NHS
University Hospitals Sussex
NHS Foundation Trust

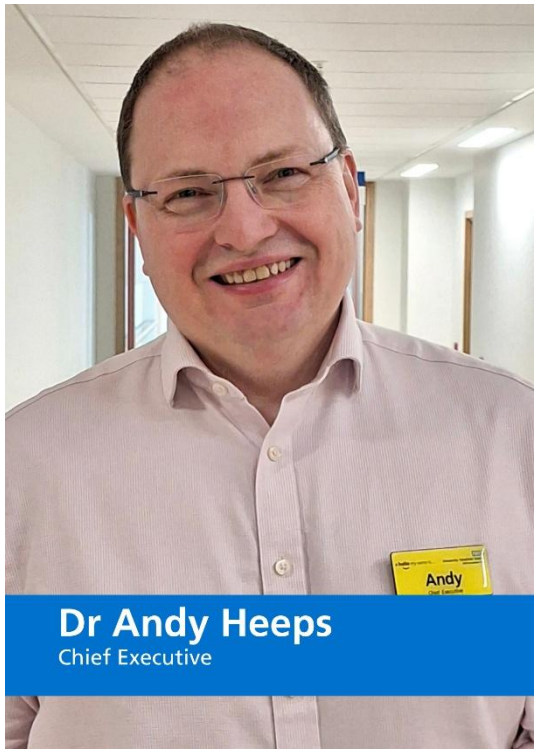
# Annual Workforce Equality Report 2026

If you would like this report in another format (e.g. large print) please contact uhsussex.inclusion@nhs.net

www.uhsussex.nhs.uk/equality

# CEO Foreword

“Colleagues across our hospitals have been working under sustained pressure throughout the last year in the face of rising demand for services and the increasingly complex needs of the communities we serve. It has also been a time of change and uncertainty for many of those communities, and for our workforce too. In this environment, how we support one another at work – and how inclusive we are as an organisation – is fundamental to the quality, safety and equity of the care we provide.




This report offers an important opportunity to reflect on that in practice. It brings together data and lived experience to help us understand where we are making progress, and where differences in experience or opportunity remain.

It highlights the progress we have made in strengthening staff voice, improving our use of equality data, and embedding inclusion through the Workforce Inclusion Programme. Above all, it shows the diversity of our workforce and communities is one of UHSussex’s greatest strengths.

However, diversity alone does not guarantee equity. Differences remain in representation, career progression, access to support, and experiences of bullying, harassment and discrimination. Recognising both our progress and the gaps that remain is essential if we are to deliver Excellent Care Everywhere.

That begins with understanding these differences. The report data highlights where we need to focus our efforts, and the experiences behind it help us understand how our culture and ways of working are felt in reality.

We also know that staff experience and patient care are closely connected. Where colleagues feel valued, respected and able to speak up, they are better able to deliver safe, high-quality care. Where inequities exist, they affect wellbeing, retention and ultimately outcomes for our communities.

For me, this underlines that inclusion must be at the heart of everyday practice; embedded in how decisions are made, how opportunities are accessed, and how we treat one another. That requires us to listen widely, act on what we hear, and be consistent in addressing behaviours and systems that do not align with our values.

There is of course more to do, and this work requires sustained focus. By continuing to understand our data, listen to our colleagues and act with purpose, we can build an organisation in which everyone feels supported to succeed and every patient receives equitable care.”

# Contents

# Summary

Welcome to the UHSussex Annual Workforce Equality Report 2026.

This report identifies workforce equality indicators that have improved, inequalities that have persisted or worsened, activity delivered during the year and areas where the available evidence remains incomplete or inconclusive. It supports our ambition to provide Excellent Care Everywhere by fostering an inclusive workplace where all colleagues feel valued, respected and able to thrive – in line with the commitments in the new national NHS Staff Standards.

The report is underpinned by the interim Workforce Inclusion Programme. During 2025/26, priorities included strengthening leadership accountability, inclusive recruitment and progression, pay and workforce disparities, reasonable adjustments, support for internationally recruited staff and tackling discrimination. Regional assurance feedback in January 2026 identified further work in relation to Board objectives, staff network sponsorship and equality impact assessments. During the year, the Trust has introduced additional recruitment controls, progressed the Career Sponsorship Scheme and introduced the centralised reasonable adjustments framework. Further implementation and evaluation are planned during 2026/27.

The report is structured around the three aims of the Public Sector Equality Duty: eliminating discrimination, advancing equality of opportunity and fostering good relations. It also includes sections on the Trust's equality objectives, workforce and service-user equality profiles, the Workforce Race Equality Standard, the Workforce Disability Equality Standard and pay gap analyses.

## Equality Profile

Workforce diversity continued to increase, particularly in relation to race and ethnicity, with colleagues from Global Majority backgrounds representing more than 30% of the workforce.

Representation was relatively balanced in some workforce groups and career pathways. However, substantial differences remained, particularly in senior clinical, non-clinical, and Medical and Dental roles. In many cases, this reflects patterns in the national NHS data.

## Eliminate Discrimination

Recruitment outcomes were broadly similar across several protected characteristics. However, White applicants remained more likely than Global Majority applicants to be appointed following shortlisting.

Experiences of discrimination, harassment, bullying and abuse continued to vary across workforce groups, with some minority and marginalised groups reporting substantially less favourable experiences.

Sexual harassment remains a particular concern. In the 2025 NHS Staff Survey, 10.7% of staff reported unwanted sexual behaviour from patients, relatives or members of the public, compared with 9.1% nationally, while 4.3% reported sexual harassment from a manager, team leader or colleague, compared with 3.5% nationally. Particularly high rates were reported by some younger, disabled, non-binary and bisexual staff, and by staff whose gender identity differs from their sex registered at birth. These findings are consistent with the Niche developmental Well-Led review, which identified sexual safety and gender-based discrimination as pronounced concerns requiring sustained and visible organisational action.

The available analyses indicate that pay gaps are associated mainly with differences in representation across pay bands, professions and senior roles. Further analysis is required to understand the relative contribution of these and other factors.

## Advance Equality of Opportunity

Satisfaction with workplace adjustments improved and was above the national average. However, approximately one in four staff who required adjustments did not feel that adequate support was in place. Disabled staff, carers and some minority groups continue to report fewer positive experiences in relation to feeling valued, work-related stress and career progression.

Participation in the Career Sponsorship Scheme increased and included colleagues from a diverse range of backgrounds. It is not yet possible to determine whether participation has resulted in improved progression or career outcomes.

## Foster Good Relations

Staff network membership and engagement continued to grow. Between the beginning of January and the end of March 2026, the number of staff registered with at least one Inclusion Staff Network increased from 1,304 to 1,477, an increase of 173 people or 13%.

Dedicated investment in staff network development through My UHSussex Charity provided additional capacity and opportunities for staff voice, representation, peer support and engagement. Evaluation of the effect of this investment on staff experience and organisational outcomes is continuing.

Staff network and wider inclusion activity included Carers Week 2025, Armed Forces Week 2025, Pride 2025, Black History Month 2025, Trans Day of Remembrance 2025, Race Equality Week 2026, LGBTQIA+ History Month 2026 and an International Women's Day programme held from 2 to 6 March 2026. Free dates and water were also made available to all staff during Ramadan and Lent. Staff networks continued to provide regular meetings, peer support and lived-experience insight to inform Trust activity.

## Conclusion

The report presents a mixed picture. Improvements are evident in some measures, including increased Global Majority and disabled staff representation, greater sharing of disability information, perceptions of equality of opportunity and satisfaction with workplace adjustments.

Other outcomes have deteriorated or remain inequitable, particularly senior representation, the continuing ethnicity gap in appointment from shortlisting, disparities affecting Global Majority staff in disciplinary and capability processes, the WDES capability disparity, experiences of discrimination, bullying and harassment, the prevalence and unequal distribution of sexual harassment, and pay outcomes.

A substantial programme of inclusion activity was also delivered, including investment in staff networks, career sponsorship, international staff support and strengthened reporting arrangements. In several areas, however, it is too early to determine whether this activity has resulted in measurable improvements in staff experience or workforce outcomes. Some findings also remain inconclusive because of incomplete information, small numbers or limitations in the available data.

The findings establish a baseline for targeted action through the Workforce Inclusion Programme and for monitoring whether activity results in sustained and measurable improvements.

# Notes

## Purpose and scope

In line with the Equality Act 2010, the Trust is legally required to publish equality information annually to demonstrate compliance with the Public Sector Equality Duty. This Annual Workforce Equality Report covers the period 1 April 2025 to 31 March 2026 and focuses on our workforce, providing insight into equality performance and supporting delivery of our strategic ambition of providing *excellent care everywhere* with an inclusive workforce representative of our communities.

This statutory report incorporates requirements from the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and national pay gap reporting. It also aligns with the NHS Equality, Diversity & Inclusion (EDI) Improvement Plan and applies consistent statistical approaches across protected characteristics. We report separately on other internal NHS requirements, such as the Equality Delivery System 2022. A summary of these requirements and any accreditation schemes is included.

### Use of Data and Information

This report draws on equality monitoring information collected when individuals join the organisation, including protected characteristics such as age, sexual orientation, disability, and ethnicity. This information is stored securely and confidentially within the Electronic Staff Record (ESR) system. Data used in this report is anonymised and handled in accordance with strict data protection requirements.

We analyse this information to identify differential outcomes and address inequalities affecting groups who share protected characteristics. Data sources include ESR, TRAC (the Trust's recruitment system), NHS Staff Survey results, and national datasets. Analysis is presented at both Trust and, where possible, divisional and site level. However, limitations in the recruitment system mean recruitment data can currently only be analysed at Trust level without extensive manual extraction.

The report uses a mixed-methods approach. Quantitative analysis includes disparity ratios, application of the four-fifths rule, pay gap analysis (mean and median), percentage point differences in staff survey responses, and representation and progression data. Qualitative insights, including staff feedback and organisational reviews, are used to contextualise findings.

Staff can review and update their personal information at any time through Employee Self-Service. However, this relies on staff having suitable digital access, confidence and time to use the system, so alternative support should be available for colleagues who may otherwise face barriers.

Some analyses within this report are based on relatively small numbers of respondents, particularly when NHS Staff Survey results are broken down by protected characteristic. In these circumstances, findings may be more sensitive to small changes in response numbers and may not provide sufficient statistical power to draw firm conclusions about differences between groups. Results for smaller groups should therefore be interpreted with appropriate caution and considered alongside other available sources of evidence.

## Terminology

This report recognises the complexity and evolving nature of equality terminology and aims to use language that is both accurate and inclusive.

We use the term Global Majority to refer to staff from ethnic groups other than White. This reflects the understanding that these groups represent the majority of the global population while also recognising that they may be under-represented or experience inequity within the Sussex and wider UK context. This terminology is used alongside standard NHS ethnicity categories. For national reporting requirements, including the Workforce Race Equality Standard (WRES), mandated definitions are retained.

Our staff network is referred to as the Multicultural and Ethnic Diversity Network, reflecting its updated and inclusive identity. Wherever possible, data is presented at a more granular ethnic group level to better reflect diversity and avoid masking differences within broad groupings.

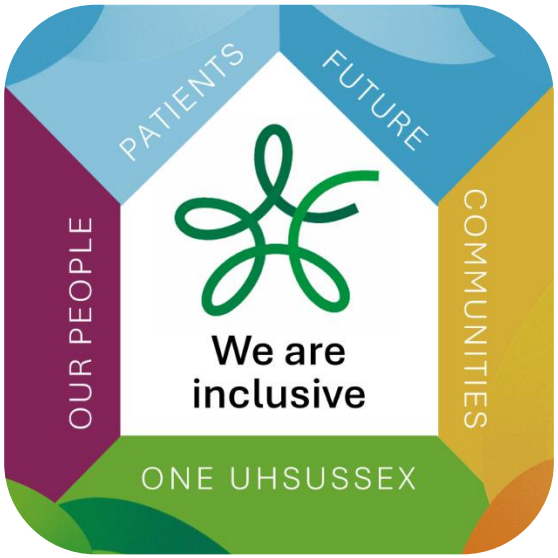
In relation to disability, the terms disability and long-lasting health condition may be used interchangeably, reflecting terminology used within the NHS Staff Survey.

We also refer to “distance from equity” to describe differences in outcomes or experiences between groups. In simple terms, this shows how far outcomes for one group differ from another, with larger gaps indicating greater inequity.

A ratio of 1 indicates equal outcomes between the groups being compared. Ratios between 0.80 and 1.25 are generally treated as broadly proportionate under the four-fifths rule[1]. Ratios outside this range are flagged for further investigation but do not, on their own, demonstrate discrimination.

[1] The four-fifths rule originates in the US Uniform Guidelines on Employee Selection Procedures. It treats a selection rate below 80% of the rate for the group with the highest rate as an indicator of potential adverse impact requiring further examination. It is used here as an analytical screening convention, not as a UK legal test or proof of discrimination. See 29 CFR §1607.4(D).

# Equality Objectives




The Trust publishes equality objectives to support delivery of the Public Sector Equality Duty and to address the most significant inequalities identified through workforce data, staff experience, engagement and external assurance.

The Trust's workforce equality objectives are delivered through the Workforce Inclusion Programme, embedded within the wider *Excellent Care Everywhere* Strategy Delivery Plan. They are intended to produce measurable improvements in workforce experience, opportunity, representation and organisational accountability.

The objectives are supported by annual delivery milestones informed by the Workforce Race Equality Standard, Workforce Disability Equality Standard, pay-gap analysis, NHS Staff Survey findings, employee-relations information, staff engagement and relevant external reviews.

The position below reflects information available at July 2026. The status statements describe the current stage of delivery and are not formal risk ratings.

## Objective 1: Strengthen leadership accountability for equality and inclusion

### Baseline

The Workforce Inclusion Steering Group and associated reporting arrangements were established during 2025/26.

Further work is required to:

- agree, embed and determine publication of Board senior leader inclusion objectives;
- translate Trust-level equality data into divisional ownership and action;
- establish consistent performance reporting;
- identify and escalate delivery risks; and
- demonstrate how equality information influences organisational decisions.

### Intended outcome

Leaders at every level understand and are accountable for the equality outcomes relevant to their responsibilities.

Progress will be assessed through:

- agreement and review of Board and senior leader objectives;
- Director sponsorship of staff networks;
- divisional equality data and improvement actions;
- effective escalation of risks and barriers; and
- evidence that equality information and staff insight inform decisions.

### Priorities for 2026/27

During 2026/27, the Trust will:

- develop a Workforce Inclusion Programme dashboard and reporting cycle;
- develop and pilot divisional inclusion packs;
- introduce structured divisional accountability conversations;
- strengthen the connection between equality reporting, organisational performance and assurance; and
- agree and embed Board and senior leader inclusion objectives for 2027/28.

### Accountability and assurance

Overall accountability sits with the Chief Executive, supported by the Chief People Officer.

Progress will be reviewed through the Workforce Inclusion Steering Group, People & Culture Committee and relevant Strategy Delivery Plan governance arrangements. Matters requiring further assurance or escalation will be reported through the appropriate Board route.

### Current position

Programme governance has been established. Board objectives, divisional accountability arrangements and the programme dashboard remain in development.

## Objective 2: Improve fairness in recruitment, career development and senior representation

### Baseline

Global Majority staff represented approximately 30.6% of the workforce at 31 March 2026 but remained under-represented in several senior clinical, management and consultant roles.

White applicants were reported to be 1.63 times more likely to be appointed from shortlisting than Global Majority applicants.

Although Staff Survey perceptions of equality of career opportunity improved, structural differences in senior representation remained.

### Intended outcome

Recruitment, development and advancement opportunities are experienced more equitably across protected groups.

Progress will be assessed through:

- appointment outcomes following shortlisting;
- representation by profession, pay band and level of seniority;
- participation in and outcomes from career-development services;
- promotion and appointment information, where available; and
- Staff Survey findings on access to career progression and promotion.

### Priorities for 2026/27

During 2026/27, the Trust will:

- introduce enhanced *Inclusive Recruitment MOTs* for senior recruitment and expand panel diversity;
- monitor recruitment outcomes following implementation;
- develop the 'Explain or Comply' model for senior recruitment;
- review and promote the Career Navigation Support Service, subject to available resources;
- continue delivery and evaluation of the Career Sponsorship Scheme;
- implement the local NHS England Step Up Career Development model; and
- develop further mentoring opportunities.

### Accountability and assurance

Overall accountability sits with the Chief People Officer, working with relevant professional and operational executive leads.

Progress will be reviewed through the Workforce Inclusion Steering Group, People & Culture Committee, relevant professional workforce governance and Strategy Delivery Plan reporting.

### Current position

Recruitment and career-development interventions are in delivery. Their longer-term effect on appointment outcomes and senior representation has not yet been established.

## Objective 3: Understand and reduce gender, ethnicity and disability pay gaps

### Baseline

The median gender pay gap was relatively narrow, but the mean gender pay gap remained material, reflecting differences in the distribution of women and men across professions and levels of seniority.

The overall ethnicity pay gap was close to parity but masked differences between individual ethnic groups, professions and pay levels.

Disabled staff continued to earn less on average than non-disabled staff.

Significant bonus-pay differences also remained across several characteristics.

### Intended outcome

The structural causes of pay gaps are understood and addressed through action on representation, recruitment, development, flexible working and access to senior and higher-paid roles. Progress will be assessed through:

- mean and median ordinary-pay gaps;
- bonus-pay gaps and bonus participation;
- workforce distribution across pay quartiles;
- representation across professions, grades and leadership roles; and
- delivery and impact of agreed action plans.

### Priorities for 2026/27

During 2026/27, the Trust will:

- complete root-cause analysis of gender, ethnicity and disability pay gaps;
- identify disparities hidden within aggregated figures;
- agree measurable actions and named executive ownership;
- monitor relevant recruitment and representation indicators; and
- report progress alongside the 2027 pay-gap position.

### Accountability and assurance

Overall accountability sits with the Chief People Officer, supported by the Chief Medical Officer and other relevant executive leads.

Progress will be reviewed through the Workforce Inclusion Steering Group, People & Culture Committee, relevant professional workforce governance and annual public reporting.

### Current position

Annual pay-gap reporting is now well established. Further work is required to strengthen disaggregated analysis, identify underlying causes and coordinate action across executive portfolios.

# Objective 4: Reduce workforce health inequalities and improve support for disabled staff

## Baseline

Disability was recorded for 7.2% of staff within the Electronic Staff Record, while 24.4% of Staff Survey respondents reported a physical or mental health condition lasting 12 months or more.

Among staff who reported requiring workplace adjustments, 75.1% said that adequate adjustments had been made. While consistently better than the national NHS benchmark, this still means approximately one in four did not feel adequately supported.

Disabled staff also reported poorer experiences across several Workforce Disability Equality Standard and Staff Survey measures.

## Intended outcome

Disabled staff and colleagues with long-term health conditions receive timely, consistent and effective support and experience equitable opportunities, wellbeing and employment outcomes.

Progress will be assessed through:

- sharing of staff disability status and data quality;
- satisfaction with workplace adjustments;
- the timeliness and completion of adjustment requests;
- capability, absence and retention outcomes; and
- relevant WDES and Staff Survey measures.

## Priorities for 2026/27

During 2026/27, the Trust will:

- evaluate the centralised reasonable-adjustments service;
- establish performance measures covering timeliness, consistency and staff experience;
- identify and address barriers to securing effective adjustments;
- strengthen manager capability in disability inclusion and workplace adjustments;
- improve the portability of adjustments when staff move roles or teams; and
- use WDES findings to inform divisional accountability and action.

## Accountability and assurance

Overall accountability sits with the Chief People Officer.

Progress will be reviewed through the Workforce Inclusion Steering Group, People & Culture Committee and relevant Health and Wellbeing, Occupational Health and workforce governance arrangements.

## Current position

The centralised reasonable-adjustments service has been introduced. Its performance framework, evaluation approach and longer-term outcome measures require further development.

# Objective 5: Strengthen the Experience, Inclusion and Development of Internationally Recruited Staff

## Baseline

International recruitment continues to play an important role in supporting workforce supply across the Trust. During 2025/26, 134 colleagues were recorded as joining the Trust from overseas, with most joining from non-EU countries.

The Trust has established dedicated support arrangements for some groups of internationally recruited staff joining from overseas, with a particular focus on clinically registered colleagues. During 2025/26, targeted pastoral and educational support was provided to internationally recruited Allied Health Professionals, Healthcare and Biomedical Scientists, International Medical Graduates and doctors joining on fixed-term contracts.

Specialist support arrangements are also in place for internationally recruited nurses, including a dedicated OSCE programme delivered through the Overseas Nursing Team.

Dedicated onboarding, educational and pastoral support arrangements are established and have been positively received by participants. Further work is planned to strengthen evaluation and outcome reporting.

## Intended Outcome

Internationally recruited colleagues experience effective onboarding, belonging, support, development and equitable access to opportunities. Progress Will Be Assessed Through:

- participation in onboarding and support programmes;
- retention and turnover;
- staff feedback and lived-experience insight;
- access to education, development and career opportunities;
- themes arising through staff networks, employee relations and Freedom to Speak Up; and
- evidence that identified concerns lead to improvement.

## Priorities for 2026/27

During 2026/27, the Trust will:

- maintain and develop the existing international staff support offer;
- evaluate participation, experience and outcomes;
- identify gaps in onboarding, pastoral and development support;
- gather qualitative insight from internationally recruited colleagues;
- assess access to career support and progression opportunities;
- evaluate the International Medical Graduate hybrid induction model and identify any further improvements required; and
- agree an improvement plan and ongoing performance measures.

### Accountability and Assurance

Overall accountability sits with the Chief People Officer, supported by relevant clinical, education and professional executive leads.

Progress will be reviewed through the Workforce Inclusion Steering Group, People & Culture Committee and relevant education and professional workforce governance arrangements.

### Current Position

Dedicated pastoral and educational support arrangements are established and continuing for a number of internationally recruited staff groups. Support currently includes bespoke induction programmes, pastoral support, educational development opportunities, information resources and access to initiatives such as The International Care Collective podcast, which shares the experiences of internationally recruited NHS staff adapting to life and work in the UK.

Available feedback has been positive. In addition, several International Medical Graduates from the 2025/26 cohort have expressed an interest in remaining within the Trust following completion of their initial placement. The International Medical Graduate induction programme is also being trialled as a hybrid model following feedback from previous cohorts.

Further work is required to strengthen evaluation, outcome measurement and reporting of longer-term impacts on retention, inclusion, development and progression.

## Objective 5: Strengthen the experience, inclusion and development of internationally recruited staff

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- participation in onboarding and support programmes;
- retention and turnover;
- staff feedback and lived-experience insight;
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- evidence that identified concerns lead to improvement.

### Priorities for 2026/27

During 2026/27, the Trust will:

- maintain and develop the existing international staff support offer;
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- gather qualitative insight from internationally recruited colleagues;
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- evaluate the International Medical Graduate hybrid induction model and identify any further improvements required; and
- agree an improvement plan and ongoing performance measures.

### Accountability and Assurance

Overall accountability sits with the Chief People Officer, supported by relevant clinical, education and professional executive leads.

Progress will be reviewed through the Workforce Inclusion Steering Group, People & Culture Committee and relevant education and professional workforce governance arrangements.

### Current Position

Dedicated pastoral and educational support arrangements are established and continuing for a number of internationally recruited staff groups. Support currently includes bespoke induction programmes, pastoral support, educational development opportunities, information resources and access to initiatives such as The International Care Collective podcast, which shares the experiences of internationally recruited NHS staff adapting to life and work in the UK.

Available feedback has been positive. In addition, several International Medical Graduates from the 2025/26 cohort have expressed an interest in remaining within the Trust following completion of their initial placement. The International Medical Graduate induction programme is also being trialled as a hybrid model following feedback from previous cohorts.

Further work is required to strengthen evaluation, outcome measurement and reporting of longer-term impacts on retention, inclusion, development and progression.

## Objective 6: Prevent and address discrimination, harassment and inequity in workplace processes

### Baseline

Global Majority staff continued to report higher levels of harassment, bullying or abuse from patients, relatives or the public than White staff.

Global Majority staff also reported higher levels of discrimination from managers, team leaders or other colleagues.

Disparities remained within some disciplinary and capability processes. Wider organisational evidence also identified continuing concerns relating to disability discrimination, sexual safety, misogyny, hate incidents and confidence in reporting.

### Intended outcome

Staff experience a safer and more inclusive workplace, have confidence to report concerns and receive fair, timely and effective organisational responses. Progress assessed through:

- Staff Survey discrimination, harassment and bullying;
- disciplinary and capability process disparities;
- discrimination and hate-incident reporting;
- the quality and timeliness of organisational responses;
- post-incident support;
- speaking-up confidence;
- staff experience of formal employment processes; and
- evidence that learning from incidents and concerns leads to sustained improvement.

### Priorities for 2026/27

During 2026/27, the Trust will:

- complete and share learning from targeted hate-incident and cultural-safety work;
- improve discrimination and hate-incident reporting;
- strengthen monitoring of data quality and organisational response;
- Evaluate the HR Decision-Making Group pilot effects upon fairness within disciplinary and capability processes;
- deliver targeted hate-crime, race-equality and inclusion activity; and
- evaluate whether interventions improve reporting, organisational response and staff experience.

### Accountability and assurance

Overall accountability sits with the Chief People Officer and Chief Strategy Officer, supported by relevant operational leaders. Progress will be reviewed through the Workforce Inclusion Steering Group, People & Culture Committee, Freedom to Speak Up arrangements, violence prevention and reduction governance and relevant operational governance routes.

### Current position

Several interventions are in delivery. Further work is required to improve data quality, review formal processes, evaluate impact and ensure that learning is applied consistently across the organisation.

## Objective 7: Support an inclusive transition from analogue to digital

### Baseline

The Trust's increasing use of digital systems creates opportunities to improve how staff work, learn and communicate. However, staff do not have consistent levels of access, confidence or capability in using digital technology.

Differences in digital skills, access to equipment, protected learning time and familiarity with clinical and corporate systems may disadvantage some staff groups and create barriers to development, participation and effective working.

A consistent Trust-wide baseline for digital confidence has not yet been established.

### Intended outcome

Staff have equitable access to the skills, support, equipment and protected time required to use digital systems confidently and effectively.

Digital change is implemented in a way that does not disadvantage staff because of their role, grade, location, disability, age or other protected characteristic.

Progress will be assessed through:

- participation in digital skills training;
- staff confidence in foundational digital skills;
- confidence in using relevant clinical and corporate systems;
- confidence in using data, information and artificial intelligence appropriately;
- differences in digital confidence by role, grade and staff group;
- access to protected learning time;
- participation in the Digital Champions Network; and
- evidence that equality and accessibility are considered when digital systems and processes are introduced.

### Priorities for 2026/27

During 2026/27, the Trust will:

- develop and launch a digital skills curriculum covering foundational digital skills, clinical and corporate systems, Microsoft 365, information literacy, artificial intelligence and digital leadership;
- build digital skills development into relevant career pathways and placements;
- provide protected time for staff to develop digital skills;
- increase access to online learning, workshops and drop-in support;
- establish a Digital Champions Network to provide peer support and practical guidance;
- develop a baseline measure of staff digital confidence;
- analyse digital skills and confidence by role, grade and staff group; and
- ensure accessibility and equality considerations are included within digital change and implementation.

### Accountability and assurance

Overall accountability sits with the Chief Strategy Officer and Chief Information Officer, working with the Chief People Officer and relevant education and operational leads.

Progress will be monitored through the Workforce Inclusion Steering Group and the relevant digital, workforce and Strategy Delivery Plan governance arrangements.

### Current position

The proposed digital inclusion framework and indicators have been identified. Baseline data, detailed delivery arrangements and measurable targets require further development during 2026/27.

## Workforce Inclusion Programme 2026

The Workforce Inclusion Programme (WIP) 2026 sets out the Trust's approach to delivering its equality objectives and embedding inclusion across the organisation. It builds on the Trust's Equality, Diversity and Inclusion (EDI) Strategy and aligns with the NHS EDI Improvement Plan, particularly the six High Impact Actions. It is integrated within the wider *Excellent Care Everywhere* Trust Strategy Delivery Plan.

The Programme focuses on improving outcomes across key areas including recruitment and selection, career progression, staff experience, workforce health inequalities, and leadership accountability. It is informed by the data and evidence presented within this report, alongside staff engagement, national benchmarks, and regulatory expectations.

The Programme translates these priorities into targeted, measurable actions designed to reduce inequalities in experience and outcomes between different staff groups. Progress against the Programme is reported regularly and used to inform continuous improvement.

## Board and Executive accountability

During 2026/27, the organisational equality objectives will be supported by a shared Board objective and role-specific Executive objectives aligned to individual portfolios.

These objectives will clarify responsibility for areas including:

- workforce equality;
- inclusive leadership and organisational culture;
- patient and workforce inequalities;
- accessible services and communications;
- digital inclusion;
- operational culture and safety;
- inclusive governance and impact assessment; and
- organisational assurance and risk escalation.

Once formally agreed, the objectives will be reflected in appraisal and performance-review arrangements and monitored through the appropriate governance routes.

Individual Board and Executive objectives will provide an additional accountability mechanism. They will not replace the collective responsibility of the Board, and they complement the organisational equality objectives set out above.

## Monitoring and reporting

Progress against the equality objectives will be monitored through the Workforce Inclusion Programme and reported through the Workforce Inclusion Steering Group and People & Culture Committee.

Relevant risks, barriers and dependencies will be escalated through Strategy Delivery Plan, corporate risk and Board assurance arrangements where required.

The Trust will publish updated equality information annually. Future reports will include:

- progress against each objective;
- changes in the principal outcome measures;
- delivery against annual milestones;
- areas where improvement has not been achieved;
- barriers or risks affecting delivery; and
- any resulting changes to priorities or action.

## Governance

Robust governance arrangements are in place to ensure accountability for delivery of the Workforce Inclusion Programme and equality objectives.

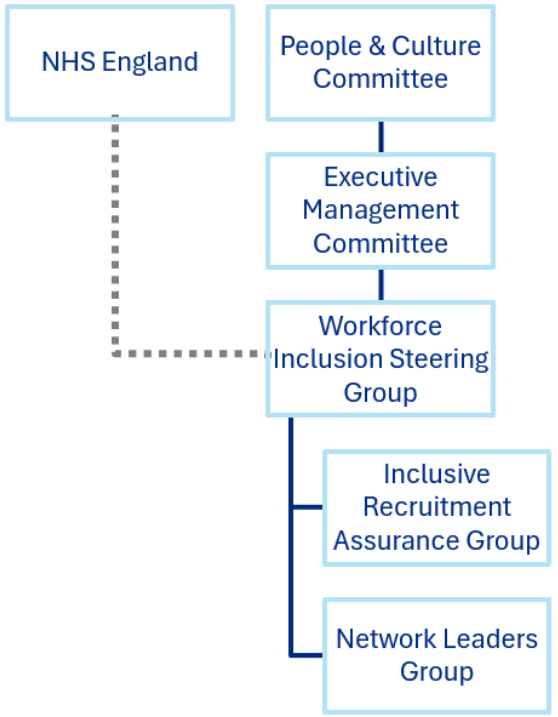
In April 2025, the Trust established a Workforce Inclusion Steering Group. This group provides oversight of progress against the WIP, monitors delivery of key actions, and ensures alignment with organisational priorities.

Progress is reported on a bi-monthly basis and escalated quarterly to the People & Culture Committee, providing Board-level assurance. Governance arrangements will be further strengthened in 2026/27 with the introduction of an overarching Workforce Steering Group, chaired by the Chief People Officer.

In addition, the Trust meets a range of national and regional reporting requirements, including:

- Workforce Race Equality Standard (WRES) submissions to NHS England
- Workforce Disability Equality Standard (WDES) submissions
- Annual gender and ethnicity pay gap reporting to the Cabinet Office
- NHS EDI Improvement Plan reporting via the Integrated Care Board (ICB)
- Contributions to the Trust Annual Report and statutory equality publications.

*Current governance arrangements:*



## Regulatory response: CQC Well-Led assessment

In its Well-Led assessment published in May 2026, the Care Quality Commission identified that further work was required to ensure the Trust makes effective use of the Workforce Race Equality Standard (WRES) and NHS Staff Survey findings so that staff from ethnic minority backgrounds are not disproportionately disadvantaged. The Trust submitted a Regulation 17 action plan in response, with delivery built into the Workforce Inclusion Programme for 2026/27.

### Action and accountability

The Trust's response prioritises fair recruitment and selection, senior career progression and representation, more equitable formal employment processes, prevention of discrimination and harassment, support for internationally recruited staff, and stronger Board and divisional accountability. Planned delivery includes enhanced inclusion controls for senior recruitment, divisional workforce inclusion data packs and accountability conversations, career sponsorship and navigation support, improved discrimination reporting, cultural safety interventions, inclusive leadership development and review of potential bias within disciplinary and capability processes.

Executive responsibility is shared between the Chief People Officer and Chief Strategy Officer. Delivery is phased over 2026/27, with key recruitment, reporting and divisional accountability milestones scheduled during 2026 and wider implementation and evaluation continuing to March 2027.

### Monitoring and assurance

Progress will be monitored through the Workforce Inclusion Steering Group, People & Culture Committee and relevant Strategy Delivery Plan reporting arrangements. Measures will include WRES indicators, NHS Staff Survey results, recruitment and employee-relations data, senior and Board representation, local pulse surveys, divisional analysis and qualitative insight from staff networks and other staff-engagement routes.

At the date of publication, established elements of the response remain in delivery, such as workforce equality reporting, inclusion governance, staff network oversight, career sponsorship and international staff support. Further controls, including divisional data packs, enhanced senior recruitment arrangements, improved discrimination reporting and review of formal employment processes, are being developed or implemented during 2026/27.

# Our framework for inclusion

How our vision, values, behaviours and leadership expectations support inclusion

NHS
University Hospitals Sussex
NHS Foundation Trust

## Our vision

**Excellent Care Everywhere**

Excellent care for our people, communities and One UHSussex depends on inclusion, fairness, belonging and respect.

## Our values

### We are compassionate

We communicate and act kindly.

### We are inclusive

We work collaboratively, value difference and involve others.

### We are respectful

We behave professionally, fairly and with dignity.

## Our Behavioural Compass

Five commitments that turn values into everyday behaviours

### We act with kindness and care

Treat people with dignity and support wellbeing.

### We include and involve

Stay curious, value difference and involve those affected.

### We work as One UHSussex

Collaborate across roles, teams, sites and services.

### We take responsibility and follow through

Act early, address issues and challenge discrimination.

### We learn, improve and speak up

Create psychological safety, welcome challenge and learn.

## Inclusive and anti-discriminatory leadership framework

How the Compass applies across four leadership levels for inclusion

### Leading a team

- Actively seeks and values input from people with different perspectives and experiences.
- Involves patients, carers or partners where this improves decisions or outcomes.
- Challenges exclusion, bias or power imbalance within the team

### Leading multiple teams

- Actively seeks and values diverse professional and personal perspectives in decision-making.
- Encourages challenge and constructive dissent to improve quality and outcomes.
- Creates space for honest dialogue across teams, disciplines and services.

### Leading the organisation

- Seeks and values challenge from different professional, personal and lived perspectives.
- Actively addresses inequity, bias or power imbalance in systems and decisions.
- Involves staff, patients and partners in shaping priorities where it improves outcomes.

### Leading UHSussex and the system

- Seeks and values diverse perspectives in Board and Executive decision-making.
- Ensures staff, patient and partner insight meaningfully informs strategy and assurance.
- Challenges exclusion, bias or group-think at senior levels.

**Shared aim:** a culture where everyone feels valued, heard, treated fairly, able to belong, and confident to speak up.

# Equality Profiles

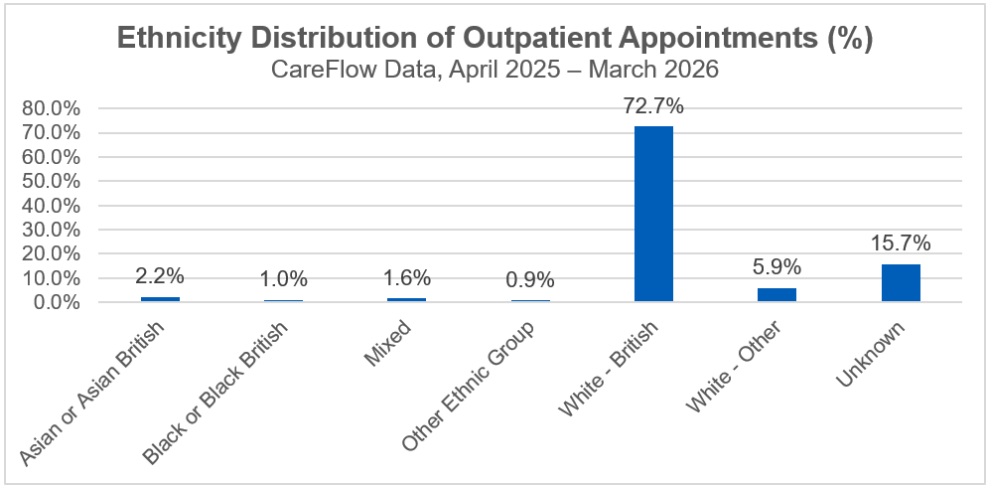
The following sections summarise the diversity and representation of the people who use our services and the workforce that delivers them. These themes bring together demographic, representation and progression data to provide context for understanding workforce experiences, opportunities and outcomes across the organisation.

## Service User Equality Snapshot

Understanding the demographic profile of people who use our services provides context for identifying potential differences in patterns of service use, patient experience and outcomes. Although this is primarily a *workforce* equality report, comparing service-user and workforce demographics also helps identify where the composition of the workforce differs from the populations it serves.

The activity data presented in this section describe recorded appointments, attendances and discharges. They do not, on their own, demonstrate whether access is equitable, because patterns of service use are also influenced by population need, age, case mix, referral routes, repeat activity, service catchments and the completeness of demographic recording. Incomplete data continue to limit more detailed analysis and underline the importance of improving data quality across clinical systems.

### Race and Ethnicity




Census 2021 data indicate that approximately 9.0% of residents across Sussex identified with an Asian, Black, Mixed or Multiple, or Other ethnic group, referred to in this report as Global Majority[2]. This compares with 19.0% across England. The proportion varied considerably by place, from 6.1% in East Sussex and 9.0% in West Sussex to 14.6% in Brighton & Hove. Across Sussex overall, approximately 3.7% of residents identified as Asian, 1.3% as Black, 2.7% as Mixed or Multiple ethnic groups and 1.3% as another ethnic group. CareFlow outpatient data, including attendances, cancellations and DNAs, show that 5.7% of recorded activity related to patients from Global Majority backgrounds and 78.6% to White patients, while ethnicity was not recorded for 15.7% of contacts. As this data is based on outpatient activity rather than unique patients, individuals with multiple appointments during the reporting period may been counted on more than one occasion. Ethnicity was recorded for 84.3% of appointments, above the national average of 77.1% for outpatient attendances.

[2] **Source:** Office for National Statistics, Census 2021 ethnic-group data for East Sussex, West Sussex and Brighton & Hove. For this analysis, "Global Majority" comprises the Census high-level Asian, Black, Mixed or Multiple, and Other ethnic-group categories and excludes all White ethnic-group categories. The Sussex percentage is population-weighted across the three areas.

Additional inpatient and Emergency Department data show a similar pattern. In inpatient activity, 81.6% of discharges related to White patients and 5.5% to Global Majority patients, while ethnicity was not recorded for 13.0%. In Emergency Department activity, 73.9% of discharges related to White patients and 6.8% to Global Majority patients, while ethnicity was not recorded for 19.4%.

Although ethnicity recording remains incomplete across all three care settings, with missing data ranging from 13.0% of inpatient activity to 19.4% of Emergency Department activity, ethnicity was recorded for between 80.6% and 87.0% of activity. This exceeds the national threshold of 60% and places the Trust amongst the top-performing organisations nationally. Nonetheless, further improvement is required to support more detailed analysis and reliable comparison with local population benchmarks. During Q4, face-to-face training and supporting materials were provided to increase staff confidence in collecting ethnicity data, alongside patient-facing leaflets and posters explaining why this information is important.

However, these figures alone do not establish whether access is equitable, as interpretation is influenced by differences in population need, age profile, service catchments, referral patterns, case mix, repeat activity and the remaining gaps in ethnicity recording.

### Disability

Approximately 18.2% of residents across Sussex identified as disabled under the Equality Act 2010 definition in the 2021 Census. This varies by place, from approximately 16.9% in West Sussex and 18.7% in Brighton & Hove to 20.3% in East Sussex. Comparable patient-level information is currently limited because disability status is not consistently recorded within clinical systems. This restricts the Trust's ability to assess whether disabled patients experience differences in access, experience or outcomes.

### Sex

Females represent approximately 51.6% of the local population (Census 2021). The proportion varies slightly by place, from 51.0% in Brighton & Hove and 51.5% in West Sussex to 52.0% in East Sussex.

Outpatient data show that 57.4% of appointments were attended by female patients and 42.6% by male patients. Male patients had a slightly higher did-not-attend rate than female patients, at 5.4% compared with 4.8%, while female patients had a higher cancellation rate, at 13.0% compared with 11.5%. A similar pattern is evident in other care settings. Females accounted for 54.2% of inpatient discharges and 52.4% of Emergency Department attendances, compared with 45.8% and 47.5% respectively for males. These activity patterns are broadly similar to the overall sex profile of the Sussex population. However, appointment,

attendance and discharge proportions alone cannot determine whether access is equitable, as they do not account for differences in healthcare need, referral patterns, age, case mix or repeat use of services.

### Gender Identity

Approximately 0.5% of residents aged 16 and over across Sussex reported that their gender identity was different from their sex registered at birth in the 2021 Census. This varied by place, from approximately 0.4% in both East Sussex and West Sussex to 1.0% in Brighton & Hove. Patient-level information on gender identity is not consistently recorded within clinical systems, limiting the Trust's ability to assess differences in access, experience or outcomes. The Census estimates should be treated as a broad indication rather than a precise measure, particularly at local level, because the question was voluntary and the Office for National Statistics has identified uncertainty affecting interpretation of the results.

### Sexual Orientation

Approximately 4.3% of residents aged 16 and over across Sussex identified as lesbian, gay, bisexual or another minority sexual orientation in the 2021 Census. This varied considerably by place, from 2.9% in West Sussex and 3.3% in East Sussex to 10.6% in Brighton & Hove. Across Sussex, approximately 2.3% identified as gay or lesbian and 1.6% as bisexual, with smaller proportions identifying as pansexual, asexual, queer or another sexual orientation. The Census question was voluntary, and these figures may not capture all residents with a minority sexual orientation. Patient-level information on sexual orientation is not consistently recorded within clinical systems, limiting the Trust's ability to assess differences in access, experience or outcomes.

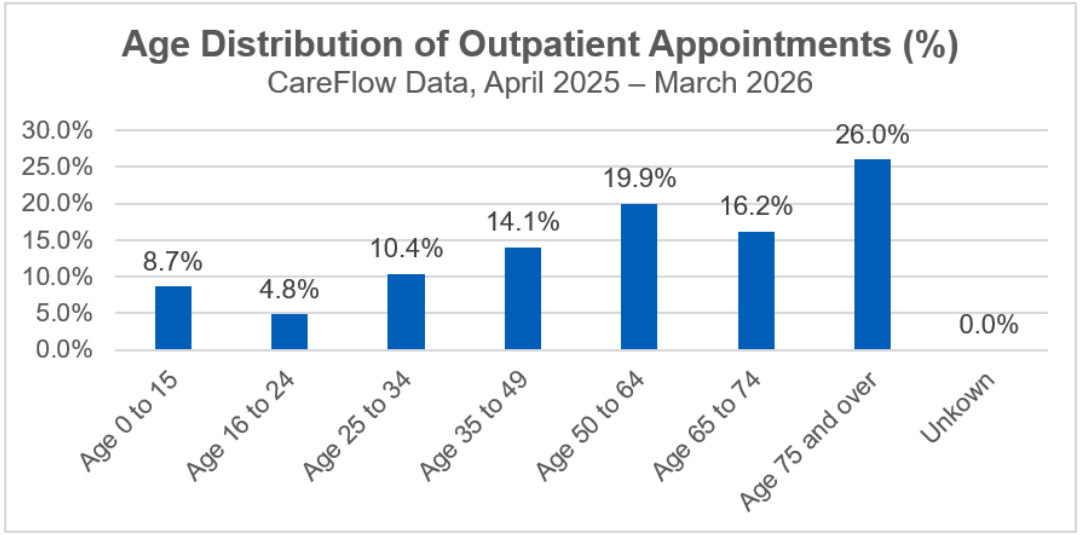
### Religion and Belief

Approximately 49.1% of residents across Sussex reported a religion in the 2021 Census. This varied by place, from approximately 37.7% in Brighton & Hove and 48.8% in East Sussex to 52.8% in West Sussex. Christianity was the most commonly reported religion overall, accounting for approximately 44.6% of the Sussex population, although this ranged from 30.9% in Brighton & Hove to 45.9% in East Sussex and 48.1% in West Sussex. Across Sussex, approximately 2.0% of residents identified as Muslim, 0.5% as Buddhist and 0.8% as Hindu. The Census question on religion was voluntary, and around 6–7% of residents did not provide an answer.

In inpatient data, 35.6% of patients were recorded as having a religion, including 33.0% recorded as Christian and 0.9% as Muslim, while 19.3% were recorded as having no religion. However, religion or belief information was missing from 45.0% of records, preventing reliable comparison with the Sussex population and limiting further analysis.

## Age

The age profile of the population varies considerably across Sussex. Brighton & Hove has a younger population, with approximately 14% of residents aged 65 and over, compared with around 23% in West Sussex and 26.1% in East Sussex. These differences are relevant when interpreting patterns of hospital activity, particularly because older populations are generally more likely to require inpatient and planned care.




Outpatient data show variation in recorded activity across age groups. Patients aged 75 and over accounted for the largest proportion of appointments, at 26.0%, while those aged 16–24 and 25–34 accounted for the smallest proportions, at 4.8% and 10.4% respectively.

Patterns differed across other care settings. In inpatient activity, the largest proportions of discharges were among patients aged 30–64, at 38.9%, and 65–84, at 34.8%, while patients aged 18–29 accounted for 7.7%. In Emergency Department activity, younger patients accounted for a greater share, including those aged 0–17, at 19.5%, and those aged 18–29, at 15.0%. This is consistent with differing patterns of service need and use across urgent, planned and inpatient care.

Younger outpatients also had higher did-not-attend rates. Patients aged 16–24 had the highest rate, at 9.4%, compared with a lowest reported rate of 3.3% among older patients. This indicates differing attendance patterns and may warrant further analysis of factors such as appointment type, communication method, transport, service location and the availability of flexible appointment options.

These activity figures should not be interpreted as direct evidence of equitable or inequitable access. Meaningful assessment would require analysis against the age profile and healthcare needs of the relevant service catchment, alongside referral rates, waiting times, repeat activity and outcomes.

### Caring Responsibilities

Approximately 8.9% of the population in Sussex provide unpaid care (Census 2021). This varies by place, from approximately 8.0% in Brighton & Hove and 8.6% in West Sussex to 9.9% in East Sussex. Patient-level data on caring responsibilities is not consistently recorded within clinical systems, limiting the Trust's ability to assess whether carers experience differences in access, experience or outcomes.

### Armed Forces

Approximately 3.6% of residents across Sussex have previously served in the UK Armed Forces (Census 2021). This varies across Sussex, from 2.4% in Brighton & Hove and 3.4% in West Sussex to 4.6% in East Sussex, indicating a higher concentration of veterans in East Sussex. The Census measure covers previous service only: people currently serving in the UK Armed Forces were instructed to answer "no" and are therefore not included in these figures. Separately, Ministry of Defence statistics recorded 183,410 UK Armed Forces service personnel nationally at 1 April 2026. This is a UK-wide personnel headcount rather than a Sussex estimate or a proportion of the general population and should not be added to, or directly compared with, the Census veteran percentage.

## Women and Children's Divisional Cultural Safety

Over the past year, we established the Divisional Cultural Safety Steering Group to provide a dedicated forum for addressing inequalities and promoting equity across our services. The group has brought together colleagues from across Women's Health Services, the EDI team, organisational networks and quality improvement leads to identify areas of disparity, share learning and develop actions to improve outcomes and experiences for both staff and the communities we serve. Through regular meetings, we have reviewed data and dashboards to better understand inequalities, received updates from organisational networks and EDI colleagues, and welcomed guest speakers to increase awareness and understanding of cultural safety and inclusion. These discussions have informed a number of quality improvement initiatives within the division, ensuring that equity and cultural safety are embedded within service development and improvement work. The Steering Group has provided an important platform for collaboration, accountability and shared learning, helping to shape a more inclusive and equitable culture across division.

## Translation and Interpreting services, 2025/26

Access to professional interpreting and translated information is essential to safe, equitable and person-centred care. It enables patients to understand their diagnosis and treatment, participate in decisions and provide informed consent. The Trust's policy requires staff to identify and record communication needs, offer professional support and avoid relying on relatives, children or unapproved translation applications for clinical communication.

During 2025/26, suppliers recorded **17,903 interpreting and translation bookings**, with associated invoice expenditure of **£891,549**. The source of this data is UHSussex supplier booking and invoice data, April 2025 to March 2026. Figures are operational data and do not reconcile directly to ledger expenditure because of invoice timing, inconsistent supplier coding and retrospective adjustments.

| Type of service | Bookings | Share of bookings | Recorded spend | Share of spend |
|---|---|---|---|---|
| **Remote telephone interpreting, international languages** | 9,381 | 52.4% | £124,362 | 13.9% |
| **Face-to-face interpreting, international languages** | 7,323 | 40.9% | £637,041 | 71.5% |
| **Face-to-face sign-language interpreting** | 892 | 5.0% | £114,750 | 12.9% |
| **Other remote, video and document translation services** | 307 | 1.7% | £15,396 | 1.7% |
| **Total** | 17,903 | 100% | £891,549 | 100% |

Remote telephone interpreting was therefore the most frequently used delivery method. However, face-to-face international-language interpreting continued to account for most expenditure because of longer minimum booking periods, interpreter travel and cancellation charges. This suggests that remote interpreting can provide a flexible and lower-cost communication option in appropriate circumstances, while face-to-face interpreting remains essential where the patient's needs, the complexity or sensitivity of the interaction, or a reasonable adjustment require it.

The most frequently recorded languages were **Arabic** (3,266 bookings), **Bangla/Bengali** (1,423), **Farsi/Persian** (1,337), **British Sign Language** (990), **Russian** (977) and **Portuguese** (917). The ten most frequently used languages accounted for 47.5% of activity across the full year, demonstrating both concentrated demand and the breadth of language needs across the Trust. Royal Sussex County Hospital accounted for 11,052 bookings, approximately 62% of the total, although 921 records did not contain a reliable site identifier.

Further details on translation and interpreting activity, demand and service delivery are provided in Appendix 3: Translation and Interpreting.

## Service improvement and assurance

The Trust continued to embed the revised approval process for advance-booked, in-person interpreters. Staff are expected to consider telephone or video interpreting first, with individual divisional approval required for planned face-to-face bookings. The process explicitly retains face-to-face support where it is clinically or otherwise necessary and is intended to improve both timely access and financial oversight.

Late cancellations remained a material issue. **1,559 bookings**, equivalent to **8.7% of all recorded activity**, were identified as late cancellations. These incurred costs of **£93,712**, or **10.5% of total recorded expenditure**. Late cancellation is not solely a financial issue. Repeated cancellation or rescheduling can disproportionately affect patients who require interpreters, particularly Deaf patients and people experiencing barriers associated with migration, poverty, transport or digital exclusion. Further work is required with high-use services to distinguish cancellations arising from patients, clinical services or suppliers and to identify whether appointment confirmation, accessible communication or booking processes can be improved.

The Trust also continued to promote **CardMedic**, which provides staff with immediate access to pre-translated clinical conversations, British Sign Language content, Easy Read and read-aloud functions. By 31 July 2025, 1,007 UHSussex staff had registered, with midwives, doctors and nurses the most frequent users. International-language content remained its primary use, while BSL and Easy Read usage was comparatively low. Work during the year explored integrating access to live interpreting suppliers through a single digital route and improving booking, reporting and invoice validation.

## Priorities for 2026/27

- Reduce avoidable late cancellations, including targeted reviews where rates are unusually high
- Improve BSL and other accessible communication pathways
- Preserve access to face-to-face interpreting where this is clinically necessary or a reasonable adjustment
- Increase appropriate use of remote interpreting and CardMedic
- Improve consistency of supplier coding, site and department data
- Strengthen reconciliation between booking, invoice and financial-ledger information

# Workforce Equality Snapshot

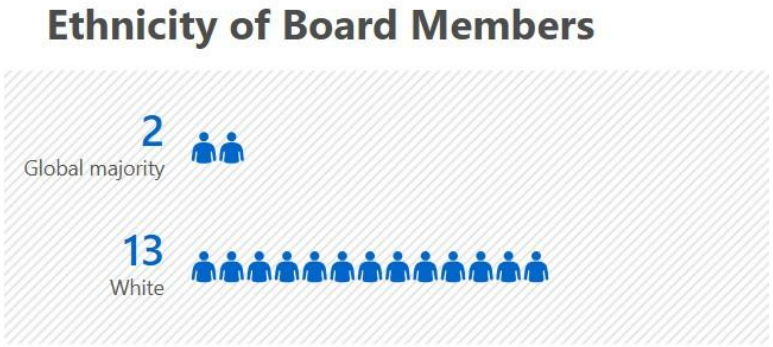
Understanding the demographic profile of our workforce helps identify how well the organisation reflects the communities it serves and provides context for understanding differences in staff experience, representation and outcomes.

## Board Composition

This section provides an overview of the composition of our Board, including both Executive and Non-Executive Directors at the snapshot date of 31 March 2026 (N = 16). Understanding the diversity of our Board is important in ensuring that decision-making reflects a range of perspectives and experiences. While sex representation is balanced, representation across several other characteristics remains limited, particularly ethnicity, disability and age.

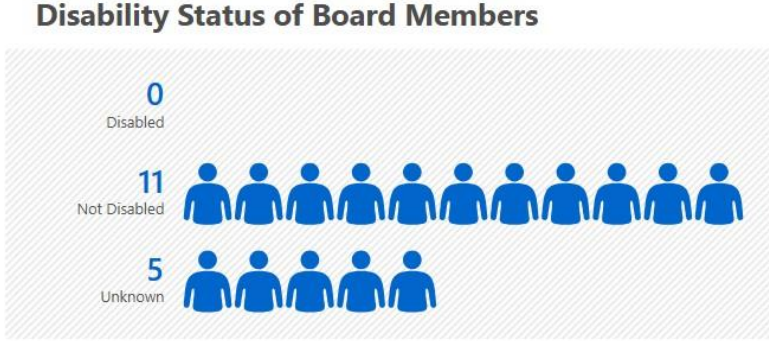
### Race and Ethnicity

Most Board members identify as White (13 members; 81.3%), with 12.5% (2 members) identifying as Global Majority. One member (6.3%) has not disclosed their ethnicity. Representation from Global Majority backgrounds is currently limited, with no representation at executive level.




### Disability

No Board members have declared a disability. Most members are recorded as not disabled (68.8%, 11 members), while 31.3% (5 members) have not disclosed their disability status.




### Sex

Sex representation across our Board is balanced overall, with equal numbers of female and male members (50.0% each; 8 members).

### Sexual Orientation

50% (8 members) of Board members disclosed their sexual orientation, while the other half have not.

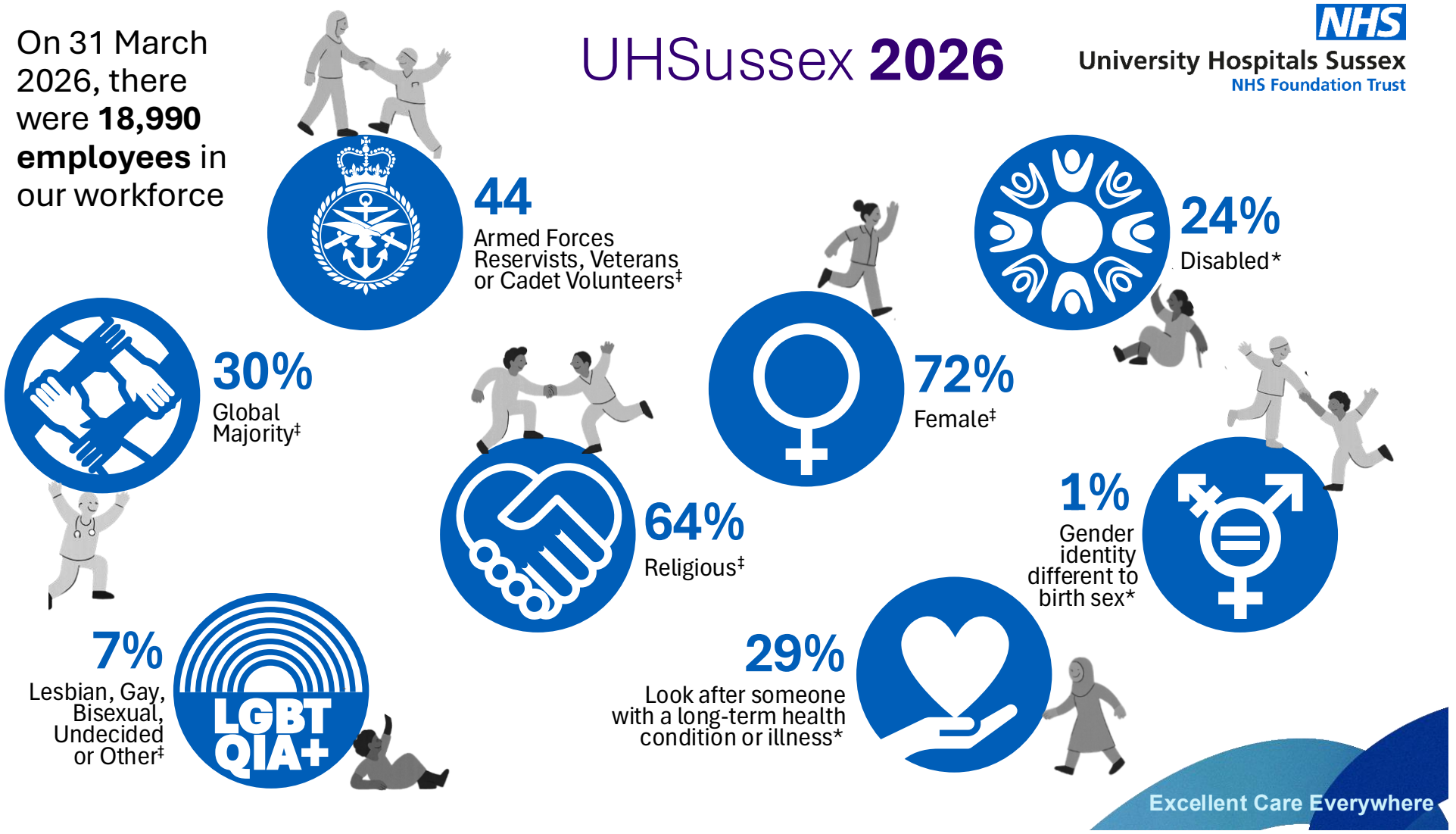
### Religion and Belief

Over half of Board members (56.3%, 9 members) have reported having a religion, while a further 37.5% (6 members) have not disclosed their religion or belief.

### Age

The Board is predominantly made up of members aged 51 and over, with the largest groups aged 51–60 and 61–70. There is limited representation from younger age groups, with only one Board member aged 40 or under.

## Workforce Composition




‡ Source: Electronic Staff Records (ESR)

* Source: National Staff Survey – UHSussex results

This section provides an overview of our workforce composition using Electronic Staff Record (ESR) data, alongside Staff Survey 2025 responses to give additional context on how our colleagues identify themselves. Percentages are supported by the accompanying charts to support interpretation. Understanding workforce composition helps identify how well the Trust reflects the diversity of the communities it serves and provides important context for understanding differences in staff experience, representation and outcomes.

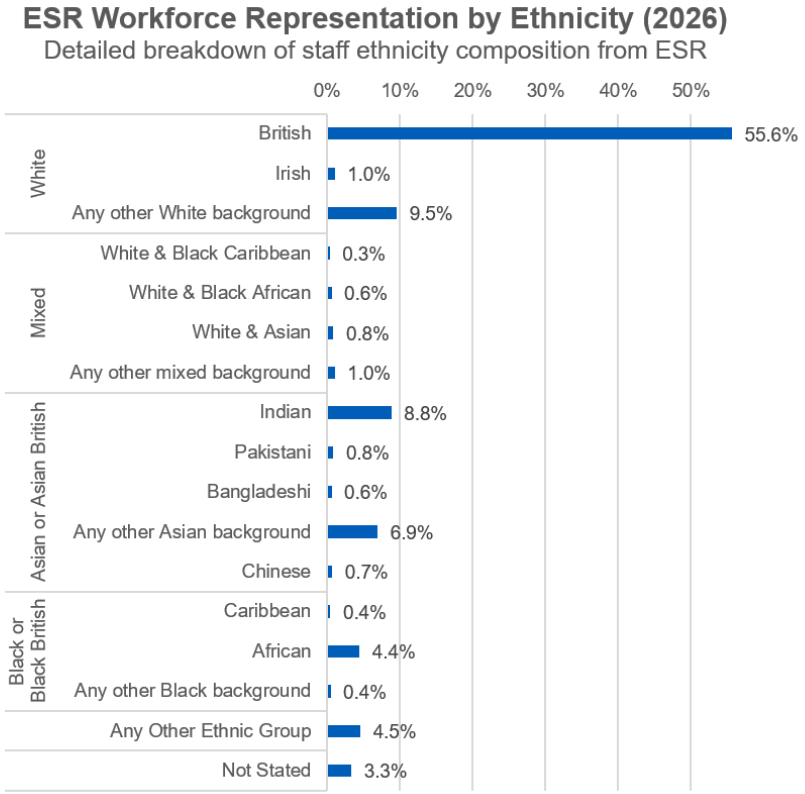
## Race and Ethnicity

Our workforce includes a diverse range of ethnic backgrounds. The majority of colleagues identify as White (66.2%, 12,541 staff), with colleagues from Global Majority backgrounds making up just under a third of our workforce (30.5%, 5,777 staff).

Staff Survey responses show a similar pattern, with 70.7% of respondents (5,905 staff) identifying as White. Within the survey, 4.6% identified as Black/African/Caribbean/Black British, 2.6% as Mixed/Multiple ethnic backgrounds, and 1.5% as from another ethnic group not listed (other). A small proportion (1.8%, 152 staff) did not provide ethnicity information.

The percentage of colleagues from Global Majority backgrounds has more than doubled over the past decade, increasing from 14.6% in 2014 and 2015. Growth was gradual up to 2021 (19.5%), followed by a more pronounced increase in recent years.

This growth reflects a steadily diversifying workforce and highlights the importance of ensuring that opportunities, experiences and outcomes remain equitable as workforce demographics continue to evolve.

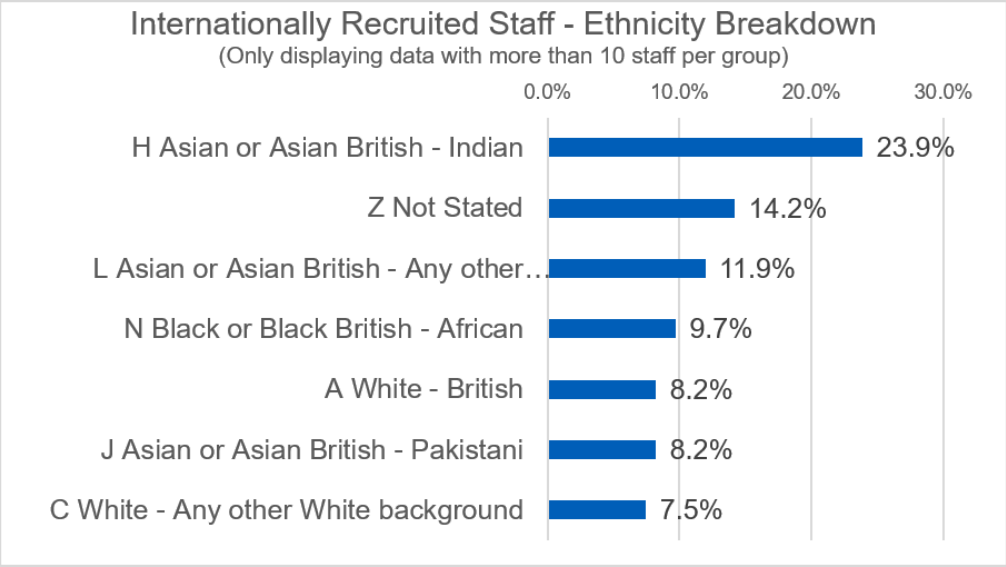


## International Recruitment

This diversity is further reflected in international recruitment, with colleagues joining the Trust from a range of countries over the past year, including the Philippines, Pakistan, Germany, South Africa, India, Brazil, Portugal, Canada, Singapore and Nigeria.

Data from the NHS Staff Movements Dashboard (ESR) indicates that 134 staff were recruited from abroad between 1 April 2025 and 31 March 2026. The majority of these recruits (94.0%) joined from non-EU countries. Over half were from India, the Philippines, Nigeria or Pakistan, highlighting the Trust's reliance on international workforce supply from these regions.

These internationally recruited colleagues are primarily based across Royal Sussex County Hospital (41.0%), Worthing (24.6%) and St Richard's (20.9%), and most commonly work within Medical and Dental roles, followed by Additional Clinical Services, Nursing and Midwifery, and Allied Health Professionals. Many were appointed to Medical Doctor, Registrar or Consultant roles, or Bands 2–5, reflecting recruitment across both clinical and support roles. Over half of these colleagues joined on permanent contracts (58.2%).




Demographic data shows that the majority identify as non-disabled (66.4%), Asian (44.0%), female (58.2%), and are aged between 26 and 35 (56.0%). A range of religions and sexual orientations are represented, although a notable proportion of staff (30.6%) chose not to disclose this information.

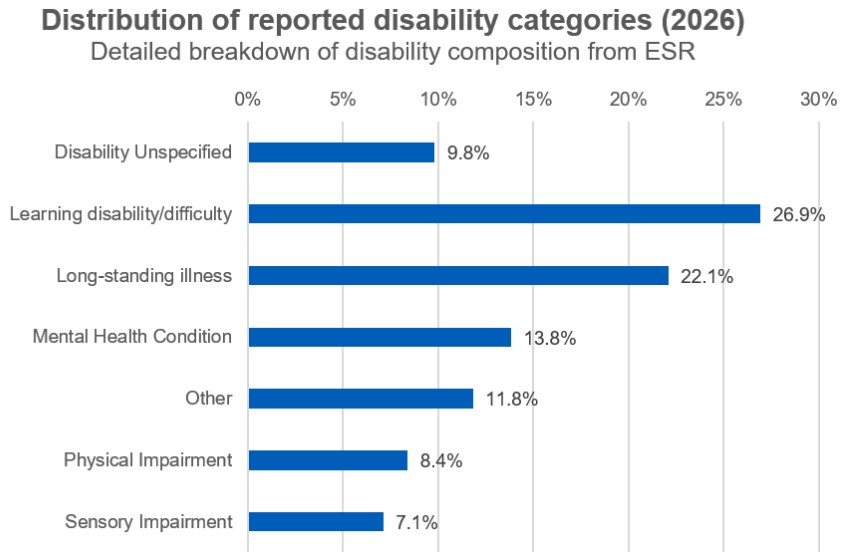
International recruitment continues to play an important role in supporting workforce supply across a range of professions and grades, reinforcing the Trust's reliance on a globally diverse workforce.

## Disability

Based on ESR data, 7.2% of our workforce (1,367 staff) have declared a disability, compared to 85.2% (16,178 staff) recorded as not disabled.

However, Staff Survey responses suggest that a larger proportion of our colleagues experience long-term health conditions, with 24.4% (2,037 staff) reporting a physical or mental health condition lasting 12 months or more, compared to 73.5% (6,143 staff) who reported they do not.

This difference suggests that disability may be underrepresented in ESR data and highlights the importance of continuing to create an environment where colleagues feel safe, supported, and confident to disclose. It may also reflect the use of more inclusive wording within the Staff Survey, which could encourage greater identification with disability and long-term health conditions.




The percentage of colleagues reporting a disability has increased over the past 10 years, rising from 4.2% in 2014. Growth was gradual up to 2022 (5.2%), followed by a more noticeable increase in recent years.

## Sex

Our workforce is predominantly female, with ESR data showing 72.2% of colleagues (13,719 staff) recorded as female and 27.8% (5,271 staff) as male. Staff Survey data closely reflects this profile, with 71.1% (5,939 staff) identifying as female and 23.4% (1,953 staff) as male. In addition, a small but significant proportion of colleagues identified as non-binary (0.4%), preferred to self-describe (0.2%), or chose not to disclose their gender (3.7%, 103 staff).

The proportion of female colleagues has decreased slightly over the past 10 years, from 76.3% in 2014. This reflects a gradual shift over time, with the proportion remaining relatively stable since 2023 (72.6%). While the workforce remains predominantly female, the gradual change over time reflects increasing gender diversity across the organisation.

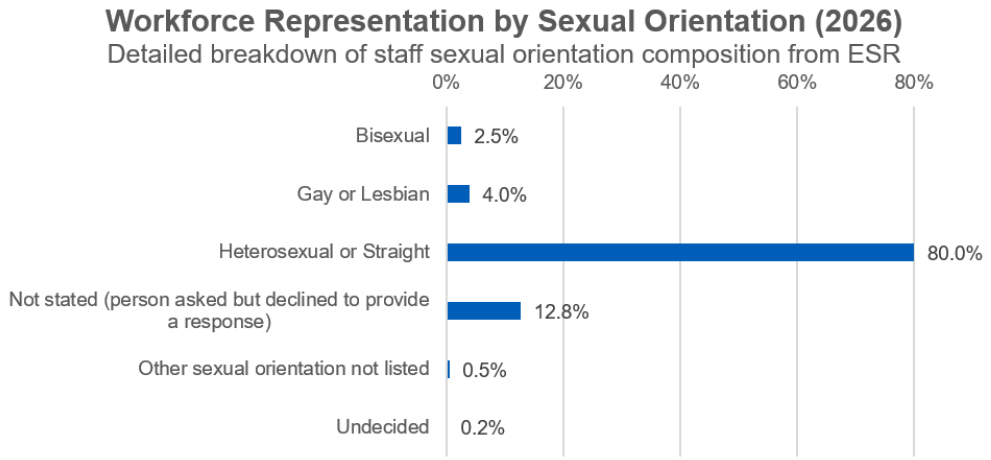
In terms of gender identity, 85.2% of colleagues (7,117 staff) reported that their gender identity is the same as the sex registered at birth, while 0.5% (45 staff) reported that it is different. 3.7% of respondents indicated they preferred not to disclose their gender identity (308 staff) and no data was available for a further 10.6% (888 staff).

### Sexual Orientation

The majority of our colleagues identify as heterosexual or straight (ESR: 80.0%, 15,148 staff; Staff Survey: 84%, 6,785 staff).

LGBUO[3] representation is captured as 7.2% (1,368 staff) in ESR data. Staff Survey data provides further insight, with 4.6% of colleagues (376 staff) identifying as gay or lesbian and 2.8% (234 staff) as bisexual.

A notable proportion of colleagues chose not to disclose their sexual orientation (ESR: 12.8%; Staff Survey: 8.4%), which may indicate ongoing barriers to disclosure and highlights the importance of maintaining an inclusive and supportive environment.




The percentage of colleagues identifying as LGBUO has increased steadily over the past decade from 3.2% in 2014, more than doubling over this period with consistent growth across the years. The increase in disclosure may reflect both changes in workforce demographics and growing confidence among colleagues to share information about their sexual orientation.

[3] LGBUO represents the sum of staff identifying as lesbian, gay, bisexual, undecided, or another sexual orientation (other)

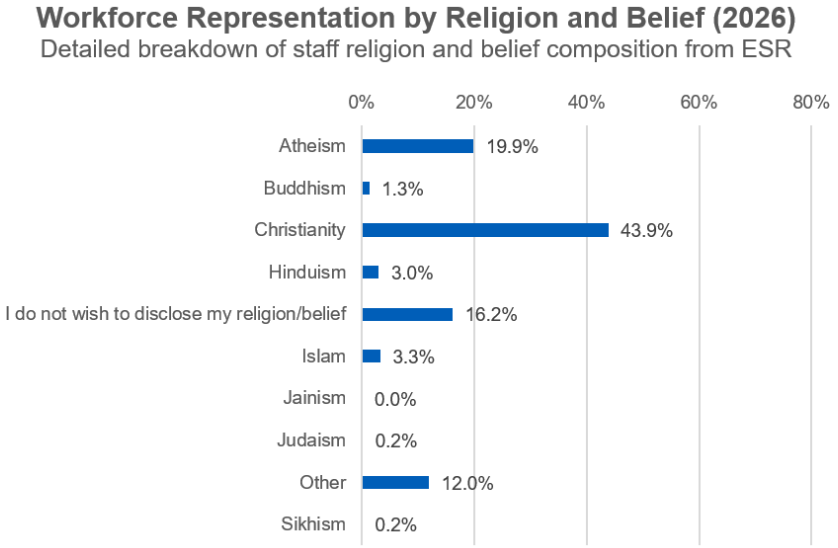
## Religion and Belief

Our workforce reflects a wide range of religions and beliefs. ESR data shows that 63.9% of colleagues (12,096 staff) identify as having a religion, while 19.9% (3,772 staff) identify as atheist.

Christianity is the most commonly recorded religion (43.9%), alongside smaller representations of Hinduism, Islam, Buddhism and other beliefs. A significant proportion of colleagues (16.2%) chose not to disclose their religion or belief.

Staff Survey data complements this, showing 52.7% of respondents holding a religion, of those 45.5% identify as Christian, while 40.1% report no religion, and 6.2% preferred to not share their religion.

The percentage of colleagues reporting a religion has remained relatively stable over the past decade, increasing slightly from 59.8% in 2014 with small fluctuations over time.




## Age

Our workforce spans a broad range of age groups, reflecting a mix of early career, mid-career and more experienced colleagues. ESR data shows that the largest proportions of colleagues are aged between 26 and 40, with 12.1% (2,406 staff) aged 26–30, 14.4% (2,874 staff) aged 31–35, and 14.9% (2,969 staff) aged 36–40. Together, these groups make up 41.3% of our workforce.

Staff Survey responses show a slightly older profile among respondents, with the largest groups aged 51–65 (32.9%), followed by 31–40 (25.3%) and 41–50 (24.4%). This difference is likely influenced by variation in survey response rates across age groups.

Overall, the workforce includes colleagues at all stages of their careers, bringing a broad range of perspectives, skills and experience to the organisation.

### Caring Responsibilities

Caring responsibilities are not widely recorded in ESR, with 0.9% of colleagues (170 staff) identified as working carers.

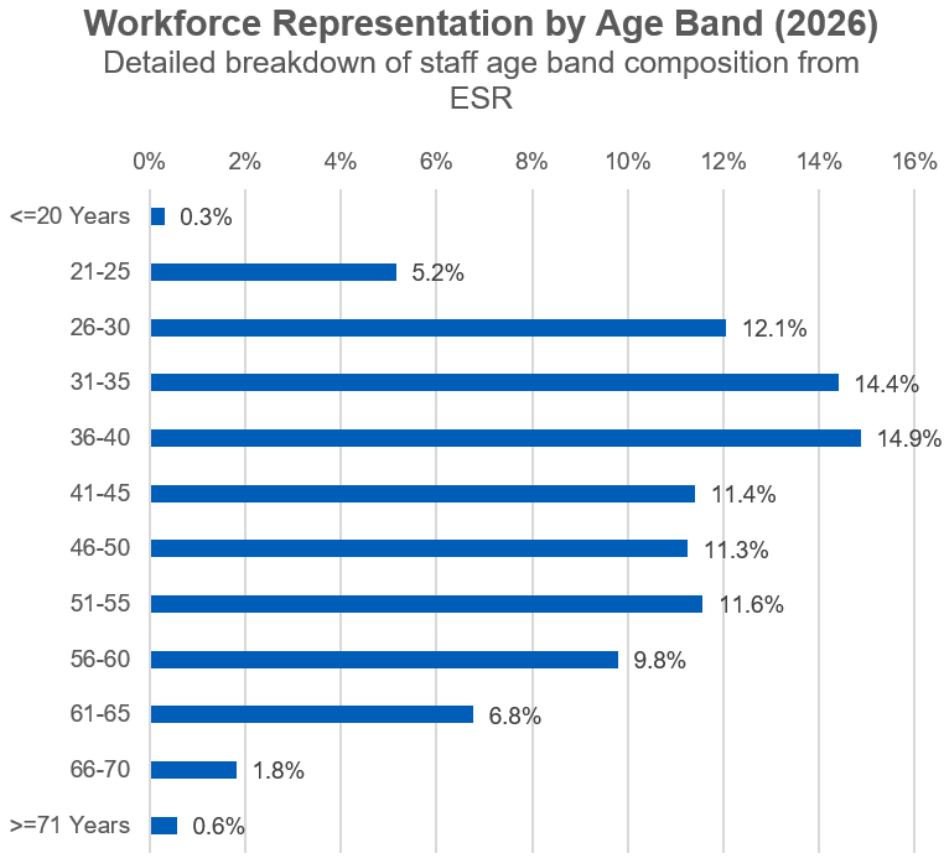
In contrast, Staff Survey responses indicate that 29.1% of colleagues (2,378 staff) provide care or support to family members, friends, or others due to long-term health conditions, disability, or age.

This highlights that caring responsibilities are likely underreported in ESR data and reinforces the importance of recognising and supporting colleagues with caring roles.

### Armed Forces

A small proportion of our workforce are part of the Armed Forces community (0.2%, 44 staff), including 8 Reservists, 31 Veterans, and 5 Cadet Force Adult Volunteers

In addition, 42 colleagues identified as Armed Forces family members.




## Workforce Representation

Disparity ratios are used in this report to compare the representation of different staff groups across workforce levels and career pathways. A value of 1 indicates equal representation between groups, while values between 0.8 and 1.25 are considered to fall within the expected equality range and are highlighted in green in the tables below. Values outside this range indicate differences in representation and may highlight areas where further exploration is required.

This analysis helps identify where barriers to progression may exist and provides insight into how opportunities and outcomes are experienced across the workforce.

### Race and Ethnicity

Analysis of disparity ratios highlights that the largest differences in workforce representation are within clinical roles, particularly at more senior levels. Compared to their representation in support and newly qualified roles (Bands 1–5), White staff were around six times more likely to be in senior clinical roles (Bands 8 and above), an increase from five times in 2025. Similarly, White staff were three times more likely to be consultants than Global Majority staff, relative to their representation in non-consultant career grade roles, an increase from three times in the previous year.

Differences are also evident at earlier stages of progression. White staff were three times more likely to be in specialist or advanced clinical roles (Bands 6–7) compared to Global Majority staff relative to entry-level roles, and similarly twice more likely to progress from Bands 6–7 into senior roles. Both of these represent increases from the previous year.

In contrast, representation in non-clinical roles shows smaller disparities than those seen in clinical pathways, although differences remain. White staff were around 1.4 times more likely to be represented in junior management roles (Bands 6–7) compared with Global Majority staff relative to their representation in support and entry-level roles (Bands 1–5), a slight increase from 1.3 in 2025. Progression from middle to senior roles (Bands 8a–VSM) was closer to the expected equality range, with a disparity ratio of 1.26, improving from 1.61 in the previous year. Overall, non-clinical representation remains more balanced than clinical and Medical and Dental pathways, although inequalities in progression are still evident.

These findings indicate that representation gaps remain most pronounced within clinical and senior roles, suggesting that progression opportunities are not yet experienced equally across all staff groups. While improvement is evident within some non-clinical career pathways, continued focus is needed to understand and address the factors contributing to disparities in progression and representation at more senior levels.

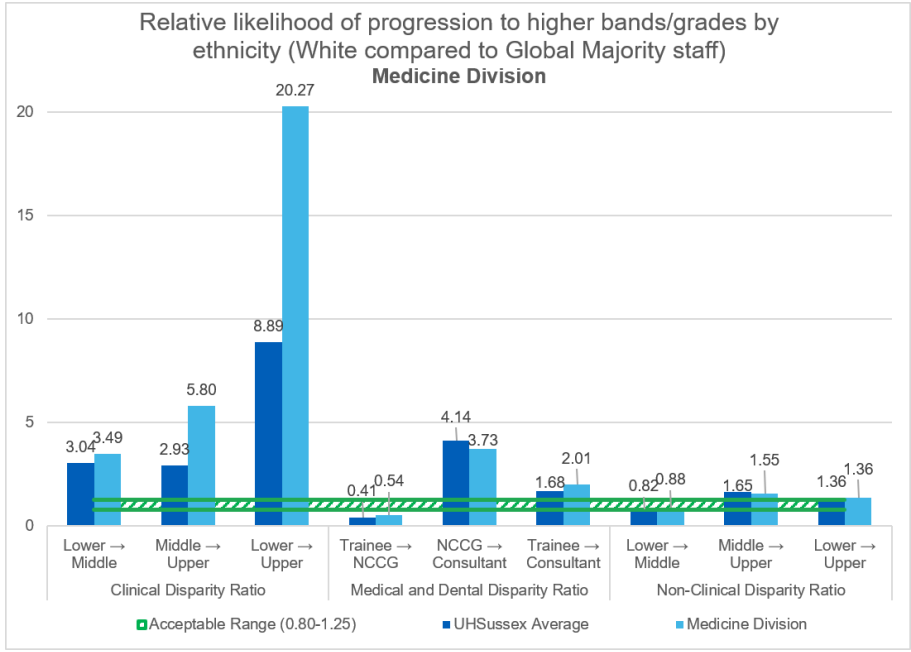
| Ethnicity (White / Global Majority) | UHSussex Mar-2023 | UHSussex Mar-2024 | UHSussex Mar-2025 | UHSussex Mar-2026 | Trend Line |
|---|---|---|---|---|---|
| Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 2.77 | 2.59 | 2.62 | 2.73 | |
| Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 1.73 | 1.84 | 1.91 | 2.30 | |
| Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 4.78 | 4.76 | 4.99 | 6.28 | |
| Medical and Dental Disparity ratio - Trainee to NCCG | 0.68 | 0.52 | 0.79 | 0.76 | |
| Medical and Dental Disparity ratio - NCCG to Consultant | 2.92 | 3.54 | 2.61 | 2.80 | |
| Medical and Dental Disparity ratio - Trainee to Consultant | 1.97 | 1.84 | 2.07 | 2.12 | |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 1.59 | 1.33 | 1.31 | 1.41 | |
| Non-Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 1.22 | 1.3 | 1.61 | 1.26 | |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 1.94 | 1.72 | 2.12 | 1.77 | |

***Note:*** Values highlighted in green fall within the equality range of 0.80 to 1.25 indicating no significant disparity compared with the reference group.

### *Divisional Variation*

Analysis of disparity ratios by division shows that differences in workforce representation are uneven across the organisation, with variation most pronounced in clinical progression to senior roles.

The greatest differences are seen in progression from lower to senior clinical bands, where all divisions show substantially higher disparity ratios than the expected equality range. However, the scale of these differences varies considerably. The Medicine Division stands out as a clear outlier, with markedly higher ratios than the Trust average, particularly for progression from lower to upper bands. Surgery also shows elevated ratios, although to a lesser extent. In contrast, Cancer and Specialist Services demonstrates higher than average ratios but is less extreme, while the Women, Children and Clinical Support Division shows comparatively lower ratios, although disparities remain present.




Within Medical and Dental grades, variation between divisions is also evident, particularly at senior transition points. Medicine and

Surgery display higher likelihood of progression to consultant roles compared to the Trust average, indicating more pronounced differences at senior levels. In contrast, Cancer and Specialist Services shows less pronounced differences, while the Women, Children and Clinical Support Division demonstrate comparatively lower ratios across several stages, suggesting relatively more balanced progression, although variation remains.

In non-clinical roles, variation between divisions is more limited, with most ratios closer to the Trust average or within the equality range. However, some differences remain, with a small number of divisions showing lower likelihood of progression to senior roles, while others remain closer to parity. This indicates a more consistent pattern of representation in non-clinical pathways compared to clinical and Medical and Dental roles.

These findings highlight that workforce representation varies across divisions, with the greatest disparities concentrated in clinical and Medical and Dental career pathways. This suggests that local workforce factors may play an important role in shaping progression and representation outcomes.

### Disability

Analysis of disparity ratios indicates a broadly balanced pattern of workforce representation for disabled staff across most areas, alongside some important differences in specific groups.

Within Agenda for Change clinical roles, disabled staff were similarly likely to be represented across all pay bands compared to non-disabled staff, with all

Within Agenda for Change clinical roles, representation of disabled and non-disabled staff remains broadly balanced across most stages of progression. Disparity ratios for progression from Bands 1–4 to Bands 5–7 (1.05) and from Bands 5–7 to Bands 8a and 8b (0.92) both fall within the expected equality range and have remained relatively stable over time. However, at the most senior clinical levels, non-disabled staff were 1.4 times more likely to be represented in Bands 8c–VSM compared to disabled staff relative to Bands 8a and 8b, resulting in an overall disparity ratio of 1.36 from Bands 1–4 to Bands 8c–VSM. This represents a notable change from previous years, when representation at these levels was closer to parity.

In non-clinical roles, representation is broadly balanced at earlier stages of progression, with a disparity ratio of 1.13 between Bands 1–4 and Bands 5–7. However, disabled staff are more highly represented at senior levels. Non-disabled staff were around 0.7 times as likely to progress from Bands 5–7 to Bands 8a and 8b, and around 0.6 times as likely to progress from Bands 8a and

8b to Bands 8c–VSM. Overall, non-disabled staff were approximately half as likely to be represented in the most senior non-clinical roles relative to entry-level bands, indicating an overrepresentation of disabled staff at these levels.

Within Medical and Dental grades, patterns vary across stages of progression. Representation between trainee and non-consultant career grade roles was broadly balanced in 2026, with a disparity ratio of 0.89 and a substantial reduction from higher ratios observed in recent years. However, non-disabled staff were approximately twice as likely to be represented in consultant roles compared to disabled staff relative to non-consultant career grade roles (2.01), resulting in an overall trainee-to-consultant disparity ratio of 1.80. This represents an increase compared to 2025 and suggests that differences in representation remain concentrated at consultant level.

Overall, workforce representation by disability remains broadly balanced across most clinical pathways and at earlier stages of progression. However, differences are evident at senior clinical grades and within consultant-level Medical and Dental roles, suggesting that representation becomes less equitable at the highest levels of some career pathways.

| Disability Status (Not Disabled / Disabled) | UHSussex Mar-2023 | UHSussex Mar-2024 | UHSussex Mar-2025 | UHSussex Mar-2026 | Trend Line |
|---|---|---|---|---|---|
| Clinical Disparity ratio - Bands 1-4 to Bands 5-7 | 1.29 | 1.18 | 1.12 | 1.05 | |
| Clinical Disparity ratio - Bands 5-7 to Bands 8a & 8b | 0.9 | 1.11 | 0.96 | 0.92 | |
| Clinical Disparity ratio - Bands 8a & 8b to Bands 8c - VSM | 0.45 | 0.61 | 0.85 | 1.40 | |
| Clinical Disparity ratio - Bands 1-4 to Bands 8c - VSM | 0.52 | 0.81 | 0.91 | 1.36 | |
| Medical and Dental Disparity ratio - Trainee to NCCG | 0.99 | 1.66 | 1.75 | 0.89 | |
| Medical and Dental Disparity ratio - NCCG to Consultant | 2.2 | 1.4 | 0.94 | 2.01 | |
| Medical and Dental Disparity ratio - Trainee to Consultant | 2.19 | 2.32 | 1.65 | 1.80 | |
| Non-Clinical Disparity ratio - Bands 1-4 to Bands 5-7 | 1.4 | 1.04 | 1.01 | 1.13 | |
| Non-Clinical Disparity ratio - Bands 5-7 to Bands 8a & 8b | 0.62 | 0.76 | 0.72 | 0.72 | |
| Non-Clinical Disparity ratio - Bands 8a & 8b to Bands 8c - VSM | 1.23 | 0.87 | 0.7 | 0.59 | |
| Non-Clinical Disparity ratio - Bands 1-4 to Bands 8c - VSM | 1.07 | 0.69 | 0.51 | 0.48 | |

***Note:*** Values highlighted in green fall within the equality range of 0.80 to 1.25 indicating no significant disparity compared with the reference group.

*Divisional Variation*

At divisional level, patterns of progression by disability status are less consistent, with variation evident across workforce groups and transition points.

Within Agenda for Change clinical roles, progression for disabled staff generally remains broadly aligned with non-disabled staff across most divisions, with many ratios falling within or close to the expected equality range. However, some variation is evident between divisions, with a small number of transitions falling outside the expected range, indicating that local factors may influence progression outcomes.

In non-clinical roles, variation between divisions is more mixed. While many transitions remain within or close to the equality range, some divisions show reduced likelihood of progression for disabled staff at higher bands, particularly at middle to upper transitions. In contrast, other areas demonstrate patterns closer to parity or slight overrepresentation at senior levels, indicating inconsistency in progression outcomes across divisions.

Within Medical and Dental grades, variation is more pronounced. Several divisions show elevated disparity ratios at key transition points, particularly from trainee to consultant roles and from trainee to non-consultant career grade roles, indicating that non-disabled staff are more likely to progress at these stages. However, this is not consistent across all divisions, with some showing less pronounced disparities or more variable patterns across pathways.

A small number of notable outliers are also evident at divisional level. For example, the Women, Children and Clinical Support Division show a substantially elevated disparity ratio for progression from middle-low to middle-upper clinical roles (8 times), while Cancer and Specialist Services shows a similarly high ratio within non-clinical roles (6 times). While these are likely influenced by smaller staff numbers, they highlight areas where progression differs markedly from the overall pattern and may warrant further local review.

Overall, divisional patterns suggest that progression outcomes for disabled staff are influenced by local workforce factors and are not experienced consistently across the organisation. While representation remains broadly balanced in many areas, the variation observed across some pathways and divisions highlights the importance of continued monitoring and local exploration of progression barriers where disparities emerge.

## Sex

Within Agenda for Change clinical roles, disparity ratios largely fall within or close to the expected equality range. Male staff were slightly less likely to be represented at higher clinical bands relative to entry-level roles, with ratios closer to the lower end of the range. Representation in progression from Bands 6 to 7 to senior roles remained within the expected range, with minimal change compared to 2025.

In non-clinical roles, representation is similarly balanced at earlier stages of progression, with ratios within the expected equality range. At more senior levels, ratios are slightly above the range, indicating a modest tendency towards higher representation of male staff. These patterns remain broadly consistent with the previous year.

Within Medical and Dental grades, ratios are slightly above the expected equality range for progression into consultant roles, indicating some variation in representation at senior levels. However, changes compared to 2025 are small and do not indicate a substantial shift in patterns.

Overall, these findings suggest that workforce representation by sex remains broadly balanced across most career pathways, with only limited variation at more senior levels. This indicates that progression and representation outcomes are generally comparable between male and female staff across the organisation.

| **Sex (Male / Female)** | **UHSussex Mar-2025** | **UHSussex Mar-2026** | **Trend Line** |
|---|---|---|---|
| Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 0.62 | 0.66 |  |
| Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 1.16 | 1.22 |  |
| Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 0.72 | 0.81 |  |
| Medical and Dental Disparity ratio - Trainee to NCCG | 1.5 | 1.37 |  |
| Medical and Dental Disparity ratio - NCCG to Consultant | 1.2 | 1.29 |  |
| Medical and Dental Disparity ratio - Trainee to Consultant | 1.8 | 1.77 |  |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 1.07 | 1.08 |  |
| Non-Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 1.43 | 1.39 |  |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 1.53 | 1.51 |  |

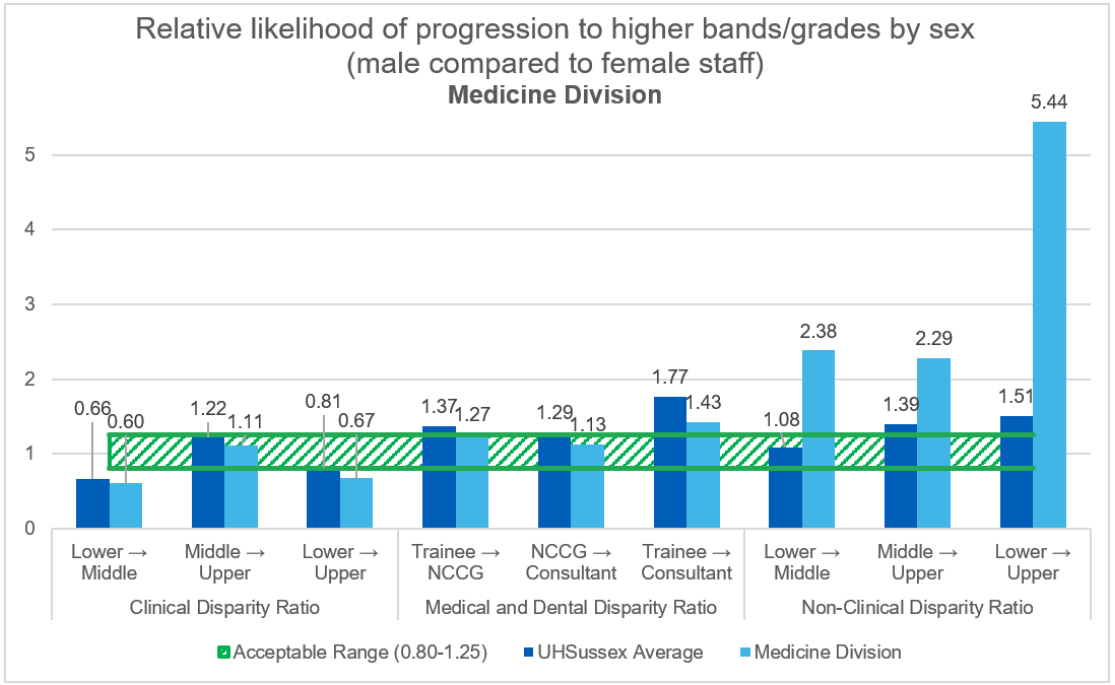
***Note:*** Values highlighted in green fall within the equality range of 0.80 to 1.25 indicating no significant disparity compared with the reference group.

*Divisional Variation*

At divisional level, patterns of progression by sex remain broadly consistent with the overall Trust position, although some variation is evident across workforce groups and transition points.

Within Agenda for Change clinical roles, progression remains largely balanced across divisions, with most ratios falling within or close to the expected equality range. Some divisions show ratios slightly above or below the range at specific transition points, but these differences are generally small and do not indicate a consistent pattern of inequality.

In non-clinical roles, variation between divisions is more evident at senior levels. While many ratios remain close to the equality range, higher progression rates for male staff are observed in Medicine (5.4), Cancer and Specialist Services (3.0), and Women, Children and Clinical Support (2.7). This indicates that, despite broadly balanced overall patterns, representation at senior levels varies across some divisions. Within Medical and Dental grades, variation remains relatively limited across divisions, with most ratios falling modestly above the expected equality range. Some divisions show slightly higher likelihood of progression to consultant roles, typically in the range of around 1.6 to 2.0, but these differences are not as pronounced as those observed in non-clinical pathways and remain broadly consistent with the Trust-level pattern.




Overall, sex representation remains broadly balanced across divisions, with the greatest variation observed within non-clinical senior career pathways. Progression and representation outcomes are otherwise generally comparable between male and female staff.

## Sexual Orientation

Analysis of disparity ratios shows variation in workforce representation between heterosexual and LGBUO staff, with different patterns across clinical, non-clinical, and Medical and Dental roles.

Within Agenda for Change clinical roles, disparity ratios are largely within or close to the expected equality range. Representation across all stages of progression shows improvement over time, with earlier differences reducing and ratios aligning closely with parity in 2026.

In non-clinical roles, disparity ratios are consistently below the expected equality range across all stages of progression. This indicates that heterosexual staff are less likely to be represented at higher bands relative to LGBUO staff, with ratios of around 0.6 to 0.7, suggesting they are approximately half as likely to be represented in senior roles compared to lower bands. While some improvement is evident in progression from middle to upper bands, these differences remain outside the equality range.

Within Medical and Dental grades, variation is more pronounced. Heterosexual staff were around 3 times more likely to be represented in consultant roles than LGBUO staff relative to trainee grades, with this difference increasing over time. Similarly, heterosexual staff were around 2 times more likely to be represented in consultant roles than non-consultant career grade roles. In contrast, differences in progression from trainee to non-consultant career grades have reduced over time but remain above the equality range.

Overall, these findings suggest that representation patterns differ between workforce groups and career pathways for LGBUO staff. While representation is broadly balanced within clinical roles, notable differences remain within non-clinical and Medical and Dental pathways, particularly at more senior levels.

| **Sexual Orientation (Heterosexual / LGBUO*)** | **UHSussex Mar-2024** | **UHSussex Mar-2025** | **UHSussex Mar-2026** | **Trend Line** |
|---|---|---|---|---|
| Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 1.02 | 1.1 | 1.01 | |
| Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 1.38 | 1.11 | 1.06 | |
| Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 1.41 | 1.21 | 1.07 | |
| Medical and Dental Disparity ratio - Trainee to NCCG | 2.2 | 1.7 | 1.45 | |
| Medical and Dental Disparity ratio - NCCG to Consultant | 0.94 | 1.61 | 2.09 | |
| Medical and Dental Disparity ratio - Trainee to Consultant | 2.08 | 2.74 | 3.03 | |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 0.76 | 0.65 | 0.71 | |
| Non-Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 0.76 | 0.93 | 0.87 | |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 0.58 | 0.6 | 0.62 | |
| **LGBUO includes staff selecting "Lesbian/Gay", "Bisexual", "Undecided" or "Other" as their sexual orientation* | | | | |

***Note:*** Values highlighted in green fall within the equality range of 0.80 to 1.25 indicating no significant disparity compared with the reference group.

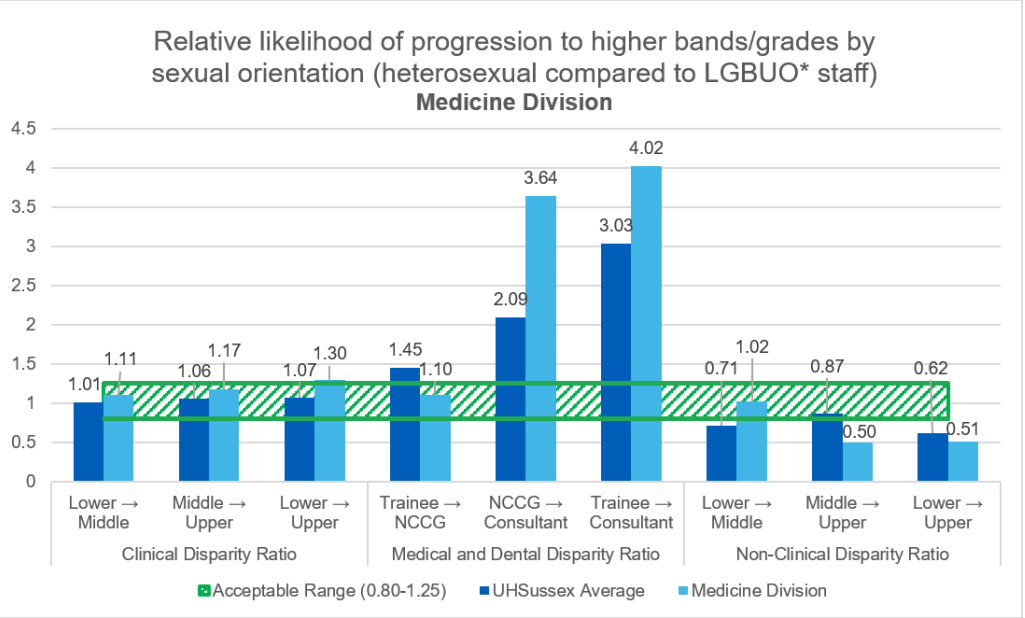
*Divisional Variation*

At divisional level, patterns of progression by sexual orientation show variation across workforce groups, with the most consistent differences evident in non-clinical roles and more pronounced disparities within Medical and Dental grades.

Within Agenda for Change clinical roles, progression remains broadly aligned across divisions, with most ratios falling within or close to the expected equality range. Some divisions show slightly elevated ratios at specific transition points, particularly from lower to upper bands, but these differences are limited and do not indicate a consistent pattern of inequality.

In non-clinical roles, a consistent pattern of lower disparity ratios is evident across all divisions, with most values falling below the expected equality range. These are typically in the range of approximately 0.5 to 0.7 for progression to higher bands, indicating that heterosexual staff are less likely to be represented at senior levels relative to LGBUO staff. While the scale varies slightly between divisions, this pattern is sustained across the organisation.

Within Medical and Dental grades, variation is more pronounced, particularly at senior transition points. Several divisions show elevated disparity ratios for progression to consultant roles, with the highest values observed in the Medicine Division (approximately 4 times for progression from trainee to consultant roles and 3.6 from non-consultant career grade roles). Elevated ratios are also observed in Cancer and Specialist Services (approximately 3 times) and Surgery (approximately 2 times), indicating a higher likelihood of progression to consultant roles for heterosexual staff within these divisions.




Overall, these findings suggest that progression patterns by sexual orientation vary across career pathways and divisions. While representation remains broadly balanced within clinical roles, differences are more evident within non-clinical and Medical and Dental pathways, particularly at senior levels.

## Religion and Belief

Analysis of disparity ratios indicates variation in workforce representation between staff with no religion and those reporting a religion, particularly within clinical and non-clinical roles.

Within Agenda for Change clinical roles, staff with no religion were just under two times more likely to be represented in middle and senior bands compared to entry-level roles, representing an increase compared to 2025. In contrast, progression from middle to senior bands remained within the expected equality range.

In non-clinical roles, a similar pattern is evident, with staff with no religion just under two times more likely to be represented in higher bands relative to lower bands. Representation from middle to senior bands remains within the expected equality range.

Within Medical and Dental grades, patterns vary across stages of progression. Staff with no religion were around a third less likely to progress from trainee to non-consultant career grade roles, while being almost twice as likely to be represented in consultant roles compared to non-consultant career grade roles. Progression from trainee to consultant roles remains below the equality range.

Overall, these findings suggest that representation patterns vary across workforce groups and career pathways by religion and belief. Differences are most evident at earlier career transitions and within consultant-level representation, while progression at more senior stages is generally more balanced.

| Religion and Belief (Atheist / Any Religion) | UHSussex Mar-2024 | UHSussex Mar-2025 | UHSussex Mar-2026 | Trend Line |
|---|---|---|---|---|
| Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 1.53 | 1.6 | 1.81 | |
| Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 0.95 | 0.83 | 0.94 | |
| Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 1.46 | 1.33 | 1.69 | |
| Medical and Dental Disparity ratio - Trainee to NCCG | 0.33 | 0.37 | 0.36 | |
| Medical and Dental Disparity ratio - NCCG to Consultant | 1.91 | 1.68 | 1.79 | |
| Medical and Dental Disparity ratio - Trainee to Consultant | 0.62 | 0.61 | 0.64 | |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 1.68 | 1.76 | 1.62 | |
| Non-Clinical Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 1.02 | 1.06 | 1.17 | |
| Non-Clinical Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 1.71 | 1.87 | 1.89 | |

***Note:*** Values highlighted in green fall within the equality range of 0.80 to 1.25 indicating no significant disparity compared with the reference group.

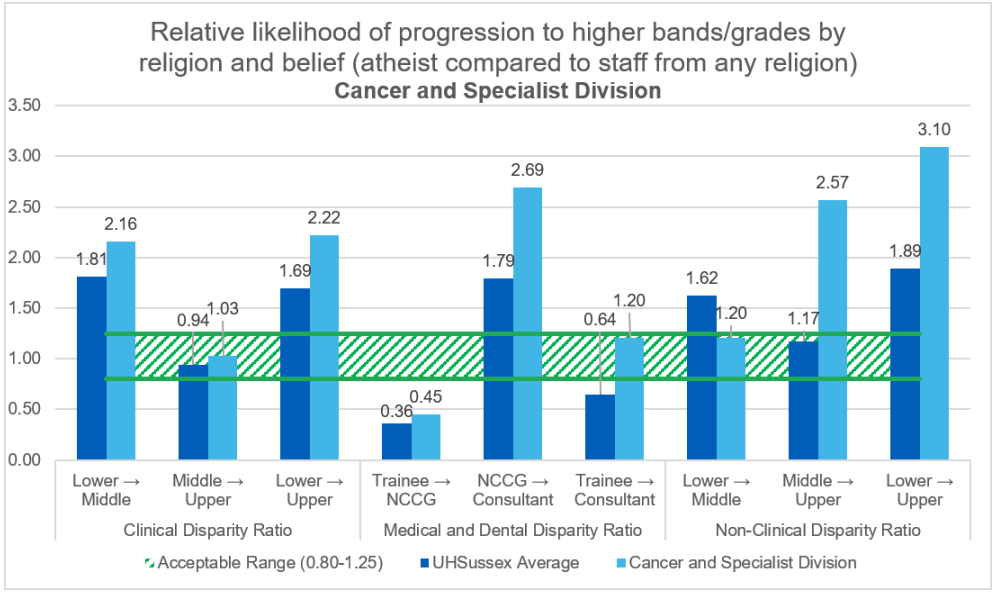
*Divisional Variation*

At divisional level, patterns of progression by religion and belief show variation across workforce groups, with more consistent differences evident within clinical and non-clinical roles and greater variation within Medical and Dental grades.

Within Agenda for Change clinical roles, most divisions show elevated disparity ratios at progression from lower to upper bands, with values typically in the range of approximately 1.6 to 2.2. This indicates that staff with no religion are more likely to be represented at higher clinical bands relative to entry-level roles. In contrast, progression from middle to senior bands remains closer to the expected equality range across divisions, indicating a more balanced pattern at this stage.

In non-clinical roles, a similar pattern is observed, with higher representation of staff with no religion at senior levels across divisions. Several divisions show elevated ratios for progression from lower to upper bands, including values of approximately 3.1 in Cancer and Specialist Services and around 1.9 in both Medicine and Women, Children and Clinical Support. Progression from middle to upper bands remains closer to the expected equality range, indicating more balanced representation at this stage.

Within Medical and Dental grades, variation is more pronounced across divisions. Progression from trainee to non-consultant career grade roles consistently falls below the expected equality range, with values typically between approximately 0.2 and 0.6, indicating lower likelihood of progression at this stage. In contrast, progression to consultant roles shows elevated disparity ratios in several divisions, including approximately 2.7 in Cancer and Specialist Services and around 2.4 in Surgery, indicating higher representation of staff with no religion at senior levels. However, progression from trainee to consultant roles remains below the equality range across divisions, highlighting inconsistency across stages of progression.




Overall, these findings suggest that representation patterns by religion and belief vary across divisions and career pathways. Differences are most evident in clinical and non-clinical progression to senior roles, while Medical and Dental pathways show more mixed patterns across stages of progression.

## Equality Profiles Summary

Overall, these findings highlight both the diversity of the people who use our services and the workforce that delivers them. While representation is broadly balanced in some areas, differences remain across certain workforce groups, professions and levels of seniority. In many cases, these also reflect patterns in the national data, underscoring the extent to which disparities are long-standing and structural. Understanding these patterns provides important context for the staff experiences, workforce outcomes and inequalities explored in the following sections.

# Eliminate Discrimination

The following sections summarise key actions and outcomes relating to the Trust's commitment to providing a fair, safe and respectful workplace for all. These themes bring together evidence relating to equality, inclusion, employee experience and organisational culture.

# Fair

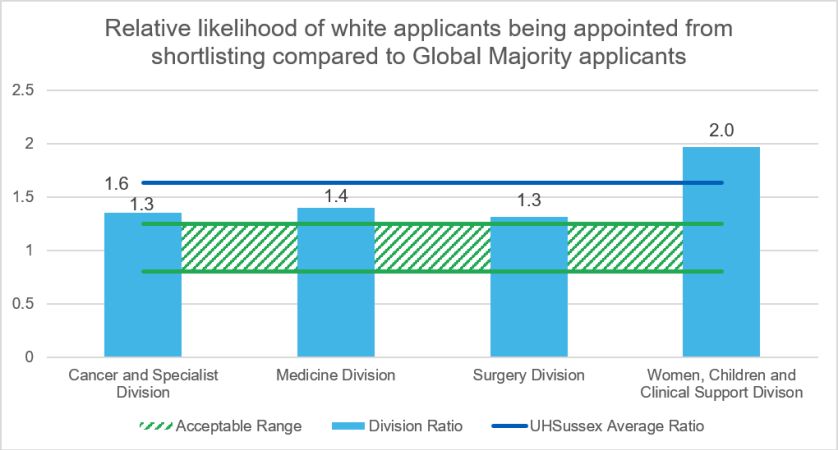
Ensuring fairness requires understanding whether workforce policies, processes and outcomes are experienced equitably across different staff groups. The following sections explore areas such as recruitment, pay and formal employment processes to identify where differences exist and where further action may be needed to support equitable outcomes.

## Inclusive Recruitment

As part of our commitment to eliminating discrimination, the Trust monitors recruitment outcomes, including the likelihood of appointment from shortlisting across different staff groups.

For ethnicity, White staff were 1.6 times more likely to be appointed from shortlisting than Global Majority staff. While this represents an improvement over time, the likelihood ratio remains above the expected range, indicating that differences in recruitment outcomes persist.

For disability, the likelihood ratio between non-disabled and disabled staff was 1.0. This indicates minimal difference in outcomes, with appointment from shortlisting broadly equitable between groups.




Analysis across other characteristics shows that outcomes for gender and sexual orientation fall within the expected equality range. The religion ratio (1.4) is slightly above this range, indicating atheist applicants were more likely to be appointed from shortlisting compared to staff from any religion.

Divisional analysis shows variation across the organisation. For ethnicity, the likelihood ratio is notably higher than the Trust average in the Women's & Children's Division, indicating greater differences in appointment outcomes. In contrast, the other three operational divisions are closer to the Trust average, although still above the expected equality range.

For disability, outcomes are broadly consistent with the Trust average across most divisions. An exception is Facilities & Estates (0.3), where results differ more significantly but should be interpreted with caution due to small numbers.

Across gender and sexual orientation, most divisions fall within the expected equality range, indicating relatively balanced outcomes. For religion, variation is more pronounced in some areas, including Women's & Children's (1.7) and Cancer & Specialist Services (1.4), where likelihood ratios are above (worse) compared to the Trust average.

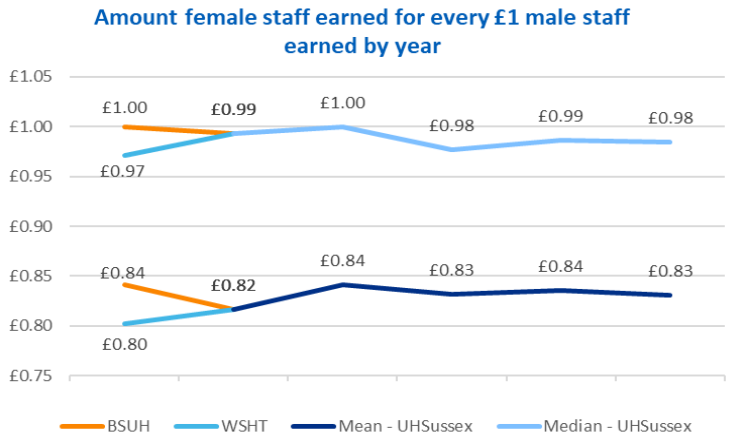
For gender identity, the Trust-level ratio (0.4) indicates a notable difference; however, this is based on small numbers so should be interpreted with caution.

Overall, recruitment outcomes are broadly equitable across most characteristics, with the notable exception of ethnicity, where differences in appointment rates persist despite gradual improvement over time. These findings suggest that while progress has been made, continued focus is needed to understand and address barriers affecting recruitment outcomes for some groups.

Further detail on the shortlisting to appointment indicator for race and disability is provided in the **Workforce Equality Standards** section of this report.

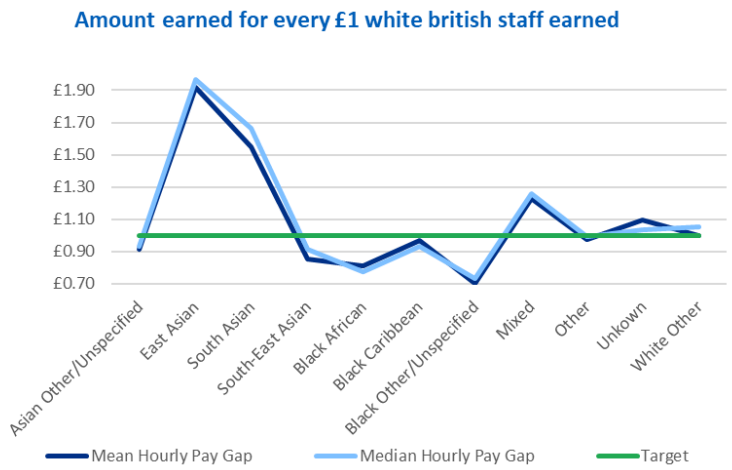
## Equal Pay

Monitoring pay gaps helps identify whether different groups experience equitable access to progression, senior roles and reward. While pay gaps do not necessarily indicate unequal pay for the same work, they can highlight structural differences in representation across grades, professions and leadership positions. As part of our commitment to eliminating discrimination, the Trust monitors pay gaps across gender, ethnicity and disability to understand differences in average pay and identify underlying structural inequalities.



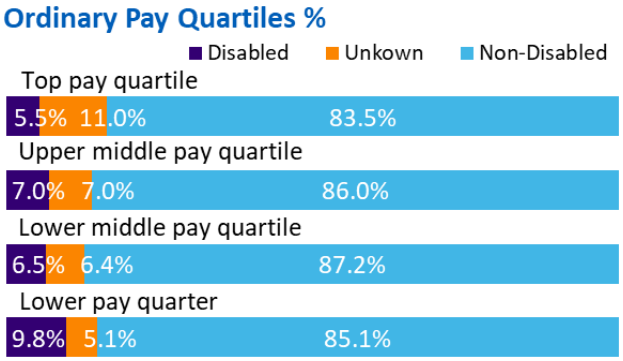
Our gender pay gap remains broadly consistent. Based on median hourly pay, women earn 98 pence for every £1 earned by men; based on mean hourly pay, they earn 83 pence. The wider mean gap reflects the concentration of men in some of the highest-paid roles, particularly senior management and consultant posts. Although women make up most of the workforce, they remain under-represented in the highest pay quartile, indicating a continuing structural imbalance in access to higher-paid roles.

Differences are also evident in bonus payments. A higher proportion of male staff receive bonuses, and the average value of bonuses remains higher for men. This is primarily linked to legacy consultant award schemes, which historically benefited a greater proportion of male staff.




Encouragingly, the overall ethnicity pay gap is now close to parity, reflecting continued improvement over recent years. However, more detailed analysis shows variation between ethnic groups, with some historically marginalised groups continuing to experience lower average pay.

The disability pay gap remains evident, with disabled staff earning less on average than non-disabled staff. This reflects differences in representation across pay bands, including lower representation of disabled staff in higher-paid roles.

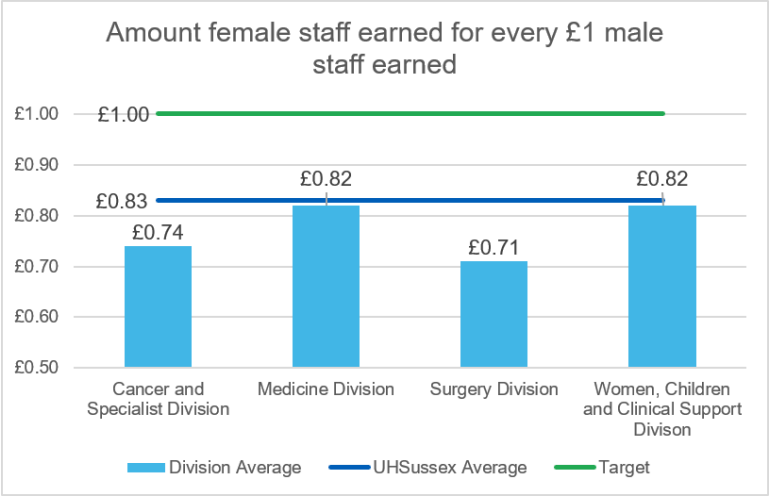



Taken together, these findings highlight that pay gaps within the Trust are primarily driven by differences in representation across roles and grades, rather than pay differences within the same roles. Addressing these structural differences remains a key priority to ensure equitable access to progression and reward across the workforce.

Divisional analysis shows variation in pay gaps across the organisation. Cancer and Specialist Services had wider pay gaps than the Trust average across all indicators, with larger differences in both ordinary and bonus pay for gender, ethnicity and disability.

Medicine and Surgery generally showed pay gaps similar to the Trust average for ordinary pay, but wider gaps for bonus pay across all three characteristics.

In contrast, Women, Children and Clinical Support demonstrated pay gaps broadly in line with the Trust average for gender, smaller ethnicity pay gaps, and larger disability pay gaps for ordinary pay. Bonus pay gaps within the division were generally similar to, or smaller than, the Trust average.




These findings highlight that pay gap patterns vary across divisions and characteristics, reinforcing the importance of understanding local workforce drivers alongside Trust-wide trends. Further detail on gender, ethnicity and disability pay gap analysis, including methodology and disaggregated findings, is provided in the Workforce Equality Standards section of this report.

## Resolving Disputes

Monitoring formal employee relations processes helps identify whether workplace concerns are being addressed fairly and consistently, and whether some groups of staff are more likely to experience formal processes than others.

Between 1 April 2025 and 31 March 2026, there were 55 investigation cases, 82 resolution cases, 80 disciplinary cases, 37 capability cases, 34 appeals, and 2 cases managed under Maintaining High Professional Standards (MHPS). Discrimination and inequality concerns are sometimes raised within resolution processes. Of the 82 resolution cases during the year, 17 (20.7%) related to discrimination or harassment. Of these, 3 cases were specifically categorised as race discrimination or harassment.

Average completion times varied across processes, with resolution cases taking an average of 109 days, investigations 79 days, and disciplinary processes 40 days.

While only a small number of resolution cases related specifically to discrimination or harassment, these findings highlight the importance of maintaining effective processes for addressing workplace concerns and monitoring outcomes to identify potential inequalities.

### Disciplinary Cases

There were 80 disciplinary cases during the reporting period. Of the colleagues involved, 36.3% (29 staff) were from Global Majority backgrounds, 48.8% female (39 staff). A smaller proportion identified as having a disability (7.5%) or as lesbian, gay or bisexual (6.3%).

Across the Trust, Global Majority staff were 1.4 times more likely than White staff to enter the disciplinary process. Disabled staff had a similar likelihood to non-disabled staff (1.0), and LGBUO staff were similarly likely to enter the disciplinary process (0.9), both falling within the expected equality range (0.8–1.25). Meanwhile, female staff were around half as likely as male staff to enter the disciplinary process (0.4). Variations in workforce composition across staff groups and services may contribute to this observed disparity.

### Capability Cases

During 2025/26, there were 37 capability cases recorded through the Employee Relations process, including both formal and informal capability cases. Of those involved, 48.6% were from Global Majority backgrounds (18 staff) and 62.2% were female (23 staff). Fewer than 10 staff recorded as disabled, lesbian, gay, bisexual or other.

Relative likelihood analysis of these capability cases indicates that Global Majority staff were 2.4 times more likely to enter the capability process than White staff. Female staff (0.6) were less likely to enter the capability process than their respective comparison group. Disabled staff (0.8) and LGBUO staff (0.8) had similar likelihoods of entering the capability process, with values falling within the expected equality range.

Separate analysis of formal capability proceedings only, covering the period 2024–2026, identified a different pattern for disability, with disabled staff being 1.58 times more likely than non-disabled staff to enter formal capability proceedings.

### Wider Process Insights

Looking across other employee relations processes, patterns vary. Global Majority staff had similar likelihoods to White staff for entering investigations (0.8), resolutions (0.8), and appeals (0.9), with these values falling within the expected equality range. However, they were more likely to enter capability processes.

Disabled staff were more likely to be involved in resolution (1.5) and appeals (1.4) processes, while having similar likelihoods of entering investigations (0.8) and capability processes (0.8) compared to non-disabled staff, with these values within the equality range. This finding relates to all capability cases (formal and informal); however, patterns may differ when considering formal capability proceedings only, where disabled staff were 1.58 times more likely than non-disabled staff to enter formal capability proceedings over the period 2024–2026.

For sex, female staff were consistently less likely than male staff to enter formal processes, including investigations (0.3), disciplinary (0.4), capability (0.6), and appeals (0.6).

For sexual orientation, LGBUO staff had similar likelihoods of entering most processes, including disciplinary (0.9), capability (0.8), and resolution (0.8) as heterosexual staff, with these values within the expected equality range. However, they were less likely to enter appeals (0.4) and more likely to be involved in investigations (1.7). However, as these findings are based on a small number of individuals, interpretation and further analysis are limited.

Overall, these findings indicate that experiences of formal employee relations processes vary across workforce groups. While many outcomes fall within the expected equality range, differences remain for some staff groups, particularly within disciplinary and capability processes. Understanding these patterns is important in ensuring that formal procedures are applied fairly and consistently across the organisation.

## Safe

A safe working environment is essential to ensuring all staff are treated with dignity and respect. The following sections explore experiences of speaking up, discrimination, harassment and violence to understand where inequalities may exist and where further action may be required.

### Freedom to Speak Up (FTSU)

Freedom to Speak Up themes provide valuable insight into staff experiences, helping the Trust identify areas for improvement and understand concerns relating to culture, inclusion, safety and wellbeing.

Between 1 April 2025 and 31 March 2026, a total of 264 cases were raised through FTSU. Of these, 14 cases (5.3%) related to discrimination or inequality as the primary reason for contact. Within this, 11 cases were recorded as discrimination and 3 as inequality. A further 34 cases included discrimination or inequality as a secondary theme, indicating that these issues can be part of more complex or interrelated concerns raised by colleagues.

Where a primary theme was recorded, the most common areas were disability (4 cases) and race (4 cases), followed by one case relating to gender reassignment discrimination. In 5 cases, the specific theme was not recorded, highlighting an opportunity to strengthen consistency in recording. One case involving discrimination or inequality as a primary concern was escalated.

Due to data protection and confidentiality requirements, particularly given the small number of cases, it is not possible to provide more detailed breakdowns without risking identification of individuals.

These findings suggest that discrimination and inequality concerns account for a relatively small proportion of Freedom to Speak Up cases but continue to be an important theme for some colleagues. Monitoring these concerns helps identify potential barriers to inclusion and ensures that issues relating to equality, diversity and inclusion can be addressed appropriately when they arise.

### Patient Safety

Between 1 April 2025 and 31 March 2026, one incident was identified that met the criteria for a Patient Safety Investigation (PSI) where discrimination was suspected. This related to concerns that a patient may have experienced differential treatment linked to alcohol dependency, poverty, and associated behaviours.

A local learning review was undertaken with Executive oversight, and safeguarding was involved as part of the process. It identified opportunities to strengthen clinical assessment, documentation, communication between services, and referral to appropriate support services, including the alcohol liaison team and community-based organisations such as Change, Grow, Live. It highlighted that the patient’s presentation, including intoxication and challenging behaviour, may have contributed to missed opportunities in assessment and diagnosis.

The review reinforced the importance of ensuring that all patients receive equitable and thorough assessment, particularly where complex needs or behaviours are present, and that care decisions are not influenced by stigma or assumptions.

## Violence and Aggression

Between 1 April 2025 and 31 March 2026, a total of 3,721 Violence and Aggression incidents were recorded through Datix reporting. A post-incident support survey was completed by 43 staff members during the same period, providing insight into staff experience following incidents. Among respondents, 59.6% were aware of the support available to them, while 54.4% reported feeling supported in the first few hours after an incident. Just over half (50.8%) felt supported on their return to work or subsequent shift and continue to feel supported in the workplace. However, fewer than half (47.4%) felt that the support they received was culturally appropriate, highlighting an area for further development.

The Trust has developed Violence and Aggression heatmaps, including hotspot analysis at cost centre level. These bring together staff survey indicators relating to physical violence, harassment, bullying or abuse, discrimination, and unwanted sexual behaviour. Cost centres are identified as hotspots where they fall within the lowest 25th percentile across at least four of these measures, including both worsening scores between 2024 and 2025 and low overall performance in 2025.

This analysis is being used to target Violence Prevention and Reduction (VPR) activity across the Trust. A key focus has been the delivery of face-to-face Conflict Management and Physical Intervention training. In total, 774 staff have been trained, including 236 staff between 1 April 2025 to 31 March 2026. Of these, 131 staff were from the 71 identified hotspot areas.

Training completion rates within hotspot teams are highest in Paediatric Critical Care (45.2%), Acute Medicine and Endocrinology (52.1%), A&E Nursing (37.7%), Care of the Elderly (30.8%), and Ardingly Ward (31.4%).

Alongside training, targeted VPR awareness activity has been delivered through the Health and Wellbeing team in partnership with Security Team, including ward-based engagement, posters, guidance, and VPR action cards to support staff following incidents. More recently, the Inclusion team has further supported this work through targeted huddles, team consultations, and interventions focused on inclusion-related violence and aggression needs, including raising awareness of hate crime reporting as part of a wider programme of work.

Nikki Kriel, Health, Wellbeing & Engagement Programme Manager (centre), wearing a VPR Aware sash alongside ward staff.

These findings highlight the significant impact that violence and aggression can have on staff experience and wellbeing. While targeted interventions are helping to focus support where it is most needed, the survey results suggest there are

opportunities to improve awareness of available support and ensure that post-incident support is experienced as accessible, appropriate and effective for all colleagues.

### Harassment, Bullying or Abuse

Understanding experiences of harassment, bullying and abuse is important in creating a safe, respectful and inclusive workplace. Monitoring these experiences helps identify whether some groups are disproportionately affected and informs action to prevent harmful behaviours and better support colleagues who experience them.

The NHS Staff Survey captures experiences of harassment, bullying or abuse from three sources: patients, relatives or members of the public; managers; and other colleagues. While experiences vary across workforce groups, some consistent patterns are evident, particularly for disabled staff, staff whose gender identity differs from their sex registered at birth, staff with caring responsibilities, and some minority ethnic, religious and sexual orientation groups.

#### From Patients, Relatives or Members of the Public

Experiences of harassment, bullying or abuse from patients, relatives or members of the public remain higher for some groups than others. Global Majority staff reported higher levels (34.4%) than White staff (27.6%), with rates increasing from the previous year. The highest levels were reported by Black – Other staff (52.6%), meaning more than one in two respondents within this group reported experiencing harassment, bullying or abuse.

Disabled staff reported higher levels (32.7%) than non-disabled staff (28.5%), while staff whose gender identity differs from their sex registered at birth reported substantially higher levels (39.5%) than staff whose gender identity is the same as their sex registered at birth (28.9%). This gap has widened compared to 2024.

For gender, non-binary staff reported the highest levels (54.6%), although small numbers limit interpretation. Female staff also reported higher levels than male staff (30.2% compared to 26.2%), a pattern that broadly reflects national findings. Differences were also evident by sexual orientation, with bisexual staff (38.1%) reporting the highest levels, compared to 28.9% of heterosexual staff.

Variation was observed across religion and belief, with the highest levels reported by staff selecting Any Other Religion (36.1%) and those who preferred not to disclose their religion (34.3%). Age-related patterns were particularly pronounced, with the youngest staff aged 16–20 reporting the highest levels (40.0%), followed by a gradual reduction across older age groups. Staff with caring responsibilities also reported higher levels (33.5%) than those without (27.8%).

### From Managers

Reported harassment, bullying or abuse from managers was generally lower than that reported from patients and the public, although some disparities remain.

Unlike national findings, White staff at UHSussex reported slightly higher levels (10.6%) than Global Majority staff (8.0%). However, some ethnic groups reported notably higher levels, including White and Black African (15.9%), Any Other Mixed Background (14.6%), and Other Ethnic Group (16.5%) staff, although small sample sizes limit interpretation.

Disabled staff reported substantially higher levels (15.8%) than non-disabled staff (8.0%), mirroring the national picture. Similar disparities were seen for gender identity, where staff whose gender identity differs from their sex registered at birth (18.6%) and those who preferred not to disclose their gender identity (19.8%) reported around twice the level experienced by staff whose gender identity is the same as their sex registered at birth (9.4%).

Gender differences between male and female staff were relatively small, although the highest levels were reported by non-binary staff and staff who preferred not to disclose their gender (21.2% for both groups). By sexual orientation, heterosexual staff reported the lowest levels (9.0%), while those selecting "Other" (16.4%) reported the highest.

Religion and belief also showed variation, with Jewish staff (21.1%) and staff who preferred not to disclose their religion (18.3%) reporting the highest levels. Older staff generally reported higher levels than younger colleagues, while staff with caring responsibilities reported higher levels (12.3%) than those without (9.0%).

### From Other Colleagues

Patterns of harassment, bullying or abuse from colleagues were broadly similar to those reported for managers but were generally more pronounced.

Overall, White staff (18.0%) and Global Majority staff (18.5%) reported similar levels. However, some ethnic groups reported substantially higher rates, including White and Asian (30.0%), White and Black African (27.9%), Bangladeshi staff (28.1%), and staff from Other Ethnic Groups (29.0%), although interpretation should be cautious due to small sample sizes.

Disabled staff again reported markedly higher levels (25.7%) than non-disabled staff (15.8%). Staff whose gender identity differs from their sex registered at birth (32.6%) and those who preferred not to disclose their gender identity (30.2%) also reported considerably higher levels than staff whose gender identity is the same as their sex registered at birth (17.8%).

The highest levels by gender were reported by non-binary staff (40.6%) and those who preferred not to disclose their gender (31.3%), while experiences among male and female staff were more comparable. By sexual orientation, staff who preferred not to disclose their sexual orientation reported the highest levels (27.6%), compared to 17.1% among heterosexual staff.

Religion and belief showed a similar pattern, with the highest levels reported by Jewish staff (31.6%), staff selecting Other Religion (28.6%), and those who preferred not to disclose their religion (28.7%). Staff with caring responsibilities again reported higher levels (23.1%) than those without (16.6%).

## Sexual Harassment

Understanding experiences of sexual harassment is important in creating a safe, respectful and inclusive workplace. Monitoring incidents and staff survey responses helps identify which groups may be disproportionately affected and informs action to prevent unwanted behaviour and support colleagues who experience it.

Within Datix reporting, 47 Sexual Harassment incidents were recorded between 1 April 2025 and 31 March 2026.

Data from the NHS Staff Survey enables us to further understand both the prevalence of incidents of unwanted behaviour of a sexual nature (sexual harassment) experienced by colleagues, distinguishing between sexual harassment from patients, relatives or members of the public, and sexual harassment from managers, team leaders or colleagues.

### Sexual Harassment from Patients, Relatives or Members of the Public

In 2025, 10.7% of UHSussex staff reported experiencing sexual harassment from patients, relatives or members of the public, compared to 9.1% nationally.

Experiences varied considerably across demographic groups. The highest levels were reported by staff from White non-British backgrounds, particularly White Gypsy or Irish Traveller staff (33.3%) and White Irish staff (25.3%), followed by staff from Caribbean backgrounds, including Mixed White and Black Caribbean staff (19.2%) and Black Caribbean staff (17.7%). While national results show a similar pattern, the differences between ethnic groups are more pronounced at UHSussex.

Disabled staff reported higher levels of sexual harassment (14.2%) than non-disabled staff (10.1%), mirroring the national picture. By gender, 13.1% of female staff reported experiencing sexual harassment compared to 5.2% of male staff. The highest rates were reported by non-binary staff (29.4%) and those who preferred to self-describe (16.7%), however small numbers limit interpretation.

Differences were also evident for gender identity. One in four (25.0%) staff whose gender identity differs from their sex registered at birth reported experiencing sexual harassment, compared with 10.6% of staff whose gender identity is the same as their sex registered at birth. This represents an increase from 20.0% in 2024 and is substantially higher than the national average.

By sexual orientation, the highest levels were reported by bisexual staff (26.3%) and those selecting "Other" (21.3%), while heterosexual staff reported lower levels (10.4%). Similar patterns are seen nationally.

Variation was also observed by religion and belief. Jewish staff (23.5%) reported the highest levels of sexual harassment, followed by atheist staff (13.8%), whereas most other faith groups reported lower levels. Nationally, reported experiences among Jewish staff are considerably lower (8.6%), although small local sample sizes should be considered when interpreting these findings.

Age showed the strongest gradient across all characteristics. Staff aged 16–20 reported the highest levels, with 40.0% experiencing sexual harassment, increasing from 29.1% in 2024. Reported experiences decreased progressively with each successive age group. While a similar pattern is seen nationally, the difference is less pronounced, with 20.1% of staff aged 16–20 reporting sexual harassment.

Only marginal differences were observed between staff with caring responsibilities (11.6%) and those without (10.8%), consistent with the national picture.

### Sexual Harassment from a Manager, Team Leader or Another Colleague

Sexual harassment from managers, team leaders or colleagues was lower overall, although rates at UHSussex (4.3%) remained slightly above the national average (3.5%).

Differences by ethnicity were less pronounced than those reported for harassment from patients and the public. The highest levels were reported by Mixed White and Black African staff (9.1%), although numbers were small.

Disabled staff continued to report higher levels of sexual harassment (6.7%) than non-disabled staff (3.4%), reflecting a pattern also seen nationally. By gender, rates were relatively similar among female (3.8%) and male (4.6%) staff. However, considerably higher levels were reported by non-binary staff (24.2%) and those who preferred not to disclose their gender (11.1%), although interpretation is limited by small sample sizes.

The largest disparity was again evident for gender identity. 19.1% of staff whose gender identity differs from their sex registered at birth reported sexual harassment from a manager, team leader or colleague, compared with 3.7% of staff whose gender identity is the same as their sex registered at birth. This represents a marked increase from 10.8% in 2024 and exceeds the national average.

By sexual orientation, bisexual staff (13.8%) and those selecting "Other" (11.5%) reported the highest levels of sexual harassment, compared with 3.6% of heterosexual staff. While the pattern is similar to that seen nationally, disparities at UHSussex are somewhat less pronounced.

Variation by religion and belief was generally limited, although Jewish staff (11.1%) reported the highest levels. Staff who preferred not to disclose their religion also reported comparatively high levels. As with several other groups, small sample sizes mean these findings should be interpreted with caution.

Unlike sexual harassment from patients and the public, age-related patterns differed from those seen nationally. At UHSussex, the highest levels were reported among staff aged 21–30 (6.7%), while staff aged 16–20 reported lower levels (3.3%). Nationally, the highest levels were reported by the youngest age group, with rates decreasing progressively with age.

Staff with caring responsibilities reported slightly higher levels of sexual harassment (4.9%) than those without caring responsibilities (3.9%), although the difference was modest and similar to national findings.

## Respectful

A respectful workplace and care environment are essential to ensuring that everyone is treated with dignity, fairness and respect. Understanding experiences of discrimination helps identify where some groups may experience unequal treatment and informs action to promote inclusion and equitable experiences for both staff and patients.

### Discrimination

Understanding experiences of discrimination is essential to creating a respectful workplace where all colleagues are treated fairly and with dignity. Monitoring discrimination helps identify whether some groups are disproportionately affected and informs action to promote inclusion, reduce inequalities and improve staff experience.

Within Datix reporting, racial discrimination was the only available classification for discrimination, with 11 incidents recorded between 1 April 2025 and 31 March 2026.

Data from the NHS Staff Survey enables us to further understand both the prevalence and perceived causes of discrimination experienced by colleagues, distinguishing between discrimination from patients, relatives or members of the public, and discrimination from managers, team leaders or colleagues.

Among all UHSussex staff who reported experiencing discrimination in the staff survey, the most commonly cited grounds were race (50.8%), sex (19.8%), and age (17.4%). This broadly reflects the national picture, where race remains the most frequently reported basis for discrimination. UHSussex reported lower levels than the national average across most grounds, including age, disability, pregnancy and maternity, religion or belief, and race. However, a higher proportion of staff attributed discrimination to gender reassignment (2.7% compared to 1.5% nationally), sex (19.8% compared to 17.1%), and sexual orientation (5.7% compared to 4.0%). Given the Trust's comparatively diverse workforce and higher levels of disclosure across some characteristics, these differences should be interpreted with appropriate context.

### From Patients, Relatives or Members of the Public

In 2025, 10.5% of UHSussex staff reported experiencing discrimination from patients, relatives or members of the public, compared to 9.3% nationally.

The largest disparities were seen by ethnicity. While 6.1% of White staff reported experiencing discrimination, this increased to 24.8% of Global Majority staff. Rates were particularly high among Filipino staff (35.7%), Asian staff overall (26.0%), and Black staff (24.5%). Although these differences remain substantial, they are less pronounced than those reported nationally.

There was no meaningful difference between disabled and non-disabled staff, with both groups reporting discrimination at a rate of 11.4%. For gender, the highest rates were reported by staff who preferred to self-describe their gender (27.8%) and non-binary staff (20.6%), yet small numbers limit interpretation. Male staff reported slightly higher levels (12.7%) than female staff (10.6%).

Differences were also evident for gender identity, with 22.7% of staff whose gender identity differs from their sex registered at birth reporting discrimination, compared to 10.7% of other staff. While this disparity remains significant, it represents an improvement from 2024, when the figure was 30.7%.

By sexual orientation, the highest levels were reported by staff selecting "Other" (19.7%) and bisexual staff (16.7%), while heterosexual staff reported the lowest levels (10.9%). Similarly, differences were evident by religion and belief, with the highest rates reported by staff identifying with any other religion (21.3%), Hindu (17.6%), and Muslim (15.4%) faith groups.

Discrimination also varied by age, with reported experiences following a broadly bell-shaped distribution. Staff aged 31–40 reported the highest levels (16.0%), while colleagues aged 66 and over reported the lowest (2.6%).

Staff with caring responsibilities reported higher levels of discrimination (12.3%) than those without caring responsibilities (10.9%), mirroring the national pattern.

### Discrimination from a Manager, Team Leader or Another Colleague

In contrast, reported discrimination from managers, team leaders or colleagues was slightly lower at UHSussex (8.3%) than the national average (8.7%).

Ethnicity continued to show the largest disparity. 10.9% of Global Majority staff reported discrimination from colleagues or managers, compared with 7.2% of White staff. Encouragingly, this represents a significant improvement over recent years, having reduced from 14.1% in 2024 and 15.3% in 2023.

Disabled staff reported substantially higher levels of discrimination (13.0%) than non-disabled staff (6.7%), a pattern consistent with national findings. Similar disparities were seen for gender identity, where 15.9% of staff whose gender identity differs from their sex registered at birth reported discrimination, compared with 7.6% of other staff. Although this remains considerably higher, it has improved markedly from 32.3% in 2024.

For gender, differences were relatively small, with 8.1% of female staff and 7.4% of male staff reporting discrimination. Higher levels were reported by staff who preferred not to disclose their gender (19.5%), preferred to self-describe (16.7%) or identified as non-binary (14.7%), although small numbers limit interpretation.

By sexual orientation, staff who preferred not to disclose their sexual orientation (16.0%) and those selecting "Other" (16.4%) reported the highest levels of discrimination, compared with 7.4% of heterosexual staff. Religion and belief also showed notable variation. The highest levels were reported by Jewish staff (21.1%) and staff who preferred not to disclose their religion (17.7%), while atheist staff reported the lowest levels (5.9%). However, small sample sizes for some groups mean findings should be interpreted with caution.

Age-related patterns differed from those seen nationally. At UHSussex, the highest reported levels were among staff aged 16–20 (10.4%) and 41–50 (9.2%), while staff aged 21–30 reported the lowest levels (6.6%).

As with discrimination from patients and the public, staff with caring responsibilities reported higher levels of discrimination (11.1%) than those without (7.2%).

## Eliminate Discrimination Summary

Overall, these findings show that while progress has been made in several areas, some staff groups continue to report different experiences and outcomes across recruitment, employee relations processes, discrimination, harassment and workplace safety. Monitoring these patterns helps the Trust identify where inequalities persist and supports action to create a fairer, safer and more inclusive working environment for all colleagues.

# Advance Equality of Opportunity

The following sections summarise key actions and outcomes relating to the Trust's commitment to advancing equality of opportunity for all colleagues. These themes bring together evidence relating to accessibility, inclusion, career development and progression to understand whether opportunities are experienced equitably across the workforce.

## Accessible

Ensuring that work is accessible to all colleagues is an important part of advancing equality of opportunity. Removing barriers and providing appropriate support helps ensure that staff can fully participate in working life, perform at their best, and access opportunities on an equitable basis.

### Central Reasonable Adjustments Framework

A centralised approach to requesting workplace adjustments was introduced in February 2026, supported by a panel that meets weekly to ensure timely review and decision-making. This has enabled applications to be considered within a matter of days, supporting a more responsive and accessible process for colleagues.

Since the introduction of the process on 19 February 2026 a total of 8 applications were received, averaging approximately two applications per month. All applications were reviewed by the panel, with the majority either approved in full or partially approved where further checks, such as IT compatibility, were required.

Most requests related to assistive software and technology, including speech-to-text tools, captioning software, and productivity applications. Requests also included training, coaching, and support to enable effective use of these tools, as well as occasional requests for equipment such as a sit-stand workstation.

Overall, colleagues thus far most commonly require support to access digital systems and working environments, and adjustments often combine technology with training or coaching to maximise effectiveness.

### Adequate Workplace Adjustments

Among staff who indicated that they required workplace adjustments, 75.2% reported that the Trust had made reasonable adjustments to support them in carrying out their work. This represents a gradual improvement from 73.2% in 2023 and is broadly in line with the national average of 74.8%. However, the results also indicate that around one in four staff requiring adjustments do not feel adequate support has been put in place, highlighting an ongoing area for improvement.

There was limited variation across most protected characteristics, suggesting a broadly consistent experience of workplace adjustments. However, some ethnic groups reported lower levels of agreement, including staff from Mixed/Multiple ethnic backgrounds – White and Asian (54.6%) and White – Any Other White Background (60.2%). As these groups represent relatively small numbers of respondents, findings should be interpreted with caution.

These findings suggest that while progress has been made, further work is needed to ensure all colleagues who require workplace adjustments receive timely, effective and appropriate support.

## Inclusive

An inclusive workplace is one where colleagues feel valued, supported and able to contribute fully. Understanding differences in staff experience helps identify whether all groups feel equally included and whether workplace factors may be affecting wellbeing, engagement and sense of belonging.

### Feeling Valued at Work

The NHS Staff Survey found that perceptions of being valued by the Trust vary across workforce groups. Some of the most positive responses were reported by staff from Indian (69.9%) and Black African (63.6%) backgrounds. In contrast, lower levels of agreement were reported by staff from Mixed White and Black Caribbean (34.6%), Mixed White and Asian (33.3%), and Other Mixed backgrounds (29.4%), although some of these groups represent relatively small numbers of respondents.

Disabled staff were less likely to agree that the Trust values their work (31.0%) than non-disabled staff (44.8%), a pattern which broadly reflects the national picture. Gender differences were generally limited, with male staff reporting the highest levels of agreement (46.4%). However, staff who preferred not to disclose their gender reported substantially lower levels (21.6%). Similar patterns were seen for gender identity, sexual orientation and religion, where staff who chose not to disclose aspects of their identity consistently reported less positive experiences than other groups.

Differences by age were generally small, although younger staff aged 16–20 reported lower levels of agreement (31.3%) than other age groups. This pattern differs from the national position and may warrant further exploration.

Overall, staff who choose not to disclose aspects of their identity report less positive experiences of feeling valued by the organisation, highlighting the importance of fostering an inclusive culture where colleagues feel safe to be themselves at work.

### Work related stress

The proportion of staff reporting that they had felt unwell as a result of work-related stress during the previous 12 months also varied across workforce groups.

Global Majority staff reported slightly lower levels of work-related stress (40.1%) than White staff (44.5%), although some ethnic groups reported considerably higher levels. In particular, White Gypsy or Irish Traveller staff (72.7%) and Mixed White and Black African staff (62.2%) reported the highest levels, with the latter increasing substantially compared to the previous year.

Disabled staff were significantly more likely to report work-related stress (59.5%) than non-disabled staff (37.8%), mirroring the national pattern. Higher levels were also reported by non-binary staff (60.6%) and staff who preferred not to disclose their gender (57.9%). Similarly, staff whose gender identity differs from their sex registered at birth (56.8%) reported higher levels of work-related stress than staff whose gender identity is the same as their sex registered at birth (42.7%).

Variation was also evident by sexual orientation. Bisexual staff (59.5%) and those selecting "Other" (56.7%) reported the highest levels of work-related stress, compared with 41.2% of heterosexual staff. By religion and belief, higher levels were reported by staff identifying with another religion (53.7%), Jewish staff (52.6%), and those who preferred not to disclose their religion (55.8%), while Hindu staff reported the lowest levels (33.2%).

Younger and mid-career staff were more likely to report work-related stress than older colleagues, with the highest levels reported among staff aged 21–30 (51.6%) and the lowest among those aged 66 and over (31.4%). Staff with caring responsibilities also reported higher levels of work-related stress (49.4%) than staff without caring responsibilities (40.9%).

These findings suggest that experiences of work-related stress are not evenly distributed across the workforce, with particularly high levels reported by disabled staff, carers, staff with diverse gender identities and sexual orientations, and several minority ethnic and religious groups. Understanding these differences can help ensure that wellbeing support is accessible, targeted and responsive to the needs of all colleagues.

## Developing

Developing and retaining a diverse workforce requires colleagues to have equitable access to progression, development and career opportunities. Understanding how staff experience career progression, development programmes and retention helps identify where barriers may exist and where additional support may be needed to enable all colleagues to thrive.

### Equality of opportunity for career progression/promotion

The NHS Staff Survey asks staff whether they believe their organisation acts fairly with regard to career progression and promotion, regardless of protected characteristics. In 2025, 53.9% of UHSussex staff responded positively to this question, broadly in line with the national average of 53.7%.

Responses varied across workforce groups. For race and ethnicity, Global Majority staff reported a more positive experience (57.9%), which is the reverse of the national pattern where Global Majority staff typically report lower levels of agreement. Some individual ethnic groups reported more extreme scores, including White Gypsy or Irish Traveller (30.0%) and Mixed White and Black Caribbean (61.5%) staff, though small sample sizes limit interpretation. Other groups reported similar levels of agreement.

Differences were more apparent for disability. 48.3% of disabled staff agreed that career progression and promotion processes were fair, compared to 55.9% of non-disabled staff, closely reflecting the national picture. Similar patterns were seen for gender identity, where 40.9% of staff whose gender identity differs from their sex registered at birth agreed, compared to 55.2% of staff whose gender identity is the same as their sex registered at birth.

Variation was also evident for sexual orientation and religion. Staff who preferred not to disclose their sexual orientation (32.5%) and those selecting "Other" (30.0%) reported the lowest levels of agreement. Likewise, staff who preferred not to disclose their religion reported notably lower agreement (31.5%) than other religious groups, which otherwise reported broadly similar results.

For gender, 55.9% of female staff agreed that the organisation acts fairly regarding career progression and promotion. The lowest score was reported by staff who preferred to self-describe their gender (17.7%), although small numbers mean findings should be interpreted cautiously. Age-related differences were less pronounced, although younger staff were generally more positive, with 65.4% of staff aged 21–30 and 60.0% of staff aged 16–20 agreeing, compared with 45.1% of staff aged 66 and over.

Staff with caring responsibilities also reported lower levels of agreement (50.7%) than staff without caring responsibilities (55.3%).

Overall, perceptions of fair career progression are broadly in line with the national average. However, lower levels of agreement among disabled staff, staff with diverse gender identities, carers, and colleagues who choose not to disclose aspects of their identity suggest that some groups may experience greater barriers to progression than others.

### Career Sponsorship Scheme

The Trust has introduced a Career Sponsorship Scheme, launched at the end of August 2025 to support career progression and improve access to development opportunities for colleagues across the organisation.

Participation in the scheme has continued to grow over the reporting period, with total participants increasing from 88 in December 2025 to 110 (25% increase) by 31 March 2026. This includes a small increase in sponsors from 30 to 33 and larger increase in sponsees from 64 to 86, reflecting strong engagement, particularly among colleagues seeking development support.

As of 31 March 2026, there are 32 active sponsorship pairs, with 54 colleagues on the waiting list. This indicates demand continues to exceed available capacity and highlights an opportunity to further expand the number of sponsors.

A review of participant demographics collected from a follow-up form sent to sponsees only shows that the scheme is engaging a diverse range of colleagues, with representation across White and Global Majority ethnic groups. The majority of participants identify as female, and around one in five report a long-term physical or mental health condition. Participants also include a range of sexual orientations and religions or beliefs.

Analysis of relative likelihood suggests that some groups are more likely to access the scheme than others. Global Majority staff and disabled staff were more likely than their comparison groups to participate, as were colleagues identifying as lesbian, gay, bisexual or other. Female staff were slightly less likely than male staff to access the scheme, and colleagues reporting a religion were less likely to participate than those reporting no religion.

Overall, the scheme is supporting retention and development by enabling colleagues to access guidance, networks and progression opportunities. The strong uptake observed during its first-year highlights both the demand for career development support and the potential of the scheme to improve equitable access to progression opportunities.

As the numbers within some demographic categories are relatively small, further detailed analysis or breakdown has not been included to protect confidentiality and avoid the risk of identifying individuals.

### Turnover

Understanding who leaves the organisation, and whether some groups are more likely to leave than others, helps identify potential inequalities in staff experience, retention and opportunity.

Between 1 April 2025 and 31 March 2026, there were 3,994 leavers across the Trust. This includes all primary assignments, including bank and reserve roles, which results in higher levels of missing demographic data than standard ESR reporting. The majority of leavers were from the Reserve workforce (2,541 staff), with smaller numbers across the main divisions, including 162 in Cancer and Specialist Services, 329 in Medicine, 290 in Surgery, and 268 in Women, Children and Clinical Support, alongside 394 from Corporate divisions.

In terms of race and ethnicity, 25.7% of leavers (1,026 staff) were from Global Majority backgrounds, compared to 66.4% (2,653 staff) who identified as White and 7.9% (315 staff) where ethnicity was not recorded. Within the Global Majority group, the largest proportion identified as Asian (15.4%), followed by Black (5.1%), Mixed (2.8%) and Other ethnic groups (2.4%). The relative

likelihood of Global Majority staff leaving compared to White staff was 0.9, falling within the expected equality range, indicating similar likelihood of leaving. At divisional level, the Medicine Division had the highest proportion of Global Majority leavers (34.0%), while the Women, Children and Clinical Support Division had the lowest (29.1%).

For disability, 5.3% of leavers (210 staff) identified as disabled, while 80.4% (3,210 staff) did not, with 9.5% preferring not to say and 4.9% (195 staff) not recorded. The relative likelihood of disabled staff leaving compared to non-disabled staff was 0.8 times less likely, a figure within the expected equality range, indicating similar likelihood. Variation across divisions shows that the Women, Children and Clinical Support Division had the highest proportion of disabled leavers (9.3%), while Cancer and Specialist Services had the lowest (3.7%).

In terms of sex, 68.0% of leavers (2,717 staff) were female and 31.0% (1,277 staff) were male. The relative likelihood of female staff leaving compared to male staff was 0.9, also within the expected equality range, indicating similar likelihood of leaving. The Women, Children and Clinical Support Division had the highest proportion of female leavers (79.9%), while Surgery had the lowest (60.3%).

For sexual orientation, 7.8% of leavers (313 staff) identified as LGBUO, while 74.0% (2,956 staff) were heterosexual and 18.2% (315 staff) were not recorded. The relative likelihood of LGBUO staff leaving compared to heterosexual staff was 1.2, within the expected equality range, indicating similar likelihood of leaving. There was minimal variation across the four major divisions, with differences of around 1.7 percentage points.

In relation to religion and belief, 56.9% of leavers (2,271 staff) reported having a religion, including 35.0% identifying as Christian, while 22.5% (898 staff) reported no religion and 20.7% (825 staff) were not recorded. The relative likelihood of staff with a religion leaving compared to those with no religion was 0.8, within the expected equality range, indicating similar likelihood. Across divisions, Cancer and Specialist Services had the highest proportion of leavers reporting a religion (85.2%), while Surgery had the lowest (81.7%).

Age data shows that turnover is concentrated among younger and mid-career staff. The largest proportions of leavers were aged between 26 and 40, including 18.6% aged 26–30, 18.5% aged 31–35, and 13.4% aged 36–40, meaning that these groups together accounted for just over half (50.5%) of all leavers. This pattern is broadly consistent across divisions, although the Medicine Division had a relatively higher proportion of leavers aged 21–25, while Cancer and Specialist Services had a higher proportion of leavers aged 55–66 compared to other divisions.

Overall, turnover is broadly comparable across most protected characteristics, with relative likelihoods generally falling within the expected equality range. However, the concentration of leavers among younger and mid-career staff highlights the importance of understanding the factors that influence retention at different stages of colleagues' careers.

### Exit survey

Between 1 April 2025 to 31 March 2026, 282 leavers completed the exit survey, providing insight into reasons for leaving and staff experience. A relatively small proportion of respondents (7.1%) identified their reason for leaving as relating to abuse, bullying, harassment, ill-treatment at work, or victimisation following raising a concern. In addition, 25.5% of respondents indicated that their reason for leaving was negatively related to at least one protected characteristic, caring responsibilities, or Armed Forces status.

Among these, the most commonly cited factors were age (13.8%), disability (7.8%), and caring responsibilities (5.0%), indicating that personal and structural factors linked to equality and inclusion continue to play a role in staff turnover.

## Advance Equality of Opportunity Summary

Overall, these findings suggest that many colleagues experience equitable access to support, development and career opportunities. However, differences remain for some staff groups in areas including workplace adjustments, inclusion, career progression and work-related stress. Understanding and addressing these differences is important to ensuring that all colleagues are able to access opportunities, reach their potential and thrive at work.

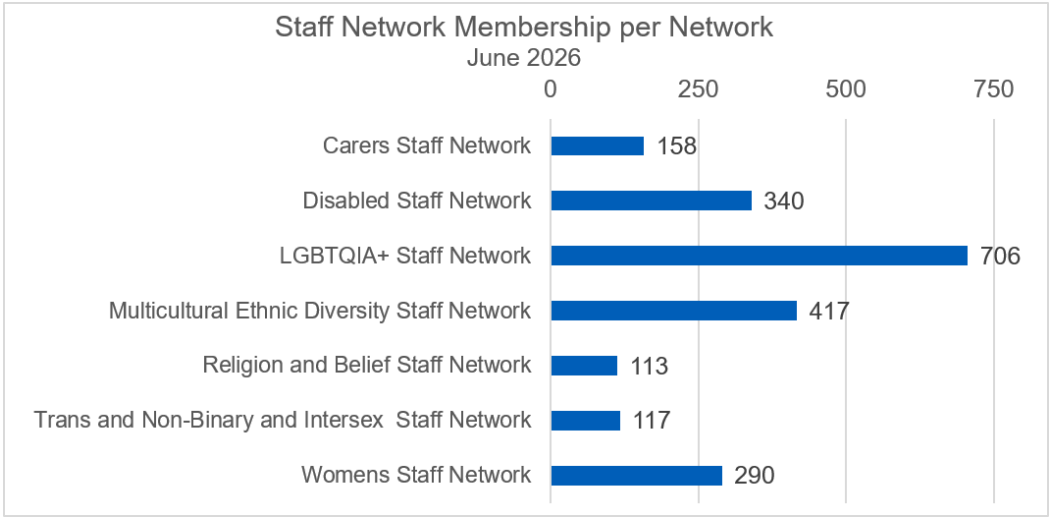
# Foster Good Relations

The following section summarises activity relating to staff voice and inclusion staff networks, highlighting opportunities for colleagues to connect, influence change and support a more inclusive workplace culture.

## Staff Voice

Staff voice is a key part of fostering good relations across the Trust. UHSussex has eight Inclusion staff networks providing opportunities for colleagues to connect, share experiences, and influence inclusive practice.

In January 2025, dedicated funding was secured through My University Hospitals Sussex Charity to support the development of all staff networks through a 20-month programme. This has enabled networks to expand activity, deliver staff-facing events, and enhance engagement. Two staff network project support managers have also been introduced in early 2026 to support six networks who chose to pool their funding, while the remaining networks have used their funding to support existing leads in delivering their programmes.




All networks are delivering against agreed 20-month plans, supporting increased engagement and a broader programme of activity across the organisation. Each network has provided a summary of its achievements over the past year, as well as key challenges and priorities for the future, these can be found in Appendix 2: Staff Networks.

Staff networks were delivering sustained engagement across the organisation, with an average of around 600 monthly views on network pages on the staff hub between January and March 2026. At 31 March, 1,477 staff (around 8% of the workforce) were recorded as members of at least one inclusion staff network, an increase of 13% since the start of the year. Total network memberships increased by 16%, from 1,646 to 1,909, reflecting membership of more than one network; 274 staff, or 19% of network members, belonged to multiple networks.

Growth was strongest in the Women's Network, which gained 94 memberships, followed by the Carers Network with 43, the Disabled Staff Network with 39, and the Multicultural and Ethnic Diversity Network with 32. Engagement with network activity was also strong: Race Equality Week generated more than 550 staff hub engagements and 205 video views, while 182 staff attended the International Women's Day webinars.

In-person events have also attracted significant participation, including 250 attendees at Philippine Independence Day activities, alongside smaller but consistent engagement for initiatives such as Lesbian Visibility Week (65 attendees) and Carers Week (29 attendees).

# Workforce Equality Standards (WES) Detailed Reports 2026

NHS
University Hospitals Sussex
NHS Foundation Trust

# Workforce Equality Standards Report 2026 Executive Summary

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## Background

This **Workforce Equality Standards Report** brings together the organisation's statutory workforce equality and pay reporting, including the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap and supporting pay gap analyses. It is – by design – an analytical report.

- **The nine WRES indicators** are derived from Electronic Staff Record (ESR) workforce data (indicators 1, 2, 3, 4 and 9) and NHS Staff Survey responses (indicators 5, 6, 7 and 8), alongside data from Trac recruitment systems (indicator 2), employee relations disciplinary records (indicator 3) and IRIS training platform (indicator 4) data.
- **The ten WDES indicators** are derived from ESR workforce data (indicators 1, 2, 3 and 10) and NHS Staff Survey responses (indicators 4, 5, 6, 7, 8 and 9), alongside data from Trac recruitment systems (indicator 2) and employee relations capability records (indicator 3).
- **Pay gap reporting** is derived from ESR hourly pay and bonus data, as of 31 March 2026.

This report sets out the Trust's statutory workforce equality standards and pay gap reporting, focusing on **nationally mandated indicators and metrics**. It does not include wider equality measures or additional analysis beyond these requirements. This report is necessary to meet the NHS England **May 2026 upload deadline** for the Trust's WRES / WDES data.

## Overall position

There is evidence of progress in representation, sharing and perceived equality of opportunity, but structural inequalities persist across race, disability and gender, particularly in senior roles, formal processes (disciplinary and capability), experiences of discrimination and pay outcomes, as they do amongst many NHS employers.

### Race (WRES)

- **Four of nine indicators improved**, including appointment from shortlisting and perceptions of career opportunity
- **Racial disparities remain** in disciplinary outcomes, senior progression, discrimination and Board representation
- **The ethnicity pay gap is close to parity**, but the bonus pay gap remains significant and masks variation between groups.

### Disability (WDES)

- **Three of ten indicators improved**, with increased sharing of disability information, workforce representation, reasonable adjustments and perceptions of opportunity

- **Disabled staff continue to experience inequity** in capability processes, senior clinical progression and experiences of bullying or harassment
- **The disability pay gap remains material**, with disabled staff earning less on average than non-disabled staff.

### Gender Pay Gap (GPG)

- **The average gender pay gap remains considerable**, driven by female under-representation in senior and consultant roles
- **The bonus pay gap remains substantial**, reflecting historic and consultant-level award scheme national eligibility, though newer schemes show early signs of improved balance.

### Focus for 2026-27

**Delivery of the Workforce Inclusion Programme (WIP)** will prioritise inclusive leadership accountability, fair recruitment and progression, safer and more equitable formal processes, improved data quality, and consistent access to reasonable adjustments, aligned to the NHS National EDI Improvement Plan.

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# Workforce Race Equality Standard (WRES) 2026

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# Introduction

The Workforce Race Equality Standard (WRES) provides a nationally mandated framework for assessing the experiences of staff from different ethnic backgrounds within NHS organisations. It brings together workforce, recruitment, employee relations and staff survey data to identify disparities in experience, opportunity and outcomes. At UHSussex, the WRES supports a systematic approach to understanding racial inequality, monitoring progress over time, and informing targeted action through the Workforce Inclusion Programme and organisational strategy.

## Use of Data and Information

This report draws on workforce data required to meet national reporting standards that NHS organisations are mandated to complete annually, i.e. the Workforce Race Equality Standard (WRES). These standards set expectations regarding the scope, format, terminology and minimum reporting requirements, to support consistency and comparability across organisations. This report has been written as a standalone report, in line with national guidance.

Staff can update their personal information, including ethnicity, on their staff record via the Employee Self-Service online portal at any time. All data used for reporting is anonymised and handled in line with information governance and data protection requirements. Anonymised data is analysed to identify and respond to issues affecting groups of staff who share protected characteristics.

## Terminology

Throughout this report, we use the term Global Majority as a narrative descriptor to refer to staff from ethnic groups other than White, recognising that these groups represent the majority of the global population, while also acknowledging that they may be under-represented or experience inequity within the Sussex or wider UK context. The term is widely used across EDI research, public sector organisations and is starting to be adopted in various parts of the NHS. Use of this term does not replace standard NHS ethnicity categories or alter how WRES indicators are calculated, and in this context refers to the same staff as the term Black, Asian and Minority Ethnic.

We use the term ***"distance from equity"*** as a descriptive, non-technical phrase commonly used in equality analysis to explain the size of differences in outcomes or experiences between groups. For representation percentages, this refers to how far the number is from the Trust average. For likelihood questions, this refers to how far the number is from zero. For other indicators, it refers to the percentage difference between Global Majority and white experiences. For example, if 20% of White staff face bullying and harassment then it would be equitable if 20% of Global Majority staff also face bullying and harassment. Here, the greater the percentage difference, the greater the inequity.

### Data collection

The WRES is an annual benchmarking tool mandated by NHS England. Trusts are only required to submit data for indicators 1-4 and indicator 9. The data for indicators 5-8 comes from our staff survey results. Bank-only workers are excluded from this data submission. The WRES data must be submitted on the Data Collections Framework (DCF) system by 31 May 2026.

## Summary

### Overview

The report outlines the data from the **National Workforce Race Equality Standard (WRES)**. The WRES is an annual benchmarking tool introduced by NHS England to assess the progress made towards achieving race and disability equality within NHS organisations. It assesses how the trust has improved against 9 indicators designed to close the gap between the experiences of White and Global Majority colleagues. These include:

- Clinical and non-clinical diversity and representation across all bands and pay grades (from ESR workforce data)
- Successful job appointment and shortlisting (from ESR workforce and Trac recruitment systems data)
- Entering formal disciplinary processes (from ESR workforce and employee relations disciplinary records data)
- Access to CPD and non-mandatory training (from ESR workforce and IRIS training platform data)
- Incidents of bullying, harassment or abuse from public (from NHS Staff Survey data)
- Incidents of bullying, harassment or abuse from staff (from NHS Staff Survey data)
- Perceptions around equal opportunities for progression or promotion (from NHS Staff Survey data)
- Incidents of bullying, harassment or abuse from managers, team leads or other colleagues (from NHS Staff Survey data)
- Proportional representation of the overall workforce at board level (from ESR workforce data).

### Main Findings

**Four of the nine WRES Indicators improved in 2026** although there is **still disparity in key areas** such as disciplinary cases, appointments, career progression, experiences of discrimination and board representation. We do not have racial equity in 7 of our 9 WRES indicators. We have seen improvements in:

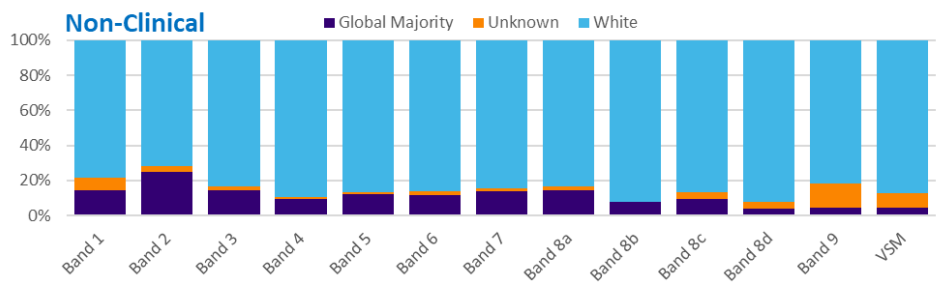
- the percentage of Global Majority staff in our workforce, especially in entry-level roles.
- the likelihood of Global Majority staff being appointed from shortlisting.
- the percentage of Global Majority staff believing in equality of opportunity for career progression or promotion.

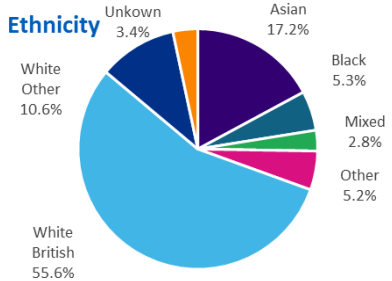
## Workforce Profile

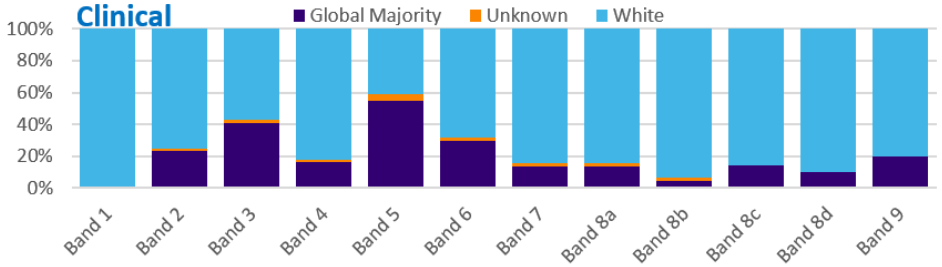
This section outlines the Trust's workforce profile by ethnicity, including overall representation and variation across pay bands and staff groups. The charts below show how staff are distributed across non-clinical, clinical, and medical and dental roles. The proportion of staff who chose not to share their ethnicity was 3.4%, representing a **small improvement** compared with 3.6% in the previous year (2025) and 4.4% in 2024.

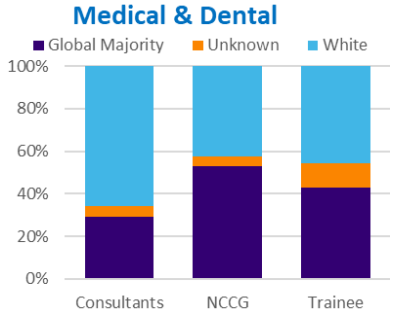
As of 31 March 2026, the Trust's permanent workforce comprised 30.6% Global Majority staff (5,796 individuals). This proportion is higher than the 19% Global Majority population across England and 9% across Sussex (Census 2021, ONS). This represents an **increase of nearly three percentage points** compared with the previous reporting year (2025: 27.7%) and five percentage points compared to 2024 (25.3%).

As the graphs below illustrate, the ethnic workforce profiles are highly structured by staff group and pay band. Staff from Global Majority backgrounds have higher representation in middle pay bands within clinical roles, with a reduction in representation at senior pay bands in both non-clinical and clinical staff groups, and at consultant level within medical and dental roles. The accompanying pie chart provides the overall Trust ethnicity context for these patterns.



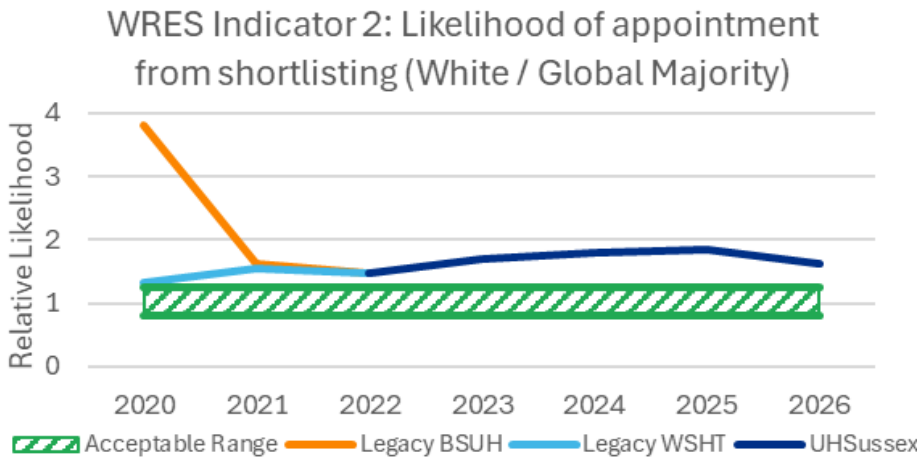
## Indicators derived from ESR Data

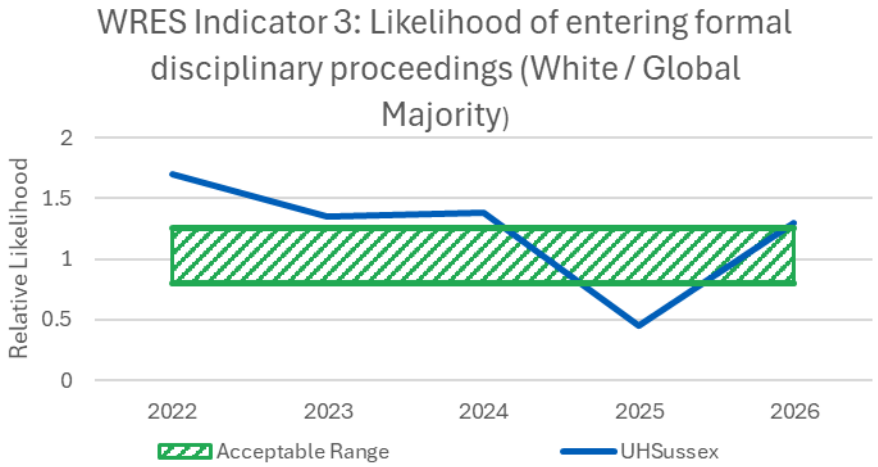
The table below brings together results for WRES indicators derived from our secure and confidential electronic staff record system (ESR) data, highlighting changes from 2025 and the relative distance from equity. The data shows progress in representation and recruitment, including increased Global Majority workforce presence and improved appointment outcomes. However, inequalities remain in disciplinary processes, training access and senior representation, particularly at Board level.

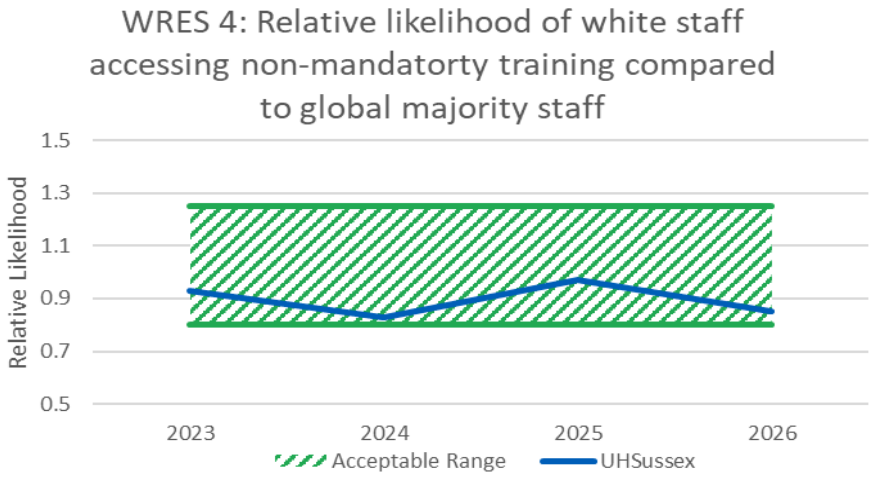
Improvement/Better
Decline/Worse

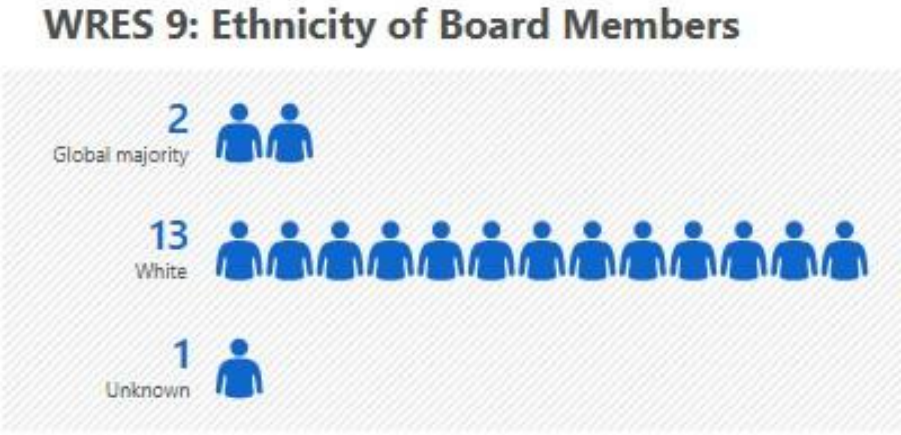
| Indicator number and description | Results | Change from 2025 | Distance from equity |
|---|---|---|---|
| **Indicator 1: Global Majority representation in the workforce by pay band** | | | |
| **Overall** | **30.6%** | **2.9%-point increase** | |
| **Non-Clinical** | **15.8%** | **1.2%-point increase** | |
| Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 1.41 | 0.10 increase | 0.41 |
| Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 1.26 | 0.36 decrease | 0.26 |
| Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 1.77 | 0.34 decrease | 0.77 |
| **Clinical** | **35.0%** | **3.6%-point increase** | |
| Disparity ratio - lower (Bands 1-5) to middle (Bands 6-7) | 2.73 | 0.12 increase | 1.73 |
| Disparity ratio - middle (Bands 6-7) to upper (Bands 8a-VSM) | 2.30 | 0.39 increase | 1.30 |
| Disparity ratio - lower (Bands 1-5) to upper (Bands 8a-VSM) | 6.28 | 1.29 increase | 5.28 |
| **Medical & Dental** | **38.2%** | **2.1%-point increase** | |
| Disparity ratio - Trainee to NCCG | 0.76 | 0.03 decrease | -0.24 |
| Disparity ratio - NCCG to Consultant | 2.80 | 0.19 increase | 1.80 |
| Disparity ratio - Trainee to Consultant | 2.12 | 0.06 increase | 1.12 |
| **Indicator 2: Likelihood of appointment from shortlisting** | | | |
| Likelihood ratio White / Global Majority | **1.63** | 0.21 decrease | 0.63 |
| **Indicator 3: Likelihood of entering formal disciplinary proceedings** | | | |
| Likelihood ratio Global Majority / White | **1.30** | 0.87 increase | 0.30 |
| **Indicator 4: Likelihood of undertaking non-mandatory training** | | | |
| Likelihood ratio White / Global Majority | **0.85** | 0.12 decrease | -0.15 |
| **Indicator 9: Difference between Global Majority representation on the board and in the workforce** | | | |
| **Overall Global Majority representation on the Board** | **12.5%** | **3.5%-point decrease** | **-18.1%-points** |
| Executive Director | 0% | unchanged | -30.6%-points |
| Voting Director | 12.5% | 5.1%-point decrease | -18.1%-points |

The charts below present WRES Indicators 2, 3, 4 and 9, showing trends in relative likelihood ratios. Taken together, these data show mixed progress across key WRES indicators, with improvements over time in appointment from shortlisting and access to non-mandatory training, alongside continued disparity in disciplinary outcomes and under-representation of staff from Global Majority backgrounds at Board level. Additional analysis relating to WRES Indicator 4 is included in the Appendix WRES 4: Non-mandatory training.



## Indicators derived from NHS Staff Survey Data

The data in the table below show changes across WRES indicators derived from annual NHS National Staff Survey data since 2025 and the relative distance from equity between staff from Global Majority backgrounds and White staff. The data indicate that two of the four indicators improved in 2026, while disparities remain across three indicators, including experiences of harassment, bullying or abuse and discrimination.

Improvement/Better
Decline/Worse

| Indicator number and description | Results | Change from 2024 | Distance from equity | National Average |
|---|---|---|---|---|
| **Indicator 5: Harassment, bullying or abuse from patients, relatives or the public in last 12 months** | | | | |
| Global Majority | **34.4%** | 1.7%-point increase | 6.8%-points | 29.0% |
| White | **27.6%** | 0.5%-point increase | | 22.9% |
| **Indicator 6: Harassment, bullying or abuse from staff in last 12 months** | | | | |
| Global Majority | **21.4%** | 0.7%-point increase | -1.5%-points | 24.1% |
| White | **23.0%** | 1.6%-point decrease | | 20.5% |
| **Indicator 7: Believing in equality of opportunity for career progression or promotion** | | | | |
| Global Majority | **57.9%** | 6.5%-point increase | 5.1%-points | 49.1% |
| White | **52.7%** | 1.0%-point decrease | | 55.5% |
| **Indicator 8: Discrimination from a manager/team leader or other colleagues in last 12 months** | | | | |
| Global Majority | **10.9%** | 0.3%-point decrease | 3.7%-point | 14.7% |
| White | **7.2%** | 3.2%-point decrease | | 6.4% |

Graphs and narrative relating to the above WRES indicators are included in the Appendix WRES 5-8: Staff experience indicators.

## Delivery actions linked to WRES from the Workforce Inclusion Programme (WIP)

| Indicator | Linked WIP action |
|---|---|
| WRES 1 & WRES 9 | **Board and Top 70 leaders' inclusion objectives** - Embed race equity objectives into Board and Top-70 leader goals, including accountability for WRES outcomes and inclusive leadership behaviours. |
| WRES 1 & WRES 2 | **Enhanced panel briefings for NMAHP 8a+ roles** - Design and deliver enhanced panel briefings and Post-Interview Development Needs feedback for 8a+ roles (including ESM/VSM) to improve fairness, transparency and progression. |
| WRES 1 | **Build career development plans into the appraisal system** - Integrate structured career development planning into appraisal conversations to support equitable progression for Global Majority staff. |
| WRES 1 | **Career Navigation Support Service (CNSS)** - Increased awareness and uptake of CNSS, particularly among Global Majority staff. |
| WRES 1 & WRES 7 | **Career Sponsorship Scheme** - Continue delivery and evaluation of the Career Sponsorship Scheme to address disparities in career progression and promotion at senior levels. |
| WRES 1 & WRES 7 | **Reverse Mentoring Scheme funding case** - Develop a funding case to sustain and scale the Reverse Mentoring Scheme, strengthening senior leader understanding of lived experience and race equity. |
| WRES 1 & WRES 5 | **Top 1,000 Inclusive Leadership training offer** – Develop a plan to deliver inclusive leadership training to the top 1,000 leaders, with a focus on race equity, psychological safety and accountability for WRES outcomes. |
| WRES 5 | **Hate Incident and VPR hotspot intervention** - Implement targeted interventions in identified hate incident and Violence Prevention & Reduction (VPR) hotspots to improve safety and reporting confidence. This includes reviewing discrimination coding and reporting, post-incident support and introduce inclusive investigation training. |

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# Workforce Disability Equality Standard (WDES) 2026

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# Introduction

The **Workforce Disability Equality Standard (WDES)** provides a nationally mandated framework for assessing the experiences of disabled staff and those with long-term conditions within NHS organisations. It brings together workforce, recruitment, employee relations and staff survey data to identify disparities in experience, opportunity and outcomes. At UHSussex, the WDES supports a systematic approach to understanding inequality, monitoring progress over time, and informing targeted action through the Workforce Inclusion Programme and our organisational strategy.

## Use of Data and Information

This report draws on workforce data required to meet national workforce equality reporting standards that NHS organisations are mandated to complete annually, i.e. the Workforce Disability Equality Standard (WDES). These standards set expectations regarding the scope, format, terminology and minimum reporting requirements, to support consistency and comparability across organisations. The WDES section has been written as standalone report, in line with national guidance.

Staff can update their personal information on their staff record via employee self-service at any time. All data used for reporting is anonymised and handled in line with information governance and data protection requirements. Anonymised data is analysed to identify and respond to issues affecting groups of staff who share protected characteristics.

The WDES utilises data from the Electronic Staff Record (ESR) and the national staff survey. The rate in 2026 that our staff shared their disability was 17.2%-points higher in the staff survey than in ESR. The former is representative for all other characteristics so we can assume that the staff survey rate for disability is more likely to be accurate than the ESR rate for disability.

## Terminology

Disability and long-lasting health conditions or illnesses may be used interchangeably in this report. This due to a change in language used nationally within the National Staff Survey which compiles qualitative data on the experiences of staff with long-term conditions (LTC) that may meet the legal criteria to be considered a disability.

Throughout this report, we will also mention **'Distance from Equity'**. For representation percentages, this refers to how far the number is from the Trust average. For likelihood questions, this refers to how far the number is from zero. For other metrics, it refers to the percentage difference between disabled and non-disabled experiences. For example, if 20% of Disabled staff face bullying and harassment then it would be equitable if 20% of non-disabled staff also face bullying and harassment. Here, the greater the percentage difference, the greater the inequity.

## Data collection

The WDES is an annual benchmarking tool mandated by NHS England. Bank-only workers are excluded from this data submission. The WDES data must be submitted on the Data Collections Framework (DCF) system by 31 May 2026.

# Summary

## Overview

The report outlines the data from the **National Workforce Disability Equality Standard (WDES)**. The WDES is an annual benchmarking tool introduced by NHS England to assess the progress made towards achieving disability equality within NHS organisations. It assesses how the trust has improved against 10 metrics designed to close the gap between the experiences of staff with declared disabilities and other colleagues. These include:

1. Clinical and non-clinical diversity and representation across all bands and pay grades (from ESR workforce data).
2. Successful job appointment and shortlisting (from ESR workforce and Trac recruitment systems data).
3. Numbers entering formal capability processes (from ESR workforce and employee relations disciplinary records data).
4. Incidents of bullying, harassment or abuse from
    a. Patients, relatives or the public (NHS Staff Survey responses data),
    b. Managers (NHS Staff Survey responses data),
    c. other colleagues (NHS Staff Survey responses data)
    d. Incidents of bullying, harassment or abuse reported by victims or colleagues compared to those without a disability (NHS Staff Survey responses data).Perceptions around equal opportunities for progression or promotion (from NHS Staff Survey responses data).
6. Pressure to work when not feeling well enough to do so (from NHS Staff Survey responses data).
7. Feeling valued by the organisation (from NHS Staff Survey responses data).
8. Receiving adequate adjustments to carry out work (from NHS Staff Survey responses data).
9. Engagement:
    a. compared to non-disabled staff and the trust average score (from NHS Staff Survey responses data) and
    b. ability to feel heard and listened to (from Disabled Staff Network).
10. Proportional representation of the overall workforce at board level (from ESR workforce data).

## Main Findings

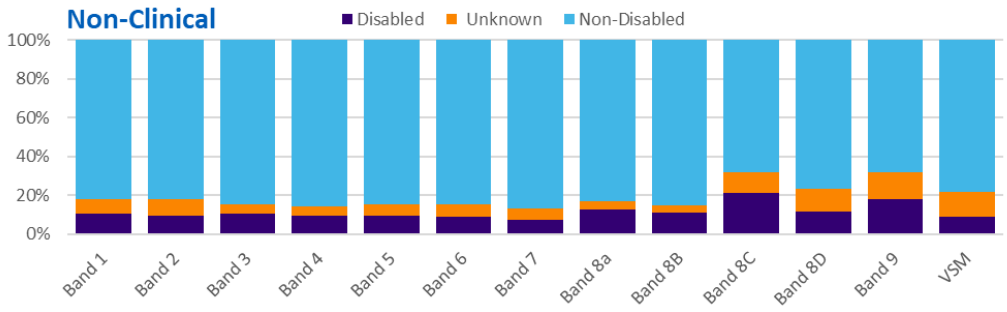
**Three of the WDES measures reported below improved in 2026**. There is still disparity in capability cases, appointments, career progression in senior clinical roles, experiences of harassment, bullying or abuse, and board representation. We have seen improvements in:

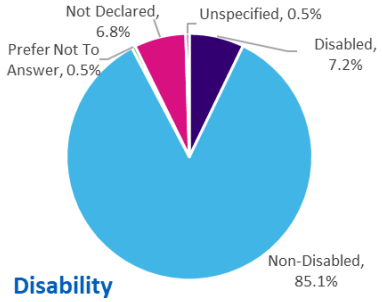
- the percentage of disabled staff in our workforce, and the percentage of staff stating their disability status.
- the likelihood of disabled staff progressing into senior non-clinical and mid-level clinical roles.
- the percentage of disabled staff believing in equality of opportunity for career progression or promotion
- the percentage of disabled staff receiving reasonable adjustments.

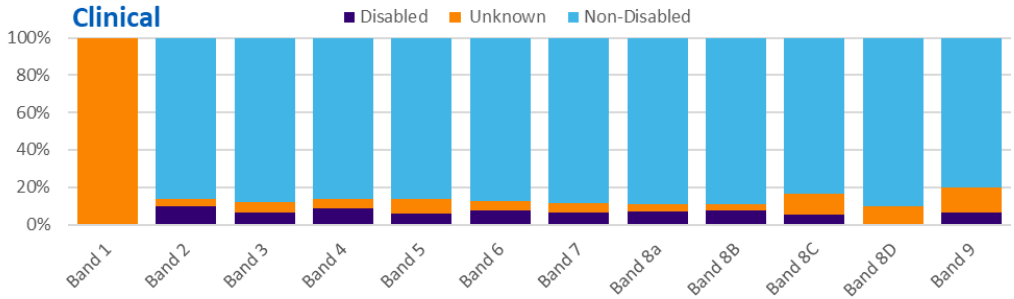
## Workforce Profile

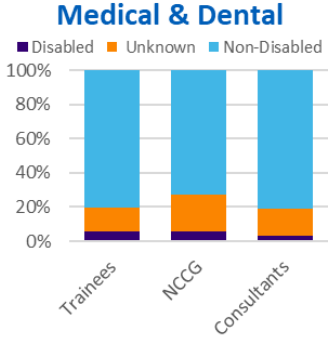
As of 31 March 2026, 7.2% (1,367) of the Trust's permanent workforce identified as disabled. This compares with 18% of the population across Sussex (Census 2021, ONS) and represents a **marginal increase** compared with the previous reporting years (6.7% in 2025 and 5.8% in 2024). Data from the 2025 NHS Staff Survey indicates that 24.4% of Trust respondents reported having a disability or long-term health condition.

The graphs below show differing patterns of disability representation across staff groups: higher representation of disabled staff at senior pay bands within non-clinical roles, lower representation at higher pay bands within clinical roles and at consultant level in medical and dental roles, and a notably higher proportion of unknown disability status across senior pay bands and medical and dental grades. The accompanying pie chart provides the overall Trust disability context for these patterns. The proportion of staff who chose not to share their disability status was 7.7%, **improved** from 8.5% in 2025 and 12.3% in 2024.



# Indicators derived from ESR Data

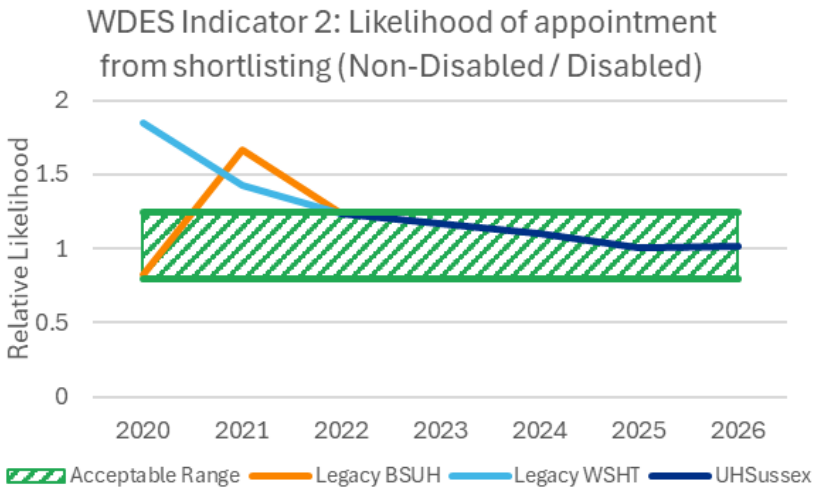
The data in the table below show changes across WDES indicators derived from ESR data since 2025 and the relative distance from equity between disabled and non-disabled staff. None of the four main indicators improved in 2026 (green) and disparities remain across all indicators, including capability, appointments, career progression in senior clinical roles, and board representation.

| Indicator number and description | Results | Change from 2025 | Distance from equity |
|---|---|---|---|
| **Indicator 1: Disabled representation in the workforce by pay band** | | | |
| **Overall** | **7.2%** | **0.5%-point increase** | |
| **Non-Clinical** | **9.8%** | **1%-point increase** | |
| Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 2 (Bands 5-7) | 1.13 | 0.12 increase | 0.13 |
| Disparity ratio - Cluster 2 (Bands 5-7) to Cluster 3 (Bands 8a & 8b) | 0.72 | -0.01 decrease | -0.28 |
| Disparity ratio - Cluster 3 (Bands 8a & 8b) to Cluster 4 (Bands 8c - VSM) | 0.59 | 0.11 decrease | -0.41 |
| Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 4 (Bands 8c - VSM) | 0.48 | 0.03 decrease | -0.52 |
| **Clinical** | **6.8%** | **0.3%-point increase** | |
| Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 2 (Bands 5-7) | 1.05 | 0.07 decrease | 0.05 |
| Disparity ratio - Cluster 2 (Bands 5-7) to Cluster 3 (Bands 8a & 8b) | 0.92 | 0.04 decrease | -0.08 |
| Disparity ratio - Cluster 3 (Bands 8a & 8b) to Cluster 4 (Bands 8c - VSM) | 1.40 | 0.55 increase | 0.40 |
| Disparity ratio - Cluster 1 (Bands 1-4) to Cluster 4 (Bands 8c - VSM) | 1.36 | 0.44 increase | 0.36 |
| **Medical & Dental** | **4.6%** | **0.7%-point increase** | |
| Disparity ratio - Trainee to NCCG | 0.89 | 0.86 decrease | -0.11 |
| Disparity ratio - NCCG to Consultant | 2.01 | 1.07 increase | 1.01 |
| Disparity ratio - Trainee to Consultant | 1.80 | 0.15 increase | 0.80 |
| **Indicator 2: Likelihood of appointment from shortlisting** | | | |
| Likelihood ratio Non-disabled / Disabled | **1.02** | **0.02 increase** | **0.02** |
| **Indicator 3: Likelihood of entering formal capability proceedings** | | | |
| Likelihood ratio Disabled / Non-disabled | **1.58** | **1.58 increase** | **0.58** |
| **Metric 10: Disabled representation on the board** | | | |
| **Overall** | **0%** | **5.6%-point decrease** | **-7.2%-points** |
| Executive | 0% | 11.1%-point decrease | -7.2%-points |
| Voting | 0% | 5.9%-point decrease | -7.2%-points |



Improvement/Better
Decline/Worse

The charts below present WDES Indicators 2 and 10, showing trends over time in the relative likelihood of appointment from shortlisting for disabled staff compared with non-disabled staff, alongside the current disability composition of Board membership, highlighting progress over time in recruitment outcomes and under-representation of disabled staff at Board level, and a relatively high proportion of Board members with unknown disability status.




## Indicators derived from NHS Staff Survey Data

The data in the table below show changes across WDES indicators derived from annual NHS National Staff Survey data since 2025 and the relative distance from equity between disabled and non-disabled staff. The data indicates three of nine measures improved in 2026, while disparities remained across six indicators, including experiences of harassment, bullying or abuse and career progress, presenteeism and feeling valued. Further graphs and narrative are in Appendix WDES 4(2) and 6-7: Staff experience indicators.

| Indicator number and description | Results | Change from 2024 | Distance from equity | National Average |
|---|---|---|---|---|
| **Metric 1 (equivalent): Proportion with a long-term condition or illness** | | | | |
| Disabled | **24.4%** | 0.3%-point decrease | | 24.45% |
| **Indicator 4a: Harassment, bullying or abuse from patients, relatives or the public in last 12 months** | | | | |
| Disabled | **32.7%** | 0.3%-point increase | 4.2%-points | 29.1% |
| Non-disabled | **28.5%** | 1.3%-point increase | | 22.6% |
| **Indicator 4b: Harassment, bullying or abuse from line managers in last 12 months** | | | | |
| Disabled | **15.8%** | 0.6%-point increase | 7.8%-points | 14.1% |
| Non-disabled | **8.0%** | 0.3%-point decrease | | 7.6% |
| **Indicator 4c: Harassment, bullying or abuse from other colleagues in last 12 months** | | | | |
| Disabled | **25.7%** | 0.3%-point increase | 9.9%-points | 24.5% |
| Non-disabled | **15.8%** | 0.2%-point decrease | | 15.6% |
| **Indicator 4d: Reporting last incident of harassment, bullying or abuse** | | | | |
| Disabled | **51.5%** | 0.4%-point increase | -0.9%-points | 53.2% |
| Non-disabled | **52.5%** | 2.8%-point increase | | 52.9% |
| **Indicator 5: Career progression** | | | | |
| Disabled | **48.3%** | 0.9%-point increase | -6.6%-points | 47.8% |
| Non-disabled | **55.9%** | 1.2%-point increase | | 55.1% |
| **Indicator 6: Presenteeism** | | | | |
| Disabled | **31.0%** | 1.32%-point increase | 12.2%-points | 27.2% |
| Non-disabled | **18.8%** | 0.6%-point decrease | | 18.2% |
| **Metric 7: Feeling valued** | | | | |
| Disabled | **31.0%** | 0.7%-point decrease | -13.8%-points | 32.1% |
| Non-disabled | **44.8%** | 3.0%-point increase | | 45.1% |
| **Metric 8: Reasonable adjustments** | | | | |
| Disabled | **75.1%** | 0.3%-point increase | | 73.7% |
| **Metric 9a: Staff engagement** | | | | |
| Disabled | **6.19** | 0.01 decrease | 0.70 | 6.29 |
| Non-disabled | **6.89** | 0.15 increase | | 6.91 |

| | |
|---|---|
| Improvement/Better | |
| Decline/Worse | |

## Delivery actions linked to WDES from the Workforce Inclusion Programme (WIP)

| Indicator | Linked action in WIP |
|---|---|
| WDES 1 & WDES 2 | **Enhanced panel briefings for NMAHP** 8a+ roles - Design and deliver enhanced panel briefings for senior clinical recruitment to mitigate disability bias and improve appointment equity. |
| WDES 1 & WDES 2 | **Accountability in Senior Recruitment (Imperial Explain or Comply Model)** scope out the framework used by Imperial that requires recruiting managers to either follow agreed inclusive recruitment standards or clearly justify, with evidence, why they are departing from them to ensure accountability and reduce bias within senior recruitment (8a+ / ESM / VSM). |
| WDES 8 | **Centralised Reasonable Adjustments** - Evaluate the new centralised reasonable adjustments service to ensure timely, consistent and transferable adjustments for disabled staff across the organisation. |
| WDES 1 & WDES 4b,c | **Top 1,000 Inclusive Leadership training offer** – Develop a proposal to deliver inclusive leadership training focusing on disability inclusion, adjustment confidence, and accountability for WDES outcomes. |
| WDES 3 | **Capability processes bias review** - Undertake a focused review of capability processes to identify and address structural bias affecting disabled staff, including reasonable adjustment considerations. |
| WDES 3 | **Inclusive investigation training** - Deliver inclusive investigation training to reduce bias in disciplinary, capability and grievance processes and improve disabled staff experience. |

NHS
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NHS Foundation Trust

# Gender Pay Gap (GPG) 2026

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# Introduction

**Gender Pay Gap** reporting shows the difference in average hourly pay and bonus payments between men and women. The Trust is required to analyse the information to identify:

- the level of gender equality.
- the balance of male and female employees in each of four salary range quartiles.
- how effectively talent is being maximised and rewarded

and to use this to identify any underlying root causes for the gender pay gap and put in place remedial actions to address and mitigate this.

- The Trust submits data annually to the Government's statutory gender pay gap reporting portal https://gender-pay-gap.service.gov.uk/employers/21657

## Important information

- This report follows the statutory gender pay gap reporting requirements for public authorities with 250 or more employees. The snapshot date is 31 March 2026. The mean and median ordinary pay gaps and pay quartiles are calculated using full-pay relevant employees employed on that date, based on ordinary pay received during the pay period that included 31 March 2026. A total of 18,346 employees were included in these calculations. The bonus pay calculations use all relevant employees employed on the snapshot date and include bonus payments made during the 12 months ending 31 March 2026. The number of employees included in the bonus calculations may therefore differ from the number included in the ordinary pay and quartile calculations.

**There are six mandatory calculations:**

- Proportion of males and females in each pay quartile
- Mean (average) gender pay gap for ordinary pay
- Median gender pay gap for ordinary pay
- Proportion of males and females receiving a bonus payment
- Mean (average) gender pay gap for bonus pay
- Median gender pay gap for bonus pay

### What is the Gender Pay Gap?

- The gender pay gap shows the difference in average earnings between men and women across the organisation. It is shown as a percentage of men's earnings.

**Types of Pay Gap Calculations**

- **Mean Pay Gap:** The average hourly pay for all men is compared to the average hourly pay for all women. Hourly pay includes basic pay and any allowances paid through payroll but excludes overtime and expenses.
- **Median Pay Gap:** The hourly pay of the middle-paid man is compared to the hourly pay of the middle-paid woman when all employees are listed from highest to lowest pay. Hourly pay includes basic pay and allowances but excludes overtime and expenses.

The gender pay gap is not the same as equal pay for doing the same job. The Trust uses a national pay system and job evaluation process for staff under Agenda for Change and medical/dental contracts.

## Summary

As on the 31 March 2026:

- Women earned 98p for every £1 men earned (median hourly pay), while the mean result is 83p
- Women made up 61.7% of employees in the highest paid quarter, compared with 70.1% in the lowest paid quarter. Relative to their representation in the lowest pay quartile, men were around 1.5 times more likely than women to be in the highest pay quartile
- 0.48% of women received bonus pay, compared with 2.14% of men
- Women's mean bonus pay was 26.57% lower than men's.

The table below shows how the gender hourly pay gap has changed over recent years, increasing marginally from 2023 to 2024, narrowing marginally in 2025, and widening again marginally in 2026; while the mean pay gap in 2026 approaches the 2024 level, the median shows a similar pattern with a less pronounced increase.

Table 1 Chart showing average mean and median hourly pay

| Gender Hourly Pay Gap | Average (Mean) Hourly Pay | | | | Median Hourly Pay | | | |
|---|---|---|---|---|---|---|---|---|
| | 2023 | 2024 | 2025 | 2026 | 2023 | 2024 | 2025 | 2026 |
| Male £ | 22.26 | 24.01 | 25.85 | 27.06 | 16.84 | 18.10 | 19.25 | 20.10 |
| Female £ | 18.73 | 19.97 | 21.60 | 22.50 | 16.84 | 17.69 | 18.98 | 19.78 |
| Difference | 3.53 | 4.04 | 4.25 | 4.57 | 0.00 | 0.41 | 0.27 | 0.32 |
| Pay Gap % | 15.86% | 16.83% | 16.43% | 16.87% | 0.00% | 2.29% | 1.40% | 1.57% |

### The ordinary (hourly rates) pay gap has increased marginally.

In 2025/26, women earned £0.83 for every £1 earned by men, representing **a one-penny decrease compared to the previous year**. "Ordinary pay" refers to pay received in the pay period that includes the snapshot date, including basic pay, allowances and shift pay, but excluding bonus pay. Overall, the **ordinary pay gap has remained broadly consistent** over recent years, with limited movement. This gap is largely driven by the continued over-representation of male staff in senior management and consultant roles, particularly within the highest pay quartile.

### Our gender bonus gap has increased and remains substantial.

The proportion of male staff receiving a bonus was **over 346% higher** than the proportion of female staff. Male staff also received **higher average and median bonus payments** than female staff. As in previous years, this gap is primarily driven by eligibility for consultant-level awards and legacy arrangements, including Discretionary Points and protected Clinical Excellence Awards, which historically benefit a greater proportion of male staff.

### Pay quartile representation has remained largely unchanged, but progression into higher pay levels remains uneven.

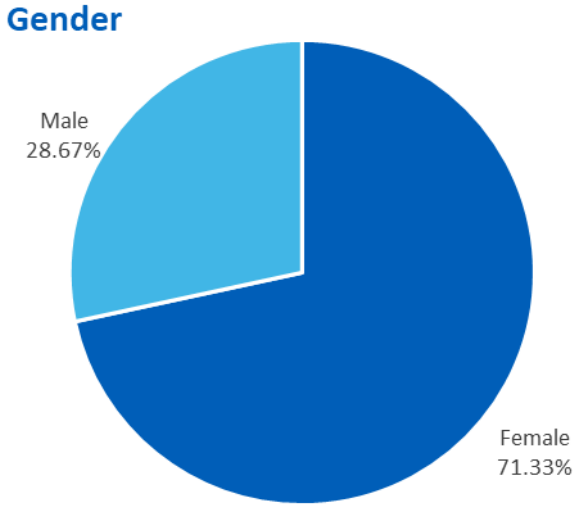
Representation across pay quartiles has shown **minimal year-on-year movement**. Despite women comprising the majority of the workforce, their representation decreases at higher pay levels, particularly within the top pay quartile.

### New national award schemes show early signs of improved balance for bonus outcomes.

Because bonuses apply to a small and specific group of staff, relatively small changes in the number or type of awards can have a disproportionate effect on reported bonus pay gaps. More recent schemes, such as National Clinical Impact Awards, demonstrate a more balanced gender distribution and may support improved equity over time as historic arrangements phase out.

# Gender Pay Gap: Representation

This section sets out how males and females are distributed across the workforce and pay quartiles, providing context for the Trust's gender pay gap and the structural factors that influence it.




## Headcount

This section sets out the workforce profile used for statutory gender pay gap reporting, including the proportion of male and female staff within the Trust. In line with the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, the ordinary pay and pay-quartile calculations include full-pay relevant employees who were employed on the snapshot date and received their usual full pay during the relevant pay period. The figures include substantive and bank staff who meet this definition and excludes those not receiving full pay e.g. due to long-term leave.

The chart shows the overall gender composition of staff counted for statutory pay gap reporting purposes, 71.6% (13,140) were female, and 28.4% (5,206) were male.

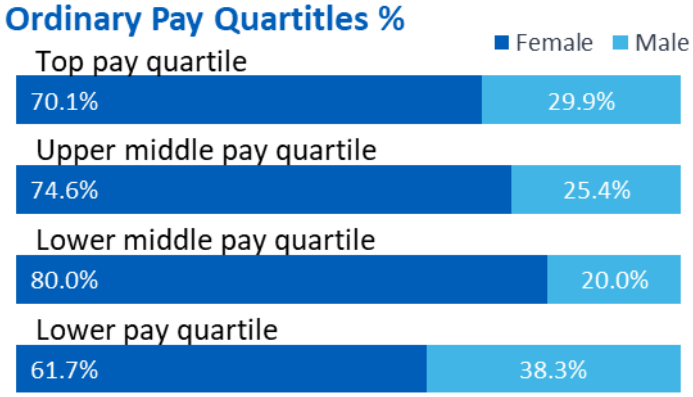
## Representation by Ordinary Pay Quartiles

This section shows how males and females are distributed across pay quartiles, providing insight into how workforce composition influences the gender pay gap. To understand how males and females are distributed across different pay levels, all full-pay employees are divided into four equal groups (called quartiles), based on their earnings, from the lowest to the highest.

The chart on the right shows the percentage of male and female employees in each pay quartile:

- 4,581 staff were in the lower pay quartile, of these 3,212 females.
- 4,475 staff were in the lower middle pay quartile, of these 3,337 females.
- 4,701 staff were in the upper middle pay quartile, of these 3,759 females.
- 4,589 staff were in the top pay quartile, of these 2,832 females.

This breakdown shows the percentage of male and female employees in each quartile, helping us assess gender balance across different pay levels.



Male staff were **2.5 times more likely** to be in the top pay quartile than female staff, compared to their representation in the upper middle pay quartile. This is up (worse) from 2.4 times in 2025 and 2.2 times in 2024.

Male staff were **1.5 times more likely** to be in the top pay quartile than female staff, compared to their representation in the lowest pay quartile. This is up (marginally) from 1.4 times in 2025 and the same as in 2024.

Our quartile pay representation has remained consistent the past few years with limited movement.

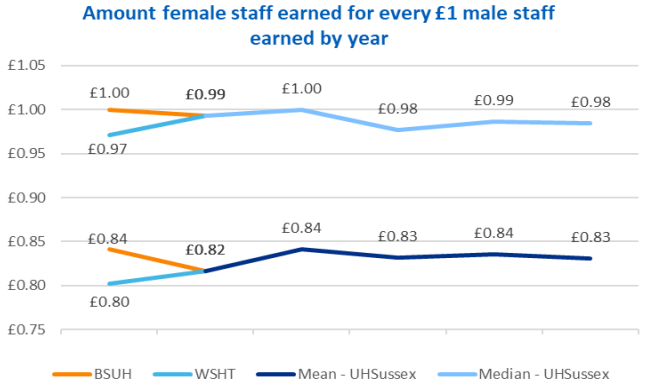
## Gender Pay Gap: Ordinary Pay

This section establishes the **average and median differences in hourly rates of ordinary pay** between male and female employees. As on the 31 of March 2026, the average hourly pay for male staff is £27.06. It is £22.50 for female staff. This makes our average gender pay gap 16.87% and the median gender pay gap is 1.57%.

Comparing average hourly wages, women earned eighty-three pence for every £1 men earned, **one penny less (worse) than in 2025**. Comparing median hourly wages (accounting for the effect of outliers), women earned ninety-eight pence for every £1 men earned, **one penny less (worse) than in 2025**.

These figures are summarised in the below table and illustrated in the chart below. The table provides a snapshot of the 2026 position, while the chart shows changes in the mean and median hourly pay gap over recent years, with limited movement and can largely be attributed to the higher proportion of male staff in senior management and consultant roles.

| | Mean | Median |
|---|---|---|
| Male | £27.06 | £20.10 |
| Female | £22.50 | £19.78 |
| Difference | 4.57 | 0.32 |
| Pay Gap % | 16.87 | 1.57 |
| For every £1 a man earns, a woman earns | **£0.83** | **£0.98** |



# Gender Pay Gap: Bonuses

This section outlines differences between males and females in bonus payments given to eligible employees during the 12 months leading up to the 31 March 2026. Bonus pay is one or more of the following payments:

- Clinical Excellence Awards (CEA)
- National Clinical Impact Awards (NCIA)
- Discretionary pay for consultants with extra responsibilities

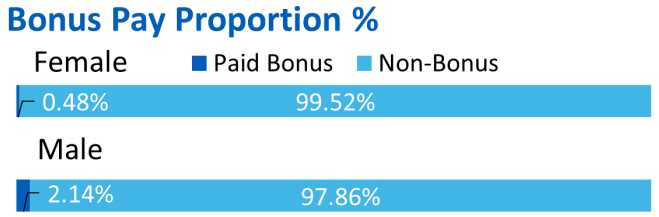
Staff who receive more than one type of bonus are counted only once.

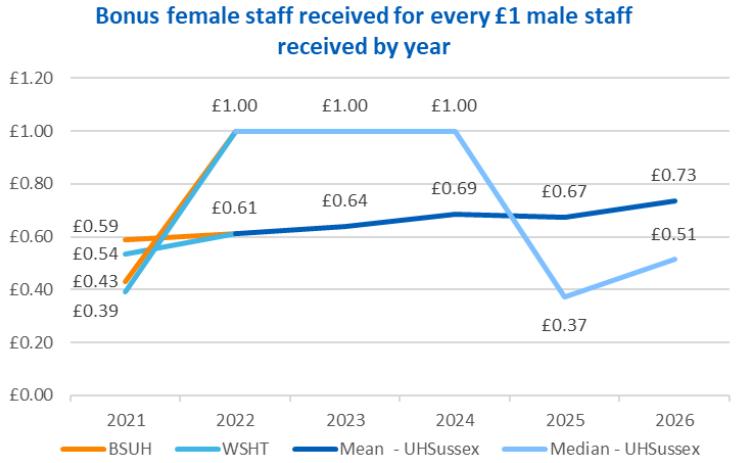
## Who Received Bonus Pay?

The chart on the top right shows the percentage of male and female employees who received bonuses:

- 2.14% of male employees received a bonus
- 0.48% of female employees received a bonus
- This means the proportion of male employees receiving a bonus is 346% higher than the proportion of female employees.
- 137 male and 75 female staff received at least one type of bonus.

Percentages are calculated using all relevant employees in full pay on the snapshot date as the denominator.




## Bonus Pay Differences

The second chart above right shows changes in the mean and median bonus pay gap over recent years; it shows that male continue to staff receive a higher overall amount in bonus pay compared to female staff. This disparity is primarily due to a greater proportion of male staff receiving bonuses, as well as some male staff receiving multiple types of awards.

Female staff received lower average (£8,931.86) and median (£4,180.20) bonus pay than male staff (£12,164.13 and £ 8,143.20 respectively). This translates to an average pay gap of 26.57% and a median pay gap of 48.67%.

### Discretionary Points Pay

- Discretionary Points are legacy consultant payments awarded to consultants in recognition of additional responsibilities under previous national arrangements and closed to new entrants. This was awarded to one male employee within the 12 months.

### Clinical Excellence Award

- Clinical Excellence Awards (CEAs) are intended to recognise consultants who make sustained contributions beyond the standard expectations of their role, including excellence in patient care, service development, teaching, research, and leadership. To be eligible, consultants must hold a substantive post and normally have completed at least one year of service at the Trust at the time of application. This includes:
- Local awards - granted by the Trust.
- National awards - granted by the Department of Health and Social Care but paid through the Trust's payroll.
- 129 (66%) male and 67 (34%) female staff received CEA-related payments within the 12-month reporting period.
- There have been national changes to the CEA scheme for consultant medical staff. Local CEAs are no longer awarded, and no new CEAs have been made under post-2018 contract arrangements. However, consultants who received awards prior to these changes retain them on a protected basis until they leave NHS service.

### National Clinical Impact Awards (NCIA)

- National Clinical Impact Awards (NCIAs) are the current national scheme intended to recognise consultants who demonstrate clinical impact beyond their employing organisation, such as regional or national leadership, guideline development, research, education, or service transformation. NCIAs replaced national Clinical Excellence Awards for consultants on newer contract arrangements and are awarded through a nationally managed process. This includes:
- National awards - granted by the Department of Health and Social Care but paid through the Trust's payroll.
- 8 female (53%) and 7 male (47%) staff received a National Clinical Impact Award within the 12 months.

# Gender Pay Gap: Menopause Action Plan

This section is included in line with current Government guidance on voluntary equality action plans alongside gender pay gap reporting. Employers with 250 or more employees may publish an action plan in conjunction with their gender pay gap data, and the guidance indicates that these plans may include actions to address the gender pay gap and to support employees experiencing menopause. This aligns with the Employment Rights Act 2025, which inserted section 78A into the Equality Act 2010, enabling the introduction of such requirements through regulations. Trust actions include:

### Manager Capability and Training

- Support for managers includes a **menopause e-learning module**, inclusion of menopause within the Mental Health Training for Managers programme, menopause-focused peer support sessions, and a managers' Menopause Guide. This guidance includes practical advice and information on recording menopause-related absence.]

### Peer Support and Awareness

- The Trust has delivered a **quarterly Menopause Café** since 2024, with approximately 400 members and around 800 cumulative attendees to date. Sessions typically attract 60-70 colleagues and include specialist input on menopause-related topics. **Resources** are shared via the staff intranet, and **Menopause Awareness Day** is marked annually. Feedback indicates the initiative is valued for both information and peer support.

### Workplace Adjustments

- Menopause Guidance outlines a range of **reasonable workplace adjustments** to support colleagues, enabling flexibility and supporting staff to remain in work.

### Café user quotes

"I know that going through this is a very lonely and frustrating time for women. I often felt that no one was listening and had not a clue what to do. This group is going to empower those women and be a much needed source of information."

- Tracy

"Love the menopause café and the community that's been built, it is such a relief to have a place to learn and not feel alone, thank you"

- Sue

## Delivery actions linked to GPG from the Workforce Inclusion Programme (WIP)

| Indicator | Linked action in the WIP |
|---|---|
| **Pay Gap** | **Self-rostering implementation** – Continue to progress self-rostering arrangements to improve flexibility, work-life balance and retention, particularly for staff with caring responsibilities, supporting participation and progression into higher-paid roles. |
| **Pay Gap** | **Supervisor Self-Service implementation** - Implement Supervisor Self-Service to improve data accuracy, timely workforce decisions and equitable management of pay, hours and progression. |
| **Pay Gap** | **Flexible working job adverts** – Continue to emphasise flexible working options in job advertisements to attract a more diverse applicant pool and reduce barriers to senior and higher-paid roles. |
| **Pay Gap** | **Nursing position title modernisation** – Explore modernisation of nursing position titles to better reflect role responsibility, skill and scope, supporting fair evaluation and progression pathways. |

NHS
University Hospitals Sussex
NHS Foundation Trust

# Ethnicity Pay Gap (EPG) 2026

uhsussex.inclusion@nhs.net

www.uhsussex.nhs.uk/equality

# Introduction

As part of our duties under the Equality Act and under the NHS EDI Improvement Plan, we are conducting a comprehensive analysis of **pay disparities** and outlining actions we are taking to eradicate pay differences on the basis of protected characteristics.

Each pay gap is the difference between the average pay of different groups according to their characteristics. The **ethnicity pay gap** is calculated using a comparator approach in which White British staff are used as the reference group, in line with recommended methodology. This compares average hourly and bonus pay between White British staff and other ethnic groups across the workforce.

As with gender pay gap reporting, this does not measure differences in pay for the same role, but differences in average pay across the workforce, influenced by representation across roles, grades and pay bands.

UK employers with 250 or more employees are required to report their gender pay gap data annually. NHS Trusts are now additionally required to report Gender, Ethnicity and Disability pay gaps, with data taken from a 31 March snapshot date.

In 2026, we analysed data relevant for Ethnicity Pay Gap calculations from 18,346 employees. There are six mandatory calculations:

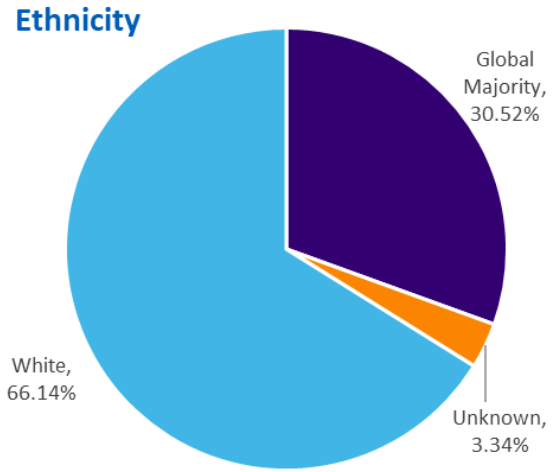
1. Proportion of ethnic groups in each pay quartile
2. Mean (average) ethnicity pay gap for ordinary pay
3. Median ethnicity pay gap for ordinary pay
4. Proportion of ethnic groups receiving a bonus payment
5. Mean (average) ethnicity pay gap for bonus pay
6. Median ethnicity pay gap for bonus pay

We also review:

- the proportion of our total UK workforce from different ethnic groups.
- the proportion of our employees who have shared their ethnicity.

# Summary

As on the 31 March 2026, the average hourly pay for white staff is £23.58, and £23.76 for Global Majority staff, making our average ethnicity pay gap -0.79% and the median ethnicity pay gap -0.33%. Our average bonus ethnicity pay gap is 28.78%. The pie chart shows the overall composition of staff counted for ethnicity pay gap reporting purposes, with Global Majority staff making up 30.52% and white staff 66.14%.




## The ordinary pay gap has decreased

The **pay gap has been slowly decreasing** year-on-year, improving by -3.75% (average) and -1.76% (median) from 2024 to 2025, and again by -2.91% (average) and -2.73% (median) from 2025 to 2026, bringing the overall position **close to parity**.

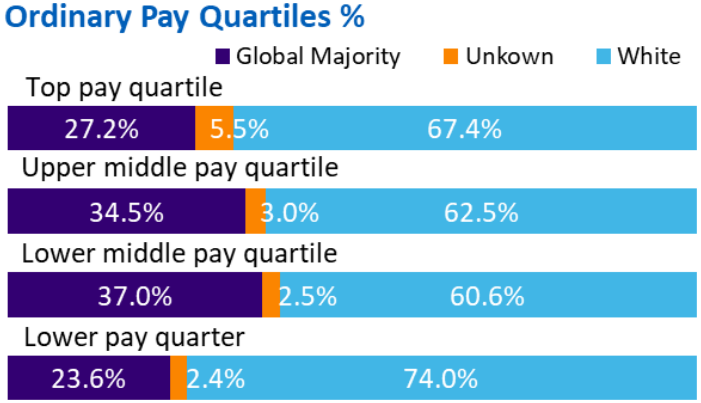
## Our ethnicity bonus gap remains substantial

**White staff were substantially more likely to receive a bonus** than Global Majority staff, with the proportion of white employees receiving a bonus around 70% higher. White British staff also received **higher average and median bonus payments** than most Global Majority groups. All percentages are based on staff included in the pay gap dataset (those in full pay on the snapshot date).

## Our quartile pay gap is slowly changing

The narrowing ethnicity pay gap coincides with increased representation of Global Majority staff in the lower and lower-middle pay quartiles, reflecting growth in entry-level and early-career roles. Improved ethnicity recording has also contributed by increasing the visibility of staff in lower-paid roles.

The chart to the right shows the percentage of Global Majority and white staff as well as the percentage of employees with unknown ethnicity in each pay quartile, indicating a lower percentage of Global Majority staff in lower and top pay quartiles.



## Disaggregated analysis highlights significant variation between ethnic groups

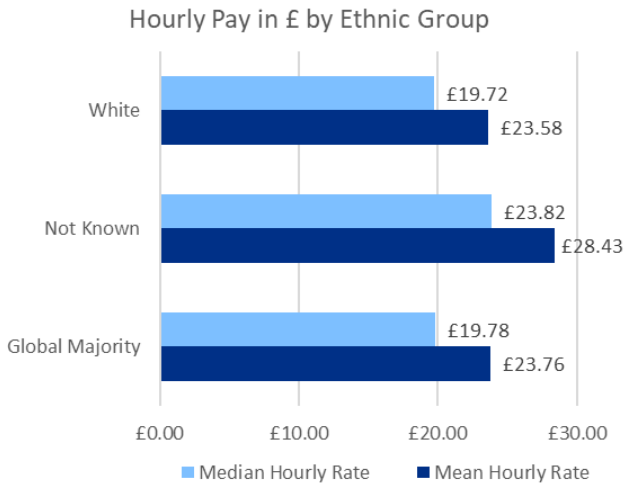
More detailed breakdowns highlight substantial differences in pay outcomes within aggregate ethnic categories. While some groups, including East Asian staff, have higher average and median pay, other historically marginalised groups, particularly South-East Asian and Black staff, continue to experience lower average pay.

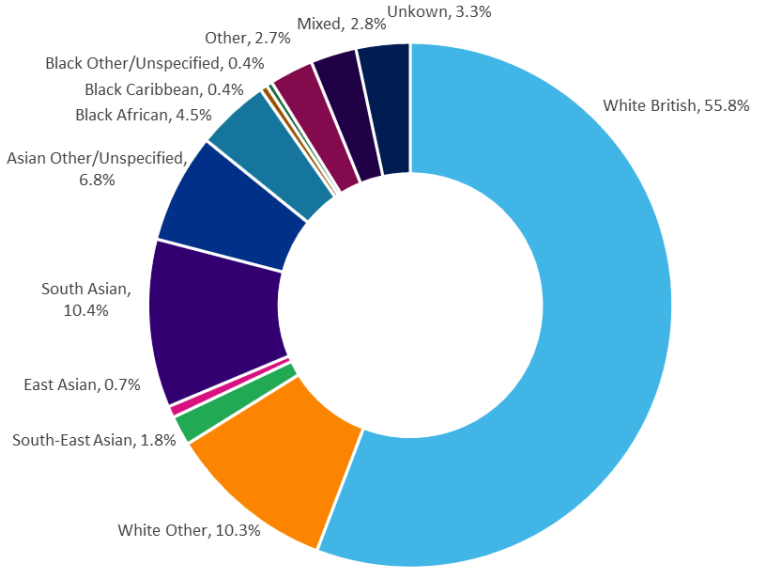
## Disaggregating Ethnic Groups

We provide a breakdown of ethnicity pay gaps that moves away from only a simple white and Global Majority model. Consistent with Government ethnicity pay reporting guidance, single aggregate pay gaps cannot adequately reflect differences between ethnic groups which more detailed breakdowns can. We utilised ONS categories to reflect our largest workforce demographic groups:

- Splitting White British groups (British, English, Scottish, Welsh, Cornish) from all other white groups.
- Splitting South-East Asian, East Asian and South Asian groups
- Splitting Black African and Black Caribbean.

The chart below compares mean and median hourly pay for White staff and Global Majority staff, providing a snapshot of how pay levels differ by broad ethnic group.




The chart above shows the workforce ethnicity profile disaggregated by detailed ethnic groups, which inform the following analyses.

# Ethnicity Pay Gap: Ordinary Pay

### Significant pay gaps exist between ethnic groups

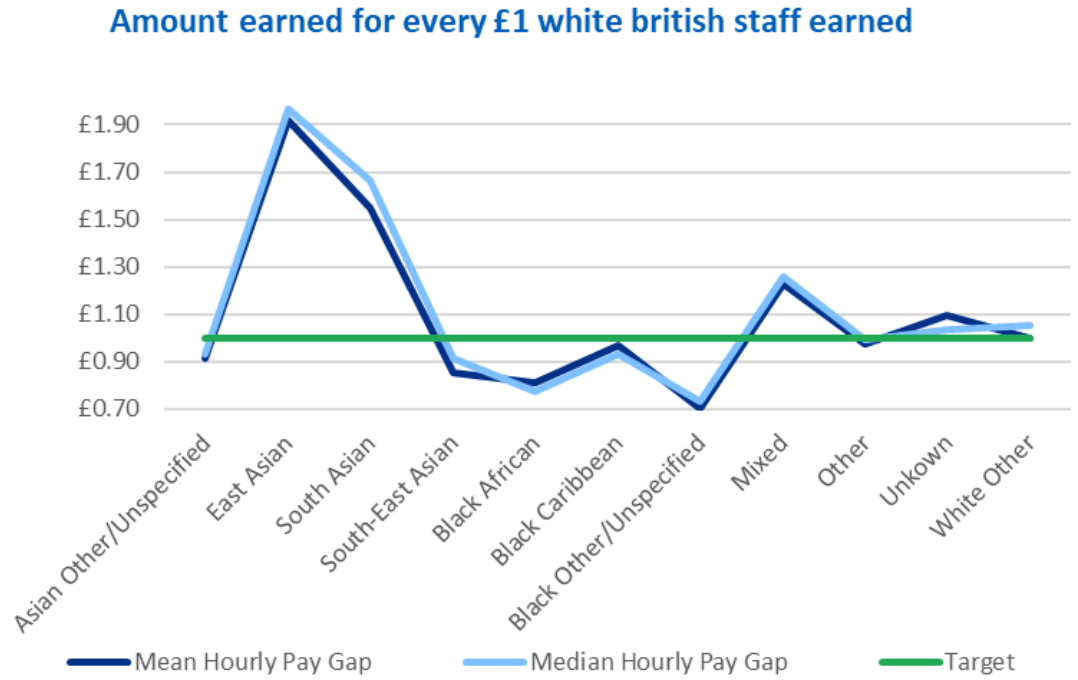
The graph below shows how mean and median hourly earnings compare across detailed ethnic groups, expressed as the amount earned for every £1 earned by White British staff, highlighting variation in pay outcomes between groups:

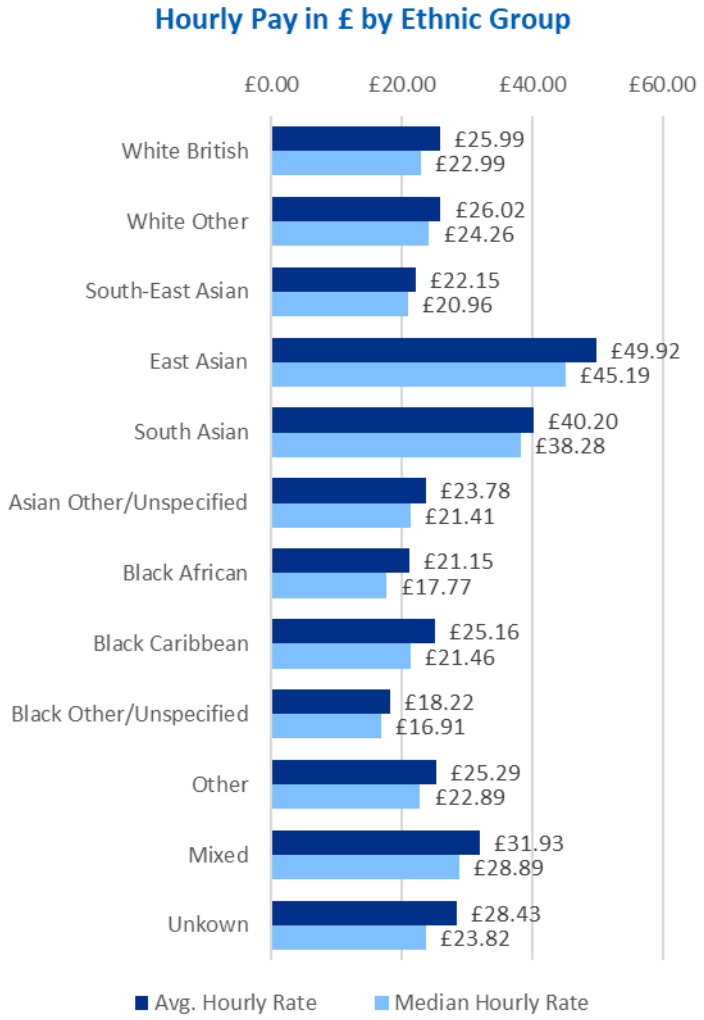
- **Highest Hourly Pay -** The ethnic group with the largest hourly pay is East Asian staff at £49.92 average and £45.19 median. This is significantly higher than the average Asian aggregate hourly pay of £24.03
- **Lowest Hourly Pay -** The ethnic group with the lowest hourly pay is staff from other or unspecified Black backgrounds at £18.22 average and £16.91 median. This is significantly lower than the average Black aggregate hourly pay of £21.30
- **The difference in hourly pay** between these groups is £31.70 / hour on average and £28.27 / hour on median. For reference, the National Living wage on 31 March 2026 was £12.21 / hour.

### Some historically marginalised ethnic groups continue to experience lower average pay

Historically marginalised groups, defined here as ethnic groups that have experienced structural disadvantage, including Global Majority groups, continue to face pay disparities.

This is particularly evident among South-East Asian and Black staff, who earn substantially less on average than several other ethnic groups. Smaller but persistent average pay gaps relative to White British staff are also observed among staff who selected ‘Other’ and Asian Other/Unspecified categories.






## White British and White Other groups show similar outcomes

The difference in average pay between White British and White Other staff is **small and has remained stable** in recent years, with White Other staff earning £1.00 for every £1 earned by White British staff. This is consistent with previous years (£1.02 in 2025 and £1.01 in 2024), indicating no material divergence in pay outcomes between these two groups.

## Significant variation in pay outcomes between Asian ethnic groups

The chart on the left compares mean and median hourly pay across detailed ethnic groups, providing a more granular view of pay levels beyond the broad demographic groupings.

Average hourly pay differs markedly between Asian ethnic groups. The disparity between East Asian and South-East Asian staff is particularly pronounced, with a difference of £27.77 per hour on average and £24.23 per hour at the median, indicating substantial heterogeneity in pay outcomes that is not visible when Asian groups are considered in aggregate.

## Pay differences by ethnicity and occupational distribution

Some ethnic groups, including East Asian, South Asian, staff from mixed ethnic backgrounds, and staff with unknown ethnicity, have higher average pay than White British staff. This is likely to be influenced by higher representation of these groups in medical and dental roles which attract higher average pay, such as Non-Consultant Career Grade (NCCG) roles.

# Ethnicity Pay Gap: Bonuses

Bonuses were given to eligible employees during the 12 months leading up to the March 2026. Anyone who received more than one type of bonus is counted only once. Bonus payments include:

- Clinical Excellence Awards (CEA)
- National Clinical Impact Awards (NCIA)
- Discretionary pay for consultants with extra responsibilities

## Who Received Bonus Pay?

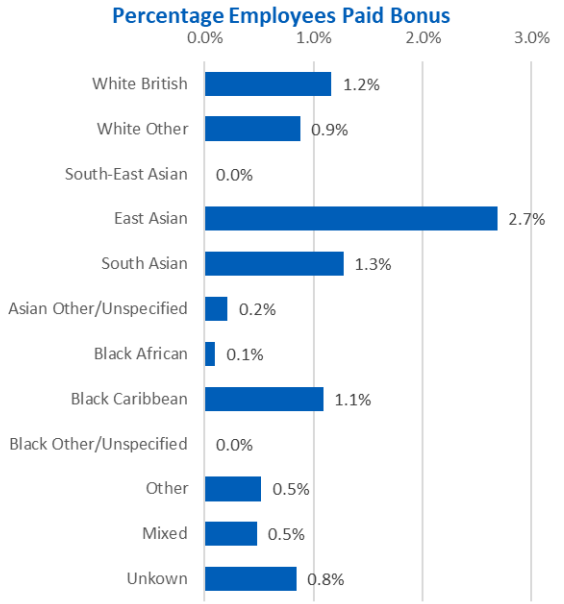
The chart on the right shows the percentage of employees who received bonuses:

- 1.12% of white employees received a bonus
- 0.66% of Global Majority employees received a bonus
- The proportion of white employees receiving a bonus is around 70% higher the proportion of Global Majority employees.

Percentages are calculated using all staff included in the ethnicity pay gap dataset as the denominator, while the counts below reflect the number of staff who received bonus payments during the 12-month reporting period. Only certain staff groups are eligible for these bonuses. In total: 161 white, 43 Global Majority, and 8 staff with unknown ethnicity received at least one type of bonus.

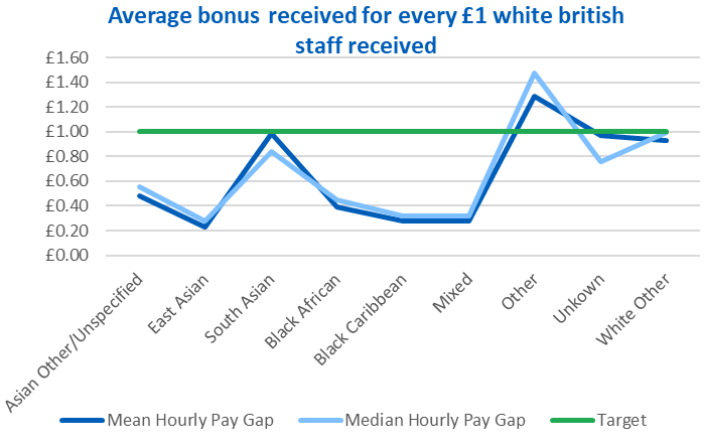
## Bonus Pay Differences

The chart opposite compares the mean and median bonus payments received by staff in each ethnic group. White British staff received higher mean and median bonus payments than most Global Majority groups, with the exception of staff recorded in the “Other” ethnic group. These figures describe the value of awards among staff who received bonus pay and are separate from the proportion of each group receiving a bonus. Differences in average award value may reflect the types and values of awards received, the distribution of eligible staff across roles and, in some cases, receipt of more than one type of award. The available data do not establish the relative contribution of each factor.




31

than



The largest difference in bonus pay to White British staff (with an average bonus of £10,875.29 and a median bonus pay of £9,496.77) was for East Asian staff (£2,516.27, and £2,612.21 respectively). This works out to a mean pay gap of 76.86% and a median pay gap of 72.49%.

NHS
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# Disability Pay Gap (DPG) 2026

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# Introduction

As part of our duties under the Equality Act 2010 and under the NHS EDI Improvement Plan, we are conducting a comprehensive analysis of pay disparities and outlining actions we are taking to eradicate pay differences on the basis of protected characteristics.

Each pay gap is the difference between the average pay of different groups according to their characteristics. The **disability pay gap** is the difference between non-disabled staff hourly and bonus pay compared to other groups.

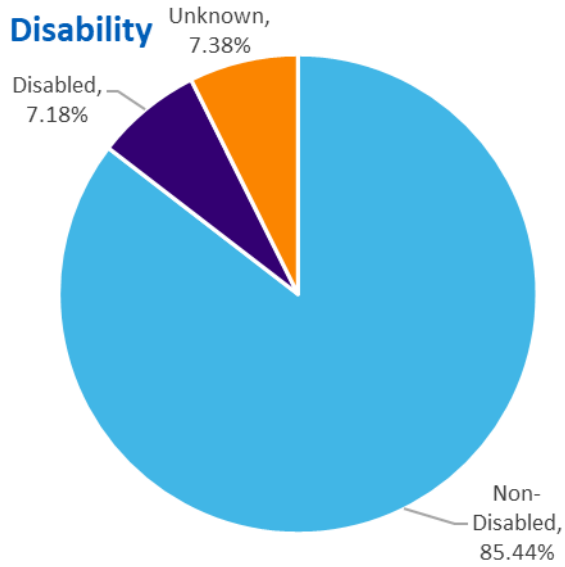
UK employers with 250 or more employees are required to report their gender pay gap data annually. NHS Trusts are now additionally required to report Gender, Ethnicity and Disability pay gaps, with data taken from a 31 March snapshot date.

Using the snapshot date of 31 March 2026, we analysed data relevant to the disability pay gap calculations for 18,303 employees. The analysis comprises six calculations::

1. Proportion of disability status in each pay quartile
2. Mean disability pay gap for ordinary pay
3. Median disability pay gap for ordinary pay
4. Proportion of disability status groups receiving a bonus payment
5. Mean disability pay gap for bonus pay
6. Median disability pay gap for bonus pay

# Summary

As on the 31 of March 2026, the average hourly pay for non-disabled staff is £23.44. It is £21.37 for disabled staff, making our average disability pay gap 8.85% and the median disability pay gap is 10.50%. Our average bonus disability pay gap is -64.13%. The top chart shows the overall composition of staff counted for disability pay gap reporting purposes, with disabled staff making up 7.18% and non-disabled staff 85.44%.




## The ordinary disability pay gap remains significant

As of 31 March 2026, the average disability pay gap was 8.85% and the median gap was 10.50%, with disabled staff earning £0.91 on average and £0.89 at the median for every £1 earned by not-disabled staff. This indicates a meaningful disparity in pay outcomes between disabled and not-disabled staff.

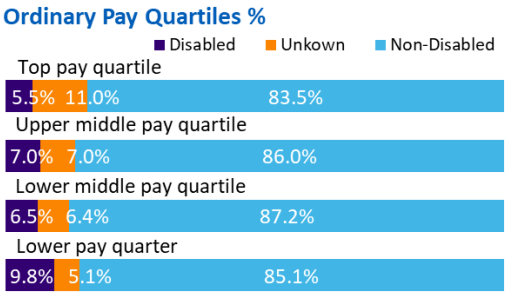
The bottom chart shows the percentage of disabled and non-disabled staff as well as the percentage of employees with unknown disability status in each pay quartile, indicating a lower percentage of disabled staff in the top pay quartile and a higher percentage of staff with unknown disability status in this quartile.

## Pay outcomes vary considerably across disability groups

Disaggregated analysis shows that most disability groups experience lower average pay relative to not-disabled staff, with the largest gaps observed among staff with long-standing illnesses, mental health conditions, and those reporting ‘other’ disabilities. The widest difference is between staff with ‘other’ disabilities and those who have not shared their disability status.

## Our disability bonus gap is mixed and reflects eligibility patterns

Non-disabled staff were around 70% more likely to receive a bonus than disabled staff. However, among those who did receive a bonus, disabled staff had a higher average bonus value, resulting in a negative average bonus gap (-64.13%). This reflects the very small number of disabled staff receiving bonuses and the concentration of awards within a limited number of roles.



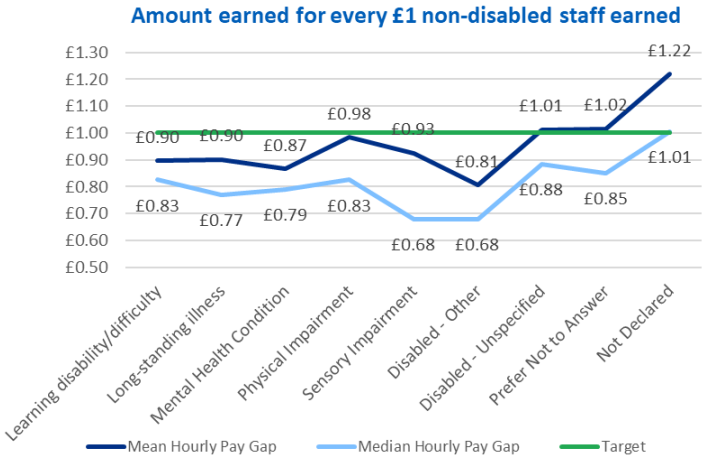
# Disability Pay Gap: Ordinary Pay

This section establishes the average and median differences in hourly rates of ordinary pay between disabled and non-disabled employees.

As on the 31 of March 2026, the average hourly pay for non-disabled staff is £23.44. It is £21.37 for disabled staff. This makes our average disability pay gap 8.85% and the median disability pay gap is 10.50%.

Comparing average hourly wages, disabled staff earned ninety-one pence for every £1 non-disabled staff earned.

Comparing median hourly wages (accounting for the effect of outliers), disabled staff earned eighty-nine pence for every £1 non-disabled staff earned.

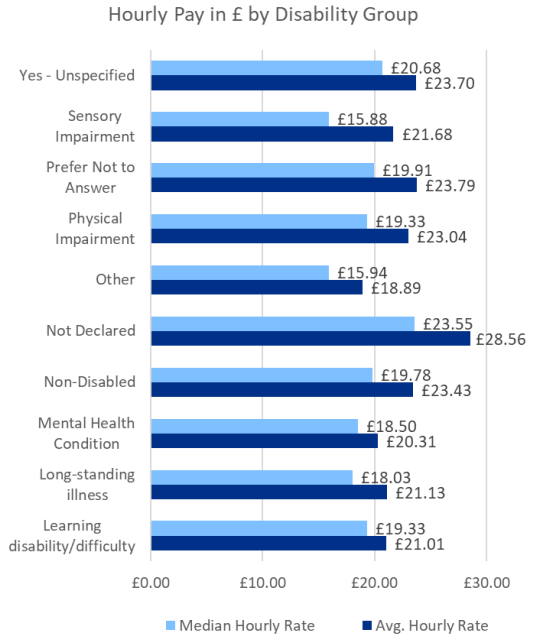



## Significant pay gaps exist between disability groups.

The disaggregated data reveals more information about pay disparity within disability types.

The top chart compares mean and median hourly earnings across disability types, expressed as the amount earned for every £1 earned by non-disabled staff. It highlights variation in relative pay outcomes by disability status. Average pay gaps relative to non-disabled staff are observed among most disability groups, with largest gaps for staff with long-standing illnesses, mental health conditions and ‘other’ disabilities.

The bottom chart compares mean and median hourly pay across disability types, highlighting how average hourly pay differs markedly between types. The largest disparity is between staff with ‘other’ disabilities and staff who have not shared their disability status, with a difference of £9.67 per hour on average and £7.61 per hour at the median.



# Disability Pay Gap: Bonuses

Bonuses were given to eligible employees during the 12 months leading up to the snapshot date. Anyone who received more than one type of bonus is counted only once. Bonus payments include:

- Clinical Excellence Awards (CEA)
- National Clinical Impact Awards (NCIA)
- Discretionary pay for consultants with extra responsibilities

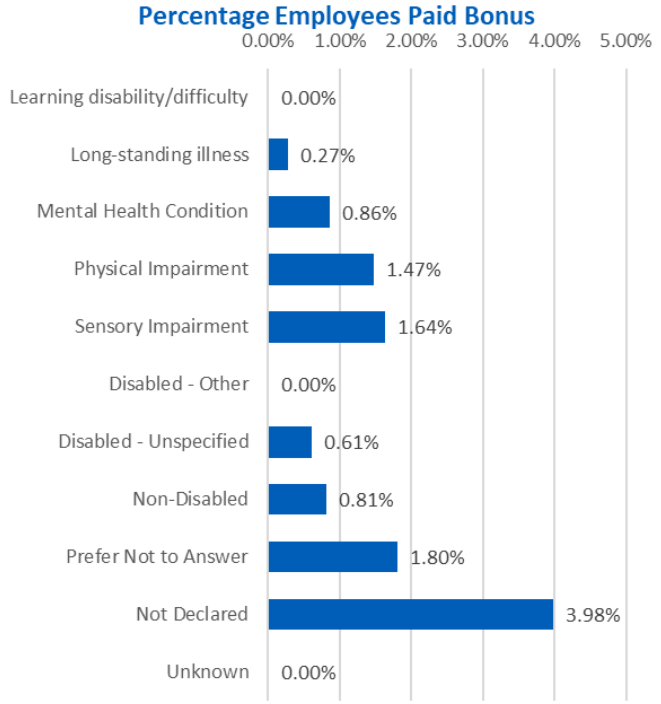
## Who Received Bonus Pay?

- 0.47% of disabled employees received a bonus.
- 0.81% of non-disabled employees received a bonus.
- This means the proportion of non-disabled employees receiving a bonus is around 70% higher than the proportion of disabled employees.

Only certain staff groups are eligible for these bonuses. In total:

- 151 non-disabled, 8 disabled staff, and 87 staff with unknown disability status received at least one type of bonus.

The chart on the right shows the proportion of employees receiving bonus payments by disability type, highlighting variation across types and a notably higher proportion of bonus recipients among staff with disability status not declared. Numbers in individual categories are small, which limits further detailed analysis by disability group.




## Bonus Pay Differences

Among staff who received bonus pay, disabled staff received a mean bonus payment of £22,301.58, compared with £13,587.82 for non-disabled staff. This produces a mean disability bonus pay gap of −64.13%. However, only eight disabled staff received a bonus, so the result is highly sensitive to the value of individual awards and should be interpreted with caution. Non-disabled staff remained more likely to receive a bonus overall. The available data do not establish why the mean award was higher among disabled recipients.

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# Appendix

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# Appendix 1: WRES and WDES

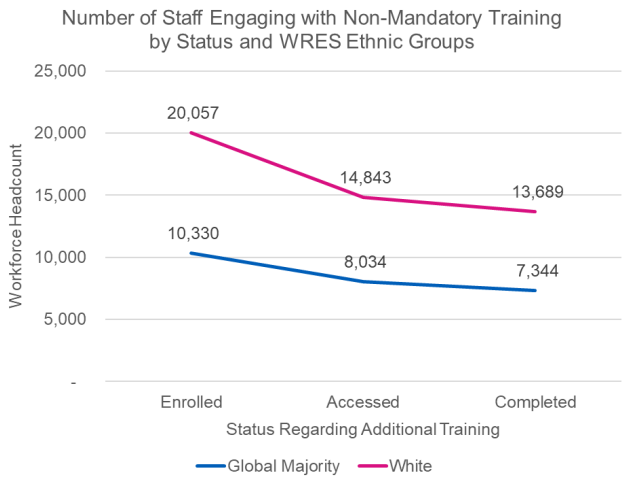
## WRES 4: Non-mandatory training

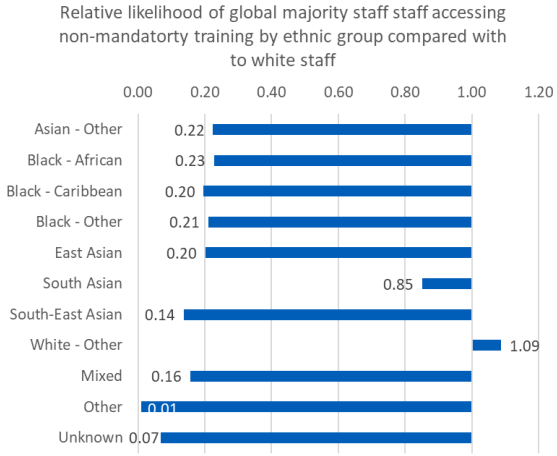
The WRES Indicator 4 assesses the relative likelihood of staff accessing non-mandatory training and Continuing Professional Development (CPD). Analysis shows that White staff (n = 14,843) were **as likely as Global Majority staff** (n = 8,034) to access non-mandatory training, with a relative likelihood ratio of 0.85. This ratio falls within the WRES equality range (0.8-1.25) and has remained stable over the past four years, indicating **sustained equity in access at an aggregate level**.

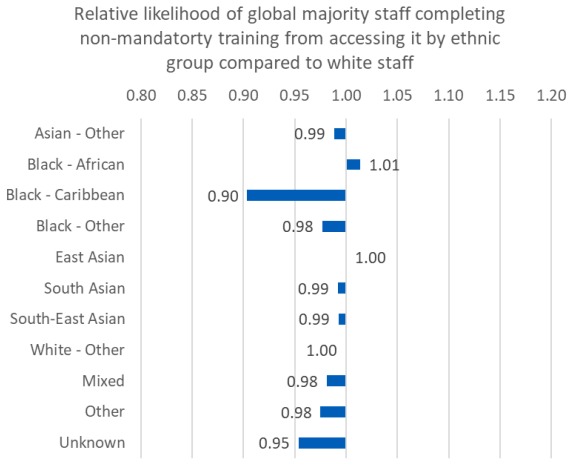
While the aggregate comparison suggests broadly equitable access, this can mask variation between individual ethnic groups.

To better reflect the Trust's ethnic diversity and move beyond the binary White versus Global Majority comparison, a more granular analysis was also undertaken. When comparing access to non-mandatory training, **most ethnic groups were found to be substantially less likely to access training opportunities than White British staff**. The exceptions to this pattern were South Asian and White Other staff, whose access rates were more comparable to those of White British staff.

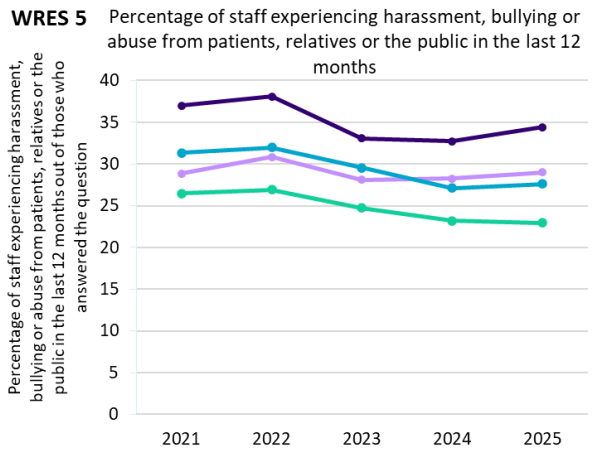
Importantly, once non-mandatory training was accessed, **completion rates were equitable across all ethnic groups**, indicating that observed disparities relate primarily to access rather than progression or completion.

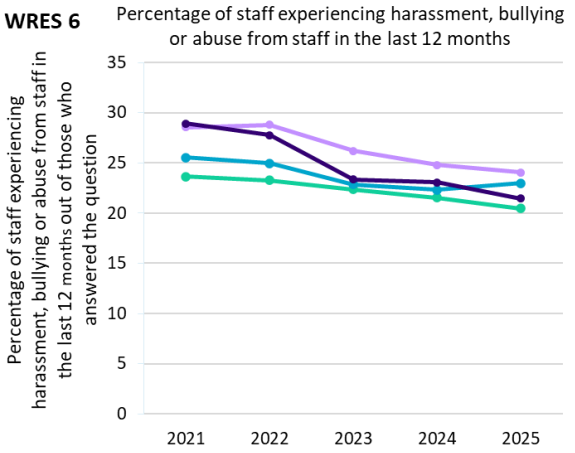

Number of Staff Engaging with Non-Mandatory Training by Status and WRES Ethnic Groups
25,000
20,000
15,000
10,000
5,000
-
Workforce Headcount
20,057
14,843
13,689
10,330
8,034
7,344
Enrolled
Accessed
Completed
Status Regarding Additional Training
Global Majority
White

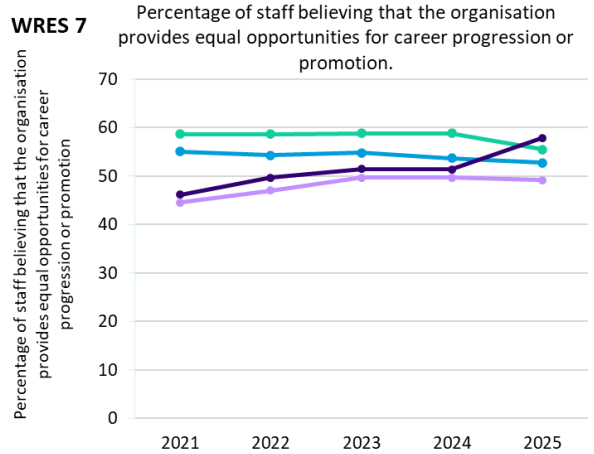

Relative likelihood of global majority staff staff accessing non-mandatorty training by ethnic group compared with to white staff
0.00
0.20
0.40
0.60
0.80
1.00
1.20
Asian - Other 0.22
Black - African 0.23
Black - Caribbean 0.20
Black - Other 0.21
East Asian 0.20
South Asian 0.85
South-East Asian 0.14
White - Other 1.09
Mixed 0.16
Other 0.01
Unknown 0.07

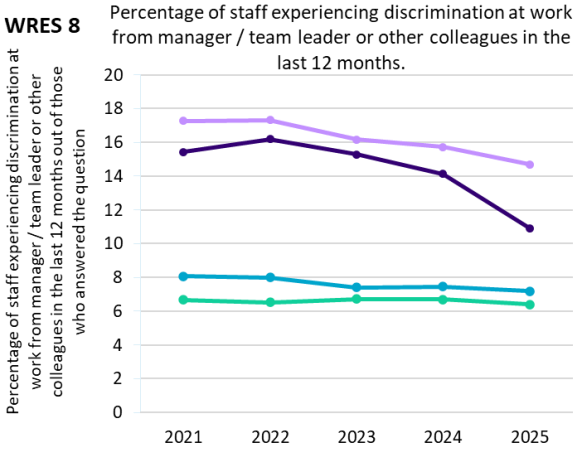

Relative likelihood of global majority staff completing non-mandatorty training from accessing it by ethnic group compared to white staff
0.80
0.85
0.90
0.95
1.00
1.05
1.10
1.15
1.20
Asian - Other 0.99
Black - African 1.01
Black - Caribbean 0.90
Black - Other 0.98
East Asian 1.00
South Asian 0.99
South-East Asian 0.99
White - Other 1.00
Mixed 0.98
Other 0.98
Unknown 0.95

# WRES 5-8: Staff experience indicators




White staff: UHSussex

All other ethnic groups*: UHSussex

White staff: National Average

All other ethnic groups*: National Average

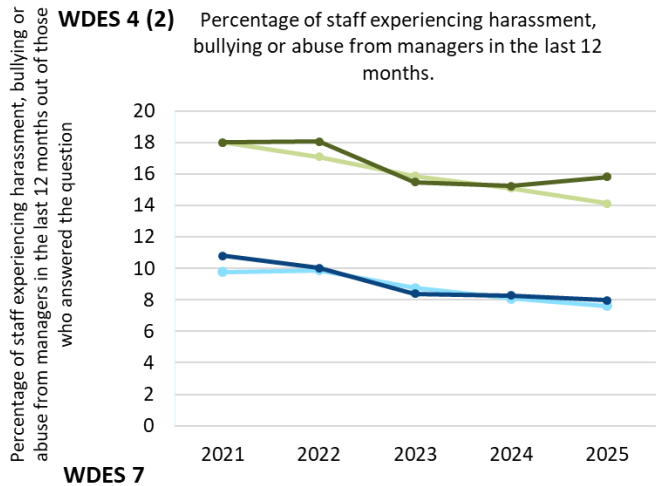
These charts show trends over time for staff survey indicators 5 to 8, comparing the experiences of White staff and all other ethnic groups at UHSussex with national averages.

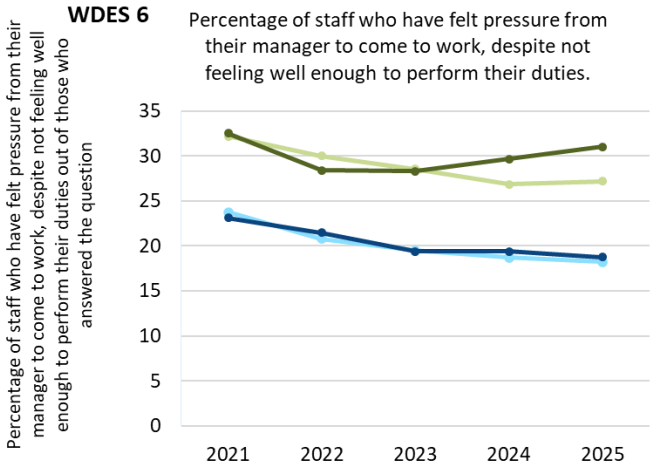
For indicator 5, UHSussex reports **higher levels of bullying, harassment or abuse from patients, relatives or the public** than the national average for both White staff and all other ethnic groups.

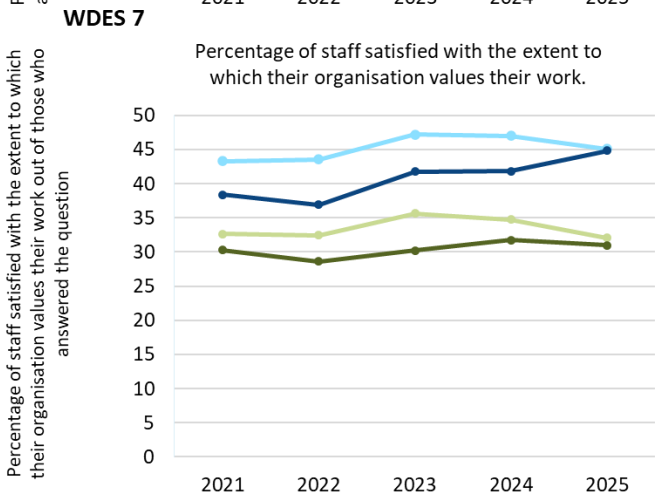
For indicator 6, White staff report **higher levels of bullying, harassment or abuse from staff than the national average**, while staff from all other ethnic groups report lower levels than the national average.

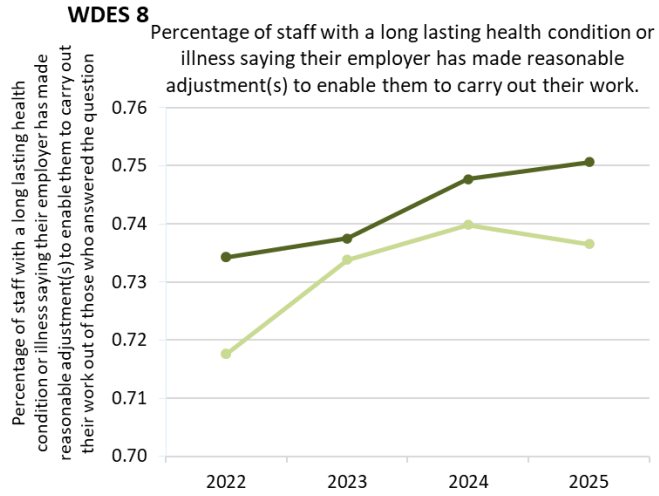
Indicator 7 shows a **marked increase in the proportion of staff from all other ethnic groups who believe the organisation provides equal opportunities for career progression or promotion**, now exceeding both White staff locally and national averages.

For indicator 8, reported **discrimination for staff from all other ethnic groups has decreased significantly** over time; while levels remain higher than for White staff, the **rate of improvement exceeds that seen nationally**. Overall, these indicators show a mixed position, with areas of poorer performance against national benchmarks alongside evidence of improvement over time.




## WDES 4(2) and 6-7: Staff experience indicators

These indicators show trends over time for staff with and without a long-term condition at UHSussex compared with national averages.

Across indicators 4 and 6, staff with a long-term condition consistently report poorer experiences than those without, including **higher levels of harassment and pressure from managers.**

Indicator 7 shows some improvement in staff satisfaction over time for both groups, but this has **stalled in the past year for staff with a long-term condition**.

- Staff with a LTC or illness: UHSussex
- Staff without a LTC or illness: **UHSussex**
- Staff with a LTC or illness: National Average
- Staff without a LTC or illness: National Average

Indicator 8 demonstrates an increase in the proportion of staff with a long-term condition reporting that reasonable adjustments have been made. Overall, while there is evidence of improvement in some areas, disparities in staff experience between those with and without a long-term condition persist.

# Appendix 2: Staff Networks

## Armed Forces Network

This has been a highly active and impactful year for the Armed Forces Network, with a range of initiatives aimed at supporting colleagues, strengthening community engagement and raising awareness of the Armed Forces community within the Trust.

Key highlights over the past year include the first-year anniversary of Veterans' Voices in April with interviews with many prominent veterans as well as service-focused content alongside recommendations to improve services for the Veteran cohort. The network has also delivered a number of high-profile fundraising and engagement events, including our first Regimental Dinner at Hove Club attended by SAS legend Billy Billingham to raise funds for Southlands Commemorative Garden and Coco's Spinnaker Tower abseil in April to raise funds for an RAMC Tommy statue.

The Network has also taken part in two Medical Endeavours, including a UHSussex team win. We have organised a strong presence in Southlands at key commemorative events such as Remembrance, VE Day and VJ Day services. Additional activities have included laying a wreath at the Chattri memorial service to honour the contribution of Sikh, Hindu and Muslim service personnel; hosting Armed Forces Network stands across Trust sites during Armed Forces Week and attending community remembrance events across East and West Sussex.

Alongside these activities, the network continues to provide direct support to Veteran staff members on HR issues. The Trust has also maintained its Veteran Aware status and successfully renewed "Gold" status for a further year.

The network has put forward a proposal for a PTSD Allotment Therapy Garden to support staff, patients and veterans, demonstrating a continued focus on wellbeing and therapeutic support.

Challenges remain, particularly in raising awareness and ensuring communications such as Veterans' Voices reach all staff. As with other networks, balancing network activity alongside day-to-day roles can be challenging and recruiting members to support events across sites remains an ongoing priority. There are also practical challenges in consistently recording and extracting Veteran status from patient administration systems.

Looking ahead, the network will focus on delivering planned projects, including the installation and unveiling of the Tommy statue and participation in further Medical Endeavours. Future fundraising activities include a proposed charity bike ride from Southlands to the National Arboretum to fund the installation of a plaque recognising the contribution of Sikh, Hindu and Muslim communities in both World Wars. The network is also developing an educational video to further raise awareness and understanding of the Armed Forces community.

"*I am really pleased to see the continued development of Veterans' Voices. The fact that this is grounded in Veterans' own experiences gives it real value and the recommendations feel both thoughtful and important*"

Andy Heeps, CEO

*"I read Veterans' Voices from the Armed Forces Network. Last Thursday I reviewed a man in his 70s in a Care Home […]. He mentioned […] that he'd been in the Army before but I didn't ask him more about it. Now, having read Veterans' Voices, I'd definitely explore it more next time. The signs of combat stress that Veteran Liz McConaghy talked about were all there in him as well"*

Dr Rafi Rogans-Watson, Consultant Geriatric Medicine

## Carers Staff Network

The Carers Network is now in its third year, and membership continues to grow.

The network holds monthly meetings where members can share experiences and offer peer support. Participants report that these sessions are a positive experience, helping to reduce feelings of isolation and supporting colleagues to address challenges related to their caring responsibilities. The network continues to explore ways to engage colleagues who are not yet aware of its work or are unable to attend events.


Carers Rights Day Conference 2026 – Panel Discussion

Panel members discuss support for carers in the workplace. From left to right: Jourdan Durairaj (Head of Inclusion), Zoe Larkai-Doherty (Carers UK), Dr Maggie Davies (Chief Nurse), Dom Duke (Carers Network Lead), Nick Groves (Associate Director, Leadership, OD & Engagement), and Faye Heffernan (Health, Wellbeing & Engagement Programme Manager).

In November 2025, the network hosted a Trust-wide conference to mark National Carers Rights Day, themed *Caring at a Distance*, recognising colleagues who provide unpaid care for loved ones who live far away. The event was attended by members of the Trust's Executive Team and included speakers covering financial and pastoral wellbeing, national initiatives to promote carers' rights, the realities of transnational caring, and strategies to support mental health and resilience. The event concluded with a panel discussion exploring how colleagues could be better supported through policies and targeted training for line managers.


Dom Duke, Carers Network Lead (left), and Michael Shann, Head of Carer Support at Carers UK (right).

The network continues to work closely with external organisations supporting unpaid carers at local and national levels, as well as with other staff networks and the Health and Wellbeing Team.

In June 2025, the network hosted information stalls across Trust sites as part of Carers Week. Several carers engaged directly with network representatives, and a number of staff members took away resources to share within their teams and work areas. Since the event, the network has seen increased awareness and growing membership.

Through funding from My Charity NHS Sussex, the Trust remains a member of Employers for Carers, providing all staff with access to a range of resources for carers, line managers, and senior leaders.

The network is grateful to Maggie Davies (Chief Nurse) for her support as Executive Sponsor since its inception. While this contribution is greatly valued, the network is pleased to welcome Nigel Kee (Interim Chief Delivery Officer) and Helen Brown (Interim Chief Corporate Affairs Officer) as new Executive Sponsors.


Carers Week 2025 – Carers Staff Network Information Stall at Princess Royal Hospital


Carers Week 2025 – Information Stall in the Louisa Martindale Building Foyer, Royal Sussex County Hospital

## Disabled Staff Network

The UHSussex Disabled Staff Network (DSN) continues to provide support, guidance and advocacy for disabled colleagues and those with long-standing health conditions. The network aims to improve staff experience, promote inclusion and ensure that disabled colleagues are supported to thrive within the Trust.

The DSN holds monthly meetings via Microsoft Teams. To maximise accessibility, sessions are scheduled on different days and at varying times to accommodate colleagues working non-standard or rotational shifts. This recognises that many staff do not work traditional Monday–Friday, 9–5 patterns and helps ensure equitable access to network support.

Network leads regularly attend Welcome Days and the annual Staff Conference to introduce the network to new and returning staff. These events provide opportunities to raise awareness of the DSN and its purpose, offer signposting to the Inclusion Team for guidance on legal rights and reasonable adjustments, direct managers to relevant training and resources, and engage directly with colleagues who may require workplace support.


Marce Quinn (former Disabled Staff Network Lead) at the National Deaf and Hard of Hearing Conference.

Lisa Bunt, Disabled Staff Network Lead, at a Coffee & Connect session.

Reaching staff with limited access to the intranet remains a key challenge. To address this, the DSN delivers monthly Coffee & Connect sessions across Trust sites, including Worthing, Brighton, Chichester and Haywards Heath. These sessions enable one-to-one conversations with colleagues in roles such as Housekeeping, Hospitality, Portering and Estates, who may otherwise be unaware of the network. This approach has increased membership and improved visibility of DSN support.

It was identified that some DSN members would benefit from additional support related to neurodiversity. In response, two members have established a Neurodiversity Group, with the first meeting scheduled to commence in July 2026.

Planning is underway for a half-day seminar in December 2026 to align with Disability History Month, focusing on awareness, education and celebrating the contributions of disabled colleagues across the Trust.

In addition, a member survey developed by the DSN Co-Lead is planned in 2026 to assess whether the network is meeting members' needs, identify gaps in support, and gather suggestions for future priorities. There are opportunities for DSN activities to be more consistently promoted across internal channels.

The DSN continues to expand its reach, strengthen engagement and provide meaningful support to colleagues across UHSussex. Ongoing challenges around communication and visibility remain, but the network's proactive initiatives demonstrate a sustained commitment to improving staff experience and fostering an inclusive workplace culture.

Staff members at a Coffee & Connect session.

## LGBTQIA+ Staff Network

The LGBTQIA+ Staff Network has had another active and impactful year. A relaunch under Emily Bevan's leadership significantly increased both visibility and the breadth of activity, followed by the appointment of Co-Chair Billie Strickland. Emily later stepped down after delivering an extensive programme of events and opportunities for members, which has provided a strong foundation for continued growth.

Emily Bevan (former LGBTQIA+ Staff Network Lead) at the Lesbian Visibility Week 2026 stall.

Chris Jepson (Project Uncut) delivering a seminar for the UHSussex LGBT+ History Month 2026 event.

Alongside the reintroduction of regular network meetings and guest speakers, the network expanded its offer to include a wide range of internal and external social events. Larger projects have also come to fruition over the past year, reflecting the continued development and ambition of the network.

Through meetings and recordings shared via the network's Teams channel, members have engaged with a diverse range of speakers, including artists and performers, Freedom to Speak Up Guardians, LGBTQIA+ colleagues, researchers in queer healthcare, senior leaders, and clinicians involved in inclusive outreach. These sessions have created valuable spaces for learning, visibility and dialogue.

Social events across the Trust's catchment area have included informal gatherings such as coffee mornings, pub socials, picnics and cultural events, as well as supportive spaces in response to recent national and political developments affecting LGBTQIA+ communities. The network has also contributed to conferences and staff inductions, delivered events during LGBTQIA+ History Month and Lesbian Visibility Week, and worked closely on preparations for Pride 2026.

A significant development this year has been the introduction of two administrative support roles, funded through pooled network charity funding. This has strengthened the network's capacity, enabled a more sustainable and coordinated programme of activity and increased its reach across the Trust.

The network continues to grow in both engagement and impact, providing a visible and supportive space for LGBTQIA+ colleagues and allies.


Dr Michael Brady (NHS England) speaking at the National LGBT+ Health Conference in London, attended by network members.

Staff celebrating Pride 2025 in the Louisa Martindale foyer at the Royal Sussex County Hospital.

Staff celebrating Pride 2025 at the LGBTQIA+ Community Parade in Brighton.

## Multicultural and Ethnic Diversity Staff Network

The Multicultural and Ethnic Diversity Staff Network has continued to grow its reach and influence, creating opportunities for connection, representation and meaningful dialogue across the organisation. Reflecting evolving language and feedback from members, the network has recently transitioned from its previous name, BAME/Global Majority, to its current name, alongside the introduction of a new logo. This change demonstrates a continued commitment to ensuring the network is inclusive and representative of the colleagues it supports. New site-specific leads have also been introduced to strengthen local engagement.


Staff celebrating Onam 2025 at the Princess Royal

Key events such as Race Equality Week**,** Onam, Philippines Independence Day, and Black History Month have provided valuable opportunities for celebration and engagement.

Staff celebrating Philippines Independence Day 2026.

The network continues to provide strong pastoral support through active group spaces and safe environments where colleagues can connect, share experiences, and support one another. This includes peer support, signposting, and opportunities to come together through activities such as Filipino mass and choirs.

However, some challenges remain, particularly in enabling staff to attend network activities due to limited release time, as well as improving engagement at formal meetings. Despite this, attendance at cultural celebrations and network-led activities has been strong, with events consistently well attended and positively received.

Looking ahead, the network aims to further strengthen in-person engagement and visibility across all sites. Plans include a hospital tour with stalls to introduce the refreshed network and encourage face-to-face engagement; closer working with ward managers to understand local challenges and identify opportunities for support; and increased participation in formal meetings. Upcoming

events, including Onam celebrations across all sites and Black History Month activities, will continue to support engagement and connection across the workforce.

Staff celebrating Onam 2025 with a traditional floral display (pookalam).

Staff gathered in front of food stalls during the Philippines Independence Day 2026 celebration.

## Religion and Belief Staff Network

The Religion and Belief Network provide a safe and inclusive space for colleagues of all faiths and none, where individual beliefs, values and identities are respected and supported. The network also welcomes allies who wish to listen and learn, supporting greater awareness and understanding across the Trust.


Jo Elliot (Religion and Belief Staff Network Lead) and Anthony Aboh (Staff Networks Project Support Manager) at the Inclusion and Health and Wellbeing Roadshow in Brighton.

The network operates in a collaborative and respectful way, with facilitated discussions that encourage open conversation while maintaining confidentiality. This approach aims to ensure that all participants feel welcomed, heard and supported.

Over the past year, the network has hosted a range of speakers and discussions on topics including fasting, with perspectives shared from Christian, Muslim and Jewish faiths, as well as sessions on staying safe at work, responding to hate speech, accessing support, and exploring themes such as mercy and prayer practices.


UHSussex Finance Conference – Corrinn Moustakim, Vital Azambourg, Johnathan Reid and Sam O'Mahoney at the My Charity stall.

The network has also supported colleagues observing Ramadan by sharing information on fasting times, helping colleagues who were working to identify when the fast would be broken. This provided practical support for colleagues who were away from home or their usual community during this important time.

Looking ahead, the network aims to further strengthen links with other staff networks and continue providing a supportive and inclusive space for colleagues across the Trust.

## Trans and Non-Binary and Intersex (TNBI) Staff Network

The Trans, Non-binary and Intersex (TNBI) Network, like the wider LGBTQIA+ Network, has seen a transition in leadership over the past year, with a valued Chair stepping down and a new Chair stepping into the role. Together, they have supported the continued delivery of social events and network meetings, creating safe and supportive spaces for members during a particularly challenging period, while also engaging with local, regional and national networks to influence decision-making and respond to ongoing developments following the Supreme Court judgement.

Over the past year TNBI people have experienced significant emotional impact from legislative updates, ramifications of the Cass Review, media campaigns, and draft EHRC guidance. Reports from TNBI network members highlight marked negative effects for in many areas of life. While this context has limited opportunities for celebration, it has strengthened the resolve of network members and leaders, resulting in a renewed focus on peer support, education initiatives and organisational engagement.

Key highlights include a meaningful Trans Day of Remembrance event delivered in collaboration with the Religion & Belief Network and collaborating with researchers to improve perinatal care for TNBI patients. The introduction of two administrative support roles, funded through pooled network charity funding, has also significantly strengthened the network's capacity to deliver activity and support members.

The TNBI Network aims to continue building on this work through expanded education initiatives, further provision of safe and inclusive spaces for members, and ongoing collaboration with national colleagues to support research and advocacy for TNBI communities.

## Women’s Staff Network

The Women’s Staff Network has built significant momentum over the past year, providing opportunities for networking, development and engagement.

Tori Cooper (Women's Staff Network Lead) and staff members at an International Women's Day 2026 Coffee & Connect session.

The Women’s Network celebrated International Women’s Day with a week-long programme of webinars and networking events centred on the theme Give to Gain. The initiative was designed to inspire collaboration, allyship, career development and meaningful connections across UHSussex. Featuring a diverse range of internal and external speakers, the programme created opportunities for colleagues to learn, share experiences and champion gender equality in the workplace. By increasing the network’s visibility, fostering collaboration and raising awareness of its purpose, the campaign significantly boosted staff engagement and resulted in the Women’s Network almost doubling its membership during the campaign period, strengthening its reach, influence and ability to represent the voices of women across the organisation.

Staff members attending the Trust's International Women's Day 2026 Coffee & Connect session.

Building on the success of the International Women’s Day programme, the Women’s Network is expanding opportunities for members to connect in person. Responding to feedback from colleagues, two face-to-face networking events have been scheduled for 17 July and 4 September 2026, providing dedicated spaces to build relationships, share experiences, strengthen peer support and continue growing an inclusive community across UHSussex.

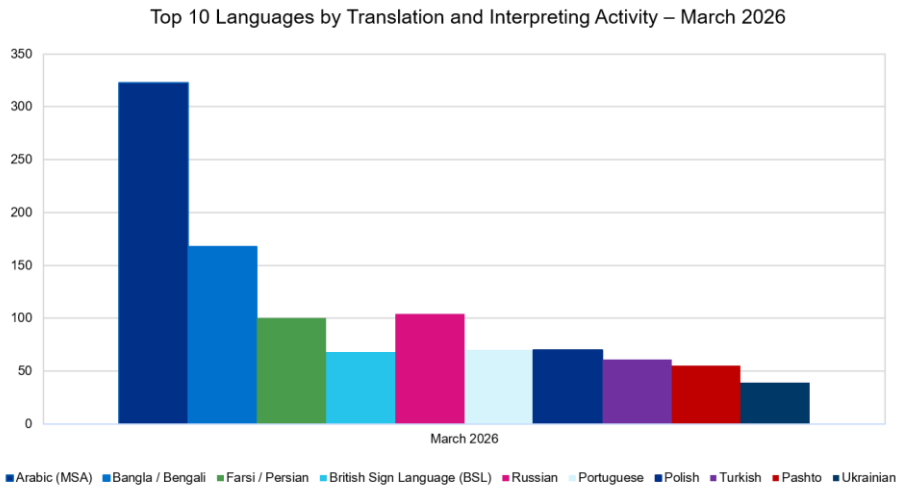
The continued growth of the Women’s Network presents an exciting opportunity to strengthen its leadership. Over the coming months, we will appoint Site Leads across each hospital site, creating a network of local champions who will support members, drive engagement, identify local priorities and ensure the voices of women are represented and heard throughout UHSussex.

Staff members at an International Women's Day 2026 celebration.

# Appendix 3: Translation and Interpreting

This appendix provides a summary of translation and interpreting activity across University Hospitals Sussex during the 2025/26 financial year. Demand for communication support remained consistently high throughout the year, with activity and expenditure remaining stable.

## Understanding Patient Need




Translation and interpreting demand are concentrated within a relatively small number of languages. In March 2026, the ten most frequently requested languages accounted for approximately 60% of activity during that month. Arabic, Bangla/Bengali and Farsi/Persian were the most requested spoken languages, alongside continued demand for British Sign Language (BSL). This pattern highlights opportunities to target translated materials, patient communications and engagement activity where need is greatest. The continued demand for both spoken language and sign language support demonstrates the importance of accessible communication in enabling patients to understand information, engage in decision-making and access services equitably. Activity was concentrated at Royal Sussex County Hospital, which accounted for approximately 62% of all recorded bookings during 2025/26, reflecting its role as the Trust's largest acute site.

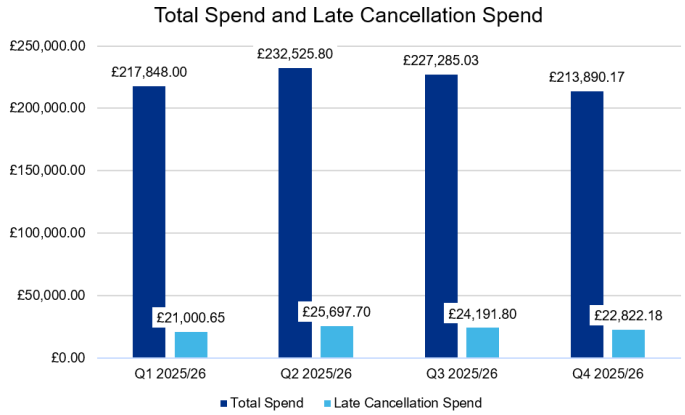
## How Services Are Being Delivered

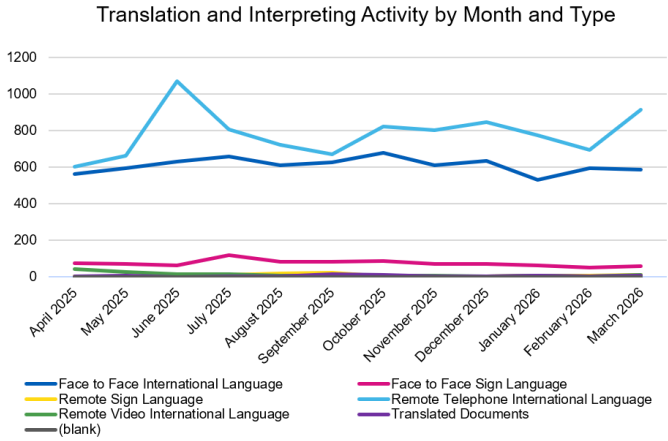
The Trust continues to utilise a range of interpreting methods, including face-to-face, telephone, video and sign language provision. Activity levels have remained broadly consistent across delivery models; however, remote telephone interpreting is now the most frequently booked interpreting modality and has continued to grow over the last year. This reflects increasing use of flexible access routes that enable timely communication support across a wide range of clinical settings. Translation of written documents remains a smaller but important component of overall activity.

Alongside formal interpreting services, the Trust continues to utilise digital communication tools such as CardMedic, which provides multilingual and accessible patient information in a range of languages and formats. Both usage and staff registrations have increased during the year, demonstrating growing adoption of accessible communication resources to support patient understanding, engagement and inclusion.

## Service Efficiency and Value

Demand and spend for translation and interpreting services remained stable throughout 2025/26, averaging approximately 1,300 bookings and £70,000 per month. While overall demand remains significant, late cancellation activity continued to decrease as a proportion of overall bookings, and late cancellation expenditure remained low and broadly stable as a proportion of total spend. Analysis of annual spend per activity also indicates that costs for several interpreting modalities have either stabilised or reduced over time.



# Appendix 4: Equality Delivery System (EDS) Grades 2026

This summary provides an indicative assessment of the Trust's progress against Domains 2 and 3 of the Equality Delivery System 2022. It draws on the Annual Workforce Equality Report 2026, the NHS Staff Survey, WRES and WDES, employee-relations and Freedom to Speak Up information, staff network insight and relevant external assurance.

These ratings will be confirmed through engagement with the relevant stakeholders.

## Domain 1: Commissioned or provided services

The assessment below provides a provisional Trust-level position based on the evidence available within the Annual Workforce Equality Report 2026. The formal EDS 2022 process requires assessment of three selected services, supported by engagement with patients, carers, communities and relevant voluntary, community and social enterprise organisations. The ratings should therefore be confirmed through the full service-level assessment process.

| Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|
| **1A: Patients and service users have required levels of access to the service** | • The Trust has begun to compare outpatient, inpatient and Emergency Department activity with the demographic profile of the Sussex population.<br>• The recorded proportion of activity relating to Global Majority patients was lower than the Sussex population benchmark across the three care settings reviewed. However, activity data alone cannot determine whether access is equitable because it does not account for population need, age, referral routes, service catchments, case mix or repeat use. | **1** | CDO / CNO |

| Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|
| | • Younger patients, particularly those aged 16–24, had the highest outpatient did-not-attend rate, at 9.4%, indicating a potential access or engagement issue requiring further investigation.<br>• Incomplete ethnicity recording ranged from 13.0% of inpatient activity to 19.4% of Emergency Department activity. Patient-level information is also not consistently available for disability, gender identity, sexual orientation, caring responsibilities or Armed Forces status.<br>• The Trust has therefore identified potential differences and data limitations, but cannot yet demonstrate consistently equitable access across protected and inclusion-health groups. | | |
| **1B: Individual patients' and service users' health needs are met** | • The service-user equality profile recognises that demographic information is required to understand differences in access, experience and outcomes.<br>• The available evidence provides some analysis by ethnicity, age and sex, and identifies the need for services to consider different population profiles and patterns of service use.<br>• Consistent patient-level information is not currently available for several characteristics, including disability, gender identity, sexual orientation, caring responsibilities and Armed Forces status. This limits assurance that individual accessibility, communication, cultural and support needs are being systematically identified and met.<br>• The report does not yet provide Trust-wide evidence that reasonable adjustments, accessible communication, personalised care and culturally responsive support are consistently recorded, delivered and evaluated.• Further development of demographic recording and service-level assessment is therefore required. | **1** | CNO |
| **1C: When patients and service users use the** | • During 2025/26, one incident met the criteria for a Patient Safety Investigation where discrimination was suspected. The concern related | **1** | CNO |

| Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|
| **service, they are free from harm** | to possible differential treatment associated with alcohol dependency, poverty and related behaviours.<br>• A local learning review was completed with Executive oversight and safeguarding involvement. It identified opportunities to improve assessment, documentation, communication between services and referral to appropriate support.<br>• This demonstrates that discrimination, stigma and exclusion can be considered within patient-safety review and organisational learning.<br>• However, the report does not yet provide systematic analysis of patient-safety incidents, harm, safeguarding outcomes or complaints by protected characteristic or inclusion-health group. It is therefore not possible to determine whether all groups are equally protected from avoidable harm. | | |
| **1D: Patients and service users report positive experiences of the service** | • The Trust has established patient-feedback, complaints and engagement arrangements, but the Annual Workforce Equality Report does not include detailed analysis of patient experience by protected characteristic or inclusion-health group.<br>• The available evidence does not yet demonstrate whether patients from different communities experience services equitably, whether identified differences have informed improvement action, or whether actions have resulted in measurable change.<br>• A developing rating is assigned provisionally, subject to confirmation through Friends and Family Test information, complaints, patient-experience data and engagement with patients, carers and communities during the formal service-level assessment. | **1** | CNO |

**Domain 1: Commissioned or provided services provisional rating = 4**

The provisional assessment indicates developing activity. The Trust has begun to improve its understanding of differences in patterns of service use and has identified significant limitations in the completeness and consistency of patient demographic information. There is also evidence that discrimination and stigma have been considered within patient-safety learning.

However, the available evidence does not yet provide sufficient assurance that access, individual needs, freedom from harm and patient experience are being systematically assessed across protected characteristics and inclusion-health groups. Priorities include improving demographic data quality, analysing access and experience at service level, strengthening equality analysis within patient-safety and complaints processes, and demonstrating that patient and community insight results in measurable improvement.

The Trust will need to complete a formal Domain 1 assessment using three selected services to fully comply:

- one service where the available evidence indicates relatively strong equality performance;
- one service where evidence indicates that improvement is required; and
- one service where equality performance is currently not sufficiently understood.

The final ratings would be informed by quantitative and qualitative evidence and engagement with patients, carers, communities and relevant voluntary, community and social enterprise organisations.

## Domain 2: Workforce health and well-being

| Outcome | Evidence and progress | Rating | Owner |
|---|---|---|---|
| **2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions** | • Work-related stress, pressure to work when unwell and workplace adjustments are monitored through the NHS Staff Survey and WDES, including analysis by protected characteristic<br>• Of staff who required workplace adjustments, 75.1% reported that adequate adjustments had been made. This has improved, although approximately one in four staff requiring adjustments did not feel adequately supported<br>• A centralised reasonable-adjustments service has been introduced to improve consistency and access. Its performance measures, evaluation | **2** | CPO |

| Outcome | Evidence and progress | Rating | Owner |
|---|---|---|---|
| | arrangements and longer-term outcome measures require further development<br>• Disabled staff and several other workforce groups continue to report substantially higher levels of work-related stress and less positive experiences of support. | | |
| **2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source** | • Harassment, bullying, abuse, violence and sexual harassment remain significant concerns and are experienced disproportionately by some protected groups.<br>• During 2025/26, 3,721 violence and aggression incidents and 47 sexual-harassment incidents were recorded through Datix<br>• In the NHS Staff Survey, 10.7% of staff reported sexual harassment from patients, relatives or the public, compared with 9.1% nationally. A further 4.3% reported sexual harassment from managers, team leaders or colleagues, compared with 3.5% nationally.<br>• Particularly high levels were reported by younger, disabled, non-binary, bisexual and trans or gender-diverse staff, although some findings are based on small numbers.<br>• Violence Prevention and Reduction heatmaps, hotspot analysis, targeted training, awareness activity and inclusion-focused interventions are in place. However, external assurance has identified continuing concerns about misogyny, sexual safety, psychological safety and whether concerns are consistently acted upon. | **1** | CPO |
| **2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment and** | • Freedom to Speak Up arrangements are established and provide an independent route outside line management. Discrimination and inequality were identified as primary or secondary themes within a number of cases during 2025/26.<br>• Eight Inclusion Staff Networks provide staff-led peer support, advice, representation and routes for lived-experience insight. Dedicated charitable investment and additional project support have increased network capacity. | **2** | CPO |

| Outcome | Evidence and progress | Rating | Owner |
|---|---|---|---|
| **physical violence from any source** | • Other support includes Staffside representation, psychological support, Health and Wellbeing services and Violence Prevention and Reduction post-incident support.<br>• The post-incident survey identified gaps in effectiveness: 59.6% of respondents were aware of available support, and 47.4% felt that the support received was culturally appropriate. Improving awareness, accessibility and cultural responsiveness remains necessary. | | |
| **2D: Staff recommend the organisation as a place to work and receive treatment** | • The Trust monitors staff advocacy, engagement, morale, retention and recommendation measures through the NHS Staff Survey and workforce reporting.<br>• Equality analysis shows that staff experience remains uneven. Disabled staff and some minority and marginalised groups report less positive experiences of feeling valued, workplace stress, discrimination, bullying, harassment and career progression.<br>• Exit-survey analysis found that 6.9% of respondents linked their departure to abuse, bullying, harassment, ill-treatment or victimisation following the raising of a concern. A further 25.7% identified a negative connection with a protected characteristic, caring responsibilities or Armed Forces status.<br>• The report does not yet demonstrate the sustained recommendation levels and equitable experience required to support an achieving rating. | **1** | CPO |

**Domain 2: Workforce health and well-being rating = 6**

## Domain 3: Inclusive leadership

| Outcome | Evidence and progress | Rating | Owner |
|---|---|---|---|
| **3A: Board members, system leaders and those with line-management responsibilities routinely** | • The Workforce Inclusion Steering Group provides senior oversight, with assurance reported to the People & Culture Assurance Committee. | **1** | Board |

| Outcome | Evidence and progress | Rating | Owner |
|---|---|---|---|
| **demonstrate their understanding of, and commitment to, equality and health inequalities** | • Executive and Managing Director sponsorship arrangements for staff networks have been refreshed, and Board and senior-leader equality objectives are being developed.<br>• The Behavioural Compass and inclusive and anti-discriminatory leadership framework establish expectations relating to fairness, inclusion, psychological safety, constructive challenge and action against bias and exclusion.<br>• These arrangements represent progress, but Board objectives, divisional accountability conversations and consistent performance review arrangements are not yet fully agreed or embedded. External reviews have also identified the need for more visible and consistent leadership on discrimination, misogyny, sexual safety and staff voice. | | |
| **3B: Board and Committee papers identify equality and health-inequality impacts and risks and explain how they will be mitigated and managed** | • Equality and health-inequality impact assessment arrangements are being strengthened, with work under way to embed assessment within corporate governance and decision-making.<br>• Regional assurance and external reviews have identified that equality impacts are not yet consistently visible in Board and Committee papers and that quality assurance, monitoring and evidence of follow-through require improvement.<br>• The Trust has therefore not yet demonstrated consistent application of impact assessment across all relevant policies, projects and decisions. | **1** | Board |
| **3C: Board members, system leaders and senior leaders ensure that levers are in place to manage performance and monitor progress with staff and patients** | • The Trust has established governance for the Workforce Inclusion Programme through the Workforce Inclusion Steering Group and People & Culture Committee.<br>• WRES, WDES, pay-gap reporting, the Annual Workforce Equality Report, Staff Survey analysis and the CQC Regulation 17 action plan provide established reporting and assurance mechanisms.<br>• Equality objectives identify accountable executives, intended outcomes, measures and 2026/27 priorities.• Divisional inclusion data packs, accountability conversations, the programme dashboard and strengthened | **2** | Board |

| Outcome | Evidence and progress | Rating | Owner |
|---|---|---|---|
| | discrimination reporting are being developed. The principal remaining requirement is to demonstrate that these mechanisms consistently result in local action and measurable improvement. | | |

**Domain 3: Inclusive leadership rating = 4**

## Overall assessment

Domain 2: Workforce health and well-being: **6**
Domain 3: Inclusive leadership: **4**

Indicative EDS score based on the domains assessed: **10**
Indicative rating: **Developing**

The assessment shows established structures and activity across workforce wellbeing, reasonable adjustments, staff support, staff networks, workforce equality reporting and governance. However, the evidence also identifies substantial remaining concerns relating to sexual harassment, bullying, violence, psychological safety, unequal staff experience, post-incident support, leadership accountability and the consistent use of equality and health-inequality impact assessment.

Priorities for 2026/27 include strengthening the organisational response to sexual harassment and gender-based discrimination, improving reporting and culturally appropriate support, embedding Board and senior-leader objectives, implementing divisional accountability arrangements, strengthening impact assessment and demonstrating that interventions result in sustained improvements in staff experience and workforce outcomes.

**Key:**
0 = Undeveloped activity
1 = Developing activity
2 = Achieving activity
3 = Excelling activity

Overall scores below 8 are rated Undeveloped, scores from 8 to 21 are rated Developing, scores from 22 to 30 are rated Achieving, and scores of 31 or above are rated Excelling.

*Sources: UHSussex Annual Workforce Equality Report 2026; NHS England, Equality Delivery System 2022 Ratings and Score Card Guidance; Niche Developmental Well-Led Review, July 2025.*