



Whittington Health
NHS Trust



*Prepared by
the Inclusion
Team*



**Public Sector Equality
Duty Compliance
Report
2024/25**

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1. Purpose

- 1.1 This report presents equality information about the Trust's workforce and patients in line with the protected characteristics set out in the Equality Act 2010. The Act requires publicly funded bodies to demonstrate how they are meeting their statutory obligations as highlighted by the general and specific duties of the public sector equality duty (PSED).
- 1.2 The report covered the period between 1 April 2024 and 31 March 2025. For datasets that require a single snapshot date, the date used is 31 March 2025.
- 1.3 The report has four main sections: background to the report; patients and service users; workforce; and equality objectives.
- 1.4 Information in each section is in headings related to the protected characteristics. Some sections contain significantly less information than others, reflecting the challenges and limitations of collecting information, and an individual's right to choose what equality information to disclose. Where there is limited information, these come with the caveat that it is hard to draw firm statistical inferences and conclusions but provide an opinion in places.
- 1.5 The Equality Act 2010 (the Act) replaced previous anti-discrimination legislation. It simplified the law, removing inconsistencies, making it easier to understand and improve compliance. The Public Sector Equality Duty (PSED) (section 149 of the Act) came into force on 5 April 2011.
- 1.6 The equality duty applies to public bodies and organisations conducting public functions. It supports good decision-making by ensuring public bodies consider how different people will be affected by their activities, helping them to deliver policies and services that are efficient and effective, accessible to all, and meet different people's needs.
- 1.7 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.
- 1.8 The information published should demonstrate the Trust's regard and support for the achievement of the three aims of the equality duty:
 - Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
 - Advance equality of opportunity between people who share a protected characteristic and those who do not;
 - Foster good relations between people who share a protected characteristic and those who do not.

2. The Protected Characteristics

- 2.1 The nine protected characteristics covered by the equality duty are:
- i. Age
 - ii. Disability
 - iii. Gender reassignment (some communities prefer using the term 'gender identity')
 - 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 and some philosophical beliefs)
 - viii. Sex (recent interpretation of the Equality Act 2010 means sex refers to biological sex e.g. male or female)
 - ix. Sexual orientation

Characteristic

Explanation

Age

This refers to an individual or group of people belonging to a particular age group. An age group includes people of the same age e.g. 65 and people of a particular range of ages e.g. 40-60.



Disability

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

- **substantial** means more than minor or trivial
- **long-term** means that the effect of the impairment has lasted, or is likely to last for at least twelve months or till the end of life (including 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 and severe disfigurements as automatically considered disabled.



Characteristic

Explanation

Gender reassignment

For the purposes of the Act, where a person has proposed, started or completed a process to change their gender to be offered protection.



Marriage and civil partnership

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



Pregnancy and maternity

The Act provides protection to those in employment during pregnancy and any statutory maternity leave to which they are entitled. This provision is now separate from protection on the grounds of sex. It is unlawful to consider an employee's period of absence due to pregnancy-related illness when making decisions about their employment.



Race

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



Characteristic **Explanation**

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. A philosophical belief for the purposes of the Act, must meet all the following:

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

The Act cites humanism and atheism as examples of philosophical beliefs. Adherence to a particular football team or political party would not be a religion or belief. A cult involved in illegal activities would not satisfy these criteria. The Act also protects people who do not have a religion or belief (non-belief).



Sex

For the purposes of the Act, sex means being a man or a woman.



Sexual orientation

The Act defines a person's sexual orientation towards whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.



3. About Whittington Health

- 3.1 Whittington Health is one of London's leading integrated care organisations – helping local people to live longer, healthier lives. Whittington Health provides 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.
- 3.2 During 2024/25, we provided a comprehensive range of acute and community health services, and we also provided dental services in ten London boroughs. 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.
- 3.3 Whittington Health has an excellent reputation for being innovative, flexible and responsive to the changing clinical needs of the local population, and for leading the way in the provision of integrated community and hospital services. We are treating more patients than ever before, and we are dedicated to improving services to deliver the best care for our patients, with a clear focus on integrating care for women, children, and the adult and frail.
- 3.4 Our strategic objectives are to:
- deliver outstanding, safe, compassionate care.
 - empower, support and develop engaged staff.
 - integrate care with partners and promote health and wellbeing.
 - transform and deliver innovative, financially sustainable services.
- 3.5 The Trust's ICARE values were developed through staff engagement and consultation and continue to be fundamental to everything we do at Whittington Health. They are underpinned by an overarching value of equity and form the basis of expected staff behaviours.



- 3.6 Our service priorities are focussed on our population needs: integrating care in all settings with an emphasis on women, children and frail adult patients and residents.
- 3.7 Our priority is to deliver the right care, at the right time, and in the right place for our patients. We provide an extensive range of services from our main hospital site and run services from over 30 community locations in Islington and Haringey, and our dental services are run from sites across ten London boroughs.
- 3.8 As an integrated care organisation, we bring safe and high-quality services closer to home and speed up communication between community and hospital services, improving our patients' experience reducing admissions and speeding up discharge. Key to our approach is partnering with patients, carers, GPs, social care, mental health and other healthcare providers.
- 3.9 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.
- 3.10 We are proud of our staff and their commitment to delivering safe and high-quality care every day of the year. During the last financial year, our community and hospital teams have once again been impressive in their professionalism. Patients were supported to be at home where they could and only came to hospital when it was necessary.



4. Whittington Health performance and achievements

Other relevant reports and data

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

- Gender pay gap report
- Workforce Disability Equality Standard
- Workforce Race Equality Standard

The Workforce Disability and Race Equality Standards is available on the [Trust's website](#). The Trust's statutory gender pay gap report is available on the [GPG Reporting Service](#).

In this report, data about the local population is from the 2021 census. The latest census provides an up-to-date and comprehensive overview of the local population, including sexual orientation and gender identity.

4.1 High Impact Actions

Over the last year the Trust has taken a number of actions to support and improve equity within the workforce, all which align with the NHS Equality, Diversity and Inclusion Plan's six high-impact actions, a summary of these actions are below, full details can be found in the [Trust's EDI Improvement Plan 2024-29](#).

High Impact Action 1: Measurable objectives on equality, diversity and inclusion for Chairs, Chief Executives and Board members

- There is a Trust Board member's anti-racism action statement.
- Our board members have disclosed their protected characteristics to support greater transparency of our diverse leadership.
- Members of the board have undergone the WRES Expert/Kings Fund Allyship programme
- Executives are leading a workstream in response to the staff survey, using a 'You Say, We Did' approach
- Executive lead sponsors in place for each of our staff equality networks
- The Board reviews data identifying areas of concern, focusing on reducing inequalities and fostering diversity.
- Regular updates from committees on the progress of work around staff wellbeing.
- We have reviewed and updated our Board Assurance Framework.
- We have an 'equity' staff award category
- Review of outcomes of workforce policies which have high relevance to the Equality Act's general and specific duties
- Board scrutiny on Equality Impact Assessments of Trust policy.
- Share and promote EDI messaging through communication channels and social media platforms.
- Annual reflection on EDI published to wider Trust/community (PSED).
- Using opportunities like staff awards to recognise EDI contributions (Equity category).

High Impact Action 2: Overhaul recruitment processes and embed talent management processes.

- 2a - The probability of white staff being appointed over ethnically diverse colleagues has decreased from 2.18 in 2018 to 1.79 in 2025. Disabled staff's probability of appointment has been within the desired target range of 0.8 - 1.25, with figures of 1.24 in 2019 and 1.16 in 2025.
- 2b – people's perception of fair progression/promotion opportunities increased from 41.2% to 51.1%.
- 2c – people saying they can access the right L&D opportunities increased from 55% to 60.4%
- For WRES indicator 4, the score is 1.09 for BME staff; the Trust has been within the target range since 2022 and is in line with London (1.06).
- We support reverse job fairs, annually jointly led by Ambitious About Autism and The Autism Project
- 2d – Disabled and ethnically diverse representation in Bands 8C and above has increased slightly.
- We review talent pipelines and share job openings in our communities, while offering apprenticeships, functional skills, project search, and work experience to widen participation.
- We've evaluated career development for BME staff and introduced successful Band 2-7 and band 8a development programs. Out of that our programme has been implemented London-wide, we aim to continue the Band 8a development programme through national schemes. We've also published the Whittington Health People Strategy for 2023-2026.

High Impact Action 3: Eliminate total pay gaps with respect to race, disability and gender.

- 3a – We already undertake Gender Pay Gap reporting; the gap has reduced from 2021/22 6.5 % to 2024/25 2.4% (median average) and 2021/22 7.6% to 2024/25 5.7% (mean average), in favour of males.
- 3a – The disability pay gap was introduced in 2023/24 with a median pay gap of 8.1% (in favour of non-disabled staff) to 2024/25 -2.7% (in favour of disabled staff) (median average).
- 3a – We introduced the ethnicity pay gap report this year. We have a median gap of 14.8% in favour of white colleagues, in 2024/25 this grew to 18.3%
- We offer flexible and remote working options as part of our policy and advertise them.
- Our pay gap reports are shared with staff through networks and accessible on our internet and intranet webpages
- The Workforce Assurance Committee addresses gender pay gap issues by analysing data, targeting actions, and benchmarking with other trusts
- The Trust has implemented the national flexible working policy which allows recording of requests on ESR.
- We have introduced a template to capture the Disability Pay Gap report for next year.

High Impact Action 4: Address health inequalities in the workforce

- We publish updated equality objectives in line with outcomes from the reports
- 4a - In response to the staff survey report of 2023, where we scored below the national average for wellbeing, we have appointed a new Head of Wellbeing who began their role in October
- 4b - All staff receive a wellbeing conversation, in line with part of the NHS people plan strategy
- We have a well-established, Staff Inclusion Group which acts as the engine room for inclusion work at Whittington Health and feedback from staff equality networks
- A Reasonable Adjustment Policy is in place, and a centralised budget ensures equity of access.
- Firmed up the internal procurement system and review and update staff training.
- We have Mental Health First Aiders and other mindfulness, a Flexible Working Policy and an internal coaching service.
- We have a newly recruited Head of Wellbeing and Psychological Support.
- Counselling services such as the Employees Assistance Programme
- We have a robust & visible Organisational Development team.

High Impact Action 5: Comprehensive induction and onboarding programme for international recruited staff.

- We send assessment tools before arrival from the education lead, conduct comprehensive international recruit inductions and Welcome Meetings via Microsoft Teams. We have been awarded the NHS Pastoral Care Quality Award.
- We have a well-established support for our international graduate nurses
- We have developed the International Medical Induction Booklet
- Peer support and information to assist international recruits in settling in.
- There is Pastoral Support Lead and the Education Leads.
- We organise networking events to encourage connections among international recruits and keep them updated.
- We offer support to international recruits with NMC processes, signposting, and visa-related matters.
- We are increasing the frequency of events and programs to ease the cultural transition of internationally trained graduates.

High Impact Action 6: Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

- 6a - Since 2021, the rate of staff experiencing harassment, bullying or abuse from patients or service users has declined. In 2024, ethnically diverse staff experience such incidents at a rate of 28.3%, while white staff experience them at 23.0%. Disabled staff are 8.6% more likely to experience harassment, bullying or abuse from managers than non-disabled colleagues.
- 6b – The percentage of staff experiencing discrimination from managers or colleagues is showing steady improvement, 15% in 2021 and 11.9% in 2024.
- 6c – The NETS score for never experiencing bullying and harassment has Improved from 79% in 2021 to 84% in 2024.

- We have the Challenging and Aggression Behaviour Policy in place and the zero tolerance for discrimination poster on display A&E, OPA & community centres
- In line with the Trust's commitment to a culture of openness, learning and restorative practice, the Just Culture programme has been implemented.
- We have strengthened the informal part of disciplinary processes and have reviewed the governance and touch in points of the disciplinary process.
- We have a well-established Freedom to Speak Up (FTSU) and a diverse group of FTSU advocates
- We have developed an individual & organisational allyship checklist
- The Head of Wellbeing provides post-incident psychological support to staff/victims of abuse.

4.2 Supported Internships

The Trust has two supported internship programmes that support young people with autism into work. The programmes combine education and work experience and help to reduce inequalities for people with autism.

Ambitious About Autism

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 to help gain future employment.



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

Job outcomes:

- 2019/20 – 3 interns (the COVID-19 pandemic impacted the scheme) – 2 young people secured employment on completion of the programme.
- 2020/21 – 5 interns off-site; the COVID-19 pandemic impacted the scheme (all interns were granted extensions in 2021/22).
- 2021/22 – 9 interns (4 returners) – 6 young people secured paid employment on completion of the programme.
- 2022/23 – 10 interns (1 returner) – 4 people secured paid employment on completion of the programme.
- 2023/24 – 9 interns (2 returners) – working in various departments, including: Laboratories, Administration, Stores, Wards, Finance, Education Centre, and Clinics.
- 2024/25 – 9 interns (1 returner) – working in Stores, CAMHS, Research Delivery, Clinic 4D, Whittington Health Education Centre, Pharmacy, Coyle Ward and Endoscopy.

The Autism Project

Care Trade partnered with Whittington Health in 2019. Together, they support The Autism Project (TAP) learners into suitable work experience placements within the trust. TAP is an employability programme for 18 – 24-year-olds who have an EHCP. TAP learners are available to work three + days a week between Monday - Friday. They work on a termly basis, so have half term and seasonal breaks. Job coaches are always on call and nearby, to support the learner and their team. Learners have worked in several different departments, such as Patient Records, Women's Health, Catering and Endoscopy.



TAP learners are hardworking, motivated and eager to learn, the programme offers a range of opportunities to support their learning, including:

- Job coaches support all learners in their work placements and meet regularly with both employer and learner to check in and ensure the placement is going well.
- Help to improve recruitment and retention of neurodivergent employees.
- TAP delivers complimentary Autism Awareness Training to enable teams to become more confident and aware of Autism and Neurodiversity.
- Host of TAP learners gain real experience of working with an autistic colleague, break down barriers and further understanding of autism and neurodiversity.



4.3 Inclusion and Engagement Activity and Events

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, 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.

The Disability Confident frameworks also provides ongoing steer of organisational issues that could help further improve equity for staff with disabilities and long-term health conditions.

The Trust's Disability Confident status is due for review in 2025/26.

Inclusion Team

The team consists of 3.2 whole-time equivalent (WTE) staff. A 1.2 WTE joint director role, an Inclusion Lead, and an Inclusion Engagement Officer (currently vacant). The joint directors are non-voting Board Members and give assurance to the Board and respective governance structures, including staff networks, on compliance with the Equality Act 2010 and other key performance indicators included within:

- Disability Confident accreditation requirements
- Gender, race and disability pay gap reporting
- Workforce Disability and Race Equality Standard submissions
- Medical Workforce Race Equality Standard
- Bank Workforce Race Equality Standard

The Trust has an executive director who leads for workforce inclusion (Chief People Officer) and our work as an anchor institution tackling health inequalities (Chief Strategy, Digital and Improvement Officer), with a non-executive lead (Glennys Thornton). They have the remit to support actions and ambitions around cultural change, ensuring the Trust is inclusive for all employees, including in areas of access and experience for all our patients, carers, visitors, volunteers, and in goals for improving health outcomes.

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



Some of the key activities supporting inclusion goals and ambitions include

Supporting our Divisions and Departments

The Inclusion Team contributes to division and department away days to provide information about improving equity and inclusion within their workforces.

The Inclusion Team continues to offer its support and has also been invited to Divisional Board meetings to present data from the Workforce Race and Disability Equality Standards.

These sessions inform divisional management about the current state of inclusion in their areas. It is intended to promote a meaningful form of engagement that furthers the division's or department's accountability through sharing their data, action plans and monitoring progress and highlighting how all of this impacts the overall Trust performance on inclusion.

Staff Open Forum

The forum is run quarterly and attended by executive and non-executive directors and other senior team. It provides engagement opportunities for all staff to hear about developments related to equality, diversity, and inclusion that are being delivered, and gives those who attend space to provide feedback. While the Inclusion Team leads this meeting, case studies from corporate departments and clinical divisions about their efforts to promote inclusion are especially encouraged.

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During 2024/25, the topics that were discussed:

- Too Hot To Handle Report with Joy Warmington – looking at racism in the NHS, and the work being undertaken in the Trust to support anti-racism.
- Being an Angelic Troublemaker with Cherron Inko-Tariah – looking at the benefits staff networks bring organisations.
- A Collaborative Journey of Change: Reflecting on Our Progress in Anti-Racism Since Our Deep Dive in 2021 with Yvonne Coghill – looking in depth at the Trust's journey to become an anti-racist organisation.

Staff Engagement and Awareness Events

The cultural events are designed to raise awareness among staff and are part of our inclusion strategy. These events provided opportunities for people from diverse backgrounds to come together, share their experiences, and build connections based on mutual respect and understanding. Staff have reported that the Trust's cultural events have helped forge relationships, cultivate respect and foster interest in different cultures among staff groups and encourage their participation in the inclusion agenda. They have created a sense of belonging and community, leading to more inclusive teams and a harmonious working environment.



Throughout 2024/25, there is a combination of Teams and Trust-wide events (supported by the Inclusion team), including:

- Autism Acceptance Awareness Day
- Black History Month
- Dementia Action Week
- Facilities and Estates Day
- Mental Health Awareness Week
- National Day for Staff Networks
- Pride Month
- See ME First Anniversary
- Windrush Day

Race Equality Week

The Trust participated in Race Equality Week between 3-9 February 2025. The week is designed to unite organisations and staff in workplace activities addressing race equality barriers. This event is the Trust's second time running Race Equality Week.

The theme for this year was #EveryActionCounts, focussed on taking action (even small steps) to sow the seed for change and acknowledging we all have a responsibility for improving race equity.

The Trust promoted the national 5-Day Challenge, run by Race Equality Matters; the challenge provides staff with five small tasks, that enable them to think about individual behaviours that contribute to inclusion.

The Inclusion Team and the LGBTQ+ Network also hosted a webinar to celebrate Race Equality Week and LGBT History Month. The webinar looked at the LGBTQ+ civil rights movement and the importance of intersectionality. There was also a strong focus on the individual actions we can all take to support inclusion.

Mentoring Programmes

The External Mentorship and Support for BME Staff Programme, initially launched as a pilot between Whittington Health and University College London Hospitals NHS Foundation Trust (UCLH) in the summer of 2022, has shown promising results. Developed with input from Organisation Development, senior management, and staff networks, the programme aims to support BME staff in their career progression. It was created as an adjunct to existing mentoring schemes, particularly to support staff experiencing racism and mistrust. During the pilot in 2022 and 2023, six mentees participated, with three progressing to more senior roles and one achieving a double promotion.

The scheme continues, and participants have reported increased confidence and motivation, a safe space for reflection and discussing challenging situations, and career planning. Mentors also continue to recognise the scheme's value. Efforts are underway to expand mentoring opportunities across North Central London, including identifying suitable staff for mentoring support when needed.

The Reverse Mentoring Programme

The Whittington Trust has recently completed its first cycle of the Reverse Mentoring Programme, a key initiative aimed at promoting diversity, inclusion, and equity within the organisation. The first cohort included junior reverse mentors and senior nursing and midwifery colleagues, providing valuable insights and feedback.

Developed in partnership with The Reverse Mentoring Practice Ltd and based on the ReMEDI© framework, the programme involved staff from various ethnic backgrounds, religions, and intersecting identities, guided by the RACE model. Feedback from participants was positive, highlighting the usefulness of the training and the supportive framework in place.

Looking ahead, the Trust is planning several strategic actions, including appointing a clinical lead for advanced practice, enhancing diversity in these roles, establishing a sickle cell network, and creating feedback channels to inform organisational decisions. Additional initiatives include promoting inclusive placements and addressing specific recruitment challenges, such as increasing staff from India.

Participants are encouraged to stay engaged through ongoing dialogues, review relevant reports, and participate in upcoming equality initiatives.

Participants reflected positively on the training and overall experience, expressing hopes and aspirations for working within the organisation. Notable quotes include:

- "Thank you. So informative and reassuring in taking part." — Reverse Mentee
- "I felt reassured by the framework that is in place to support mentors and mentees. I cannot wait to get started now. Many thanks for the session." — Reverse Mentor

The Trust will reconvene with relevant partners by August 2026 to review progress and align efforts with its anti-racism strategies. This ongoing work underscores Whittington Trust's dedication to fostering an inclusive, equitable environment for staff and service users alike.

The Reciprocal Mentoring Programme

The programme continues to evolve as an integral part of our commitment to inclusion and diversity. Building on the success of the 2023/24 cycles where nineteen staff pairs engaged in meaningful exchanges, future plans include expanding participation to incorporate more staff across various levels and departments. We aim to deepen the impact by incorporating structured feedback mechanisms and tailored training to enhance mentors' and mentees' experiences. Additionally, we plan to develop targeted initiatives that focus on specific themes such as racial equity, gender inclusivity, and accessibility, ensuring that the programme remains responsive to emerging organisational and societal needs. Our goal is to foster a sustainable culture of shared learning, empathy, and proactive change that benefits both individuals and the organisation as a whole.



Supporting Staff with disabilities

Over the last 2 years the Trust has been reviewing the support to staff with disabilities and long-term health conditions. It has been a consistent factor as an area for improvement from the NHS Staff Survey and requires a considered approach to make progress.

The Reasonable Adjustment Guidelines were provided with input from a range of stakeholders to help improve the effectiveness of the of document. They provide staff and managers guidance around the Trust expectations on supporting people with disabilities and long-term health conditions. Within the guidance there are clear pathways for providing support in several different situations.

The Trust has created a centralised budget to help support staff by funding reasonable adjustments. Cost can sometimes be a barrier to providing support and the budget helps to alleviate that barrier. In 2024/25 there were 35 individual claims against the budget, with a total spend of £50,888.56.

The Inclusion Team provide one-to-one advice for staff and managers to provide guidance about supporting staff with health conditions and promoting disability equity. In 2024/25 there were over 40 unique individuals supported with advice and guidance.

The health passport was launched to help improve conversations around identifying support needs for disability and reasonable adjustments. The document allows staff

to examine their working life and their health to make identifying any support needs easier; it also supports a review cycle to ensure that this is an ongoing conversation between the member of staff and their manager.

The Trust had also launched a portal called 'The Disability Support Hub' for staff and managers to access a range of resources in a centralised area relating to disability and long-term health conditions, to make finding information easier and more efficient. This resource is available to staff and managers on the Trust's intranet and Internet sites.



Anonymised Case Studies from Staff that have Received Support from the Centralised Budget

A's Story

A works in Occupational Therapy, they have dyslexia, Tourette's and is awaiting an ADHD assessment. A faced several challenges in their role; A struggles with reading and processing information, organising workloads, and communicating ideas effectively in writing, which led to stress.

Adjustments and Support: A received a combination of support from their line manager and the Access to Work service:

- Line Manager Support: Before involving external services, A's manager provided key initial adjustments, regular 1-2-1's to help prioritise and manage caseloads. They also referred A to Occupational Health, which helped him establish a more structured work schedule.
- Access to Work: A secured a comprehensive package of support, including: MindView Software a mind-mapping tool with an AI function that has been particularly helpful for report writing; coaching providing support with managing A's neurodivergence at work; dedicated administration support - A receives 7.5 hours of weekly support from an assistant who helps manage A's caseload, set timescales, and complete administrative tasks like data entry.

Impact: The adjustments are a work in progress, but A is already seeing significant improvements. A's caseload is more manageable, and feels they have more mental clarity because they are not constantly worrying about unfinished work.

B's Story

B is a senior nurse with carpal tunnel syndrome, which caused painful and swollen fingers, wrists, and arms. They also experience multiple joint pains, including back pain, that made carrying heavy equipment difficult. Over time, they developed Long COVID, which led to severe fatigue and other symptoms that made their physically demanding role challenging.

Adjustments and Support: A variety of adjustments and support systems were put in place to help B continue their work:

- Ergonomic and Physical Support: A trolley was provided to help with carrying equipment, and an appropriate office chair to reduce back strain. The Manual Handling Team provided advice on setting up the equipment for office and home.
- Accessibility and Technology: Access to Work provides taxis for commuting and inter site travel, which helps with fatigue. To reduce physical strain B was given a soft-touch keyboard, an ergonomic mouse, and dictation software and equipment. A digital writing pad and a monitor filter were also provided to help with notetaking and to reduce headaches and fatigue.
- Work Arrangements and Managerial Support: B is allowed to work from home when possible. Occupational Health recommended phased returns from sickness, which allowed them to safely adjust to work without causing further strain. The Equality, Diversity, and Inclusion team helped them feel empowered to ask for the help they needed.

Impact: These adjustments had a significant positive impact. The physical support and transport reduced the strain on their body, while the technological aids made documentation and screen-based work more manageable. The phased returns and flexible working arrangements reduced anxiety about not being able to cope and helped them avoid further sick absences.

C's Story

C works in administration and experiences significant pain from inflammation and spasms in their back and wrists. These conditions, which developed in adulthood, have required surgery and ongoing treatment, and they make it difficult for C to perform their job without support.

Adjustments and Support: C received an ergonomic keyboard and a wireless mouse from IT. The centralised reasonable adjustments budget paid for a new monitor, creating a dual-screen setup. C is also in talks with the Moving and Handling Team about potentially getting a new desk.

Although C is still awaiting an assessment from the Access to Work service, C has been advised that it can also provide long-term grants for commuting costs, which they plan to explore due to the pain C experiences on public transport.

Impact: The adjustments have made C more efficient in their role by reducing the strain and pressure on their back and wrists. The dual-screen setup, in particular, has made it easier to navigate information. The support has helped create a more level playing field, allowing C to contribute to their full potential. C notes that the adjustments have also improved their overall well-being, creating a "domino effect" that ultimately benefits everyone.

D's Story

D, a mental health professional, has dyslexia, which affects a number of areas of their life, including grammar, sentence structure, and organisational skills for appointments and administrative tasks. D explains that sentences can sometimes be confusing to read, and a lack of organisational skills can lead to feelings of shame. D notes that confidence as a dyslexic person can be historically shattered, causing them to shy away from opportunities for development.

Adjustments and Support: D obtained reasonable adjustments after going through the Access to Work process. This involved a request for an assessment, which resulted in a report with recommendations for equipment and software. D received the Read and Write software and Dragon Medical One, a dictation software, along with training for both. They also participated in coaching specific to their dyslexic needs, which focused on the operational part of their role and their self-perception. Their team also provided a quiet office for staff with neurodiversity. The process involved their line manager and the support of various departments.

Impact: The adjustments have had a significant positive impact on D's work and wellbeing. The software has increased their speed in producing high-quality work, which has led to less burnout and an improved quality of life. The combination of dictation and text-to-speech tools allows them to check the accuracy and structure of their work more effectively, boosting their overall accuracy. As a result, their confidence has improved immensely, and they feel better able to articulate themselves. The support has also been helpful with academic courses they have undertaken. The quiet office has reduced distractions and allowed them to connect with other neurodiverse colleagues.

Training activity

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

Corporate Induction

The Trust includes a fifteen-minute allocation for equity, diversity and inclusion (EDI) as part of its monthly corporate inductions of new employees. The purpose of including EDI training in corporate induction is to communicate the Trust's commitment to creating an inclusive and diverse workforce and environment to new employees. It also sets the expectation that all employees are required to uphold and promote our EDI values. The training highlights the value the Trust places on diversity and inclusion and helps them understand how their actions and behaviours can impact others. In essence, it sets the foundation for a positive and respectful work environment where all employees feel valued and empowered to contribute to an inclusive culture and belonging.

Anti-Racist and Inclusive Cultures

The Trust has created a program for staff development that focuses on fostering an anti-racist and inclusive culture. This initiative is a part of the Trust's overall equality, diversity and inclusion program, with a specific emphasis on advancing anti-racist and inclusive goals.

The program is integrated into our staff development and leadership initiatives, aiming to support continuous self-reflection, learning and personal growth among our staff in relation to anti-racism and inclusion. We have also developed an Anti-racist and Inclusive toolkit to help individual staff members reflect on their personal biases and stereotypes.

This approach is intended to help eliminate discrimination, bias and inequality among our staff, team leaders, and senior managers, creating a fair environment that promotes equal opportunities for growth and advancement for all employees, regardless of their ethnicity and race.

Disability and Reasonable Adjustments

The Trust runs monthly training sessions on disability and reasonable adjustments. This session aims to educate employees and managers about reasonable adjustments in the workplace and how to implement them effectively.

The session helps meet legal requirements and increases awareness and understanding of how to apply the reasonable adjustment guidelines, what constitutes a reasonable adjustment and why it is essential to create an inclusive and accessible work environment. Importantly, the training equips managers with practical skills to communicate and collaborate effectively with individuals who may require adaptations, helping employees with disabilities or health conditions perform at their best and feel supported in the Trust.

Preceptorship programme

The inclusion team continue to enhance its efforts within the Trust Capital Nurse preceptorship programme by providing comprehensive equality, diversity, and inclusion sessions, alongside cultural competency training. These initiatives are tailored explicitly for newly qualified professionals to build a solid foundation of knowledge and awareness in diversity, equity, and inclusion right at the start of their careers. Such education aims to integrate these vital principles into their daily practice early on. The cultural competency development programme equips new professionals with essential skills to deliver inclusive and culturally competent care, considering social determinants of health, addressing biases, and customising care to meet individual needs. Additionally, the training covers the Trust's legal obligations related to diversity and inclusion, including anti-discrimination laws, patient rights, and ethical standards. This helps staff contribute towards reducing health disparities and improving outcomes across diverse patient populations. From April 2024 to March 25, over 263 newly qualified staff members have completed these preceptorship EDI sessions.

In 2025, we combined the two sessions into one, and it is named 'EDI & Cultural Competence for Health Care Professionals'.

Maternity Equality & Diversity Session

The maternity unit continues to hold monthly midwife development sessions. Recently, the sessions have included presentations on equality, diversity, and inclusion in maternity care, delivered by the Joint Director of Inclusion, who has vast experience in midwifery and improving maternity services for BME women and birthing people. These sessions provide opportunities for midwives to reflect on diversity, understand the needs of pregnant individuals from various backgrounds, and discuss strategies to address disparities in maternal and perinatal outcomes. Emphasising culturally informed care and awareness of racism and bias and their implications for safe outcomes and the experience of maternity services remains a key focus. Since the program's inception last year, a total of 116 midwives have participated in these comprehensive day-long sessions.

Allied Health Leadership Fellowship

The inclusion team contributes to the anti-racism and inclusive team staff development session element of this programme for allied health professional colleagues.

Inclusion calendar

To assist with services better delivering tailored healthcare to their patients and better supporting the workforce, the Inclusion Team have launched the Inclusion Calendar. The calendar highlights the important dates related to Religious, spiritual or belief-based festivals and inclusion dates/awareness events throughout the year.

To complement this, the Communication team promote the calendar highlighting the main festivals or events for that month.

Inclusion newsletter

The communication efforts since May 25 have been actively supported through the production of newsletters and blogs by the inclusion team. These tools serve as

efficient means for promoting inclusion and boosting engagement across the organisation. The monthly newsletter and blogs foster accessible, consistent channels for sharing information, amplifying diverse voices, and building community trust.

The aim is to maintain reach and consistency through regular posts and emails to keep everyone informed, with tailored content to showcase diverse perspectives via contributions from employees and community based colleague, encouraging two-way engagement through comments and event attendance, promoting a sense of belonging by sharing stories of inclusive practices and celebrating success, and ensuring transparency and trust with updates on policies and progress.

Practical strategies implemented involve using inclusive language, inviting diverse guest authors, fostering interaction, and ensuring distribution across various platforms.

Overall, these initiatives have successfully increased awareness, created dialogue spaces, and strengthened participation among diverse groups of staff.

Responding to national events



The events surrounding the racism-led incidents and civil unrest of the summer of 2024 significantly impacted our diverse workforce. This was a challenging period, particularly for Black, Asian, and minoritised ethnic staff, including those recruited internationally many of whom experienced heightened anxiety and fear regarding their safety during travel and within their local communities.

The Trust acknowledged the impact of societal racism on staff and, in response, implemented a coordinated wellbeing initiative for all staff, including:

- The senior management team, including the CEO Briefing, was used to reiterate the Trust's support and highlight available resources, including Vivup, occupational health, counselling, chaplaincy, and staff networks.

- The Head of Wellbeing facilitated an online session led by an external trauma management psychologist to address the emotional impact of the events and offer coping strategies.
- The Trust communication team widely promoted the session to reach staff across clinical, non-clinical and community settings. The session received high attendance and positive feedback.
- The Trust maintained the promotion of additional resources, encouraged team check-ins, and supported staff in accessing services to ensure that those in need of support receive this through a variety of wellbeing supports available to staff.

As a Trust, we are committed to supporting our staff, as required by the NHS People Promise and the NHS EDI Improvement Plan and continue to work with our staff networks to ensure that our policies and wellbeing initiatives reflect the diverse needs of our workforce.

4.4 Organisational Development and Inclusion

Workforce Culture and “Caring for those Who Care”

Through its Workforce Assurance Committee, the Board monitors culture and behaviours in workforce information reports (for example, employee relations cases), the annual equality workforce submissions on disability and race and ensures they are aligned with WH’s values which are shown on page 6). The Trust’s work to support good working relationships, and to promote compassion and inclusion throughout the Whittington Health culture, has continued, alongside a focus on providing staff with rest and respite in short lunchtime sessions.

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

- The range of services offered under the branded ‘Caring for Those Who Care’ or “#CFTWC” logo has been continuously augmented, with a range of new programmes and services offered in-house, within the integrated care system (ICS), and nationally, to provide staff with the widest choice of supportive opportunities.
- Trauma Informed Management has been launched to support staff support and response to incidents.
- Targeted listening events and community engagement roadshows, a simple and impactful back-to-basics initiative that aims to bring staff support teams to colleagues, meeting staff where they are.
- Relunched our Living our Values training for all staff
- The Restorative Just Culture programme continued to take place across the organisation and further training dates have been secured for 2025-26.
- Cherron Inko-Tariah, MBE and Inclusion Leader, was invited to be a keynote speaker at the Trust’s Leadership Conference to highlight the importance of staff voice in making meaningful changes to the organisation and supporting culture change.

Staff Development

Whittington Health places great value on developing staff through courses, this year we have been able to do this using a hybrid approach of face-to-face and virtual delivery with internal and external trainers. In the last year, the following was delivered by in-house staff and with partners:

- A fourth cohort of the Band 2-7 BME career development programme ran, which supports BME staff in AFC bands 2-7 in Whittington Health Trust providing career development, personal development and insights into understanding Whittington Health's recruitment and selection process. Whittington Health has been awarded funding by NHS England to run two cohorts for all NHS organisations across London.
- A new Band 8A and above BME leadership programme has run, called 'Working Uphill' which was delivered by BRAP, a leading charity focusing on equality through learning, change, research, and engagement.
- The Organisational Development team is continuing to review the leadership development offering and is working on a tiered programme approach for aspiring, new and existing managers. In 2024/25, a series of standalone leadership, management and personal development courses which were delivered in-house and by internal and external subject matter experts and consisted of the following modules:
 - Bringing Values to Life (new)
 - PowerPoint Tips and Tricks (new)
 - Telling Powerful Stories (new)
 - Meeting Facilitation (new)
 - Communicating with Confidence (new)
 - Coaching Conversations (new)
 - Open Interview Coaching and Practice (new)
 - Time Management (new)
 - Minute Taking
 - Report Writing
 - Understanding your Drivers
 - Communicating with Authority
 - Discovering your Motivation
 - Seven Influencing Tactics
 - Resolving Telephone Conflict
 - Courageous Conversations
 - Restorative Conversations for Managers
 - Workplace Conflict
 - Giving and Receiving Feedback
 - Situational Leadership
 - Assertiveness and Boundary Setting

- Introduction to Finance
- Managing Sickness Absence
- Employee Relations
- Recruitment and Selection training
- Capability Policy Implementation Training
- Anti-racist and Inclusive Cultures
- Workforce Disability Equality Standards and Reasonable Adjustments
- Understanding off autism in the workplace training (Ambitious About Autism)

Additional Leadership Development and OD and Wellbeing interventions:

- Appraisal Training for Managers and Appraisal Training for Appraisees has been re-designed and re-launched
- British Sign Language
- Mental Health First Aid Training and Refresher (MHFA England)
- Trauma Informed Management Training
- Bespoke workshops and interventions for teams that need support in developing team-working and improving morale
- Affina Team Journey, this focused on the research and findings from Professor Michael West on effective team working
- Coaching for individuals to support career development and working relationships
- Mediation training for staff to become accredited mediators and to join the internal mediation service
- Myers Briggs Type Indicator reports and feedback sessions to support team dynamics
- 360-degree feedback for individuals to understand how they impact on others and to support career development
- Functional skills in maths and English to support staff developing via an apprenticeship
- Various apprenticeships in both clinical and non-clinical areas to support staff development, ranging from level 2 (GCSE's level) to level 7 (master's level).

The following modules were delivered by NHS Elect:

- Interview Skills
- Career Planning
- Teaming and Psychological Safety
- Online Facilitation
- Applications Skills (for career development)
- Compassionate Leadership

- Conflict and Difficult Conversations
- Communication Skills
- Emotionally Intelligent Leadership
- Leading Change

4.5 Staff Health and Wellbeing

In 2024/2025, we continued our commitment to staff wellbeing and engagement, building on a proactive and preventative approach while enhancing expedited support when needed. Our vision remains clear: to prioritise staff wellbeing in everything we do. As a result, this year saw significant positive improvements in this area, including a 4% increase in staff survey responses indicating that employees feel the organisation supports their wellbeing – The largest Increase since 2020 in this element of the staff survey.

Key Achievements and Initiatives

- The successful launch of the Whittington Staff Wellbeing brand and publication of the Staff Wellbeing Booklet - raising awareness and making the staff wellbeing service more accessible through a comprehensive five-levels of wellbeing framework.
- A positive shift in staff engagement, with employees moving from disengagement to a hopeful belief in meaningful action.
- A noticeable cultural shift in staff wellbeing and engagement is evident, with executive and senior leaders integrating wellbeing into their daily work and interactions, embedding staff wellbeing into the fabric of the organisation.
- The recruitment of a Senior Staff Wellbeing Practitioner has enhanced the team's ability to deliver tailored wellbeing support and foster a wellbeing-focused culture across the Trust.
- Over 65% of the 2024/2026 strategic staff wellbeing objectives have already been achieved, allowing us to set even more ambitious goals for the future of staff wellbeing and engagement.

New and ongoing internal staff wellbeing and engagement offers include:

- Vivup Employee Assistance Programme & Benefits Platform: Offering 24/7 confidential counselling, online GP access, a personalised wellbeing platform, exclusive lifestyle discounts, and resources to support emotional, physical, and financial health.
- TRiM (Trauma Risk Management) Support: a gold-standard, evidence-based approach to support staff who have experienced traumatic events. This structured framework provides early intervention, helping identify individuals at risk and offering timely support to minimise the impact of Trauma. Sixteen TRiM Practitioners and ten TRiM managers were trained in quarter four.
- Team Reflective Sessions: Providing staff with a space to decompress and navigate challenges together, promoting quicker and positive recovery and team cohesion.

- Specialist Psychological Support: Partnership with Health City for expert support on complex psychological issues such as global conflict trauma.
- Ongoing inhouse Mental Health First Aid Training: Regular in-house training for Mental Health First Aiders - reducing stigma around mental health support, promoting early intervention, and providing a structured approach to mental health support across the workplace.
- Wellbeing Champions – Numbers continue to grow through active recruitment by the Wellbeing Team, these peer volunteers lead small but impactful wellbeing initiatives to embed wellbeing in teams and signpost to relevant wellbeing resources in a timely manner.
- Staff Engagement Roadshow: taking staff support services directly to teams across all areas, enhancing inclusion and fostering a sense of belonging, particularly for remote or hard-to-reach services/teams.
- Touch Tuina Medical Massage: Providing therapeutic massage for staff within high-pressure environments like A&E- to alleviate physical and mental stress, improve focus, and support overall wellbeing.
- Strong collaboration with Haringey Talking Therapies to offer regular tailored wellbeing webinars for Whittington staff, proactively addressing issues such as stress, burnout etc.
- Health Promotion Webinars: Regular webinars on topics such as Men's Mental Health Awareness and Boosting Immunity, providing staff with strategies to enhance their mental and physical health.
- Leadership Development Training: In-house training for leaders to facilitate reflective sessions, fostering a supportive environment for staff wellbeing.
- Menopause Support: Monthly Menopause Café, funded by the Whittington Charity, offering a safe space for discussion and peer support for staff experiencing menopause.
- Chair Yoga – A gentle, accessible lunch time wellbeing offer supporting relaxation for all staff, specifically desk-based staff. An ideal activity for wheelchair users.
- Wellbeing Wednesday: A focus on midweek wellbeing initiatives/activities encouraging staff to focus on self-care, reflection.
- Wellbeing Calendar: A structured schedule of targeted wellbeing campaigns and health promotions covering topics like mental health, stress, nutrition, hydration, grief etc.
- Healthy Eating Initiatives: Introduction of the "Five a Day" healthy eating fruit and veg stall at Whittington Hospital to encourage nutritious eating habits.
- Subsidised onsite physical activity classes such as Pilates are available at the hospital site to improve physical wellbeing.
- Financial wellbeing resources are available on the intranet.
- The Trust has an inhouse smoking cessation specialist.
- Regular wellbeing visits to teams across the Trust are conducted by the Wellbeing Team raising awareness and encouraging early wellbeing interventions.

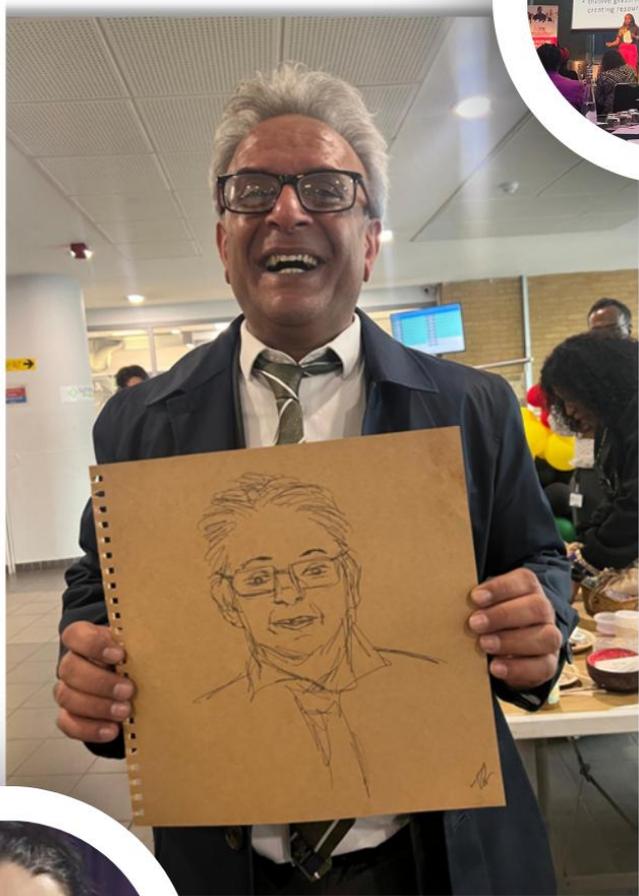
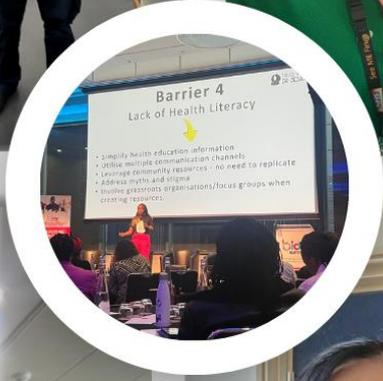
- The 'check-in and check-out' toolkit for managers to look after their staff continues to be promoted for use at the start and end of team meetings.

External routes of support

National and regional wellbeing support services are regularly promoted and made accessible. These include, but are not limited to:

- Bereavement Support Line: A confidential bereavement support line, operated by Hospice UK, free to access for NHS staff from 8:00am - 8:00pm, seven days a week.
- Frontline19 UK: Service offering one off or weekly sessions as needed. Psychological support for frontline workers via phone or remote platform.
- Practitioner Health is a free, confidential NHS primary care mental health and addiction service with expertise in treating health & care professionals.
- The BMA: Offers a free 24/7 counselling service to all doctors, their partners and dependents.
- Haringey Talking Therapies (formerly IAPT Haringey): A free NHS, psychological therapy service offering support for a range of common mental health difficulties such as depression and anxiety, OCD, PTSD and more.
- Switchboard LGBT+ Helpline: A safe space for anyone to discuss anything.
- A host of staff wellbeing courses from NHS England and NHS Elect such as – Happier working lives initiative (aimed at creating happier, healthier, and more productive teams across the NHS.) are offered and promoted.





4.6 Staff Equality Networks and See ME First

The Trust's staff networks are essential in engaging staff from different protected groups with the inclusion agenda and acting as critical friends. The networks also provide a forum where like-minded people and allies can meet to discuss issues and developments that particularly impact them and their community.

The networks also offer peer support and provide a route to escalate issues impacting their members. The staff networks are members of the Staff Inclusion Group meeting where they can highlight their successes, current issues highlighted by their members and any issues they need support or require escalation. At present, there are four staff networks, which include:

Staff networks in 2024/25

Lesbian, Gay, Bisexual, Transgender, Queer Plus Network

The network and inclusion team continued to work through the feedback from the rainbow badge survey to make our services more LGBTQ+ friendly. The network ran several workshops/trainings throughout the year including a couple on Transgender Inclusion in healthcare. They also worked with the library team to bring in a new collection of LGBTQ+ books for staff.



Staff Race Equity and Nationality Network

The network ran events to promote awareness and celebrate our diverse populations, including Black History Month, Windrush Day and Southeast Asian History Month.



WhitAbility Network

A network for staff with disabilities, long-term health conditions, and allies. To celebrate Disability History Month, there were a range of activities including a workshop around Autism and a creative writing session.



Women's Network

The network celebrated International Women's Day by providing coffee packs to their members. The network ran events throughout the year for all staff to engage with and to raise the profile of the work of the women's network including 'Ambition and Imposter Syndrome' with Anna Whithouse (AKA Mother Pukka), 'Women with caregiving responsibilities' with a panel of senior women in the Trust, and 'Accelerate Action' discussion forum. They have also had their inaugural meeting of the new Women's+ network steering group who will help to develop the network's action plan over the coming year.



See ME First

See ME First is an initiative to promote a more respectful, civil, and inclusive culture within Organisations to give staff a sense of belonging. As See ME First approaches its fifth anniversary on 29 October 2025 and EQUITY now underpins the Whittington Health NHS Trust ICARE values, the message that “... people should not be judged by the colour of their skin but by the content of their character....” is even stronger.

Over 2,500 staff have pledged, and over 30 other NHS organisations are ‘following our lead’ and have either adopted or are looking to adopt the initiative. Islington Council – Social Care is the first Organisation outside the NHS, launched in October 2022. As a testament to the effect of See ME First, we are now also receiving See ME First Impact Testimonials from staff who have made their pledge and want to share their experiences and the tangible changes that have occurred.

Two See ME First Impact Testimonials:

“I pledged to wear the 'See ME First' badge because I believe in creating an inclusive and respectful environment where everyone feels seen, valued, and heard. It's important to me that we celebrate diversity and actively challenge discrimination. Wearing the badge is a daily reminder of my commitment to treating others with dignity and compassion.”

“I am part of an open, inclusive, and non-judgemental NHS organisation that treats all staff with dignity and respect, regardless of skin colour, religion, disability, sexual orientation, or marital status. I uphold Whittington Health's values of motivation, compassion, accountability, respect, and excellence. I am sending the message that "you can talk to me".”

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



5. Patients and Service Users



5.1 Patient Equality Information

This report presents two sets of patient equality information. First, data about who uses our services; secondly, data about the patient experience while under our care. Some data is unavailable for analysis as it is not routinely collected via Medway or Rio, our patient management systems. This information could be held in patients' written medical or nursing notes. The Chief Nursing Information Officer is working on this as part of our ongoing work to digitalise patient records. The available data shows service usage for patients that were outpatients, inpatients, and using emergency services and community services during 2024/25.

Age

5-1: Overall Representation of Age Groups in Haringey and Islington Local Population

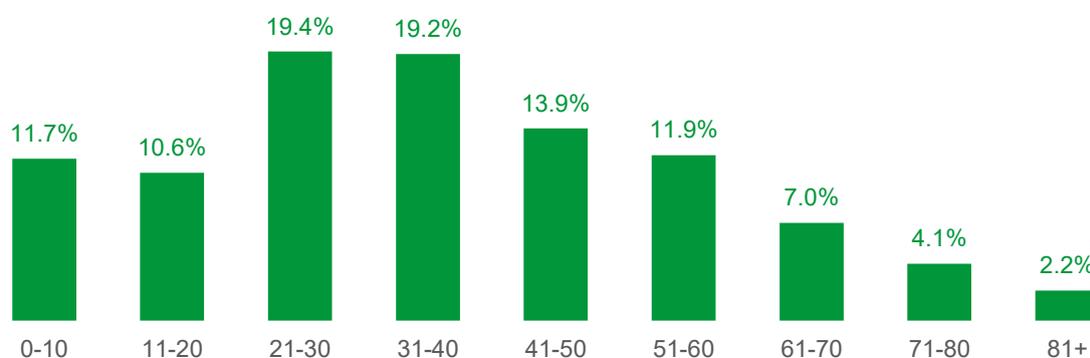


Chart 5-1 (above) shows the overall representation of age groups in the local population within Haringey and Islington, showing that the population is relatively young (over 50% of the population is aged between 21-50). A decreasing representation trend can be seen aged 21 onwards. This provides a useful point of comparison when reviewing patient service use demographic data.

5-2: Representation of age groups using outpatient services compared to the local population

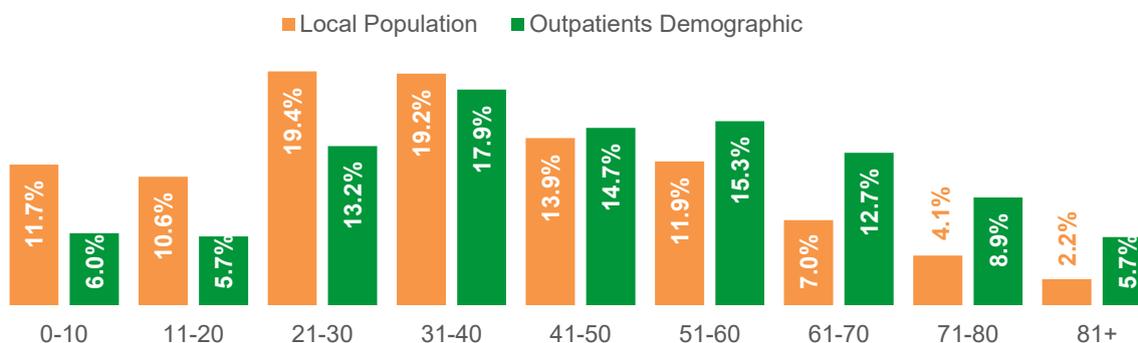


Chart 5-2 (above) shows a broad correlation in the general trend of patients attending outpatient services compared to the local demographics. There is a lower representation of patients using services up to age 40, and a higher representation of patients using Trust services 41+.

5-3: Representation of age groups using outpatient services compared to the local population

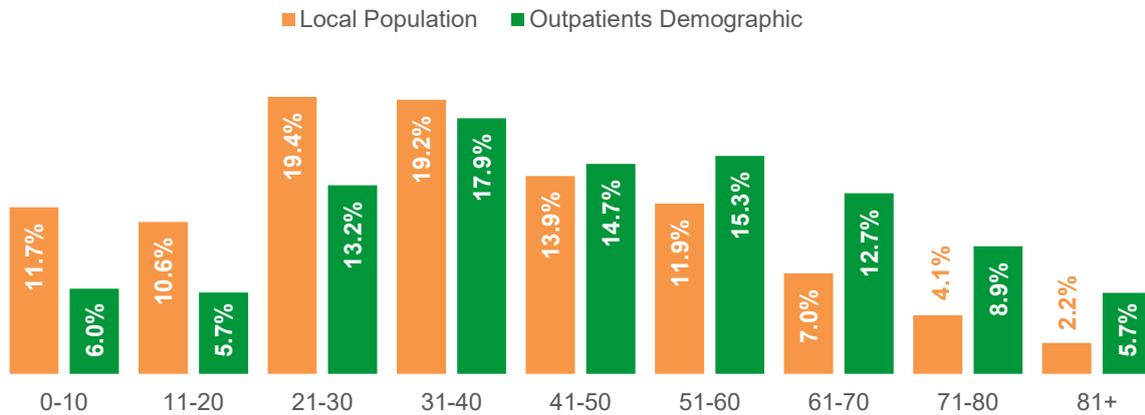


Chart 5-3 (above) shows an overall broad correlation in the general trend of patients attending inpatient services compared to the local demographics. From 41+, there is a greater proportional representation within inpatient services compared to the local population, from ages 0-40 there is a lower proportional representation.

5-4: Representation of age groups using emergency services compared to the local population

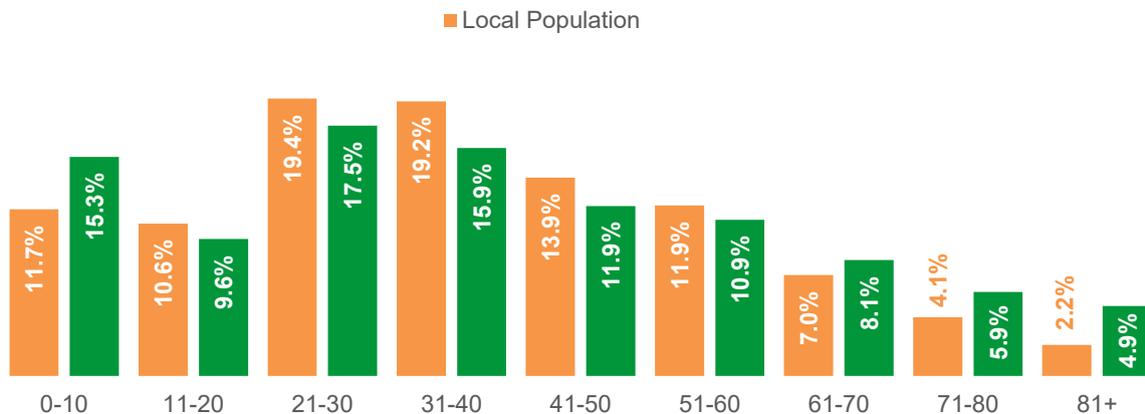


Chart 5-4 (above) shows a broad correlation in the general trend of patients attending emergency services compared to the local demographics. For patients aged 0-10 and 61+ there is a greater representation within emergency services compared to the local demographic, and a lower representation for staff aged 11-60.

5-5: Representation of age groups using community services compared to the local population

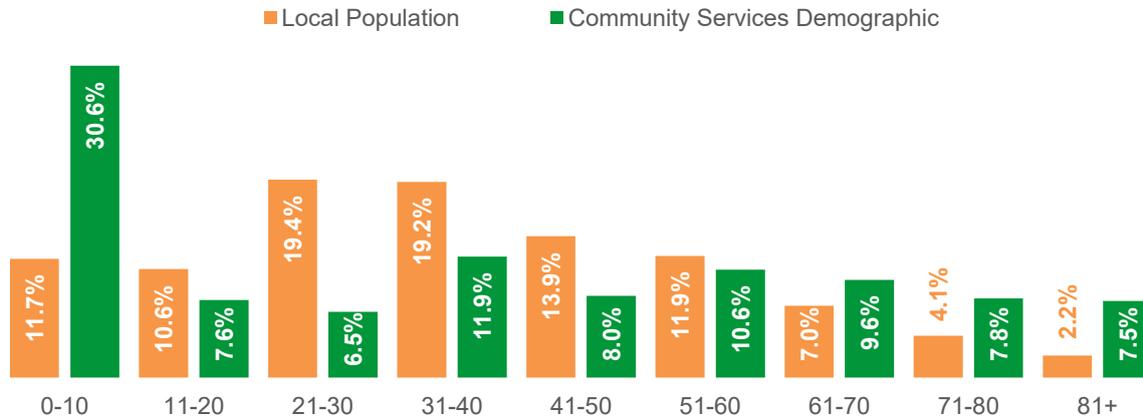


Chart 5-5 (above) shows for patients aged 0-10 and 61+ there is a greater representation of patients using community services compared to the local population; for patients aged 11-60, there is a lower representation.

Disability and gender reassignment

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

Marriage and Civil Partnership

5-6: Overall Representation of Marriage and Civil Partnerships in Haringey and Islington Local Population

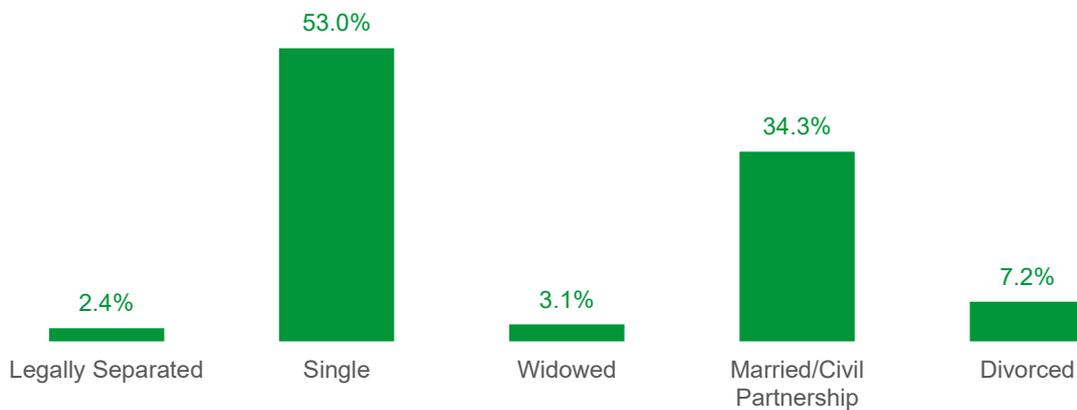


Chart 5-6 (above) shows an overall representation of marriage and civil partnership in the local population within Haringey and Islington, 34.3% of the population share this relationship status. Because of the way data is recorded on the Trust's patient information systems both marriage and civil partnership have been aggregated.

5-7: Representation of patients in a marriage/civil partnership using outpatient services compared to the local population

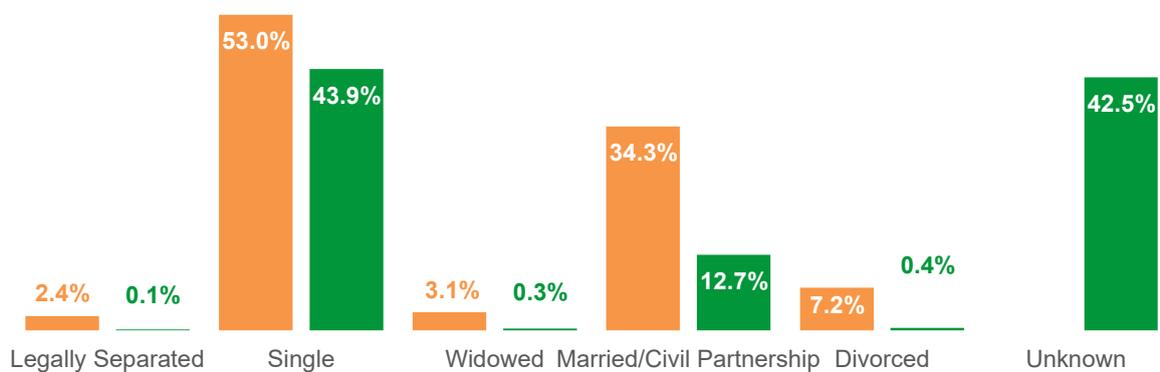


Chart 5-7 (above) shows overall, there is a much lower representation of patients in a marriage/civil partnership compared to the local population (about a third less). However, with over 40% of patient’s marital status is unknown, a true reflection of service use cannot be demonstrated until this reduces.

5-8: Representation of marriage/civil partnerships using inpatient services compared to the local population

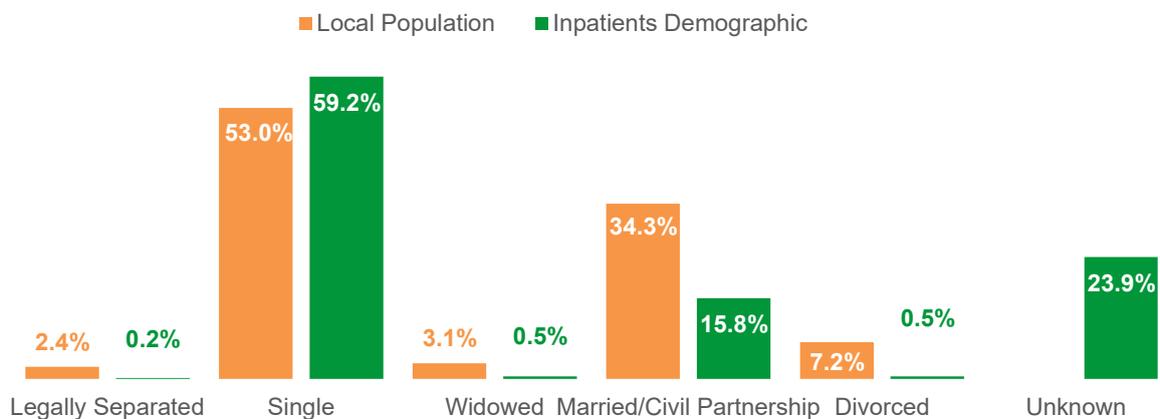


Chart 5-8 (above) shows compared to the local demographics there is a much lower proportion of patients in a marriage or civil partnership that has attended inpatient services.

5-9: Representation of marriage/civil partnerships using emergency services compared to the local population

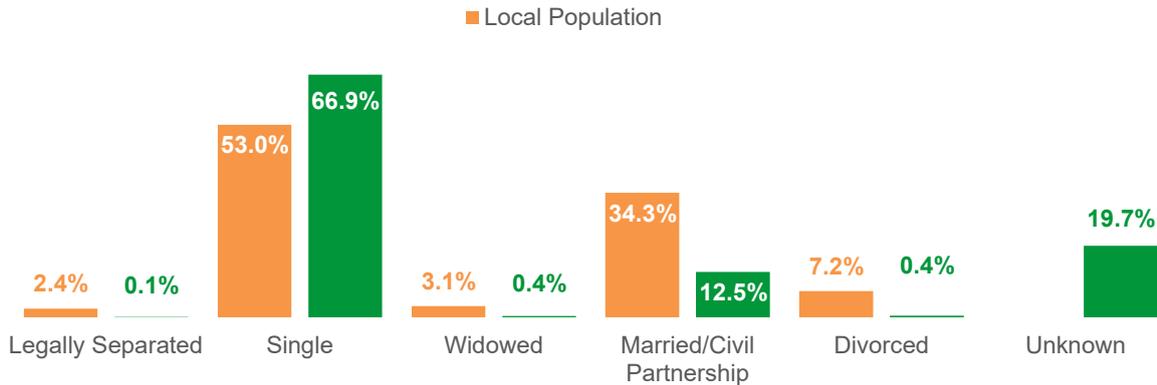


Chart 5-9 (above) shows there is a much lower proportion of patients in a marriage/civil partnership using Trust services compared to the local population using the Trust’s emergency services.

Over 91% of patients using the Trust’s community services did not share if they are in a marriage or civil partnership. As such there is no accurate conclusion that have been drawn from this information (no chart to show representation).

Pregnancy and maternity

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

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

5-10: Overall Representation of Race/Ethnicity in Haringey and Islington Local Population

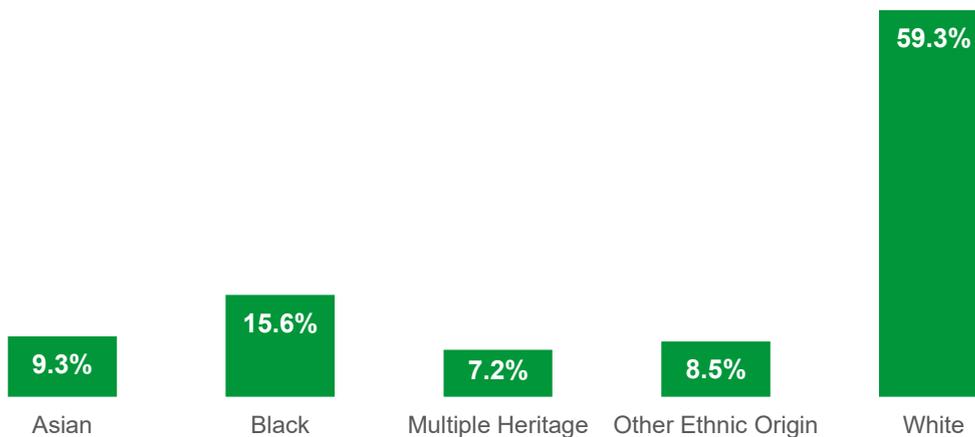


Chart 5-10 (above) shows the largest group ethnicity group is white with 59.3% of the local population, followed by Black (15.6%), Asian (9.3%) other ethnic group (8.5%) and finally residents that are from multiple heritage backgrounds.

5-11: Representation of patient's race/ethnicity using outpatient services compared to the local population

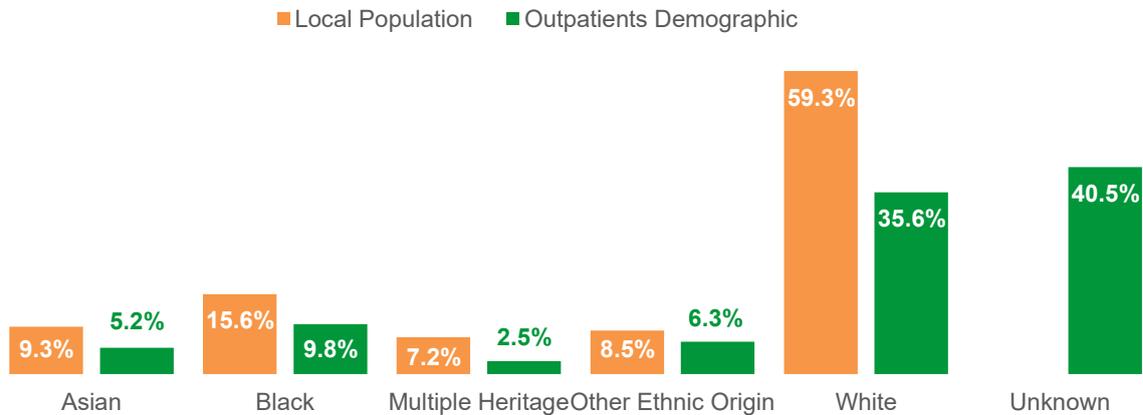


Chart 5-11 (above) shows, the broad trend of representation in ethnicity groups in the local population aligns with patient demographic data using outpatient services. However, when comparing the proportional representation (to the local population), there is a lower representation in all groups, however, with over 40% of patient's ethnicity groups being 'unknown', the true level or representation in Trust demographic data cannot be seen till this improves.

5-12: Representation of patient's race/ethnicity using inpatient services compared to the local population

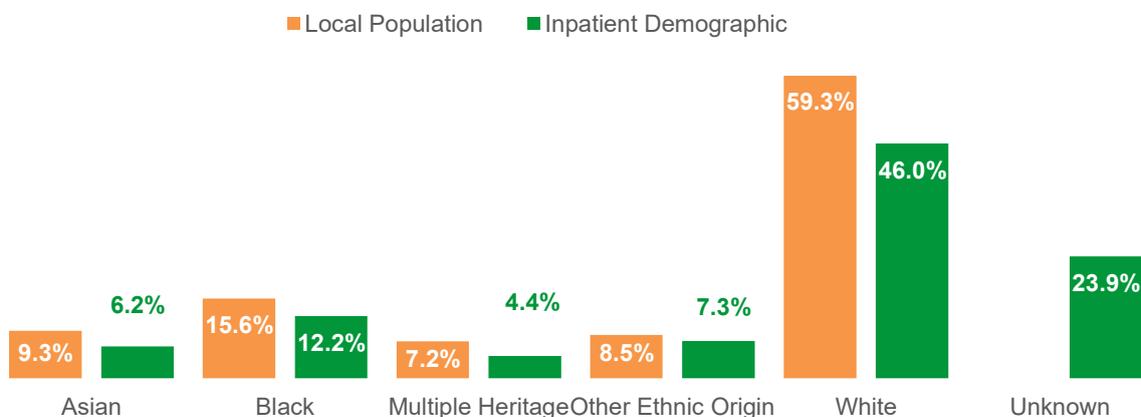


Chart 5-12 (above) shows, the overall broad trend of representation in ethnicity groups in the local population aligns with patient demographic data using outpatient services. However, when comparing the proportional representation, there is a lower representation in all groups, but with nearly 24% of service user's ethnicity not known, a true picture of representation will not be known until this improves.

5-13: Representation of patient's race/ethnicity using emergency services compared to the local population



Chart 5-13 (above) shows, the overall broad trend of representation in ethnicity groups in the local population with patient demographic data using outpatient services is similar. However, when comparing the proportional representation (to the local population) most groups have a lower representation in service use except Black and other ethnic groups which are broadly in line. 17.5% of patient’s ethnicity is unknown.

5-14: Representation of patient's race/ethnicity using community services compared to the local population

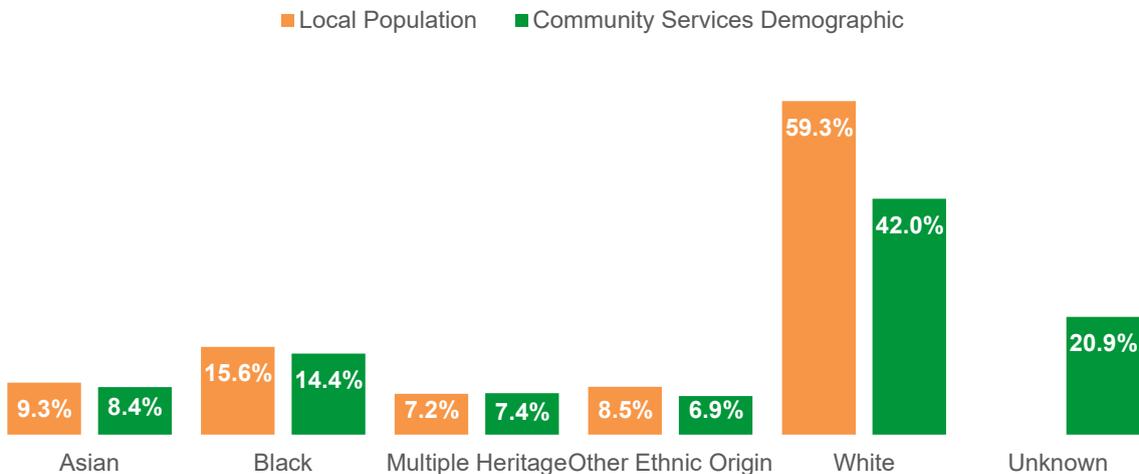


Chart 5-14 (above) shows, the broad trend of representation in ethnicity groups of the local population aligns with patient demographic data using community services. Most groups are represented in broad proportion to the local population, however, patients from ‘other’ and white ethnic groups are lower. A fifth of patient’s ethnic origin is unknown.

Religion or belief

Declaration of this protected characteristic is low throughout all patient services, as such, offers little insight into service use, and has been excluded from this report.

Sex

5-15: Overall Representation of sex in Haringey and Islington Local Population

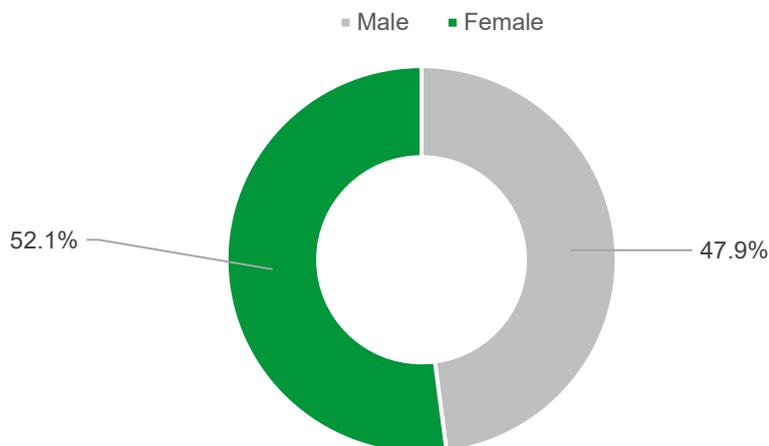


Chart 5-15 (above) shows that within the local population there are slightly more female residents (52.1%) than male (47.9%).

5-16: Representation of sex of patients using outpatient services compared to the local population

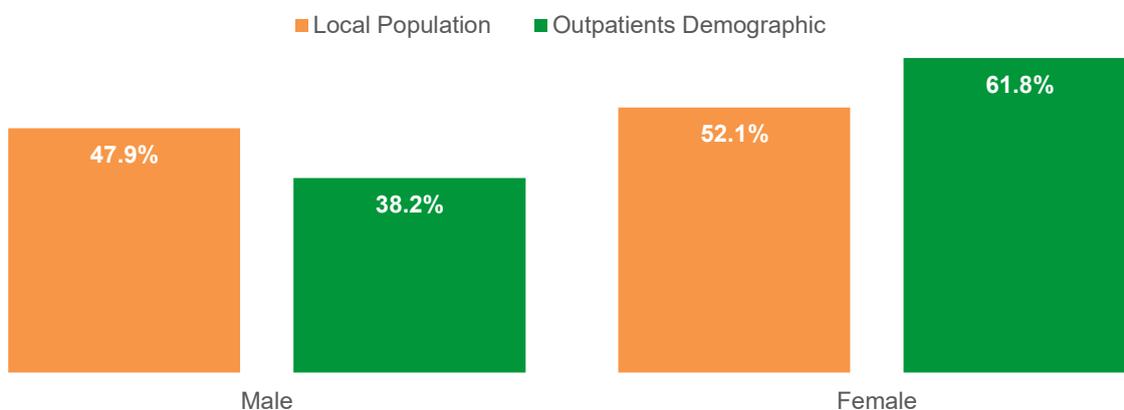


Chart 5-16 (above) shows there is a much higher proportion of female patients using outpatient services than male. When compared to the local population, there is also a greater-than-expected representation of female patients and a lower-than-expected of male patients using outpatient services.

5-17: Representation of sex of patients using inpatient services compared to the local population

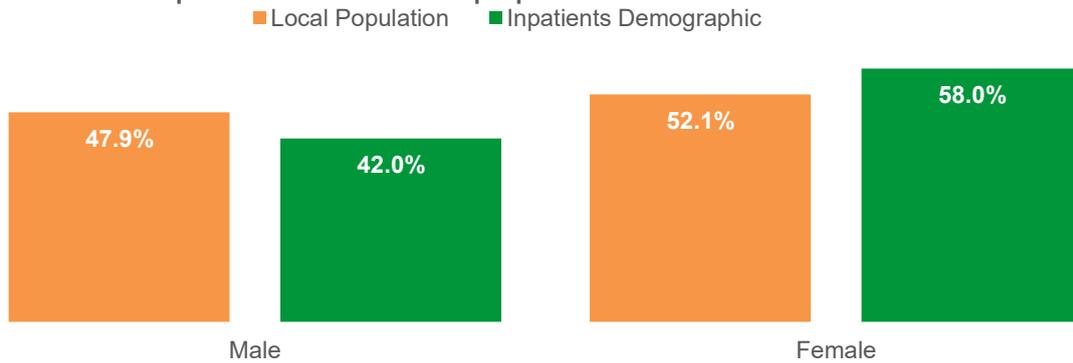


Chart 5-17 (above) shows there are a greater number of female patients compared to male patients using inpatient services. Compared to the local population, there is a slightly higher-than-expected representation of female patients and a slightly lower- than-expected of male patients.

5-18: Representation of patient's sex using emergency services compared to the local population

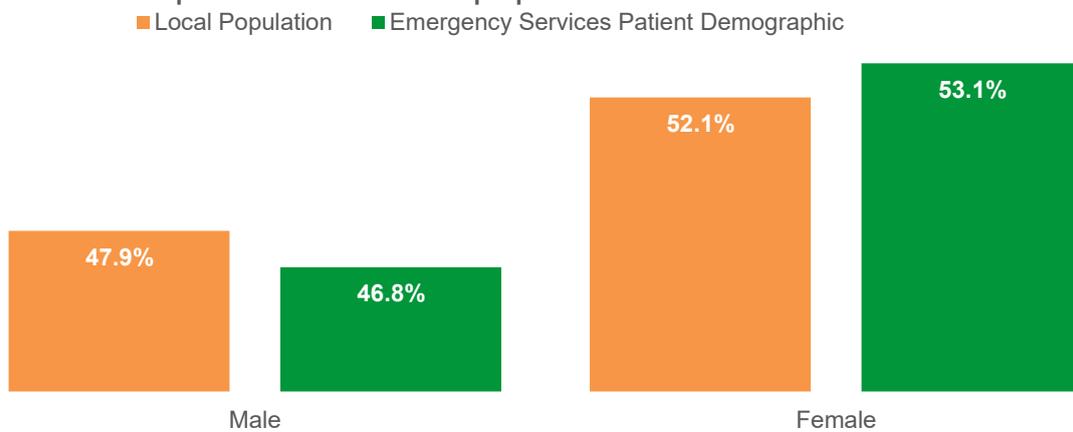


Chart 5-18 (above) shows there are slightly more female patients using emergency services than male. Compared to the local population, there is broadly equal proportion of female and male patients using Trust services.

5-19: Representation of patient's sex using community services compared to the local population

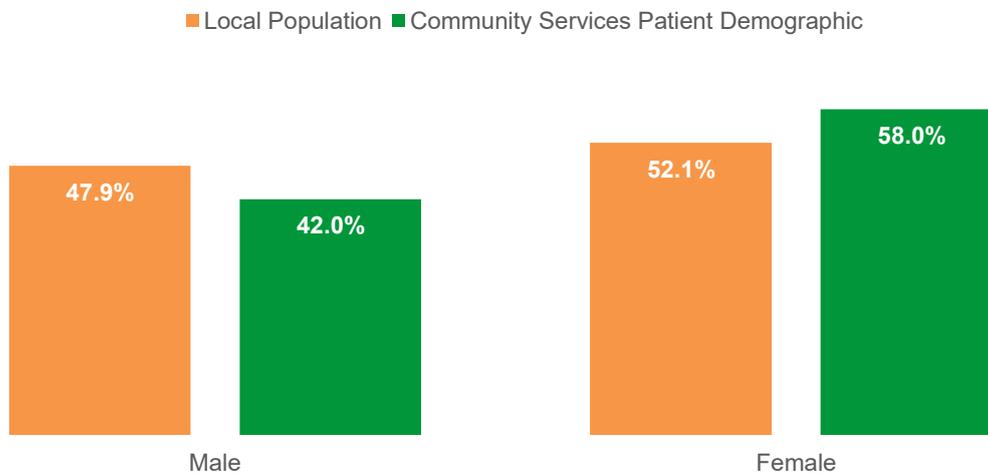


Chart 5-19 (above) shows there are a greater number of female patients compared to male patients using inpatient services. Compared to the local population, there is a slightly higher-than-expected representation of female patients and a slightly lower-than-expected of male patients.

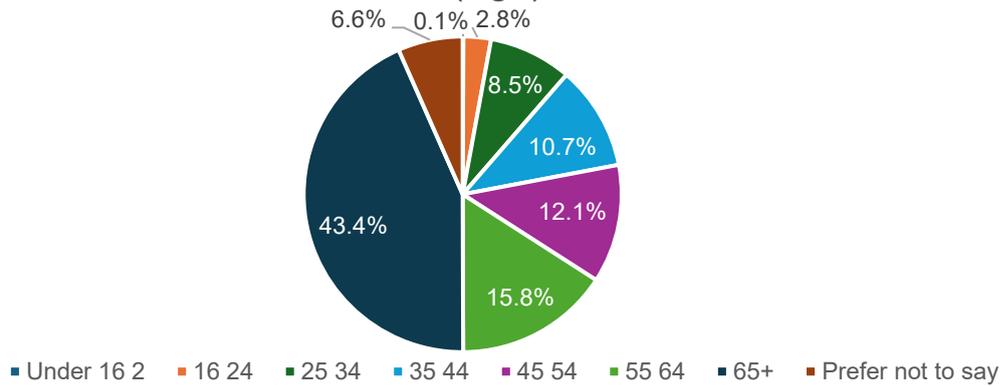
Sexual orientation

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

5.2 Patient Surveys

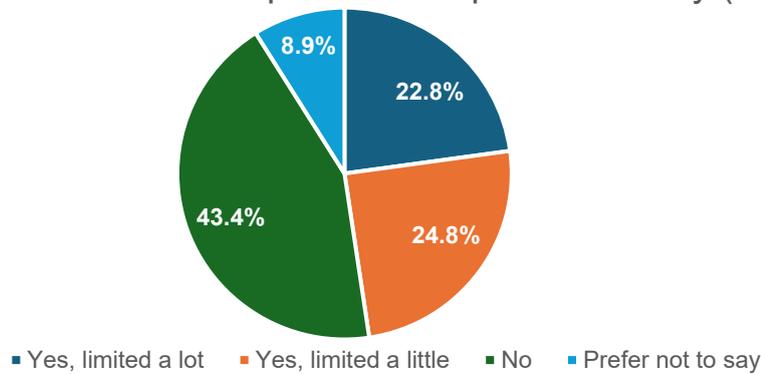
The surveys measures patient satisfaction with their experiences of using our services. The surveys explore different aspects of patients' experiences of using Trust services. At present, it is not possible to break down the responses to questions by protected characteristics. Still, it is possible to provide a profile for overall responses, and these are shown in the next pages.

5-20: Breakdown of Responses to Inpatient Survey (Age)



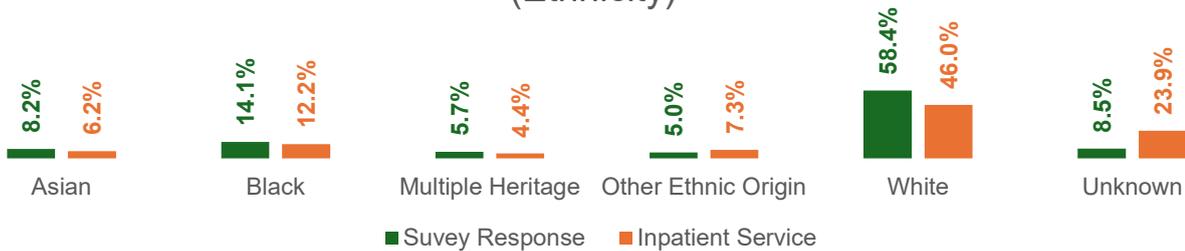
The age categories recorded in the patient survey are not compatible with Trust patient data on service use.

5-21: Breakdown of Responses to Inpatient Survey (Disability)



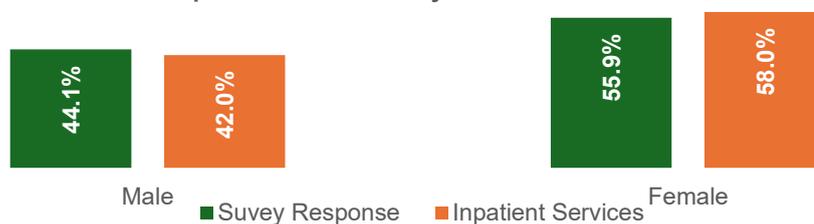
The categories recorded in the patient survey are not compatible with Trust patient data on service use. Patients were asked 'Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?'

5-22: Responses from Inpatient Survey vs. Service use (Ethnicity)



There is generally a broadly equal representation for most groups compared to service use data.

5-23: Responses from Inpatient Survey vs. Service use Representation by sex



2024-25 Inpatient Services Survey - Responses



95.8% of patients rated their overall experience at the Trust as good or very good.



89.2% of patients stated that they had as much involvement as they wanted in their treatment



- 90.3% of patients had confidence in their treating doctors
- 90.7% of patients had confidence in their nurses treating them
- 89.2% of patients said nurses provided answers to their questions in a way they could understand



91.2% of patients felt they were treated with kindness and compassion.



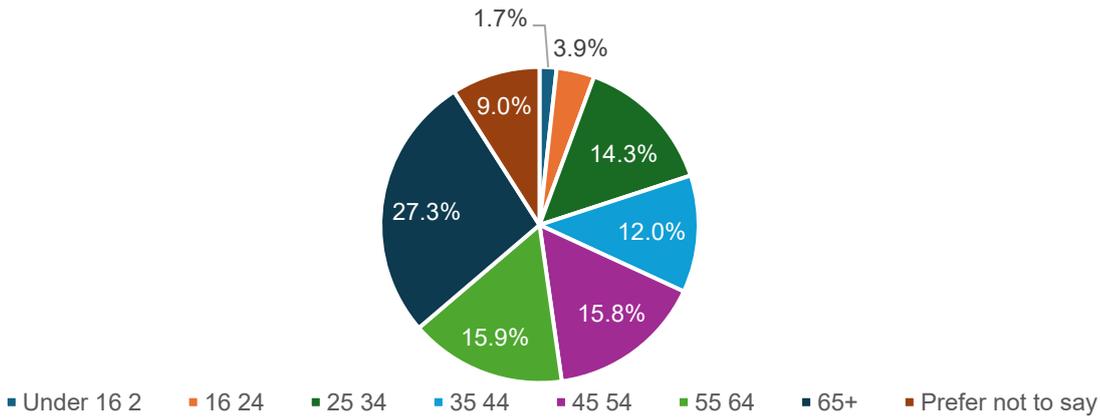
89.2% of patients felt their medicines and any possible side effects were explained to them



- 87.6% of patients received enough help with their food
- 81.3% of patients was happy with the choice and quality of food

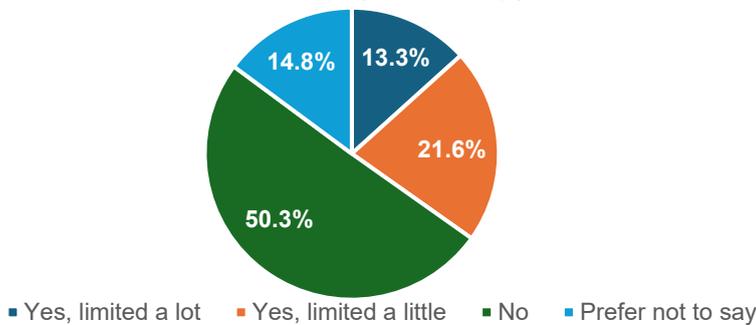
Patients who felt they were treated unfairly because of their (out of 2,666 responses): 10 gender, 23 race/ethnicity, 16 religion, 23 sexual orientation, 8 disability, 5 age, 9 another reason, 30 did not know, 540 stated they were not treated unfairly and 2,002 said this was unapplicable.

5-24: Breakdown of Responses to Outpatient Survey (Age)



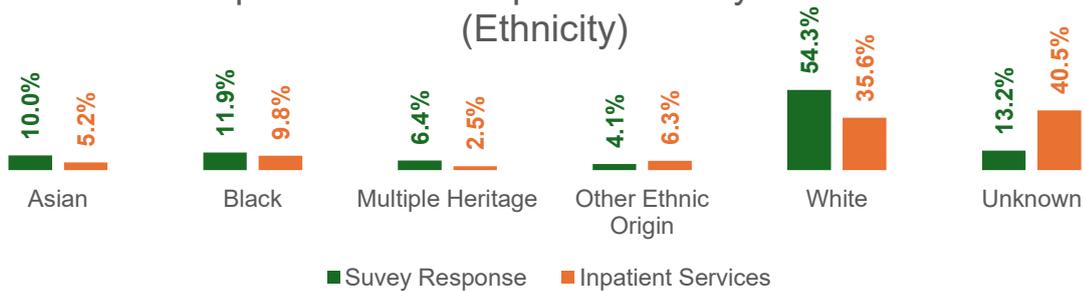
The age categories recorded in the patient survey are not compatible with Trust patient data on service use.

5-25: Breakdown of Responses to Outpatient Survey (Disability)



The categories recorded in the patient survey are not compatible with Trust patient data on service use. Patients were asked 'Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?'

5-26: Responses from Outpatient Survey vs. Service use (Ethnicity)



There is a greater representation in survey responses compared to service, except for 'other'.

5-27: Responses from Outpatient Survey vs. Service use Representation by sex



2024-25 Outpatient Services Survey - Responses



91.5% of patients rated their overall experience at the Trust as good or very good



91.9% of patients would recommend the service to friends or family member



89.6% of patients rated courtesy of the receptionist on arrival as excellent or good



91.4% of patients stated that they had as much involvement as they wanted in their treatment



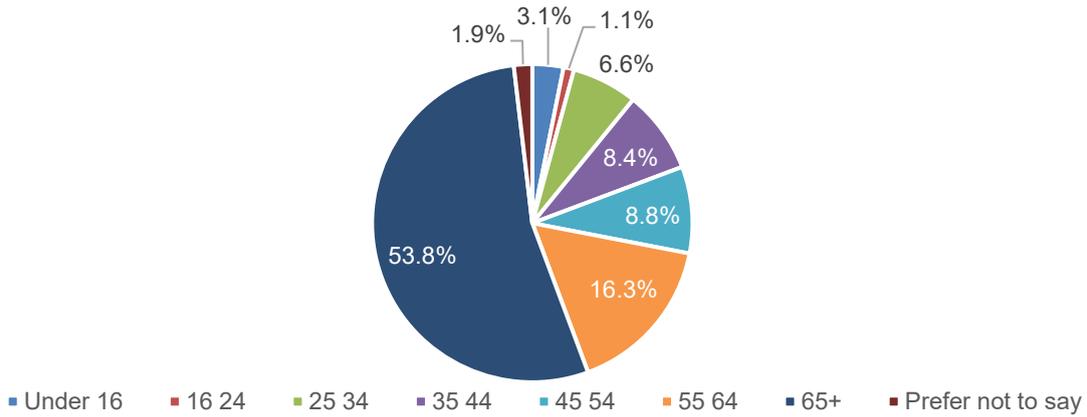
- 90.0% of patients said their doctor explained the reasons for any treatment or action in a way they could understand



22.7% of patients who requested an interpreter for their appointment had one present who could interpret for them.

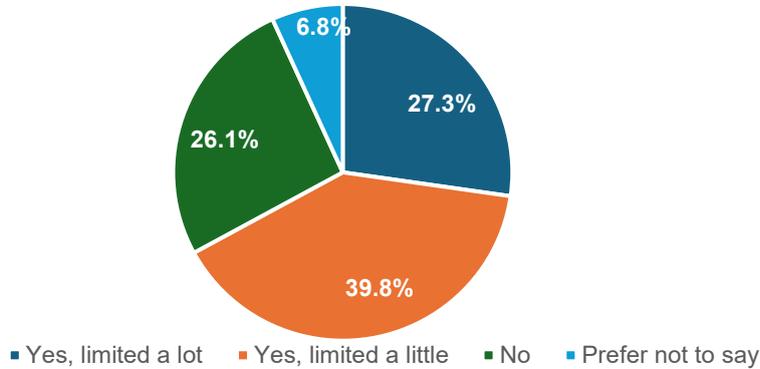
93.8% of patients felt that they were treated with dignity and respect while they were at the Outpatient Department

5-28: Breakdown of Responses to Community Patient Survey (Age)



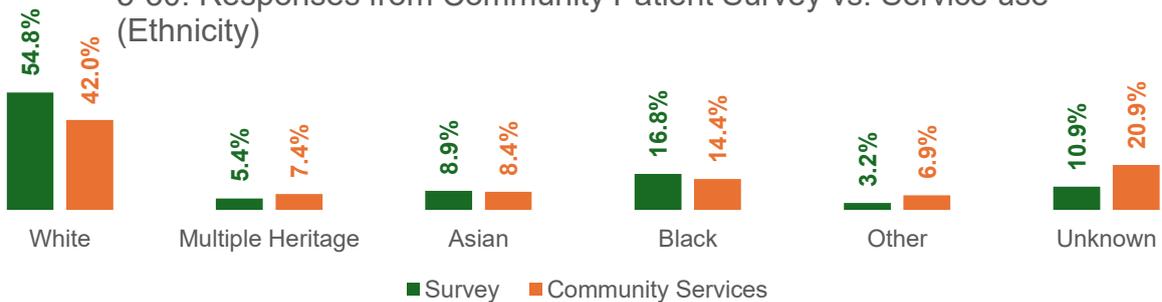
The age categories recorded in the patient survey are not compatible with Trust patient data on service use.

5-29: Breakdown of Responses to Community Patient Survey (Disability)



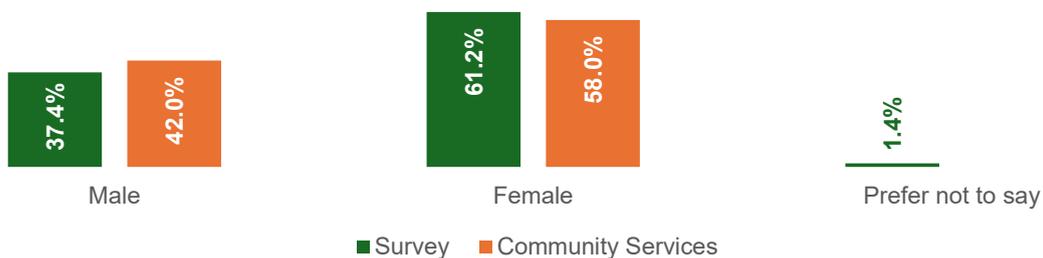
The categories recorded in the patient survey are not compatible with Trust patient data on service use. Patients were asked 'Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?'

5-30: Responses from Community Patient Survey vs. Service use (Ethnicity)



There is generally lower or broadly equal representation in for most groups compared to service use data.

5-31: Responses from Community Patient Survey vs. Service use Representation by sex



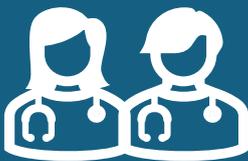
2024-25 Community Services Survey - Responses



95.5% of patients rated their overall experience at the Trust as good or very good



98.5% of patients felt they were treated with kindness and compassion



98.2% of patients had confidence in the staff treating/caring for them or their child.



96.0% of patients stated that they had as much involvement as they wanted in their or their child's treatment

Who completed the surveys? (out of 5,338): 3,484 by patients, 1,660 by parent/relative and 194 by a carer.

Complaints and Concerns Raised with Patient Advice and Liaison Service

Complaints and concerns are essential types of feedback that allow the Trust to make improvements for individual patients and our services. However, due to the low declaration of all protected characteristics within the data, there is no meaningful analysis that can be drawn from the data available.

From the Complaint and PALS data there were a total of 2,945 contacts, of which:

- 241 contacts had an age recorded
- 128 contacts had a disability status recorded
- 195 contacts had an ethnicity recorded
 - Ethnicities recorded: 73 Asian (2.5%), 167 Black (5.7%), 52 Multiple Heritage (1.8%), 95 other ethnicity (3.2%), 826 White (28.0%), 1,732 Unknown (58.8%).
- Sex recorded: 1,247 Female (42.3%), 795 Male (27.0%) and 903 unknown (30.7%)

5.3 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. Interpreting services are offered either face-to-face, via video or on the phone. 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, these are covered by external providers.

During 2024/25 the Trust provided interpreting support, in a variety of languages, in 19,914 prebooked interpreting appointments and 20,516 telephone interpreting on demand consultations (where a pre-booking had not been made). The top 10 languages of all interpretation requests received were:

| Language | Number of requests received |
|-----------------|------------------------------------|
| Turkish | 12,576 |
| Spanish | 4,715 |
| Arabic | 2,962 |
| Albanian | 2,607 |
| Bengali | 2,265 |
| Portuguese | 2,247 |
| Somali | 1,852 |
| Polish | 1,821 |
| Farsi Persian | 1,782 |
| Bulgarian | 1,503 |

In addition, the trust translated a number of patient's records, letters, questionnaires, reports and patient information leaflets in a variety of languages.

5.4 Patient data – waiting times

Overleaf, in line with NHS England's statement on health inequalities, the next few pages set out waiting times disaggregated by age, deprivation, ethnicity and sex for waiting times for diagnostic test, referral to treatment, cancer services and in the emergency department.



Diagnostic waits

| Ethnicity | % of diagnostic waits by ethnicity | Age group | % of diagnostic waits by age group | Deprivation (decile) | % of diagnostic waits by deprivation (decile) |
|-----------------------------------|------------------------------------|---------------|-------------------------------------|----------------------|---|
| Any other ethnic group | 7.67% | [Age 18 - 44] | 35.32% | 3 | 19.00% |
| Asian – Bangladeshi | 1.07% | [Age 45 - 64] | 31.30% | 2 | 17.91% |
| Asian – Indian | 1.29% | [Age 65 - 74] | 13.12% | 4 | 13.80% |
| Asian – Other | 1.89% | [Age 75 - 84] | 10.19% | 6 | 11.76% |
| Asian – Pakistani | 0.40% | [Age 0 - 17] | 6.30% | 5 | 10.85% |
| Black – African | 5.00% | [Age 85+] | 3.77% | 8 | 6.44% |
| Black – Caribbean | 3.59% | Grand Total | 100.00% | 1 | 6.02% |
| Black – Other | 1.99% | | | 7 | 5.69% |
| Chinese | 0.48% | Sex | % of Diagnostic Waits by Sex | 9 | 4.37% |
| Mixed – Other | 1.43% | Female | 63.66% | 0 | 3.65% |
| Mixed - White and Asian | 0.22% | Indeterminate | 0.01% | 10 | 0.51% |
| Mixed - White and Black African | 0.15% | Male | 36.31% | Grand Total | 100.00% |
| Mixed - White and Black Caribbean | 0.54% | Not Stated | 0.01% | | |
| Not Stated | 33.66% | Grand Total | 100.00% | | |
| White – British | 23.97% | | | | |
| White – Irish | 1.77% | | | | |
| White – Other | 14.89% | | | | |
| Grand Total | 100.00% | | | | |

Referral to treatment time waits

| Ethnicity | % of RTT waits by ethnicity |
|-----------------------------------|------------------------------------|
| Not Stated | 44.99% |
| White – British | 18.85% |
| White – Other | 12.60% |
| Any other ethnic group | 6.75% |
| Black – African | 3.82% |
| Black – Caribbean | 3.51% |
| Black – Other | 1.93% |
| Asian – Other | 1.72% |
| White – Irish | 1.47% |
| Mixed – Other | 1.14% |
| Asian – Indian | 0.92% |
| Asian - Bangladeshi | 0.90% |
| Mixed - White and Black Caribbean | 0.43% |
| Chinese | 0.31% |
| Asian – Pakistani | 0.30% |
| Mixed - White and Asian | 0.20% |
| Mixed - White and Black African | 0.17% |
| Grand Total | 100.00% |

| Age group | % of RTT waits by age group |
|--------------------|------------------------------------|
| [Age 18 - 44] | 36.82% |
| [Age 45 - 64] | 33.41% |
| [Age 65 - 74] | 12.60% |
| [Age 75 - 84] | 8.93% |
| [Age 0 - 17] | 5.49% |
| [Age 85+] | 2.74% |
| Grand Total | 100.00% |

| Sex | % of RTT waits by sex |
|--------------------|------------------------------|
| Indeterminate | 0.01% |
| Not Stated | 0.03% |
| Male | 43.97% |
| Female | 0.5599 |
| Grand Total | 100.00% |

| Deprivation (decile) | % of RTT waits by deprivation (decile) |
|-----------------------------|---|
| 3 | 20.00% |
| 2 | 18.42% |
| 4 | 13.69% |
| 6 | 10.81% |
| 5 | 9.96% |
| 7 | 6.09% |
| 8 | 6.00% |
| 1 | 5.34% |
| 9 | 4.73% |
| 0 | 3.97% |
| 10 | 1.00% |
| Grand Total | 100.00% |

Cancer waits

| Ethnicity | % of cancer waiting time by ethnicity |
|-----------------------------------|---------------------------------------|
| Any other ethnic group | 6.90% |
| Asian – Bangladeshi | 0.71% |
| Asian – Indian | 0.51% |
| Asian – Other | 1.14% |
| Asian – Pakistani | 0.14% |
| Black – African | 3.83% |
| Black – Caribbean | 5.10% |
| Black – Other | 2.79% |
| Chinese | 0.72% |
| Mixed – Other | 0.82% |
| Mixed - White and Asian | 0.23% |
| Mixed - White and Black African | 0.15% |
| Mixed - White and Black Caribbean | 0.18% |
| Not Stated | 32.68% |
| White – British | 27.68% |
| White – Irish | 2.74% |
| White – Other | 13.68% |
| Grand Total | 100.00% |

| Age group | % of cancer waiting time by age group |
|---------------|---------------------------------------|
| [Age 45 - 64] | 35.37% |
| [Age 65 - 74] | 21.09% |
| [Age 18 - 44] | 21.04% |
| [Age 75 - 84] | 16.13% |
| [Age 85+] | 6.20% |
| [Age 0 - 17] | 0.17% |
| Grand Total | 100.00% |

| Sex | % of cancer waiting time by sex |
|-------------|---------------------------------|
| Female | 56.06% |
| Male | 43.94% |
| Grand Total | 100.00% |

| Deprivation (decile) | % of cancer waiting time by deprivation(decile) |
|----------------------|---|
| 3 | 19.03% |
| 2 | 15.76% |
| 4 | 12.68% |
| 6 | 12.00% |
| 5 | 10.69% |
| 8 | 7.94% |
| 7 | 7.70% |
| 9 | 5.92% |
| 1 | 5.42% |
| 0 | 2.53% |
| 10 | 0.32% |
| Grand Total | 100.00% |

Emergency Department (ED) waits

| Ethnicity | % of ED waiting time by ethnicity |
|-----------------------------------|-----------------------------------|
| White – British | 27.00% |
| White – Other | 19.90% |
| Not Stated | 15.70% |
| Any other ethnic group | 9.10% |
| Black – African | 7.20% |
| Black – Caribbean | 4.80% |
| Black – Other | 4.20% |
| Asian – Other | 2.80% |
| Mixed – Other | 2.40% |
| White – Irish | 2.30% |
| Asian – Indian | 1.20% |
| Asian – Bangladeshi | 1.00% |
| Mixed - White and Black Caribbean | 0.80% |
| Chinese | 0.50% |
| Mixed - White and Asian | 0.40% |
| Asian – Pakistani | 0.40% |
| Mixed - White and Black African | 0.30% |
| Grand Total | 100.00% |

| Age group | % of ED waiting time by age group |
|---------------|-----------------------------------|
| [Age 18 - 44] | 36.10% |
| [Age 45 - 64] | 23.00% |
| [Age 0 - 17] | 15.90% |
| [Age 75 - 84] | 9.30% |
| [Age 65 - 74] | 9.20% |
| [Age 85+] | 6.40% |
| Grand Total | 100.00% |

| Sex | % of ED waiting time by sex |
|---------------|-----------------------------|
| Female | 53.00% |
| Male | 46.90% |
| Indeterminate | 0.00% |
| Unknown | 0.00% |
| Grand Total | 100.00% |

| Deprivation (decile) | % of ED waiting time by deprivation (decile) |
|----------------------|--|
| 3 | 20.30% |
| 2 | 18.20% |
| 4 | 13.10% |
| 6 | 10.70% |
| 5 | 10.20% |
| 1 | 6.90% |
| 7 | 5.70% |
| 8 | 5.50% |
| 0 | 4.50% |
| 9 | 4.40% |
| 10 | 0.50% |
| Grand Total | 100.00% |

5.5 Population health and anchor institution work

Whittington Health has continued to develop its Health Equity programme. The focus has been on inclusive communication, targeted service improvements aligned with Core20PLUS5 priorities, enhanced data quality, and collaborative action as an Anchor Institution. Key initiatives include tailoring services to address disease burden, improving ethnicity and deprivation data, and working with local partners to influence the wider determinants of health. These efforts support our population health approach and strategic goal of helping local people live longer, healthier lives.

Anchor institution

As part of our 2025/26 strategy, we are strengthening our role as an anchor institution through initiatives in employment, procurement, sustainability, and civic leadership across Islington and Haringey.

| Strategic Objective | Current projects |
|--|--|
| <p>Employment Create local jobs paying the living wage, caring for the mental and physical health of our staff.</p> | <p>Through the Islington Anchor work the Whittington is advancing several workforce and community-focused initiatives, including:</p> <ul style="list-style-type: none"> • Local outreach: Developing school work placements and supported internships for young people with special educational needs. • Partnership with the Health and Social Care Academy: focusing on enrolment and shared best practices. <p>The Whittington is a new member of the Haringey Business Forum, through which it is committed to working in partnership with Haringey Council on initiatives that support both health and economic development such as workforce wellbeing, local recruitment, or social value initiatives.</p> |
| <p>Procurement Create social value through our procurement</p> | <p>Whittington continues to participate in the procurement workstream, reviewing where appropriate, supporting local businesses and SMEs through inclusive and transparent procurement.</p> |
| <p>Bricks and mortar Design vibrant community spaces that improve Health, and benefits the environment.</p> | <p>Whittington Health is implementing a Decarbonisation Strategy focused on embedding sustainable construction standards in all developments, transitioning to renewable energy sources, and phasing out gas use across the estate. The Trust is also actively pursuing external funding, including Low Carbon Skills Fund and Salix Finance, to support delivery of these initiatives.</p> <p>Whittington Health is delivering a Sustainability Strategy focused on reducing environmental impact through renewable energy use, water-saving technologies, biodiversity planning,</p> |

| | |
|---|---|
| | and low-carbon food options. The strategy also aims to cut travel and procurement emissions and achieve Planet Mark Accreditation. |
| Corporate and civic Lead, influence and partner with others using data to prioritise actions that reduce inequalities. | External civic role and partnerships: Part of Islington Anchor network, member of NHS London Anchor Strategy and Change Network, member of the Haringey Business Forum. Internal anchor ownership: Allocated leads for each of the strategies within the local Anchor institute report to the steering group to track progress against the agreed priorities |

Health Equity Programme

Assurance Committee on the monitoring, analysis, and publication of health inequalities and population health data. The group aims to support services in addressing inequalities, facilitate shared learning, identify cross-ICSU opportunities, and report progress against the CORE20PLUS5 priorities through improved service delivery, access, and data quality.

Key workstreams are summarised in the table below.

| Strategy | Current projects |
|--|---|
| Core 20 24% of Islington and 34% of Haringey’s population live in the 20% most deprived neighbourhoods in England | The Equity Dashboard, launched in 2024, has been shared with service and admin leads via the Operational School. It disaggregates PTL and DNA data by ethnicity, deprivation, age, and gender—enabling services to identify disparities and tailor interventions to reduce inequalities and improve access. Work is underway to pilot projects in priority areas to address DNAs and cancellations. |
| Plus population groups experiencing poorer-than-average health access, experience and/or outcomes | Whittington provides multiple services which treat some of the most deprived patients in our communities, these include: <ul style="list-style-type: none"> • Sickle cell service • Integrated frailty service, proactive frailty service. • Prevention and management of type 2 diabetes in a deprived community in West Haringey- this project improved outcomes for patients. |

| Strategy | Current projects |
|--|--|
| <p>Reducing inequalities in maternity and neonatal services</p> | <p>Through the North Central London Local Maternity and Neonatal System (NCL-LMNS) the Whittington is committed to deliver on the joint Equity and Equality Action Plan. Key objectives are to:</p> <ul style="list-style-type: none"> • Reduce disparities in maternal and neonatal outcomes, especially for minoritised and marginalised groups. • Improve personalised care, access, and patient experience. • Strengthen workforce equity and cultural competence. • Enhance data quality, shared learning, and system-wide collaboration. |
| <p>Severe Mental Illness 22.5% of people aged 16+ have a common MH condition. One-in-three out-of-work benefit claims are due to mental illness</p> | <p>The Trust has established a Physical Health / Mental Health Working Group in partnership with North London NHS Foundation Trust, focusing on:</p> <ul style="list-style-type: none"> • Enhancing physical health input on mental health wards • Reviewing and planning service level agreements (SLAs) for dietetic support in mental health settings • Improving care pathways for pregnant individuals with mental health needs • Monitoring and enhancing care for mental health patients in emergency departments • Developing a joint smoking cessation post to reduce tobacco dependency among mental health inpatients |
| <p>Chronic Respiratory Disease Islington has higher than average mortality from respiratory diseases</p> | <p>The Pulmonary Rehab (PR) team have undertaken multiple projects to improve outcomes for patients with Chronic Obstructive Pulmonary Disease (COPD) including:</p> <ul style="list-style-type: none"> • Improved PR access for marginalized groups through data analysis, community engagement, translated materials, and increasing staff cultural competency. • Enhanced PR access for mental health patients by collaborating with inpatient and community MH teams, upskilling staff, establishing referral pathways, and offering flexible venue options. • Collaborated with Age UK Islington for case finding, promoted PR through carer networks, and conducted focus groups—leading to the PR team collecting data on personalised care needs. • For inclusion health groups the team developed a sustainable PR pathway through risk assessment, strategic partnerships (e.g., Arsenal, Groundswell), and co-produced resources. Upskilled staff across PR, addiction, and homelessness services. Achieved strong engagement (55%) among referred patients, especially from deprived areas, with outcomes comparable to standard PR. |

| Strategy | Current projects |
|---|---|
| <p>Address the increased burden of disease from cardiovascular disease</p> | <p>The Community Heart Failure Inequalities Service, triages heart failure patients across Haringey practices from the most deprived 20% of the population to improve outcomes and reduce readmissions.</p> |
| <p>Address the increased burden of disease from cancer</p> | <p>Whittington is participating in the Macmillan Reach Project: London Quality of Life and Personalised Cancer Care (2025–2027) is a three-year, Macmillan-funded initiative to co-develop inclusive, personalised cancer care for underserved communities in London. Aligned with the national guidance, it aims to improve quality of life and reduce health inequalities through tailored assessments and care planning.</p> <p>Further projects include:</p> <ul style="list-style-type: none"> • Improving early cancer diagnosis among seldom heard and health inclusion groups through tailored outreach and by addressing access barriers • Increasing survey participation within these communities to better understand their needs, experiences, and outcomes • Focusing on inclusive, personalised care to ensure equitable access and improved quality of life for LGBTQIA+ cancer patients |



6. Workforce



6.1 Workforce representation

The following information is displayed in order of protected characteristics.

Age

6-1: Workforce vs local demographic representation by age group

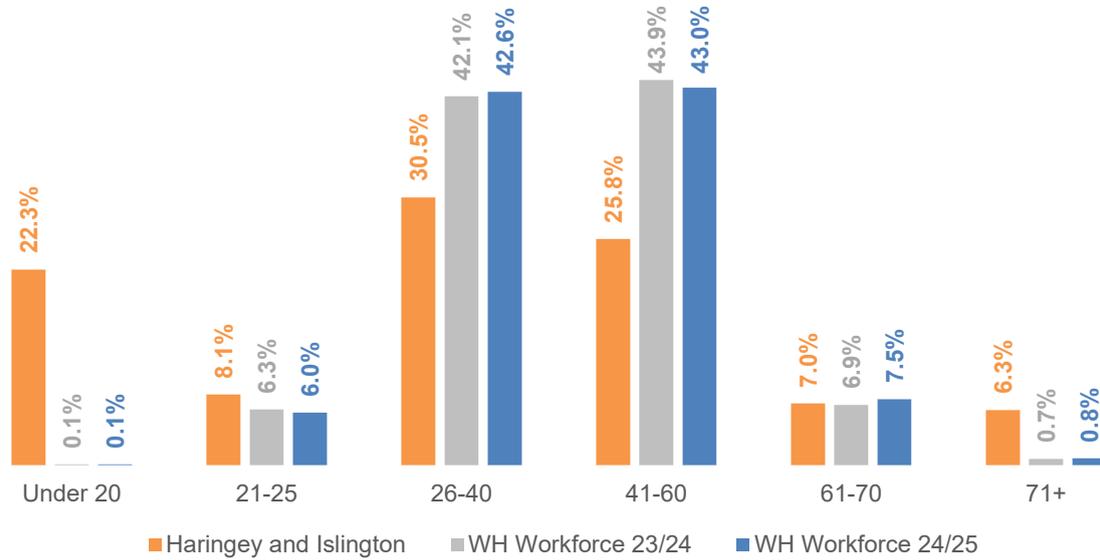


Chart 6-1 (above) shows the greatest proportion of the workforce is aged between 26-60 years old. The chart demonstrates compared to the local population, there is a greater representation within the workforce of staff aged between 26-60, broadly equal of staff aged 61-70 and lower of under 20-25 and 71+. Compared to 23/24 the age profile has been remained at similar levels with only a small increase in those aged 61-70.

Table 6-2 (over the page) shows a representation of the paybands by age, data in bold shows a greater-than-expected representation in the payband compared to the overall workforce.

6-2: Workforce representation within pay structures by age

| | Under 20 | 21-25 | 26-40 | 41-60 | 61-70 | 71+ |
|-------------------------------------|-----------------|--------------|--------------|--------------|--------------|--------------|
| <i>Band 2</i> | 0.2% | 3.5% | 22.9% | 50.9% | 19.3% | 3.1% |
| <i>Band 3</i> | 0.3% | 8.9% | 40.8% | 38.2% | 10.8% | 1.1% |
| <i>Band 4</i> | 0.3% | 6.1% | 35.8% | 47.2% | 9.8% | 0.8% |
| <i>Band 5</i> | | 13.9% | 52.4% | 28.7% | 4.5% | 0.5% |
| <i>Band 6</i> | | 7.5% | 49.3% | 36.9% | 5.6% | 0.7% |
| <i>Band 7</i> | | | 43.7% | 49.6% | 6.2% | 0.6% |
| <i>Band 8 - Range A</i> | | | 32.1% | 60.9% | 7.0% | |
| <i>Band 8 - Range B</i> | | | 26.1% | 70.1% | 3.7% | |
| <i>Band 8 - Range C</i> | | | 24.5% | 71.7% | 3.8% | |
| <i>Band 8 - Range D</i> | | | 16.7% | 77.8% | 5.6% | |
| <i>Band 9</i> | | | 15.4% | 76.9% | 7.7% | |
| <i>VSM</i> | | | 7.7% | 53.8% | 15.4% | 23.1% |
| <i>Medical - Training</i> | | 12.1% | 80.7% | 7.2% | | |
| <i>Medical - Middle Grade</i> | | | 49.6% | 46.0% | 4.4% | |
| <i>Medical - Consultants</i> | | | 18.8% | 70.7% | 9.6% | 0.8% |
| Age Group W/F Representation | 0.1% | 6.0% | 42.6% | 43.0% | 7.5% | 0.8% |

Table 6-2 (above) shows the greatest representation for most bands/grades are staff aged 41-60 compared to the overall workforce representation. In the majority of paybands there is a higher-than-expected representation of staff are within this age group.

Compared to the overall workforce representation:

- Staff aged under 20, have a higher-than-expected representation in pay bands 2-4, given current training routes and low levels of apprenticeship roles may account for this. There is no representation of this age group in any other paybands.
- Staff aged 21-25, have a high-than-expected representation in paybands 3-6 and medical training grades. There is no further representation in the pay bands, however, the typical training routes for several professional roles may account for this.
- Staff aged 26-40, have representation throughout all paybands/grades; this group has a higher-than-expected representation in bands 5-7 and make up most medical trainee grades and about half of medical middle grades, however, this age group has a lower-than-expected representation in all other pay bands/grades.
- Staff aged 41-60, have representation throughout all pay bands/grades; this group has a higher-than-expected representation in bands 2, 4, 7-VSM and medical consultant and middle grades. There is a slightly lower-than- expected representation in bands 5-6 and a much lower representation in medical training grades.
- Staff aged 61-70, have representation in most bands/grades except for medical training grades; this groups has a higher-than-expected representation in bands 2-4, 9, VSM and medical consultant grades, for all other paybands/grades there is a lower-than-expected representation.

- Staff aged 71+, have a higher-than-expected representation in bands 2-4, VSM and medical consultant grades; this group has a lower-than-expected representation in bands 5-7, and no further representation in other bands/grades.

Disability

Chart 6-3 (below) shows that 5.9% of Trust staff have declared that they have a disability/long-term health condition, compared to the local population of 14.8% suggests an underrepresentation in the Trust’s data. However, 28.2% of staff disability/long-term health condition status is unknown, meaning the true level of representation will not be known until the overall declaration rate improves. Compared to the workforce demographic the previous year, there was an increase of 1.5% of staff that declared a disability/LTHC, and 8.8% reduction of staff where their disability/LTHC status is unknown.

The 2024 NHS Staff Survey highlights that 18.2% of respondents highlighted that they have a disability/LTHC. This means there is a 12.3% difference between the NHS Staff Survey and local ESR data.

6-3: Representation of disability status WH Workforce and Haringey Population

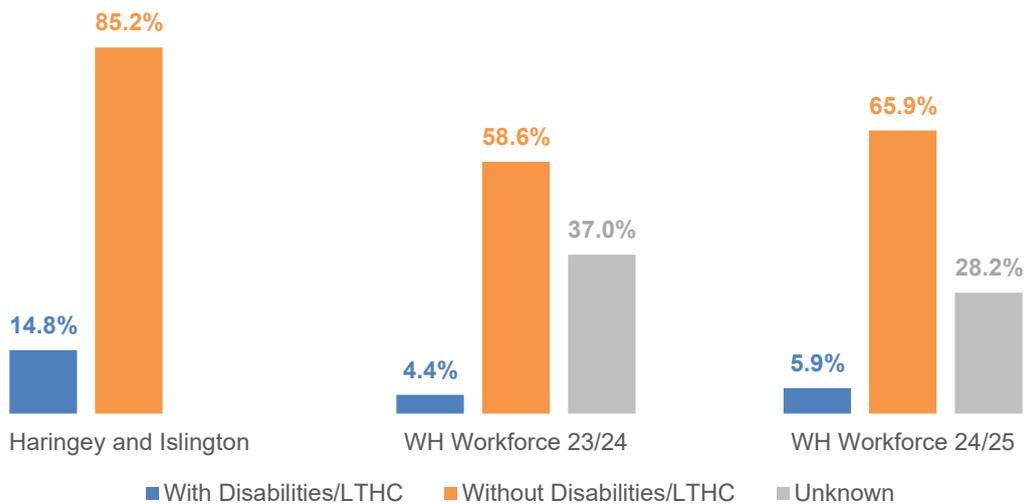


Table 6-4 shows the representation of staff by paybands by disability/long-term health condition status, the data in bold show a higher-than-expected representation compared to the overall workforce.

6-4: Representation of disability/LTC status in pay structures

| | Disabled/LTHC | No Disability/LTHC | Unknown |
|--|----------------------|---------------------------|----------------|
| <i>Band 2</i> | 3.5% | 58.3% | 38.2% |
| <i>Band 3</i> | 5.3% | 68.7% | 26.0% |
| <i>Band 4</i> | 5.0% | 63.8% | 31.2% |
| <i>Band 5</i> | 5.5% | 59.8% | 34.7% |
| <i>Band 6</i> | 7.4% | 69.0% | 23.6% |
| <i>Band 7</i> | 7.1% | 69.2% | 23.7% |
| <i>Band 8 - Range A</i> | 8.2% | 64.9% | 26.9% |
| <i>Band 8 - Range B</i> | 6.7% | 74.6% | 18.7% |
| <i>Band 8 - Range C</i> | 9.4% | 75.5% | 15.1% |
| <i>Band 8 - Range D</i> | 5.6% | 83.3% | 11.1% |
| <i>Band 9</i> | 7.7% | 69.2% | 23.1% |
| <i>VSM</i> | 0.0% | 38.5% | 61.5% |
| <i>Medical - Training</i> | 6.2% | 72.8% | 21.0% |
| <i>Medical - Middle Grade</i> | 3.5% | 51.3% | 45.1% |
| <i>Medical - Consultants</i> | 2.1% | 67.8% | 30.1% |
| Disability Status Representation in W/force | 5.9% | 65.9% | 28.2% |

Compared to the overall workforce representation of declared disability/long-term health conditions, 6-4 (above) shows that there is a higher-than-expected representation of staff with disabilities/long-term health conditions in bands 6-8C, 9 and medical training grades, a similar representation in bands 3-5 and 8D, a lower-than-expected representation in bands 2 and medical consultant and middle grades and no representation at VSM.

However, there is a high number of staff where their disability status is unknown, which may be hiding the true level of representation throughout the pay structures. But the level of declarations for disability/long-term health conditions continues to improve year-on-year.



Gender reassignment

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

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

Marriage and civil partnership

6-5: Representation of Marriage and Civil Partnership in the workforce and Haringey and Islington population

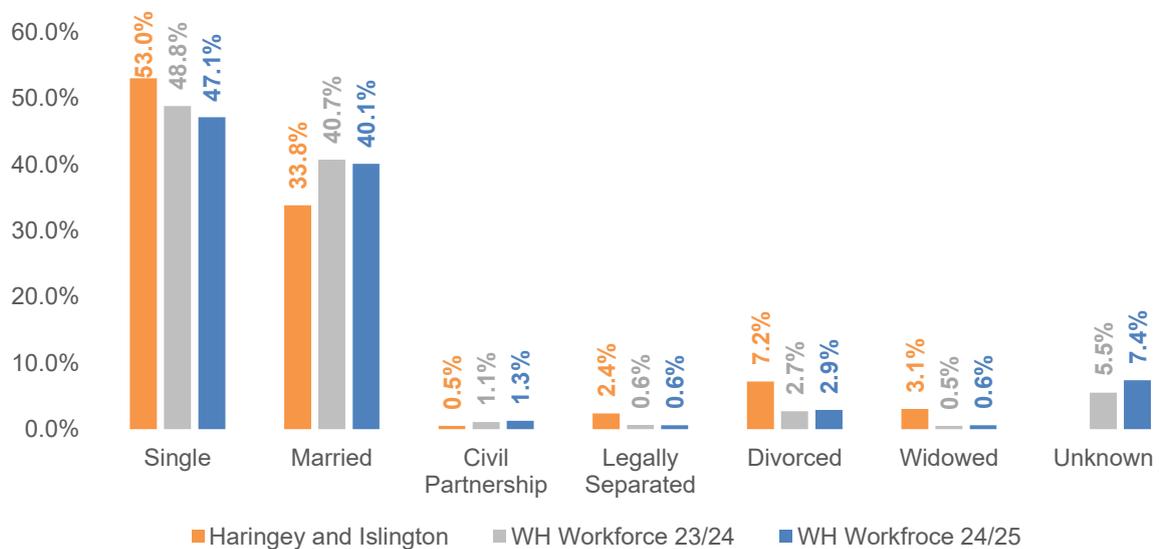


Chart 6-5 (above) shows that compared to the local demographic profile, there are a higher-than-expected proportion of staff who are either married or in a civil partnership. Compared to the representation in the workforce from the previous year this has remained at a similar level for staff who are married or in a civil partnership.

Table 6-6 (over the page) shows the representation of marriage and civil partnership within the paybands, data that is in bold shows a higher-than-expected representation compared to the overall workforce.

6-6: Representation of marriage and civil partnership in pay

| | Civil Partnership | Divorced | Legally Separated | Married | Single | Widowed | Unknown |
|---|-------------------|-------------|-------------------|--------------|--------------|-------------|-------------|
| <i>Band 2</i> | 2.4% | 3.3% | 0.5% | 45.8% | 39.4% | 0.7% | 8.0% |
| <i>Band 3</i> | 1.4% | 4.6% | 1.2% | 37.9% | 46.6% | 0.6% | 7.8% |
| <i>Band 4</i> | 1.3% | 3.7% | 0.3% | 34.7% | 49.9% | 1.1% | 9.0% |
| <i>Band 5</i> | 1.2% | 2.2% | 0.8% | 33.2% | 57.1% | 0.1% | 5.4% |
| <i>Band 6</i> | 1.3% | 1.7% | 0.7% | 35.1% | 54.7% | 0.6% | 5.9% |
| <i>Band 7</i> | 1.2% | 3.5% | 0.8% | 41.9% | 43.5% | 1.0% | 8.1% |
| <i>Band 8 - Range A</i> | 0.7% | 3.0% | 0.2% | 52.7% | 34.6% | 1.0% | 7.7% |
| <i>Band 8 - Range B</i> | 1.5% | 3.0% | | 60.4% | 28.4% | | 6.7% |
| <i>Band 8 - Range C</i> | | 7.5% | | 58.5% | 24.5% | | 9.4% |
| <i>Band 8 - Range D</i> | | 5.6% | | 72.2% | 16.7% | | 5.6% |
| <i>Band 9</i> | | 7.7% | | 53.8% | 30.8% | | 7.7% |
| <i>VSM</i> | | | | 69.2% | 7.7% | | 23.1% |
| <i>Medical - Training</i> | | 0.3% | 0.3% | 27.5% | 62.6% | | 8.2% |
| <i>Medical - Middle Grade</i> | | 4.4% | | 46.9% | 37.2% | 0.9% | 10.6% |
| <i>Medical - Consultants</i> | 0.8% | 1.7% | | 59.4% | 30.5% | | 7.5% |
| <i>Representation of Marital Status in W/force</i> | 1.3% | 2.9% | 0.6% | 40.1% | 47.1% | 0.6% | 7.4% |

Staff that are married: a lower-than-expected representation within paybands 3-6 and medical training grades and a higher-than-expected representation in paybands 2, 8a-9, VSM and consultant and non-consultant medical grades (majority of staff in these grades are married).

Staff that are in a civil partnership: have no representation in paybands 8c-9, VSM and medical training and middle grades, a similar representation or higher-than expected representation in paybands 2-6, 8B and lower-than expected in paybands 7-8A and medical consultants.

Pregnancy and maternity

Data is not reportable for this protected characteristic.

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

6-7: Representation of Ethnicity in WH Workforce and Haringey and Islington population

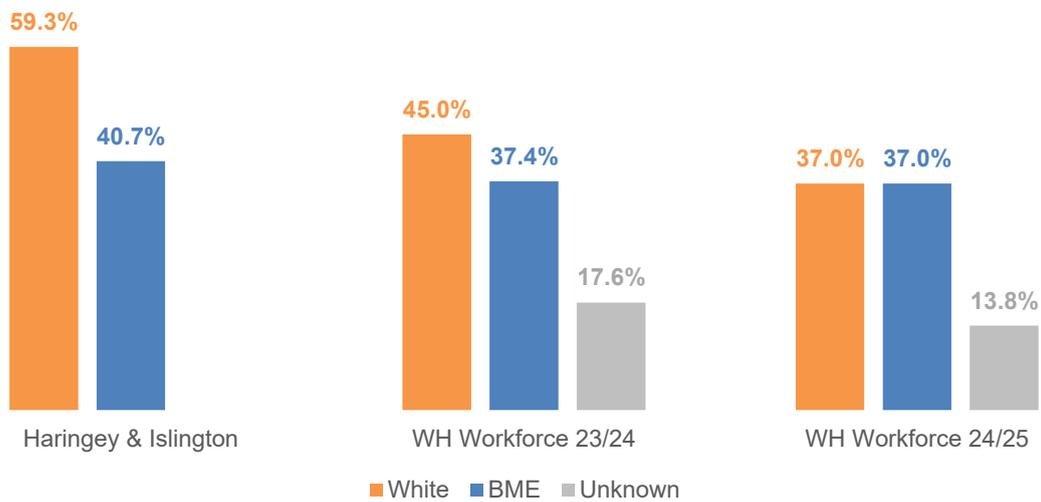


Chart 6-7 (above) shows that within the Trust’s workforce there is a higher-than expected representation of BME staff compared to the local population, a lower-than-expected representation of white staff. However, it should be noted that 13.8% of the workforce have not declared their ethnicity. Compared to the previous year, the workforce representation of white staff was similar, there was a 11.8% increase of BME staff and 3.8% reduction of staff where their ethnicity is not known.

6-8: Representation of ethnicity (detailed) in WH workforce vs Haringey and Islington population

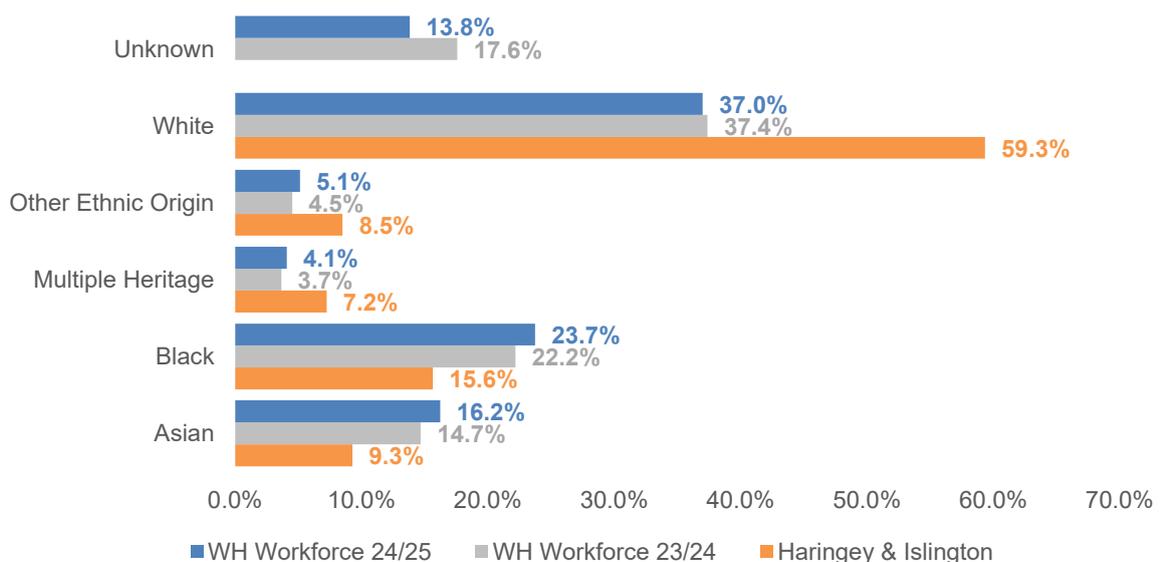


Chart 6-8 (previous page) shows a further breakdown of the BME category, compared to the local demographic, there is a higher-than-expected representation of Black and Asian staff and a lower-than-expected representation of staff from white, multiple heritage and other ethnic origins. The representation in the workforce compared to the previous year for all groups was relative similar with only nominal increases.

6-9: Representation of ethnicity in pay structures

| | Asian | Black | Multiple Heritage | Other Ethnic Group | White | Unknown |
|---|--------------|--------------|-------------------|--------------------|--------------|--------------|
| Band 2 | 10.1% | 51.9% | 2.4% | 5.9% | 14.2% | 15.6% |
| Band 3 | 17.7% | 35.7% | 4.3% | 6.0% | 26.0% | 10.4% |
| Band 4 | 12.6% | 30.6% | 5.4% | 3.2% | 33.1% | 15.0% |
| Band 5 | 18.0% | 25.0% | 2.8% | 6.0% | 23.2% | 24.9% |
| Band 6 | 18.7% | 22.6% | 4.5% | 7.4% | 36.5% | 10.3% |
| Band 7 | 10.7% | 18.0% | 3.7% | 4.8% | 53.8% | 9.1% |
| Band 8 - Range A | 11.7% | 15.2% | 4.0% | 3.0% | 57.2% | 9.0% |
| Band 8 - Range B | 10.4% | 14.2% | 3.7% | 3.7% | 63.4% | 4.5% |
| Band 8 - Range C | 15.1% | 13.2% | | 1.9% | 66.0% | 3.8% |
| Band 8 - Range D | 16.7% | 5.6% | 5.6% | | 72.2% | |
| Band 9 | 15.4% | | | | 53.8% | 30.8% |
| VSM | 7.7% | 7.7% | | | 53.8% | 30.8% |
| Medical - Training | 24.6% | 4.6% | 6.2% | 4.3% | 41.0% | 19.3% |
| Medical - Middle Grade | 37.2% | 3.5% | 7.1% | 2.7% | 20.4% | 29.2% |
| Medical - Consultants | 28.0% | 4.2% | 5.0% | 4.2% | 51.5% | 7.1% |
| Representation of Ethnicity in W/force | 16.2% | 23.7% | 4.1% | 5.1% | 37.0% | 13.8% |

Table 6-9 (above) shows the breakdown of paybands/grades by ethnicity, data in bold shows where there a higher-than-expected representation compared to the overall workforce.

Asian staff are represented throughout all paybands; they have a higher-than-expected representation in paybands 3, 5-6, 8D and all medical grades, and a lower-than-expected representation in all other paybands.

Black staff are represented throughout most paybands except Band 9; they have a higher-than-expected representation in paybands 2-5, a similar representation in band 6 but much lower-than-expected representation in all other bands.

Multiple heritage staff are represented throughout the majority of paybands; they have a higher-than-expected representation in pay bands, 3-4, 6, 8D and all medical grades, a similar representation in paybands 7-8B, a lower-than-expected representation in paybands 2 and 5 and no representation in paybands 8C, 9 and VSM.

Staff from other ethnic groups are represented throughout most paybands except senior management (paybands 8D-9 and VSM); there is a higher-than-expected representation in paybands 2-3 and 5-6, a similar representation in payband 7 and medical training and consultant grades and lower-than-expected representation in all other paybands.

White staff show a general pattern of increased representation as paybands increase – correlating in a decreasing representation from staff from a BME background as the seniority increases. Overall, there is a higher-than-expected representation in paybands 7-9, VSM and medical training and consultant grades, a similar representation in payband 6, and lower-than expected representation in all other paybands.

Nearly 14% of the workforce have not declared their ethnicity which will be masking the true level of representation of ethnicity within the workforce, however, this is an improving situation year-on-year.

Religion or belief

6-10: Representation of religion or belief in the workforce compared to Haringey and Islington

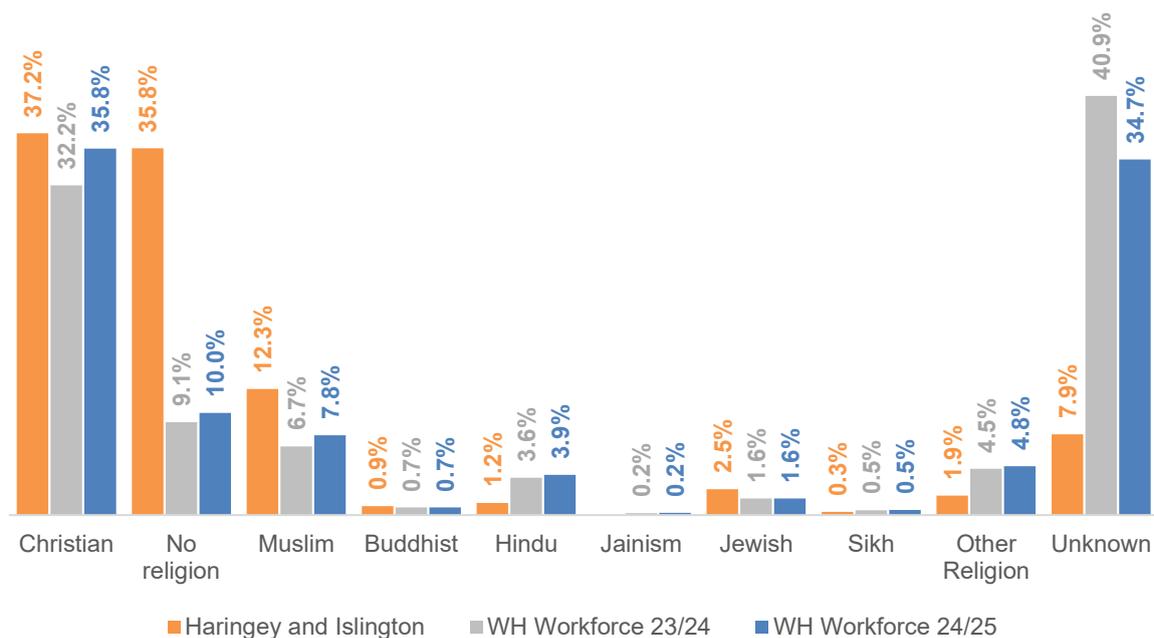


Chart 6-10 (above) shows, compared to the local population the workforce has a larger-than-expected representation of Hindu, Sikh and staff from other religions, a lower-than-expected representation of Christians, No religion, Muslims Buddhist, and Jewish staff. Compared to the previous year, the workforce has seen small increases in Christians, no religion, Muslims and a decrease in staff where their religion or belief is not known.

Jainism is not recorded as a separate religion in the 2021 Census.

6-11: Representation of religion or belief in pay structures

| | Atheism | Buddhism | Christianity | Hinduism | Islam | Jainism | Judaism | Other | Sikhism | Prefer not to say | Unknown |
|---|--------------|-------------|--------------|--------------|--------------|-------------|-------------|-------------|-------------|-------------------|--------------|
| <i>Band 2</i> | 0.7% | 0.2% | 34.2% | 1.4% | 8.0% | 0.2% | 0.2% | 2.4% | 0.2% | 20.0% | 32.3% |
| <i>Band 3</i> | 4.0% | 1.2% | 42.7% | 3.8% | 12.4% | 0.5% | 0.2% | 4.3% | 0.3% | 15.9% | 14.8% |
| <i>Band 4</i> | 5.9% | 0.2% | 38.1% | 3.7% | 7.7% | 0.2% | 0.5% | 6.2% | 0.2% | 19.4% | 18.1% |
| <i>Band 5</i> | 6.7% | 0.7% | 35.8% | 2.9% | 6.5% | | 0.9% | 4.1% | 0.5% | 25.3% | 16.8% |
| <i>Band 6</i> | 8.2% | 1.2% | 40.1% | 2.8% | 8.8% | 0.1% | 1.7% | 5.4% | 0.2% | 13.2% | 18.3% |
| <i>Band 7</i> | 14.6% | 0.6% | 37.0% | 2.8% | 4.8% | 0.2% | 2.4% | 5.9% | 0.2% | 16.9% | 14.5% |
| <i>Band 8A</i> | 15.4% | | 33.6% | 4.0% | 4.0% | 0.5% | 3.0% | 5.2% | 1.0% | 20.6% | 12.7% |
| <i>Band 8B</i> | 15.7% | | 43.3% | 2.2% | 2.2% | 0.7% | 1.5% | 9.7% | 0.7% | 15.7% | 8.2% |
| <i>Band 8C</i> | 15.1% | | 37.7% | 1.9% | 11.3% | | 3.8% | 3.8% | 3.8% | 11.3% | 11.3% |
| <i>Band 8D</i> | 16.7% | | 55.6% | 5.6% | | | | | 5.6% | 11.1% | 5.6% |
| <i>Band 9</i> | 7.7% | | 30.8% | 15.4% | | | | 7.7% | | 15.4% | 23.1% |
| <i>VSM</i> | 15.4% | | 15.4% | | | | | | | 23.1% | 46.2% |
| <i>Medical - Training</i> | 30.8% | 1.0% | 20.3% | 9.5% | 12.8% | 0.7% | 3.3% | 3.9% | | 14.8% | 2.0% |
| <i>Medical - Middle Grade</i> | 9.7% | 1.8% | 13.3% | 12.4% | 16.8% | | 2.7% | 2.7% | 2.7% | 21.2% | 16.8% |
| <i>Medical - Consultants</i> | 14.2% | 2.1% | 21.8% | 10.9% | 6.7% | | 5.4% | 1.7% | 1.3% | 16.7% | 19.2% |
| <i>Representation of R&B in W/force</i> | 10.0% | 0.7% | 35.8% | 3.9% | 7.8% | 0.2% | 1.6% | 4.8% | 0.5% | 18.2% | 16.5% |

Table 6-11 (above) shows a breakdown of representation of religion or belief in paybands, data that is in bold shows where there is a higher-than-expected representation compared to the overall workforce.

- Staff that are Atheist – are represented throughout the pay structures, there is a high-than-expected representation in paybands 7-8D, VSM and consultant and training medical grades; a similar representation in medical middle grades and a lower-than-expected representation in paybands 2-6 and 9.
- Staff that are Buddhist – have a higher-than-expected representation within paybands 3,5-6 and all medical grades, a similar representation in payband 7, a lower-than-expected representation within paybands 2 and 4 and no representation in bands 8a-9 and VSM.
- Staff that are Christian – are represented throughout all pay structures; they have a higher-than-expected or similar representation in paybands 2-8D, but lower-than-expected representation in payband 9, VSM and all medical grades.
- Staff that are Hindu – have a higher-than-expected representation in paybands 8A, 8D-9 and all medical grades, a similar representation in paybands 3-4, no representation in VSM and a lower-than-expected representation in paybands 2 and 5-7.

- Staff that are Muslim – have a greater-than-expected representation in paybands 2-3, 6, 8C and medical training and middle grades, a similar representation in paybands 4, and a lower-than-expected representation in paybands 5, 7-8B and no representation in paybands 8D-9 and VSM.
- Staff that are Jains – where represented (paybands 2-4, 6-8b and training medical grades) have an equal or higher-than-expected representation, however, are not represented in paybands 5,8c-9, VSM or consultant or non-consultant medical grades.
- Staff that are Jewish have a higher-than-expected or equal representation in paybands 6-8C and all medical grades, there is a lower-than-expected representation in paybands 2-5 and no representation in paybands 8D-9 and VSM.
- Staff with any other religion or belief – are represented throughout most paybands (except 8D and VSM), they have a higher-than-expected or similar representation in payband 3-8B and 9 and a lower-than- expected representation in bands 2, 8C and all medical grades.
- Staff that are Sikhs – are presented throughout the pay structures (except 9 and VSM), there is a higher-than-expected representation within paybands 5, 8A-8D and medical consultant and middle grades, there is a lower-than-expected representation in bands 2-4 and 6-7.
- There is a high proportion of staff that have not shared or chosen not to share their religion or belief, this particular evident in more junior agenda for change bands, VSM and medical grades.

Sex

6-12: Representation of sex in WH workforce v. Haringey & Islington population

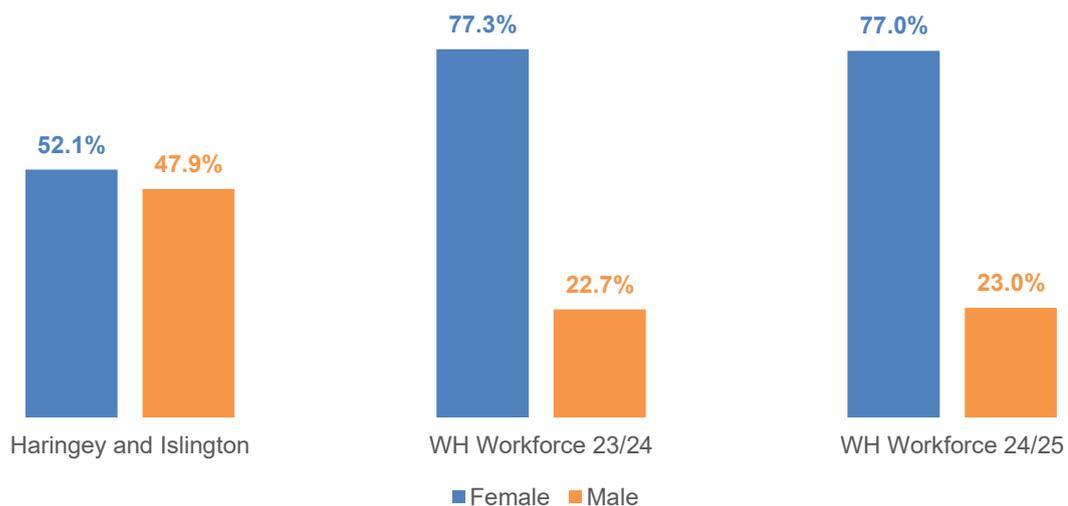


Chart 6-12 (above) shows that the Trust has a greater proportion of female staff than male staff in the workforce, which is consistent with the national NHS pattern of 77% female and 23% male. There is also a higher proportion of female staff (and lower of male) compared to the local demographics. Compared to the previous year, the representation of sex has remained similar.

6-13: Representation of sex in pay structures

| | Female | Male |
|----------------------------------|---------------|--------------|
| <i>Band 2</i> | 63.0% | 37.0% |
| <i>Band 3</i> | 74.4% | 25.6% |
| <i>Band 4</i> | 80.3% | 19.7% |
| <i>Band 5</i> | 84.8% | 15.2% |
| <i>Band 6</i> | 83.8% | 16.2% |
| <i>Band 7</i> | 82.4% | 17.6% |
| <i>Band 8 - Range A</i> | 78.1% | 21.9% |
| <i>Band 8 - Range B</i> | 65.7% | 34.3% |
| <i>Band 8 - Range C</i> | 67.9% | 32.1% |
| <i>Band 8 - Range D</i> | 66.7% | 33.3% |
| <i>Band 9</i> | 53.8% | 46.2% |
| <i>VSM</i> | 38.5% | 61.5% |
| <i>Medical – Training</i> | 58.0% | 42.0% |
| <i>Medical - Middle Grade</i> | 74.3% | 25.7% |
| <i>Medical – Consultants</i> | 61.9% | 38.1% |
| Gender W/F Representation | 77.0% | 23.0% |

Table 6-13 (above) shows the representation of sex in pay structures, data in bold shows a higher-than-expected representation compared to the overall workforce.

It is clear to see that female staff have an equal or higher-than-expected paybands 3-8A and medical middle grades, however, there is lower-than-expected representation in paybands 2, 8B-9, VSM and medical training and consultant grades. There is an inverse pattern for male staff. Overall women are overrepresented in lower and middle paybands, and male staff are overrepresented at middle and senior grades.



Sexual orientation

6-14: Representation of sexual orientation in WH workforce and Haringey and Islington population

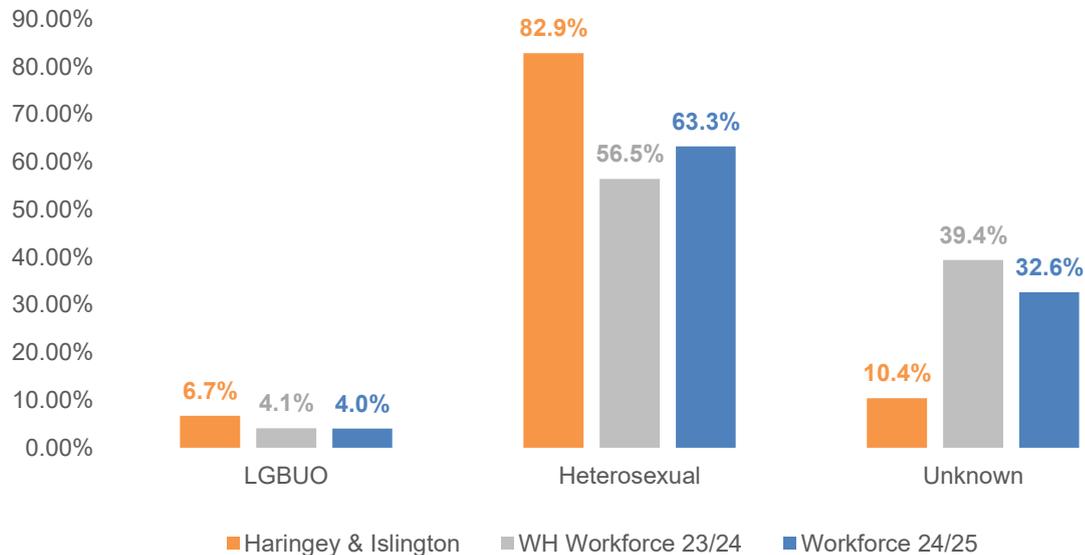


Chart 6-14 (above) show that compared to the local population, there is an underrepresentation staff that have declared their sexual orientation. Nearly 33% of the workforce have not declared their sexual orientation; until this improves it is not possible to have an accurate picture of representation within the workforce. Compared to the previous year there has been a decrease of unknown, increase in staff that have declared themselves to be heterosexual and LGBUO has remained similar.

Due to the low declaration numbers, non-heterosexual declared sexual orientations have been grouped together to form the LGBUO. These groups include lesbian, gay, bisexual, undecided and other.



6-15- Representation of sexual orientation in pay structures

| | LGBUO | Heterosexual | Prefer not to say | Unknown |
|-------------------------------|--------------|---------------------|--------------------------|----------------|
| <i>Band 2</i> | 1.7% | 43.2% | 22.6% | 32.5% |
| <i>Band 3</i> | 1.7% | 67.8% | 14.5% | 16.0% |
| <i>Band 4</i> | 3.7% | 61.0% | 16.6% | 18.7% |
| <i>Band 5</i> | 3.7% | 55.6% | 23.8% | 16.9% |
| <i>Band 6</i> | 3.4% | 66.4% | 11.7% | 18.5% |
| <i>Band 7</i> | 4.2% | 68.0% | 13.2% | 14.6% |
| <i>Band 8 - Range A</i> | 6.5% | 64.4% | 16.4% | 12.7% |
| <i>Band 8 - Range B</i> | 8.2% | 71.6% | 12.7% | 7.5% |
| <i>Band 8 - Range C</i> | 3.8% | 75.5% | 9.4% | 11.3% |
| <i>Band 8 - Range D</i> | 22.2% | 66.7% | 5.6% | 5.6% |
| <i>Band 9</i> | 7.7% | 61.5% | 7.7% | 23.1% |
| <i>VSM</i> | | 30.8% | 23.1% | 46.2% |
| <i>Medical - Training</i> | 10.5% | 78.7% | 9.2% | 1.6% |
| <i>Medical - Middle Grade</i> | 2.7% | 62.8% | 17.7% | 16.8% |
| <i>Medical - Consultants</i> | 3.8% | 65.3% | 11.3% | 19.7% |
| <i>Grand Total</i> | 4.0% | 63.3% | 15.8% | 16.8% |

Table 6-15 (above) shows the breakdown of representation of sexual orientation in pay structures, data that is highlighted shows where there is a higher-than-expected representation compared to the overall workforce.

LGBUO staff have a greater-than-expected representation in bands 7-8B, 8D-9 and training medical grades, a broadly equal level of representation in bands 4-6, 8C and medical consultants, a lower representation in bands 2-3 and medical middle grades and finally no representation at VSM.

Heterosexual staff have a broadly equal or greater-than-expected representation in paybands 3-4, 6-9 and all medical grades, and a lower-than-expected representation in bands 2, 5 and VSM grades. It should be noted that there is a high level of non-declaration within the workforce (nearly 33%), so the true picture of representation will not be seen until this reduces further.

6.2 Recruitment

This section reviews recruitment data from 2024/25; 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.

Age

6-16: Representation of age in Trust recruitment processes



Chart 6-16 (above) shows in conversion from application to shortlisting stages, there is a slight reduction in representation for candidates aged <20 to 39 (except in 25 where there is a larger reduction); for candidates aged 40+ there is an increase.

From conversion from shortlisted to appointment generally there is an increase in representation of most age groups except 25-34 where there is a reduction.

Disability

6-17: Representation of disability in Trust recruitment processes



Chart 6-17 (above) shows, the conversion from application to shortlisting stage there is a greater representation of applicants with disabilities/long-term health conditions and where their status is not known, and a lower for those with no disabilities/long-term health conditions.

When going from the shortlisted to appointment stage, there is a decrease of applicants with and without disabilities/long-term health conditions but an increase in those where their disability/long-term health conditions status is unknown.

Marriage and civil partnership

Data for this protected characteristic in recruitment was not available at the time of authoring this report.

Race and ethnicity

6-18: Representation of race in Trust recruitment processes



Chart 6-18 (above) shows in when progressing through application to shortlisted stages, all minority groups representation decreases while white and applicants whose ethnicity is unknown increases.

Conversion from application to shortlisting stage sees a decrease in Asian and Black candidates, but an increase in all other ethnic groups.

Sex

6-19: Representation of sex in Trust recruitment processes

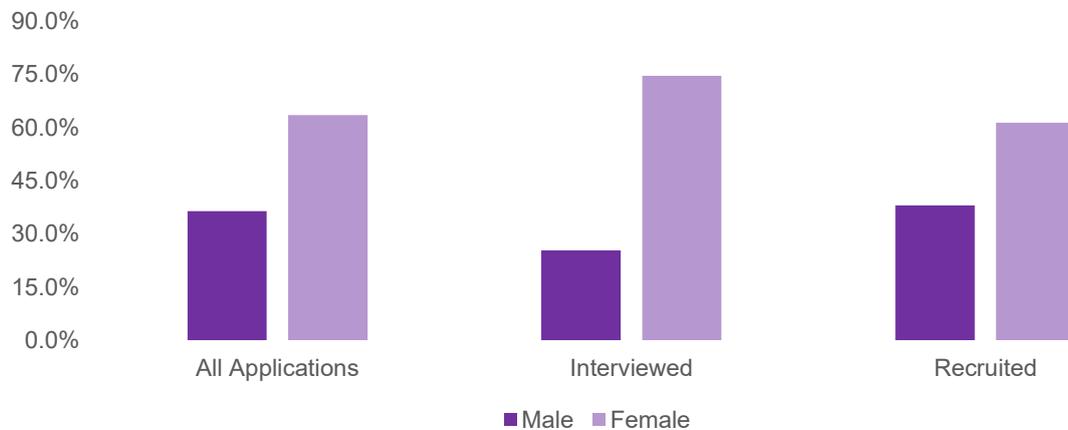


Chart 6-19 (above) shows conversion from application to shortlisting stages sees a decrease of male applicants and increase for female applicants; whereas from shortlisting to appointment stages sees an increase in male and decrease in female applicants.

Sexual Orientation

6-20: Representation of sexual orientation in Trust recruitment processes

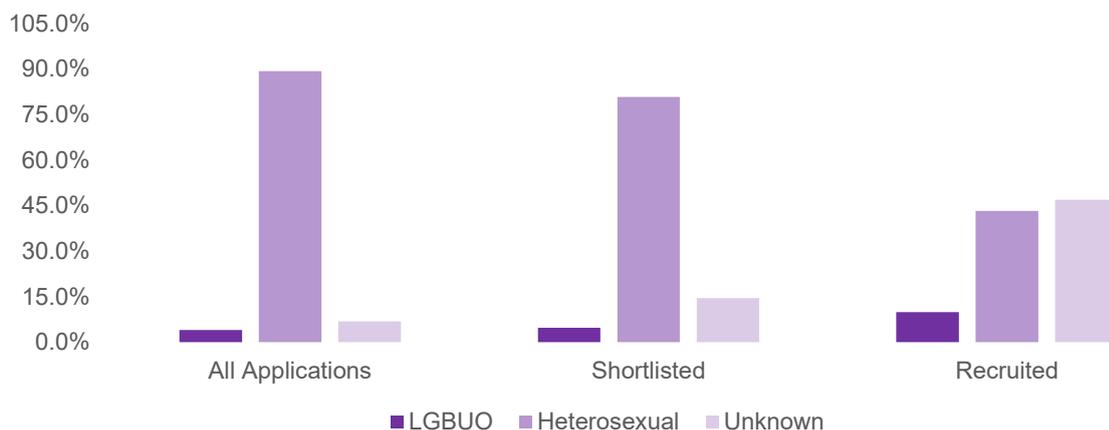


Chart 6-20 (above) shows conversion from application to shortlisting stage sees a decrease of heterosexual applicants and increase for LGBUO applicants; whereas from shortlisting to appointment stage sees an increase in LGBUO and decrease in heterosexual applicants.

6.3 Employee Relations Processes

Table 6-21 (below) provides an overview of the employee relations process that occurred within the Trust during 2023/24 and 2024/25.

| Employee Relations Process | 2023/24 | 2024/25 |
|---|----------------|----------------|
| <i>Disciplinary Processes</i> | 16 | 15 |
| <i>Grievance Processes</i> | 11 | 3 |
| <i>Bulling and Harassment Processes</i> | 4 | 7 |
| <i>Capability (Performance) Processes</i> | 4 | 8 |

Recording of employee relations:

- Those who are under a process – disciplinary and capability
- Those who have made a complaint – grievances and bullying & harassment

The following sections review the demographical breakdown in representation compared to the workforce.

Age

6-22: Representation of age within employee relations processes compared to the overall workforce representation

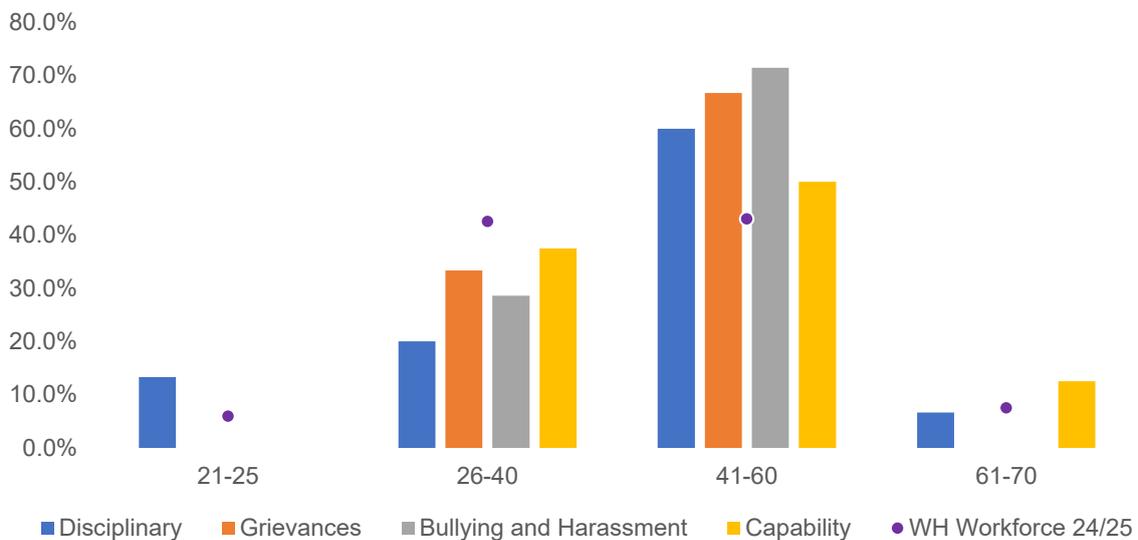


Chart 6-22 (above) shows that only staff aged between 21-70 were involved in employee relations cases. Compared to the overall representation of the workforce:

- Those aged between 21-25 are only involved in disciplinary processes, there is an overrepresentation of this age group for this process.
- Those aged between 26-40 are involved in all types of employee relations cases and the proportional representation within those processes is lower.
- Those aged 41-60 are involved in all employee relations processes, and they are overrepresented in all processes.

- Those aged between 61-70 are only involved in disciplinary and capability processes

Disability

6-23: Representation of disability status within employee relations processes compared to the overall workforce representation

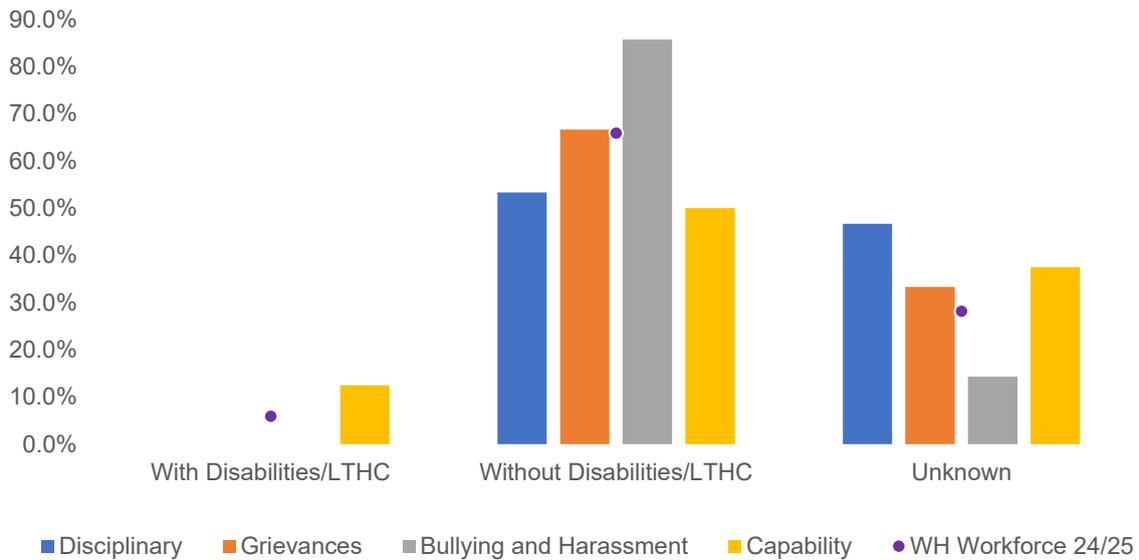


Chart 6-23 (above) shows staff with a disability or long-term health condition are only represented in capability processes which they are overrepresented in. Staff without a disability or long-term health condition are represented in all employee relations processes, with a proportional or lower presentation in disciplinaries, grievances and capability, and an overrepresentation in bullying and harassment.



Marriage and civil partnership

6-24: Representation of staff that are married or in a civil partnership within employee relations processes compared to the overall workforce representation

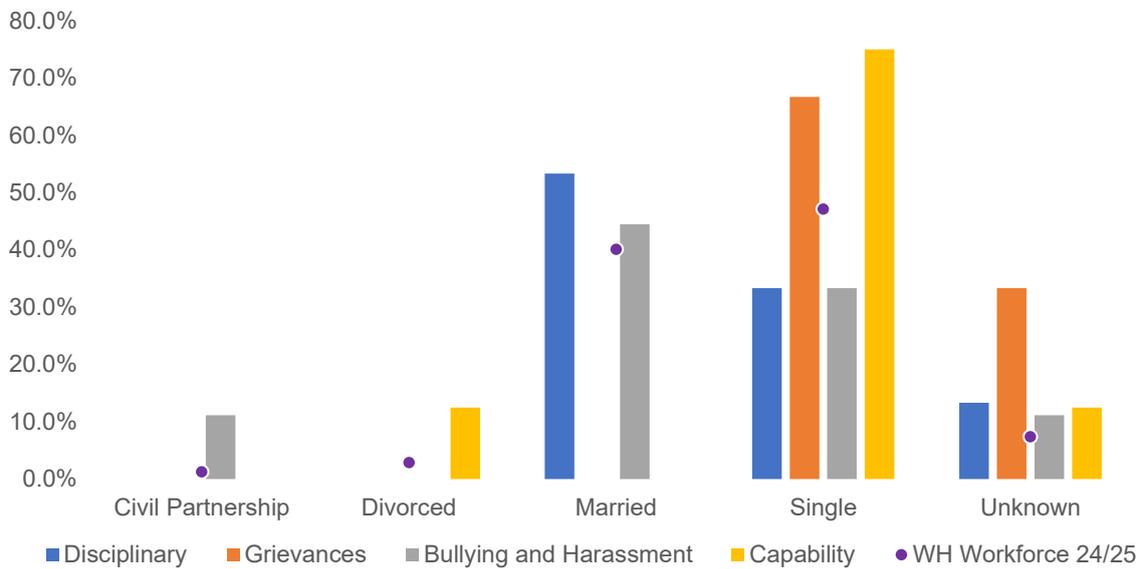


Chart 6-24 (above) shows that staff in a civil partnership are involved in bullying and harassment processes and are overrepresented; staff that are married are only involved in disciplinary and bullying & harassment processes which they are overrepresented in.

Race and ethnicity

6-25: Representation of staff by race/ethnicity within employee relations processes compared to the overall workforce representation

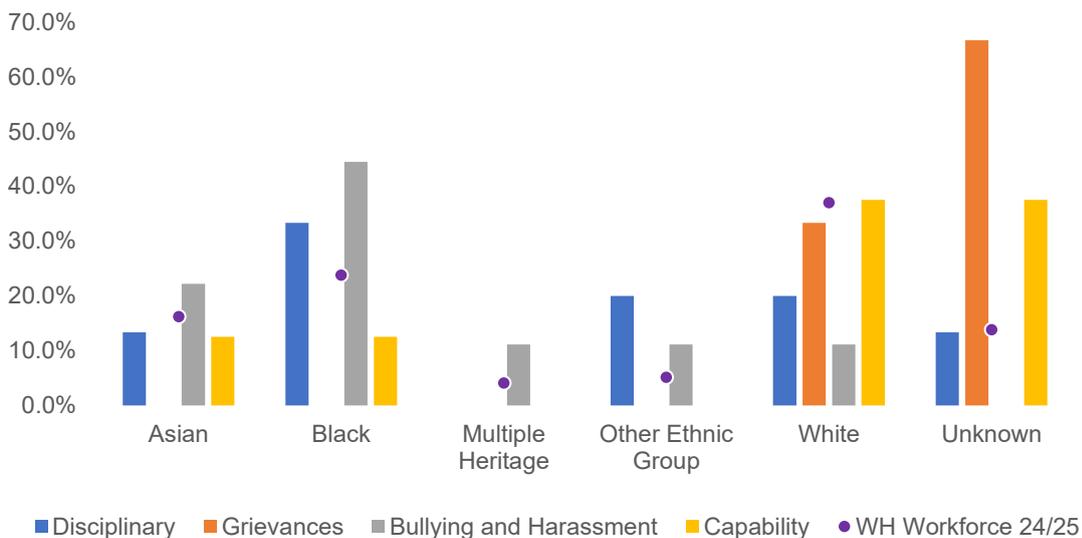


Chart 6-25 (above) shows:

- Asian staff are represented in disciplinary, bullying & harassment and capability processes, they are overrepresented in bullying and harassment cases.
- Black staff are represented in disciplinary, bullying & harassment and capability processes, they are overrepresented in disciplinary and bullying & harassment cases.
- Staff from multiple heritage backgrounds are represented in bullying and harassment processes, which they are overrepresented.
- Staff from other ethnic backgrounds are represented in disciplinary and bullying & harassment processes, they are overrepresented in disciplinary and bullying & harassment cases.
- White staff are overrepresented in all types of employee relations processes, they are only slightly overrepresented in capability processes.
- Overall, all staff from BME backgrounds are overrepresented in bullying and harassment and some in disciplinary processes. There is a sizable proportion of staff where their race/ethnicity is not known, which may be masking the true level of representation.

Religion or belief

6-26: Representation of staff by religion or belief within employee relations processes compared to the overall workforce representation

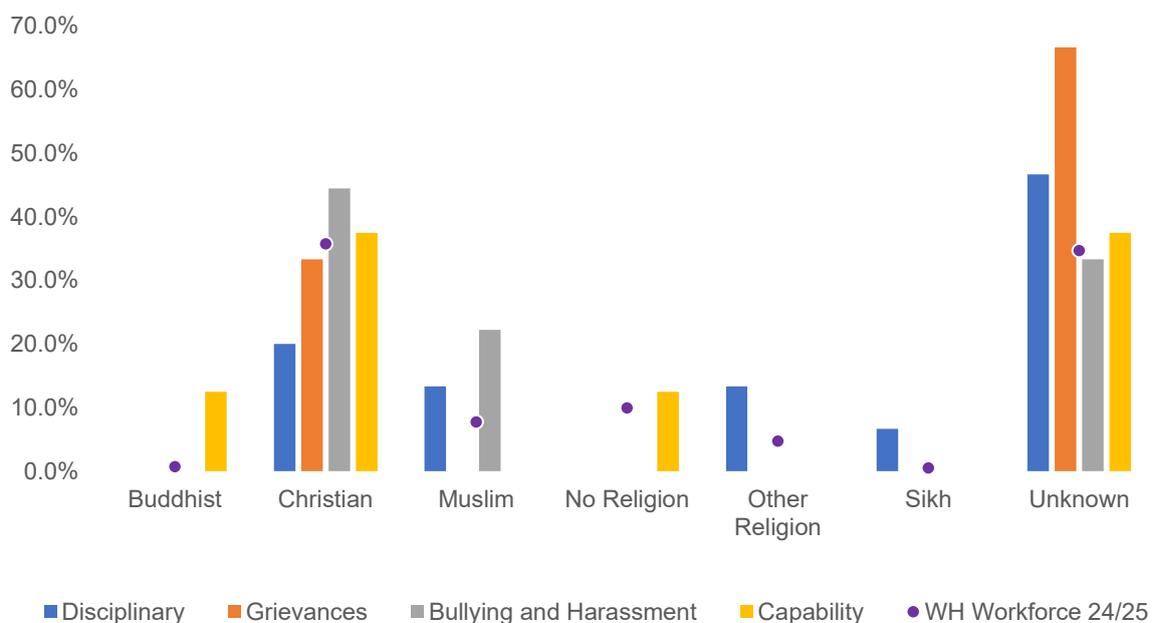


Chart 6-26 (above) shows Christians (the majority group) are impacted by all types of

employee relations processes and are overrepresented in bullying & harassment and capability processes. Minority groups that are represented in employee relations processes are overrepresented, this includes, Buddhists with capability, Muslims with disciplinary and bullying & harassment, those with no religion with capability, those with other religions/beliefs and Sikhs with disciplinary.

With nearly 35% the workforce who have not shared their religion or belief, the true picture of representation in employee relations cannot be seen till this improves. Throughout all employee relations process between 33-67% of those involved have not declared their religion or belief. The percentage of staff that have not declared their religion or belief has decreased by 6% since 23/24.

Sex

6-27: Representation of staff by sex within employee relations processes compared to the overall workforce representation

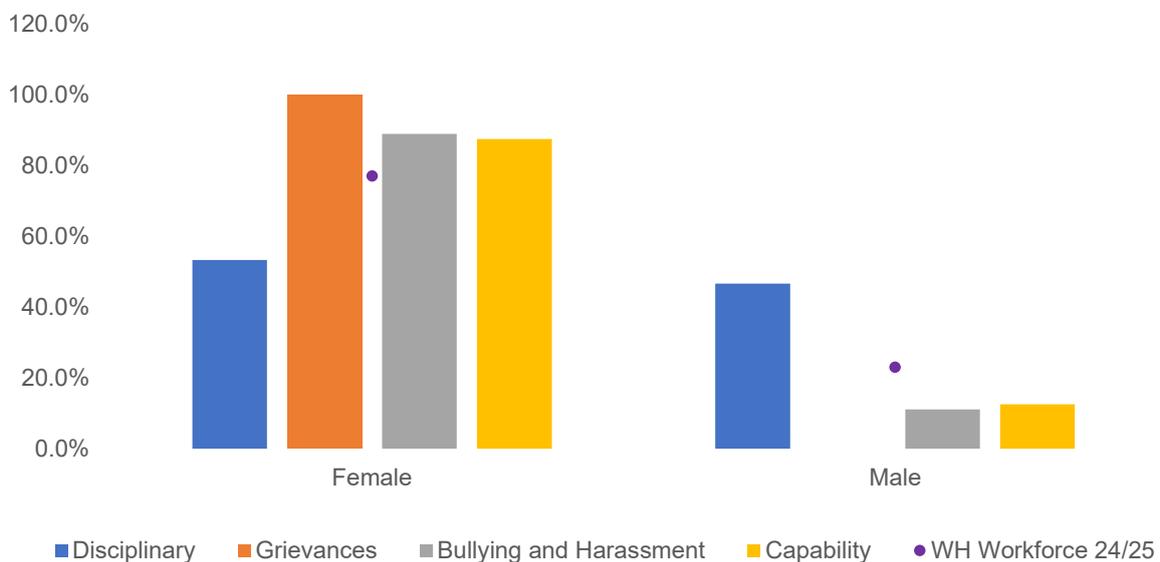


Chart 6-27 (above) shows that when compared to the overall workforce representation, that female staff have a lower representation in disciplinary processes and an overrepresentation in all other employee relations processes.

Male staff have an overrepresentation in disciplinary processes, but an underrepresentation in bullying & harassment and capability processes.

Sexual Orientation

6-28: Representation of staff by sexual orientation within employee relations processes compared to the overall workforce

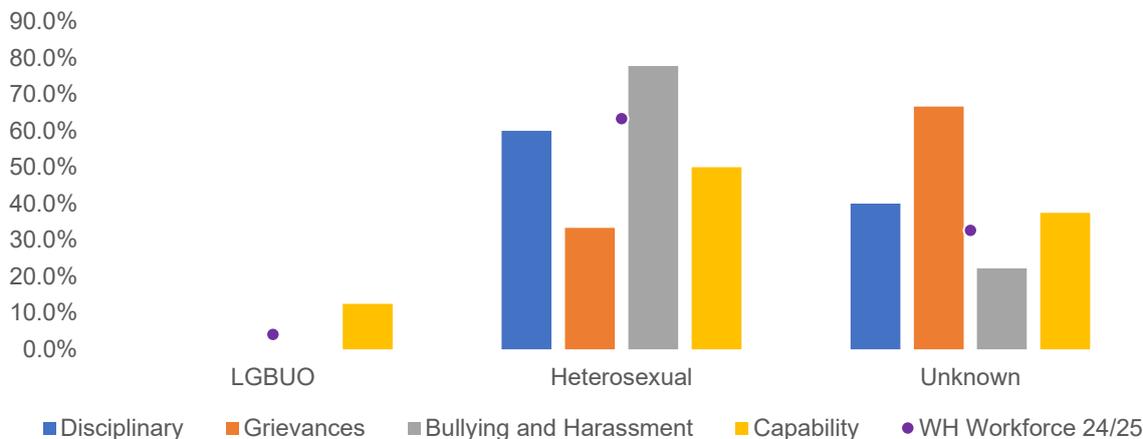


Chart 6-28 (above) shows when compared to the overall workforce representation, LGBUO staff have a greater representation in capability procedures. Heterosexual staff are represented in all employee relation processes but are only overrepresented in bullying and harassment processes.

However, with nearly 33% of the workforce not declaring their sexual orientation, between 22-67% in each employee relations processes sexual orientation is not known. As such this will be masking the true level of representation within the Trust's employee relations processes. The percentage of staff that have not declared their sexual orientation has decreased by 6.8% since 23/24.

6.4 Non-Mandatory Training and Continued Professional Development (CPD)

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

There are several budgets that fund non-mandatory or CPD training for Trust staff, a general workforce development budget that is administered by Learning and Development, an apprenticeship levy administered by Learning and Development and a CPD budget for nurses, midwives and allied health professionals.

During 2024/25:

- The general workforce development budget funded 1,063 non-mandatory/CPD placements for staff.
- The apprenticeship levy funded 38 staff to undertake vocational programmes.
- The Nursing, midwifery and AHP CPD budget funded 640 non-mandatory/CPD training placements for staff.

This section will review the demographic breakdown of the staff that undertook training, as both funds are administered separately, the funds will be shown separately for each protected characteristic.

Age

6-29: Access to non-mandatory/CPD from the general workforce development budget by age compared to workforce representation

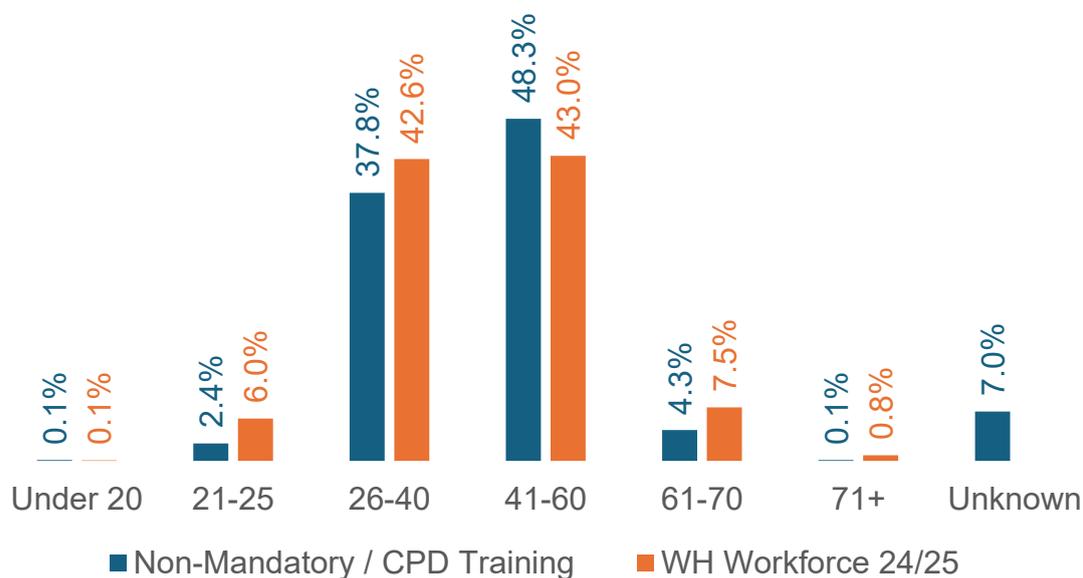


Chart 6-29 (above) shows that when compared to the overall workforce, there is a proportional representation of staff under 20, a higher-than-expected representation of staff aged 41-60 and a lower-than-expected representation of all other age groups in non-mandatory/CPD training.

There is an overall trend of underrepresentation in non-mandatory/CPD training for staff aged 61+.

6-30: Access to non-mandatory/CPD funded from the apprenticeship levy by age group

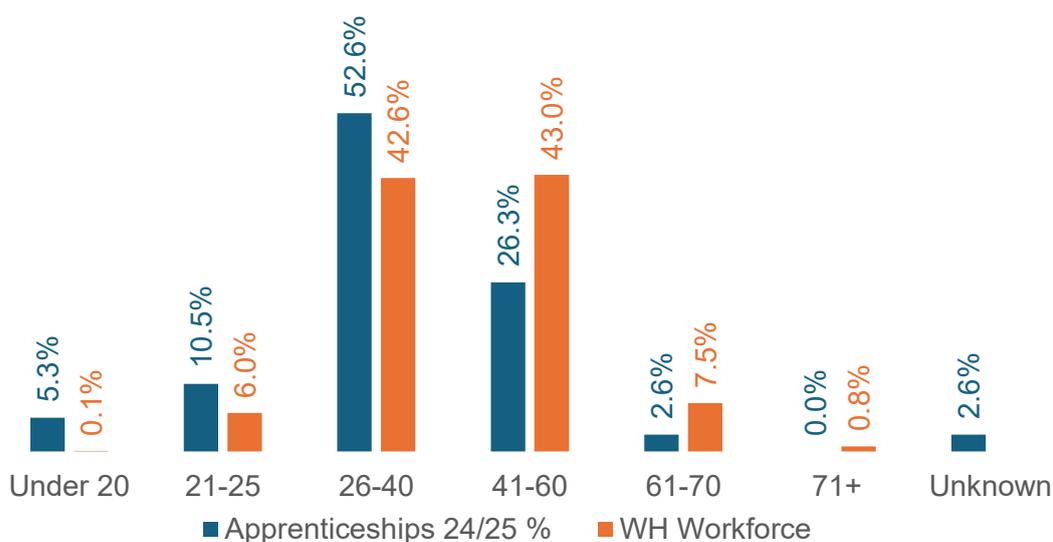


Chart 6-30 shows that a greater proportion of staff (compared to overall workforce representation) aged from under 20-40 undertook apprenticeships, while a lower proportion of staff aged 41+ undertook apprenticeships.

6-31: Access to non-mandatory/CPD funded from the nursing, midwifery and AHP CPD budget by age group.

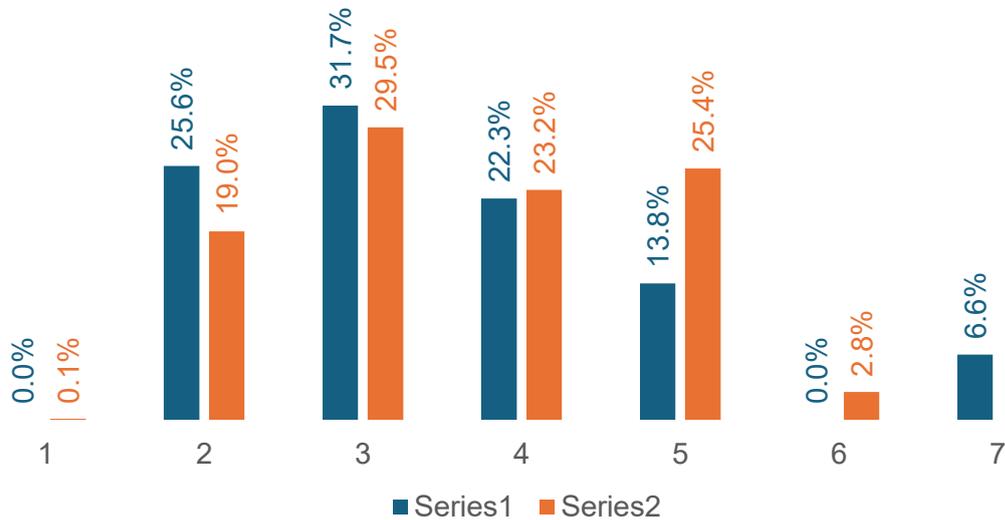


Chart 6-31 shows that compared to the overall workforce, there is a higher-than-expected representation of staff aged 21-40 attended non-mandatory/CPD training, a slightly-lower-than-expected representation of staff aged 41-50 and no representation from staff aged 16-20 and 66+.

Disability

C6-32: Access to non-mandatory/CPD funded by the general workforce development fund by disability/LTCH status.

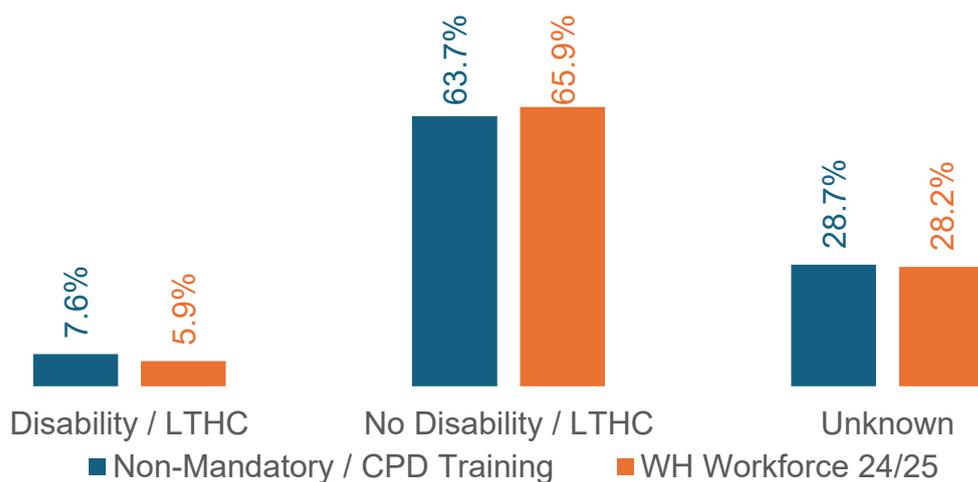


Chart 6-32 (above) shows in comparison to the overall workforce that there is a higher-than-expected representation of staff with disabilities/long-term health conditions undertaking non-mandatory/CPD training and a broadly proportional number of staff without disabilities/long-term health conditions. However, with near 29% of staff where their disability/long-term health condition status is unknown, it may be masking the true level of representation in training.

Data relating to staff undertaking apprenticeship training by disability/long-term health condition status was not available at the time of authoring this report.

6-33: Access to non-mandatory/CPD for nurses, midwives and AHPs by disability/long-term health condition status

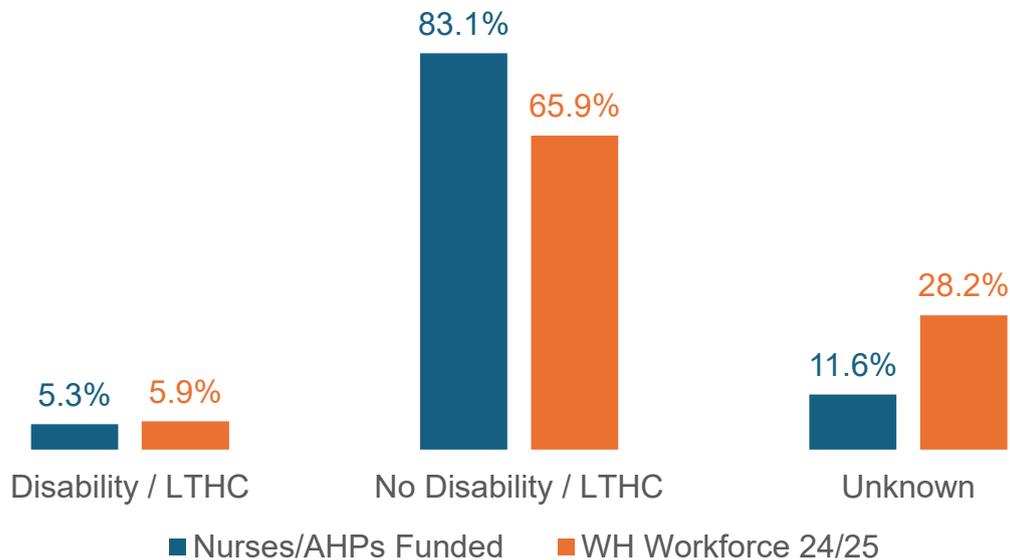


Chart 6-33 (above) shows compared to the overall workforce, there is a proportional number of staff with disabilities/long-term health conditions attending non-mandatory/CPD training, and a higher-than expected representation of staff without disabilities/long-term health conditions.

Marriage and civil partnership

6-34: Access to non-mandatory/CPD funded by the general workforce development budget by marriage and civil partnership.

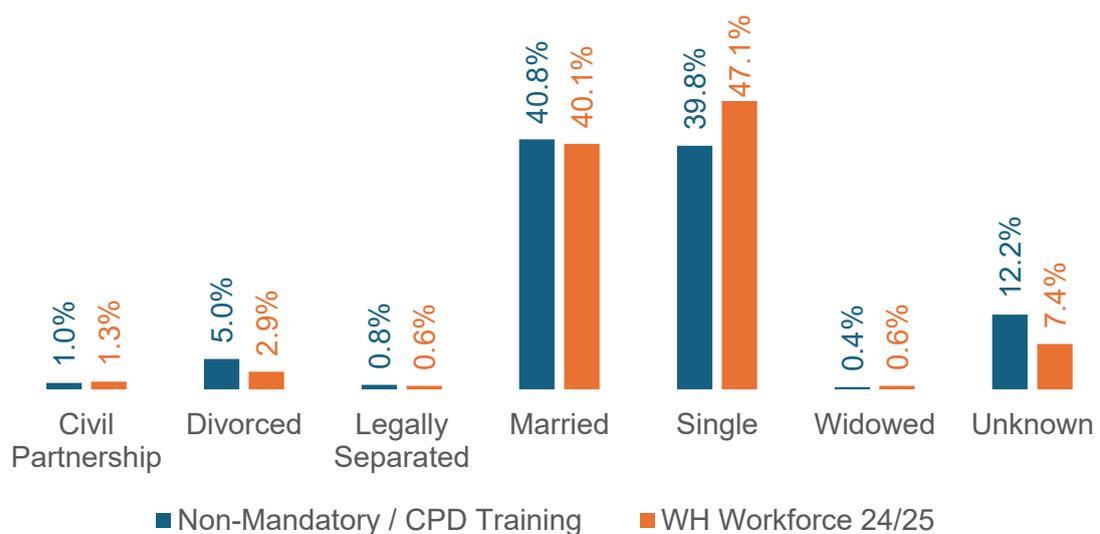


Chart 6-34 (previous page) shows compared to the overall workforce representation there is a broadly proportional representation of staff who are either married on in a civil partnership in attending non-mandatory/CPD training

Data regarding the Nursing, Midwifery and AHP CPD fund and apprenticeships broken down by marriage and civil partnership was not available at the time of authoring this report.

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

6-35: Access to non-mandatory/CPD funded by the general workforce development budget by race compared to the workforce representation



Chart 6-35 (above) shows compared to the overall workforce, within non-mandatory/CPD training there is a greater-than-expected representation of Black staff, a proportional representation of staff from ‘other’ ethnic groups and a lower-than-expected representation of Asian, mixed heritage and White staff. However, with nearly 20% of staff where their ethnicity is not known, the true representation within non-mandatory/CPD training may be being masked.

6-36: Access to non-mandatory/CPD funded by the apprenticeship levy by race compared to the workforce representation

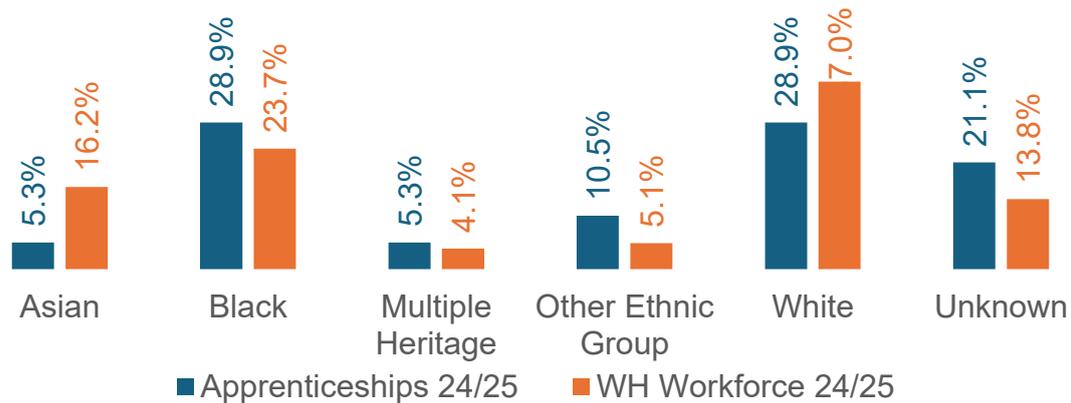


Chart 6-36 (above) shows in comparison to the overall workforce, there is a higher-than-expected representation for most minority groups (except Asian which is lower), and a lower-than-expected representation of white staff in non-mandatory/CPD training. However, with over 21% of those who started an apprenticeship ethnicity being unknown, the true picture of representation will be masked.

6-37: Representation of race/ethnicity in non-mandatory/CPD training funded by the Nursing, Midwifery and AHP CPD Fund

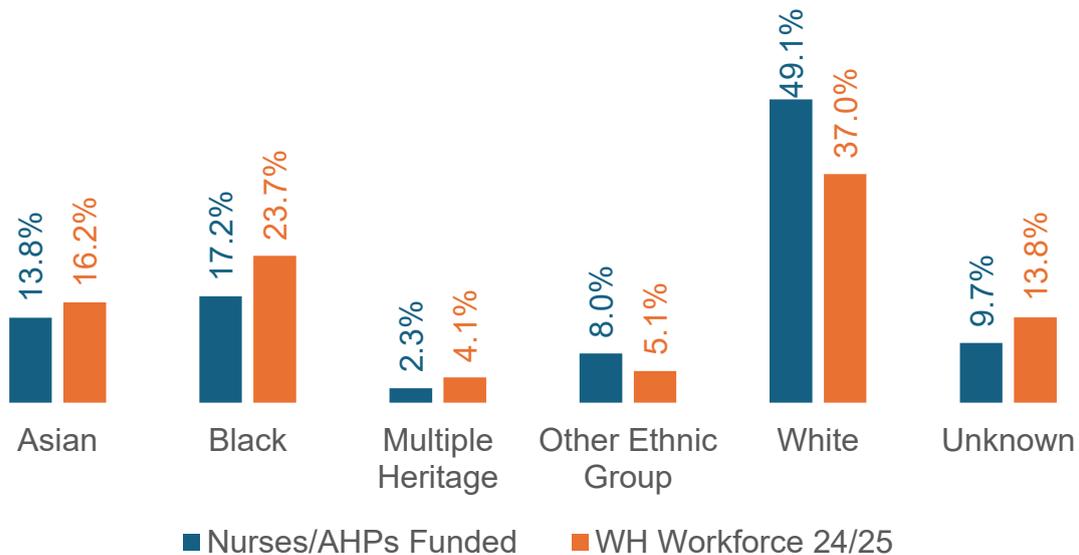


Chart 6-37 (above) shows that when compared to the overall workforce, there is a lower-than-expected representation of Asian, Black and multi heritage, there is a higher-than-expected representation of 'other' ethnic groups and white staff.

Religion or belief

6-38: Access to non-mandatory/CPD training funded by the general workforce development budget by religion or belief

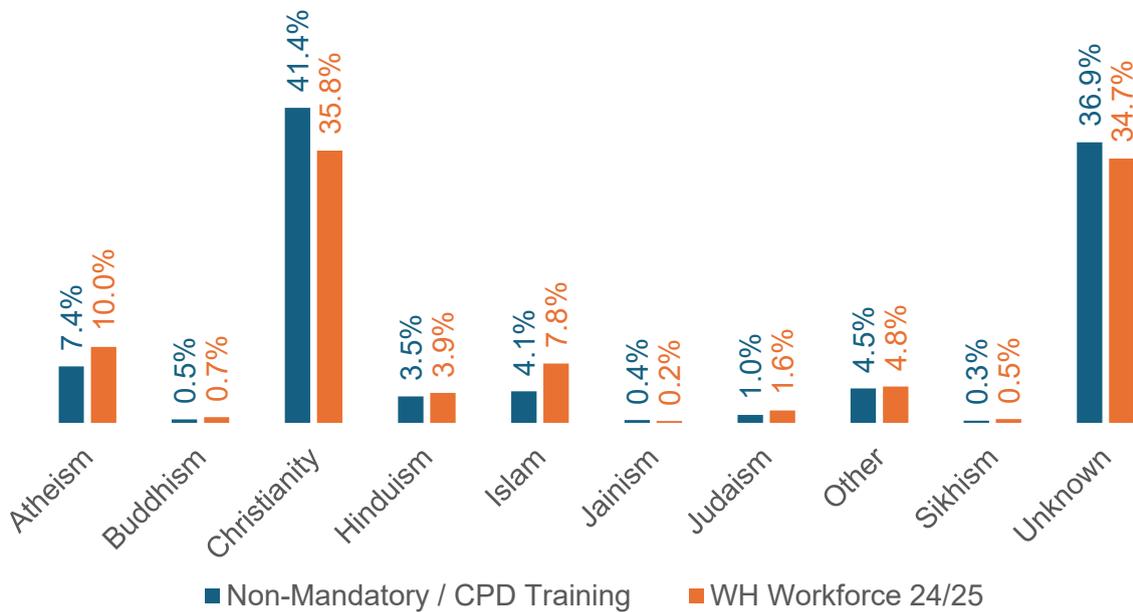


Chart 6-38 (above) shows compared to the overall workforce, there is a lower-than-expected representation of Atheist, Muslims, Jewish and Sikh staff, a broadly equal representation of Buddhist, Hindus and staff from other religions and finally a higher-than-expected representation of Christians and Jains within non-mandatory/CPD training activity. However, with nearly 37% of staff where their ethnicity is unknown, the true level of representation will be masked.

Data relating to staff starting an apprenticeship by religion or belief was not available at the time of authoring this report.

6-39: Representation of religion or belief in non-mandatory/CPD training funded by the Nursing, Midwifery and AHP CPD Fund.

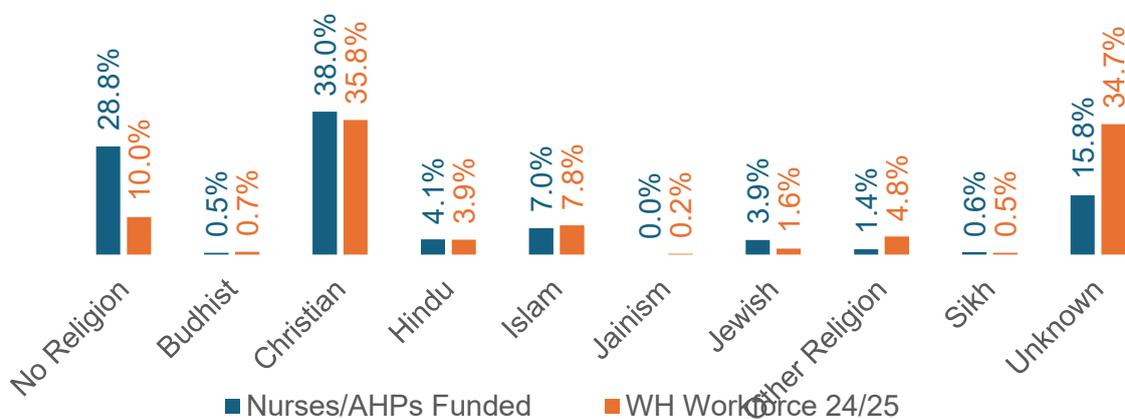


Chart 6-39 (above) shows that compared to the overall workforce, there is a lower-than-expected representation of Buddhist, Jains and staff from other religions, a broadly equal representation of Muslim and Sikh staff, and finally, a higher-than-expected representation of staff with no religion, Christian, Hindu and Jewish staff that have attended non-mandatory/CPD training. Nearly 16% of staff who have attended non-mandatory/CPD training have not declared their ethnicity, so this may be masking the true level of representation.

Sex

6-40: Access to non-mandatory/CPD training funded by the general workforce development fund

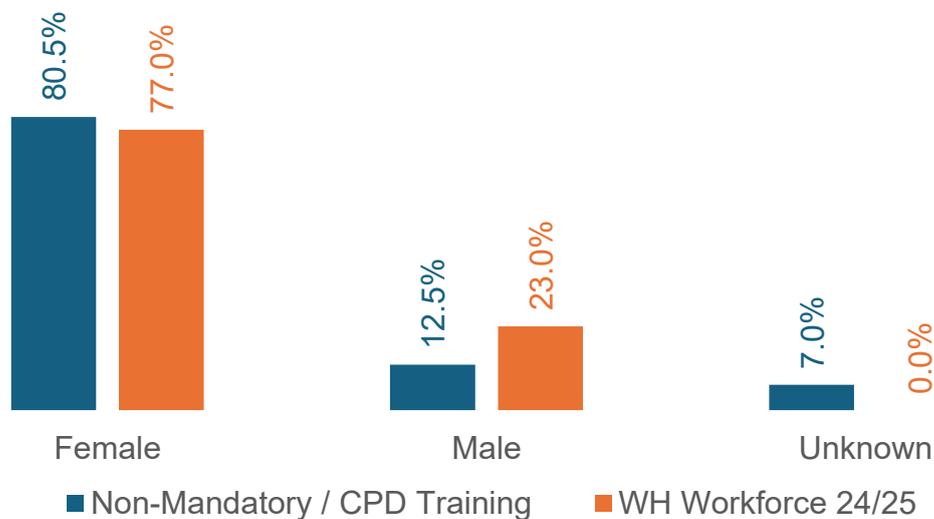


Chart 6-40 (above) shows compared to the overall workforce there is a slightly higher of female and lower-than-expected representation of male staff attending non-mandatory/CPD training.

6-41: Representation of staff starting apprenticeships by sex

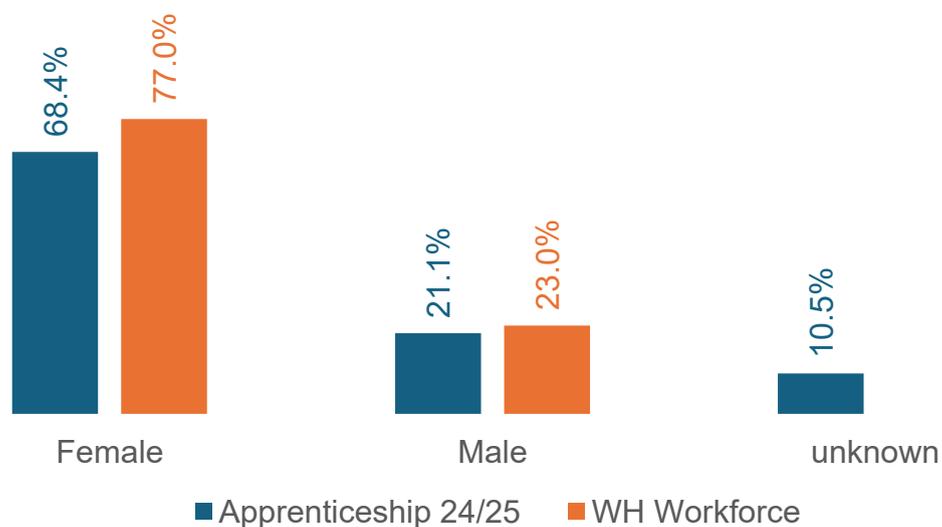


Chart 6-41 (above) shows compared to the overall workforce, there is a lower-than-expected representation of female and male (slight) in staff starting apprenticeships.

6-42: Representation of sex in non-mandatory/CPD training funded by the Nursing, Midwifery and AHP CPD Fund.

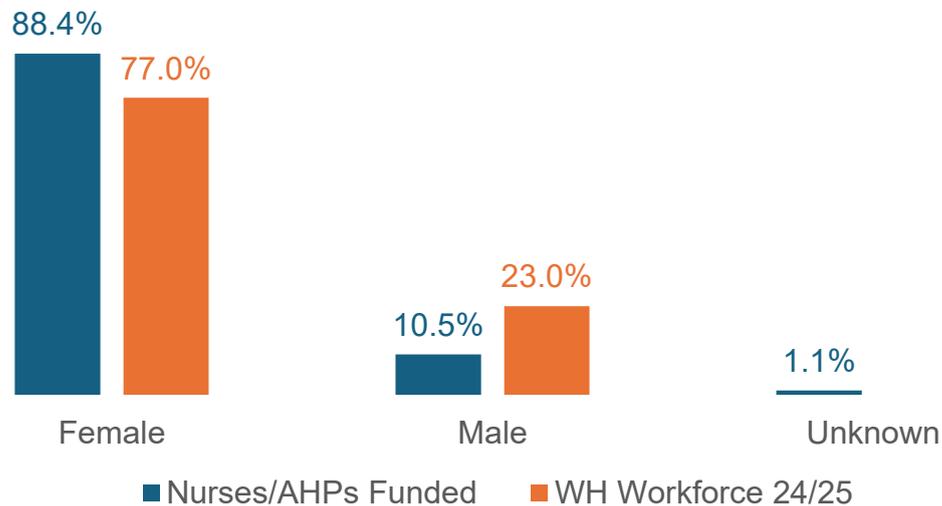


Chart 6-42 (above) shows compared to the overall workforce, that there is a higher-than-expected representation of female staff and a lower than-expected representation of male staff in non-mandatory/CPD training funded by the Nursing, Midwifery and AHP CPD Fund.

Sexual orientation

A breakdown of training activity funded by the general workforce development fund by sexual orientation was not available at the time of authoring this report.

6-43: Representation of sexual orientation in staff starting apprenticeships

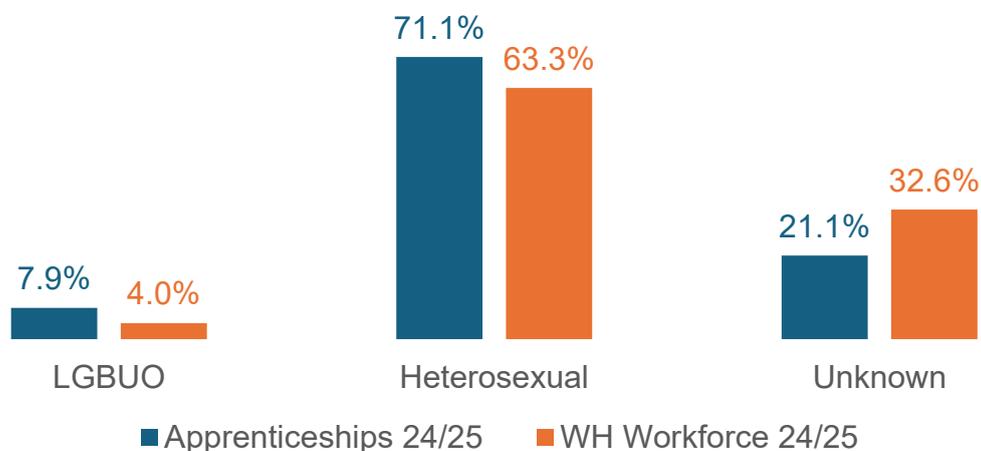


Chart 6-43 (above) shows compared to the overall workforce representation, there is a greater proportion of LGBUO and heterosexual staff starting apprenticeships. However, with over 20% of staff that have started apprenticeships did not declare their sexual orientation, the true level of representation may be masked.

6-44: Representation of sexual orientation for courses funded by the Nursing, Midwifery and AHP CPD Fund.

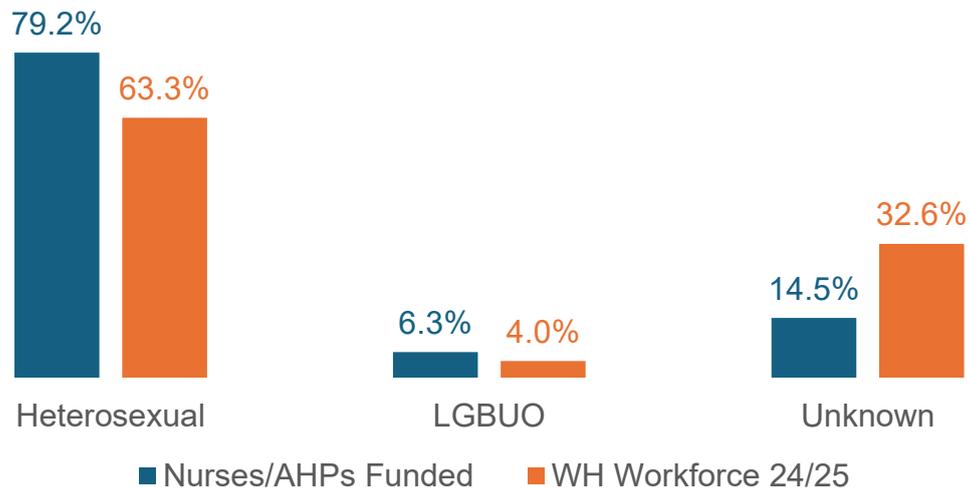


Chart 6-44 shows when compared to the overall workforce, that there is a higher-than-expected representation of heterosexual and LGBUO accessing training from this site. However, with nearly 15% of staff not declaring their sexual orientation, the true level of representation may be masked.

6.5 Contract types

Flexible working

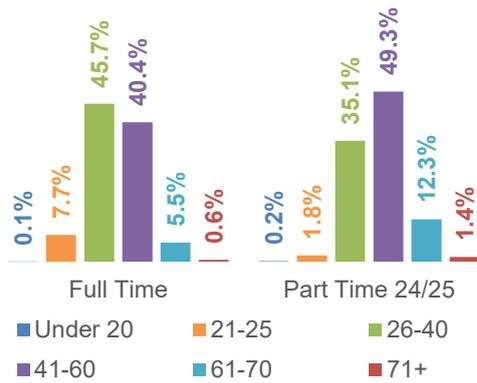
The Trust has many staff that benefit from flexible working, which helps staff balance the needs of their work and personal lives. Currently, flexible working requests are dealt with on a departmental basis, and information about those who have applied and been accepted for flexible working is not centrally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

In the future, flexible working will be recorded on the Trust’s Electronic Staff Records (integrated Human Resources and Payroll system) to enable reporting on flexible working arrangements.

Less than full-time (part time) contracts

The Trust has a range of staff that undertake their roles in less than full-time hours. Below will show information about the demographics of staff that work less than full-time hours.

Age:

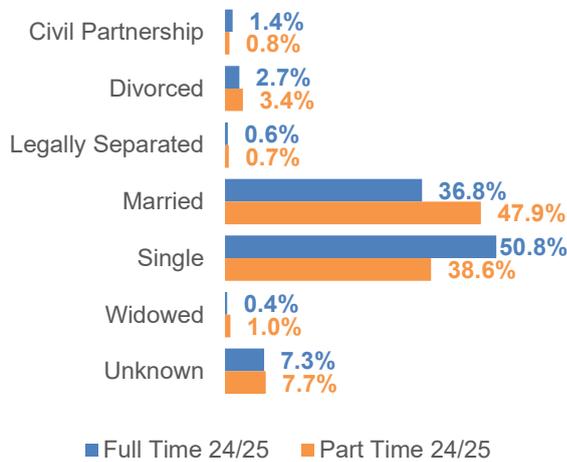


Disability/long-term health condition:

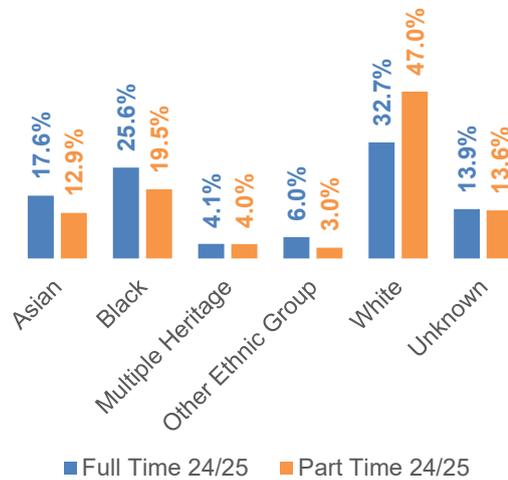
6.5% of part time staff have a disability/LTHC, whereas **5.7%** of full-time staff have a disability/LTHC

59.5% of part time staff have a do not have a disability/LTHC, whereas **68.6%** of full-time staff do not have a disability/LTHC.

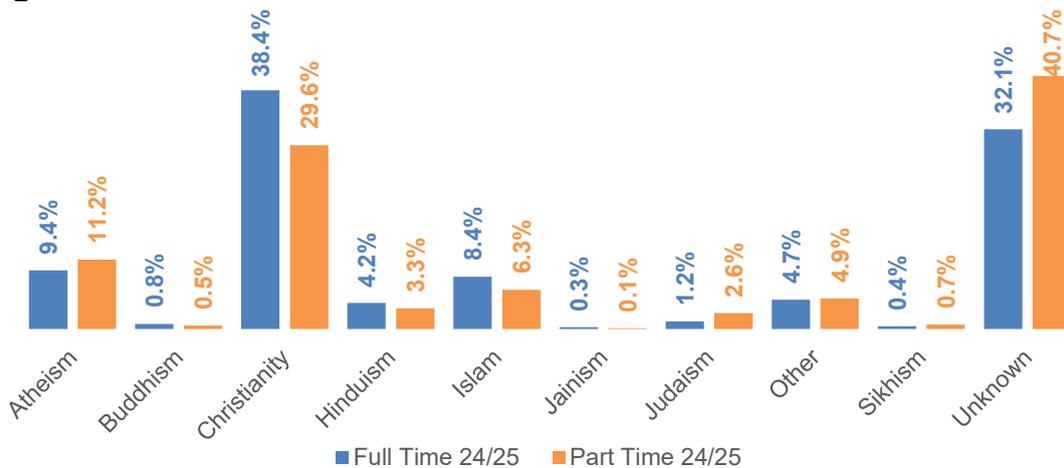
Marriage and Civil Partnership:



Race:



Religion or Belief:



Sex:

88.1% of less part time staff are female, whereas **72.3%** of full-time staff are female.

11.9% of part time staff are male, whereas **27.7%** of full-time staff are male.

Sexual Orientation:

3.0% of less part time staff are LGBUO, whereas **4.5%** of full-time staff are LGBUO.

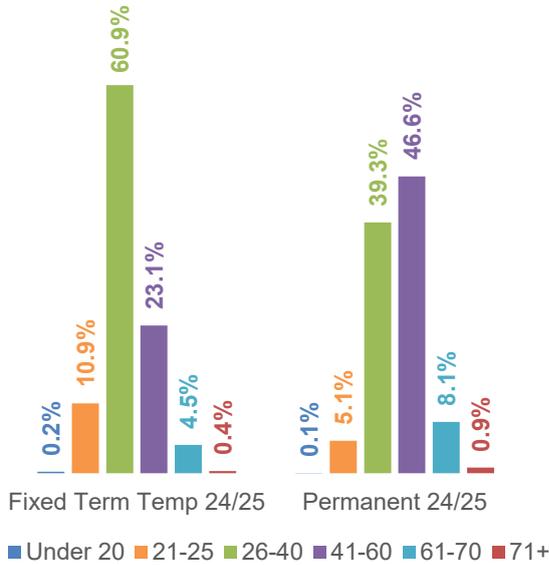
58.4% of part time staff are heterosexual, whereas **65.4%** of full-time staff are heterosexual.

From the data available, we can see when compared to the overall representation of the workforce:

- A higher proportion of staff aged 40+ are part time, while staff aged under 20 to 39 are more likely to work full time.
- Disabled staff are proportional more likely to work part time.
- Staff in civil partnerships are more likely to work full time, while married staff are more likely to be part time.
- BME staff are more likely to work full time, while white staff are more likely to work part time.
- Proportionally, more staff with no religion, Jewish, Sikh and from other religions are more likely to be part time, all other groups are proportionally more likely to be full time.
- Proportionally, female staff are more likely to be part time, and male staff are more likely to be full time.
- Both LGBUO and heterosexual staff are proportionally more likely to work full time.

Fixed-Term Contracts

Age:

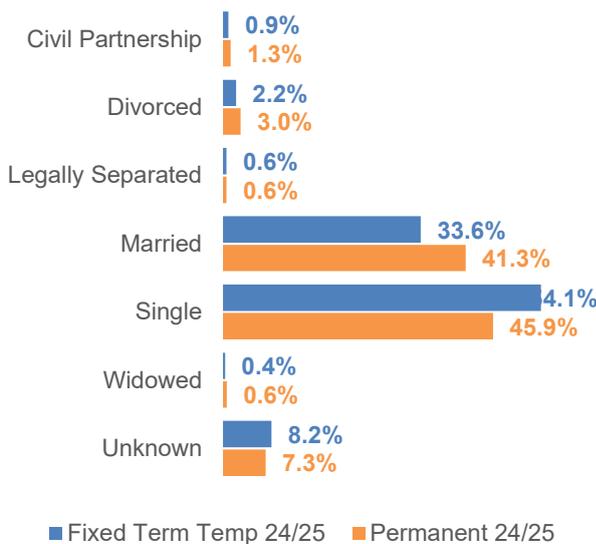


Disability/long-term health condition:

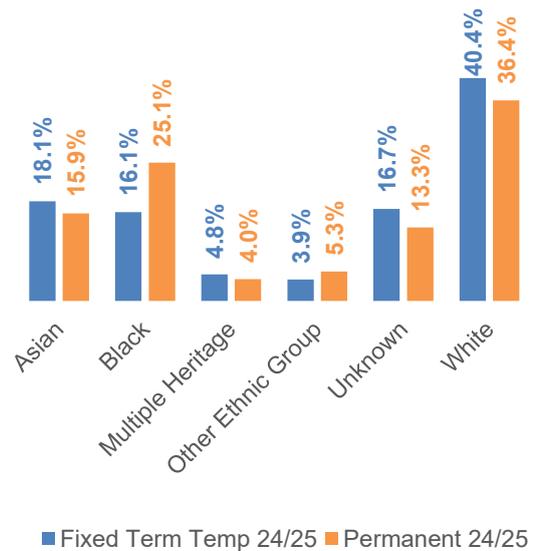
6.5% of fixed-term contracts are staff that have a disability/LTHC, whereas **5.8%** of permanent contracts are staff that have a disability/LTHC

72.7% of fixed-term contracts are staff that do not have a disability/LTHC, whereas **64.7%** of permanent contracts are staff that do not have a disability/LTHC.

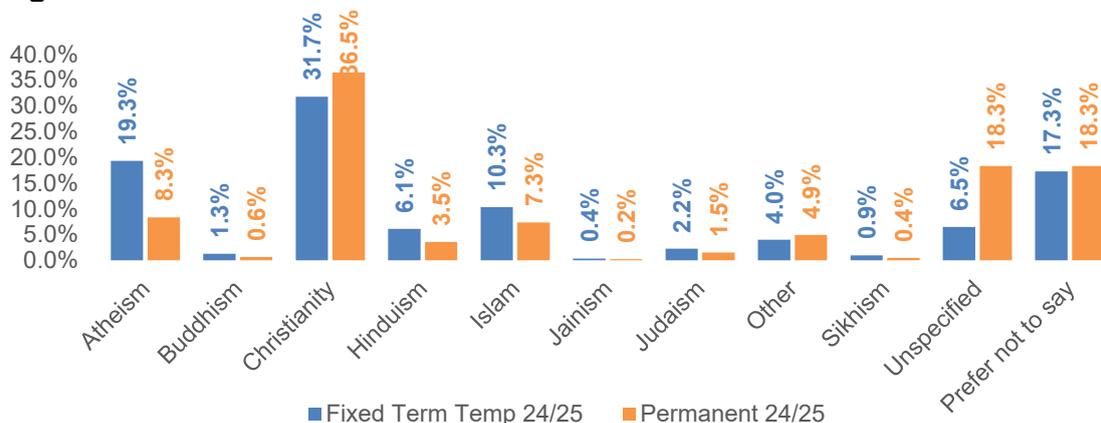
Marriage and Civil Partnership:



Race:



Religion or Belief:



Sex:

73.2% of fixed-term contracts are female staff, whereas **77.7%** of permanent contracts are female staff.

26.8% of fixed-term contracts are male staff, whereas **22.3%** of permanent contracts are male staff.

Sexual Orientation:

6.6% of fixed-term contracts are staff that are LGBUO, whereas **3.6%** of permanent contracts are staff that are LGBUO.

75.1% of fixed-term contracts are heterosexual staff, whereas **61.2%** of permanent contracts are staff that are heterosexual.

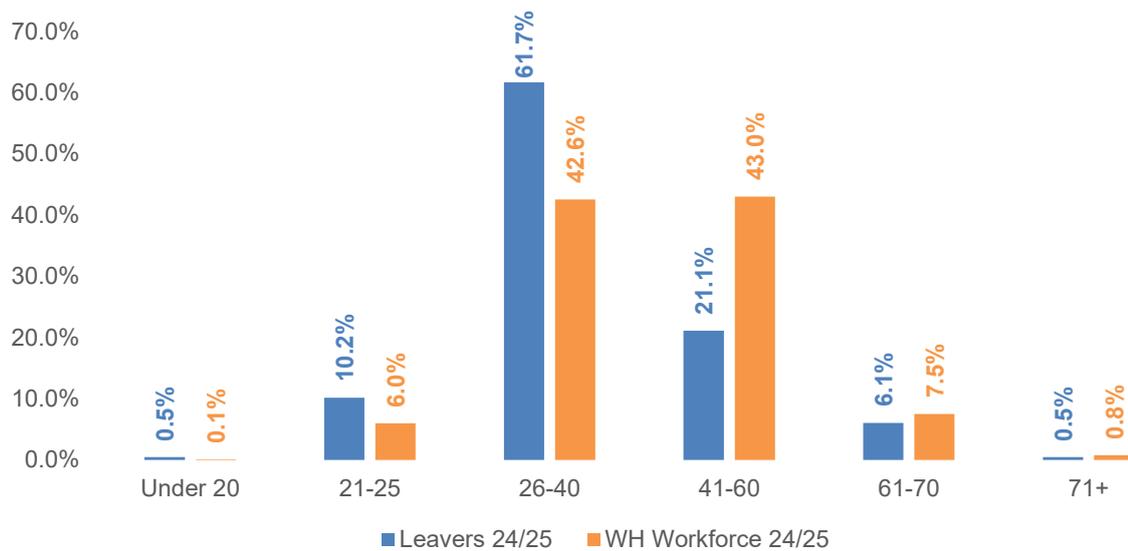


6.6 Leavers

During 2024/25, a total of 856 staff left the organisation. This section will review the demographic breakdown of staff that left the Trust in greater detail.

Age

6-45: Breakdown of leavers in 24/25 by age groups

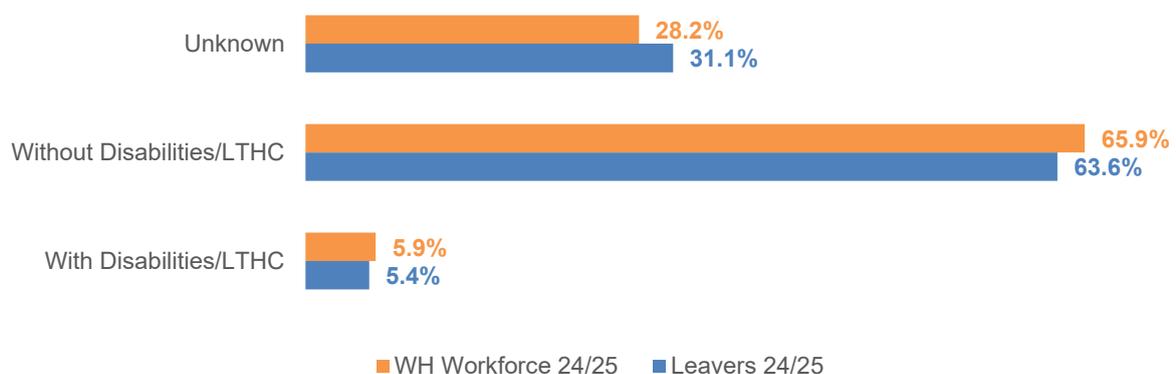


6-45 (above) shows a greater proportion of leavers aged under 20 to 40 left the organisation in comparison to the overall workforce representation, leaver aged 41+ left at a lower proportion. Most leavers were aged 26-40.

Disability

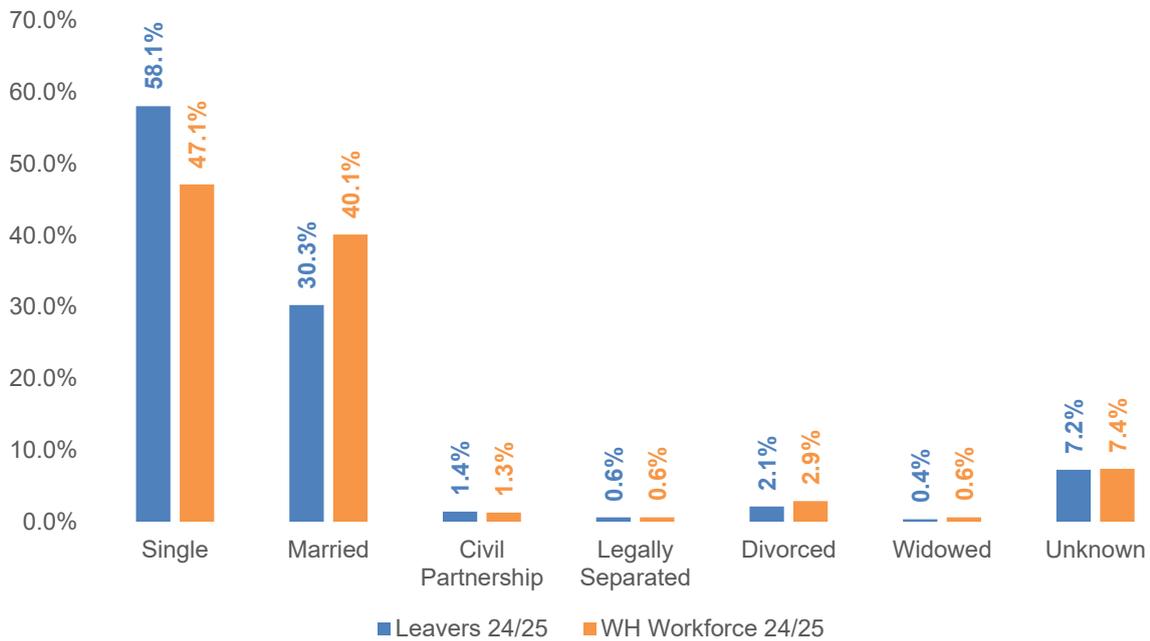
Chart 6-46 (below) shows, all declared groups are leaving the organisation in broadly equal proportions as the overall workforce representation.

6-46: Breakdown of leavers in 24/25 by disability/long-term health conditions



Marriage civil partnership

6-47: Breakdown of leavers in 23/24 by marriage and civil partnership



6-47 (above) shows compared to the overall workforce representation, proportionally lower-than-expected number of staff that are married and proportionally broadly equal proportion of staff in civil partnerships are leaving the organisation.

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

6-48: Breakdown of leavers in 24/25 by race/ethnicity

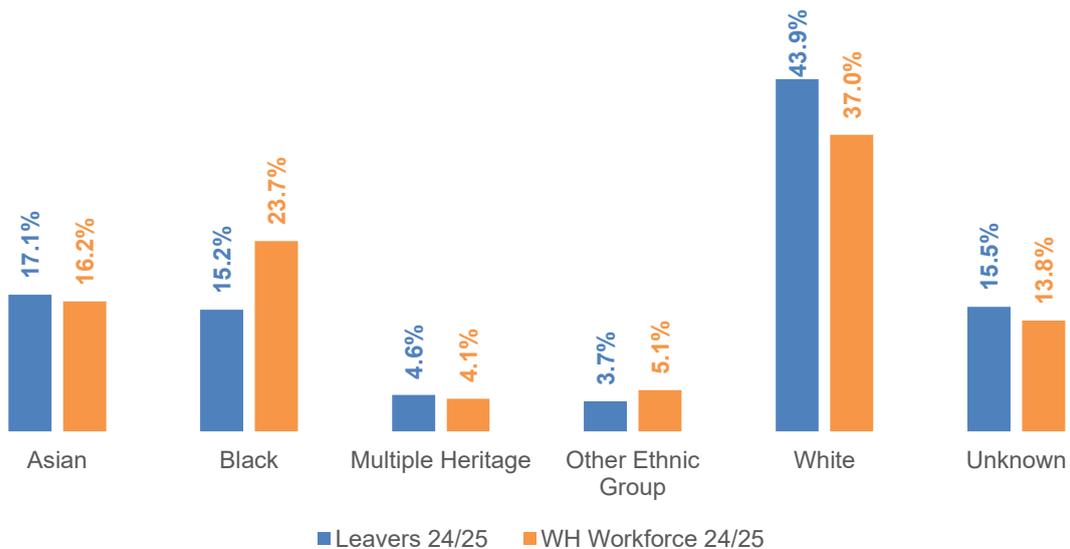


Chart 6-48 (above) shows that when compared to the workforce representation, proportionally fewer Black and staff from 'other' ethnic groups, broadly equal proportion of Asian and staff from and multiple heritage backgrounds are leaving the organisation. However, with nearly 16% of leavers not having declared their race a true picture of representation may be masked.

Religion or Belief

6-48 Breakdown of leavers in 24/25 by religion or belief

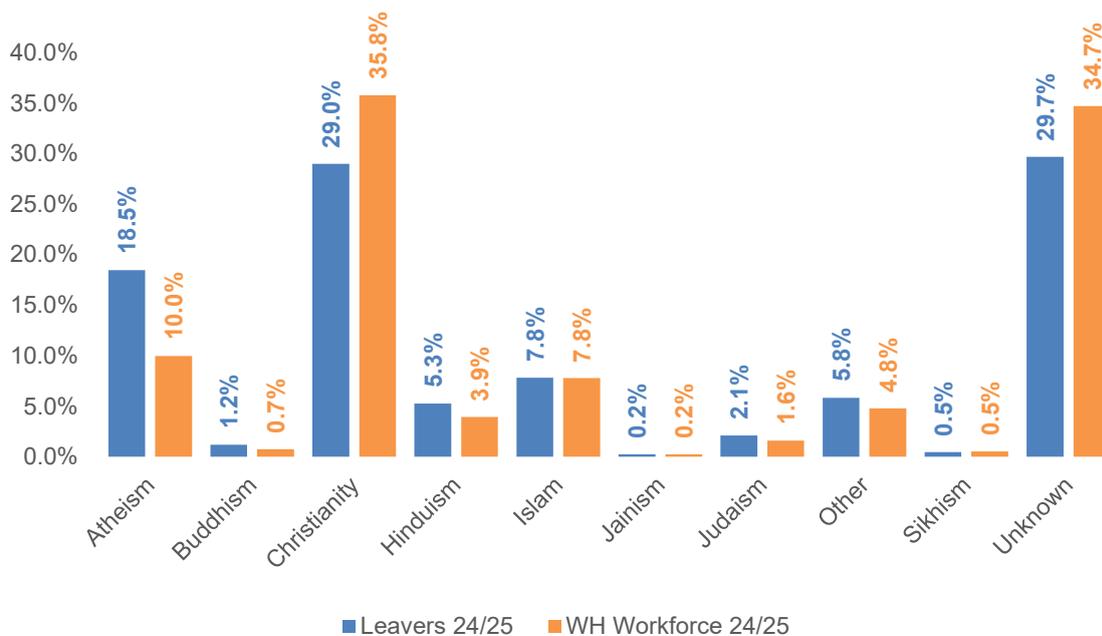


Chart 6-48 (above) shows when compared to the overall workforce, there was a lower proportion of Christians, a broadly equal proportion of Muslim, Jains, and Sikhs, and greater proportion Buddhist, Hindus, Jewish and staff from 'other' religions/beliefs leaving the organisation. However, with nearly 30% of leavers not declaring their religion or belief, a true picture of representation within leaver data will be masked.

Sex

6-49: Breakdown of leavers in 24/25 by sex

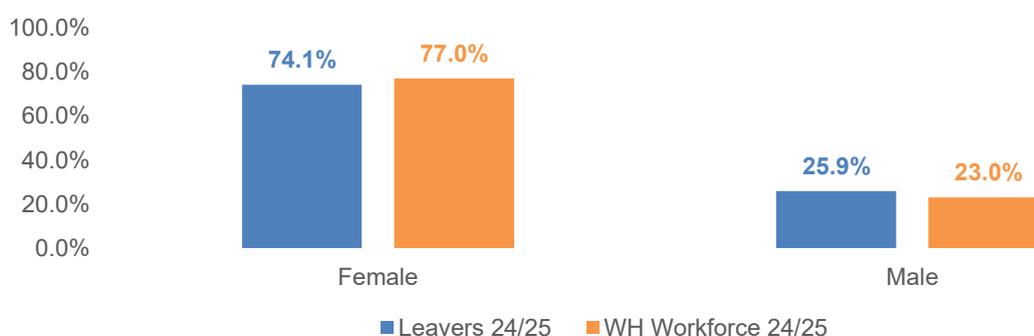
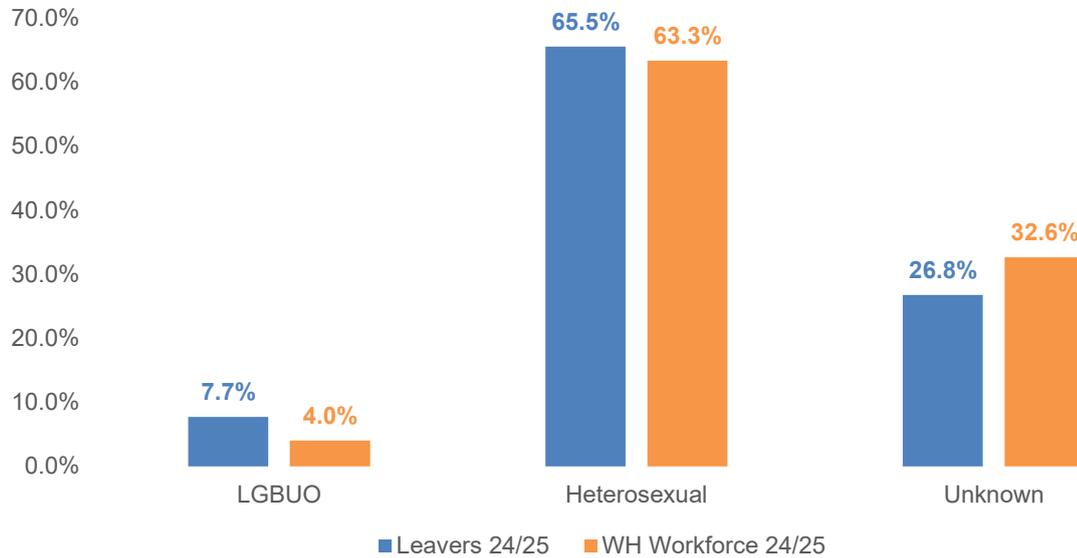


Chart 6-49 (previous page) shows compared to the overall workforce, broadly proportion numbers of male and female staff are leaving the organisation.

Sexual Orientation

6-50: Breakdown of leavers in 24/25 by sexual orientation



6-50 (above) compared to the overall workforce, there are a higher-than-expected number of LGBUO and broadly proportionally equal of heterosexual staff leaving the organisation. However, nearly 27% of leavers not declaring their sexual orientation, the true picture of representation in leaver data will be masked.



6.7 NHS Staff Survey

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

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

Where the Whittington Health score is in red, it indicates worse performance compared to the national acute average, where orange indicates performance is within 1% and where it is green, it indicates better performance.

In the columns breaking down the scores for individual groups within the protected characteristics, a red score would indicate worse performance than the Whittington average; an amber score indicates performance within 1%; and a green score would indicate better performance.



Age

Table 6-51 (below) shows the breakdown of staff survey questions by age

| | | 21-30 | 31-40 | 41-50 | 51-65 | 66+ | WH | Acute Average |
|-----------------------------|--|-------|-------|-------|-------|-------|-------|---------------|
| Relationships and Behaviour | 14a - Bullying, harassment and abuse: from patients/public | 28.2% | 32.2% | 23.4% | 21.5% | 12.5% | 26.7% | 24.68% |
| | 14b - Bullying, harassment and abuse: from managers | 5.7% | 10.4% | 13.0% | 11.9% | 14.8% | 11.7% | 10.00% |
| | 14c - Bullying, harassment and abuse: from colleagues | 14.5% | 18.7% | 19.2% | 16.8% | 17.0% | 18.9% | 18.5% |
| | 14d - Reported Bullying, harassment and abuse last time experienced. | 62.1% | 57.3% | 52.5% | 48.7% | 30.8% | 52.7% | 51.9% |
| | 16a - Experienced discrimination from patients/public | 13.8% | 16.5% | 11.0% | 8.8% | 10.7% | 12.9% | 8.8% |
| | 16b - Experienced discrimination from staff | 8.7% | 11.9% | 12.5% | 11.7% | 5.5% | 11.9% | 9.4% |
| | 16c - Discrimination because of age | 23.9% | 15.0% | 13.5% | 23.2% | - | 17.8% | 16.2% |
| | 5c - Relationships at work are (not) strained | 62.5% | 49.7% | 53.4% | 49.2% | 48.2% | 50.2% | 45.9% |
| Wider Inclusion Issue | 11b - Experienced Musculo-skeletal issues | 27.2% | 30.6% | 32.2% | 35.2% | 25.0% | 32.8% | 30.3% |
| | 12b - Experienced burnout | 33.9% | 36.2% | 28.4% | 25.3% | 15.8% | 30.5% | 30.8% |
| | 17a - Experienced sexual unsafety from patients/public | 11.4% | 7.7% | 4.7% | 2.0% | 1.8% | 5.9% | 8.0% |
| | 17b - Experienced sexual unsafety from staff | 5.7% | 3.5% | 3.8% | 2.5% | 0.0% | 3.9% | 3.5% |
| | 21 - Organisation respects individual differences (e.g. culture, work styles, etc) | 80.0% | 70.4% | 71.6% | 69.8% | 69.6% | 70.7% | 70.1% |
| | 4d - Has flexible working options | 46.7% | 54.5% | 62.1% | 59.9% | 52.7% | 54.3% | 56.4% |
| Wider Employee Experience | 15 - Believes trust provides equal opportunities for progression/development | 60.7% | 53.6% | 51.5% | 47.6% | 46.3% | 51.1% | 56.0% |
| | 26a - Intention to leave the organisation | 30.5% | 33.5% | 24.3% | 24.5% | 12.3% | 28.2% | 28.4% |
| | 4c - Satisfied with level of pay | 22.2% | 24.1% | 29.3% | 32.9% | 32.7% | 27.8% | 31.1% |

Disability

Table 6-52 (below) shows the breakdown of staff survey questions by disability.

| | | With Disability/LTHC | Without Disability/LTHC | WH | Acute Average |
|-----------------------------|--|----------------------|-------------------------|-------|---------------|
| Relationships and Behaviour | 14a - Bullying, harassment and abuse: from patients/public | 31.4% | 24.3% | 26.7% | 24.68% |
| | 14b - Bullying, harassment and abuse: from managers | 17.7% | 9.2% | 11.7% | 10.00% |
| | 14c - Bullying, harassment and abuse: from colleagues | 22.9% | 16.3% | 18.9% | 18.5% |
| | 14d - Reported Bullying, harassment and abuse last time experienced. | 50.3% | 55.5% | 52.7% | 51.9% |
| | 16a - Experienced discrimination from patients/public | 13.5% | 12.0% | 12.9% | 8.8% |
| | 16b - Experienced discrimination from staff | 20.4% | 9.3% | 11.9% | 9.4% |
| | 16c - Discrimination because of disability | 22.5% | 1.5% | 17.8% | 16.2% |
| | 5c - Relationships at work are (not) strained | 46.3% | 54.0% | 50.2% | 45.9% |
| Wider Inclusion Issue | 11b - Experienced Musculo-skeletal issues | 45.8% | 28.5% | 32.8% | 30.3% |
| | 12b - Experienced burnout | 44.4% | 27.0% | 30.5% | 30.8% |
| | 17a - Experienced sexual unsafety from patients/public | 8.4% | 5.2% | 5.9% | 8.0% |
| | 17b - Experienced sexual unsafety from staff | 7.4% | 2.7% | 3.9% | 3.5% |
| | 21 - Organisation respects individual differences (e.g. culture, work styles, etc) | 61.2% | 74.1% | 70.7% | 70.1% |
| | 4d - Has flexible working options | 62.8% | 58.1% | 54.3% | 56.4% |
| Wider Employee Experience | 15 - Believes trust provides equal opportunities for progression/development | 42.0% | 54.6% | 51.1% | 56.0% |
| | 26a - Intention to leave the organisation | 38.8% | 25.2% | 28.2% | 28.4% |
| | 4c - Satisfied with level of pay | 20.5% | 29.3% | 27.8% | 31.1% |

Race

Table 6-53 (below) shows the breakdown of staff survey questions by race/ethnicity.

| | | White Staff | BME Staff | WH | Acute Average |
|-----------------------------|--|-------------|-----------|-------|---------------|
| Relationships and Behaviour | 14a - Bullying, harassment and abuse: from patients/public | 23.0% | 28.3% | 26.7% | 24.68% |
| | 14b - Bullying, harassment and abuse: from managers | 10.5% | 11.5% | 11.7% | 10.00% |
| | 14c - Bullying, harassment and abuse: from colleagues | 15.6% | 19.3% | 18.9% | 18.5% |
| | 14d - Reported Bullying, harassment and abuse last time experienced. | 53.9% | 54.8% | 52.7% | 51.9% |
| | 16a - Experienced discrimination from patients/public | 6.3% | 17.9% | 12.9% | 8.8% |
| | 16b - Experienced discrimination from staff | 7.9% | 14.4% | 11.9% | 9.4% |
| | 16c - Discrimination because of race/ethn. | 46.7% | 74.8% | 17.8% | 16.2% |
| | 5c - Relationships at work are (not) strained | 55.7% | 49.7% | 50.2% | 45.9% |
| Wider Inclusion Issue | 11b - Experienced Musculo-skeletal issues | 25.1% | 37.2% | 32.8% | 30.3% |
| | 12b - Experienced burnout | 28.3% | 31.4% | 30.5% | 30.8% |
| | 17a - Experienced sexual unsafety from patients/public | 6.4% | 5.2% | 5.9% | 8.0% |
| | 17b - Experienced sexual unsafety from staff | 3.5% | 3.7% | 3.9% | 3.5% |
| | 21 - Organisation respects individual differences (e.g. culture, work styles, etc) | 75.2% | 69.3% | 70.7% | 70.1% |
| | 4d - Has flexible working options | 62.8% | 50.9% | 54.3% | 56.4% |
| Wider Employee Experience | 15 - Believes trust provides equal opportunities for progression/development | 59.0% | 46.9% | 51.1% | 56.0% |
| | 26a - Intention to leave the organisation | 29.5% | 26.0% | 28.2% | 28.4% |
| | 4c - Satisfied with level of pay | 32.8% | 23.3% | 27.8% | 31.1% |

Religion or Belief

Table 6-54 (below) shows the breakdown of staff survey questions by religion or belief

| | | No religion | Christian | Buddhist | Hindu | Jewish | Muslim | Sikh | Other Religion | prefer not to say | WH | Acute Average |
|-----------------------------|--|-------------|-----------|----------|-------|--------|--------|------|----------------|-------------------|-------|---------------|
| Relationships and Behaviour | 14a - Bullying, harassment and abuse: from patients/public | 25.3% | 26.2% | 12.5% | 23.2% | 25.4% | 25.1% | - | 18.9% | 28.6% | 26.7% | 24.68% |
| | 14b - Bullying, harassment and abuse: from managers | 9.1% | 10.8% | 7.1% | 8.3% | 11.9% | 6.9% | - | 17.0% | 20.4% | 11.7% | 10.00% |
| | 14c - Bullying, harassment and abuse: from colleagues | 15.3% | 17.6% | 14.3% | 18.7% | 12.1% | 14.9% | - | 18.9% | 26.9% | 18.9% | 18.5% |
| | 14d - Reported Bullying, harassment and abuse last time experienced. | 54.3% | 54.1% | - | 61.3% | 52.6% | 55.1% | - | 44.4% | 54.1% | 52.7% | 51.9% |
| | 16a - Experienced discrimination from patients/public | 8.3% | 13.0% | 6.7% | 14.8% | 13.6% | 15.7% | - | 20.4% | 14.1% | 12.9% | 8.8% |
| | 16b - Experienced discrimination from staff | 6.8% | 11.9% | 13.3% | 10.3% | 12.1% | 12.4% | - | 14.8% | 19.3% | 11.9% | 9.4% |
| | 16c - Discrimination because of religion/belief | 3.8% | 5.5% | - | 13.6% | 83.3% | 50.0% | - | 7.7% | 7.0% | 17.8% | 16.2% |
| | 5c - Relationships at work are (not) strained | 59.5% | 50.7% | 62.5% | 47.7% | 50.9% | 56.2% | - | 51.9% | 41.2% | 50.2% | 45.9% |
| Wider Inclusion Issue | 11b - Experienced Musculo-skeletal issues | 24.6% | 33.1% | 25.0% | 41.1% | 22.0% | 33.0% | - | 29.6% | 41.2% | 32.8% | 30.3% |
| | 12b - Experienced burnout | 30.7% | 26.2% | 25.0% | 37.0% | 30.5% | 34.1% | - | 24.1% | 42.7% | 30.5% | 30.8% |
| | 17a - Experienced sexual unsafety from patients/public | 9.4% | 4.4% | 12.5% | 1.9% | 1.7% | 3.9% | - | 11.1% | 5.7% | 5.9% | 8.0% |
| | 17b - Experienced sexual unsafety from staff | 3.0% | 4.0% | 0.0% | 0.9% | 1.7% | 5.1% | - | 3.7% | 4.0% | 3.9% | 3.5% |
| | 21 - Organisation respects individual differences (e.g. culture, work styles, etc) | 74.7% | 72.7% | 62.5% | 79.6% | 79.7% | 72.6% | - | 64.8% | 57.0% | 70.7% | 70.1% |
| | 4d - Has flexible working options | 60.8% | 57.1% | 75.0% | 56.5% | 67.8% | 52.3% | - | 50.0% | 42.0% | 54.3% | 56.4% |
| Wider Employee Experience | 15 - Believes trust provides equal opportunities for progression/development | 57.7% | 51.8% | 60.0% | 58.3% | 54.2% | 53.4% | - | 41.5% | 36.7% | 51.1% | 56.0% |
| | 26a - Intention to leave the organisation | 31.7% | 23.6% | 37.5% | 22.2% | 28.8% | 23.6% | - | 34.6% | 38.3% | 28.2% | 28.4% |
| | 4c - Satisfied with level of pay | 31.8% | 28.8% | 31.3% | 28.7% | 37.3% | 21.9% | - | 18.9% | 15.9% | 27.8% | 31.1% |

Sex

Table 6-65 (below) shows the breakdown of staff survey questions by sex.

| | | Female | Male | WH | Acute Average |
|-----------------------------|--|--------|-------|-------|---------------|
| Relationships and Behaviour | 14a - Bullying, harassment and abuse: from patients/public | 25.8% | 24.4% | 26.7% | 24.68% |
| | 14b - Bullying, harassment and abuse: from managers | 10.5% | 10.5% | 11.7% | 10.00% |
| | 14c - Bullying, harassment and abuse: from colleagues | 17.3% | 16.1% | 18.9% | 18.5% |
| | 14d - Reported Bullying, harassment and abuse last time experienced. | 55.9% | 50.7% | 52.7% | 51.9% |
| | 16a - Experienced discrimination from patients/public | 11.7% | 13.1% | 12.9% | 8.8% |
| | 16b - Experienced discrimination from staff | 11.3% | 8.2% | 11.9% | 9.4% |
| | 16c - Discrimination because of sex | 14.7% | 21.8% | 17.8% | 16.2% |
| | 5c - Relationships at work are (not) strained | 53.7% | 51.5% | 50.2% | 45.9% |
| Wider Inclusion Issue | 11b - Experienced Musculo-skeletal issues | 53.7% | 51.5% | 32.8% | 30.3% |
| | 12b - Experiences burnout | 30.3% | 27.9% | 30.5% | 30.8% |
| | 17a - Experienced sexual unsafety from patients/public | 6.0% | 4.6% | 5.9% | 8.0% |
| | 17b - Experienced sexual unsafety from staff | 3.2% | 4.2% | 3.9% | 3.5% |
| | 21 - Organisation respects individual differences (e.g. culture, work styles, etc) | 72.9% | 73.4% | 70.7% | 70.1% |
| | 4d - Has flexible working options | 56.7% | 60.0% | 54.3% | 56.4% |
| Wider Employee Experience | 15 - Believes trust provides equal opportunities for progression/development | 53.3% | 53.7% | 51.1% | 56.0% |
| | 26a - Intention to leave the organisation | 26.8% | 26.9% | 28.2% | 28.4% |
| | 4c - Satisfied with level of pay | 27.0% | 33.5% | 27.8% | 31.1% |

Sexual Orientation

Table 6-66 (below) shows the breakdown of staff survey questions by sexual orientation.

| | | Heterosexual | Gay or Lesbian | Bisexual | Other | Prefer not to say | WH | Acute Average |
|-----------------------------|--|--------------|----------------|----------|-------|-------------------|-------|---------------|
| Relationships and Behaviour | 14a - Bullying, harassment and abuse: from patients/public | 25.0% | 32.2% | 39.5% | 28.6% | 28.0% | 26.7% | 24.68% |
| | 14b - Bullying, harassment and abuse: from managers | 10.8% | 8.1% | 2.6% | 10.0% | 16.1% | 11.7% | 10.00% |
| | 14c - Bullying, harassment and abuse: from colleagues | 17.3% | 19.5% | 13.2% | 15.8% | 22.1% | 18.9% | 18.5% |
| | 14d - Reported Bullying, harassment and abuse last time experienced. | 54.2% | 55.9% | 64.3% | - | 50.0% | 52.7% | 51.9% |
| | 16a - Experienced discrimination from patients/public | 12.0% | 18.6% | 18.4% | 14.3% | 12.5% | 12.9% | 8.8% |
| | 16b - Experienced discrimination from staff | 11.2% | 8.2% | 5.3% | 25.0% | 14.1% | 11.9% | 9.4% |
| | 16c - Discrimination because of sexual orientation | 68.7% | 42.9% | - | - | 53.9% | 17.8% | 16.2% |
| | 5c - Relationships at work are (not) strained | 53.2% | 54.0% | 55.3% | 50.0% | 44.7% | 50.2% | 45.9% |
| Wider Inclusion Issue | 11b - Experienced Musculo-skeletal issues | 30.9% | 31.0% | 26.3% | 40.0% | 41.3% | 32.8% | 30.3% |
| | 12b - Experienced burnout | 29.4% | 28.7% | 44.7% | 19.1% | 38.8% | 30.5% | 30.8% |
| | 17a - Experienced sexual unsafety from patients/public | 5.2% | 8.1% | 23.7% | 9.5% | 7.9% | 5.9% | 8.0% |
| | 17b - Experienced sexual unsafety from staff | 3.2% | 8.1% | 2.6% | 0.0% | 5.5% | 3.9% | 3.5% |
| | 21 - Organisation respects individual differences (e.g. culture, work styles, etc) | 72.7% | 77.0% | 65.8% | 75.0% | 61.2% | 70.7% | 70.1% |
| | 4d - Has flexible working options | 57.7% | 57.5% | 47.4% | 50.0% | 46.7% | 54.3% | 56.4% |
| Wider Employee Experience | 15 - Believes trust provides equal opportunities for progression/development | 53.5% | 60.0% | 52.6% | 61.9% | 35.5% | 51.1% | 56.0% |
| | 26a - Intention to leave the organisation | 26.5% | 33.3% | 47.4% | 28.6% | 34.3% | 28.2% | 28.4% |
| | 4c - Satisfied with level of pay | 28.4% | 34.5% | 23.7% | 15.0% | 20.1% | 27.8% | 31.1% |

6.8 Other Standards and Reporting to Measure Inclusion

The Trust undertakes several other activities to further understand the level of equity within the workforce; these include:

- Gender Pay Gap Reporting (statutory reporting)
- Workforce Disability Equality Standard (NHS mandated standard)
- Workforce Race Equality Standard (NHS mandated standard).

The Trust has also participated in several voluntary measures this year to further understand inequity within the workforce, including:

- Disability Pay Gap
- Race/Ethnicity Pay Gap

The role of pay gap reporting is to review the level of ordinary pay and bonus pay experience of different groups i.e. women and men, disabled and non-disabled staff and BME and white staff. It helps identify levels of inequity regarding pay as well as representation within workforces. The Trust's Gender Pay Gap report and actions to address can be found on the [Gender Pay Gap Reporting Service](#). Pay gap reporting uses several measures:

- Median average (the middle figure of a list of numbers) – of pay/bonus pay, it is a statistically more accurate way of reporting pay differences as it is unaffected by very high or low pay. The median is typically the number that is discussed when talking about pay gaps.
- Mean average (the sum of all the numbers divided by the total number of values) – provides a useful illustrative figure for issues regarding pay in the workforce.
- Quartiles (splitting the workforce into broadly equal quarters) – provides an overview of the representation of different groups within lower, lower middle, upper middle and upper pay groups, helping to identify if any groups are over or underrepresented in junior/senior roles.

The role of the NHS equality standards is to compare the experiences of different groups i.e. disabled/non-disabled staff and BME/white staff, to identify if there are areas that need to be improved. The comparison includes measures looking at representation, recruitment, employee relations, staff experiences relating to behaviour and views from the NHS Staff Survey, accessing training and support and board representation. The Trust's disability and race equality standards report can be found on the [Inclusion pages on the Trust's website](#).

For some of the factors, the standards use a term a 'relative likelihood' (measure how likely that something is going to happen), ideally this measure is as close to a measure of '1.00' as this means that there is equity (i.e. no difference in the experience of the groups being compared); however, there is a target range of a score anywhere between 0.8 and 1.25 which would suggest that there is not a statistical disadvantage (known as the rule of 'four-fifths').

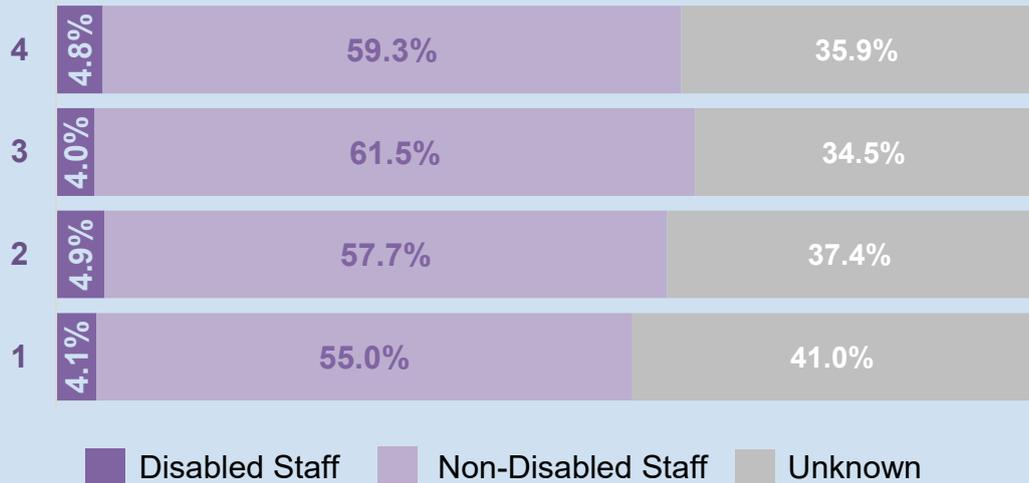
Disability Pay Gap Information Snapshot Date 31/03/2024



There were **4,962 staff** in the workforce. 220 (**4.4%**) staff who had a disability, 2,897 (**58.4%**) staff who did not have a disability and 1,845 (**37.2%**) where their disability status was unknown



Disability Status Representation in Pay Quartiles



| Average Hourly Pay | | | |
|--------------------|----------------|----------------------------|---------------------------|
| | Disabled Staff | Staff Without Disabilities | Unknown Disability Status |
| Mean | £24.80 | £26.14 | £25.94 |
| Median | £24.21 | £23.59 | £22.96 |

Mean Average: Staff with disabilities earn £1.34 less per hour than staff without disabilities, this suggests a mean average pay gap of -5.1%.

Median Average: Staff with disabilities earn 63p more per hour than staff without disabilities, this means for every £1 staff with disabilities earn, staff without disabilities earn 97p (median average pay gap of 2.7%).



| Bonus Pay | | | |
|---------------|------------------|----------------------------|---------------------------|
| | Disabled Staff | Staff Without Disabilities | Unknown Disability Status |
| Mean | £3,928.06 | £5,289.03 | £4,978.56 |
| Median | £3,928.06 | £3,928.06 | £3,928.06 |

0.9% of disabled and 4.9% of staff without disabilities received a bonus.

Mean Average: Staff with disabilities earn £1,360.97 less in bonuses than staff without disabilities, this suggests a mean average bonus pay gap of -25.7%.

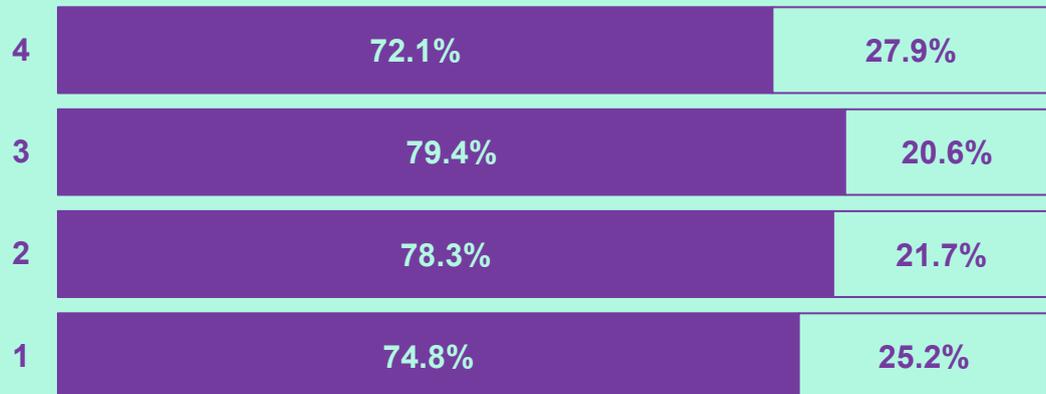
Median Average: Median average is the same for all groups (£3,928.06) suggesting that there is no median average gap in bonus pay.

Gender Pay Gap Information Snapshot Date 31/03/2024



There were **4,962** staff in the workforce. **3,779 (76.2%)** female staff and **1,183 (23.8%)** male staff.

Sex Representation in Pay Quartiles



■ Female Staff □ Male Staff



Average Hourly Pay

| | Male | Female |
|---------------|---------------|---------------|
| Mean | £25.65 | £24.20 |
| Median | £22.41 | £21.88 |

Mean Average: Female staff earn £1.45 less per hour than male staff with, this suggests a mean average pay gap of -5.7%.

Median Average: Female staff earn 53p less per hour than male staff, this means for every £1 male staff earn, female staff earn 98p (median average pay gap of -2.4%)



Bonus Pay

| | Male | Female |
|---------------|------------------|------------------|
| Mean | £6,668.69 | £7,108.11 |
| Median | £3,928.06 | £3,928.06 |

2.9% of female staff and 5.2% of male staff received a bonus.

Mean Average: Female staff earn £439.43 more in bonuses than male staff, this suggests a mean average bonus pay gap of 6.6%.

Median Average: Median average is the same for both groups (£3928.06) suggesting that there is no median gap in bonus pay.



Race Pay Gap Information Snapshot Date 31/03/2024



There were **4,962 staff** in the workforce, this can be broken down to: Asian 753 (**15.2%**), Black 1,109 (**22.3%**), Multiple Heritage 180 (**3.6%**), other ethnicity groups 229 (**4.6%**), White 1,829 (**36.9%**) and unknown 862 (**17.4%**).



Race/Ethnicity Representation in Pay Quartiles

| | Asian | Black | M/Herit. | Other | White | Unknown |
|-----------------------|--------------|--------------|-------------|-------------|--------------|---------|
| Lower Quartile | 14.5% | 32.6% | 3.4% | 4.8% | 25.9% | 18.8% |
| Lower Middle Quartile | 13.7% | 26.4% | 3.5% | 3.9% | 29.6% | 22.9% |
| Upper Middle Quartile | 14.2% | 18.4% | 3.6% | 6.4% | 40.7% | 16.7% |
| Upper Quartile | 18.4% | 12.1% | 3.9% | 3.5% | 51.2% | 11.0% |

Figures in bold show where there is an underrepresentation compared to the overall workforce.

Mean Average Difference (£)

| | Compared to: | | | |
|------------|----------------|----------------|----------------|----------------|
| | M/Heritage. | Asian | Black | Other |
| White | -£ 2.18 | -£ 1.31 | -£ 7.05 | -£ 4.54 |
| M/Heritage | | £ 0.87 | -£ 4.87 | -£ 2.36 |
| Asian | | | -£ 5.74 | -£ 3.23 |
| Black | | | | £ 2.51 |



Mean Average Difference (%)

| | Compared to: | | | |
|------------|--------------|--------------|---------------|---------------|
| | M/Heritage | Asian | Black | Other |
| White | -7.5% | -4.5% | -24.4% | -15.7% |
| M/Heritage | | 3.3% | -18.2% | -8.8% |
| Asian | | | -20.8% | -11.7% |
| Black | | | | 11.5% |

Mean Average (compared to white staff): Multiple heritage are paid £2.18 less per hour with a pay gap of -7.5%, Asian staff are paid £1.31 less per hour with a pay gap of -4.5%, Black staff are paid £7.05 per hour less with a pay gap or -24.4% and staff from 'other' groups are paid £4.54 less per hour with a pay gap of -15.7%.



Median Average Difference (£)

| | Mixed | | Asian | | Compared to: Black | | Other | |
|-------------|-------|------|-------|------|-----------------------|------|-------|------|
| | £ | | £ | | £ | | £ | |
| White | -£ | 1.46 | -£ | 1.45 | -£ | 7.21 | -£ | 3.55 |
| Multiple H. | | | £ | 0.01 | -£ | 5.75 | -£ | 3.55 |
| Asian | | | | | -£ | 5.76 | -£ | 3.55 |
| Black | | | | | | | £ | 3.66 |

Median Average Difference (%)

| | Mixed | | Asian | | Compared to: Black | | Other | |
|-------------|-------|--|-------|--|-----------------------|--|--------|--|
| | % | | % | | % | | % | |
| White | -5.5% | | -5.5% | | -27.2% | | -13.4% | |
| Multiple H. | | | 0.0% | | -23.0% | | -14.2% | |
| Asian | | | | | -23.0% | | -14.2% | |
| Black | | | | | | | 19.0% | |

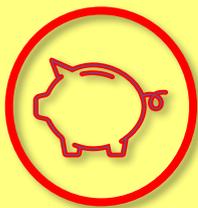
Median Average (compared to white staff): Multiple heritage are paid £1.46 less per hour with a pay gap of -5.5% - meaning this group earns 96p for every £1 white staff earn, Asian staff are paid £1.45 per hour with a pay gap of -5.5% - meaning this group earns 96p for every £1 white staff earn, Black staff are paid £7.21 per hour less with a pay gap or -27.2% - meaning this group earns 73p for every £1 white staff earn and staff from 'other' groups are paid £3.55 less per hour with a pay gap of -13.4% - meaning this group earns 87p for every £1 white staff earn.

Mean Bonus Pay (£)

| | M/Heritage | Asian | Black | Other |
|-------|------------|-------------|------------|-------------|
| White | £ 314.85 | -£ 689.48 | £ 543.63 | -£ 741.50 |
| Mixed | | -£ 1,004.32 | £ 228.78 | -£ 1,056.35 |
| Asian | | | £ 1,233.11 | -£ 52.03 |
| Black | | | | -£ 1,285.13 |

Mean Bonus Pay (%)

| | M/Heritage | Asian | Black | Other |
|-------|------------|--------|-------|--------|
| White | 5.9% | -12.9% | 10.2% | -13.8% |
| Mixed | | -17.7% | 4.0% | -18.6% |
| Asian | | | 26.4% | -1.1% |
| Black | | | | -21.8% |



7.4% Asian, 1.0% Black, 5.0% multiple heritage, 4.4% other groups, 8.0% of white staff received a bonus.

Mean Average (compared to white staff): Multiple heritage are paid £314.85 more in bonuses with a pay gap of 5.9%, Asian staff are paid £689.48 less in bonuses with a pay gap of -12.9%, Black staff are paid £543.64 less in bonuses with a pay gap or -10.2% and staff from 'other' groups are paid £741.50 less in bonuses with a pay gap of -13.8%.

Median Average: Median average is the same for all groups (£3928.06) suggesting that there is no median average pay gap in bonus pay.

Whittington Health 2025 WRES Outcomes Comparison to 2024 and 2018



Whittington Health
NHS Trust

Performing Well

Indicator 4

Non-Mandatory Training

1.09

Position improved from 2024
(Inside target range of 0.8-1.25)
2024: ▲ 0.84
2019: ▼ 1.24

Some Improvement – Further Work Needed

Indicator 5

Harassment: Patients

White: 23.0% BME: 28.3%

Position Improved from 2024
2024: White: ▼ 27.2%, BME: ▼ 30.0%
2018: White: ▼ 28.4%, BME: ▼ 29.1%

Indicator 6

Harassment: Staff

White: 20.9% BME: 24.1%

Position Improved from 2024
2024: White: ▲ 20.6%, BME: ▼ 25.1%
2018: White: ▼ 32.5%, BME: ▼ 26.7%

Indicator 7

Equal Ops / Progression

White: 59.0% BME: 46.9%

Position Improved from 2024
2024: White: ▲ 56.4%, BME: ▲ 46.3%
2018: White: ▼ 59.5%, BME: ▲ 39.8%

The arrows shows a comparison to 2024/25, a green arrow shows better performance and a red shows worse performance

Improvement Needed

Indicator 2

Recruitment

1.79

Position declined from 2024
(Outside target range of 0.8-1.25)
2024: ▲ 1.63
2019: ▼ 2.14

Indicator 3

Disciplinary

2.51

Position declined from 2024
(Outside target range of 0.8-1.25)
2024: ▲ 1.11
2019: ▲ 1.18

Indicator 8

Discrimination from manager/colleagues

White: 7.9% BME: 14.4%

Position declined from 2024
2024: White: ▲ 7.4%, BME: ▲ 11.8%
2018: White: ▼ 8.2%, BME: ▼ 17.1%

Indicator 9

Board Representation

26.7%

Position remained the same from 2024
2024: ► 26.7%
2019: ▲ 20.7%

Whittington Health 2025 WDES Outcomes Comparison to 2024 and 2019 (Start of the Standard)



Whittington Health
NHS Trust

Performing Well

Metric 2

Recruitment

1.16

Position improved from 2024
(Inside target range of 0.8-1.25)
2024: ▼ 1.28
2019: ▼ 1.24

Metric 10

Board Representation

12.5%

Position improved from 2024
2024: ▲ 11.1%
2019: ▲ from 0.0%

Some Improvement – Further Work Needed

Metric 4

Bullying and Harassment
N/D: 16.6% Dis: 24.0%

Position Improved from 2024
2024: N/D: ▼ 18.5%, Dis: ▼ 25.0%
2019: N/D: ▼ 23.7%, Dis: ▼ 30.1%

Metric 3

Capability

4.44

Position improved from 2024
(Outside the target range of 0.8-1.25)
2024: ▼ 6.74
2019: ▲ 1.74

Metric 5

Equal Ops / Progression
N/D: 54.6% Dis: 42.0%

Position improved from 2024
2024: N/D: ▲ 54.2%, Dis: ▲ 39.4%
2019: N/D: ▲ 50.2%, Dis: ▼ 46.6%

Improvement Needed

Metric 6

Presenteeism

N/D: 20.1% Dis: 34.4%

Position declined from 2024

2024: N/D: ▼ 19.2%, Dis: ▲ 29.2%
2019: N/D: ▼ 22.0%, Dis: ▼ 33.5%

Metric 7

Feeling Valued

N/D: 51.8% Dis: 36.2%

Position declined from 2024

2024: N/D: ▲ 49.6%, Dis: ▼ 38.4%
2019: N/D: ▲ 51.6%, Dis: ▼ 39.3%

Metric 8

Reasonable Adjustments

62.9%

Position declined from 2024

2024: N/D: ▼ 66.1%
2019: N/D: ▼ 68.1%

The arrows shows a comparison to 2024/25, a green arrow shows better performance and a red shows worse performance

Medical Workforce Race Equality Standard

The Medical Workforce Race Equality Standard (MWRES) and 11 indicators were introduced in September 2020 to recognise how the medical workforce differs from the rest of the NHS workforce. The first MWRES report was published in July 2021. In response, the Trust was one of the first NHS providers to introduce the MWRES lead role. Supported by the Joint Directors of Inclusion, one core focus of the MWRES Lead role is to improve the Trust's support and development of International Medical Graduates (IMG). A programme and handbook have been produced to support the newly appointed IMGs settle into UK, understand the workplace cultural expectations of a UK workforce and meet their professional and regulatory requirements.

During 2023/24, Trusts were required to submit a return relating to measuring equity for medical staff, this data and information is currently being reviewed by the national Workforce Race Equality Standards Team.

7. Next steps

The Trust has comprehensive action plans looking to address areas of inequity within the organisation and implementation of the NHS England High Impact Action. Within the action plans there is provision to work to address the outcomes highlighted within this report. Specifically:

- To improve the inclusion data, we hold about our workforce, this will provide a better understanding of representation and the equity within our workforce policies.
- To review the effectiveness of our Diverse and Inclusion Panel in recruitment to ensure it can be strengthened to deliver better outcomes for applicants from diverse backgrounds.
- Continue to deliver the Restorative and Just Culture programme, to ensure that employee relations policies and procedures are fair.
- Through the Health Inequalities forum, work to refine the equalities dashboard to strengthen our inclusion reporting
- Work with organisational development colleagues to continue to promote the band 2-7 development programme for staff and evaluate the programme aimed at bands 8 and above.
- Participate in the Trust's engagement sessions relating to the 2024 NHS Staff Survey results to identify core issues related to inclusion.