Sussex Community
NHS Foundation Trust

ANNUAL EQUALITY REPORT

2022-23

Excellent care at the heart of the community

CONTENTS

INTRODUCTION

Welcome to our annual equality report 2022-23

This report shows what we have achieved and where we need to continue working towards equality in our mission of excellent care at the heart of the community.

The first five sections report on equality of opportunity within employment, broken down by the following:

1. race
2. religion and belief
3. gender
4. sexual orientation
5. disability
6. age

The last section focuses on equality of opportunity within services (patient care equity).

Each section includes key findings against a number of measures of equality, and ends with key next steps to address the findings over the coming year.

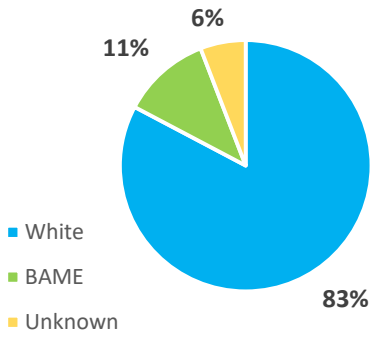
This report meets our duty under the Equality Act, our duty to publish gender pay gap information, and our publication obligations relating to the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES).

A note about the data: The report does not include information about fewer than 20 people to preserve privacy, except where specified.

Workforce information is based on data from electronic staff records, staff surveys, human resources information systems, and the Trust's recruitment management system. Care equity data is from patient administration systems and incident management systems

RACE IN THE WORKFORCE

Fig. 1 Workforce by ethnic group



KEY FINDINGS: RACE

Workforce ethnicity representation (WRES 1)

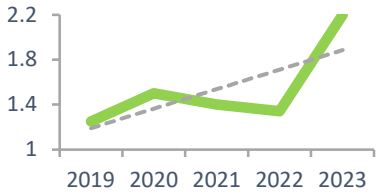
1.1. The number of BAME people in the workforce on 31 March 2023 was 623, or 11.4% of the workforce overall (n. 5,450). The BAME workforce grew by 17% since 2022, while the number of white people in the workforce reduced by 3%.

1.2. AfC band 5 continued to have the largest absolute BAME workforce population (n. 155), increasing 32% since last year. While there was an increase in BAME representation at band 8c, overall the numbers of BAME staff in AfC bands 8a-9 stayed static, highlighting the need for the Trust to do more to increase representation within our senior leadership.

Ethnicity shortlisting-to-appointment likelihood (WRES 2)

1.3. The Trust appointed 124 people from BAME groups and 879 white people in 2022-23. The Trust was 2.2 times more likely to appoint White people from shortlisting than people from BAME groups, compared to 1.3 times more likely last year.

Fig. 2 Likelihood white staff appointed



A note about relative likelihoods: If the relative likelihood of an outcome for one group compared to another is less than 0.80 or higher than 1.25, the process is considered to have an adverse impact. Relative likelihoods between 0.8 and 1.25 suggest there is statistically no difference between groups, though this should **not** be interpreted to mean people do not experience inequality.

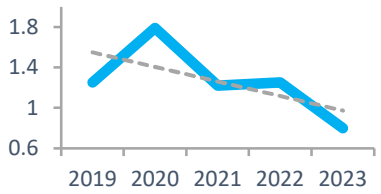
1.4. Data suggests that increasing numbers of applicants requiring sponsorship to work in the UK may have influenced this metric, particularly with healthcare support workers now eligible for Health & Care Worker Visas. There has been an increase in numbers of shortlisted candidates who are not eligible for sponsorship and who are unable to secure the right to work in the UK.

1.5. A change in how the Trust uses its recruitment software has also impacted on the quality of this data, as not all successfully appointed staff can be reported on currently. The nationally recognised challenges with fraudulent and computer-generated applications may also have had an impact on shortlisting to appointment data.

1.6. While there are some technical reasons for the worsening picture, evidence suggests a lack of understanding from some recruiting managers about how to manage applications from international candidates is likely to also have had a negative impact. Guidance has now been produced to address this and urgent work is underway to improve data quality.

Formal disciplinary likelihood by ethnicity (WRES 3)

Fig. 3 Likelihood BAME staff disciplinary

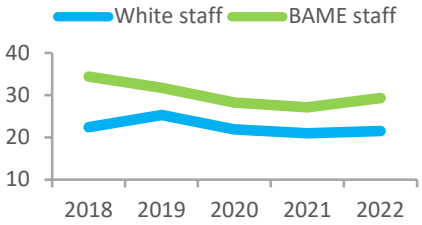


1.7. People from BAME groups were less likely (0.80 times as likely) than the white people to enter formal disciplinary, compared to their proportion in the overall workforce. This likelihood has decreased by from last year's score of 1.25.

Non-mandatory training (WRES 4)

1.8. BAME staff were more likely to access non-mandatory training than white staff, with white staff 0.98 times as likely to do so. Numbers of staff accessing non-mandatory training increased significantly in 22/23 compared to the previous year: 1.8 times for white staff and 2.2 times for BAME staff. Lower numbers in 21/22 were influenced by the COVID-19 pandemic.

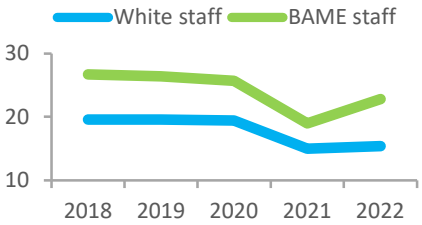
Fig. 4 Patient-on-staff harassment (%)



Bullying from patients or public by ethnicity (WRES 5)

1.9. 29% of BAME staff experienced harassment, bullying or abuse from patients, relatives, or the public; compared to 27% in 2021. This increase follows a five-year downward trend. 21.5% of white staff in the Trust reported this in the NHS staff survey 2022. Staff with a white and black Caribbean background were most likely to experience this than other groups, followed by Indian staff and those from 'any other black / African Caribbean background.

Fig. 5 Staff-on-staff harassment (%)

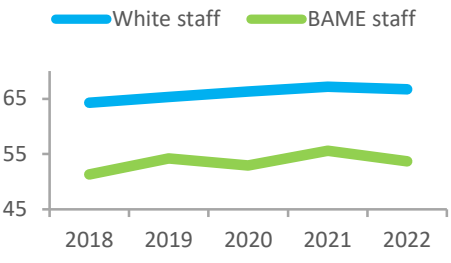


Bullying from colleagues by ethnicity (WRES 6)

1.10. Almost 23% of BAME staff experienced harassment, bullying or abuse from managers or other colleagues in the prior 12 months; compared to 15% of white staff. This rate increased almost 4% since last year. Doctors and dentists were more likely to say they had experienced this than other staff groups, with 45% saying they had.

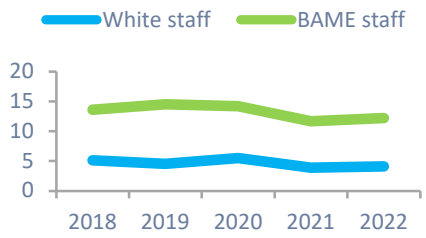
Racial equality of opportunity for promotions (WRES 7)

Fig. 6 Equal opportunities for promotion (%)



1.11. Almost 54% of BAME staff reported that they felt they had opportunities for promotion, compared to 67% of white staff.

Fig. 7 Staff experiencing discrimination (%)



Discrimination from manager or colleague (WRES 8)

1.12. 12% of BAME staff experienced discrimination at work from their manager or colleagues, compared to 4% for white staff, with these numbers the same as last year. BAME nurses reported higher levels of discrimination than other staff groups, at 17%.

Negative experiences by ethnicity

1.13. BAME staff are slightly more likely to have negative experiences at work than white colleagues. The gap between experience scores is 0.4 (7.7 for BAME people compared to 8.1 for white people, with a higher score being better). Those from a Black British, African, or Caribbean background had a worse experience score (7.6) than other groups.

A note about negative experiences: The NHS Staff Survey measures 'negative experiences', which includes work related stress and MSK problems, coming to work when unwell, and experiencing physical violence or bullying, harassment, and abuse. A higher score is better.

Board ethnicity membership (WRES 9)

1.14. Two board members (13%) shared they were in a BAME ethnic group compared to 8% estimated in the Sussex resident BAME population.

NEXT STEPS FOR RACE EQUALITY 2023-24

- Address disparity in likelihood of recruiting BAME people from shortlisting. As there has been such a significant variation from last year, a 'deep dive' review will be completed to understand the factors driving this disparity. Actions will include steps to reduce bias and tackle discrimination in recruiting, ensure good practice around sponsorship of international staff, and implementing technical solutions to improve data quality.
- Accelerate work to increase representation at senior levels.
- Embed our violence prevention and reduction standards, including a focus on tackling bullying, harassment, and discrimination between colleagues.

KEY FINDINGS: RELIGION AND BELIEF

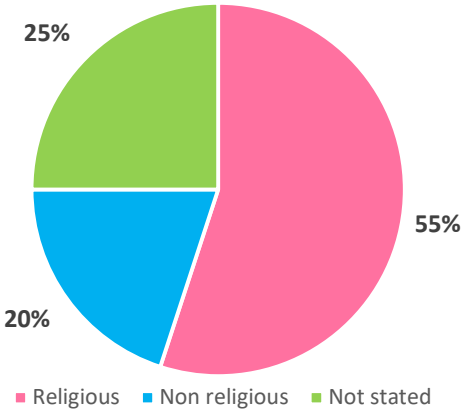
Workforce religion and belief representation

2.1. The number of people sharing their religion or belief on 31 March 2023 was 4,086, 75% of the workforce.

2.2. Christianity was the largest belief group at 45% (n. 2,438), followed by the atheist group at 18% (n. 975). Nine percent (n. 513) of staff shared their religion or belief as 'Other' on their staff record. These proportions were broadly the same as last year.

2.3. The 25% of staff not wishing to share their belief is significantly higher than the 8% of the Sussex population in the corresponding category of the Census 2011.

Fig. 8 Workforce by belief group



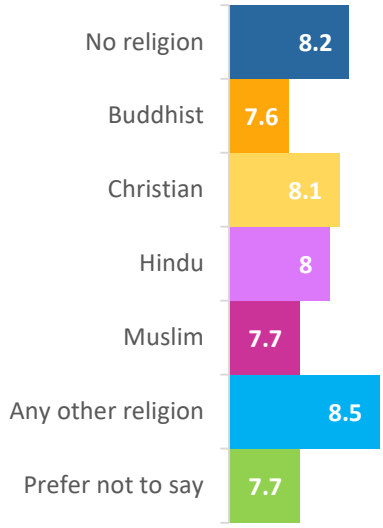
Negative experiences by religion and belief

2.4. Muslim and Buddhist staff reported more negative experiences than people in other belief and atheist groups. Scores were 7.7 and 7.6 respectively, compared to 8.1 for staff overall (a higher score is better). The experience for Muslim staff has worsened 0.7 since last year, when scores were also higher than average. Small numbers in these groups should be noted.

2.5. Staff with no religion (8.2) and 'other' religion (8.5) scored higher than other groups, and staff overall.

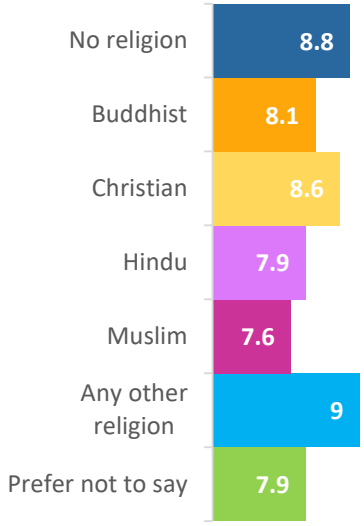
A note about negative experiences: The NHS Staff Survey measures 'negative experiences', which includes work related stress and MSK problems, coming to work when unwell, and experiencing physical violence or bullying, harassment, and abuse. A higher score is better.

Fig. 9 Negative experiences score (religion and belief group)



Religion and belief diversity and equality score

Fig. 20 Diversity and equality score (religion and belief group)



2.6. Staff with 'any other' (9) and no religion (8.8), scored higher than the Trust average score for all staff of 8.6. The group that scored the lowest in the Trust was Muslim staff at 7.6.

> **A note about diversity and equality scores:** The NHS Staff Survey includes a 'diversity and equality score', which includes equal opportunities for career progression, discrimination at work, and respect for individual difference. The higher the score the better the experience

NEXT STEPS FOR RELIGION AND BELIEF EQUALITY 2022-23

- Working with our Religion & Belief Staff Network, continuing to celebrate different faith days and hold awareness raising sessions about different religion & belief groups.
- Encouraging more staff to share their belief (or non-belief) with us as part of their staff record.

GENDER IN THE WORKFORCE

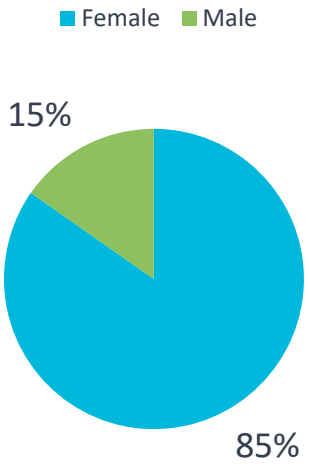
KEY FINDINGS: GENDER

Workforce gender representation

3.1. 85% of staff records (n. 4,641)show female and 15% (n. 811) show male. These proportions have stayed static for several years and are comparable with the broader NHS workforce. The national Electronic Staff Records (ESR) system only records binary sex. 13 people who answered the gender question on the 2022 staff survey identified as non-binary or other, an increase from eight people in 2021.

3.2. The Board comprised of seven men and eight women, inclusive of both executive directors and non-executive directors, and those with and without voting rights.

Fig. 11 Workforce by sex



Flexible working opportunities

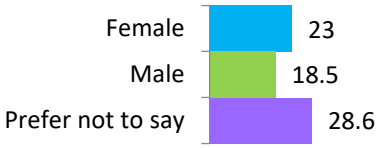
3.3. In the staff survey 2021, 66.4% of respondents were satisfied or very satisfied with their opportunities for flexible working, varying to 71% of males, 66 of females, and 47% of those who prefer not to say their gender.

Harassment, bullying or abuse by gender

3.4. 7.5% of female and 6.3% of male staff experienced harassment, bullying, or abuse from patients, relatives, or members of the public in 22/23. Rates of male and female staff experiencing harassment, bullying, or abuse from managers or other colleagues were broadly comparable.

3.5. Men were less likely to report and the gap between men and women has remained consistent from last year.

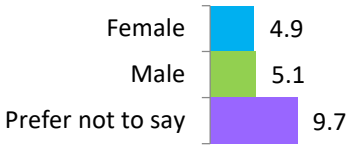
Fig. 12 Patient / public-on-staff harassment by gender (%)



Discrimination from managers, team leader, or colleagues

5.1% of male and 4.9% of female staff experienced gender discrimination from managers, team leaders, or colleagues in the past 12 months.

Fig. 13 Discrimination from managers or colleagues by gender (%)



Negative experiences by gender

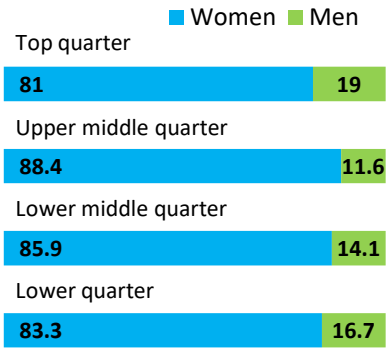
3.6. People who preferred not to share their gender on the NHS Staff Survey were more likely to have negative experiences than those who did.

GENDER PAY GAP

Hourly wages pay gap

3.7. Women earned £98p for every £1 men earned when comparing median hourly wages. When comparing mean hourly wages, women earned 93p for every £1 men earned. This gap has changed by 1p since 2022.

Fig. 14 % gender in each pay quarter



Proportion of women in each pay quarter

The calculation of pay quarters splits all employees in the Trust into four groups according to their level of pay. Women represent 81% of the highest pay quartile and men 19%. This means women are technically under-represented in the top quarter, as the workforce is 85% female. There is greater representation of women in the upper-middle quartile (88.4%), where men are under-represented.

Gender bonus gap

3.8. Women earned £1.25 for every £1 that men earned in median bonus pay, a reduction from £1.75 in 2023. When comparing mean bonus pay, women earned 77p for every £1 men earned.

NEXT STEPS FOR GENDER EQUALITY 2023-24

- Focus on increasing opportunities for flexible and agile working.
- Embed our violence prevention and reduction standards, including a focus on tackling bullying, harassment, and discrimination.

SEXUAL ORIENTATION IN THE WORKFORCE

KEY FINDINGS: SEXUAL ORIENTATION

Workforce sexual orientation representation

4.1. 4,529 staff shared a sexual orientation in their staff record on 31 March 2023, or 83% of the workforce. 4% of staff shared they were lesbian, gay, or bisexual (LGB) in 2023, a slight increase from 3.7% last year.

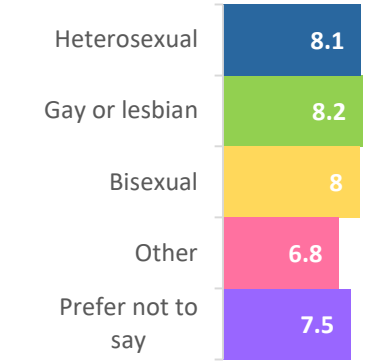
Harassment, bullying or abuse by sexual orientation

4.2. Staff who shared that their sexuality was LGB or 'other' (9.8%) were more likely to experience harassment, bullying, or abuse from managers than heterosexual staff (6.1%), but less likely to experience this from other colleagues (10.8% compared to 12.5%). LGB and 'other' staff who experienced harassment, bullying, or abuse were more likely to report these incidents harassment than heterosexual colleagues (74% and 66% respectively).

Negative experiences by sexual orientation

4.3. Experiences of LGB staff were comparable to heterosexual staff in terms of negative experiences. The experience for those who shared that their sexuality was 'other', or preferred not to tell us, was poorer, at 6.8 and 7.5 respectively. The Trust average score for all staff was 8.1 out of 10. The higher the score, the better the experience.

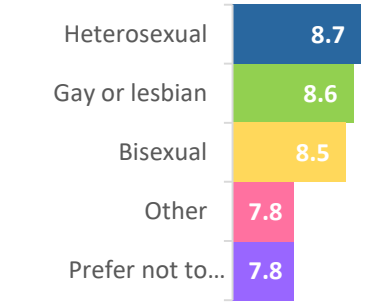
Fig. 15 Negative experiences score (sexual orientation)



Sexual orientation diversity and equality score

4.4. The 'diversity and equality' score for LGB staff were comparable to heterosexual staff. The score for those who shared that their sexuality was 'other', or preferred not to tell us, was poorer, at 7.8. The Trust average score for all staff was 8.6 out of 10. The higher the score, the better.

Fig. 16 Diversity and equality score (sexual orientation)



NEXT STEPS FOR SEXUAL ORIENTATION EQUALITY 2023-24

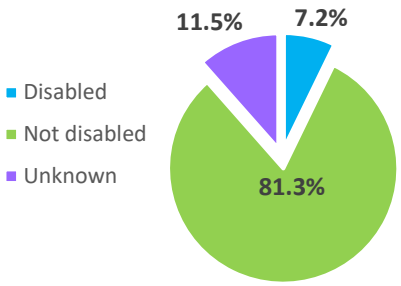
- Roll out our ongoing gender awareness training offer, which replaces previous ad hoc training sessions. This will support the growing numbers of both staff and service users who are sharing that they are trans or non-binary.

DISABILITY IN THE WORKFORCE

KEY FINDINGS: DISABILITY

Workforce disability representation (WDES 1)

Fig. 17 Workforce by disability status

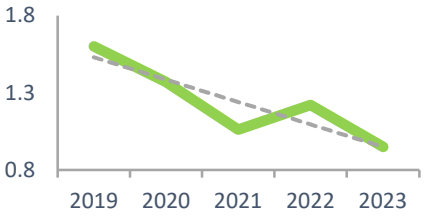


5.1. 395 people shared a disability on their staff record as of 31 March 2022, or 7.3% of the workforce. This was an increase of 12% on the 352 staff a year earlier, and this was consistent with the increase last year, too. 24.5% of staff who answered the staff survey in 2022 shared a health condition or illness that fell within the legal definition of a disability (broadly similar to 2021).

5.2. Disabled staff are more represented in AfC bands 1 to 4 than in other bands (9.9%). While overall numbers are still very small (6 staff), the proportion of medical & dental staff sharing that they were disabled increased by 50% in 2023.

Shortlisting-to-appointment by disability (WDES 2)

Fig. 18 Likelihood non-disabled staff appointed



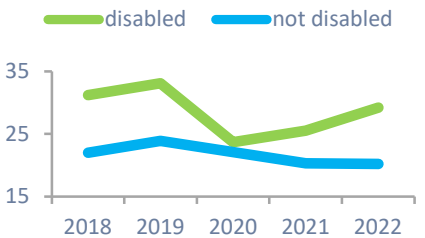
5.3. There were 101 disabled people, and 861 non-disabled people appointed in 22/23. The Trust was more likely to appoint disabled people than non-disabled people from shortlisting, a relative likelihood of 0.95. 30% of shortlisted disabled candidates were appointed compared to 23% in 21/22. 29% of non-disabled candidates were appointed.

Formal capability likelihood by disability (WDES 3)

5.4. Disabled people were slightly less likely (0.93 times) as non-disabled people to enter a formal capability process between 2021 and 2023. It should be noted that numbers are very small with only one disabled and 15 non-disabled staff going through a capability process in this period. Employee relations advisors encourage staff to share their disability status within the process, however the level of sharing affects the data reliability as three people in a process had an unknown disability status.

Harassment, bullying or abuse by disability (WDES 4)

Fig. 19 Patient / public-on-staff harassment by disability status



5.5. 29% of disabled staff experienced harassment, bullying or abuse from patients, relatives, or the public, compared to 20% of non-disabled. The rate increased from 25.5% since last year, while the rate for non-disabled staff stayed the same for the fourth year in a row.

5.6. 10.5% of disabled staff experienced harassment, bullying or abuse from managers. While this has improved slightly from 12% in 21/22, it is double the rate for non-disabled colleagues. 16% of disabled staff experienced harassment, bullying or abuse from other colleagues, down from 17% last year. Rates for non-disabled staff were 11.5%. The gap between experiences of disabled and

non-disabled staff reduced for the fifth year running. Rates of disabled and non-disabled staff saying that they reported harassment, bullying or abuse grew by 6% and 3% respectively.

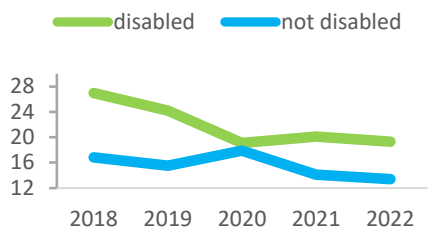
Disability and equal opportunities for promotion (WDES 5)

5.7. 62% of disabled staff felt the Trust provided equal opportunities for promotion, compared to 66% of non-disabled staff. Both numbers were similar to last year.

Pressure to work from manager when unwell (WDES 6)

5.8. 19% of disabled staff felt management pressure to come to work when not feeling well enough, compared to 13.5% of non-disabled staff. Numbers were similar to last year.

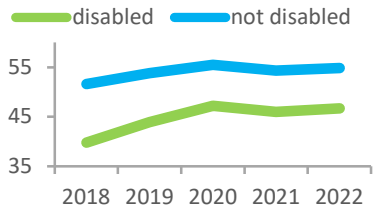
Fig. 20 Pressure to work when unwell



Staff satisfaction that Trust values their work (WDES 7)

5.9. 47% of disabled staff felt the Trust valued their work, compared last year

Fig. 21 Staff satisfaction (valued work)



Adequate adjustments for disabled people (WDES 8)

5.10. 85% of disabled staff felt the Trust made adequate adjustments.

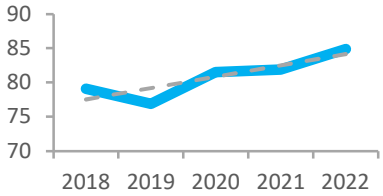
Disabled staff engagement (WDES 9)

5.11. Disabled staff had a Staff Survey engagement score of 6.9 out of 10 (a higher score is better). Non-disabled staff scored 7.3 out of 10. The gap between the scores has remained largely static over five years.

Disabled staff negative experiences

5.12. Disabled staff are more likely to have negative experiences at work than non-disabled colleagues. The gap between experience scores is 0.9 (7.4 for disabled people compared to 8.3 for non-disabled, with a higher score being better). Disabled staff had a higher experience of 'burnout', scoring 0.8 percentage points higher than non-disabled staff.

Fig. 22 Adequate adjustments (%)



Board disability membership (WDES 10)

5.13. No board members shared a disability compared to 19% of working age people in the South-East population (2020, DWP. Family Resource Survey).

NEXT STEPS FOR DISABILITY EQUALITY 2023-24

- Build on our centralised 'reasonable adjustments' fund, streamlining the process for accessing resources and embedding good practice around supporting people with long term conditions at work.

AGE IN THE WORKFORCE

Fig. 23 staff by age group (%)

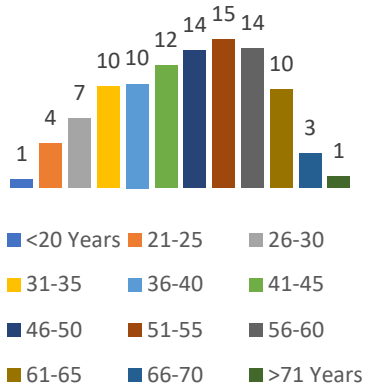


Fig. 24 Negative experiences score (age)

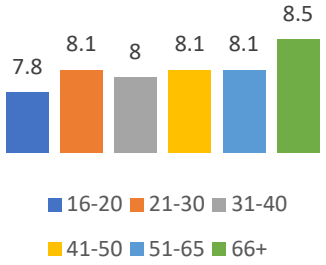
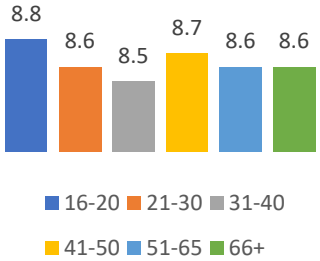


Fig. 25 Diversity and equality score (age)



KEY FINDINGS: AGE

Workforce age representation

6.2. The largest age group is 46-50 years old, with 15% of staff falling in this category. 42% of staff are between the ages of 46 and 60.

Negative experiences by age

6.3. Staff aged over 66 were far more likely to have experienced work-related stress of musculoskeletal problems than other age groups, at 77%. Other age groups were broadly in line with the overall Trust rate of 61%. The rate of people in the over 66 age group saying they often or always felt exhausted by the thought of another shift at work was also over 20% higher than other groups, at 61.5%. In general, the rate of staff saying they had come to work when unwell increased gradually as age increased.

6.4. Despite this, the 66 and over age group had the highest (best) negative experiences score of any age group in the staff survey 2022, at 8.5 out of 10, four or five points better than other age groups.

Age diversity and equality score

6.5. The diversity and equality scores for all age groups are broadly in line with the overall Trust score of 8.6.

NEXT STEPS FOR AGE EQUALITY 2022-23

- Improve our flexible and agile working offer, which will support those in older age groups who may have multi-generational caring responsibilities.
- Continue to target stress and MSK as part of our health and wellbeing offer.

PATIENT CARE EQUITY

Through 2022-23 the Trust continued to develop its work to promote equity in service provision and care inclusion for patients, carers, and families drawn from a diverse range of populations.

7.1. Understanding the demographic characteristics of the patients we care for is the first step in identifying and addressing disparities in access, outcomes, and experience within our own services.

7.2. We know the completeness of some patient demographic information varies across services. We are working to standardise and improve data completeness, and to use demographic data to improve service accessibility and patient experience and outcomes.

KEY FINDINGS: CARE EQUITY

Referrals by age

7.3. We provide healthcare for people of all ages, from new-born to those over 100 years old. We analysed hundreds of thousands of referrals received by the Trust in 2022 and existing referrals that were still open at the start of that year. Of the adult patients we see over 50% are aged 60 years or over.

7.4. Our health visitors see all new-born babies in West Sussex and Brighton & Hove. The age profile for children and young people reflects this with almost 90% aged 0-9 years.

Referrals by deprivation

7.5. Levels of deprivation vary across our patient groups. For the analysis of 2021 patients, we measured deprivation based on where each person lives, using the English Indices of Deprivation.

7.6. The Indices use a range of measures, such as health, employment, and income. These measures combine to form an index of the relative deprivation of almost 33,000 neighbourhoods in England. There are ten groupings of neighbourhoods, called deciles. Decile 1 includes the 10% most deprived areas in the country, Decile 2 the next 10% most deprived.

7.7. Of the patients included in our analysis, 7% live in the 20% most deprived areas in England. Patients cared for by our service are more likely to come from more deprived areas, with a higher proportion from deciles 1-5 and a lower proportion from deciles 7-10.

Fig. 26 Adult and specialist services referrals by age

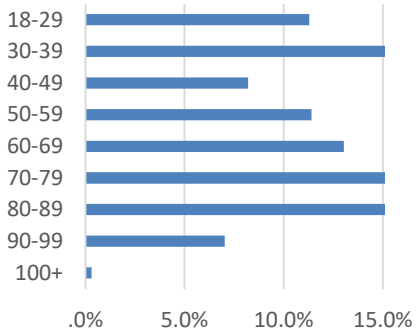


Fig. 27 Children and Young People services referrals by age

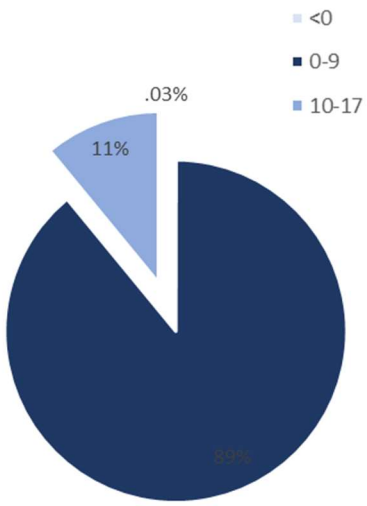
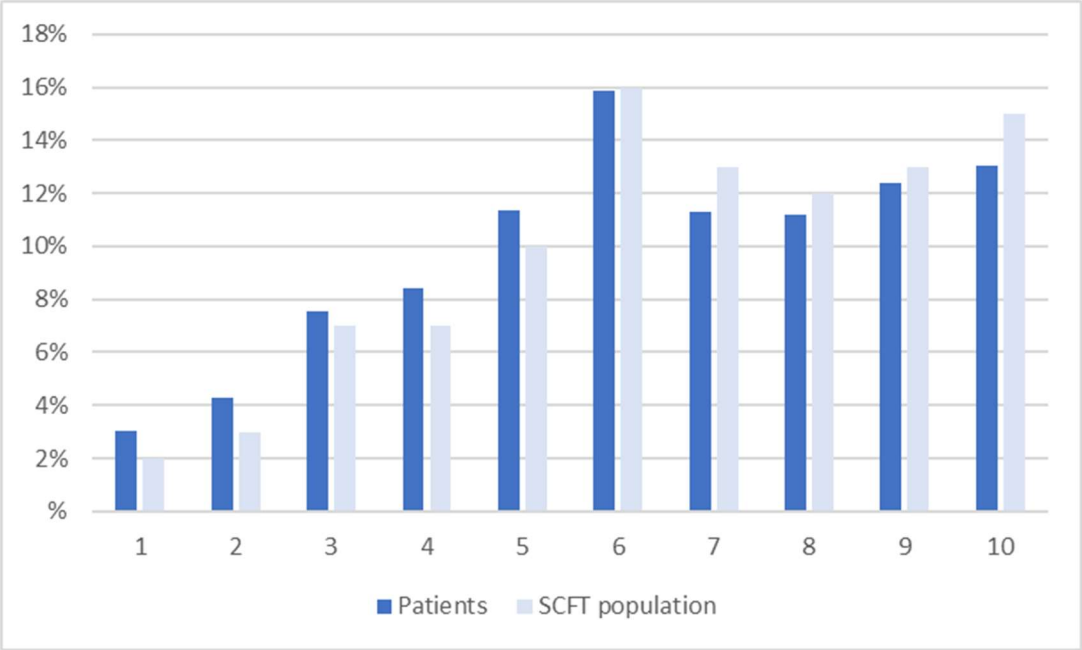


Fig. 28 Patients by deprivation decile

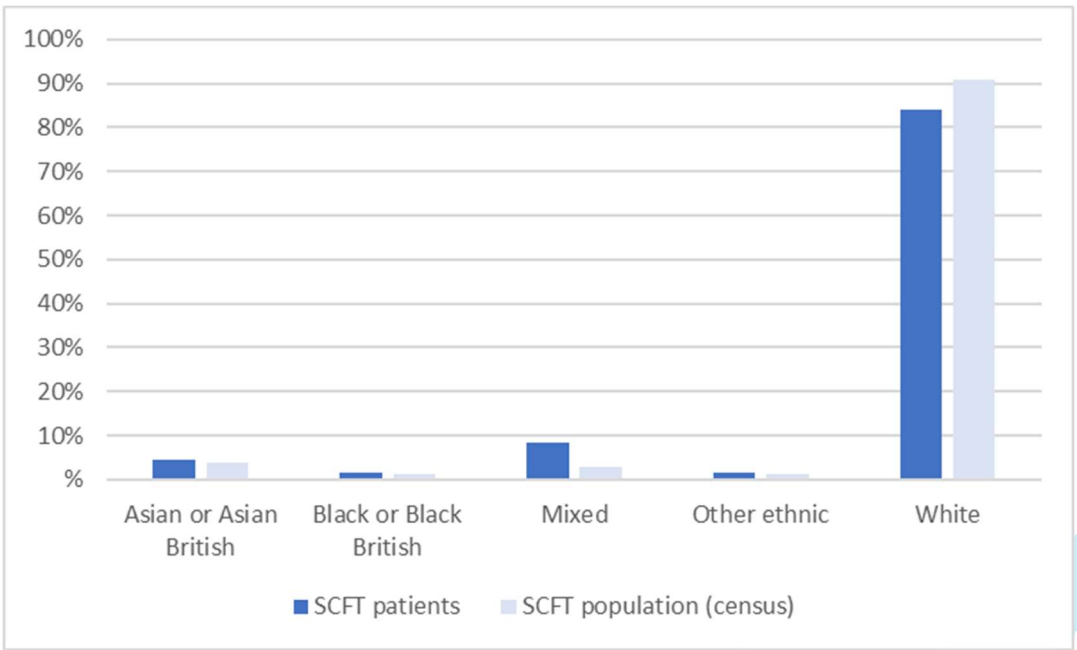


Referrals by ethnicity

7.8. The NHS Digital Data Quality Maturity index provides monthly snapshots of data quality across a range of indicators. The data quality metric measures the proportion of records for which data was complete and met national requirements. Included in this is patient ethnicity. There is variation across services and within services across the year.

7.9. When we compare our patients to the population covered by SCFT services we see there is a higher proportion of patients identified being from having 'Mixed Ethnicity' groups and fewer than expected from groups identified as having 'White Ethnicity'. The higher proportion of patients from 'Mixed' groups is likely a reflection of the large number of children and young people cared for in our services. The under representation from 'White' groups is being explored.

Fig. 29 Patients by ethnicity



Addressing healthcare inequity

There are a range of initiatives and programmes of work to address inequity in service provision:

- Under our strategic goal for addressing healthcare inequities we have committed to reviewing all waiting list services to understand if we are adversely impacting patients with different demographic characters. Where inequities are identified, action plans will be developed and implementation commenced, to address and reduce disparities between patient groups.

- In developing a systematic approach to identifying and addressing inequities in access, we are exploring and refining a number of methodologies:

- **Who is missing from our patient cohort** by examining how referral patterns reflect underlying population structures and the epidemiology of the conditions we provide care for. In special care dentistry we found that patient's accessing our Crawley clinic closely reflected the local population, with minor variations that could be accounted for by the differing level of need within the population.

- **Whether patients from vulnerable or marginalised populations experience delays in care** as evidenced by waiting times. Our work on the child neurodevelopmental pathway has not identified any systematic differences in waiting time based on deprivation or ethnicity.

- Our teams are working with ICB, Local Authority and VCSE partners in ICB funded Health Inequalities projects supporting vulnerable communities within our population, including:

    - Enhancing footcare for people experiencing street homelessness in Brighton and Hove.
    - Working with Gypsy, Roma and Traveller communities to improve access to childhood immunisations.
    - Supporting asylum seekers and refugees.

Population health

7.10 We continue to develop our approach to understand inequities in the care we provide, developing and implementing actions to address barriers to patient care. Further developing this approach, we aim to understand how effective our services are for patients with different demographic features using information about people who do not attend or drop-out of our services, as well as reviewing patient outcome measures.

Patient experience

7.11 Throughout 22/23 we continued to collect information about the protected characteristics (age, ethnic background etc) of people making a complaint or contacting the Patient Advice and Liaison Service (PALS). Within the year, 47% of the 1574 people making contact with the patient experience team provided information on their protected characteristics. Everyone contacting PALS is also asked their preferred method of communication.

7.12 We are using a patient experience scoping survey to better understand what engagement, co- production and involvement is happening within services and where we could do more to enhance this.

7.13 We have increased our range of feedback methods and patients have the opportunity to provide feedback on their experience by telephone, text message, through the website, via a QR code, or by completing a feedback form. The patient experience team also provide face to face PALS/Patient experience surgeries within a range of services, including our intermediate care units, so patients and their families (who may find it easier to provide feedback on their experiences verbally and face to face) are provided with his opportunity.

7.14 These PALS/Patient experience surgeries are increasing in 23/24 and will include places of worship, community events, and within our specialist teams.

7.15 Every patient information leaflet has information on how people can provide feedback about their experiences. All patient information is tested with a reading group (patients, representative and volunteers), prior to publication to ensure the language and material is appropriate for the intended audience.

7.16 There has been an increased focus on engagement with Children & Young People, for those within our current services and for those transitioning to adult services.