NHS
Whittington Health
NHS Trust

Whittington Health

2021 – 2022

Public Sector Equality Duty

Compliance Report

Diversity & Inclusion

January 2023

Contents

A. Context of the report

1.0 Purpose of the Report

1.1 This report presents equality information about the Trust's workforce and patient/service user population and relates to the protected characteristics identified in the Equality Act 2010.
The goal is to set out the how the Trust is meeting the general and specific duties of the PSED in line with the statutory requirements

1.2 The Equality Act 2010 requires the Trust to declare its compliance with the PSED annually. This requires Whittington Health to illustrate compliance with both the general and specific duties of the PSED.

1.3 The report reviews data between 1st April 2021 and 31st March 2022; some datasets require a single snapshot date which will be 31st March 2022.

1.4 The report is split into four main Sections: 'A. Context of the report'; 'B. Patients and Service Users'; 'C. Workforce' and 'D: Equality Delivery System' (EDS2). Information in each section is presented mainly in headings related to the nine protected characteristics. Some sections likely contain significantly less information than others, reflecting the challenges and limitations of collecting information and individual personal rights to choose what to disclose. Where there is limited information, these come with the caveat that it is hard to conclude except give an opinion in places.

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

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

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

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

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

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

i. Age
ii. Disability
iii. Gender reassignment
iv. Marriage and civil partnership (elimination of unlawful discrimination only)
v. Pregnancy and maternity
vi. Race (this includes ethnic or national origins, colour or nationality)

vii. Religion or belief (this includes lack of belief)
viii. Sex
ix. Sexual orientation

2.0 The Protected Characteristics

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

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

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

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

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

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

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

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

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

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

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

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

2.8 **Sex** – For the purposes of the Act, sex means being a man or a woman. Men share the sex characteristic with other men and women with other women.

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

- People of the same sex as them (a person is a gay man or a lesbian).
- People of the opposite sex from them (the person is heterosexual).
- People of both sexes (the person is bisexual).
- People sharing a sexual orientation mean that they are of the same sexual orientation and therefore share the characteristic of sexual orientation.

3.0 About Whittington Health

3.1 Whittington Health is one of London's leading integrated care organisations – helping local people to live longer, healthier lives.

3.2 We provide hospital and community care services to over half a million people living in Islington and Haringey, as well as those living in Barnet, Enfield, Camden and Hackney.

3.3 Whittington Health provided over 40 acute and 60 community health services in 2021/22. In addition, we provide dental services in 10 London boroughs.

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

3.5 Our services and our approach are driven by our vision. We have an excellent reputation for being innovative, responsive and flexible to the changing clinical needs of the local population. We are treating more patients than ever before, and we dedicate our efforts to improving services to deliver the best care for our patients, with a clear focus on integrating care for women, children, and the adult frail.

3.6 Our 2019/24 strategy has four main objectives:

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

3.7 The Trust values; the ICARE values developed through staff engagement and consultation continue to be fundamental to everything we do at Whittington Health and form the basis of expected staff behaviours. In the last year, we supplemented the ICARE values with an additional overarching value of equity.

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

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

3.10 As an integrated care organisation, we bring safe and high-quality services closer to home and speed up communication between the community and hospital services,

improving our patients' experience, reducing admissions, and speeding up discharge. Key to our approach is partnering with patients, carers, GPs, social care, mental health and other healthcare providers.

3.11 Our organisation has a highly regarded educational role. We teach undergraduate medical students (as part of University College London Medical School) and nurses and therapists throughout the year, alongside providing a range of educational packages for postgraduate doctors and other healthcare professionals. We also have a growing research arm which is exceeding Clinical Research Network targets.

3.1 Other relevant reports and data

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

These include:

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

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

3.1.2 When writing this report, data and information from the 2021 Census were unavailable. Where local demographic comparison has been made, the 2011 Census data has been used.

3.2 Trustwide EDI-Related Achievements during 2021/22

The Whittington Health Trust maintain its commitment into making sure that equality is a goal and a decisive factor in delivering excellent patient care and creating a workplace environment that is considerate of our celebrated and diverse workforce. The Trust has adopted various initiatives and projects including :

3.2.1 Supported Internships

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

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

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

Job outcomes:

- 19/20 – 2 out of 3 interns in paid work (the COVID-19 pandemic impacted the scheme)
- 20/21 – 5 interns off-site; the COVID-19 pandemic impacted the scheme (all interns were granted extensions in 21/22)
- 21/22- 9 interns (4 returners) – this was our first full year on-site, and we saw 5 out of 9 young people enter FT paid work, including 1 FT at WH. 1 intern has returned this year for an extension of this programme. 3 are still job seeking with support from supported

employment agency Kaleidoscope Sabre

3.2.2 Disability Confident – Level 3

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

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

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

As part of the Trust's submission, we provided a range of information to be validated, including the Recruitment and Selection Policy, WhitAbility Terms of Reference (disabled staff network) and the North Central London Apprenticeship Policy.

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

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

Talent management

There has been good initiatives in several Integrated Care Service Unit / Directorates to help increase the diversity of their senior staff. In addition, discussions have taken place with the NHS Leadership Academy for Whittington Health to block book 20 places on its development programmes for middle and senior leaders. The programmes involved are Elizabeth Garrett Anderson, Nye Bevan, Rosalind Franklin and Stepping Up. In addition, there may be an opportunity to have places for Whittington Health on the North Central London Integrated Care system's Future Leaders' Programme which is also aimed to increasing the diversity in NCL bodies.

In addition to the above the Trust Mentorship for Black, Asian & ethnic minority staffprogrammeThe plan is underway to enable external mentorshipfor Black Asian and Minority Ethnic colleagues, particularly those in Bands7 & 8A,who would benefit from independent support with recognising their career potentialand with career development planning.

The scheme we have introduced acknowledges mentees in the mentorship programme as partners with their mentors and builds on the ethos of reciprocal mentorship. Alongside the talent management initiative, the scheme act as a deliberate conduit to build inclusion leadership, help shape and develop inclusive and systems-focused talent management and succession planning for Whittington Health as part of the local health and care system. The idea is given a working title of 'Whittington Health –Mentorship for Black, Asian & Ethnic minority (BME) staff programme to support career progression and potential. mentors.

Race Equality Week

The Trust took part in Race Equality Week. which took place this year between 7–13th February 2022. The week is designed to unite organisations and staff in activities that address the barriers to race equality in the workplace. This is the first time the Trust has engaged in the national initiative and several successful staff open forum sessions occurred in support of the event. This year's theme was 'actions not words' and sessions explored important topics such as the benefit of wellbeing, focussing on encouraging take up by Staff from Black, Asian and ethnic minority groups. There was an update on the role and success of See ME First as a Trust engagement initiative which, as a pioneering trust, we have seen spread to 22 other NHS organisations.

Nursing Narratives: Racism and the Pandemic

The Nursing Narratives –Racism and the Pandemic undertaken by academics from Sheffield Hallam University and the Exposed video, which looked at the impact of racism on ethnic minority nurses and care workers during the Covid-19 Pandemic was published in March 2022. A Trust Wide Open Forum screen showing with support from the Trust Clinical Health Psychology Team occurred on the 21st April 2022. The aim was to allow staff and managers to watch and discuss the issues that have come out of the film and explore what action can be taken in support of any negative experience by BME nurses working at the hospital.

Medical Workforce Race Equality

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

The first MWRES report was published in July 2021. In response, the Trust has created the post of Medical Workforce Race Equality Standard (MWRES. The Trusts is one of the first to introduce the MWRES lead role. Among other focus, the role will emphasise improving the Trust's support and development of International Medical Graduates (IMG's) by setting up and evaluating a suitable induction programme and identifying potential areas of action. It will also include work with clinical leaders to ensure that medical recruitment is fair and equitable by ensuring the principles outlined in the De-biasing Toolkit are embedded at all stages of the recruitment process.

3.2.3 Race, Equality, Diversity, and Inclusion (REDI) Team

In August 2021, The REDI Team was established with the appointment of the Joint Directors of REDI. Tina Jegede and Swarnjit Singh, job share this role. The directors provide strategic direction for the REDI agenda at the Trust.

Both are existing staff members; Tina is also the Nurse Lead for Islington Care Homes, and Swarnjit is the Trust Secretary.

Margo Innocent works as the Staff Engagement and Team Administration Assistant.

Simon Anjoyeb was recruited as the EDI Lead to address the operational aspects of delivering REDI within the organisation. He was in post from April 2022.

Below are some highlights of work that occurred during 2021/22:

- Open Forum sessions were held that were open to staff to attend as an opportunity for staff to receive updates and provide their views on developments within the inclusion agenda. Some topics explored at Open Forum were nursing reports about their experiences and BME staff sharing their experiences working at the Trust.
- The Team have provided support and leadership for the staff networks, especially regarding facilitated time for co-chairs and an annual budget to support network activities.
- The Joint Directors of REDI have been working with organisations across the North Central London ICS. The Joint Directors co-chaired a task and finish group to produce a best-practice recruitment framework across the ICS.
- The REDI team have also participated in many Trust training programmes, for example, International Medical Graduates induction, Allied Health Professional Leadership Development, Corporate Induction and the Trust's Leadership Development Programme.

Other activities/staff engagement initiatives include :

- Review and update of Equality Diversity & Inclusion Policy
- Reviewed of Reasonable Adjustment Process
- Reviewed Equality & Diversity Training
- Reviewed Equality Impact Analysis
- Commitment to the Equality Delivery System
- Introducing pronouns to the staff name badge
- Celebration of World Mental Health Day
- Celebration of Independence Day, i.e., Filipino, Nigeria, etc.

3.2.4 Organisational Development

Following the successful establishment of three additional staff networks (Women's, LGBTQ+ and WhitAbility) to the Trust's existing BAME Network, now known as SRENN, The Trust earmarked resources to improve information on staff needs. In particular for employees with disabilities and long-term conditions (LTC). A specialist disability organisation was commissioned to hold focus groups which were confidential meetings, and those attending confirmed their disability or LTC before being booked into a group. The recommendations in the resulting report are currently being explored and will inform action plans to improve the experience of disabled staff.

The Trust continues its relationship with two organisations for autistic young adults to provide work experience placements across the hospital site to maximise their employability. This year saw a high percentage of interns achieving permanent job offers at the end of their work experience.

In the interests of staff wellbeing, particularly following the unequal impact of covid on different ethnic groups, the Trust commissioned the services of a local culturally sensitive counselling organisation. The organisation has provided both confidential one-to-one services for individuals seeking personal therapy and reflective group sessions to enable people to decompress and support each other in their recent experiences.

Last year, the Trust saw increased mediation requests, including team mediation. Aligned to this approach to reach an agreed resolution between parties, Whittington Health is now implementing Restorative Just Culture (RJC) as its process for managing incidents. Several introductory training sessions have been provided to managers; now looking for more involved training. A development group has been created for representatives across all ICSUs and Directorates to drive this forward.

In support of the Model Employer equality suggested targets, OD ran a pilot BAME Band 2-7 experiential development programme launched with 22 delegates from 54 applicants. Those not on the programme were offered personal development plan coaching resulting in a written summary of the plan. So far, several employees (those in and not in the cohort) have progressed with their development and career progression. This pilot will be evaluated in more detail for a future iteration, likely including neighbouring trusts who have expressed interest in participating, which will widen the opportunity for experiential placements.

A career development workbook was published alongside the Band 2-7 programme. It is available in print and on the Intranet to support coaching and all training programmes, to enable people to work at their own pace through their career development.

3.2.5 See Me First

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

As See ME First approaches its second anniversary on 29th October 2022 and the Whittington Health NHS Trust ICARE values are now underpinned by EQUITY, the message that "….people should not be judged by the colour of their skin but by the content of their character…." is even stronger.

Over 1800 staff have now made their pledge (1:3 staff) and 22 other NHS organisations are 'following our lead' and have either adopted or are looking to adopt the initiative. Islington Council – Social Care are the first Organisation outside of the NHS who are looking to formally launch during October Black History Month. We recently held the inaugural See ME First #StrongerTogether Event where there was representation from 18 of those Organisations who recognise the importance of working together for an inclusive NHS for the betterment of our staff and our patients.

We received the following feedback

"Thank you for inviting us, great to see, See ME First across the UK"

"Thank you for the invite, a worthwhile session"

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

One See ME First Impact Testimonials reads,

"See ME First is a platform that allows for open and honest discussions even when the topics are difficult, It has particularly given me a voice and has empowered me to help others".

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

B. Patients and Service Users

4.0 Patient Equality Information

4.0.1 There are two sets of patient equality information that are available. Firstly, data relates to who is using our services, and secondly, data relates to the patient experience while they are under our care. Some data is unavailable to be analysed as it is not routinely collected via Medway or Rio, our patient management systems. This information could be held in patients' written medical or nursing notes. The issue has been reported to the Chief Nursing Information Officer, who will act on this as part of our ongoing work to digitalise patient records.

The available data shows service usage for patients that were outpatients, inpatients, and using emergency services and community services during 2021/22.

4.0.2 Age

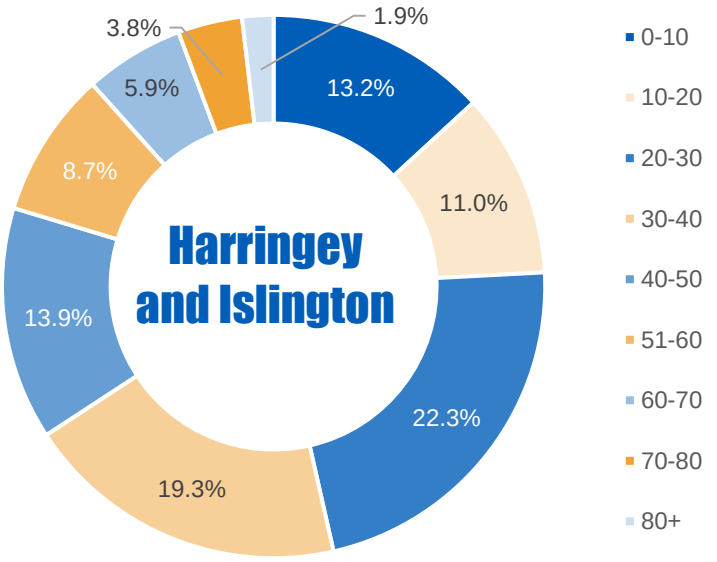


Chart 1 (left) shows the representation of the local population of Haringey and Islington broken down by age group. The local breakdown of the local population helps provide a point of comparison when looking at patient and service use data.

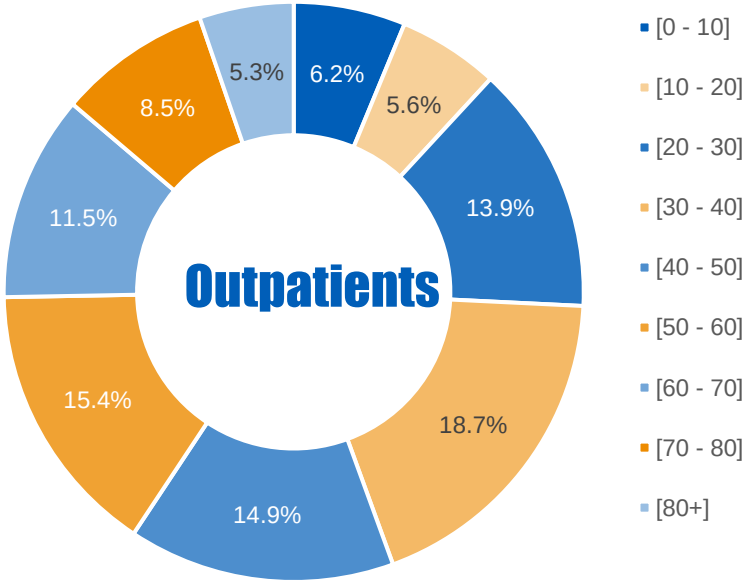


Chart 2 (left) represents outpatient service use by age group. In outpatient services, most patients are 20-70 years of age.

Comparing service use to the age demographic of Haringey and Islington, there is a lower-than-expected representation of patients and service users aged 0-40 and a higher-than-expected representation for those aged 40+. Patients aged 70-80 are represented in outpatients 2.2 times more than the local population, and patients aged 80+ are represented 2.7 times more.

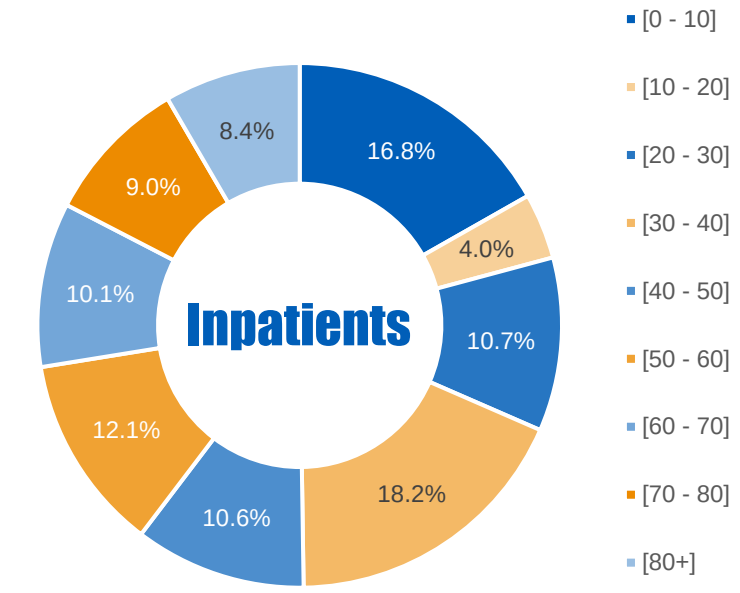


Chart 3 (left) represents inpatient service use by age group. In inpatient services, most service usage is from patients aged 0-10 and 20-70.

Comparing service use to the age demographic of Haringey and Islington, there is a lower-than-expected representation of patients and service users aged 10-50 and a higher-than-expected representation for those aged 0-10 and 50+. Patients aged 70-80 are represented in inpatients 2.4 times more than the local community, and patients aged 80+ are represented 4.4 times more.

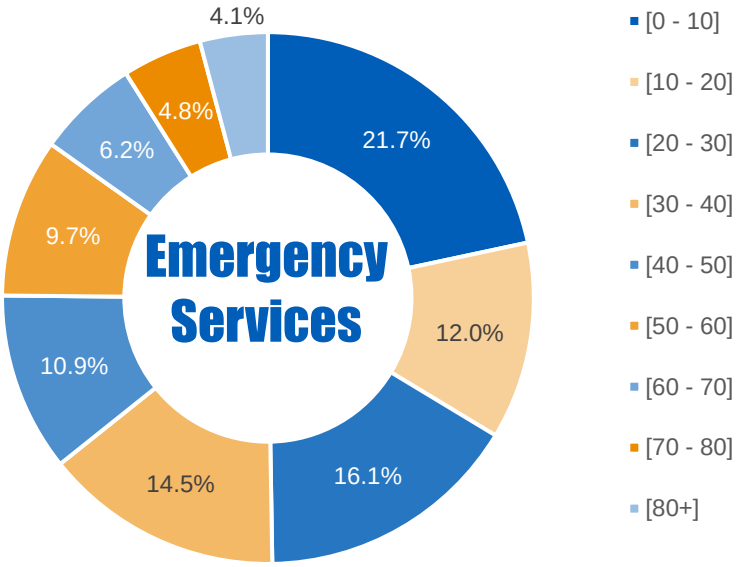


Chart 4 (left) represents patient use of emergency services by age groups. For these services, most service usage is from patients aged 0-50.

Comparing service use to the age demographic of Haringey and Islington, there is a lower-than-expected representation of patients and service users aged 30-50 and a higher-than-expected representation for those aged 0-10 and 50+. However, most age groups, whilst higher, are broadly in line with the local demographic.

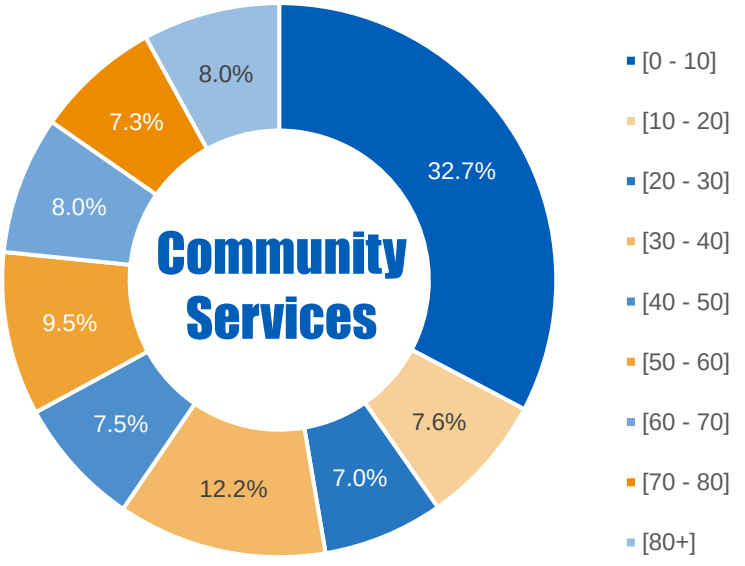


Chart 5 (left) represents patient use of community services by age group. The groups with the greatest representation in community services are 0-10, 30-40 and 50-60.

Comparing service use to the age demographic of Haringey and Islington, there is a lower-than-expected representation of patients and service users aged 10-50 and a higher-than-expected representation for those aged 0-10 and 50+. Patients 80+ have a 4.2 times greater representation in services compared to the local population

4.0.3 Disability

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

4.0.4 Gender Reassignment

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

4.0.5 Marriage and Civil Partnership

This section reviews patient attendance data by marital status who attended emergency services or were inpatients and outpatients. This information is unavailable for community patients as it is not routinely collected in Rio.

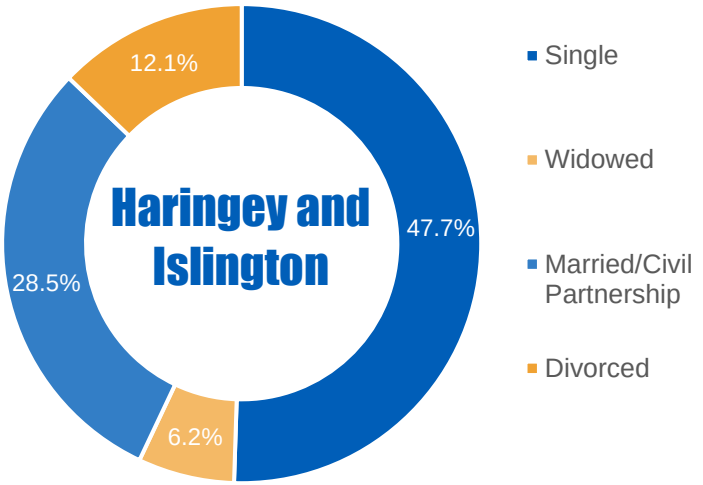


Chart 6 (left) represents the local population of Haringey and Islington broken down by marital status. The breakdown helps provide a point of comparison when looking at patient and service use data.

The categories have been adjusted to align with the Trust's Patient Management System categorisation to allow for direct comparison.

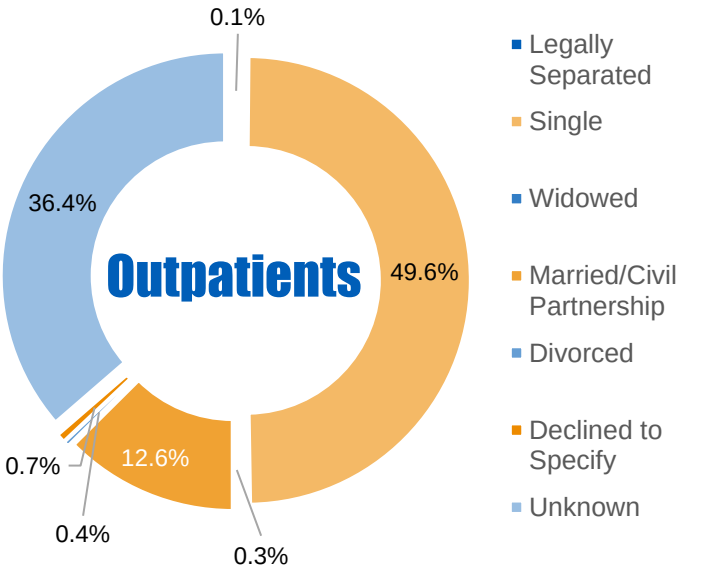


Chart 7 (left) represents patients that attended outpatient services broken down by marital status. Overall, the largest groups to have attended outpatient services are single and patients where their status is unknown.

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

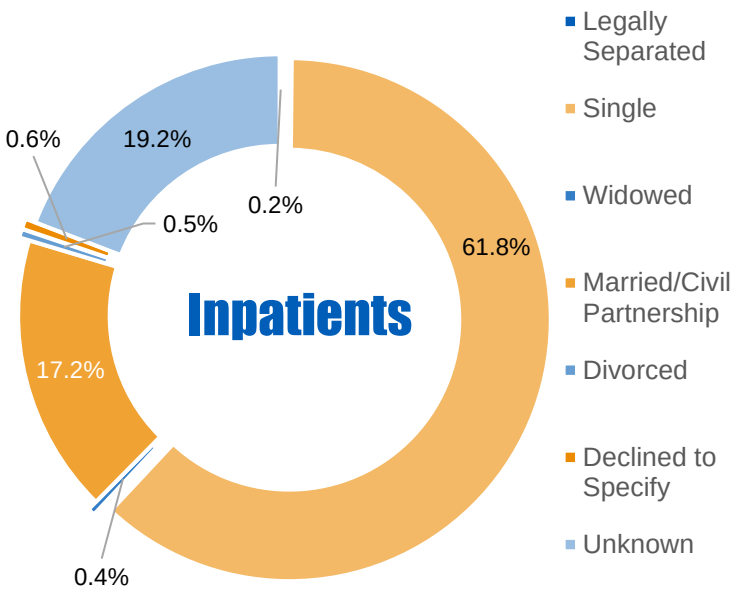


Chart 8 (left) represents patients that attended inpatient services broken down by marital status. Overall, the largest groups to have attended inpatient services are single and patients where their status is unknown, followed by those who are married or in a civil partnership.

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

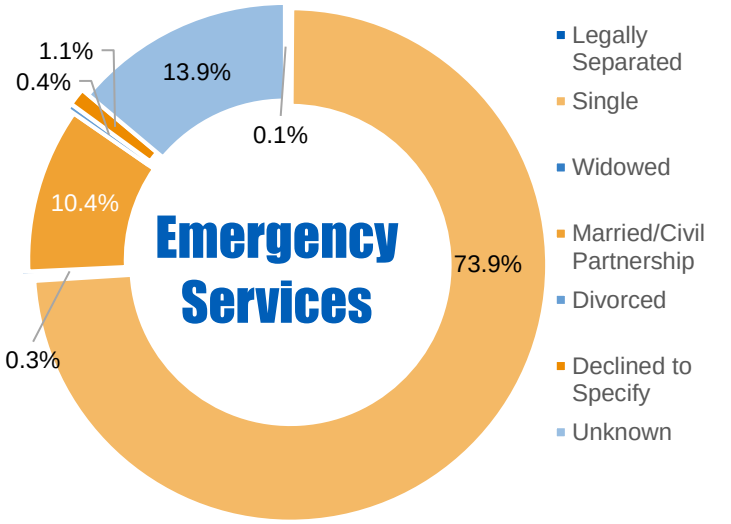


Chart 9 (left) represents patients that attended emergency services broken down by marital status. Overall, the largest groups to have attended emergency services are single and patients where their status is unknown, followed by those who are married or in a civil partnership.

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

4.0.6 Pregnancy and Maternity

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

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

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

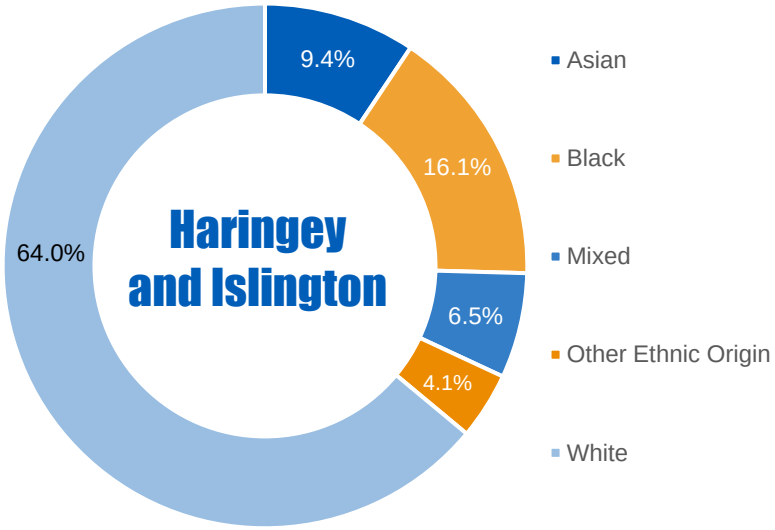


Chart 10 (left) shows the representation of ethnic categories in the local population of Haringey and Islington. The local demographic data will help aid comparison when looking at the use of Trust services by patients.

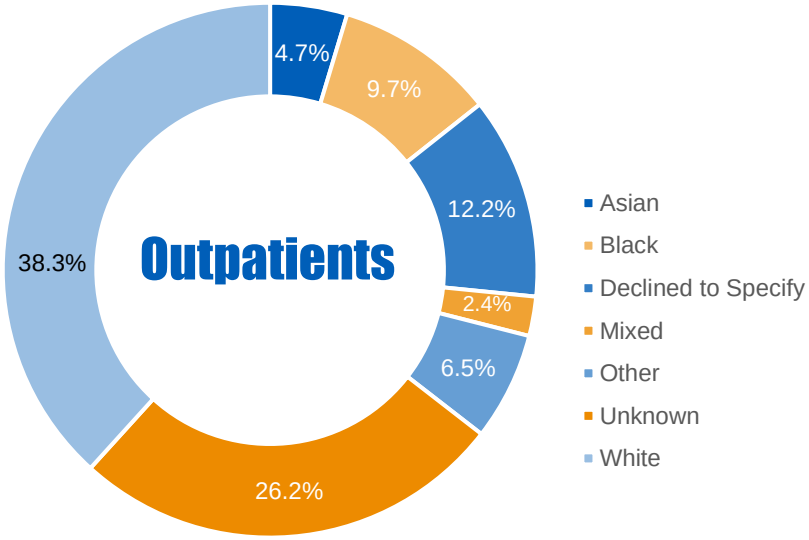


Chart 11 (left) represents patients that attended outpatient services broken down by ethnic categories. Overall, the largest groups to have attended inpatient services are White, followed by patients whose ethnic category is unknown.

When comparing to the local population of Haringey and Islington, there is a lower representation in most groups (nearly half as much) using outpatient services. For 'other' patients, there is a greater representation using outpatient services (nearly a third more).

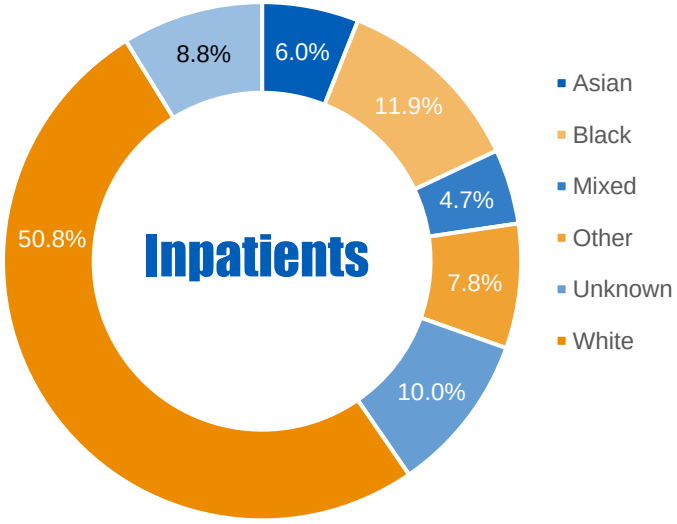


Chart 12 (left) represents patients that attended inpatient services broken down by ethnic categories. The largest groups to use inpatient services are White and Black patients.

Compared to the local population of Haringey and Islington, most groups have a lower representation (Asian, Black, and Mixed, about a third less). There is a greater representation of patients in the 'other' category (nearly twice more).

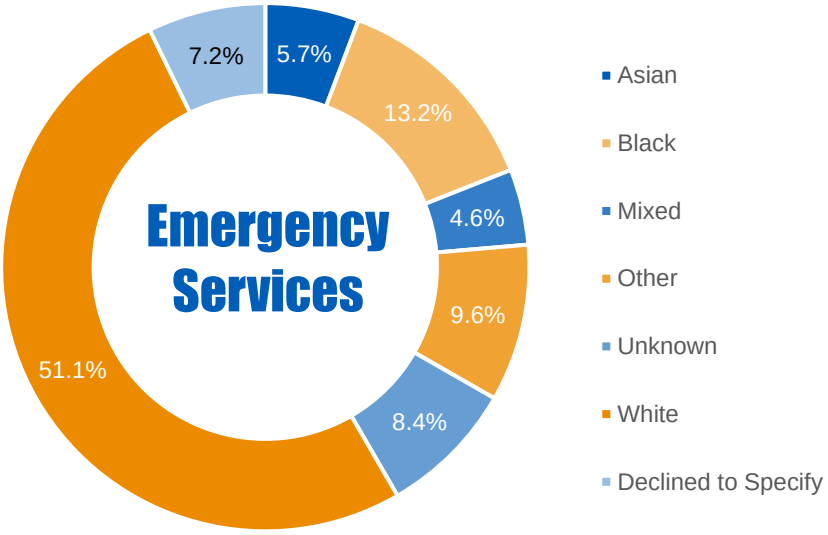


Chart 13 (left) represents patients using emergency services at the Trust. The largest groups to use these services are White and Black patients.

When comparing to the local population, there is a lower representation in most groups; the exception to this is patients in the 'other' category, where there is a greater representation

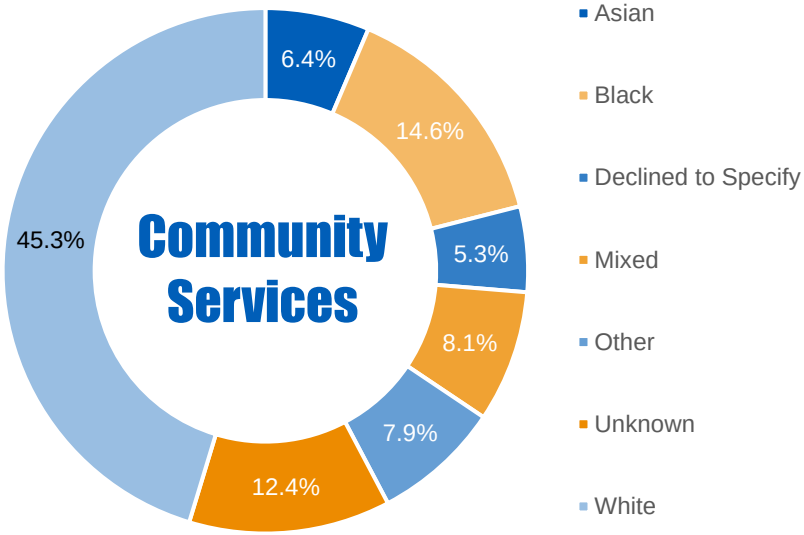


Chart 14 (left) represents patients using community services at the Trust. Overall, the largest groups to use these services are White, Black, and patients whose ethnic category is unknown.

When comparing to the local population, there is a lower representation in most groups; the exception to this is patients in the 'Other' category, where there is a greater representation

4.0.8 Religion or belief

It is difficult to comment accurately on patients' religion or belief representation, as over 50% of patients' demographic data in all services is unknown. Where religion or belief is known, 10-20% register as having no religion, and 13-6-18.6% are Christian or of a Christian denomination. Patients with 50 different religions or beliefs attended Whittington Health last year. This information is not routinely collected on Rio, so it is impossible to comment about community patients.

Table 1 (below) shows the limited data available from the service use of patients at the Trust.

Religion	Haringey and Islington	Outpatients	Inpatients	Emergency Services
Buddhist	1.1%	0.2%		0.2%
Christian	42.8%	13.6%	18.5%	14.4%
Declined to specify		2.4%	2.5%	4.3%
Hindu	1.4%	0.5%	0.5%	0.3%
Jewish	2.1%	0.8%	1.3%	0.5%
Muslim	12.1%	4.5%	5.3%	5.6%
No Religion	27.4%	10.0%	12.7%	20.2%
Other	0.5%	0.3%	0.4%	0.2%
Sikh	0.3%	0.1%	0.1%	0.1%
Unknown	12.4%	67.7%	58.8%	54.2%

4.0.9 Sex

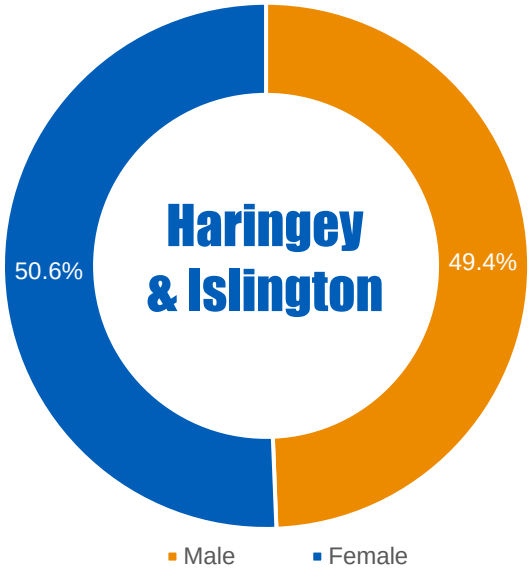


Chart 15 (left) shows the representation of sex in the local population of Haringey and Islington.

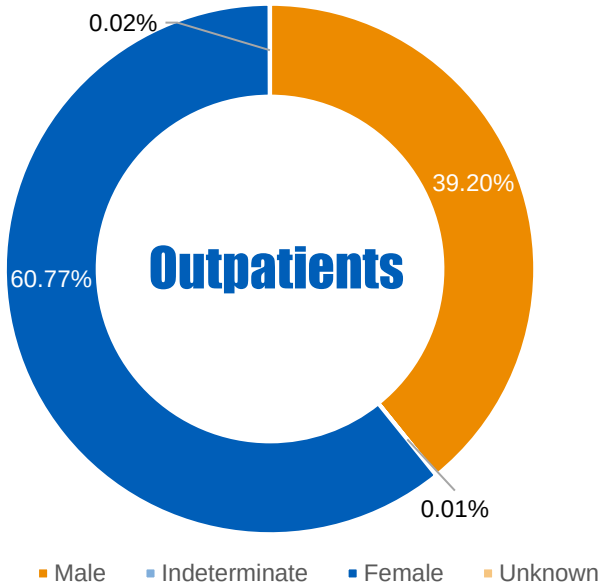


Chart 16 (left) represents the sex of patients using outpatient services. Overall, there are more women than men who have attended outpatient appointments.

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

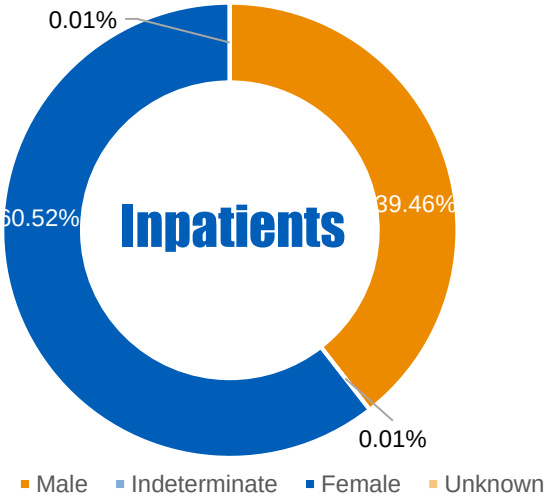


Chart 17 (left) represents the sex breakdown in patients attending inpatient services at the Trust.

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

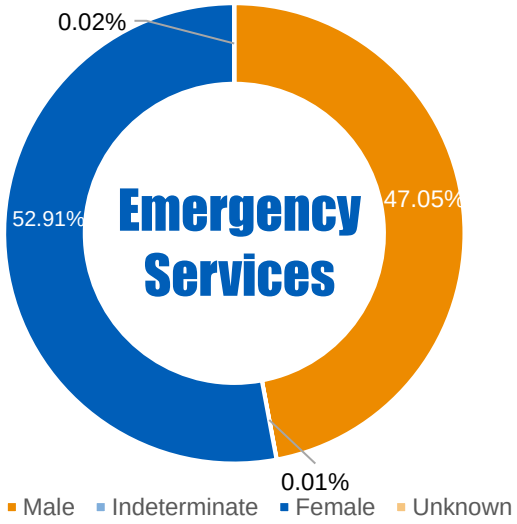


Chart 18 (left) represents the sex breakdown in patients attending emergency services at the Trust.

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

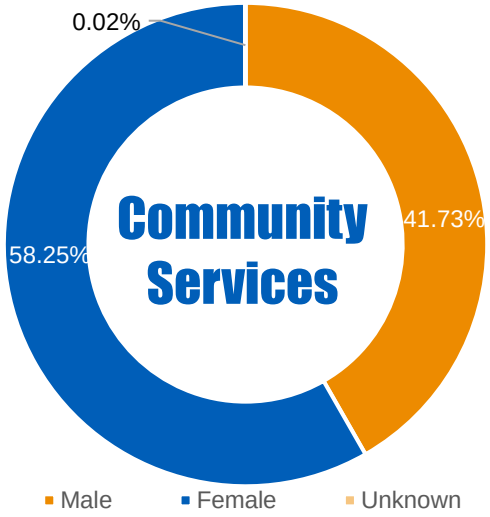


Chart 19 (left) represents the sex breakdown in patients attending community services at the Trust.

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

4.0.10 Sexual orientation

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

4.1 Complaints

This section highlights information about patients that have raised concerns or complaints by our Complaints Department or PALS Team. Not all protected characteristics are reported on in this section:

4.1.1 Age (Profile of complainants)

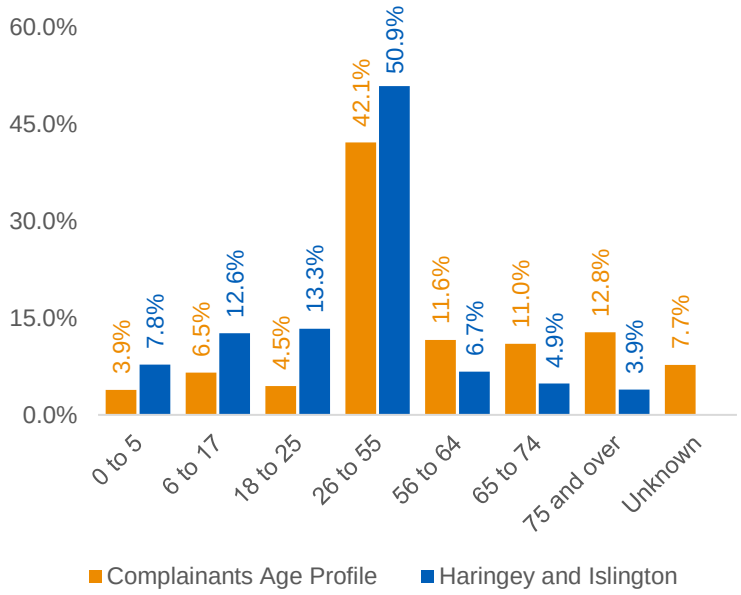


Chart 20 (left) shows the age profile of those raising complaints/concerns during 21/22. The local population of Haringey and Islington is included for comparison.

The group raising the majority of complaints and concerns are those aged 26-55 – however, this is the largest group, so it is not surprising. From 0-55, there is a lower proportion of people raising complaints and concerns compared to the local demographic; however, from 56+, there is a greater proportion than the local demographic. Data for service use representation is incompatible with the complainant's data profile; therefore, no meaningful comparison can be made.

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

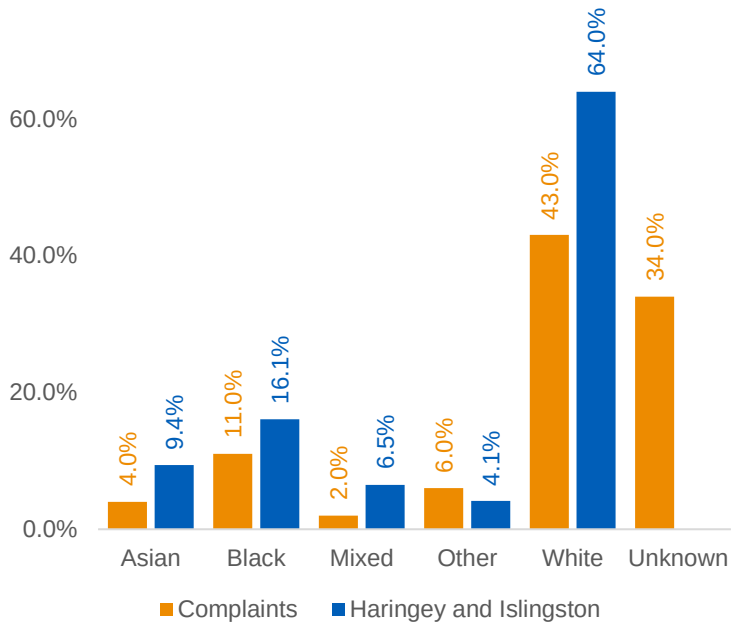


Chart 21 (left) shows the number of complaints/concerns raised during 21/22 broken down by race. The local population of Haringey and Islington is included for comparison.

The groups that have raised the majority of complaints and concerns are white, and where their race is unknown. For those raising complaints/concerns, the representation is lower than the local profile, except for the Other group (slightly higher). When comparing to service use data, none of the known groups would suggest an overrepresentation in complaints. However, with over a third of complaints, the race category is unknown; this may not be an accurate assessment.

4.1.3 Sex

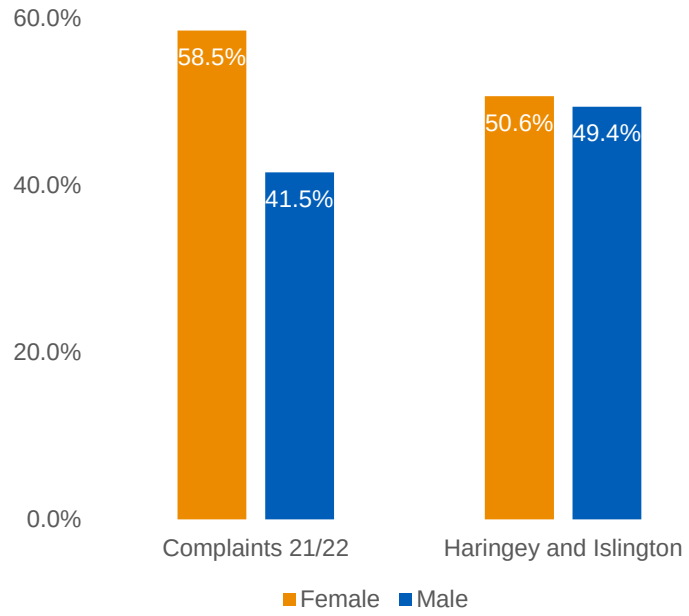


Chart 22 (left) shows the breakdown of the number of complaints/concerns raised by sex, the demographic information for Haringey and Islington has been included for comparison.

Females have raised most complaints, proportionally higher than the local population. Compared to service use data, the gender breakdown of complaints is broadly in line, except in Emergency services, where women are slightly overrepresented and men under in complaints/concerns data.

4.3 Serious Incidents

Serious Incidents in health care are adverse events where the consequences to patients, families and carers, staff or organisations are so significant that the potential for learning is so great that a heightened level of response is justified.

Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death and injury resulting in serious harm. This includes those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

During 2021/22, there were 30 serious incidents; this section explores the demographical breakdown of these incidents. Please note that some incidents will involve multiple people, and only the protected characteristics that can be reported are listed below.

4.3.1 Age

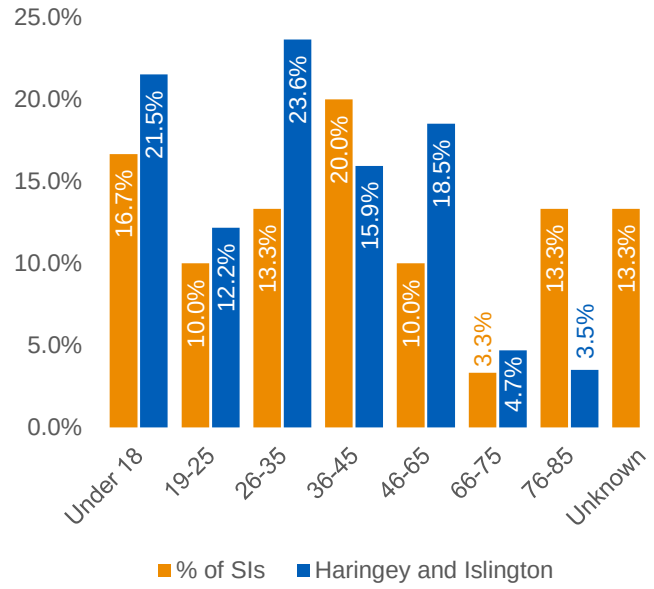


Chart 23 (left) shows the representation of age in serious incidents; comparable demographical data for Haringey and Islington is also included to aid comparison.

When comparing the local demographic data to Trust data about serious incidents, most groups are not overrepresented except for groups 36-45 and 76-85. Data from service use is not compatible with the serious incident data; therefore, a meaningful comparison cannot be made.

4.3.2 Disability

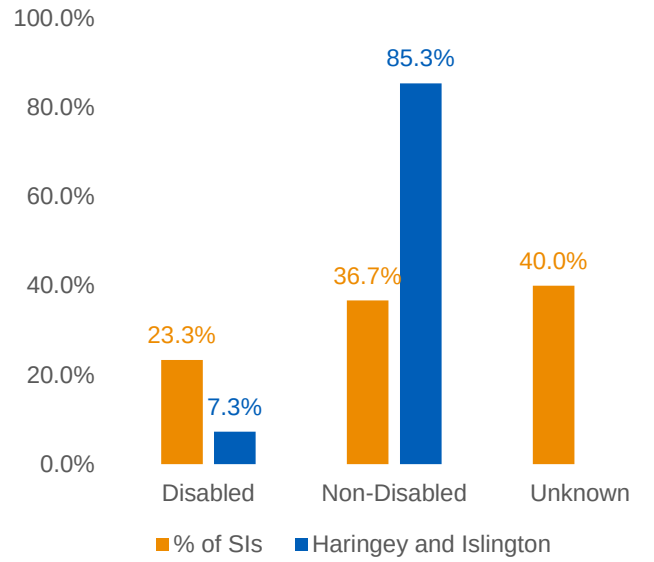


Chart 24 (left) shows the representation of disability in reported serious incidents, the demographic data relating to the local population have been included to aid comparison.

Disabled patients are overrepresented in the Trust's reported serious incidents data compared to the local demographic data by nearly three times more. Non-disabled representation is just under half the representation of the local population. There is no service use data on disability to compare serious incidents.

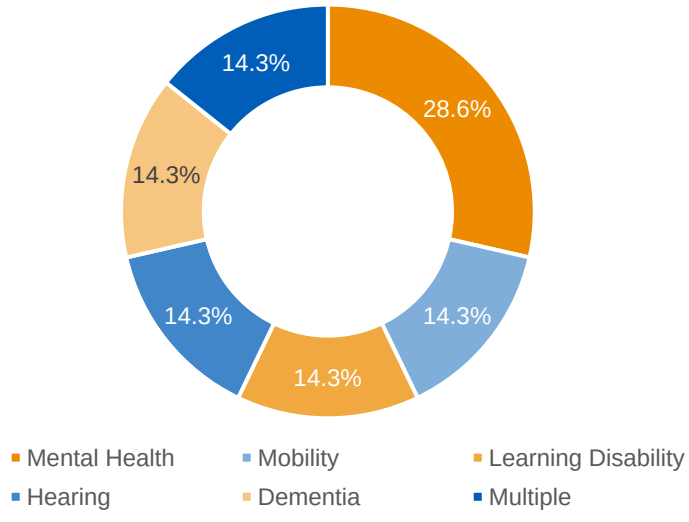


Chart 25 (left) provides a further breakdown of the health conditions of the disabled patients featured in (Chart 24 above).

The group with the highest level of representation are patients with mental health conditions.

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

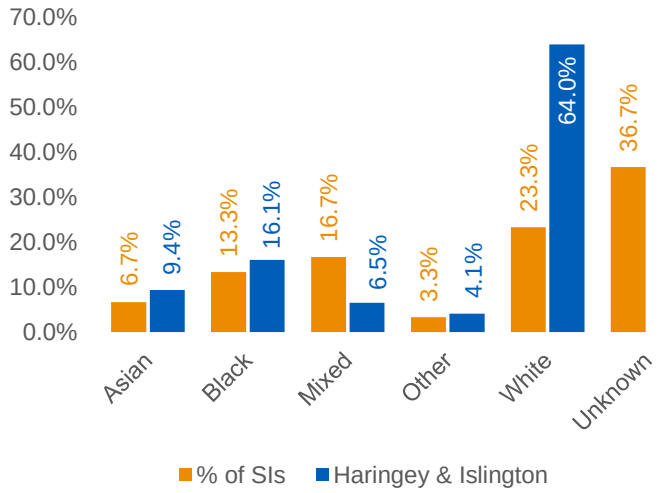


Chart 26 (left) shows the representation of race in serious incidents; the local population demographic data is included to aid comparison.

The Mixed group has a higher representation in the Trust's serious incidence data than the local population. All other groups have lower representation; however, with over 36% of serious incidents being unknown, this may not be an accurate assessment.

Compared to service use data, the mixed group has a greater representation, the Black group has a higher representation of serious incidents than inpatient and community services, and the Asian group has a greater representation (serious incidents) than community services.

4.3.4 Sex

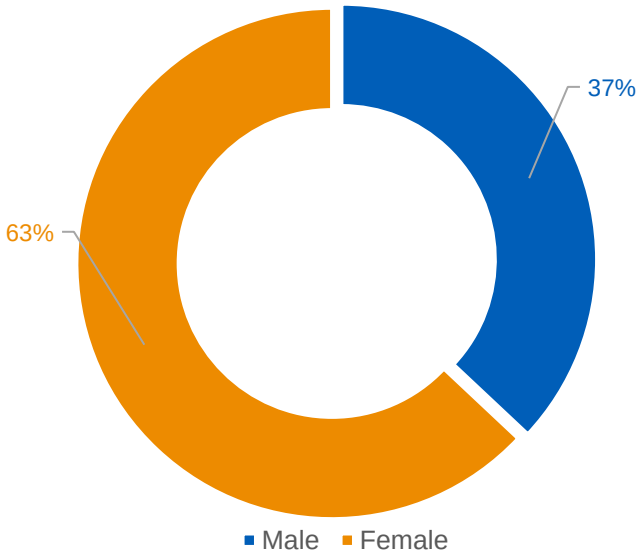


Chart 27 (left) shows the representation of sex in serious incidents.

Females are overrepresented in serious incidents compared to the local population, and males are underrepresented.

Compared to service use data, the gender breakdown of complaints is broadly in line, except in Emergency services, where women are slightly overrepresented and men under in serious incidents data.

4.3 Patient language and communication services

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

During 2021/22, the top ten languages used throughout our acute and community services were:

1 Turkish
2 Spanish
3 Bengali
4 Arabic
5 Albanian
6 Somali
7 Polish
8 Portuguese
9 Farsi/Persian
10 Romanian

During 2021/22, the Trust received 425 British Sign Language interpreting requests, of which 240 came from acute services and 185 from community services. Our in-house interpreters completed 308 (72.5%) sessions, 65 (15.3%) sessions were covered by our external supplier and 52 (12.2%) were not covered, usually leading to a rebooking.

4.4 Summary of observations from patient data

4.4.1 Age

Overall, the greatest attendees to all our services are from age groups 0-10 and 50+; compared to the local demographic, we see a high representation of patients aged 70+ in our outpatient, inpatient, and community services.

Patients aged 56+ appear to raise a higher-than-expected number of complaints. Patients aged 36-45 and 76-85 appear to be proportionally overrepresented in serious incidents.

4.4.2 Disability

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

Compared to local demographic data, disabled patients are overrepresented in serious incidents. However, with 40% of serious incidents where the patient's disability status is unknown, this may not be an accurate picture.

4.4.3 Gender Reassignment

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

4.4.4 Marriage and Civil Partnership

Data collection is only available for service use for this protected characteristic. However, it is not collected in community services. A high level of unknowns within the datasets impacts the data quality.

4.4.5 Pregnancy and Maternity

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

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

Compared to the local demographics, most groups have a lower-than-expected representation in service use data for most services; the only exception is for patients in the 'Other' ethnic category.

For complaints data, over a third of complainants' ethnic category was unknown, impacting data quality. The only group that demonstrated an overrepresentation in the process was patients from the 'Other' ethnic category.

Most groups have a lower-than-expected representation in serious incident data, except for the Mixed ethnic category. However, 36.7% of the patient's ethnic category is unknown, impacting data quality.

4.4.7 Religion or Belief

For service use, an extremely high number of patients use our services where their religion or belief is unknown (circa 60%). Religion or belief is not collected in community services.

4.4.8 Sex

For the majority of Trust services, compared to the local demographic, there is a greater proportion of female patients; this ultimately means a lower-than-expected number of male patients are using Trust services. The exception is within Emergency Services, where representation is broadly equal to the local population. This same trend follows into representation in complaints/concerns and serious incidents; however, representation in these processes is broadly in line with service use.

4.4.9 Sexual Orientation

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

C. Workforce

5.0 Workforce Representation

The following information is displayed in order of protected characteristics.

5.0.1 Age

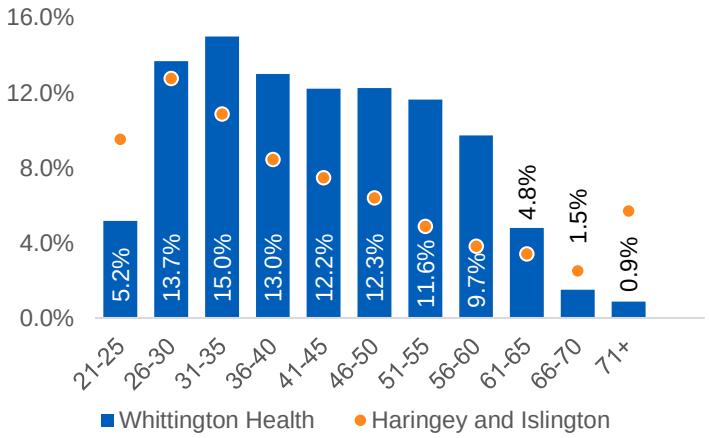
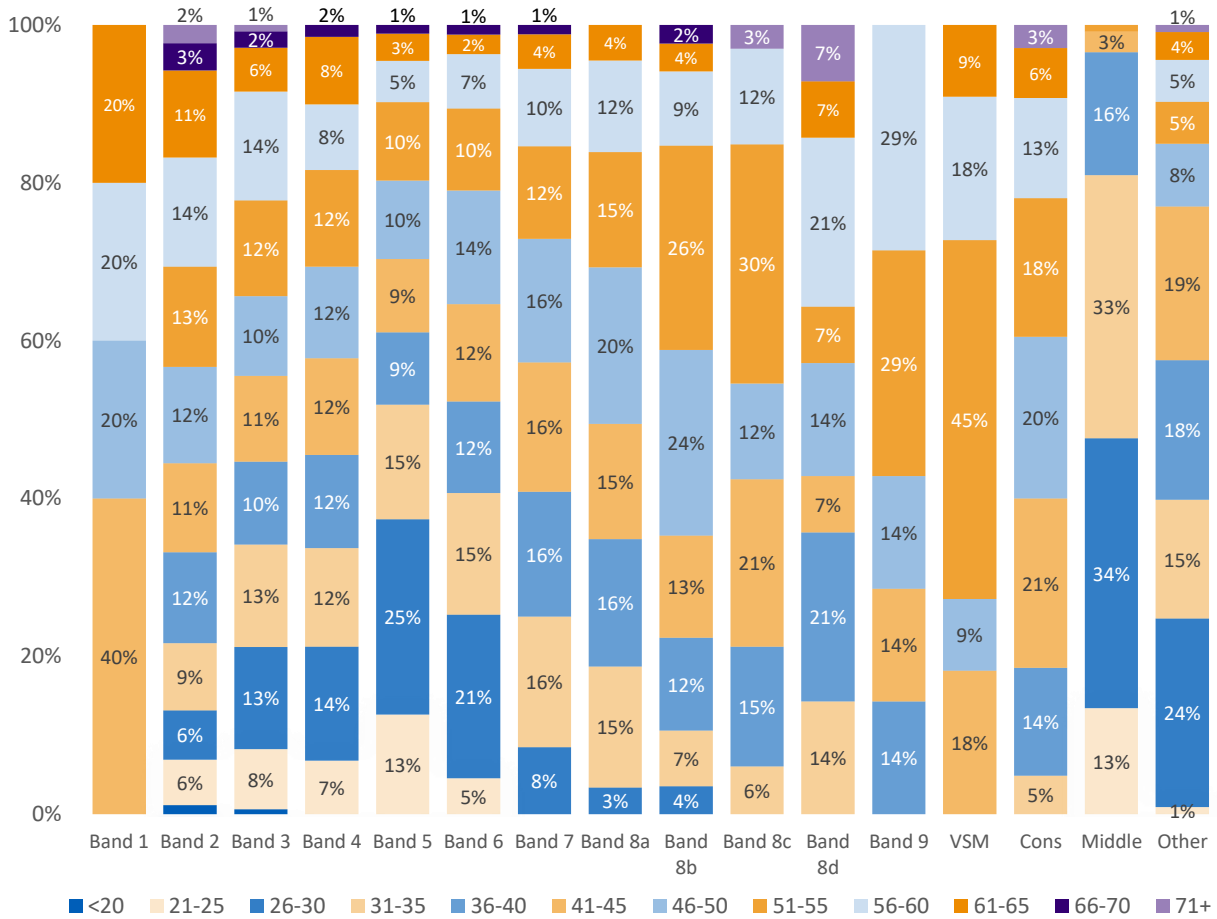


Chart 28 (left) shows the age profile of the Trust's workforce and the profile of residents of Haringey and Islington.

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

Chart 29 (below) shows the breakdown by pay band of the Trust's workforce by age.



Pay band or grade	*Age groups that have the highest representation in pay band or grade*
Band 1	*41-50*
Band 2	*26-65*
Band 3	*26-60*
Band 4	*26-55*
Band 5	*21-55*
Band 6	*26-55*
Band 7	*31-55*
Band 8a	*31-55*
Band 8b	*36-55*
Band 8c	*41-55*
Band 8d	*36-40, 46-50 and 56-60*
Band 9	*51-60*
VSM	*51-60*
Medical – consultants	*41-55*
Medical – middle grade	*26-35*
Medical - other	*26-45*

Table 2 (left) highlights what age groups have the greatest representation of pay bands and grades.

Typically, we will see the greatest concentration of younger workers in bands 2-6 and medical roles classified as other or middle grade.

Conversely, older workers have high levels of representation in more senior roles (band 8 a-d, 9, VSM and medical consultants). However, older workers are represented throughout all pay bands and grades.

Table 3 (below) compares the representation of the age group in the workforce to the actual representation in the band/grade. Higher means greater than workforce representation, lower representation is lower than workforce representation, and equal representation is equal to workforce representation.

Age group	*Higher representation*	*Equal representation*	*Lower representation*	*No representation*
<20	Bands 2 and 3	None	None	Bands 4-9, VSM and medical grades
21-25	Bands 2-5, medical- middle	Band 6	Medical – other	Bands 7-9, VSM and medical consultants
26-30	Bands 5-6, medical middle and other	None	Bands 2-4, 7-8b.	Bands 8c-9, VSM and medical consultants
31-35	Bands 5-8a and medical middle and other	Band 8d	Bands 2-4, 8b-c and medical consultants	Band 9 and VSM
36-40	Bands 7-8a, 8c-9 and all medical roles	Bands 2, 4 and 8b	Bands 3, 5 and 6	VSM
41-45	Bands 1,7, 8c, VSM medical consultant and other	8a	Bands 2-6, 8b, 8d-9 and medical middle	None
46-50	Bands 1-6, 8b, 8d-9 and medical consultants	None	Bands 2-5, 8c, VSM and medical consultants	None
51-55	Bands 2, 8a-c, 9 VSM and medical consultants	Bands 3-4	Bands 5-7, 8d and medical middle & other	None
56-60	1-3, 7-8a, 8c-9, VSM and medical consultants	8b	Bands 4-6 and medical - other	Medical middle
61-65	Bands 1-4, 8d, VSM and medical consultants	None	Bands 5-8b and medical - other	Bands 8c, 9 and medical middle
66-70	Bands 2-4 and 8b	Band 5-7	None	Bands 8a, 8c-9, VSM, all medical
71+	Bands 2-3, 8c-d and medical consultants and other	None	None	Bands 4-8b, 9, VSM and medical middle

5.0.2 Disability

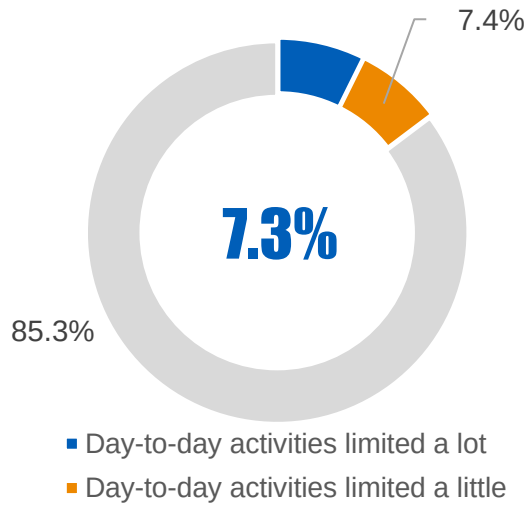


Chart 30 (left) represents the local population of Haringey and Islington by health status.

The categories asked in the Census are not entirely compatible with data held on our Electronic Staff Record system. However, at least 7.3% of local residents are likely to have a disability. However, there are approximately 5% fewer staff within the Trust than in the local community.

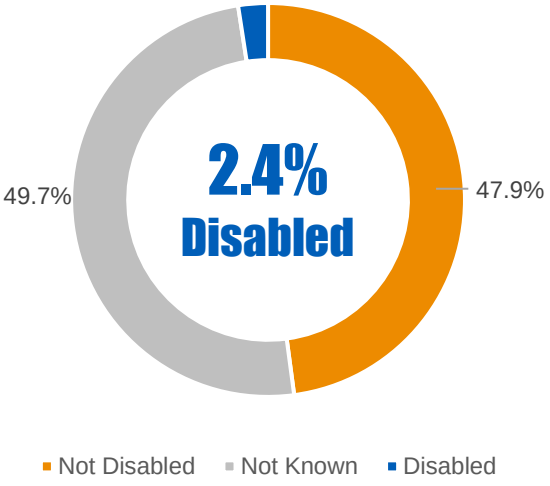


Chart 31 (left) represents the Trust's workforce. 2.4% of staff have declared that they have a disability; this is the same as last year. One of the Trust's priorities is to improve the data on the Electronic Staff Records system about diversity data, as 48% of the workforce's disability status is unknown.

In the 2021 NHS Staff Survey, 17% of respondents highlighted that they have a disability. This means there is a 15% difference between the NHS Staff Survey and local ESR data.

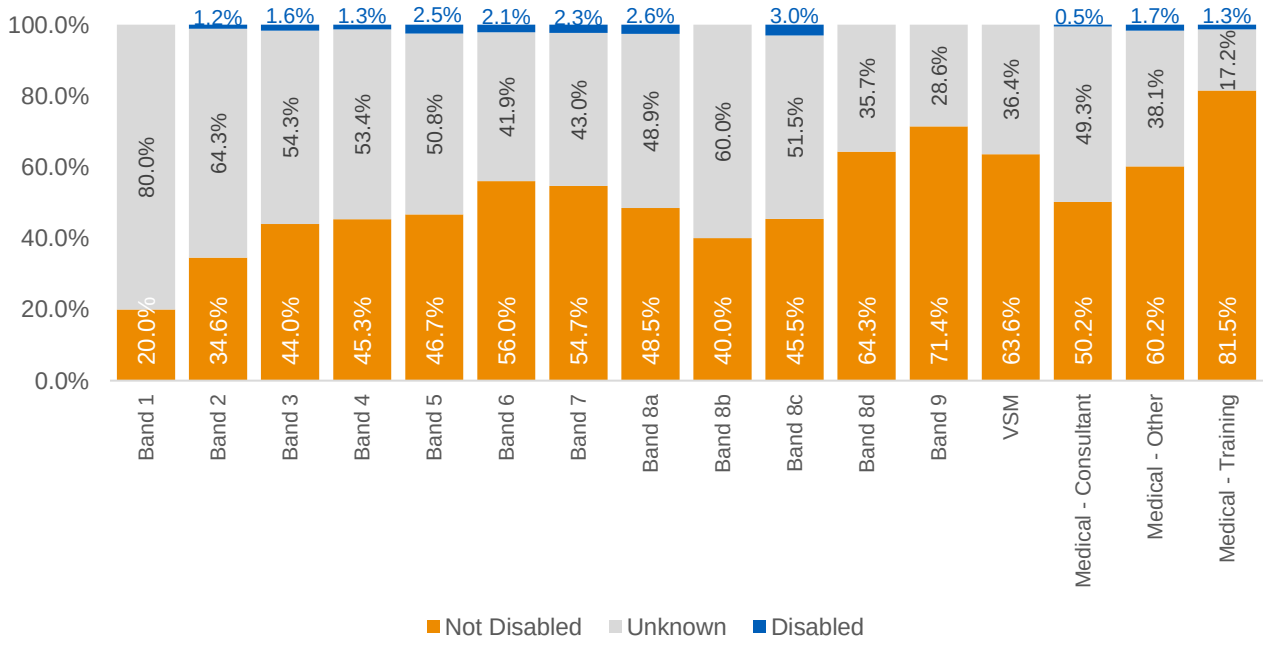


Chart 32 (above) shows the pay bands and grades broken down by disability status. There is not sufficient data to draw firm and accurate conclusions.

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

- In bands 2-4 – there is a slight underrepresentation of disabled staff
- In bands 5-8a and 8c, there is a slightly higher than expected representation of disabled staff.
- In bands 8b, 8d-9, and VSM, staff have not declared their disability status.
- All medical roles have an under-representation of staff that have declared they are disabled.
- There is a high level of staff whose disability status is either unknown or elected not to share their status.

5.0.3 Gender Reassignment

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

5.0.4 Marriage and civil partnership

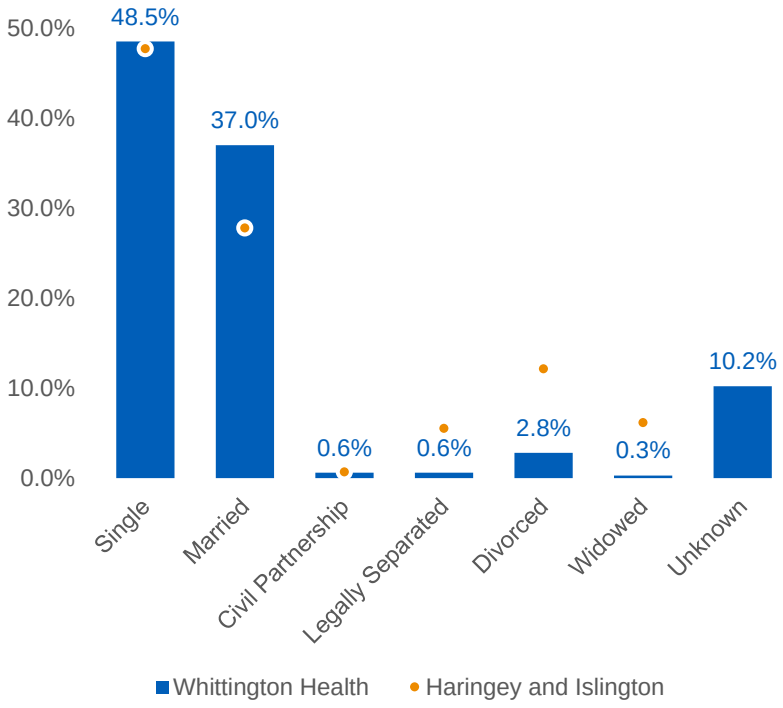


Chart 33 (left) shows the Trust's workforce broken down by marital status compared to the residents of Haringey and Islington.

The Trust's workforce has proportionally more people that are either married or single compared to the local population. There are slightly fewer staff than the population in a civil partnership, and all other categories (except unknown) have a greater representation in the local community than in the workforce.

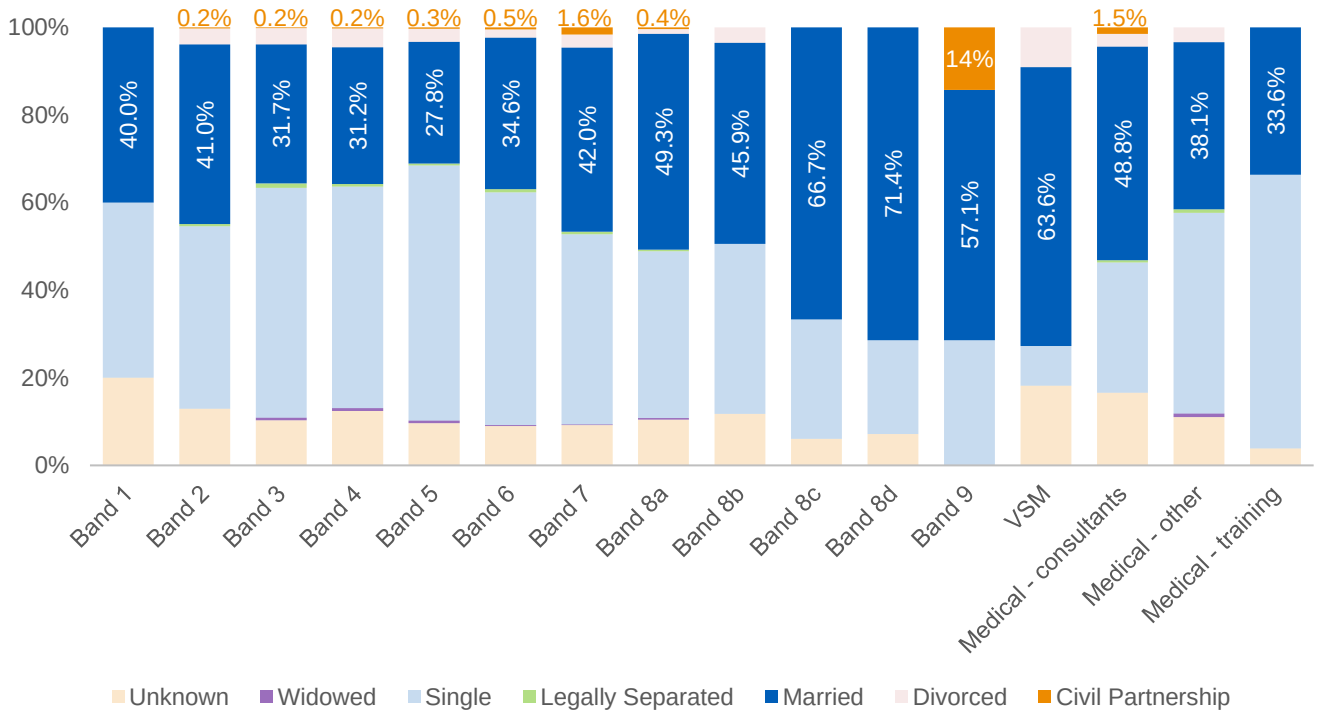


Chart 34 (above) shows pay bands and grades by marital status. Please note only the categories married and civil partnership have been labelled and will be commented on.

When comparing the breakdown provided in chart 33 to the overall workforce representation:

- For the characteristic of marriage: there is a greater than expected representation in bands 1-2, 7-9, VSM and medical consultants and other. There is a lower-than-expected representation in bands 3-6 and medical in training.
- For the characteristic of civil partnership: there is a greater than expected representation in bands 7, 9 and medical consultants. All other bands have either a lower-than-expected representation or no representation.

5.0.5 Pregnancy and maternity

One hundred twenty-seven women were recorded on ESR as being on maternity leave as a snapshot on 31st March 2022. This represents just 0.03% of the female population of the Trust. It is impossible to know the number of all women in the Trust who are pregnant because there is no requirement to record it until the Maternity Certificate can be issued after 20 weeks of pregnancy. ESR will only record those who have completed and submitted their certificates.

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

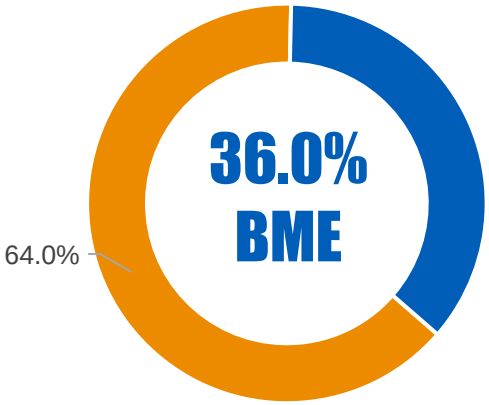


Chart 35 shows the representation of the population of Haringey and Islington broken down by ethnicity.

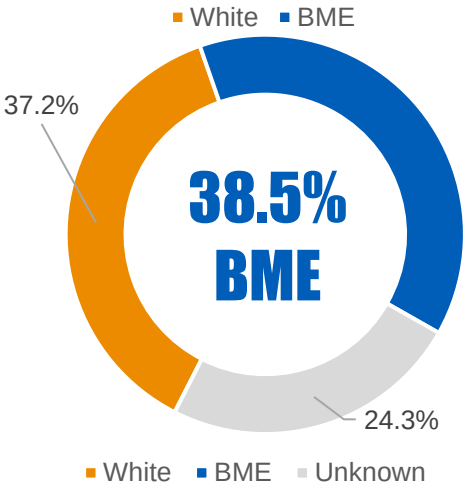


Chart 36 (left) represents the Trust's workforce by ethnicity.

Compared to the local population (chart 35), there is a greater representation of BME staff and fewer white staff. However, about one-quarter of the workforce's ethnicity is not known.

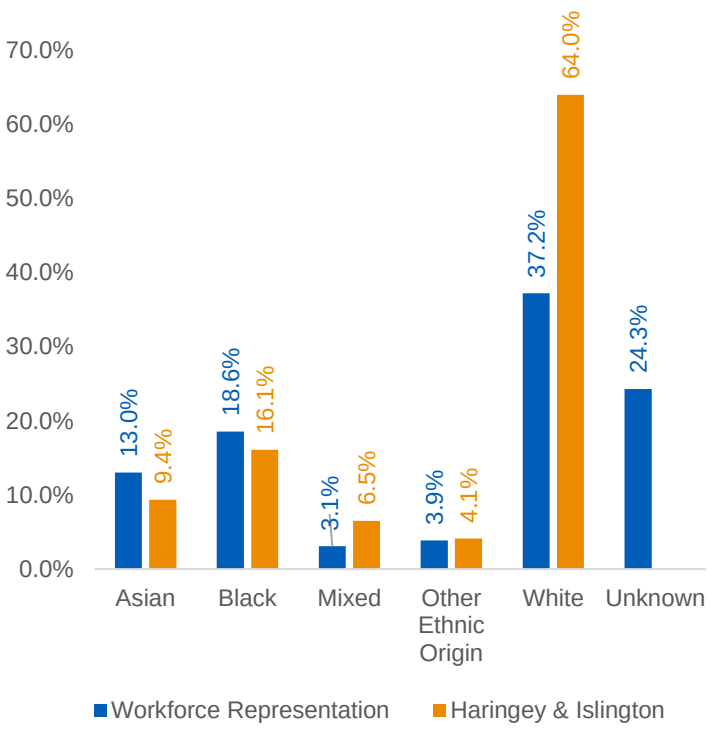


Chart 37 (left) breaks down the representation of the BME category into smaller ethnic groups for the workforce at the Trust and the local population of Haringey and Islington.

Compared to the local population, the workforce has a higher-than-expected representation of Asian and Black staff, a lower-than-expected representation of mixed and White staff, and about the same representation of staff in the other ethnic origin category.

With nearly a quarter of the workforce's ethnic origin being unknown, the available data may not represent an accurate picture of the racial demographic breakdown of the workforce.

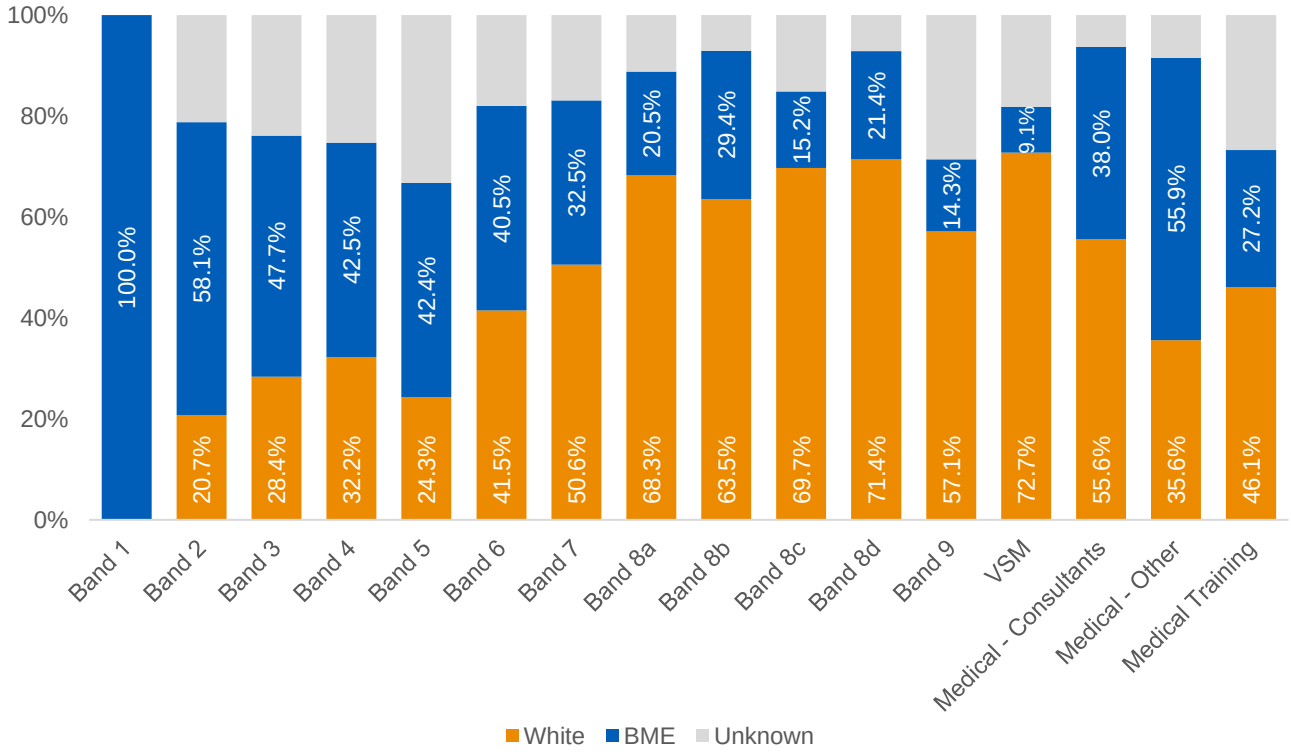


Chart 38 (above) shows the breakdown by pay band of the Trust's workforce by ethnicity. Although there is a 1% difference in the number of BME to white staff, the career path is notably different, with most BME staff represented up to Band 5, and white staff are in the majority from Band 6 onwards.

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

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

5.0.7 Religion or belief

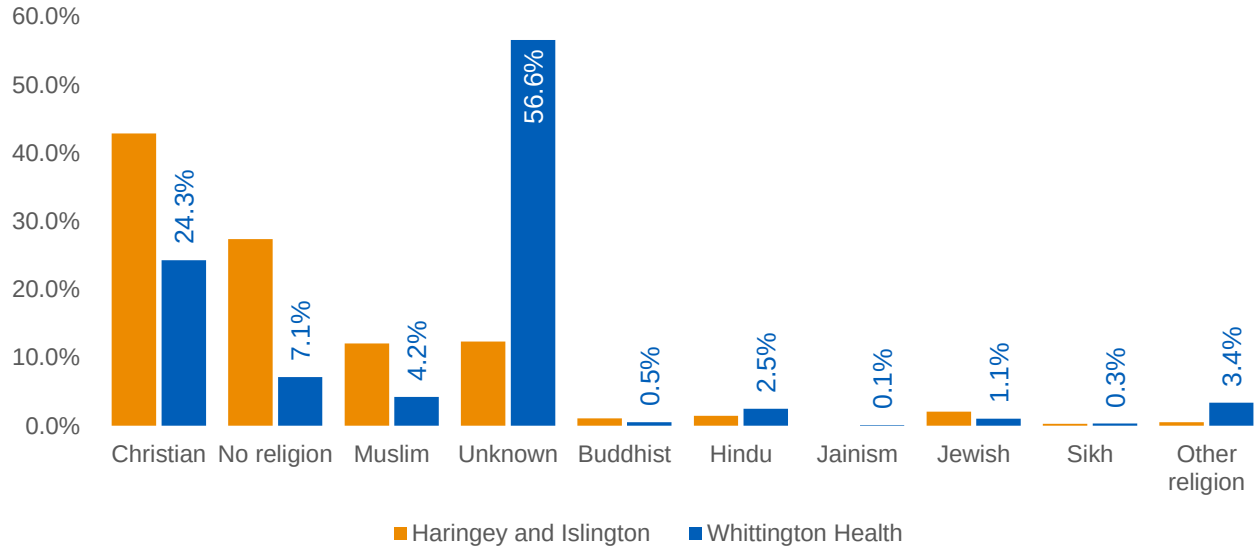


Chart 39 (above) shows the representation of religion and belief of the population of Haringey and Islington and the Trust's workforce. Within the Trust, the greatest representation is staff whose religion or belief is unknown/staff have elected not to share that information; the second largest group is Christian, and the third largest group are staff with no religion or belief.

When comparing the workforce to the local population, there is equal representation of Sikhs. There is a lower representation of Christians (-18.6%), those with no religion (-20.2%), Muslims (-7.8%), Buddhists (-0.6%) and Jews (-1.0%); conversely, there is a greater representation in the workforce of those where their religion or belief is unknown or where staff have elected not to share this information (+44.2%), Hindus (+1.0%), other religion (+2.9%). Jainism is not recorded as a separate religion in the 2011 Census.

Table 4 (below) represents the religion or belief broken down by pay band or grade, the items highlighted in green illustrate a higher-than-expected representation compared to the overall workforce.

	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9
Atheism	0.5%	2.5%	4.1%	3.6%	4.3%	9.2%	8.8%	8.9%	20.0%	20.0%	9.1%
Buddhism	0.3%	0.8%	0.2%	0.3%	0.49%	0.4%					
Christianity	25.2%	26.8%	24.1%	19.3%	27.7%	26.7%	26.4%	25.7%	20.0%	33.3%	18.2%
Hinduism	1.9%	1.7%	1.3%	1.2%	1.1%	2.2%	3.0%	2.0%			9.1%
Islam	3.8%	5.7%	3.6%	3.2%	3.2%	3.5%	2.4%	3.0%	5.7%		
Jainism	0.3%		0.2%		0.1%	0.1%			2.9%		
Judaism		0.2%	0.2%	0.5%	1.3%	1.3%	1.0%	2.0%			
Other	2.7%	3.4%	4.3%	2.6%	2.7%	3.5%	5.1%	4.0%	5.7%	20.0%	
Sikhism		0.4%		0.2%	0.1%	0.6%			2.9%		
Declined to answer	7.8%	11.0%	16.6%	5.1%	11.0%	15.5%	25.3%	22.8%	14.3%	6.7%	9.1%
Unknown	57.6%	47.5%	45.4%	64.0%	48.0%	37.0%	28.0%	31.7%	28.6%	20.0%	54.5%

	VSM	Medical - Consultant	Medical - Other	Medical - Trainee
Atheism	7.1%	12.9%	4.8%	33.0%
Buddhism		1.4%	1.2%	1.4%
Christianity	28.6%	21.7%	15.7%	15.4%
Hinduism		7.4%	10.8%	8.2%
Islam		6.5%	19.3%	7.5%
Jainism				
Judaism		4.1%	1.2%	3.2%
Other		1.4%	2.4%	4.7%
Sikhism		1.4%	1.2%	0.7%
Declined to answer	14.3%	13.8%	16.9%	17.9%
Unknown	50.0%	29.5%	26.5%	7.9%

With high levels of staff with either unknown or declined to specify (56.6%), no meaningful conclusions can be made about the representation of religion or belief in pay bands or grades.

5.0.8 Sex

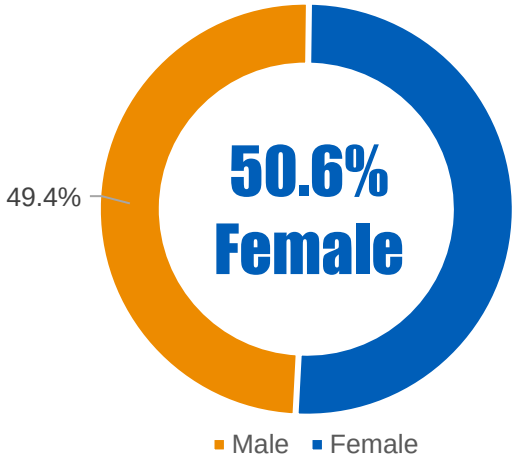


Chart 40 (left) shows the breakdown of the population of Haringey and Islington by sex. 49.4% of the population is male, and 50.6% is female.

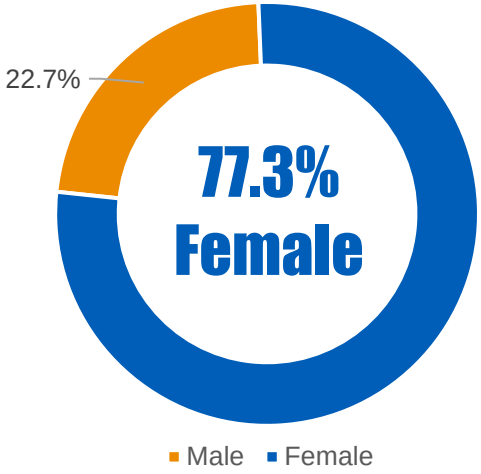


Chart 41 (left) shows the breakdown of the Trust's workforce by sex. Whilst the representation in the Trust does not reflect the local population, it does mirror the national NHS pattern of 77% female and 23% male.

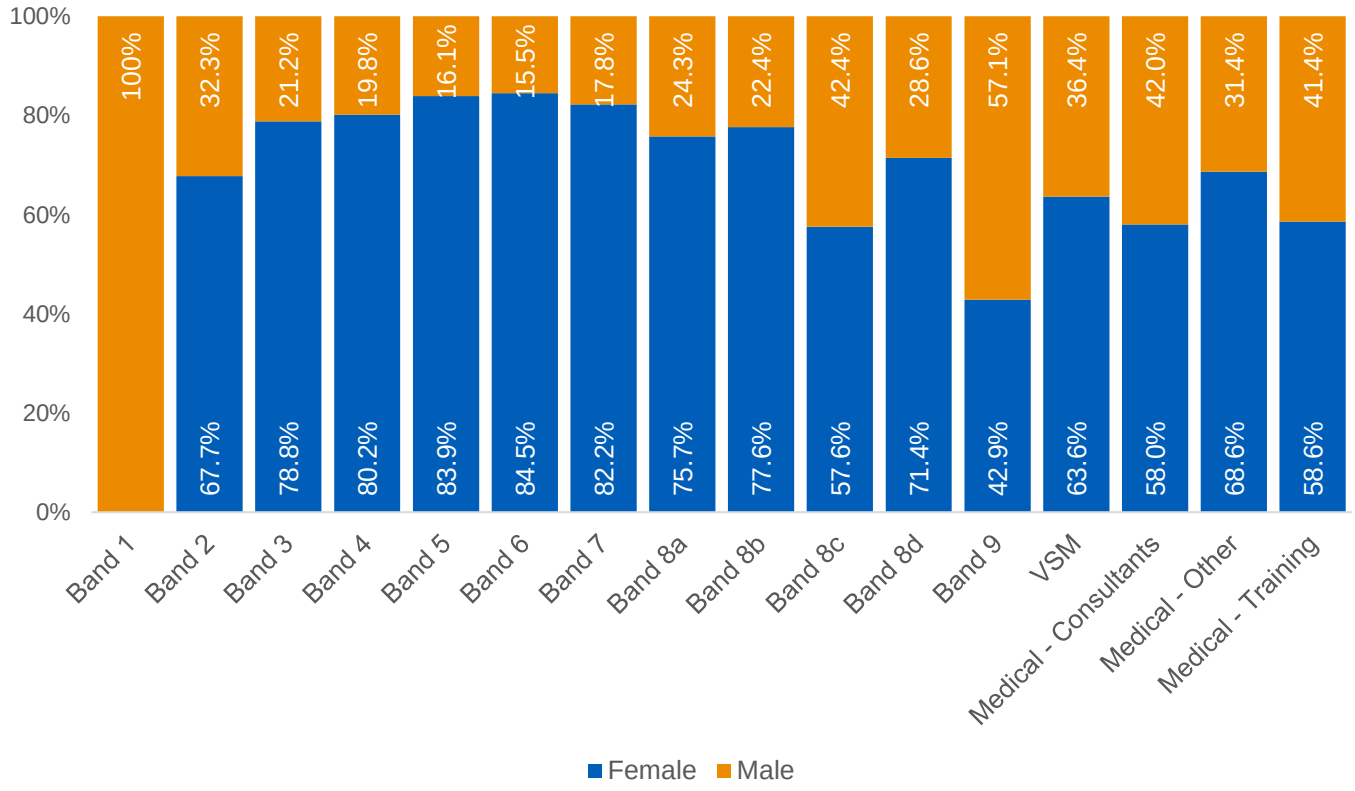


Chart 42 (above) shows the breakdown of pay bands and grades by sex; male and female staff are well represented across all bands and grades.

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

Table 5 (below) highlights the 2021/22 Gender Pay Gap Report; the report is available on the Gender Pay Gap Reporting Service. Lower representation in senior manager bands and medical grades may impact the gender pay gap at the Trust.

GPG Factor	Observation
Women's hourly pay	Median hourly pay is 6.5% lower than men's Mean hourly pay is 7.6% lower than men's
Pay quarters – female representation	Lowest quarter – 76% Lower middle quarter – 79.9% Upper middle quarter – 78.8% Upper quarter – 71.2%
Women's bonus Pay	Median bonus pay is 32.5% lower than men's Mean bonus pay is 2.2% lower than men's 1.6% of women and 2.7% of men received bonus payments

5.0.9 Sexual orientation

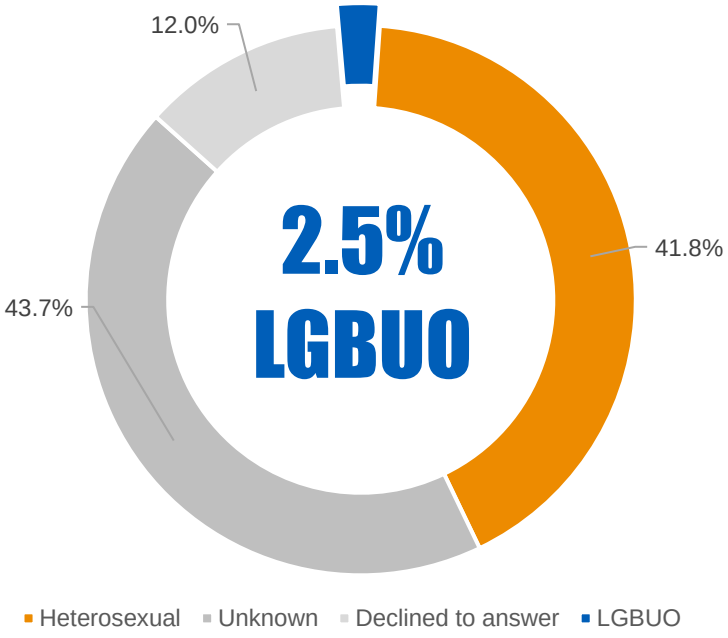


Chart 43 (left) represents the Trust's workforce by sexual orientation. In the 2011 Census, data about sexual orientation was not collected.

Because the level of declaration for sexual orientation is very low throughout the organisation, Lesbian, Gay, Bisexual, Undecided and Other Sexual Orientation Not Listed categories have been aggregated (LGBUO). However, as the declaration rates are so low, it is impossible to draw meaningful conclusions, as we do not have an accurate picture of the demographic profile for this protected characteristic.

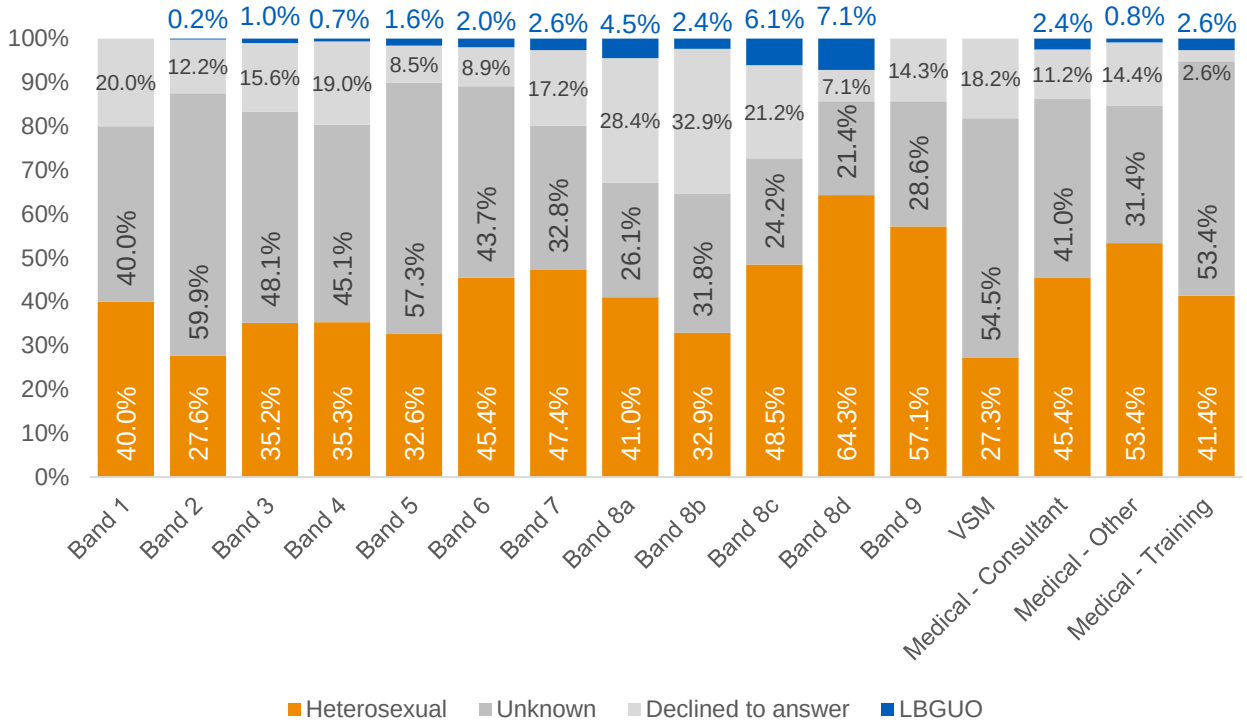


Chart 44 (above) shows the workforce broken down by pay band/grade and sexual orientation.

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

Comparing the representation in pay bands and grades to the overall workforce. LGBUO staff have good (higher than expected) representation in bands 5-8d, medical consultant and training; there is lower than expected representation in bands 2-4 and medical other; and no representation in band nine and VSM.

Heterosexual staff are well represented throughout most pay bands and grades; in most cases have a greater representation in the band/grade compared to the overall representation in the workforce. The bands and grades with a lower-than-expected representation are bands 2-5, 8b and VSM.

5.1 Recruitment

This section reviews recruitment data from 2021/22; it breaks down the representation of protected characteristics through three stages of recruitment – application, shortlisting, and appointment. To aid comparison, data relating to workforce representation is also included.

During 2021/22, there were:

- 12,269 applications received
- 6,924 applicants that were shortlisted to progress to interview
- 935 applicants were appointed

5.1.1 Age

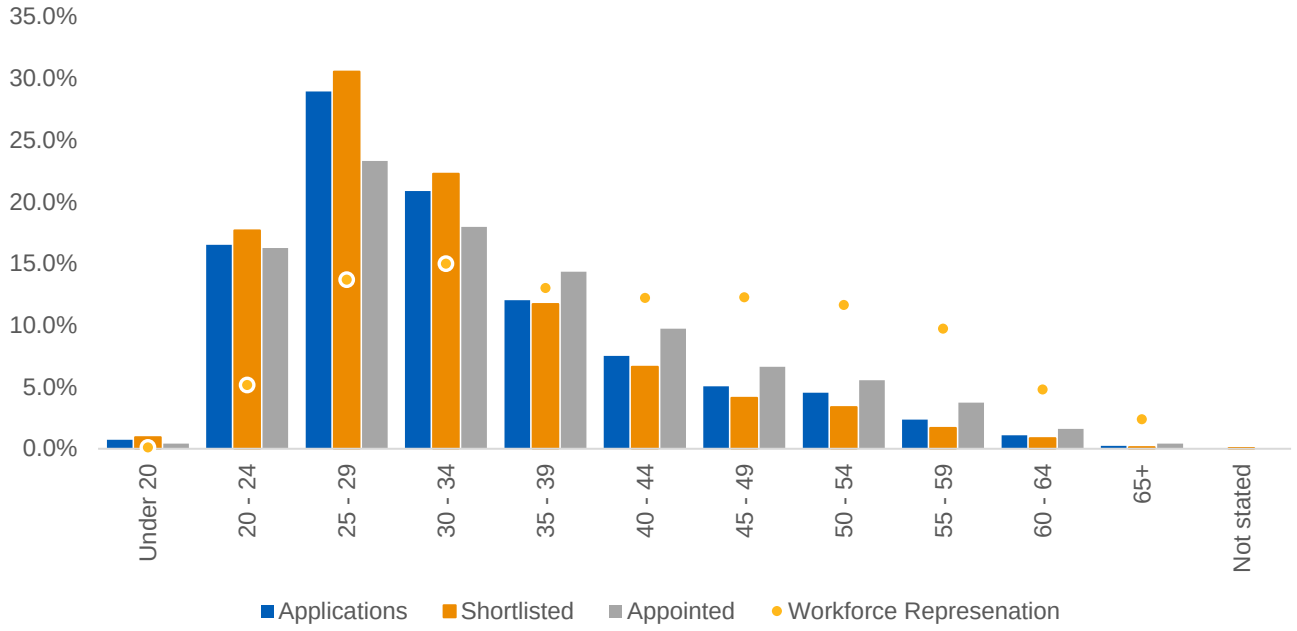


Chart 45 (above) shows the representation throughout the recruitment stages broken down by age; the workforce representation data has also been included to aid comparison.

Compared to the overall workforce representation, there is a greater proportion of applicants aged 20-34 in the recruitment processes; conversely, there is a broadly lower-than-expected representation for those under 20 and 35+.

There is an overall trend of younger applicants (under 20 to 34) having a greater proportional representation when progressing from the application to shortlisting stage but a lower representation from shortlisting to the appointment stage. In all cases, the representation at the appointment stage is lower than at the application stage.

For applicants aged 35+, in all cases, when progressing from the application to shortlisting stage, there is a lower proportional representation; however, at the appointment stage, there is a greater proportional representation. In all cases, the representation at the appointment stage is more significant than at the application stage.

5.1.2 Disability

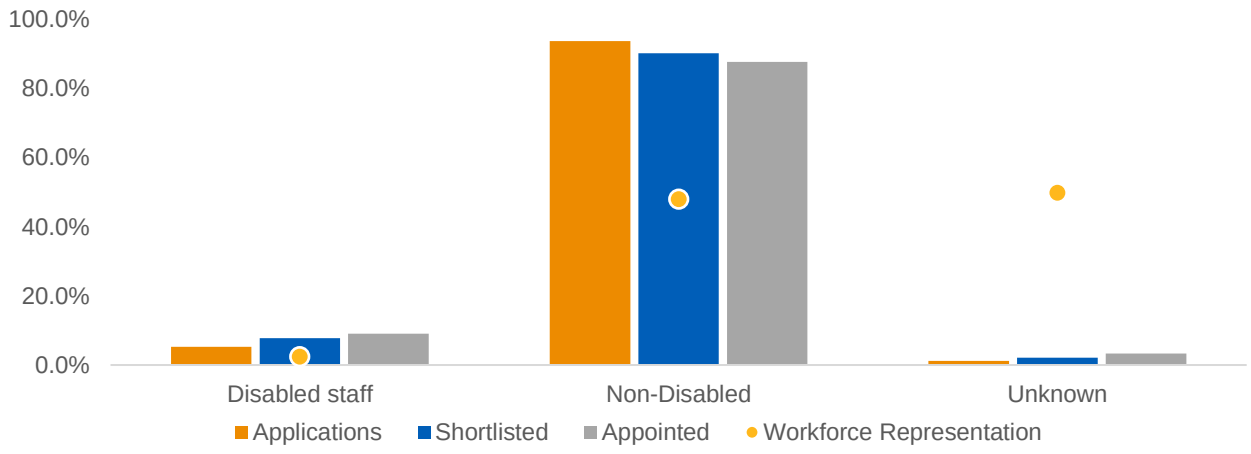


Chart 46 (above) shows the representation throughout the recruitment stages broken down by disability; the workforce representation data has also been included to aid comparison.

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

Overall, there is a staggered proportional increase in disabled applicants as they progress through the recruitment stages; the opposite is true for non-disabled applicants.

5.1.3 Marriage and civil partnership

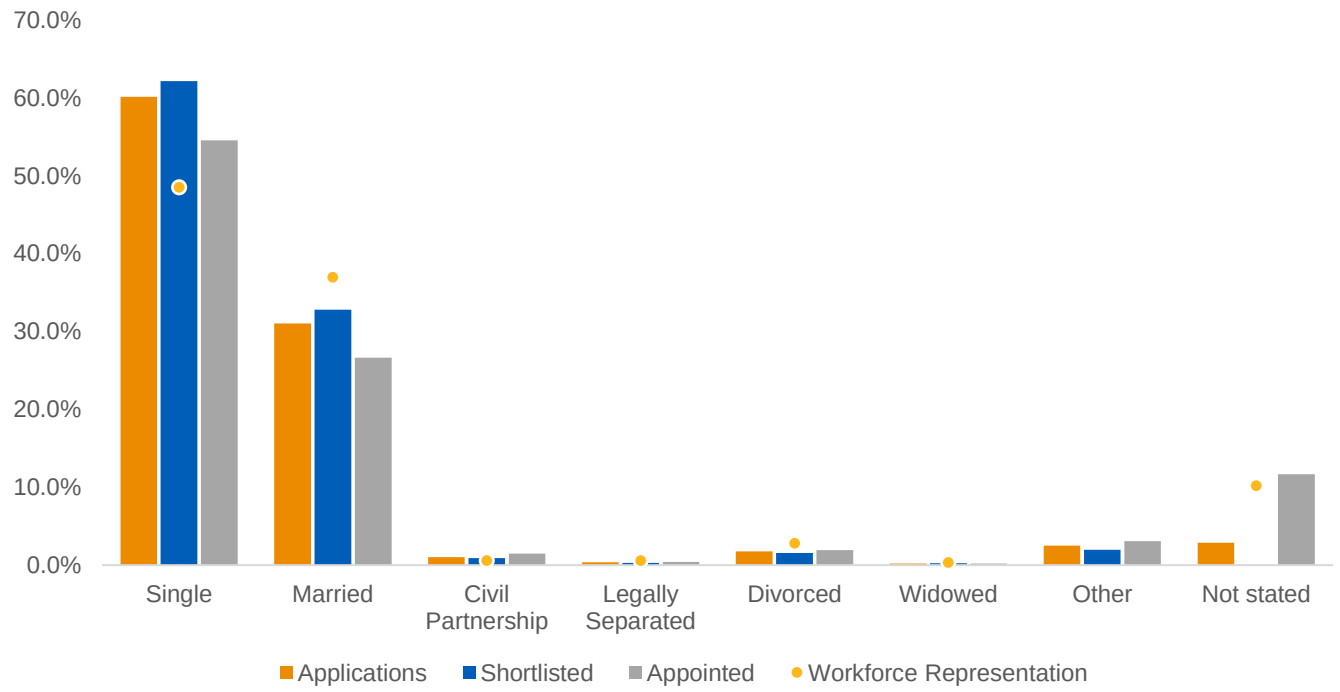


Chart 47 (above) shows the representation throughout the recruitment stages broken down by the applicants' marriage or civil partnership status; the workforce representation data has also been included to aid comparison.

Compared to the overall workforce representation, there is a greater proportion of applicants in a civil partnership in the recruitment processes; conversely, there is a lower proportional representation where the applicants are married.

For married applicants, proportional representation increases when progressing from application to the shortlisted stage, which then drops to the appointment stage. There is a lower representation of married applicants appointed than in the application stage.

For applicants in a civil partnership, there is a slight decrease from application to the shortlisted stage, which increases when progressing to the appointment stage. There is a great representation of applicants in a civil partnership that has been appointed compared to the application stage.

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

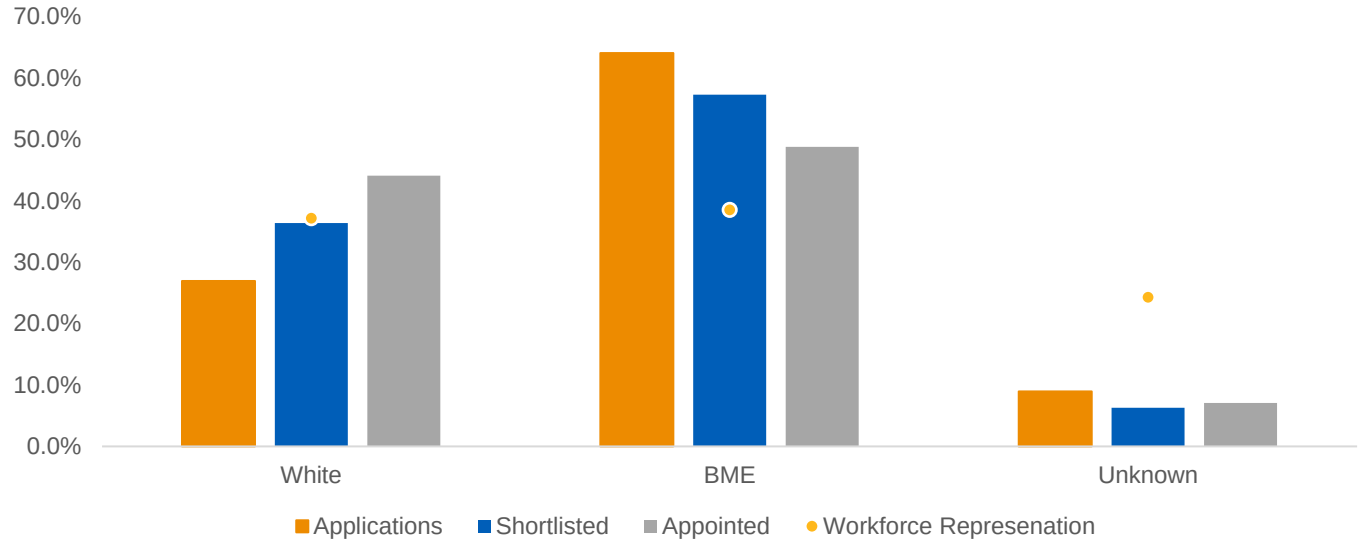


Chart 48 (above) shows the representation throughout the recruitment stages broken down by the applicants' race; the workforce representation data has also been included to aid comparison.

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

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

5.1.5 Religion or belief

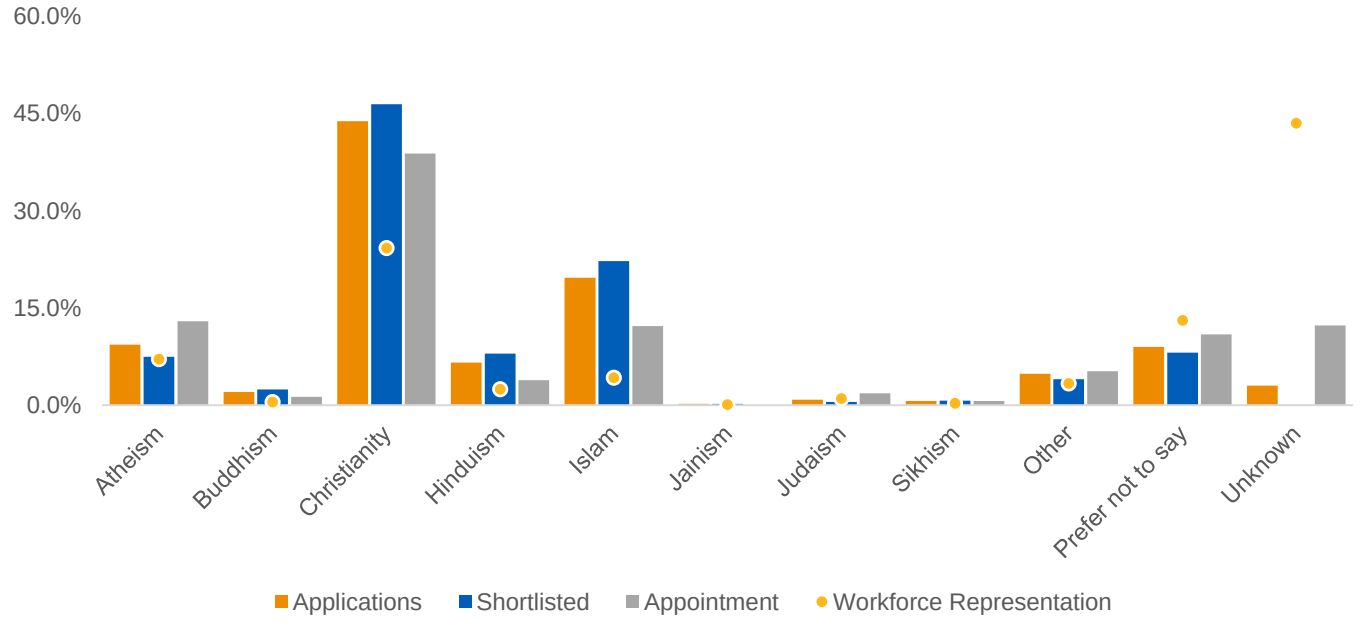


Chart 49 (above) shows the representation of religion or belief in the recruitment process; overall workforce representation has been included to aid comparison.

Compared to the workforce representation, there is an overall greater representation of Atheists, Christians, Hindus, Muslims, Sikhs, Others, and those that have declined to share their religion or belief. There is a lower-than-expected representation of Buddhists, Hindus and those whose religion or belief is unknown; for Jewish candidates, there is a lower-than-expected representation at application and shortlisted stages but a greater-than-expected representation at appointment.

When progressing from shortlisted to the appointment stage, Atheist, Jewish, unknown and prefer not to say applicants saw an increased representation, whilst all other groups saw a degradation; applicants that are either Hindu or Muslim saw the largest proportional decreases.

When comparing the appointment stage, Atheists, Jewish and Other groups saw a representation greater than at the application stage.

5.1.6 Sex

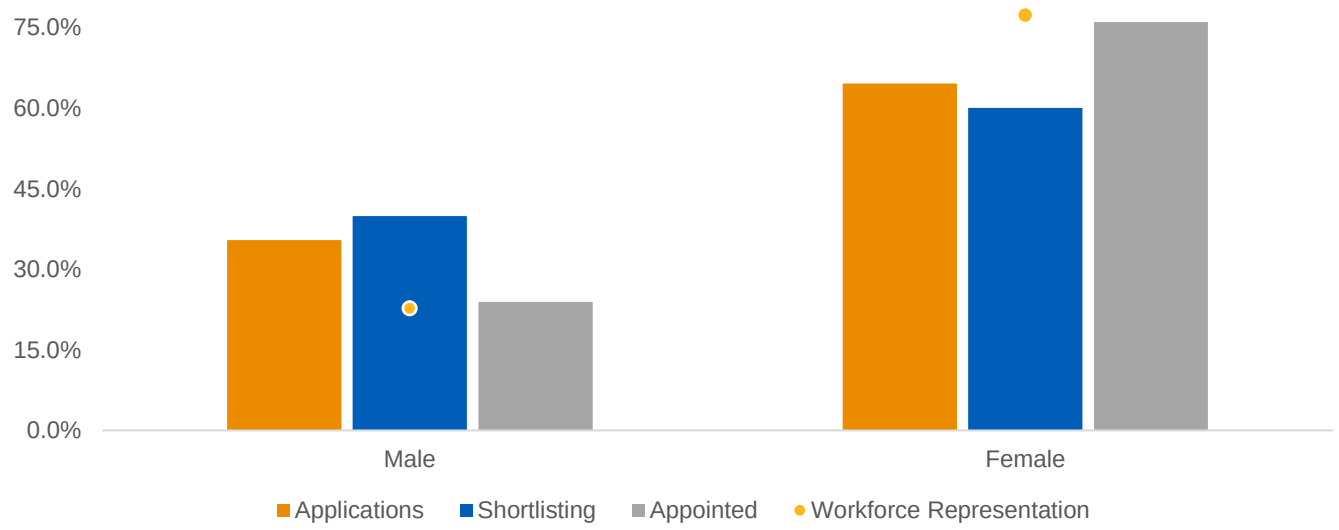


Chart 50 (above) shows the representation of sex throughout the recruitment process; the workforce representation has been included to aid comparison.

Compared to the workforce representation, fewer female applicants are represented in the Trust's recruitment processes, and more male applicants are represented in the recruitment processes.

When progressing through the stages of recruitment, the proportional representation of female applicants decreased from the application to the shortlisting stage and increased from shortlisting to the appointment stage. Male candidates follow the opposite trend.

When comparing proportional representation at appointment from application stages, female applicants have a greater representation, and male applicants have are lower.

5.1.7 Sexual Orientation

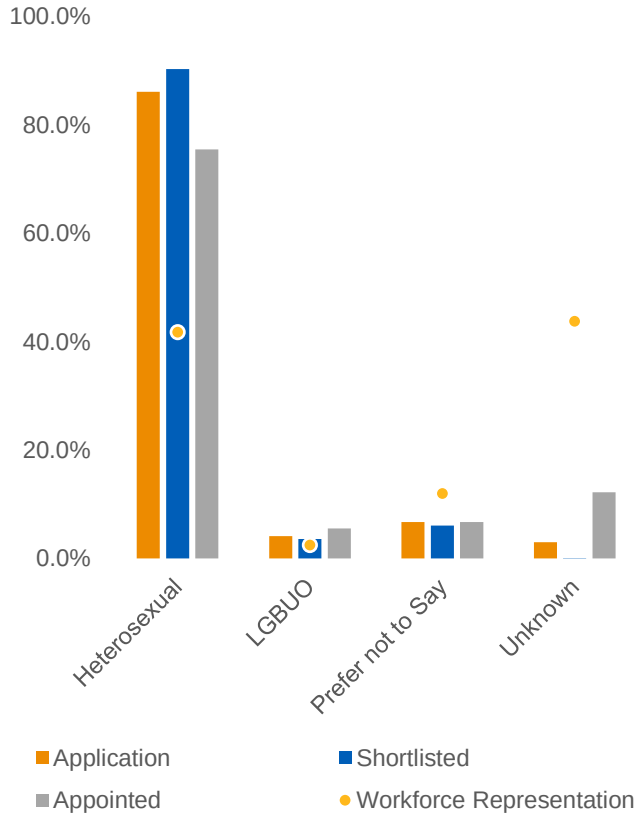


Chart 51 (left) shows the representation of sexual orientation in the Trust's recruitment processes; the workforce representation data is included for comparison.

Compared to the workforce representation, there is a greater representation of candidates that are LGBUO, fewer that are heterosexual, prefer not to say and are unknown.

Looking at progression through the stages, LGBUO candidates see an initial decrease in representation from the application to shortlisting stages; then, it increases from shortlisting to the appointment stages. The opposite trend is true for heterosexual applicants.

When comparing representation from appointment to the application stage, there is a greater representation of LGBUO applicants and a lower representation of heterosexual applicants.

5.2 Employee Relations Processes

During 2021/22, there were 28 disciplinary cases; 11 involved clinical staff, eight involved non-clinical staff and 9 were unknown. Looking at the staff that had been through a disciplinary process by pay band, 9 cases were in bands 1-4, 9 cases were in bands 5-7, 1 case was in band 8a-b, and 9 cases were unknown.

The next sections review the demographical breakdown in representation compared to the workforce. Not all protected characteristics are recorded against the employee relations case; as such, only those characteristics with useful data are included in this report.

5.2.1 Disability

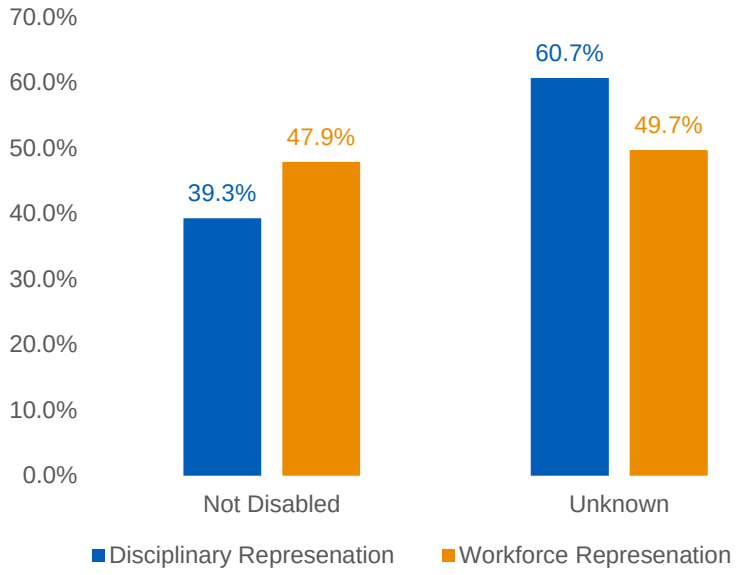


Chart 52 (left) shows the representation within disciplinary procedures compared to the representation in the overall workforce.

No disabled staff have been through the disciplinary process in 2021-22.

However, compared to representation in the general workforce, non-disabled staff have a lower-than-expected representation in disciplinary procedures; staff whose disability status is unknown is higher.

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

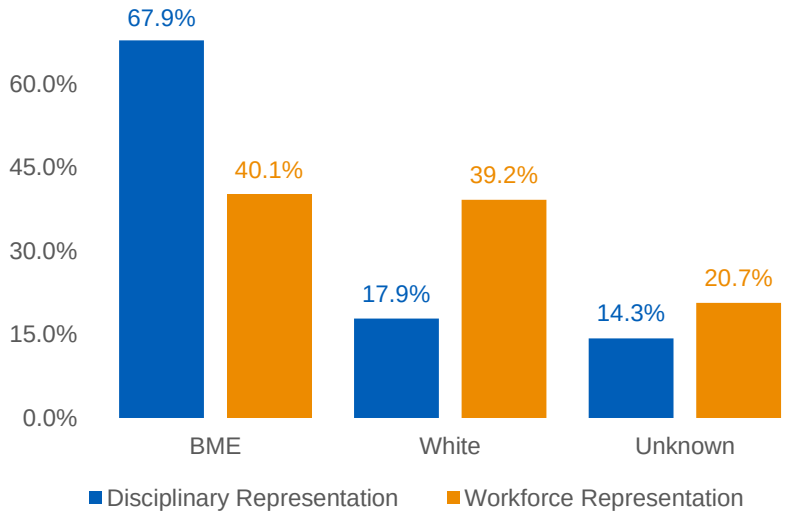


Chart 53 (left) shows the representation in the disciplinary procedures by ethnicity; workforce representation is also included for comparison.

Compared to the workforce representation, BME staff are overrepresented; white staff are underrepresented in disciplinary procedures.

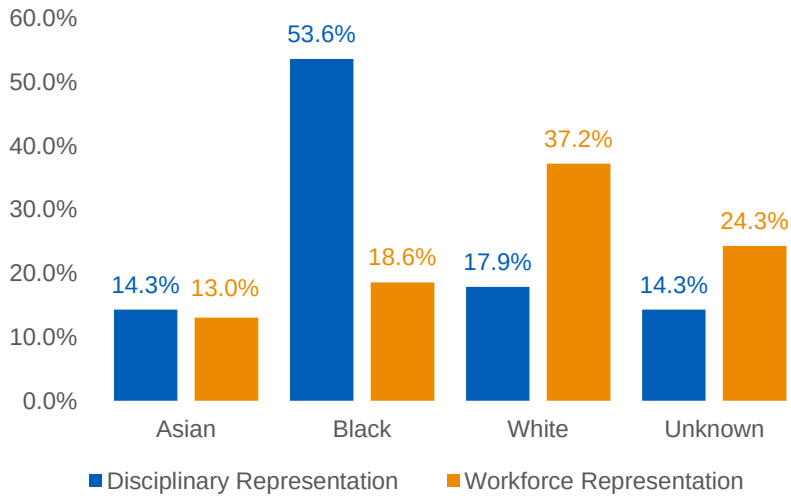


Chart 54 (left) further breaks down the BME category in the representation in the disciplinary procedures; workforce representation is included for comparison.

Staff from black groups are overrepresented in disciplinary procedures; Asian staff have broadly similar representation, and white staff have a lower-than-expected representation compared to the overall workforce.

5.2.3 Sex

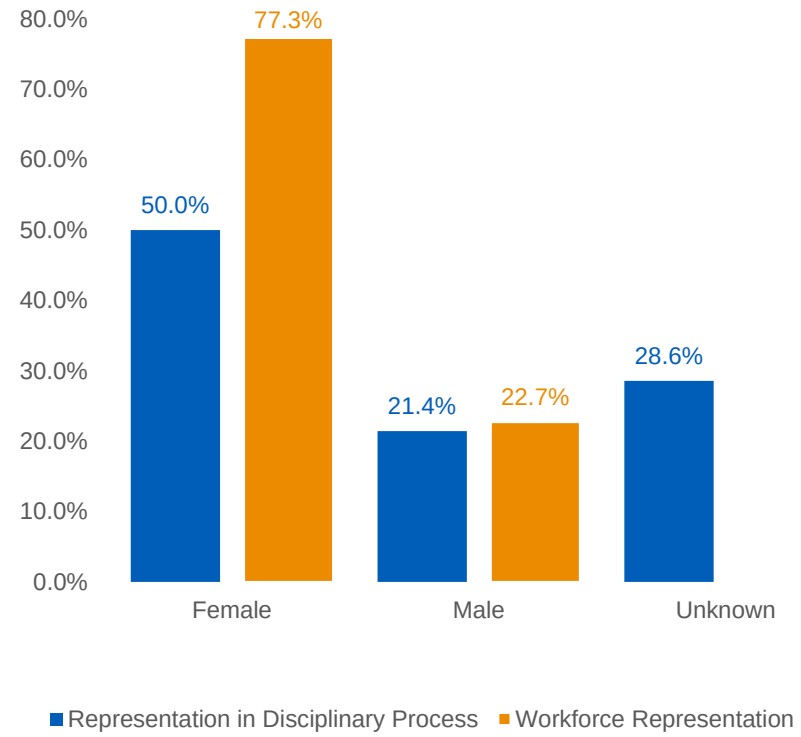


Chart 55 (left) shows the representation of sex in the disciplinary procedures; workforce representation data is included for comparison.

Compared to the workforce, female staff have a lower-than-expected representation in disciplinary procedures, while male staff have about the same representation. For nearly 30% of those going through the disciplinary process, their sex was not recorded.

5.2.4 Sexual Orientation

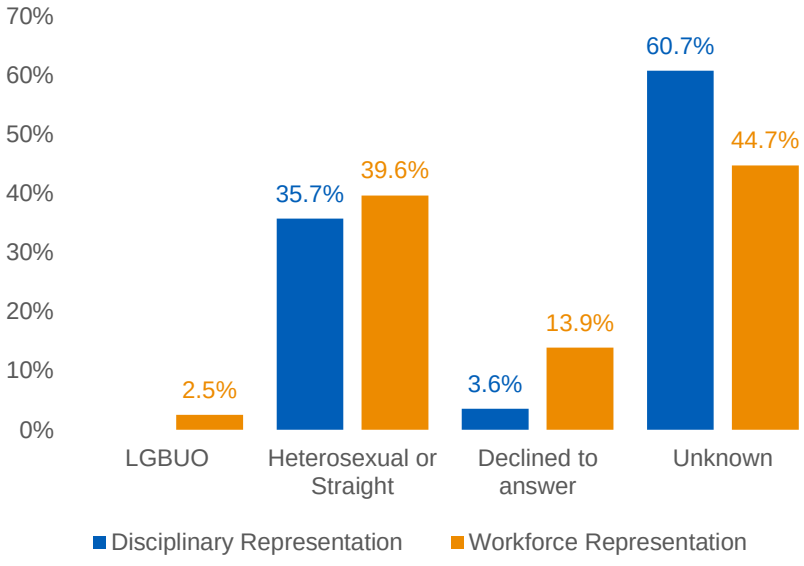


Chart 56 (left) shows the representation of sexual orientation in the disciplinary procedures; workforce representation data is included for comparison.

There were no Lesbian, Gay, Bisexual, Undecided or Other staff that have been through disciplinary procedures, heterosexual staff have about equal representation, and there is an overrepresentation of staff whose sexual orientation is unknown.

5.3 Non-Mandatory Training and Continued Professional Development

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

During 2021/22, a total of 1,382 undertook training that was either non-mandatory or related to continued professional development. This section will review the demographic breakdown of the staff that undertook training. Not all the data for the protected characteristics were available at the time of writing this report.

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

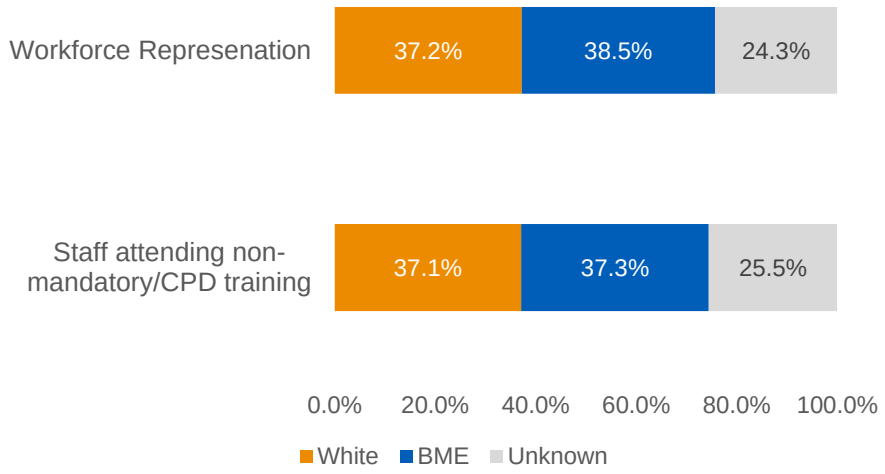


Chart 57 (left) shows the breakdown of staff that accessed non-mandatory training or CPD broken down by race; overall workforce representation has been included to aid comparison.

Compared to the overall workforce representation, all groups access this type of training proportionally.

5.3.2 Sexual Orientation

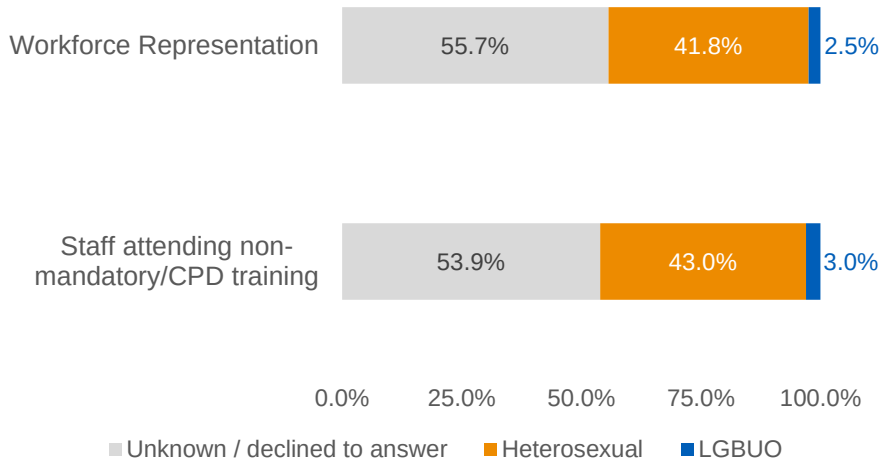


Chart 58 (left) shows the breakdown of staff that accessed non-mandatory training or CPD; the workforce representation has been included to aid comparison.

Compared to the workforce representation, all groups that undertook this type of training are broadly in line. However, it should be noted that LGBUO staff have a slightly higher-than-expected representation.

5.4 Leavers

During 2021/22, a total of 937 staff left the organisation. This section will review in greater detail the demographic breakdown of staff that left the Trust.

5.4.1 Age

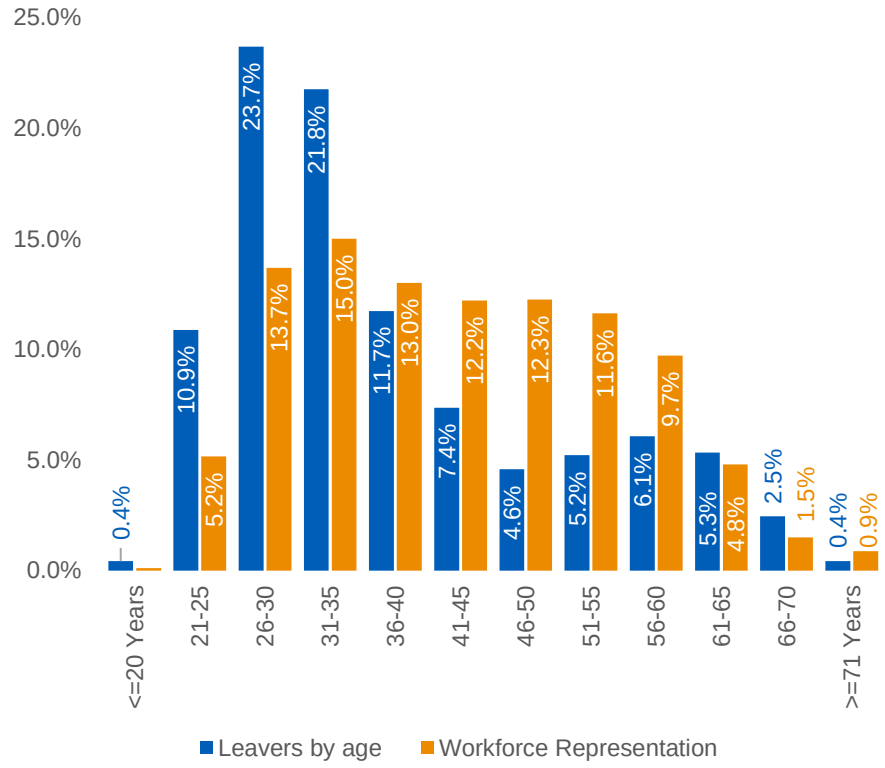


Chart 59 (left) shows the representation of staff that have left Whittington Health by age; the overall workforce representation has been included to aid comparison.

Most staff that have left the Trust are aged between 21 and 35.

Compared to the overall workforce representation, a greater than expected proportion of staff aged <20-35 and 61-70 have left the organisation. For all other age groups, fewer staff have left the organisation.

5.4.2 Disability

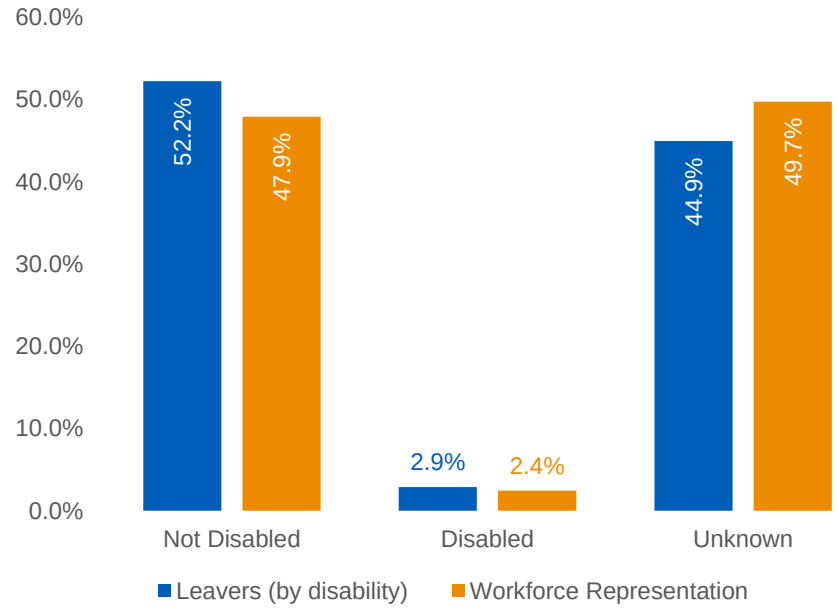


Chart 60 (left) shows the representation of staff that have left the Trust by disability status; the overall workforce representation has been included to aid with comparison.

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

5.4.3 Marriage civil partnership

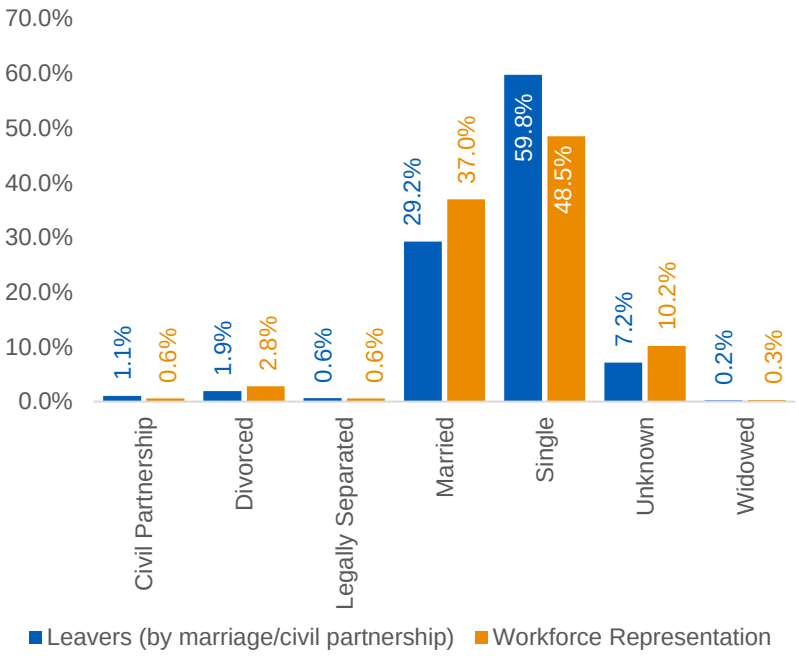


Chart 61 (left) shows the breakdown of staff that have left the organisation by marriage and civil partnership; workforce representation data have been included to aid comparison.

Compared to the overall workforce, more staff in a civil partnership have left the organisation and a lower-than-expected representation of married staff.

A greater proportion of single or divorced staff has also left the organisation compared to the overall workforce representation.

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

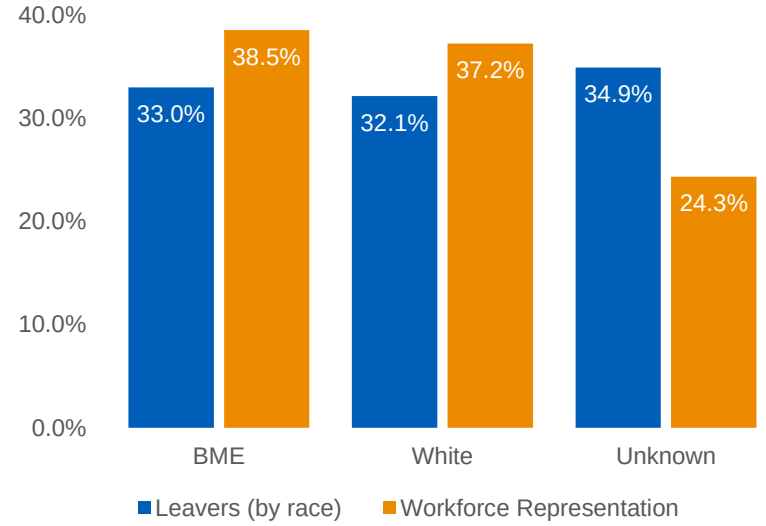


Chart 62 (left) shows the representation of ethnicity of staff that have left the Trust; overall workforce representation has been included to aid comparison.

Compared to the overall workforce, a lower-than-expected proportion of BME and White staff have left the organisation. Still, a greater-than-expected proportion of staff where ethnicity is unknown has left.

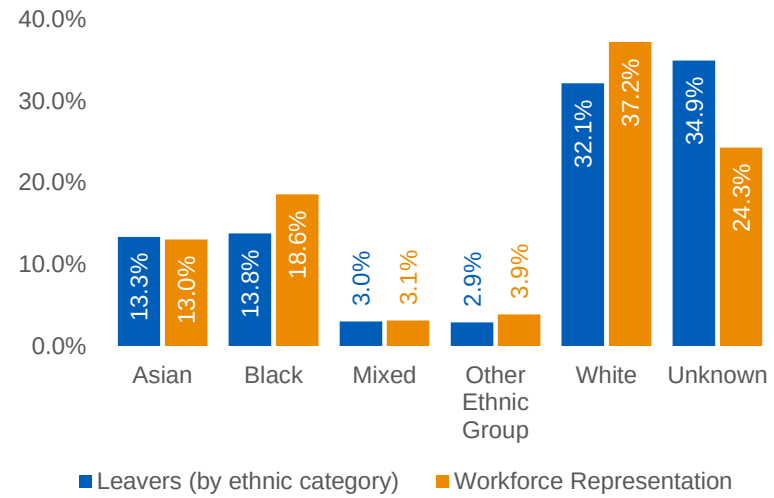


Chart 63 (left) breaks down the BME Category above into main ethnicity categories. Broadly a proportional number of Asian and Mixed staff has left the organisation compared to the workforce representation.

A lower proportion of Black, Other and White staff have left the Trust compared to the overall workforce representation.

5.4.5 Religion or Belief

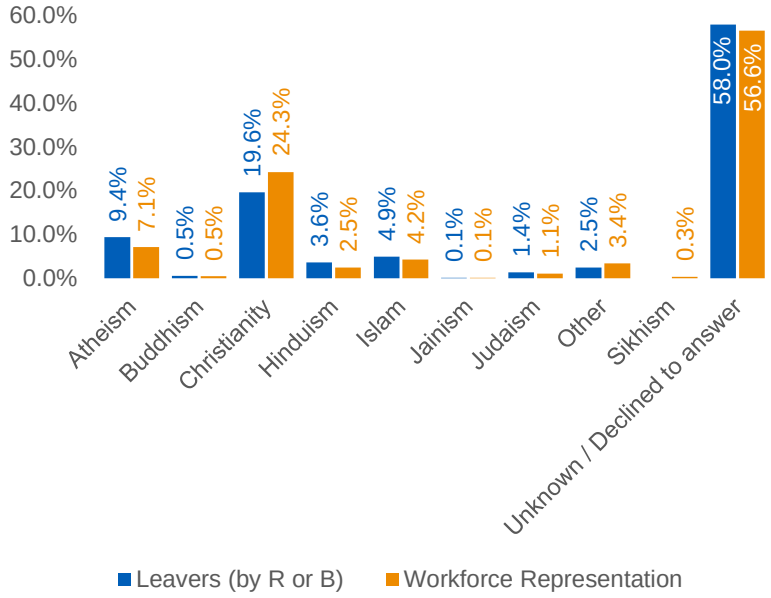


Chart 64 (left) shows the breakdown of leavers by religion or belief; overall workforce representation has been included to aid comparison.

Compared to the overall workforce, there is a greater than expected representation of Atheists, Hindu, Muslim and Jewish staff members whose religion or belief is unknown or they have elected not to share. There is a lower-than-expected representation of Christians, Sikhs and staff with other religions or beliefs and broadly equal representation for Buddhists and Jains.

5.4.6 Sex

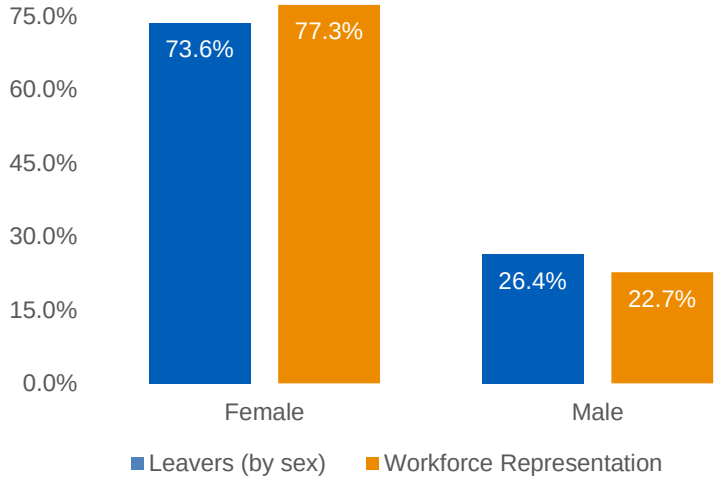


Chart 65 (left) shows the breakdown of leavers by sex; the overall workforce representation has been included to aid in comparison.

Compared to the workforce representation, there are slightly fewer women represented in staff that have left and slightly more men.

5.4.7 Sexual Orientation

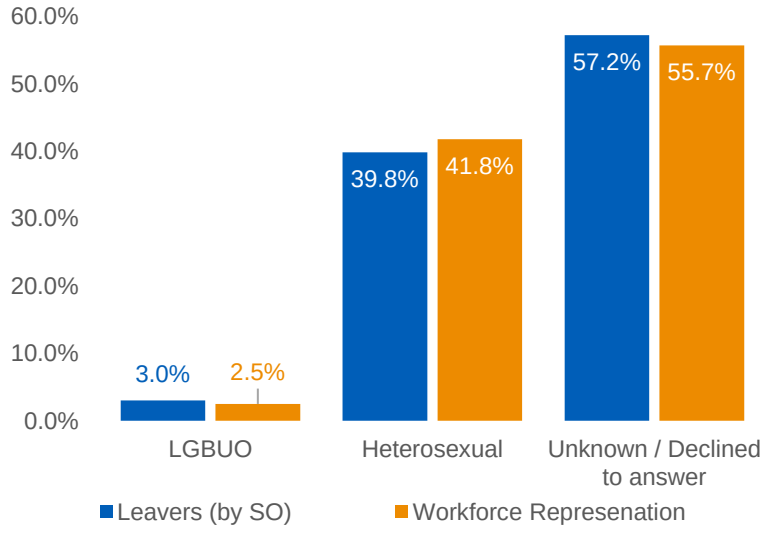


Chart 66 (left) shows a breakdown of leavers by sexual orientation; the overall workforce representation has been included to aid comparison.

Broadly, all groups are represented in line with the workforce representation. However, LGBUO staff appear to be slightly overrepresented in staff that have left the Trust.

5.5 NHS Staff Survey

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

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

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

In the columns breaking down the scores for individual groups within the protected characteristics, a red score would indicate worse performance than the Whittington average; a green score would indicate better.

5.5.1 Age

	21-30	31-40	41-50	51-65	66+	Whittington Health Average	Acute Average
q.4b - The organisation values my work	41.0%	44.6%	46.6%	43.9%	35.7%	**42.8%**	40.7%
q.9e - Feels their manager values their work	76.2%	74.4%	74.6%	70.6%	69.8%	**72.0%**	69.4%
q.7h - Feels valued by my team	67.6%	70.1%	73.8%	66.9%	69.8%	**42.8%**	40.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	51.4%	47.0%	51.1%	42.4%	38.1%	**46.2%**	55.7%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	34.1%	34.3%	24.8%	24.0%	14.3%	**28.5%**	27.3%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	13.4%	12.9%	16.8%	16.9%	20.0%	**16.2%**	11.9%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	19.1%	22.4%	21.9%	21.2%	17.1%	**22.8%**	19.5%
q.14d - The last time bullying, harassment, and abuse experience was reported	54.2%	51.8%	46.2%	43.6%	25.0%	**47.7%**	46.5%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	16.2%	15.1%	11.1%	9.1%	7.0%	**12.5%**	6.9%
q.16b - Experienced discrimination from staff in the last 12 months	10.2%	10.0%	10.9%	14.9%	7.1%	**12.3%**	8.8%
q.16c(6) - Age was the cause of the discrimination	32.9%	15.0%	10.2%	31.3%		**21.5%**	18.9%

5.5.2 Disability

	Staff with Disabilities	Staff without Disabilities	Whittington Health Average	Acute Average
q.4b - The organisation values my work	33.8%	46.5%	**42.8%**	40.7%
q.9e - Feels their manager values their work	67.0%	74.9%	**72.0%**	69.4%
q.7h - Feels valued by my team	63.8%	71.1%	**42.8%**	40.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	38.5%	49.2%	**46.2%**	55.7%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	33.4%	27.4%	**28.5%**	27.3%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	22.7%	13.8%	**16.2%**	11.9%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	27.7%	19.9%	**22.8%**	19.5%
q.14d - The last time bullying, harassment, and abuse experience was reported	44.7%	48.6%	**47.7%**	46.5%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	13.6%	11.9%	**12.5%**	6.9%
q.16b - Experienced discrimination from staff in the last 12 months	18.7%	10.2%	**12.3%**	8.8%
q.16c(5) - Disability was the cause of the discrimination	18.9%	1.3%	**21.5%**	18.9%

5.5.3 Race

	BME Staff	White Staff	Whittington Health Average	Acute Average
q.4b – The organisation values my work	44.0%	44.9%	**42.8%**	40.7%
q.9e - Feels their manager values their work	71.2%	75.9%	**72.0%**	69.4%
q.7h - Feels valued by my team	66.7%	73.1%	**42.8%**	40.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	39.9%	54.4%	**46.2%**	55.7%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	28.6%	27.9%	**28.5%**	27.3%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	16.2%	14.2%	**16.2%**	11.9%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	22.0%	19.8%	**22.8%**	19.5%
q.14d - The last time bullying, harassment, and abuse experience was reported	50.3%	45.8%	**47.7%**	46.5%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	18.7%	6.7%	**12.5%**	6.9%
q.16b - Experienced discrimination from staff in the last 12 months	15.2%	8.3%	**12.3%**	8.8%
q.16c(1) - Race was the cause of the discrimination	79.9%	35.0%	**21.5%**	18.9%

5.5.4 Religion or Belief

	Atheist	Christian	Buddhist	Hindu	Judaism	Muslim	Other religion	Prefer not to say	Whittington Health Average	Acute Average
q.4b – The organisation values my work	46.0%	46.3%	50.0%	51.1%	28.9%	46.6%	47.9%	29.1%	42.8%	40.7%
q.9e - Feels their manager values their work	76.5%	74.6%	75.0%	77.3%	68.9%	76.0%	70.8%	59.0%	72.0%	69.4%
q.7h - Feels valued by my team	73.7%	71.5%	50.0%	73.9%	71.1%	69.0%	72.9%	52.2%	42.8%	40.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	49.0%	48.8%	65.0%	52.9%	46.7%	44.1%	48.9%	36.1%	46.2%	55.7%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	26.1%	28.1%	36.8%	29.5%	25.0%	26.2%	27.9%	36.5%	28.5%	27.3%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	13.2%	15.3%	0.0%	11.5%	13.6%	15.1%	9.3%	25.5%	16.2%	11.9%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	17.7%	22.7%	26.3%	10.5%	13.6%	25.2%	20.9%	28.1%	22.8%	19.5%
q.14d - The last time bullying, harassment, and abuse experience was reported	46.8%	51.0%		48.4%	53.3%	39.2%	50.0%	39.1%	47.7%	46.5%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	6.3%	14.9%	0.0%	6.8%	15.6%	16.4%	16.7%	14.1%	12.5%	6.9%
q.16b - Experienced discrimination from staff in the last 12 months	7.5%	12.6%	5.0%	9.1%	13.3%	13.2%	8.3%	19.7%	12.3%	8.8%
q.16c(3) - Religion was the cause of the discrimination		0.9%		7.7%		57.6%		13.7%	21.5%	18.9%

5.5.5 Sex

	Female	Male	Prefer not to say	Whittington Health Average	Acute Average
q.4b – The organisation values my work	44.8%	45.7%	29.8%	**42.8%**	40.7%
q.9e - Feels their manager values their work	73.3%	77.8%	54.2%	**72.0%**	69.4%
q.7h - Feels valued by my team	70.0%	72.8%	48.2%	**42.8%**	40.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	47.9%	48.9%	32.5%	**46.2%**	55.7%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	29.4%	24.4%	33.3%	**28.5%**	27.3%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	14.8%	16.0%	26.0%	**16.2%**	11.9%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	21.7%	19.4%	26.9%	**22.8%**	19.5%
q.14d - The last time bullying, harassment, and abuse experience was reported	50.2%	40.3%	39.4%	**47.7%**	46.5%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	12.4%	11.0%	14.3%	**12.5%**	6.9%
q.16b - Experienced discrimination from staff in the last 12 months	11.7%	10.0%	20.5%	**12.3%**	8.8%
q.16c(2) - Sex was the cause of the discrimination	20.3%	29.1%	28.6%	**21.5%**	18.9%

5.5.6 Sexual Orientation

	Heterosexual	Gay or Lesbian	Prefer not to say	Bisexual	Other	Whittington Health Average	Acute Average
q.4b – The organisation values my work	45.4%	49.4%	29.2%	50.0%	46.2%	**42.8%**	40.7%
q.9e - Feels their manager values their work	74.5%	83.5%	60.8%	82.4%	61.5%	**72.0%**	69.4%
q.7h - Feels valued by my team	70.3%	82.1%	60.2%	88.2%	46.2%	**42.8%**	40.7%
q.15 - Feels the organisation acts fairly regarding promotion/progression regardless of protected characteristic	48.3%	60.7%	33.3%	44.1%	41.7%	**46.2%**	55.7%
q.14a - Has experienced bullying, harassment and abuse from patients, services users, etc., in the last 12 months	27.1%	35.8%	35.2%	29.4%	36.4%	**28.5%**	27.3%
q.14b - Has experienced bullying, harassment and abuse from their manager in the last 12 months	14.7%	12.3%	25.5%	5.9%	9.1%	**16.2%**	11.9%
q.14c - Has experienced bullying, harassment and abuse from other colleagues in the last 12 months	20.7%	24.4%	27.5%	12.1%	9.1%	**22.8%**	19.5%
q.14d - The last time bullying, harassment, and abuse experience was reported	48.9%	46.3%	39.7%			**47.7%**	46.5%
q.16a - Experienced discrimination from a patient, service user, etc., in the last 12 months	11.8%	14.3%	12.4%	14.7%	30.8%	**12.5%**	6.9%
q.16b - Experienced discrimination from staff in the last 12 months	11.1%	10.6%	16.4%	8.8%	15.4%	**12.3%**	8.8%
q.16c(4) - Sexual orientation was the cause of the discrimination	0.9%	52.6%				**21.5%**	18.9%

5.6 Summary of observations from workforce data

5.6.1 Age

Most of the workforce is aged between 26-55; there is a lower-than-expected representation of staff aged <20-25 and 66+ compared to the local population.

In the pay bands, younger workers are concentrated in more junior roles; older workers are concentrated in either junior or senior roles; while workers aged 26-55 generally have a good representation across all pay bands/grades. For medical roles, the greatest representation of staff aged 26-65; in senior manager roles, representation of staff 36-60 and VSM 51-60.

In the Trust recruitment and selection process, at the appointment stage, there is a greater workforce representation of applicants under 40, whilst those over 40 have a proportional lower representation.

Data relating to employee relations and training were not available at the time of writing.

Most age groups have a lower representation in leavers data than overall workforce representation. Only staff aged <20-35 and 61-70 are leaving at a proportionally higher rate.

Staff aged 21-30 and 66+ are less likely to feel the organisation values their work compared to the Whittington Health average. Staff aged 51+ are less likely to feel their manager values their work; all groups state they feel valued by their team to a high degree compared to the Whittington Health Average.

Staff aged 51+ are less likely to feel that the Trust acts fair regarding equal opportunities for promotion or progression compared to the Whittington Health average; all other groups score higher.

Younger workers are more likely to experience poor behaviour from patients, service users, etc. They are also more likely to state that they have experienced discrimination based on age. Those under 40 are more likely to report bullying, harassment and abuse incidents than the Whittington Health average.

Staff aged 41+ are more likely to experience poor behaviour from their manager, and those aged 51-65 are more likely to state the discrimination they experience was related to their age – compared to the Whittington Health average.

5.6.2 Disability

The representation of disabled staff is lower than the local population; however, there is also a disparity of 15% of staff that have stated they have a disability in the 2021 Staff Survey compared to data held on Electronic Staff Records. Nearly half of the organisation has either not declared or chose not to declare their disability status, impacting the quality of the Trust's data.

Disabled staff have a good representation within bands 5-8a and 8c. However, there is low to no representation in bands 2-4, 8b, 8d-9, VSM and all medical roles. However, given that nearly 50% of the organisation has not declared, a true picture of the representation will not be seen until this improves.

Within the Trust's recruitment processes, there is an increase in the representation of disabled applicants throughout the three main stages. This could indicate that initiatives such as the

guaranteed interview scheme are performing well and positively impacting the recruitment data. There is also a higher proportional representation of disabled applicants in the recruitment processes than workforce representation.

From the data available, there were no disabled staff involved in disciplinary cases; however, there is an overrepresentation of staff where disability status is unknown. This overrepresentation could be masking the true picture. There is more information about disability equity in the Workforce Disability Equality Standard report, which is available on the Trust website.

At the time of writing this report, no data relating to non-mandatory and continued professional development training broken down by disability available.

There is a slightly higher representation of disabled staff leaving the organisation than the overall workforce representation. However, with a higher representation of disabled applicants being appointed, workforce representation should still increase.

Overall, disabled staff experiences detailed in the Staff Survey are lower than the Whittington Health average. Comparing non-disabled staff to disabled staff demonstrates a worse experience in all factors relating to poor behaviour, feeling valued and perception of equal opportunities.

There is more information about disability equality in the Workforce Disability Equality Standard Report on the Trust's website.

5.6.3 Gender Identity

Data for this protected characteristic is either not recorded.

5.6.4 Marriage and Civil Partnership

Regarding workforce representation, staff in a civil partnership are broadly in line with the local population, while married staff have a greater representation than the local population.

When comparing to overall workforce representation, staff in a civil partnership there is a higher than expected representation in bands 7, 9 and medical consultants. Lower than expected representation in bands 2-6, and no representation in 8b-d, VSM and medical other and training grades. Married staff have a higher-than-expected representation in senior management and VSM roles but a low representation in bands 3-7 and all other grades; it is broadly in line with workforce representation.

In the Trust's recruitment and selection processes, applicants in a civil partnership representation in appointments are proportionally lower than the overall workforce, whilst married applicants have a higher representation.

When this report was written, data relating to employee relations or accessing non-mandatory or continued professional development broken down by this protected characteristic was not available.

Overall, staff in a civil partnership are leaving at a proportionally higher rate than the overall workforce representation, but married staff are leaving at a lower rate.

Data from the staff survey for this protected characteristic is not available.

5.6.5 Maternity and pregnancy

Data for this protected characteristic is not routinely collected.

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

Compared to the local population, there is a slightly higher proportion of BME staff in the workforce. However, nearly a quarter of the workforce not declaring their ethnicity will impact the quality of Trust data. When disaggregating the BME category, compared to the local population, there is a greater than expected representation of Asian and Black staff and a lower than expected representation of Mixed and White.

BME staff representation follows the national pattern of higher representation in lower bands and lowers in more progressively senior roles. BME staff have a lower-than-expected representation in bands 7-9 and VSM; this staff group is also well-represented in all medical roles.

There is a good representation of BME applicants in the Trust's recruitment processes (compared to the workforce); however, there is a progressive step down for this group when looking at the three reported stages. It should be noted that BME applicants have a greater representation at the appointment stage than the overall workforce representation.

BME staff are overrepresented in disciplinary procedures. When disaggregating this category, Black staff have the highest representation level.

BME staff was accessing non-mandatory and continued professional development training in broad proportion to the representation within the workforce.

BME staff are not overrepresented in leavers data; all ethnicity categories representation is broadly in line or lower than the workforce representation.

Staff Survey data suggest that BME staff are less likely to feel valued; also less likely to feel that the organisation acts fairly concerning equal opportunities compared to the Whittington Health average. BME staff are also slightly more likely to experience bullying, harassment and abuse than the Whittington Health average and white colleagues; but are more likely to report such incidents. However, BME staff are twice more likely to experience discrimination than their white colleagues, and the reported discrimination is likely related to race (BME staff rate this factor four times higher than the Whittington Health average).

More details on race equity can be found in the Workforce Race Equality Standard on the Trust's website.

5.6.7 Religion or belief

Nearly 60% of the workforce have not declared their religion or belief on Electronic Staff Records, which impacts data quality. From the data available, compared to the local population, there is a higher than an expected representation of Hindu, Jains and Sikhs staff.

There is a good representation of most religions or belief groups (except Christianity and Other) for most medical roles. In bands 2-6, declaration rates are generally very low; only Christian and Other have consistently good representation across all pay bands.

In the Trust's recruitment and selection processes, there is a good representation of most religions or belief groups throughout, which is greater than the workforce representation.

There was no employee relations or non-mandatory/continued professional development training data at the time of writing this report that was broken down by this protected characteristic.

Nearly 60% of leavers' religion or belief was unknown; from the available data, there appears to be a greater proportion of Atheist, Hindu, Muslim and Jewish staff leaving than workforce representation. All other groups are leaving in proportion or at a lower rate.

Data from the staff survey suggests that Jewish staff are less likely (nearly half compared to the Whittington Health Average) to feel that the organisation values their work. Jewish and other religions are less likely to feel that their manager values their work. However, all groups state that they feel supported by their team more than the Whittington Health average.

Buddhist and Hindu staff are more likely to experience bullying, harassment, and abuse from patients, service users, colleagues, etc. Compared to the Whittington Health average, all declared groups are less likely to report bullying, harassment and abuse from their manager. Atheists and Muslim staff are less likely to report bullying, harassment and abuse incidents.

Christians, Jewish, Muslims and Other religions are more likely to state that they have experienced discrimination. However, disproportionately high numbers of Muslims state the discrimination they have experienced based on their religion.

Many staff have decided not to share their religion or belief in the Staff Survey.

5.6.8 Sex

Female staff make up more than three-quarters of the workforce; this does not correlate with the local population but does with national NHS workforce statistics.

Compared to overall representation, female staff have good representation in bands 3-8b but low representation in 2, 8c-9 and VSM roles. Male staff have good representation across most pay bands and grades; however, there is a slightly lower representation in bands 4-7. Male staff are overrepresented in senior manager, VSM and medical roles.

In the Trust recruitment processes, female and male applicants are appointed proportionately to workforce representation.

In employee relations, female staff have a lower-than-expected representation, and male staff have an equivocal representation in disciplinaries. However, in nearly a third of cases, the sex was unknown, impacting the data quality.

At this report's writing, non-mandatory/continued professional training data disaggregated by sex was unavailable.

Both female and male staff leave the organisation in broad proportional representation to the overall workforce representation.

Both male and female staff are more likely (compared to the Whittington Health average) to report that they feel valued and that the Trust acts fairly regarding equal opportunities.

For the majority of factors looking at bullying, harassment and abuse – both male and female staff are less likely (compared to Whittington Health ave) to report experiencing this type of behaviour. Except female staff receiving bullying, harassment and abuse from patients, service users, etc. Male staff are less likely to report bullying, harassment and abuse incidents than the Whittington Health average.

Both male and female staff state they have experienced discrimination at a lower rate than the Whittington Health average; however, male staff are more likely to state the discrimination they faced was due to their sex.

5.6.9 Sexual Orientation

Declaration of sexual orientation is very low; as a result, Lesbian, Gay, Bisexual, Undecided and Other (LGBUO) groups were combined to help analyse the data. There is a disparity of staff that have declared their sexual orientation on ESR (2.5%) and Staff Survey (6.1%).

Staff in the LGBUO group have a proportional higher representation in bands 7-8d and medical–consultant and training roles. There is no representation in band 9 and VSM and a low representation in all other bands/grades.

In recruitment, LGBUO applicants are appointed proportionally higher than workforce representation.

No LGBUO staff were involved in disciplinaries; heterosexual staff have a broadly similar representation to the workforce. However, 60% of the disciplinaries sexual orientation was unknown, which impacted the data quality.

LGBUO staff are accessing non-mandatory and continued professional development training at a slightly higher rate than the overall workforce representation.

LGBUO staff leave the organisation at a slightly higher proportional rate than the overall workforce representation.

From the Staff Survey, many staff elected not to share their sexual orientation; however, this group's experience was poorer on nearly all factors relating to feel valued, equal opportunities, discrimination and bullying/harassment/abuse. Most groups stated that they felt valued to a greater extent than the Whittington Health average, except for 'prefer not to say (organisation and manager) and 'Other' (manager).

Gay and Lesbian staff are more likely than heterosexual staff to say they feel the organisation acts fairly concerning equal opportunities; bisexual staff, however, are less likely compared to the Whittington Health average.

Unlike the Whittington Health average, all minoritised groups are more likely to report experiencing bullying, harassment or abuse from patients, service users, etc. All minoritised groups are less likely to report bullying, harassment or abuse from their manager; only gay and lesbian groups are likely to report this behaviour from other colleagues. Gay and Lesbian staff are also less likely to report incidents of bullying, harassment and abuse compared to the Whittington Health average.

All minoritised groups are more likely to report they have experienced discrimination from patients, service users, etc., and only 'Other' is also like to report discrimination from staff. Gay and Lesbian staff are disproportionately (compared to the Whittington Health average) likely to state the discrimination they experienced was due to their sexual orientation.

D. Equality Delivery System

6.0 Equality Delivery System (EDS2) Activities

6.1 The EDS2 is the second 'slimmer and more flexible version' of this tool to help NHS organisations, in discussion with local partners, including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. It aims to support four goals:

- Better health outcomes
- Improved patient access and experience
- A representative and supported workforce
- Inclusive leadership

6.2 The goals have specific elements to consider when grading performance:

6.2.1 **Goal 1: Better health outcomes** considers whether:

- Services are commissioned, procured, designed and delivered to meet the health needs of local communities
- Individual people's health needs are assessed and met in appropriate and effective ways
- Transitions from one service to another for people on care pathways are made smoothly with everyone well-informed
- When people use NHS services, their safety is prioritised, and they are free from mistakes, mistreatment and abuse
- Screening, vaccination and other health promotion services reach and benefit all local communities

6.2.2 **Goal 2: Improved patient access and experience** considers whether:

- People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
- People are informed and supported to be as involved as they wish to be in decisions about their care
- People report positive experiences with the NHS
- People's complaints about services are handled respectfully and efficiently

6.2.3 **Goal 3: A representative and supported workforce** considers whether:

- Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
- The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
- Training/development opportunities are taken up and positively evaluated
- When at work, staff are free from abuse, harassment, bullying and violence from any source
- Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
- Staff report positive experiences of their membership in the workforce

6.2.4 **Goal 4: Inclusive leadership** considers whether:

- Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
- Papers that come before the Board and other major Committees identify equality-related impacts, including risks, and say how these risks are to be managed

- Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

6.3 The EDS2 tool requires organisations to grade performance on each goal and outcome collaboratively with staff, patients and partners. The grading system provides four levels of performance as follows:

- **Undeveloped** if there is no evidence one way or another for any protected group of how people fare or if evidence shows that the majority of people in only two or less protected groups fare well
- **Developing** if evidence shows that the majority of people in three to five protected groups fare well
- **Achieving** if evidence shows that the majority of people in six to eight protected groups fare well
- **Excelling** if evidence shows that the majority of people in all nine protected groups fare well

6.4 The NCL joint grading events were paused as a result of COVID. The Trust, therefore, undertook a self-assessment, which was presented to the Patient Experience Group. Alternative methods to engage with stakeholders will be sought.

6.5 Concerning staff and leadership-related goals 3 and 4, several focus groups have been scheduled; however, in comparison to the previous year, they were not well attended, possibly as a result of the already high level of engagement with other equality and inclusion initiatives, and possibly as a result of the focus to manage the pandemic.

6.6 Tables 6 and 7 below show the grading for goals one and two

Table 6

Outcomes for Goal One – Better Health Outcomes	Grading
1. Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Developing
2. Individual people's health needs are assessed and met in appropriate and effective ways	Developing
3. Transitions from one service to another for people on care pathways are made smoothly with everyone well-informed	Developing
4. When people use NHS services, their safety is prioritised, and they are free from mistakes, mistreatment and abuse	Achieving
5. Screening, vaccination and other health promotion services reach and benefit all local communities	Developing

Table 7

Outcomes for Goal Two – Improved patient access and experience	Grading
1. People, carers & communities can readily access hospital, community health or primary care services & should not be denied access on unreasonable grounds	Developing
2. People are informed and supported to be as involved as they wish to be in decisions about their care	Developing
3. People report positive experiences with the NHS	Achieving
4. People's complaints about services are handled respectfully and efficiently	Developing

6.7 Tables 8 and 9 below show the grading for goals three and four

Table 8

Outcomes for Goal Three – A representative and supported workforce	Grading
3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Developing
3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Achieving
3.3 Training and development opportunities are taken up and positively evaluated by all staff	Developing
3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source	Developing
3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Developing
3.6 Staff report positive experiences of their membership in the workforce	Developing

Table 9

Outcomes for Goal Four – Inclusive Leadership	Grading
4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Developing
4.2 Papers that come before the Board & other major Committees identify equality-related impacts, including risks, and say how these risks are to be managed	Developing
4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	Developing

6.7 The focus groups' discussions indicate that more tangible evidence is required in the form of data, particularly reportable data from ESR. This needs to be one of the equality objectives. Results indicate that the policies and procedures underpin good practice in supporting equality and inclusion in the workplace. More consistency is required in compliance with agreed processes, particularly new procedures relating to recruitment specifically designed to reduce bias and monitor outcomes.

7.0 Equality objectives

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

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

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

1.1.3 Details of equality objectives can be found in Appendix A

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

GOAL ONE: BETTER HEALTH OUTCOMES

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

GOAL TWO: IMPROVED PATIENT ACCESS AND EXPERIENCE

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

GOAL THREE: A REPRESENTATIVE AND SUPPORTIVE WORKFORCE

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

membership in the workforce		measures from the Staff Survey, Staff FFT/Pulsepoint Survey etc	These objectives must be supported wherever possible by existing programmes of work where they align.

GOAL FOUR: INCLUSIVE LEADERSHIP

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