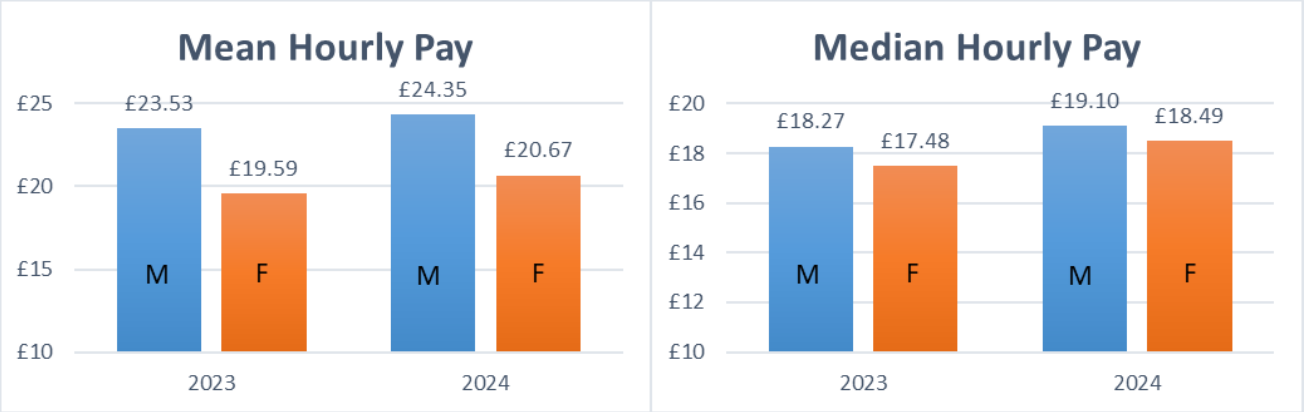
AT UHBW and within the NHS, our pay structure and reward terms and conditions are linked to time served. Pay increases after certain milestones of length of service are met.

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 7



Graph 7 shows the mean and median pay rates on which the pay gap calculation is based:

- UHBW's Mean Gender Pay Gap for 2023 is 15.11% in favour of male employees.
- UHBW's Median Gender Pay Gap for 2023 is 3.19% 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 2023/24 AfC pay award. The mean pay gap of 15.11% is a modest reduction on the 2023 gap of 16.20%.

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 4.34% 2023 to 3.19%, the lowest rate since 2020/21. 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).

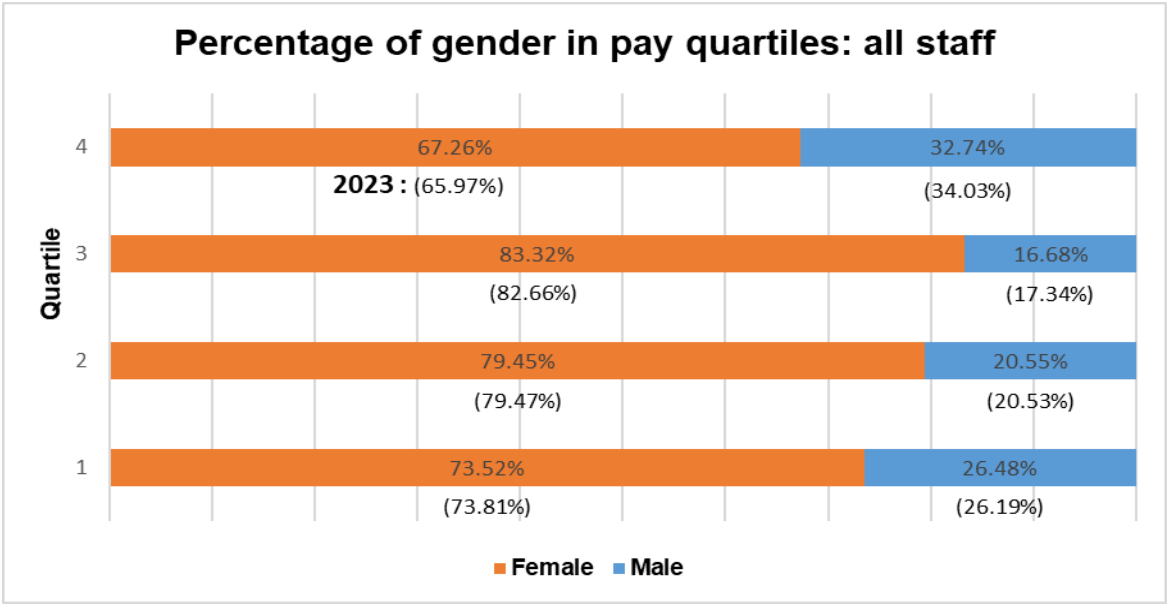
Pay Quartiles

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 8. In broad terms this shows that compared to the position across the workforce as a whole, where males represent 23.5%, there are proportionally more males in the highest pay quartile (32.74%).

Again, this is not unexpected given the stratification of gender in roles across the organisation and is a modest reduction on the 2023 figure (34.03%).

Quartile 4 is the highest pay quartile.

Graph 8



Medical and Dental

As shown in table 2, the mean gender pay gap becomes 4.18% 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 2	Male Average Hourly Pay	Female Average Hourly Pay	Difference	Mean Pay Gap
Medical and Dental staff	£42.17	£39.15	£3.02	7.16%
All other staff	£17.89	£18.67	-£0.78	-4.18%

The mean pay gap for medical and dental staff of 7.16% is a negligible reduction from the 2023 figure of 7.17%.

Agenda for Change pay bands

Table 3 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.

It shows that the majority of the lower bands have higher mean pay rates for female staff, 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.

In previous years, AfC bands 8b and above have typically shown a modest pay gap in favour of male staff, but this has effectively disappeared in the last year.

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 3	**Mean Hourly Pay Rate by AfC Band (& VSM)**						
Band	Headcount Male	Headcount Female	Male Mean Hourly Rate	Female Mean Hourly Rate	Difference	Gap	2023
Band 1	23	29	13.99	16.03	-£2.04	-14.6%	-8.5%
Band 2	616	1166	13.42	13.21	£0.21	1.6%	-2.5%
Band 3	498	1879	14.03	14.10	-£0.07	-0.5%	0.3%
Band 4	201	853	14.17	14.01	£0.16	1.1%	-0.3%
Band 5	343	2185	17.67	18.68	-£1.01	-5.7%	-3.4%
Band 6	301	1568	20.61	21.28	-£0.67	-3.3%	-3.3%
Band 7	243	1108	24.48	24.87	-£0.39	-1.6%	-2.5%
Band 8a	113	359	27.65	27.74	-£0.09	-0.3%	-0.7%
Band 8b	48	99	32.07	31.82	£0.25	0.8%	3.3%
Band 8c	26	56	37.55	38.16	-£0.61	-1.6%	-0.5%
Band 8d	14	17	43.41	42.71	£0.70	1.6%	3.5%
Band 9	9	9	55.52	56.93	-£1.41	-2.5%	3.2%
VSM	4	5	95.23	83.31	£11.92	12.5%	25.8%

Table 4 displays the same breakdown of this data into medical grades.

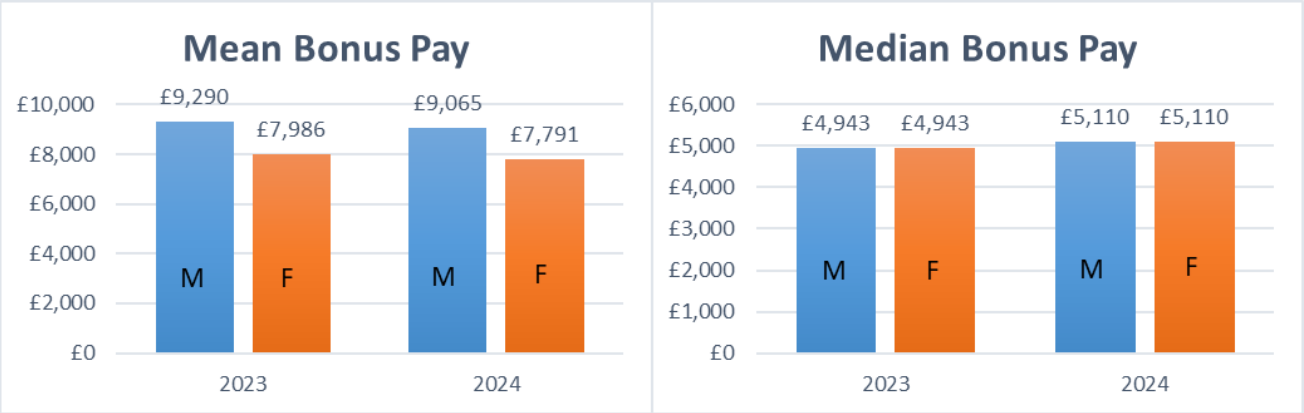
Table 4	**Mean Hourly Pay Rate by Medical grade**						
Grade	Headcount Male	Headcount Female	Male Mean Hourly Rate	Female Mean Hourly Rate	Difference	Gap	2023
Foundation Y1	24	41	£17.91	£18.23	-£0.32	-1.8%	-2.2%
Foundation Y2	22	84	£19.80	£19.55	£0.25	1.3%	1.3%
Trust Grade Docs	158	178	£34.95	£34.81	£0.14	0.4%	3.0%
Specialty Registrar	229	288	£32.57	£32.42	£0.15	0.5%	-2.9%
Specialty Doc/ Associate Specialist	48	66	£37.16	£39.14	-£1.98	-5.3%	N/A
Consultant	371	334	£54.53	£53.77	£0.76	1.%	0.8%

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 9



Graph 9 shows the mean and median bonus pay. The mean bonus pay gap in 2024 is 14.05%, effectively unchanged from 14.04% in 2023. The median gap is 0%, with no difference from 2023.

Under the national terms and conditions for Consultants, the Trust has been required to spend on Local Clinical Excellence Awards (LCEAs) a nationally agreed sum per consultant whole time equivalent.

From this were deducted all pre-2018 LCEAs. These were paid on a long-term basis and in most cases are only lost upon retirement. The remainder has, since the pandemic, been split equally among eligible consultants rather than requiring applications.

National awards are also paid on a long-term basis for clinical excellence, but these are not administered by the Trust. Recipients of national awards have not received local awards. As recipients of national and pre-2018 awards retire, the mean bonus pay gap has reduced over time as these historic payments are lost.

As part of the consultant pay award agreed in April 2024, the LCEAs will no longer be paid, with the funding reallocated permanently into basic salaries. This does mean that we can expect the median bonus gap to increase in 2024/25, since only national award holders will be paid any bonus at all.

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 5	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%

Summary

Based on the data, work is underway to introduce a new Local Clinical Excellence Award scheme to be designed with gender equality as a core principle, but this has been abandoned following the national pay deal for consultants, which abolished these awards.

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. For the indicator breakdowns, where possible we have provided division level data to inform local level prioritisation of actions.

Summary report

Key

R **Red:** Indicator has become worse since previous year or is significantly negative. Gap increasing or gap large.

A **Amber:** Indicator has improved since previous year but still needs improvement. Gap reducing but action still needed.

Non-priority: Gap is minimal and stable. Specific EDI action not needed at a trust level but might be needed at a division level.

pp: percentage point

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.	4.2% of colleagues identify as disabled	↑ by 0.5pp	R	Disabled colleague representation remains low with high levels of non-disclosure. Representation has only increased by 1.1 percentage points since 2022.

Measure		Performance Summary			
Measure	**Description**	**Current position**	**Performance year on year**	**Position since previous year**	**Executive Summary**
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. 31.3% of Non-Disabled Colleagues compared to 29.1% of Disabled colleagues (2.2pp gap)	Relative likelihood ↓ by 0.28		The gap in the likelihood of non-disabled colleagues being appointed from shortlisting compared to disabled colleagues has decreased and the gap is minimal.
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.	0.44% of Disabled Colleagues enter the formal capability process compared to 0.16% of non-disabled colleagues (0.28pp gap)	Relative likelihood ↓ by 0.89	A	Disabled colleagues are 2.73 times more likely to enter the formal capability progress than non-disabled colleagues. This has reduced since 2022 but there is still a significant gap.

Measure		Performance Summary			
Measure	**Description**	**Current position**	**Performance year on year**	**Position since previous year**	**Executive Summary**
WDES Indicator 4a	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse	11.9% of Disabled Colleagues experiencing harassment, bullying or abuse from managers compared to 6.5% of non-disabled colleagues (5.4pp gap) 25.0% of Disabled Colleagues experiencing harassment, bullying or abuse from other colleagues compared to 14.5% of non-disabled colleagues (10.5pp gap) 29.5% of Disabled Colleagues experiencing harassment, bullying or abuse from patients/service users compared to 21.0% of non-disabled colleagues (8.5pp gap)	From managers ↓0.6pp From other colleagues ↑0.1pp From patents/service users ↑0.3pp	R	The gap in experience of harassment, bullying or abuse for Disabled Colleagues compared to non-disabled colleagues is high, with large gaps in all divisions (apart from Facilities and Estates).
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.	52.5% of Disabled Colleagues compared to 49.8% of non-disabled colleagues (2.7pp gap)	Gap ↓ by 0.8pp		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.

Measure		Performance Summary			
Measure	**Description**	**Current position**	**Performance year on year**	**Position since previous year**	**Executive Summary**
WDES Indicator 5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	54.6% of Disabled Colleagues compared to 60.3% of non-disabled colleagues (5.7pp gap)	Gap ↑ by 3.1pp	R	Disabled colleagues have a lower belief that the Trust provides equal opportunities for career progression or promotion. The gap has more than doubled from the previous year.
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.	14.9% of Disabled Colleagues compared to 20.9% of non-disabled colleagues (6.0pp gap)	Gap ↓ by 2.7pp	A	Disabled colleagues have felt more pressure from their manager to come to work, despite not feeling well enough to perform their duties. This gap is roughly the same comparing 2021 to 2023.
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.	39.5% of Disabled Colleagues compared to 50.1% of non-disabled colleagues (10.6pp gap)	Gap ↑ by 1.8pp	R	Disabled colleagues feel much less valued than non-disabled colleagues and this gap is increasing.

Measure		Performance Summary			
Measure	**Description**	**Current position**	**Performance year on year**	**Position since previous year**	**Executive Summary**
WDES Indicator 8	Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.	79.4% of Disabled Colleagues	↑ by 1.1pp	**A**	Reasonable adjustment implementation has remained consistent for 3 years but could increase.
WDES Indicator 9	The staff engagement score for Disabled staff, compared to non-disabled staff.	6.7 for disabled colleagues compared to 7.2 for non-disabled colleagues (0.5 gap)	↔ no movement	**R**	Disabled staff have a 0.5 lower engagement score compared to non-disabled colleagues. This gap has remained fairly constant for 3 years.
WDES Indicator 10	Percentage difference between the organisation's board voting membership and its organisation's overall workforce, disaggregated.	0% of the Board are disabled	Representation ↓ by 6.3pp	**R**	None of the members of the board identify as disabled and 20% have not disclosed.

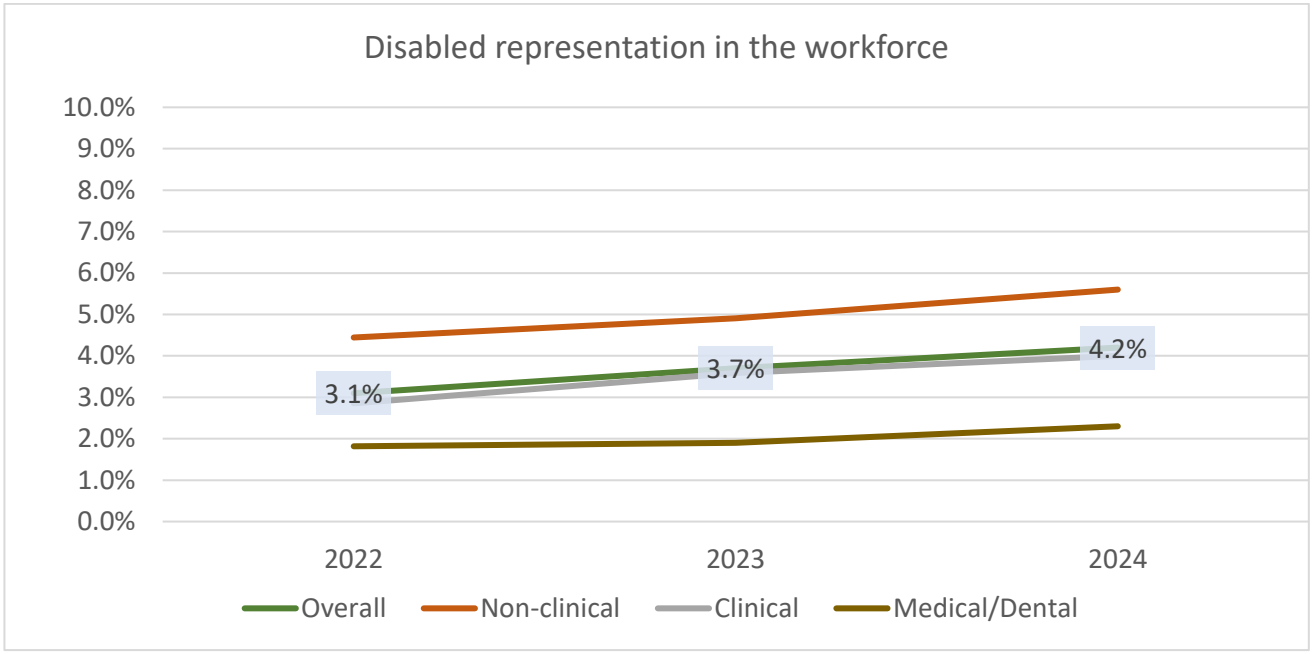
WDES Indicator 1

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.

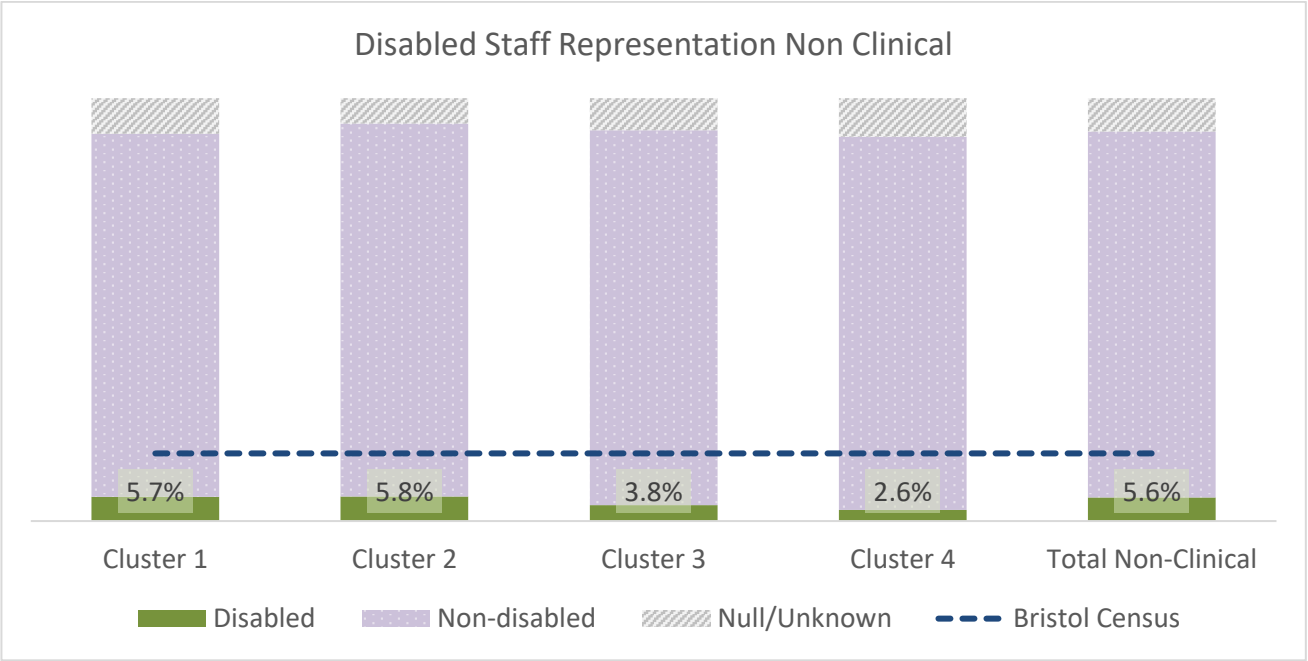
Across all AfC bands for Non-Clinical, Clinical (non-medical) and Medical / Dental the trust has low representation of Disabled colleagues, with 4.2% of the overall workforce identifying as Disabled. This has only increased by 1.1 percentage points since 2022. In the Bristol census 2021 "people who have 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 non-disclosure rate which could be potentially masking disabled colleague representation.

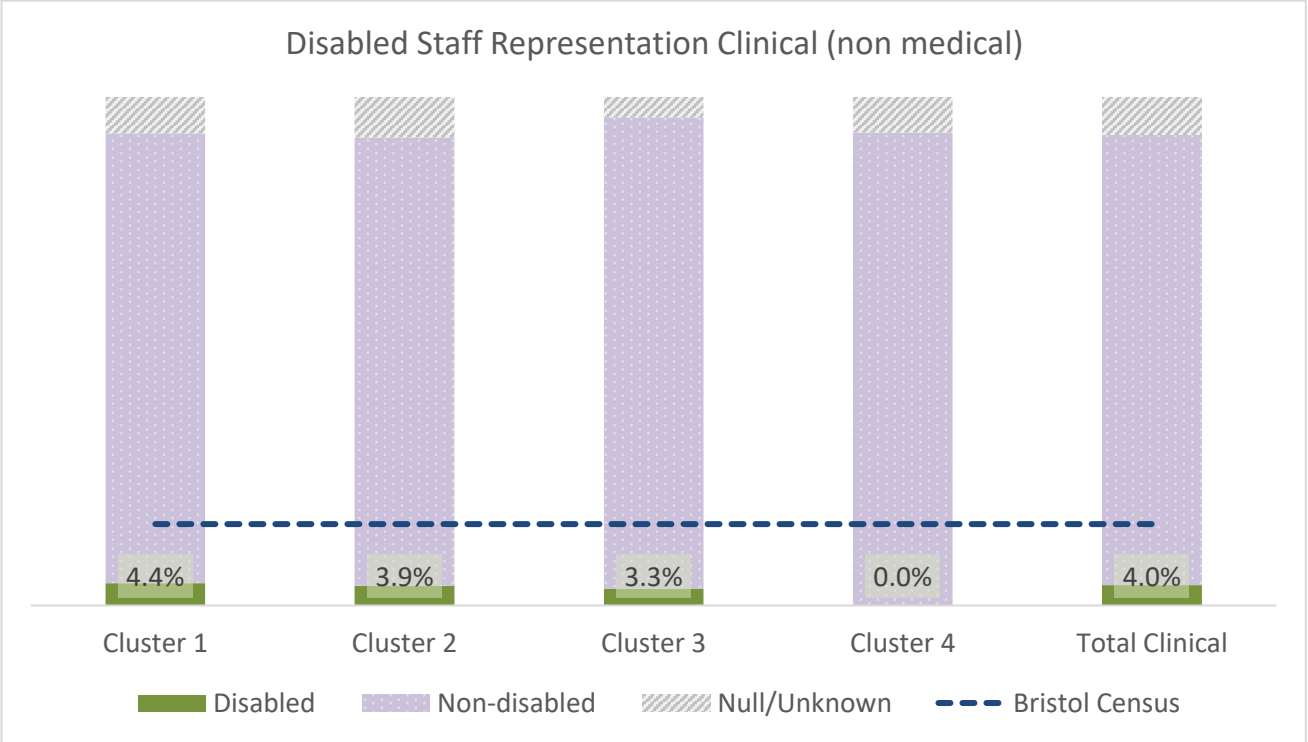
Graph 10



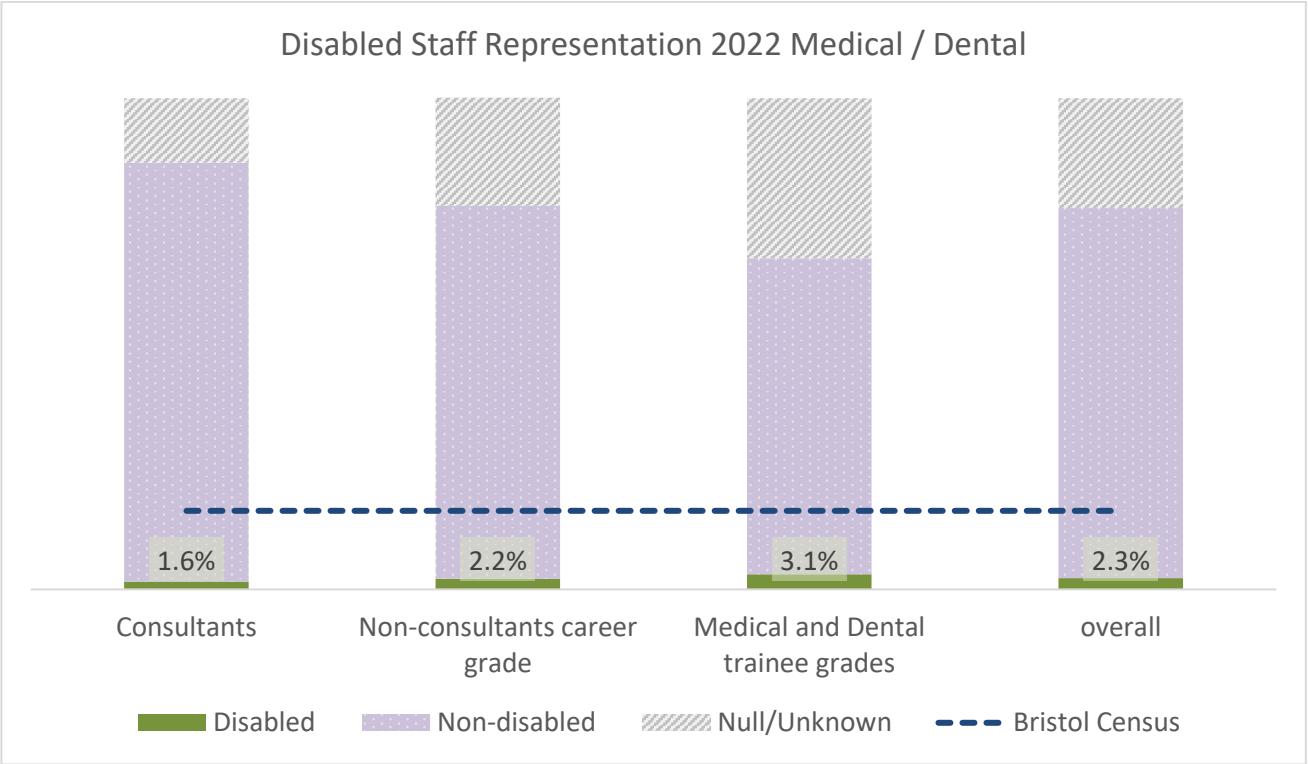
Graph 11



Graph 12



Graph 13


Disabled Staff Representation 2022 Medical / Dental
1.6%
2.2%
3.1%
2.3%
Consultants
Non-consultants career grade
Medical and Dental trainee grades
overall
Disabled
Non-disabled
Null/Unknown
Bristol Census

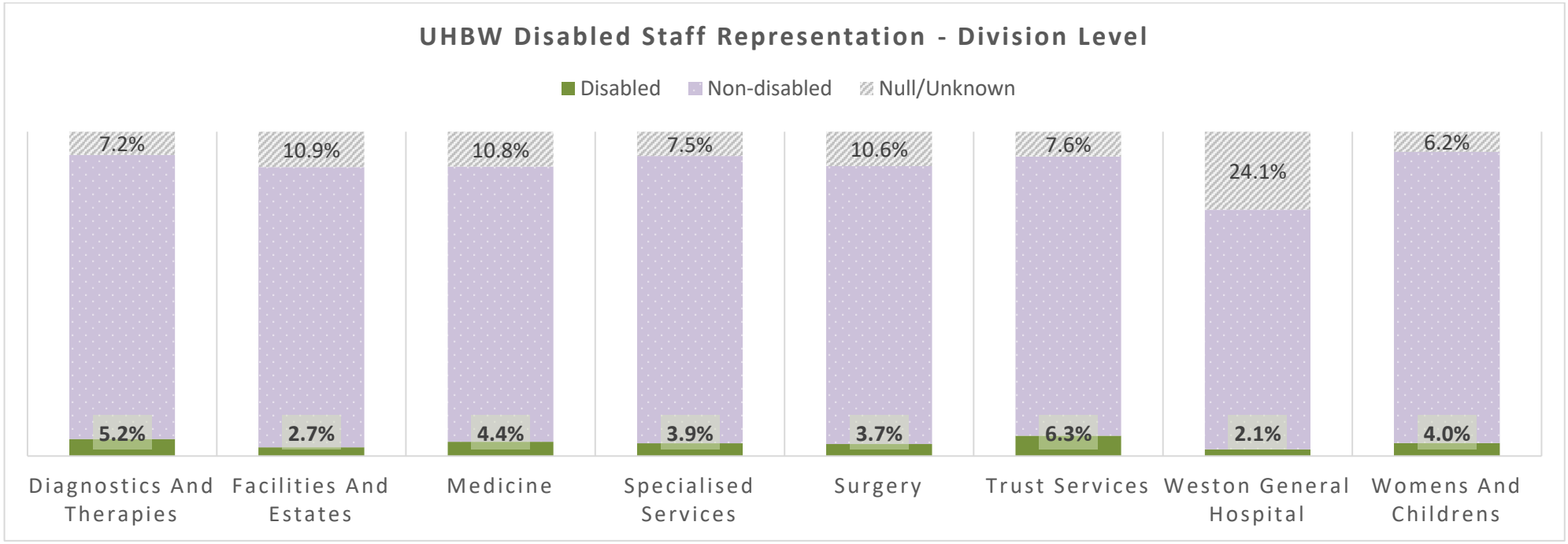
Division Level

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

- Weston General Hospital 2.1% (24.1% did not disclose)
- Facilities and Estates 2.7% (10.9% did not disclose)
- Surgery 3.7% (10.6% did not disclose)
- Specialised Services 3.9% (7.5% did not disclose)

As the low representation of colleagues is across all AfC clusters, e data for clusters at division level will be extremely small numbers and the data will not be robust.

Graph 14



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 is 1.08 (a figure of 1.0 shows equal rates of appointment). The gap in appointment rates has reduced.

Division level

- Weston General Hospital is a significant outlier with a 21.2 percentage point gap between the appointment of non-disabled colleagues and disabled colleagues.
- Specialised Services has a 8.5 percentage point gap.
- Facilities and Estates has a 6.6 percentage point gap.

Graph 15

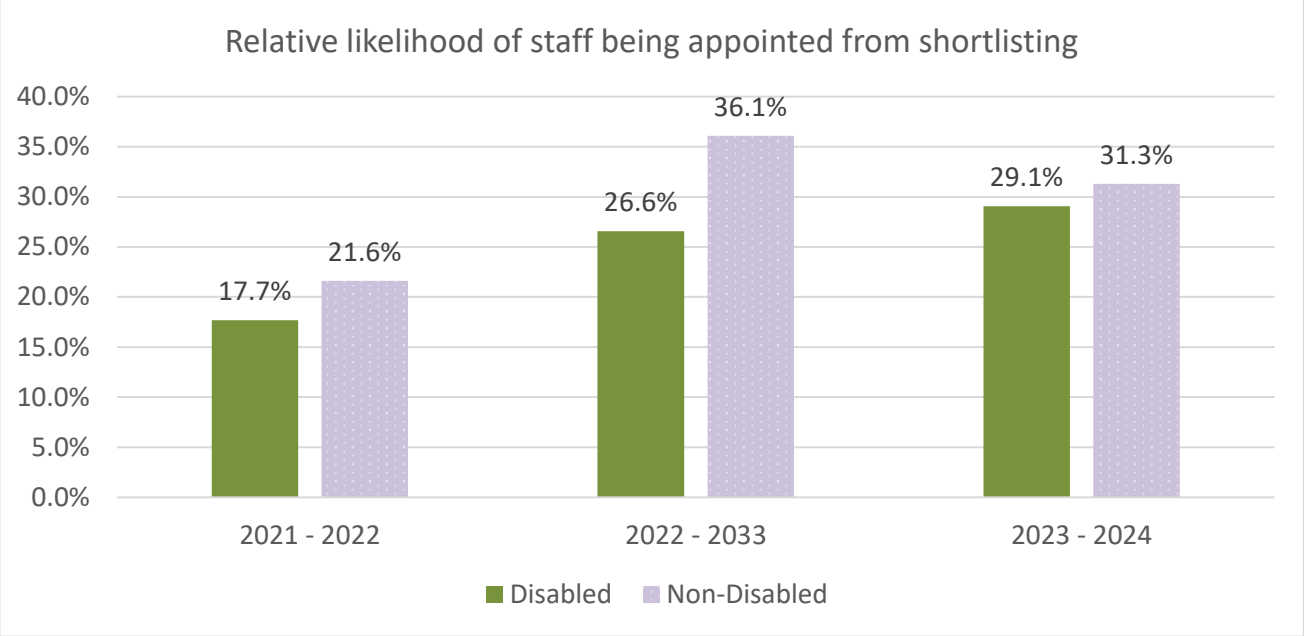


Table 6

Division	Disabled	Non-Disabled	Gap Disabled to non-disabled (percentage Points)
Diagnostics And Therapies	27.3%	28.0%	-0.8
Facilities And Estates	19.4%	25.9%	-6.6
Medicine	32.1%	31.3%	0.7
Specialised Services	26.7%	35.2%	-8.5
Surgery	32.9%	28.8%	4.1
Trust Services	33.7%	31.2%	2.5
Weston General Hospital	11.1%	32.3%	-21.2
Womens And Childrens	47.7%	40.2%	7.5

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 slightly and the proportion of disabled colleagues entering the formal capability process has only marginally increased. This has resulted in the relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff reducing to 2.73 times as likely, which is still quite high.

We launched the respecting everyone approach in 2023, which could be one of the reasons the rate of colleagues entering the formal capability process has reduced. Progress and impact so far since launching:

- A six-month review of Respecting Everyone has been completed. This shows that cases continue to decline with the latest position showing a reduction over the past 6 months of the Respecting Everyone Policy live date of 49% versus the previous year (266 cases reduced to 133).
- There continues to be a year-on-year reduction in Employee Relations cases with 78 *formal* employee relations cases in Q4 2023/2024 compared to 120 in Q4 2022/2023.
- 43% of cases were dealt with informally using Respecting Everyone principles.

As we are looking at less than 30 staff for each demographic, if we cut the data at a division level the numbers would be too small for robust analysis.

Graph 16

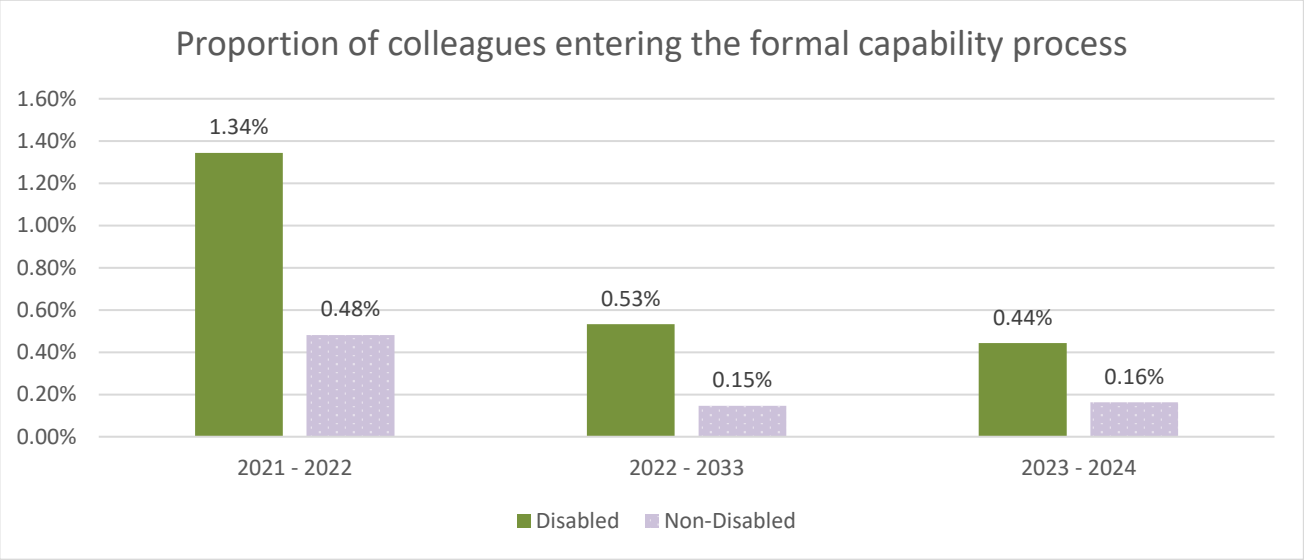


Table 7

	Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff
2021 - 2022	2.79
2022 - 2033	3.62
2023 - 2024	2.73

WDES Indicator 4

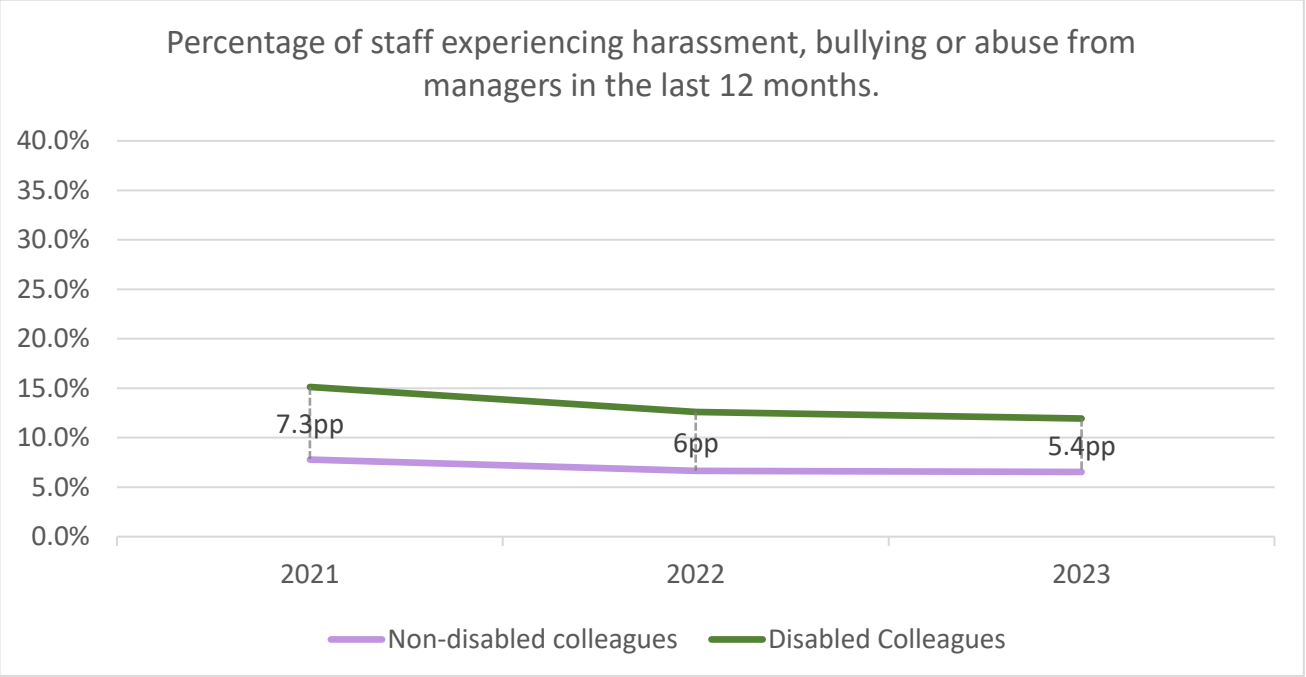
4a. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse.

The gap in experience of staff experiencing harassment, bullying or abuse from managers continues to reduce however there is still a gap of 5.4 percentage points where disabled colleagues experience a higher rate.

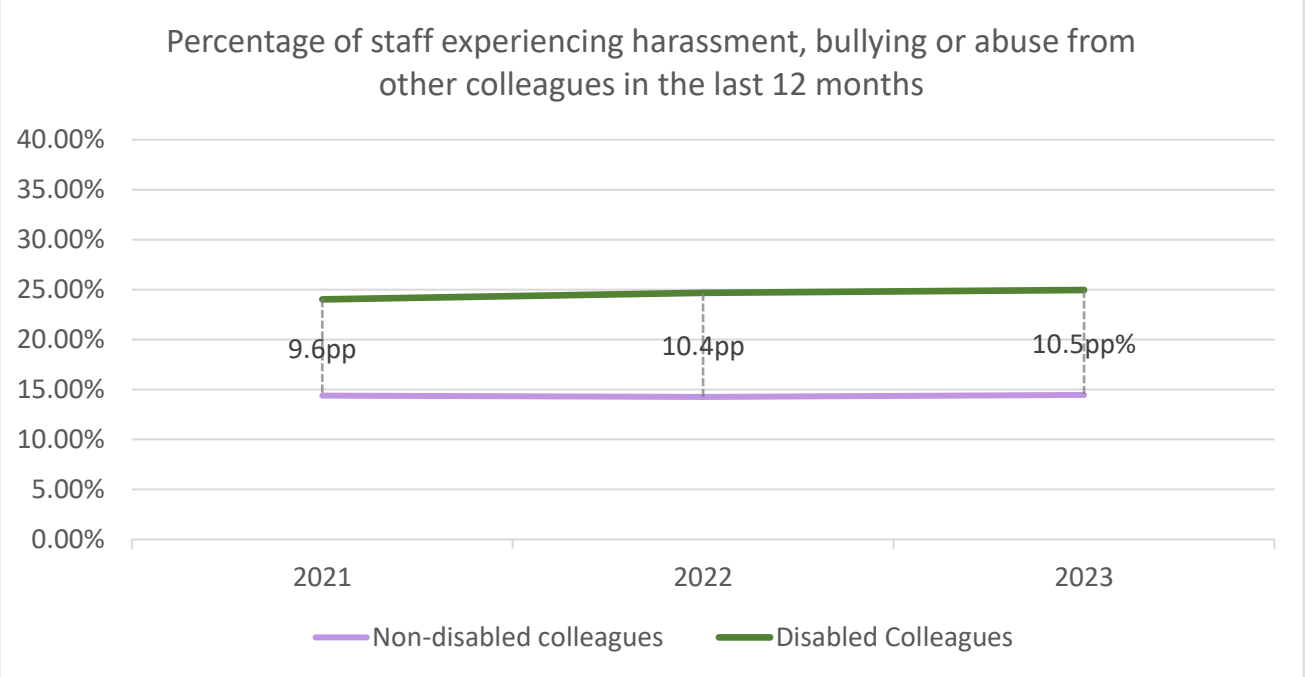
The gap in experience of staff experiencing harassment, bullying or abuse from other colleagues remains roughly the same, with a 0.9 percentage point increase from 2021 to 2023. The gap is large where disabled colleagues experience a higher rate.

The gap in experience of staff experiencing harassment, bullying or abuse from patients/service users remains roughly the same, with a 1.2 percentage point increase from 2021 to 2023. The gap is large where disabled colleagues experience a higher rate.

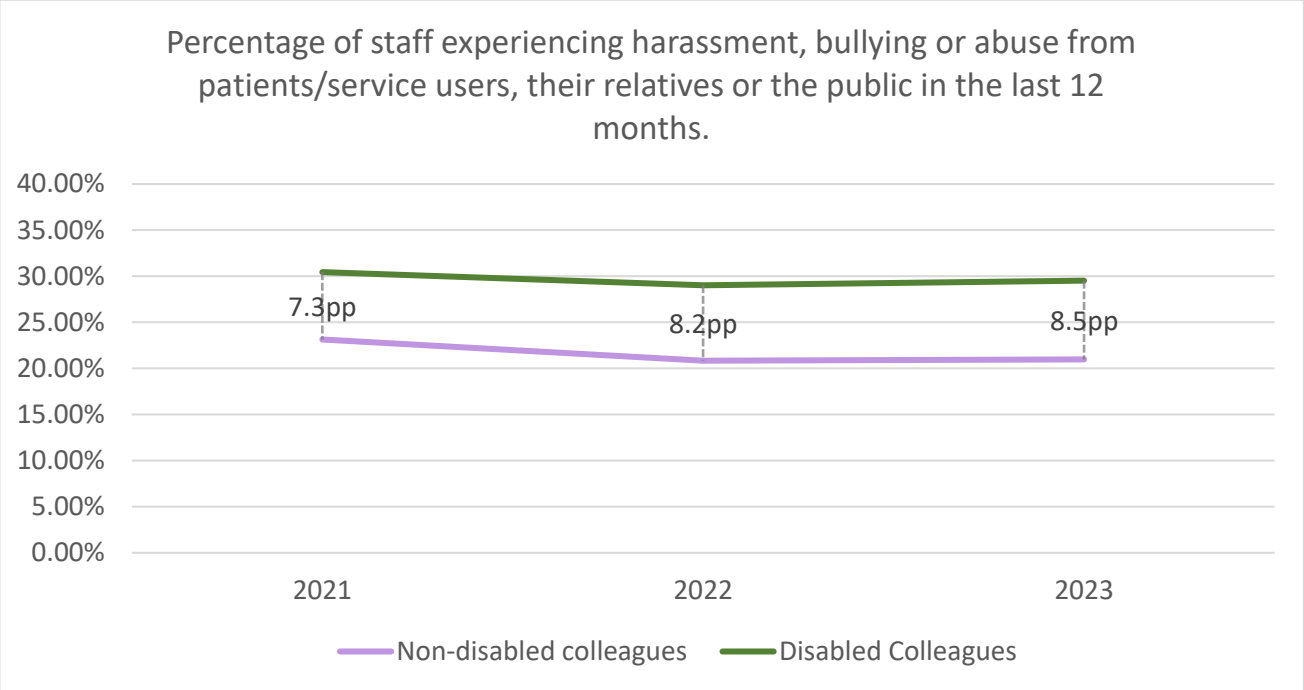
Graph 17



Graph 18



Graph 19



All divisions (apart from Facilities and Estates) have large gaps of at least 10.5percentage points where Disabled colleagues experience more harassment, bullying and abuse than non-disabled colleagues.

Table 8

Division	Disabled	Non-Disabled	Gap Disabled to non-disabled (percentage Points)
Diagnostics And Therapies	37.9%	24.4%	**13.5**
Facilities And Estates	23.9%	21.9%	**2.0**
Medicine	64.1%	45.1%	**19.0**
Specialised Services	45.2%	32.3%	**12.9**
Surgery	53.8%	35.6%	**18.2**
Trust Services	33.3%	16.6%	**16.8**
Weston General Hospital	57.5%	46.9%	**10.5**
Womens And Childrens	46.5%	28.9%	**17.6**

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 colleagues saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it increased whereas the proportion of non-disabled colleagues remained the same, therefore the gap in experience reduced.

Three Divisions showed a negative gap where disabled colleagues experienced less reporting than non-disabled colleagues. These gaps were:

- Specialised Services (6.5pp)
- Diagnostics And Therapies (4.1pp)
- Surgery (4.0pp)

Positively, Weston General Hospital had the highest proportion of disabled colleagues experiencing the reporting of incidents (72.3% of disabled colleagues).

Graph 20

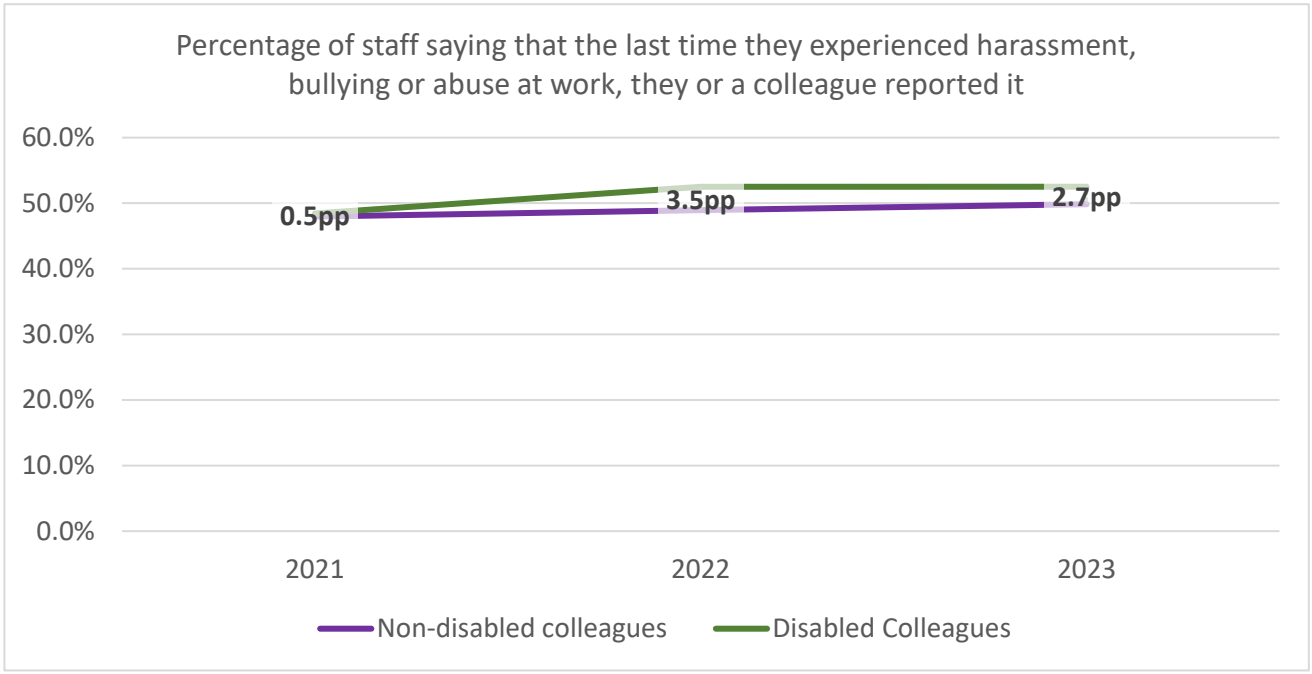


Table 9

Division	Disabled	Non-Disabled	Gap Disabled to non-disabled (percentage Points)
Diagnostics And Therapies	37.7%	41.8%	**-4.1**
Facilities And Estates	60.0%	54.6%	**5.4**
Medicine	57.6%	57.3%	**0.4**
Specialised Services	41.8%	48.3%	**-6.5**
Surgery	47.7%	51.7%	**-4.0**
Trust Services	55.6%	46.4%	**9.1**
Weston General Hospital	72.3%	54.6%	**17.7**
Womens And Childrens	55.3%	42.3%	**13.0**

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 increased however, the satisfaction of non-disabled staff has increased more, widening the gap in experience.

All Divisions show an experience gap where disabled colleagues feel they have less opportunities for career progression or promotion compared to non-disabled colleagues. The largest gaps in experience are:

- Diagnostics And Therapies (12.4pp)
- Surgery (11.7pp)
- Trust Services (6.5pp)

The following divisions have the lowest proportions of disabled colleagues believing that the Trust provides equal opportunities for career progression or promotion.

- Surgery (46.8%)
- Facilities And Estates (48.8%)

Graph 21

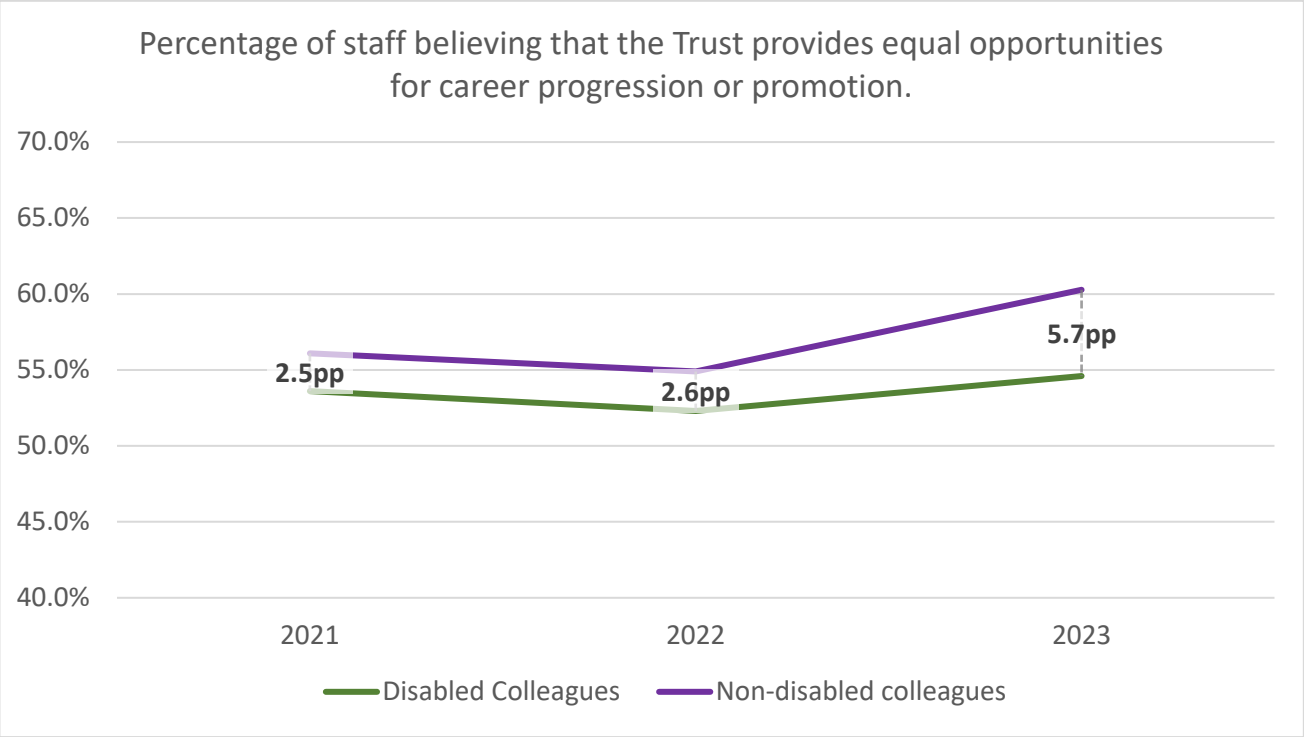


Table 10

Division	Disabled	Non-Disabled	Gap Disabled to Non-disabled (Percentage Points)
Diagnostics And Therapies	50.5%	63.0%	**12.4**
Facilities And Estates	48.8%	52.5%	**3.6**
Medicine	61.4%	62.9%	**1.4**
Specialised Services	58.2%	61.6%	**3.4**
Surgery	46.8%	58.6%	**11.7**
Trust Services	53.8%	60.3%	**6.5**
Weston General Hospital	55.8%	59.0%	**3.2**
Womens And Childrens	62.0%	63.8%	**1.8**

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 2023 remains roughly the same.

All Divisions show an experience gap where disabled colleagues feel pressure to come to work when not well compared to non-disabled colleagues. The largest gaps in experience are:

- Trust Services (13.1pp)
- Facilities And Estates (11.8pp)
- Weston General Hospital (7.6pp)
- Diagnostics And Therapies (7.5pp)

The following divisions have the highest proportions of disabled colleagues feeling pressure to work when not well.

- Facilities And Estates (30.8%)
- Diagnostics And Therapies (23.1%)
- Surgery (21.7%)

Graph 22

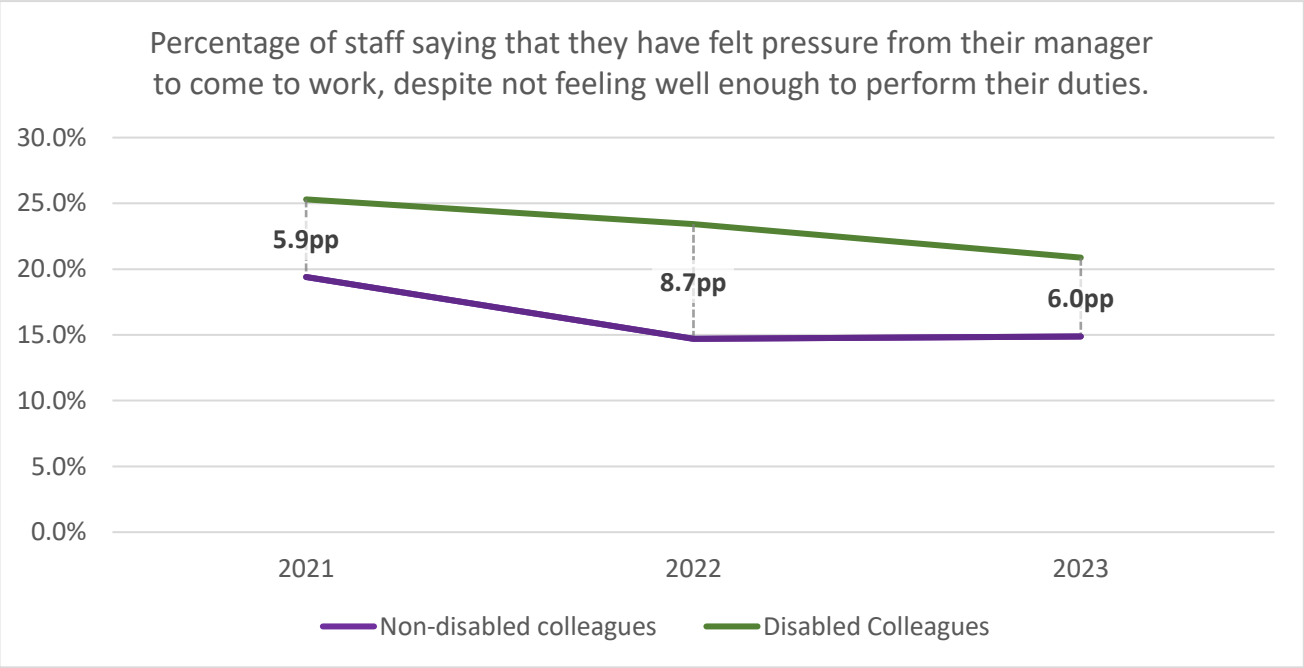


Table 11

Division	Disabled	Non-Disabled	Gap Disabled to Non-disabled (Percentage Points)
Diagnostics And Therapies	23.1%	15.6%	**7.5**
Facilities And Estates	30.8%	18.9%	**11.8**
Medicine	17.1%	12.5%	**4.6**
Specialised Services	15.0%	14.2%	**0.8**
Surgery	21.7%	14.9%	**6.8**
Trust Services	20.3%	7.3%	**13.1**
Weston General Hospital	20.0%	12.4%	**7.6**
Womens And Childrens	19.8%	18.7%	**1.0**

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 both disabled colleagues and non-disabled colleagues satisfied with the extent to which their organisation values their work has increased however, the satisfaction of non-disabled staff has increased more, widening the gap in experience.

All Divisions show a considerable experience gap where disabled colleagues feel less valued by the organisation compared to non-disabled colleagues. The largest gaps in experience are:

- Weston General Hospital (15.5pp)
- Medicine (15.1pp)
- Surgery (13.8pp)
- Womens And Childrens (11.6pp)

The following divisions have the lowest proportions of disabled colleagues feeling valued.

- Surgery (33.5%)
- Diagnostics And Therapies (34.7%)
- Weston General Hospital (35.6%)

Graph 23

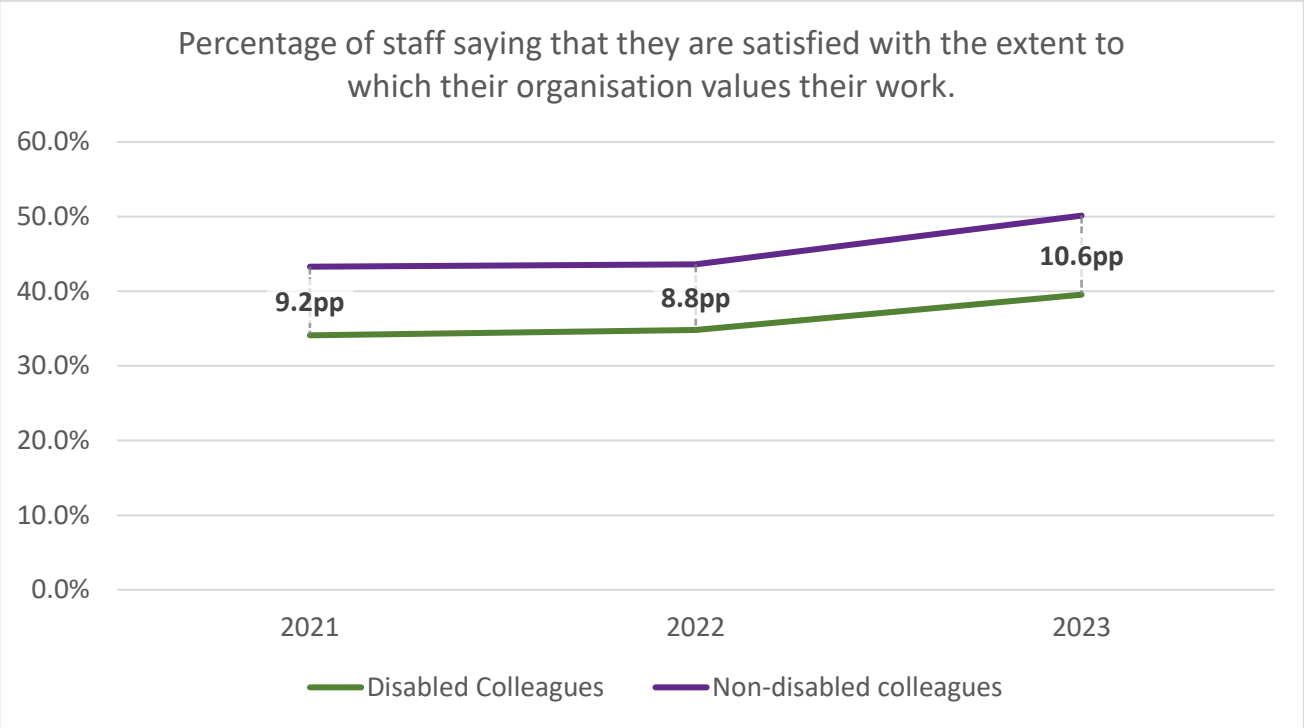


Table 12

Division	Disabled	Non-Disabled	Gap Disabled to Non-disabled (Percentage Points)
Diagnostics And Therapies	34.7%	43.7%	**9.0**
Facilities And Estates	44.4%	51.0%	**6.6**
Medicine	37.3%	52.4%	**15.1**
Specialised Services	43.7%	48.9%	**5.2**
Surgery	33.5%	47.3%	**13.8**
Trust Services	51.0%	61.2%	**10.2**
Weston General Hospital	35.6%	51.2%	**15.5**
Womens And Childrens	36.9%	48.6%	**11.6**

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 has remained fairly constant for the last 3 years (around 79%). Ideally this would be closer to 100% and show an increase in percentage each year.

The division level data shows how far from 100% each division is (although we are not expecting this to ever be at 100% as not all disabled colleagues will want or need reasonable adjustments). The three divisions that are the furthest from 100% are:

- Surgery (20.1pp)
- Weston General Hospital (28.6pp)
- Medicine (21.1pp)

Graph 24

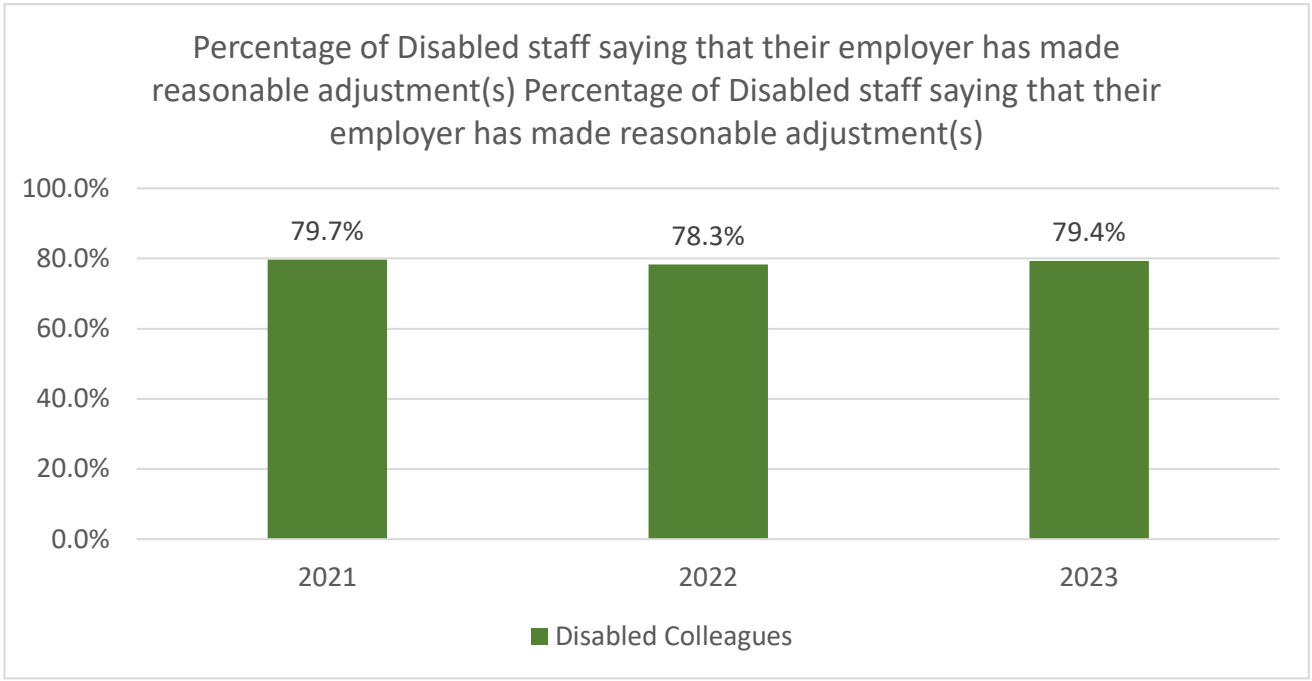


Table 12

Division	Colleagues with reasonable adjustments	Percentage points off 100%
Diagnostics And Therapies	81.2%	**18.8**
Facilities And Estates	81.1%	**18.9**
Medicine	78.9%	**21.1**
Specialised Services	82.7%	**17.3**
Surgery	70.9%	**29.1**
Trust Services	85.3%	**14.7**
Weston General Hospital	71.4%	**28.6**
Womens And Childrens	81.1%	**18.9**

WDES Indicator 9

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

Disabled colleagues have a 0.5 lower engagement score compared to non-disabled colleagues. This gap has remained consistent over 3 years.

All Divisions show a gap where disabled colleagues have lower engagement scores. The largest gaps in experience are:

- Surgery (0.8)
- Weston General Hospital (0.8)
- Diagnostics And Therapies (0.5)
- Facilities And Estates (0.5)

Graph 25

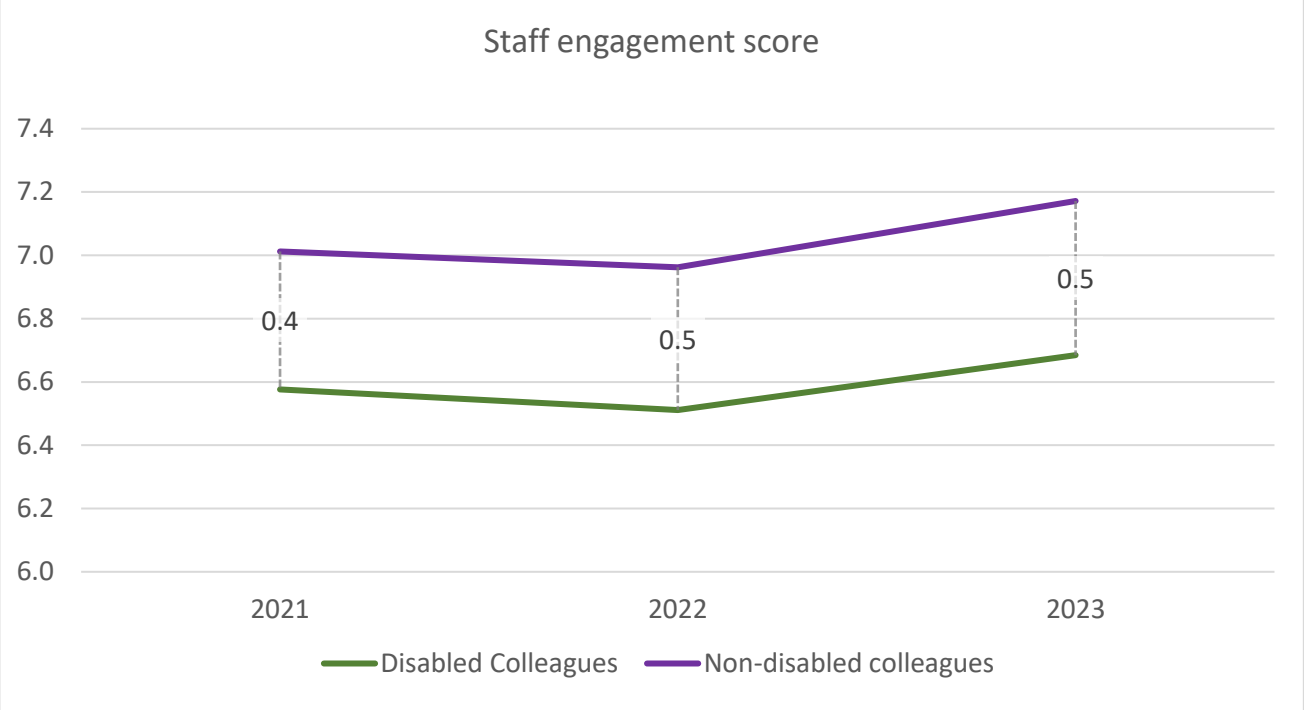


Table 13

	Staff Engagement Score		
Division	**Disabled**	**Non-Disabled**	**Gap Disabled to non-disabled**
Diagnostics And Therapies	6.4	6.9	**0.5**
Facilities And Estates	6.5	6.9	**0.5**
Medicine	6.8	7.2	**0.4**
Specialised Services	7.1	7.2	**0.1**
Surgery	6.4	7.2	**0.8**
Trust Services	6.8	7.2	**0.4**
Weston General Hospital	6.6	7.4	**0.8**
Womens And Childrens	6.9	7.3	**0.4**

WDES Indicator 10

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

0% of the Board identified as disabled within the electronic staff record, with representation decreasing year on year. There is a high rate of board members where it is unknown whether they are disabled.

Work needs to be undertaken to encourage staff to update their electronic records as we know that the board has disabled colleague representation, but this is not represented in the electronic staff record where this data is pulled from.

Table 14

	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%

Summary

From our data we can see that Disabled colleagues have a significantly worse experience than non-disabled colleagues, with six indicators being flagged as red, three as amber and two as a non-EDI priority.

Priorities from the EDI Strategic Action plan to address identified WDES areas of concern

- Divisions have EDI objectives in their Culture and People plans. They will be using their divisional level data from this report to deliver the strategic priority (patient first) pro-Equity breakthrough objective to address inequalities.
- This year the trust is focussing on ensuring that good inclusive practice is being delivered consistently across the trust. This includes reasonable adjustments, where HR services continue to develop their expertise to be the central place to hold reasonable adjustments, aligning with the NHS England approach.
- To tackle inequalities the trust needs to adopt the Social Model of Disability as their approach, which will be introduced to the trust through our Pro-Equity work. We are also working with HR colleagues to create Pro-Equity training which will cover the social model of disability and approaches to tackling ableism.

- It is anticipated that further embedding Respecting Everyone will further shift the dial to ensuring a fairer work environment for all colleagues.
- Further details of the actions underway to help mitigate the issues identified can be found in the EDI Strategic Action plan (appendix 2).

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. For the indicator breakdowns, where possible we have provided division level data to inform local level prioritisation of actions.

Summary report

Key

R — **Red:** Indicator has become worse since previous year or is significantly negative. Gap increasing or gap large.

A — **Amber:** Indicator has improved since previous year but still needs improvement. Gap reducing but action still needed.

Non-priority: Gap is minimal and stable. Specific EDI action not needed at a trust level but might be needed at a division level.

Definitions

pp: percentage point

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): Ethnically Minoritised staff have a 6.88 times greater gap between the proportion of staff at lower bands compared to upper bands than White staff.	RDR lower to upper ↑ 1.53	A	The Race Disparity ratio has widened 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.

Measure		Performance Summary			
Measure	**Description**	**Current position**	**Position since previous year**	**Performance year on year**	**Executive Summary**
WRES Indicator 2	The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants.	White candidates are 1.92 times more likely to be appointed than Ethnically Minoritised candidates from shortlist. 20.3% of Ethnically Minoritised Colleagues compared to 39.1% of white colleagues (18.2pp gap)	Relative likelihood ↑ by 0.3	R	The gap in the likelihood of white colleagues being appointed from shortlisting compared to ethnically minoritised colleagues has increased and the gap is still large. This gap is prevalent in all divisions.
WRES Indicator 3	The relative likelihood of BME staff entering the formal disciplinary process compared to white staff	0.44% of Ethnically Minoritised Colleagues enter the formal disciplinary process compared to 0.27% of white colleagues (0.17pp gap)	Relative likelihood ↑ by 0.31	R	Ethnically Minoritised colleagues are 1.59 times more likely to enter the formal disciplinary progress than white colleagues. The proportion of Ethnically Minoritised colleagues entering the formal disciplinary process has increased from 2022 to 2023.
WRES Indicator 4	The relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff	92.2% of Ethnically Minoritised Colleagues have accessed non-mandatory training and CPD compared to 71.9% of white colleagues (20.3pp gap)	Relative likelihood ↓ by 0.07		Ethnically Minoritised Colleagues are more likely to access non-mandatory training and CPD compared to white colleagues. This could be due to the induction process of internationally recruited colleagues 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.	23.9% of Ethnically Minoritised Colleagues compared to 22.3% of white colleagues (1.5pp gap)	Gap ↓ by 0.6pp		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 levels overall remain high for all colleagues.

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	20.5% of Ethnically Minoritised Colleagues compared to 19.7% of white colleagues (0.8pp gap)	Gap ↓ by 2.5pp		The gap in experience for Ethnically Minoritised Colleagues compared to White colleagues has reduced to only 0.8 percentage points. However, Womens and Childrens division is an outlier with a gap of 6.4 percentage points. Levels overall remain high for all colleagues.
WRES Indicator 7	Percentage of staff believing that trust provides equal opportunities for career progression or promotion	55.7% of Ethnically Minoritised Colleagues compared to 59.9% of white colleagues (4.2pp gap)	Gap ↓ by 6.7pp	A	Gap has halved so moving in the right direction, but still large experience gaps in divisions.
WRES Indicator 8	Percentage of staff experiencing discrimination at work from other staff in the last 12 months	11.8% of Ethnically Minoritised Colleagues compared to 5.4% of white colleagues (6.4pp gap)	Gap ↓ by 6.7pp	A	Gap has almost halved so moving in the right direction, but still large experience gaps in divisions.
WRES Indicator 9	The representation of BME people amongst board members	20% of the Board are ethnically minoritised colleagues	Representation ↑ by 7.5pp		The Board representation is slightly higher than the Bristol census.

WRES Indicator 1

Percentage and number of staff in NHS trusts by ethnicity

Workforce distribution by ethnicity WRES 2023 (Taken on 31st March 2024)

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 46.6% Ethnically Minoritised colleague representation.

When looking at model employer data, there has been an increase (greater than 1pp) in the proportion of Ethnically Minoritised colleagues at the following bands from 2022 to 2023:

- Band 5 = 10.0 percentage point increase
- Band 3 = 9.1 percentage point increase
- Band 2 and under = 4.7 percentage point increase
- Band 6 = 3.2 percentage point increase

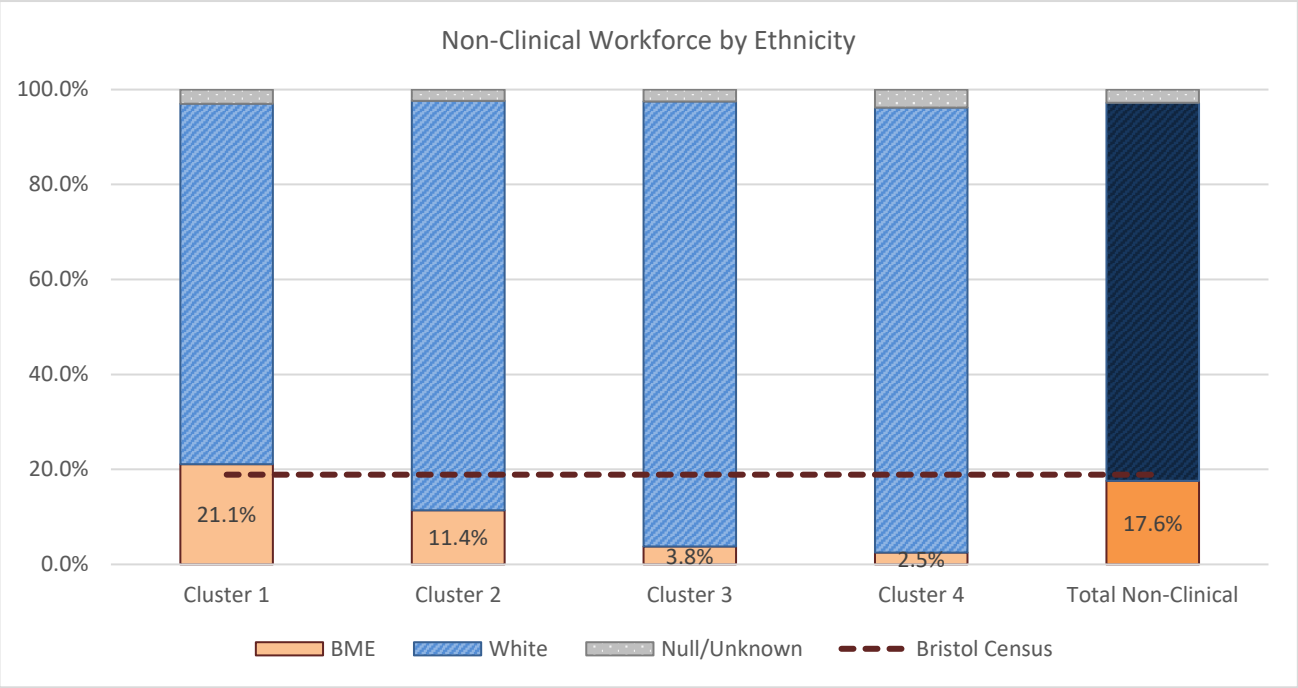
In 2023-24 we recruited over 470 Internationally Educated Nurses which is one of the main contributing factors to the increased ethnic diversity of our workforce.

Race Disparity Ratio

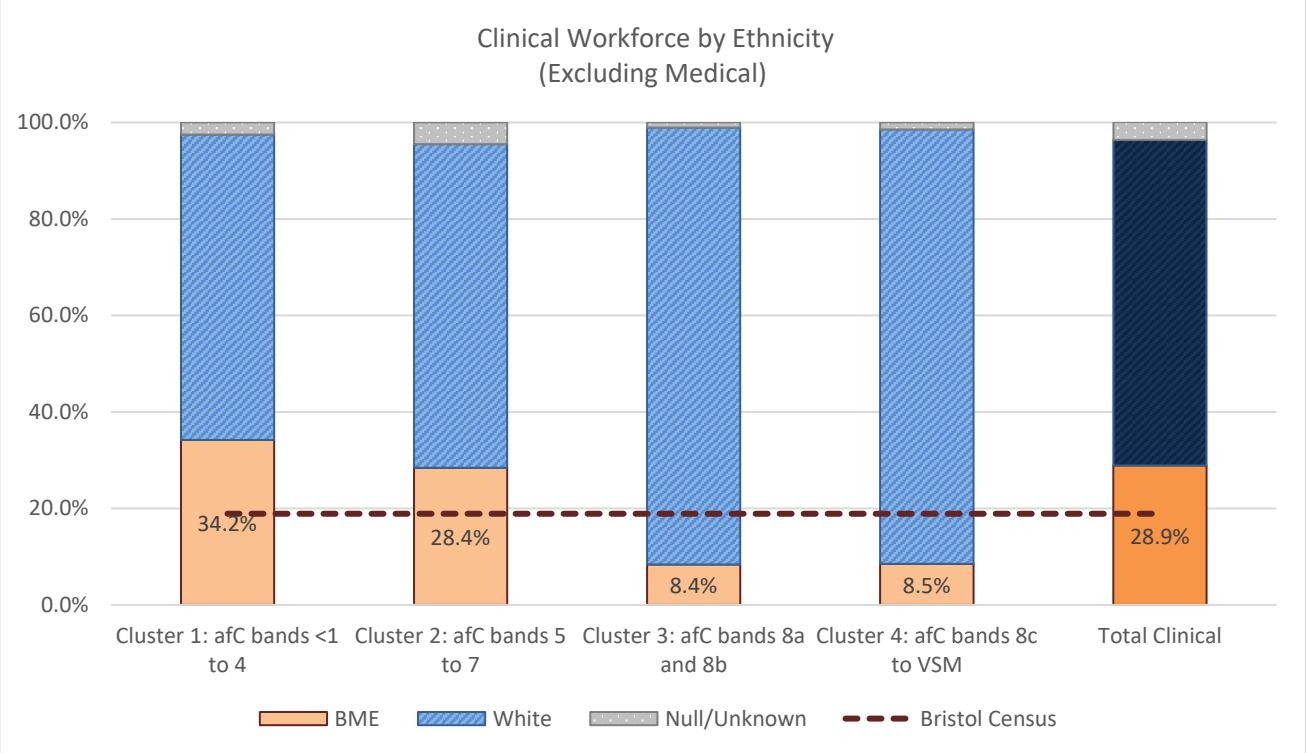
In 2023 Ethnically Minoritised staff have a 6.88 times greater gap between the proportion of staff at lower bands compared to upper bands than White staff, which has increased since 2022. However, this is due to the increase in representation of Ethnically Minoritised colleagues in bands 6 and below, meaning we need to work on our staff pipeline to ensure these colleagues progress into higher bands.

WRES Indicator 1: Trust Level Data

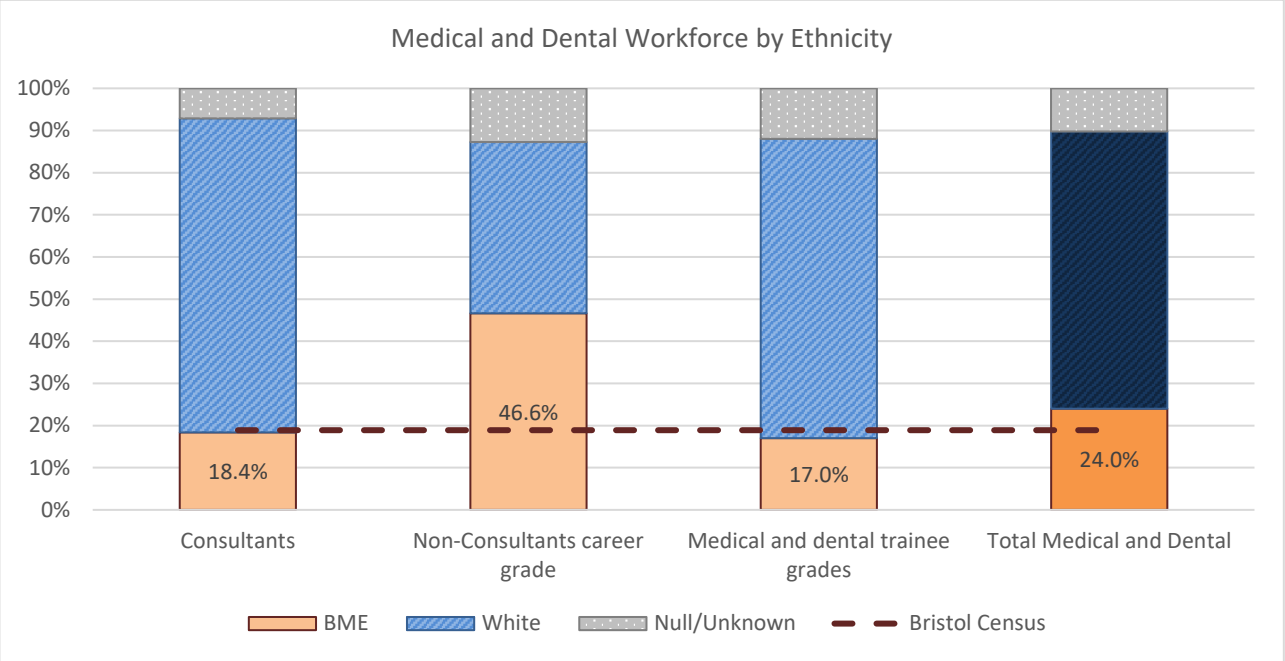
Graph 26



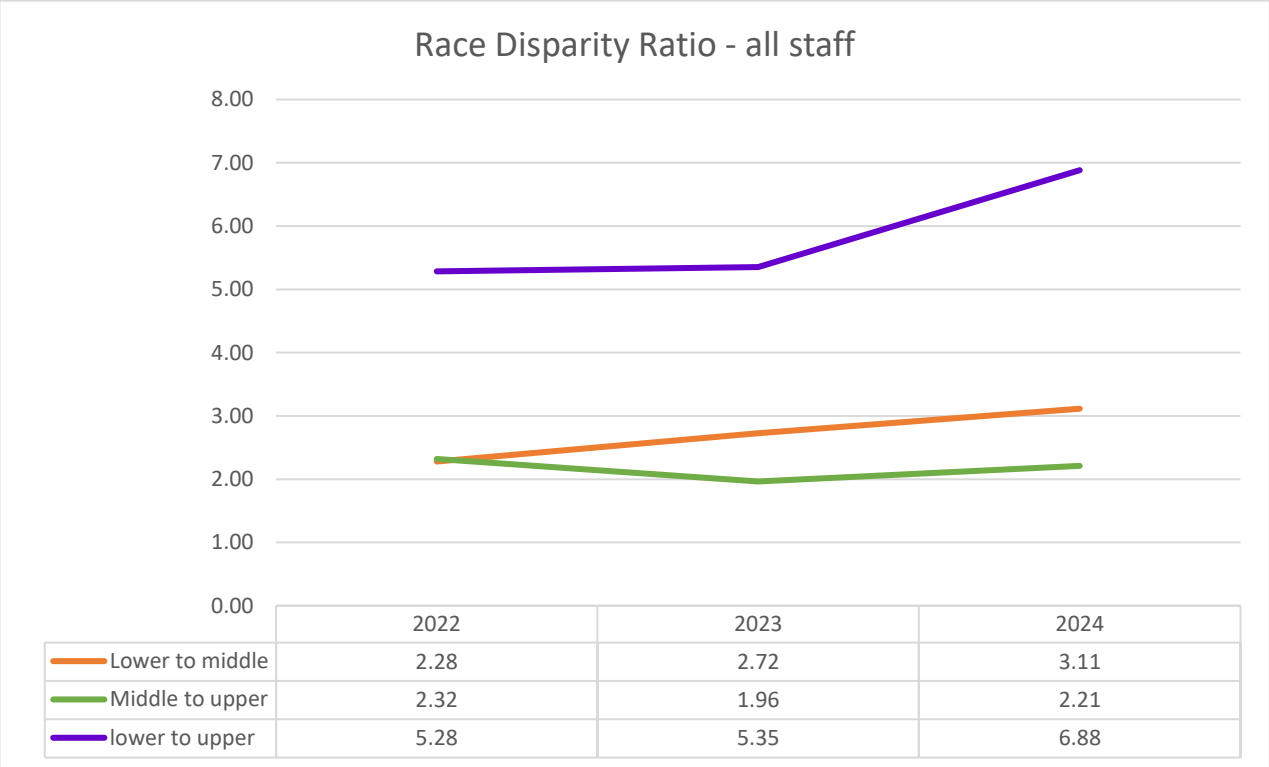
Graph 27



Graph 28

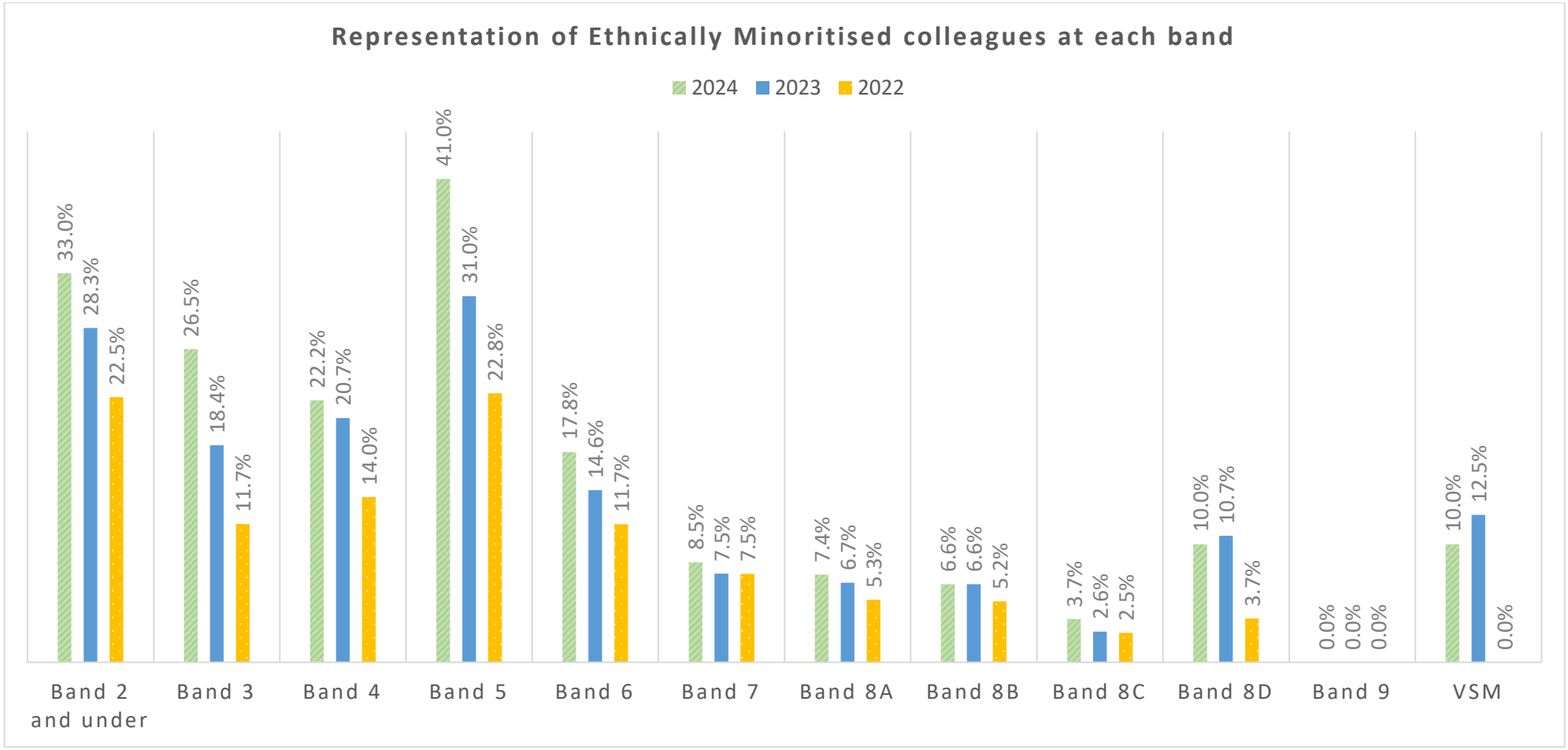


Graph 29



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

Graph 30


Representation of Ethnically Minoritised colleagues at each band
2024
2023
2022
33.0%
28.3%
22.5%
26.5%
18.4%
11.7%
22.2%
20.7%
14.0%
41.0%
31.0%
22.8%
17.8%
14.6%
11.7%
8.5%
7.5%
7.5%
7.4%
6.7%
5.3%
6.6%
6.6%
5.2%
3.7%
2.6%
2.5%
10.0%
10.7%
3.7%
0.0%
0.0%
0.0%
10.0%
12.5%
0.0%
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 Summary

Ethnically Minoritised Colleague Representation

The following divisions have Ethnically Minoritised colleague representation below the Bristol Census rate of 18.9%:

- Trust Services 14.1%
- Womens and Childrens 14.8%
- Diagnostics and Therapies 16.2%

AfC Clusters

Ideally, representation of Ethnically Minoritised colleagues should be similar across pay bands however, there is a trend of higher representation at lower grades.

Cluster 1 to Clusters 3 and 4 disparities

- Facilities and Estates: 30.9 percentage point gap between cluster 1 and clusters 3 and 4
- Medicine and Specialised Services: 23.6 percentage point gap between cluster 1 and clusters 3 and 4
- Surgery: 21.1 percentage point gap between cluster 1 and clusters 3 and 4

Cluster 2 representation

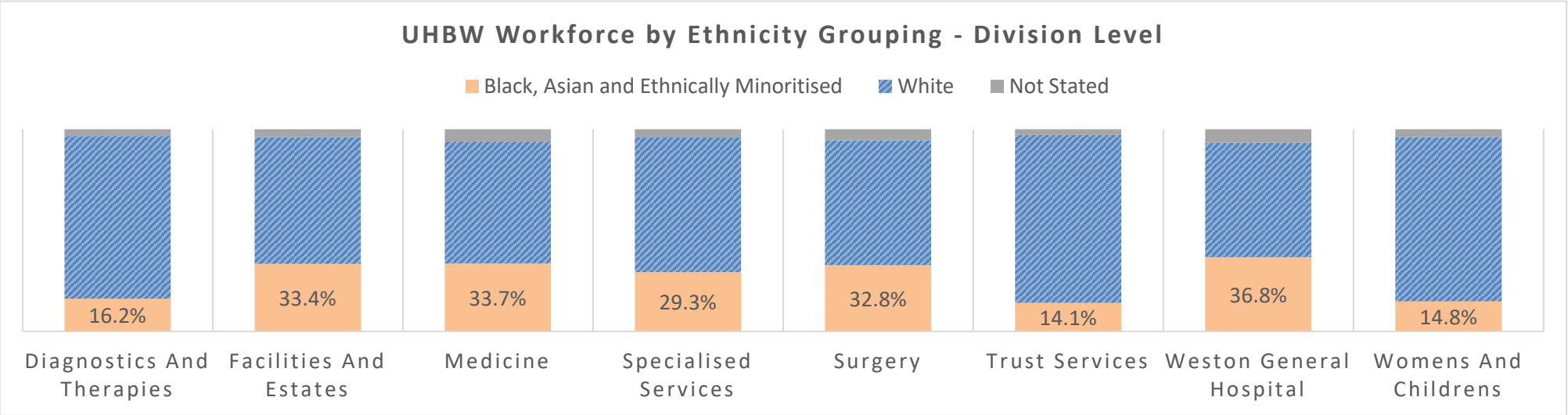
Positively, Weston and Surgery have the highest representation at Cluster 2 however, they need to focus on progressing these colleagues into Clusters 3 and 4 to increase representation.

Lowest representation at Cluster 2:

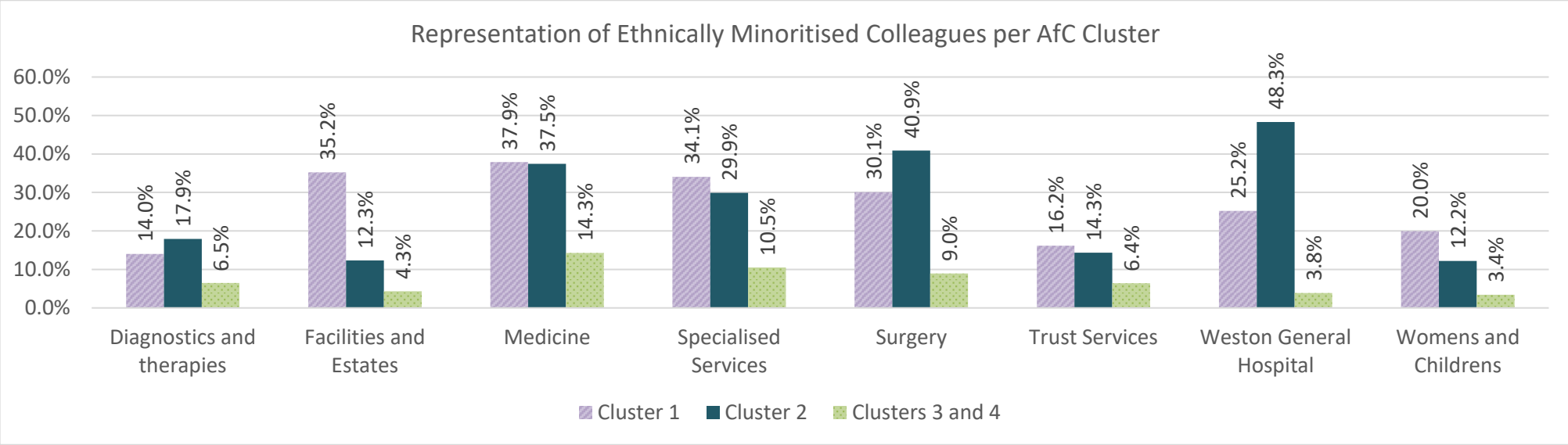
- Womens and Childrens 12.2%
- Facilities and Estates 12.3%
- Trust Services 14.3%

WRES Indicator 1: Division Level Data

Graph 31



Graph 32



WRES Indicator 2

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

The difference between the proportion of Minority Ethnic Colleagues being appointed from shortlisting compared to White colleagues is increasing.

The relative likelihood of white candidates being appointed from shortlisting compared to Ethnically Minoritised candidates has increased from 2022 to 2023, from white colleagues being 1.62 times more likely to be appointed in 2022 to being 1.92 times more likely to be appointed in 2023. This increase has been caused by proportionately less Ethnically Minoritised colleagues being appointed fr0m shortlisting (dropping from 25.0% of colleagues to 20.3% of colleagues).

The following Divisions show the highest experience gap where Ethnically Minoritised colleagues are less likely to be appointed form shortlisting:

- Womens and Childrens (28.7pp)
- Medicine (19.2pp)
- Diagnostics and Therapies (18.2pp)

However, it is important to note that all divisions have a gap of at least 13.8pp and that this is a whole trust recruitment issue. When colleagues without the right to work in the UK are removed from the dataset, for the majority of the divisions the gap gets wider, showing the gap is not due to shortlisted individuals not being appointed due to visas or sponsorship. It is reasonable to believe that institutionally racist practices are in place within our recruitment processes and practices.

Graph 33

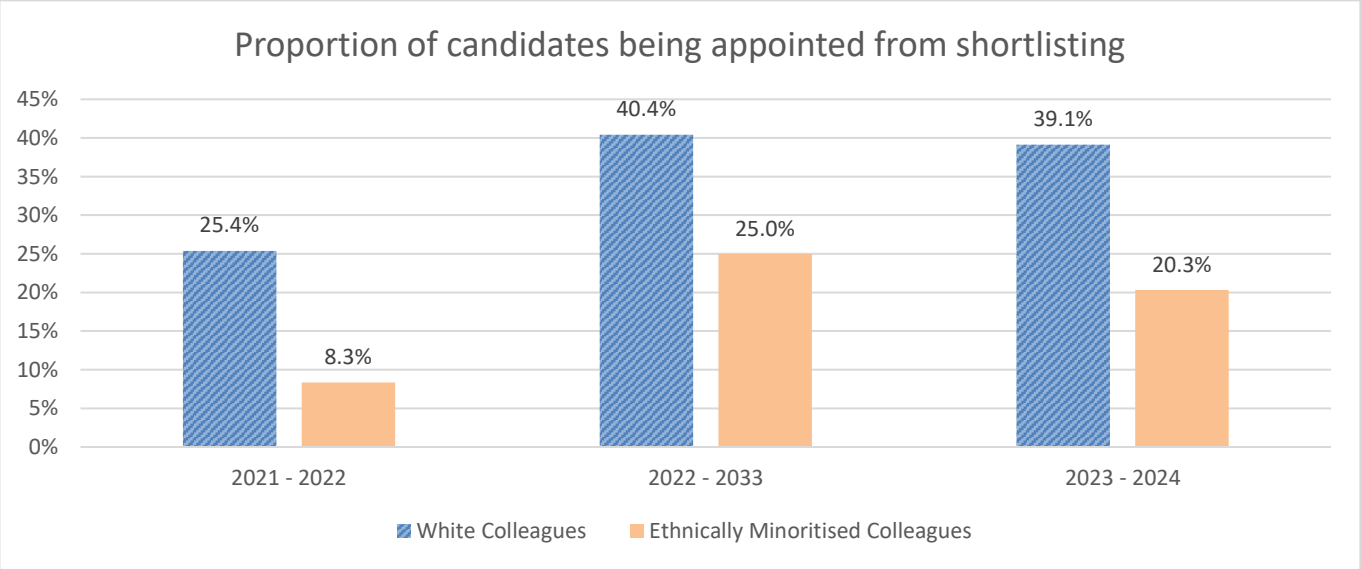


Table 15

Division	Ethnically Minoritised	White	Gap Ethnically Minoritised to White (percentage Points)	
Diagnostics And Therapies	16.8%	35.0%	**18.2**	
Facilities And Estates	19.2%	33.3%	**14.1**	
Medicine	20.6%	39.8%	**19.2**	
Specialised Services	24.9%	41.2%	**16.3**	
Surgery	20.9%	36.5%	**15.6**	
Trust Services	24.1%	37.9%	**13.8**	
Weston General Hospital	21.5%	36.5%	**15.0**	
Womens And Childrens	19.4%	48.1%	**28.7**	

WRES Indicator 3

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

Although the proportion of both White and Ethnically Minoritised colleagues entering the formal disciplinary process has reduced, the gap in experience has widened, with the relative likelihood of Ethnically Minoritised colleagues entering the formal disciplinary process being 1.92 times more likely than white colleagues (table 16).

We launched the respecting everyone approach in 2023, which could be one of the reasons the rate of colleagues entering the formal disciplinary process has reduced. Progress and impact so far since launching:

- A six-month review of Respecting Everyone has been completed. This shows that cases continue to decline with the latest position showing a reduction over the past 6 months of the Respecting Everyone Policy live date of 49% versus the previous year (266 cases reduced to 133).
- There continues to be a year-on-year reduction in Employee Relations cases with 78 *formal* employee relations cases in Q4 2023/2024 compared to 120 in Q4 2022/2023.
- 43% of cases were dealt with informally using Respecting Everyone principles.

In light of the Too Hot to Handle Report, focusing on the experiences of raising allegations of racism within NHS organisations, and the people team focus to improve inclusion within HR we will be

working with BNSSG Partners and UWE Bristol to create Pro-Equity training for HR colleagues which will focus on anti-racist practice.

As we are looking at less than 30 staff for each demographic, if we cut the data at a division level the numbers would be too small for robust analysis.

Graph 34

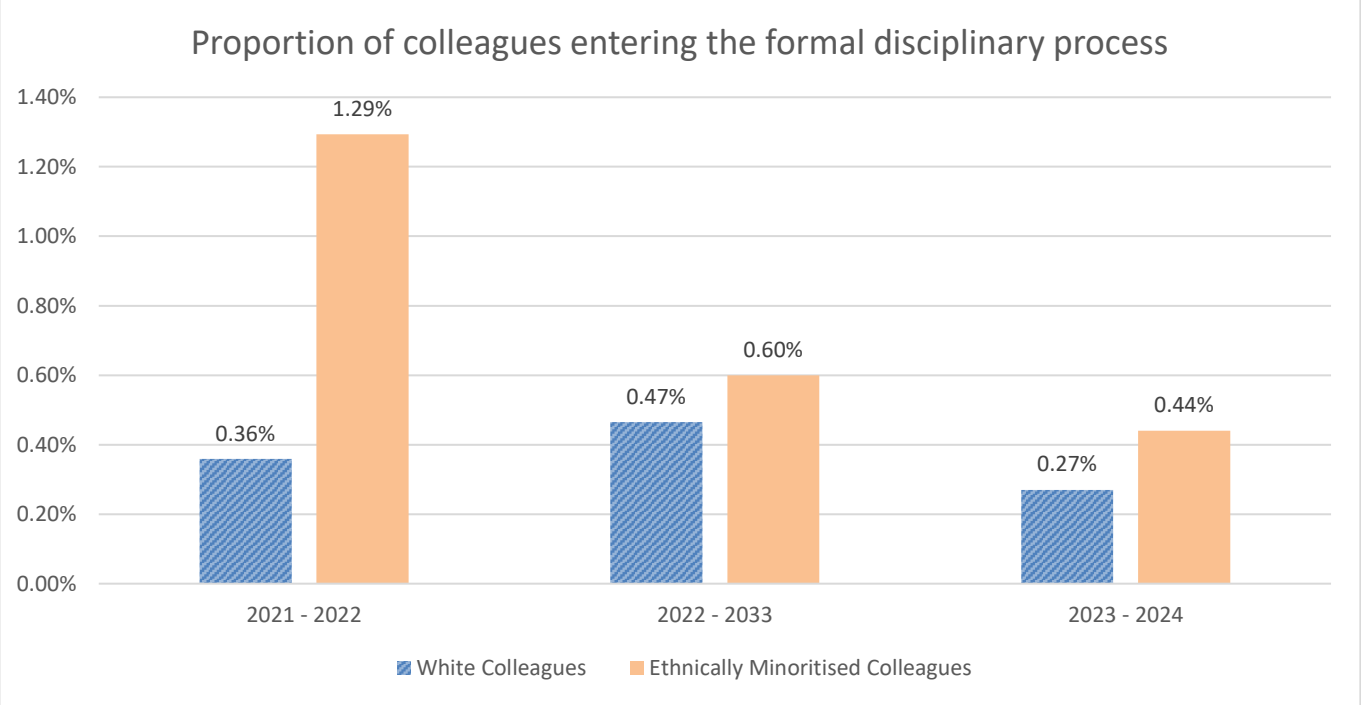


Table 16

	Relative likelihood* of Ethnically Minoritised staff entering the formal disciplinary process compared to white staff
2021 - 2022	3.13
2022 - 2033	1.62
2023 - 2024	1.92

*A figure above 1.00 would indicate that Ethnically Minoritised colleagues are more likely than White colleagues to enter the formal disciplinary process. A figure below 1.00 would indicate that Ethnically Minoritised colleagues are less likely than White colleagues to enter the formal disciplinary process.

WRES Indicator 4

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

Year on year, the proportion of colleagues accessing non-mandatory training and CPD increases. Ethnically Minoritised colleagues are more likely to access non-mandatory training and CPD than White colleagues (table 17) however, this could be due to the increased international colleague recruitment and their induction process counting as on-mandatory training.

As the data is falsely positive, cutting the data at divisional level will not provide further information or guidance on inequalities.

Graph 35

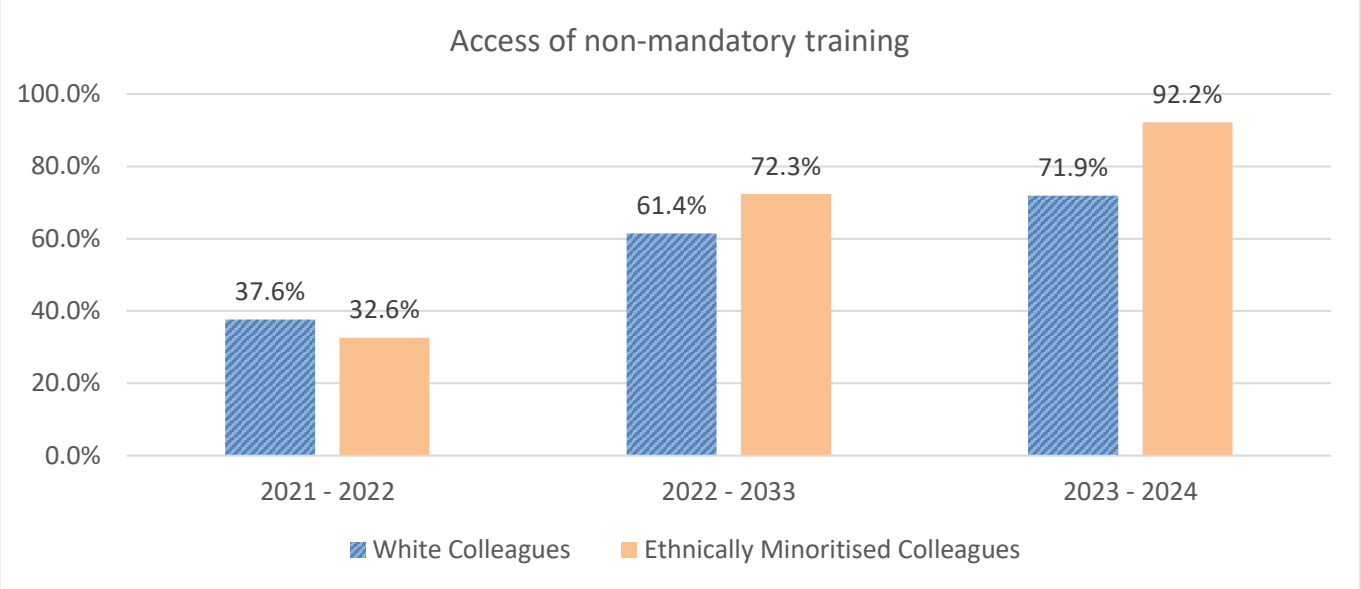


Table 17

	Relative likelihood* of white colleagues accessing non-mandatory training and CPD compared to Ethnically Minoritised colleagues
2021 - 2022	1.15
2022 - 2033	0.85
2023 - 2024	0.78

*A figure above 1.00 would indicate that White colleagues are more likely than Ethnically Minoritised colleagues to access non-mandatory training and CPD. A figure below 1.00 would indicate that White colleagues are less likely than Ethnically Minoritised 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.

The following Divisions show an experience gap where Ethnically Minoritised colleagues experience harassment, bullying or abuse from patients / service users, their relatives, or the public in the last 12 months:

- Facilities and Estates (4.0pp)
- Diagnostics and Therapies (3.5pp)
- Weston General Hospital (3.5pp)

Although for Medicine, more White staff experience harassment, bullying and abuse, they have the second highest proportion of Ethnically Minoritised Staff experiencing it (36.7% of Ethnically Minoritised Colleagues). Culturally both Medicine and Weston general Hospital have overall high levels of harassment, bullying or abuse from patients / service users, their relatives, or the public compared to the other divisions.

Graph 36

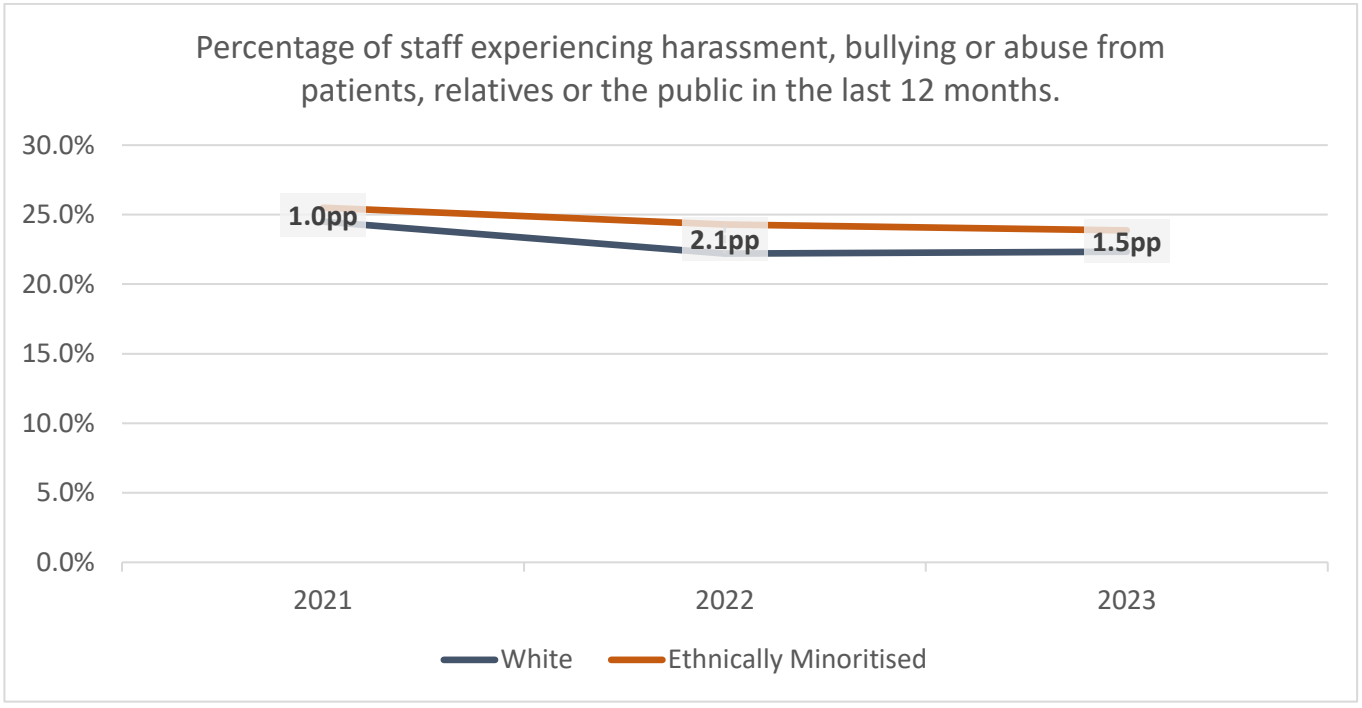


Table 18

Division	Ethnically Minoritised	White	Gap Ethnically Minoritised to White (Percentage Points)
Diagnostics And Therapies	20.2%	16.7%	3.5
Facilities And Estates	13.8%	9.8%	4.0
Medicine	36.7%	45.2%	-8.4
Specialised Services	25.8%	24.8%	1.1
Surgery	21.4%	27.7%	-6.3
Trust Services	9.0%	7.3%	1.7
Weston General Hospital	40.8%	37.2%	3.5
Womens And Childrens	19.4%	22.7%	-3.3

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 reduced to only 0.8 percentage points.

However, this should not take away from the fact that 19.7% of Ethnically Minoritised Colleagues and 20.5% of White colleagues have experienced harassment, bullying or abuse from staff in last 12 months, which is a high proportion. This is being addressed by the 'Respecting Everyone' and the 'It Stops With Me' campaign.

The Women's and Childrens division is an outlier with a 6.4 percentage point experience gap where Ethnically Minoritised colleagues experience higher rates of harassment, bullying or abuse from staff in last 12 months.

Although some divisions White colleagues experience harassment, bullying and abuse, they still have high proportions of Ethnically Minoritised Staff experiencing it:

- Weston General Hospital 25.4%
- Women and Children's 23.5%
- Surgery 23.5%

Graph 37

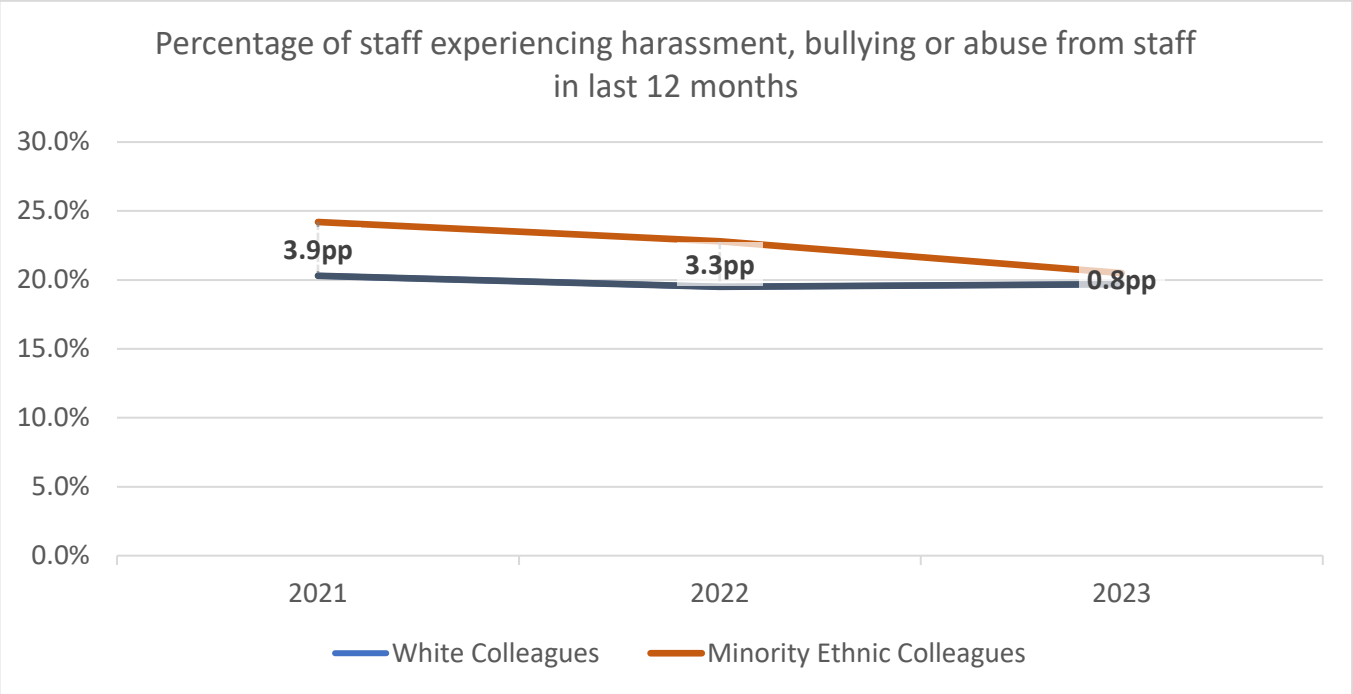


Table 19

Division	Ethnically Minoritised	White	Gap Ethnically Minoritised to White (percentage Points)
Diagnostics And Therapies	17.0%	16.0%	**1.0**
Facilities And Estates	15.6%	18.1%	**-2.6**
Medicine	22.8%	22.1%	**0.7**
Specialised Services	16.0%	18.7%	**-2.7**
Surgery	23.5%	25.5%	**-1.9**
Trust Services	16.2%	16.1%	**0.1**
Weston General Hospital	25.4%	30.8%	**-5.4**
Womens And Childrens	23.5%	17.1%	**6.4**

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 more than halved in year last year (10.9 percentage points in 2022 and only 4.2 percentage points in 2023).

Overall, the proportion of Ethnically Minoritised colleagues who feel they have been provided with equal opportunities for career progression has increased to 55.7% (3.6 percentage point increase since 2022). However, this is still only slightly more than half of colleagues.

The following Divisions have the three largest experience gaps where Ethnically Minoritised colleagues report lower opportunities of career progression compared to White colleagues:

- Trust Services (10.1pp)
- Womens and Childrens (7.1pp)
- Diagnostic and Therapies (6.7pp)

Graph 38

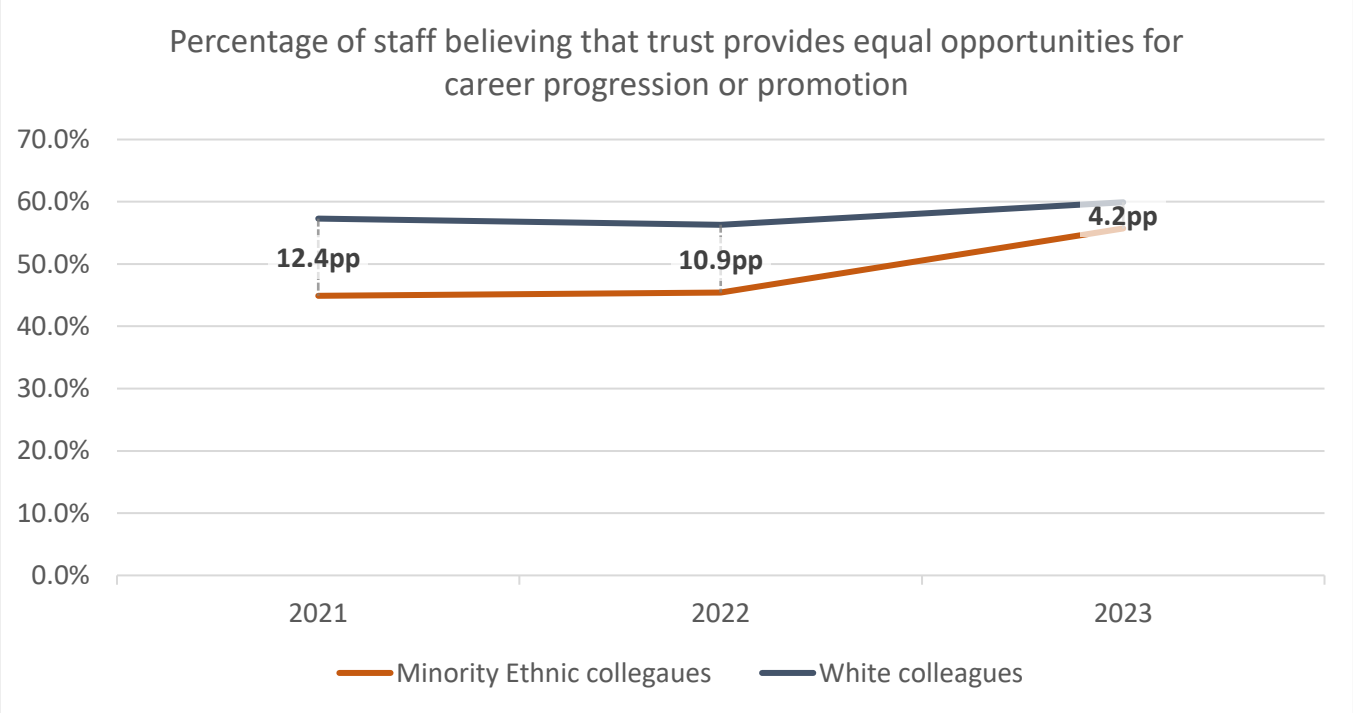


Table 20

Division	Ethnically Minoritised	White	Gap Ethnically Minoritised to White (percentage Points)
Diagnostics And Therapies	54.3%	60.9%	**6.7**
Facilities And Estates	55.4%	50.4%	**-5.0**
Medicine	60.8%	63.1%	**2.3**
Specialised Services	56.7%	62.0%	**5.3**
Surgery	53.4%	57.2%	**3.8**
Trust Services	49.5%	59.6%	**10.1**
Weston General Hospital	56.9%	59.0%	**2.1**
Womens And Childrens	57.0%	64.0%	**7.1**

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 reduced by 5.3 percentage points.

Overall, the proportion of Ethnically Minoritised colleagues who experienced discrimination at work from other staff has decreased to 11.8% (2.5 percentage point increase since 2021).

The following Divisions have the three largest experience gaps where Ethnically Minoritised colleagues report higher incidences of discrimination at work compared to White colleagues:

- Womens and Childrens (11.9pp)
- Specialised Services (10.2 pp)
- Weston General Hospital (6.2pp)

Graph 39

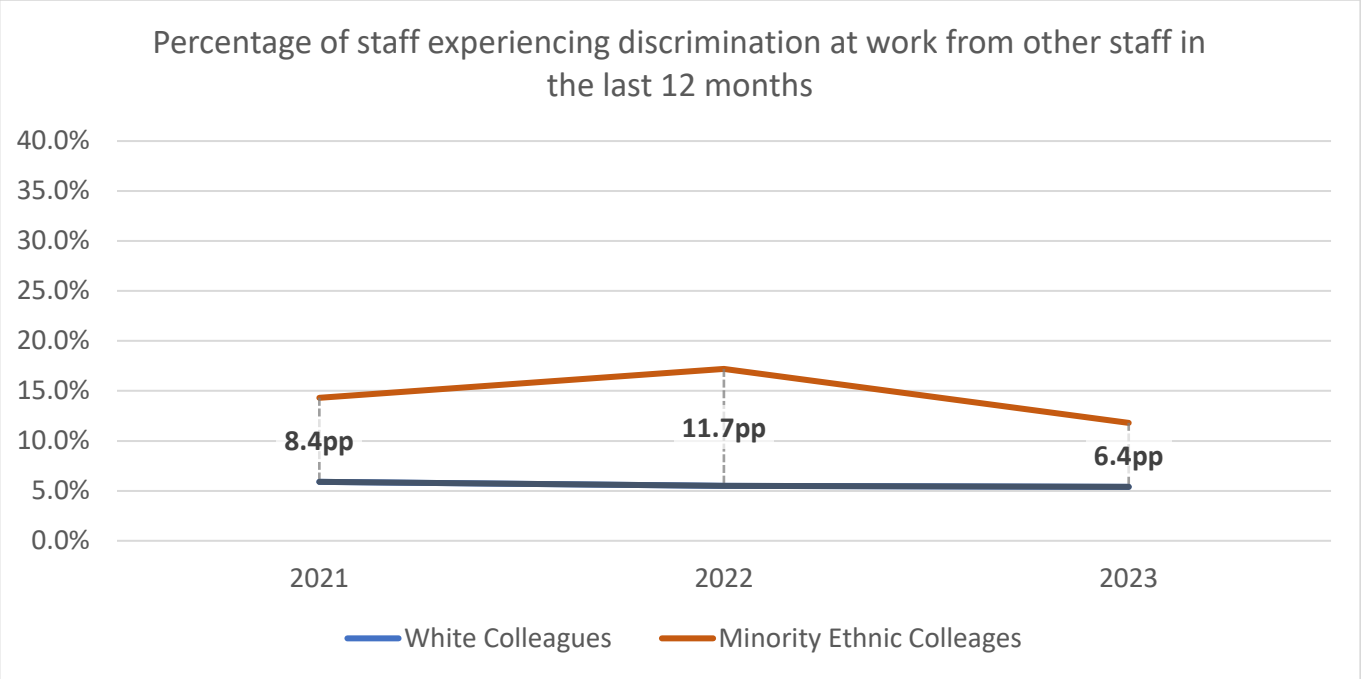


Table 21

Division	Ethnically Minoritised	White	Gap Ethnically Minoritised to White (percentage Points)
Diagnostics And Therapies	8.5%	4.1%	**4.4**
Facilities And Estates	8.0%	6.0%	**2.0**
Medicine	10.8%	5.8%	**5.1**
Specialised Services	15.3%	5.1%	**10.2**
Surgery	12.5%	7.7%	**4.9**
Trust Services	7.1%	4.8%	**2.4**
Weston General Hospital	14.4%	8.1%	**6.2**
Womens And Childrens	15.9%	3.9%	**11.9**

WRES Indicator 9

The representation of BME people amongst board members

Year on year the representation of Ethnically Minoritised colleagues on the Board is increasing. However, it is important to note that representation does not equate to inclusive practices or diversity of thought.

Table 22

	All Board Members		
	White	Ethnically Minoritised	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%

Summary

From our data, two indicators are flagged as red, three as amber and four as a non-EDI priority. This is a better picture than the WDES indicators however, there are still areas (WRES indicators 2 and 3) that require targeted action to eradicate inequalities.

It is reasonable to believe that institutionally racist practices are in place within our recruitment processes and practices.

As the Division of Womens and Childrens has the largest gaps for indicators 2, 6 and 8, the second largest gap for indicator 7 and the second lowest representation of Ethnically Minoritised colleagues out of all divisions, it is reasonable to believe that there is an institutionally racist culture within the division.

Priorities from the EDI Strategic Action plan to address identified WRES areas of concern

- Divisions have EDI objectives in their Culture and People plans. They will be using their divisional level data from this report to deliver the strategic priority (patient first) pro-Equity breakthrough objective to address inequalities.
- To tackle recruitment inequalities, the nationally recognised Bridges Programme, a positive action recruitment programme, continues to support Ethnically Minoritised colleagues with their career development, with cohort 5 starting in September 2025.

- Within the EDI Strategic Plan 2024-25 we have a large commitment to making our recruitment practices more inclusive, with the adoption of the BNSSG inclusive resourcing toolkit, working with the system to strengthen the resources provided and cover any gaps. We will also be creating Pro-Equity training for HR colleagues which will cover anti-racist practice. This training will also help reduce gaps in experience through the formal disciplinary process.
- We are also embedding the newly launched Respecting Everyone approach, aims to resolve issues regarding bullying and harassment, grievances, conduct and capability, as quickly, and as fairly, as possible.
- From the RDR, we can see we now have a good representation of Ethnically Minoritised colleagues in bands 6 and below however, more work needs to be done to develop this pipeline of colleagues. Later this year, options for Bridges+, the next stage of the Bridges programme will be explored, to determine the best approach for career development support into bands 7 and above. The inclusive recruitment work will also support this.
- To target discrimination at work, the EDI advocate scheme has been reviewed, with a refreshed approach launching summer 2024, educating colleagues on inclusive practice and increasing their skills and awareness around EDI topics. The respecting everyone approach will also support in tackling this.

Further details of the actions underway to help mitigate the issues identified can be found in the EDI Strategic Action Plan (appendix 2).

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.

This year, the focus of the EDI Strategic Action Plan is to lay the foundations of inclusive practice though:

- Community building (Staff Networks)
- Confidence building and teaching inclusive thought processes (EDI Advocates, HR Training, Education)
- Divisional A3 thinking (Patient First Breakthrough Objective)

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.

In 2024/25 we are working with our four staff networks to align their Practices to the NHS England Staff Network Toolkit. The priority for networks will be community building, creating safe spaces for colleagues with shared protected characteristics. We aspire to have networks that are joyous, passionate, connected and inclusive.

At the staff network development morning, network chairs fed back that their main challenge is time for the role. There is a large administrative burden on Network leads, and they spend a significant amount of time managing inboxes and coordinating meetings rather than connecting with their network. It is also difficult for network members to be released for meetings.

We are using our central EDI resource to work with the network chairs to streamline the administrative burdens and we hope that the work with our EDI Advocates and Divisional A3 thinking, colleagues will recognise the value of releasing colleague time for network activity.

7. Pro-Equity

As a trust, we have been working to define our approach to tackle inequalities to ensure this is done in a genuine and purposeful way, avoiding tokenistic EDI activity.

The Board and SLT have been working with Eden Charles, an external expert since January 2023. They explored a different approach to make cultural transformation noting that the traditional plans arising from data sets such as the WRES/WDES had failed to deliver real change in the NHS. The Board explored the cultural web model and New Power, and the sessions were framed to describe how once we can 'see differently' we can 'behave differently.

From this work, the Pro-Equity approach was defined as the way forward at UHBW, and a Pro-Equity Approach was drafted to summarise our intent and the way forward: Building a place where everyone feels truly safe to be themselves and can expect the same experience and opportunities at work. To be pro-equity we must be against that which prevents it. We will be anti-racist, anti-ableist, anti-sexist, anti-homophobic. We aspire to be actively against all forms of discrimination.

Our Pro-Equity charter was signed off at SLT on June 20th, our communications and engagement plan will commence the first week of July which will include our Staff Networks, EDI Advocates, Divisions, using a number of communication channels including Viva Engage.

8. Next Steps

We have a two-pronged approach to embedding Pro Equity at UHBW: our Patient First Breakthrough Objective (appendix 4) and our Pro-Equity Approach.

Patient First Breakthrough Objective	Pro-Equity Approach
• Whole trust action to address inequalities • Divisions will use this report to inform A3 thinking and divisional catch ball activity, identifying areas for focussed activity.	• Co-creation of an Anti-racism statement • Co-creation of a Social model of Disability statement • Co-creation of an inclusive language guide

To bring the Pro-Equity Approach to life, and ensure our work resonates with minoritised colleagues, we will be working with our Black, Asian, Chinese, Multiple Hertiage and other ethnically minoritised colleagues to co-produce and anti-racism statement. We will also work with disabled colleagues to co-create a social model of disability statement. These will cement our intentions in tackling racism and ableism in all forms (institutional, interpersonal, and internalised).

As much as the Pro-Equity Approach and associated work will help embed our approach, the action to drive change is defined within the patient first project charter (appendix 4). This was signed off by the Senior Leadership Team (SLT) on the 20th of June.

Divisions have EDI objectives in their Culture and People plans. They will be using their divisional level data from this report to deliver the strategic priority (patient first) pro-Equity breakthrough objective to address inequalities.

EDI Action Plan

It is recognised that a number of factors have the potential to impact on the agreed targets and overall aim. Below is a high level summary of the planned activity this year, further detail can be found in the EDI Strategic Action plan (appendix 2).

Interpersonal actions (how we treat each other)

- Embedding the learning from the Staff Network National Framework review through staff network workshops to make space for creative thinking and to set annual goals and delivery plans with each network.
- Complete the EDI Advocate scheme review to clarify the role and objectives. Launch new approach with a recruitment drive.
- Implement the Sexual Safety action plan focusing on three key areas; policy, communication and listening aligned to the NHS Sexual safety in healthcare – organisational charter.

Institutional actions (our policies, practices, and procedures)

- Deliver the pro-equity breakthrough objective, using continuous improvement methodology.
- Review and Embed evaluation into the Bridges scheme to show learner progress from start to finish and to identify areas for development within the programme.
- Develop training offer for the HR Services team to develop the Inclusive HR agenda and progress conversations to improve the experience and support of disabled and ethnically minoritised colleagues.
- Continue to Establish clear career progression pathways, focusing on administration and clerical staff, medical/doctors, pharmacy and more challenging healthcare science in 2024/25.
- Continue to lead the implementation of the Trust 'Respecting Everyone' framework with the ambition to improve early resolution and reduce cases of bullying and harassment, conduct, capability and grievance.
- Implement and Embed BNSSG Inclusive Resourcing Toolkit, building on the learnings from the Medicine pilot.
- Refresh divisional race disparity ratio plans as part of the divisional A3 thinking process.

People Committee is asked to:

- Note the findings of this report.
- Support the delivery of the Divisional CAP plans and EDI Strategic Action plan 2024-25, incorporating the GPG, WDES, WRES, Model Employer and RDR key areas of concern, as described in this report.
- Receive an update in November 2024 as part of the EDI Biannual report which will also include progress against the Pro-Equity Patient First Objective.

9. 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).

Ethnically Minoritised

This term is used in this report to represent Black, Asian, Chinese, Multiple Heritage and Other Ethnic Minorities when grouped together. We have used 'Minoritised' as these ethnicities can be in the global majority however, they are minoritised in the UK, either by their representation or the way they are treated. We are using this term instead of BAME or BME (unless this is within a direct quote).

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 Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) 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)
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.

Stay with us : Together making UHBW the best place to work !

Organisational Development: Equality, Diversity and Inclusion Strategic Plan 2024/2025

People Strategy Theme: Inclusion And Belonging

People Strategy Objective: Develop a culture where we embed our values in policy and practices / Remove the experience gap between colleagues with minority protected characteristics

Strategic Driver	No	EDI Strategic Objective	Key Milestones	Timeline	Accountable Lead	Collaborators
PS1 PS2 EDS2G4	1	As leaders we role model the Values and Leadership behaviours creating an environment that encourages feedback and where staff feel safe to challenge **High Impact Action 2** **High Impact Action 6**	a. To complete the EDI Advocate scheme review to clarify the role and objectives. Launch new approach with a recruitment drive.	End of Q1	People EDI Manager	Patient EDI Manager Learning & Development Manager EDI Advocates HRBPs
			b. Create annual content plan for the EDI Advocates that aligns with the EDI calendar and key trust projects and priorities. With the aim of increasing confidence of colleagues when talking about EDI topics, especially racism and ableism.	End of Q1	People EDI Manager	Patient EDI Manager Learning & Development Manager EDI Advocates HRBPs
			c. Design a training and development programme for EDI advocates to build confidence, community and contemporary skills development.	End of Q2	People EDI Manager	Learning & Development Manager Head of Resourcing
			d. Review and Embed evaluation into the Bridges scheme to show learner progress from start to finish and to identify areas for development within the programme.	End of Q1	Learning & Development Manager	EDI Manager Bridges Cohorts
			e. Bridges + programme: research options for career progression positive action for minority ethnic colleagues at bands 6 to 8.	End of Q4	Head of Education	Learning & Development Manager Head of Resourcing

People Strategy Objective: Develop a culture where we embed our values in policy and practices

Strategic Driver	No	EDI Strategic Objective	Key Milestones	Timeline	Accountable Lead	Collaborators
PS1 PS2 WRES2-4 WRES6-9 WDES2-3 WDES5-9	2	We are 'committed to inclusion in everything we do' and this is evident in all our people policies and practices	a. Increase collaboration between People and Patient EDI activity, finding ways of working to find points of crossover and collaborative working. Set up quarterly meetings for collaborative working including collaborating on embedding EDS 2022 into our annual cycle, referring to good practice in BNSSG and the south west.	End of Q1	People EDI Manager	Patient EDI Manager BNSSG colleagues

People Strategy Objective: Celebrate and value the contributions of all our colleagues by ensuring they have a voice and are listened to

Strategic Driver	No	EDI Strategic Objective	Key Milestones	Timeline	Accountable Lead	Collaborators
PS1 PS2 WRES2-3 WDES8 WDES10-13	3	We celebrate and value the contribution all our staff make at all levels of the organisation **High Impact Action 6**	a. Champion Divisional data led decisions, good practice sharing and collaborative interventions for EDI, aligning Culture and People Plans to EDI data reporting.	End of Q1	Divisional HRBPs	Head of Education Head of Human Resource Services Head of Resourcing
			b. Create an annual plan for celebration events (history months and significant days) with supporting task groups allocated to each to ensure cross site and intersectional delivery.	End of Q1	People EDI Manager	Staff Network Leads EDI Advocates Divisional EDI Leads
			c. Develop training offer for the HR Services team to develop the Inclusive HR agenda and progress conversations to improve the experience and support of disabled colleagues.	Phase 1 end Q1 Phase 2 Inclusive HR end Q2 Full training offer end Q3	Head of Human Resource Services supported by People EDI Manager	People EDI Manager Head of Education Head of Human Resource Services Head of Resourcing

People Strategy Objective: Remove the experience gap between colleagues with minority protected characteristics

Strategic Driver	No	EDI Strategic Objective	Key Milestones	Timeline	Accountable Lead	Collaborators
PS2 PS4 GPG WRES WDES	4	We will encourage shared learning by openly sharing our diversity data in a meaningful way **High Impact Action 3** **High Impact Action 6**	a. Create baseline report summarising EDI Data that combines Model Employer, WRES, WDES, Gender Pay Gap, EDI High Impact Actions and Staff Survey data (including Division level data).	End of Q1	People EDI Manager	HRIS Recruitment
			c. Ensure annual reporting cycle in place and is robustly managed to support Divisions to update against their plans and demonstrate positive actions taken to remove experience gap and meet model employer gap.	End of Q1	People EDI Manager	HRBPs Deputy HRBPs Division EDI Leads
			b. Set up task and finish group to create EDI data development timeline to improve robustness, frequency of reporting and division level information. Prioritising promotion data	End of Q3	People EDI Manager	HRIS Recruitment

People Strategy Objective: Develop a culture where we embed our values in policy and practices						
Strategic Driver	**No**	**EDI Strategic Objective**	**Key Milestones**	**Timeline**	**Accountable Lead**	**Collaborators**
PS1 PS4 GPG WRES WDES	5	Our strategy is communicated at all levels reflecting our commitment to change	a. Champion the approach to tackling racism, following on from the pro equity discussions at SLT, ensuring all actions are aligned to this approach.	Launch phase 1 End of Q1 Embedding phase 2 End of Q3	People EDI Manager	Chief People Officer Patient EDI Lead
			b. Strengthen the EDI provision on internal website to include helpful guides and resources for colleagues, including good practice examples, collaborating with Experience of Care & Inclusion Team where appropriate	Phase 1 end of Q1 Phase 2 end of Q2	People EDI Manager	EDI Coordinator
			See 1b and 3b			

People Strategy Objective: Remove the experience gap between colleagues with minority protected characteristics / Celebrate and value the contributions of all our colleagues by ensuring they have a voice and are listened to						
Strategic Driver	**No**	**EDI Strategic Objective**	**Key Milestones**	**Timeline**	**Accountable Lead**	**Collaborators**
PS1 PS4 EDS3.3 WRES4	6	Our Education Strategy focuses on inclusion and is a key enabler to delivering the vision supported by our Trust values **High Impact Action 5**	a. Establish clear career progression pathways for staff groups	Administration & clerical end of Q2	Head of Education	Apprenticeship (CIAG) Manager, A&C pathway lead, ICB partners
			b. Continue to review and evolve the induction model based upon robust inductee feedback. Implement a consistent medical induction across all sites.	Phase 1 end of Q2 Phase 2 Implementation end of Q4	Head of Education	Workforce and Reporting Manager, Medical Education Manager, induction stakeholders
			c. Support language cafe's to improve staff proficiency in spoken English	End of Q1	Head of Education	Apprenticeship (CIAG) Manager, ICB partners, training providers
			d. Develop T-level pathways across each relevant staff group. Bring on stream alternative work experience provision, such as Prince's Trust and those with learning difficulties. Review how widening engagement programmes feed the Trust's recruitment pipeline and develop a diverse work experience offer to reflect the Trust's local community.	End of Q4	Head of Education	Head of Resourcing, Apprenticeship (CIAG) Manager, ICB partners and ICB Project Leads, local colleges
			e. Develop with system partners the one-stop careers hub model. Devise an apprenticeship hub across the system	Phase 1 careers hub end of Q2 Phase 2 wider roll out end of Q4	Head of Education	Apprenticeship (CIAG) Manager, ICB partners and ICB project leads
			f. Develop a BNSSG stepping up programme for our ethnic minority, disabled and LGBTQ+ colleagues	Phase 1 development end of Q2 Phase 2 implementation end of Q4	Head of Education	Leadership, Management and Coaching Lead, ICB partners and key stakeholders
			g. Deliver leadership development for all staff groups, integrate and expand the graduate and talent programmes	Leadership Provision: Phase 1 plan end of Q2 Phase 2 implementation end of Q4 Graduate programme: Phase 1 governance end of Q1 Phase 2 implementation end of Q2	Head of Education	Leadership, Management and Coaching Lead, NHSE
			h. Improve the percentage of staff from minority groups who access learning opportunities	Phase 1 learner dashboard end of Q2 Phase 2 data end of Q3	Head of Education	Workforce and Reporting Manager, L&D service leads
			i. Improve curriculum materials and resources to be more representative of all learner groups. Support digital resource which meets the needs of the audience	Phase 1 review end of Q1 Phase 2 implementation end of Q3	Head of Education	Leadership, Management and Coaching Leads, essential training subject leads, Library, Knowledgement Management and Digital Lead

People Strategy Objective: Develop a culture where we embed our values in policy and practices / Remove the experience gap between colleagues with minority protected characteristics						
Strategic Driver	**No**	**EDI Strategic Objective**	**Key Milestones**	**Timeline**	**Accountable Lead**	**Collaborators**
PS2 PS4 WRES3 WRES9 WDES3 WDES5 WDES9 WDES11	7	Inclusion is integral in our people policies encouraging positive conversation and introducing informal processes where possible **High Impact Action 3** **High Impact Action 6**	a. Continue to lead the implementation of the Trust 'Respecting Everyone' framework with the ambition to improve early resolution and reduce cases of bullying and harassment, conduct, capability and grievance.	Phase 1 lessons learnt session end of Q1 Phase 2 Introduce and embed case management system end Q1 Phase 3 Co-create training plan for HR services through the inclusive HR agenda (see 3c) end of Q3	Head of HR Services	HR Services team Divisional Leads (WWSG / HRBP) Line Managers and Supervisors Freedom to Speak Up Guardian & Champions Equality, Diversity and Inclusion team and EDI network Education team Workplace Wellbeing team Wellbeing Lead for Doctors and Dentists Staff Side (Unions) Commissioned service providers (TCM Group, etc.)
			b. Ensure policy group governance is revised to ensure inclusion is core to the development or amendment of policy and a policy schedule is in place by end of Q1	End of Q1	Head of Human Resource Services	

People Strategy Objective: Celebrate and value the contributions of all our colleagues by ensuring they have a voice and are listened to						
Strategic Driver	**No**	**EDI Strategic Objective**	**Key Milestones**	**Timeline**	**Accountable Lead**	**Collaborators**
PS1 PS2 EDS3 EDS4.1 WDES13	8	Staff Networks grow to become an increased staff voice who represent our workforce and the community we serve	a. Lead on embedding the learning from the Staff Network National Framework review through staff network workshops to make space for creative thinking and to set annual goals and delivery plans with each network.	End of Q1	People EDI Manager	Network Leads Network Executive Sponsors
			b. Embed the plan from staff network workshops to improve collaboration and connection from networks to their members to widen membership and increase engagement.	end of Q3	People EDI Manager	Network Leads Network Executive Sponsors

People Strategy Objective: Remove the experience gap between colleagues with minority protected characteristics						
Strategic Driver	**No**	**EDI Strategic Objectives**	**Key Milestones**	**Timeline**	**Accountable Lead**	**Collaborators**
HIA2 PS2 PS3 PS4 EDSG3 WRES WDES	9	We will be recognised as an inclusive employer committed to ensuring our workforce reflects the community it serves. **High Impact Action 2**	a. Implement and Embed BNSSG Inclusive Resourcing Toolkit, building on the learnings from the Medicine pilot.	End of Q1	Head of Resourcing	People EDI Manager
			b. Undertake a root and branch review of the accessibility of the recruitment process and documentation.	End of Q3	Head of Resourcing	People EDI Manager
			c. Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes.	End Q3	Head of Resourcing	People EDI Manager, Head of Education
			d. Expand BNSSG Inclusive Resourcing Toolkit using best practice to include de-bias content	End of Q4	Head of Resourcing	People EDI Manager
			e. Implement recruitment and promotion disparity task and finish group, looking at developing data measures and a strategic plan to reduce gaps in experience and outcomes during the recruitment and promotion process, based on the actions / data identified in the Culture and People Plans.	End of Q4	Head of Resourcing HRBPs	People EDI Manager

People Strategy Objective: Remove the experience gap between colleagues with minority protected characteristics						
Strategic Driver	**No**	**EDI Strategic Objective**	**Key Milestones**	**Timeline**	**Accountable Lead**	**Collaborators**
PS1 PS2 PS3 EDSG3 EDSG4	10	We will seek opportunities to learn from others, developing our partnerships at a regional and national level	a. Implement the Sexual Safety action plan focusing on three key areas; policy, communication and listening aligned to the NHS Sexual safety in healthcare – organisational charter.	Phase 1 end of Q2 Phase 2 to be determined	Associate Director of Organisational Development and Wellbeing	Chief People Officer Women's staff network Comms
			b. Ensure the Hotspots of Sexual Harassment that are identified in the staff survey have actions to address within the division's Culture and People plans.	End of Q1	People EDI Manager	HRBPs Deputy HRBPs Division EDI Leads
			c. Establish UHBW as a integrated member of the Bristol and South West EDI community by engaging with BNSSG, Bristol Women's in Business, Race in the City, SW EDI Leads and have a plan in place to share learning and co-creation opportunities.	End of Q1	People EDI Manager	Patient EDI Manager System Partners
			d. Engage with the NHSE Inclusive Training within Practice (ITP) Project to collaborate, share, discuss and promote good practice on at a multi-system level	End of Q3	Head of Clinical Learning and Development	BNSSG UWE Bristol ITP Project members

EDI High Impact Actions

High Impact Action 1:Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

No	Actions (EDI Strategic Objective)	Plan to achieve success measure (Key Milestones)	Timeline	Accountable Lead	Collaborators
HIA1	Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.	a. Every Board and Executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process.	End of Q2	Chief People Officer	People EDI Manager Board Members
		b. Board members should demonstrate how organisational data and lived experience have been used to improve culture. Progress will be tracked and monitored via the Board Assurance Framework.	Ongoing	Chief People Officer	People EDI Manager Board Members
		c. NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework.	Ongoing	Chief People Officer	People EDI Manager Board Members

High Impact Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

No	Actions (EDI Strategic Objective)	Plan to achieve success measure (Key Milestones)	Timeline	Accountable Lead	Collaborators
Embedded into objectives number 1 and 9					

High Impact Action 3: Develop and implement an improvement plan to eliminate pay gaps.

No	Actions (EDI Strategic Objective)	Plan to achieve success measure (Key Milestones)	Timeline	Accountable Lead	Collaborators
Embedded into objectives number 4 and 7					

High Impact Action 4: Develop and implement an improvement plan to address health inequalities within the workforce.

No	Actions (EDI Strategic Objective)	Plan to achieve success measure (Key Milestones)	Timeline	Accountable Lead	Collaborators
HIA4	Line managers and supervisors should have regular effective wellbeing conversations with their teams (by October 2023).	a. Deliver the appraisal recovery plan, this will ensure all colleagues have a wellbeing conversation which can be measured	Ongoing and managed through Executive reviews.	HRBPs	Organisational Development team - Staff Engagement Divisional Leads (WWSG / HRBP) Education team (Kallidus)
		b. Lead on the development of a line manager support guide to build the confidence of leaders to undertake regular, effective wellbeing conversations with all colleagues as identified in the Trust Appraisal Recovery Plan, monitored via Kallidus.	End of Q2	Workplace Wellbeing Manager and Staff Engagement teams (OD)	Organisational Development team - Staff Engagement Divisional Leads (WWSG / HRBP) Wellbeing Lead for Doctors and Dentists Workplace Wellbeing Advocate Network Education team (Kallidus)
	Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health Observatory.	c. Pending the successful potential joint bid to the Race and Health Observatory, undertake a joint Action learning set to support improvements in maternal health outcomes for minority ethnic communities.	End of Q2	Patient EDI Lead	

High Impact Action 5: Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.						
	No	Actions (EDI Strategic Objective)	Plan to achieve success measure (Key Milestones)	Timeline	Accountable Lead	Collaborators
	Embedded into objective number 6					

High Impact Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.						
	No	Actions (EDI Strategic Objective)	Plan to achieve success measure (Key Milestones)	Timeline	Accountable Lead	Collaborators
	See objectives number 1, 3, 4 and 7					
	HIA6	Review disciplinary and employee relations processes.	Bi-annual Employee Relations Report and the introduction of more robust triangulation across partners will support a greater understanding of colleague experience and 'hot spots'	End of Q1	Head of HR Services	

Appendix 3 EDI High Impact Actions

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)

Appendix 4 Pro Equity Patient First Project Charter

True Norths supported: Our People

Breakthrough Objective Breakthrough Objective

University Hospitals Bristol and Weston NHS Foundation Trust

Project charter: Delivering our Pro-equity promise **Version** 0.2 **Date:** 03/06/24 **Date charter approved:** **Start date:** May 2024 **End date:** March 2025

1.Problem statement

Background: All colleagues at UHBW should have an equitable experience at work however, we know through the UHBW Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), 2023 Staff Survey indicators and retention data that this is not the case. Bridges programme cultural web and Race Equaility and Inclusion Network feedback further highlights we are not hearing and responding to staff lived experience and miss opportunities to make a difference. To support Divisions learn and improve they have received their specifc data for WRES and WDES for the first time in 2024, to enable them to focus on targeted improvements.

Problem: We do not treat all of our staff fairly and equitably. Inclusive practices (listening and acting on feedback, QEIA, intercultural communication, reasonable adjustments etc) are not embedded in our ways of working, and accountability for inequalities in experience are not owned at a local level.

Impact: A culture of inequity leads to us compromising the wellbeing of our people, as well as being a potential risk to our organisational reputation which could impact on our ability to recruit in the future, limiting the diversity of our workforce. The EDI Annual Report shows disparities, key headlines are: 39.5% of Disabled Colleagues are satisfied with the extent that the trust values their work, compared to 50.1% of non-disabled colleagues. 11.8% of Minority Ethnic Colleagues have experienced discrimination at work from other staff compared to 5.4% of White Colleagues. Employee Relations cases relating to discrimination on the grounds of race account for 65% of all discrimination cases compared to 35% of discrimination of cases relating to other types of discrimination relating to all other protected characteristics. 4% of staff in the staff survey 2023 experienced unwanted behaviour of a sexual nature from other colleagues' The 2023 Learner Survey (NETS) found 23.68% experienced bullying and harassment and 3.72% of learners stated they had experienced some sort of sexual harassment.

2. Scope

IN

- All colleagues regardless of their employment status in UHBW.
- Protected characteristics: Dissability and Ethnicity

OUT

- Patients
- Other 7 protected characteristics until further data is available

3. Goal

In order to deliver our True North people ambition to be in the top 10% of organisations for staff recommending us as a place to work, a 5% improvement year on year, we are going to establish our Pro-Equity approach. Pro-Equity is inclusion in everything we do and embracing full hearted care to eliminate disparities in experience, by March 2025. *Measures to track reducing inequalities experienced to be determined.*

4. Exit Criteria

- The true data position is identified and develop a methodology to support this being an embedded BAU process.
- Inclusive practices are embedded in our ways of working, and accountability for inequalities in experience are owned at a local level and measureable through the defined data position.
- We will continue to benchmark ourselves against the best actue average for the 3 key headline staff survey measures (staff engagement, recommended organisation as a place to work, respecting everyone 8b and 8c), but we aspire to be best in the NHS also against these 3 measures.

5. Sponsor & Project Team

Executive Sponsor	Chief People Officer
Senior Responsible Officer	Associate Director OD and Wellbeing
Process Owner	EDI People Manager
Project Team	Luke Britt (HRBP D&T), Rachael Bailey (Staff Side Chair), Rebecca Clinton (L&D rep), Rachel Hartles (Able+ rep), Isabel Khadour (REIN rep) . Ben Osguthorpe (HRIS), Naomi Adams (HR Services), Lisa Balmforth (HRBP Medicine), Rhiannon Clancy (Communications), Kate Hanlon (FTSU)
Patient Group	n/a

6. Governance Structure

Responsible To directly manage and deliver the project	Pro Equity Project Team
Accountable Ultimate To oversee the project and ensure delivery of the stated objectives and outcomes	People Learning and Development Group
Consulted To be engaged in the development and delivery of the project. To ensure engagement with the wider organisation	Staff Networks
Informed To be assured about progress towards the delivery of the project	People Committee, EDI Steering Group, Divisional Workforce Committees

7. High level roadmap & timescales

Action	By When
Deliver the EDI Strategic Action Plan, which will impact on sexual safety, anti-racism and tackling ableism.	Ongoing
Focus groups to consult on the draft Anti-racism statement promise.	June-July 2024
Set up EDI data group to determine the 'True data' measures.	End of August 24
Agree our Anti-racist statement and approach as part of our Pro-Equity Promise	September 24
Development of the safe learner enviromnemt charter with clear impact measures	September 24
Mini catchball process at Divisional Strategy Deployment Reviews for areas to determine which component of this priority they will have as a Driver	To be determined

8. Critical Success Factors

- Requires co ownership of the problem / solution
- Divisional leadership and engagement to achieve delivery locally.
- Requires a focussed training provision within HR people function to consider approach through a different lens.
- Ability to work collaboratively to align multiple objectives.
- Having robust data.

9. Risks to Success

- That a trauma informed approach is not followed resulting in a retraumatising impact on minoritised colleagues.
- Lack of collective ownership and resource to deliver locally.
- Lack of real time data available to track progress on a monthly basis.

10.Impact

Outcome measure - used for monitoring and reporting progress:

- Improvement on true data measures (TBD) once all data has been stratified and triangulated. See 7 action 3.
- Improvement in confidence in implementing inclusive practice as identified in QPP and HR Services data (TBD)
- Determine baseline measures to monitor progress on pro equity and measure progressional impact.