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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Cyfarfod Cyhoeddus y Bwrdd/ Public Board Meeting

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 September 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Strategic Equality Plan Annual Report 2025/26 (incorporating workforce equality data and pay gap reports)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Lisa Gostling, Executive Director of Workforce and Organisational Development/Deputy CEO
SWYDDOG ADRODD: REPORTING OFFICER:	Lisa Gostling, Executive Director of Workforce and Organisational Development/Deputy CEO

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Public Sector Equality Duty (PSED) Wales requires that the Health Board produces an annual report by 31 March each year for the preceding year which details the progress made against the Health Board's Strategic Equality Plan (SEP) and objectives. The requirement to publish an annual workforce equality report has been integrated into the SEP Annual Report and statistical information is presented as an appendix based on staff employed on 31 March 2026, in line with the PSED requirements.

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 came into force on 6 April 2017 and requires employers with more than 250 employees to publish annual data on their gender pay gap. Although public sector organisations in Wales are exempt from these regulations, NHS Wales has agreed to work to publish its own gender pay data in line with the regulations, using a report designed to meet the requirements in Electronic Staff Register Business Intelligence (ESRBI). Alongside our Gender Pay Gap, we are publishing our pay gap position for Ethnicity and Disability.

The Board is requested to approve the SEP Annual Report 2025/26, noting that this is a consolidated report bringing together all reporting requirements established under the Equality Act 2010 and approve this for publication.

Cefndir / Background

Hywel Dda University Health Board is committed to delivering fair, inclusive and person-centred care, supported by a diverse and valued workforce. Equality and inclusion are central to both service delivery and workforce practice.

The Equality Act 2010 covers discrimination relating to the following nine protected characteristic groups: Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion or Belief, Sex and Sexual Orientation. Public bodies

are required to consider needs, by reference to these characteristics, when designing and delivering public services.

As a public sector body, the Health Board must, in its policies and practices, have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and other conduct that is prohibited by or under the Act;
- Advance equality of opportunity between persons who share relevant protected characteristics and persons who do not;
- Foster good relations between persons who share relevant protected characteristics and persons who do not.

The public sector in Wales has an obligation to fulfil PSED as prescribed in law. These duties include the development and implementation of a rolling 4-year SEP and objectives, and the publication of an annual report detailing the steps taken to meet the objectives in the SEP. The following four objectives were agreed for the Health Board:

Objective 1 – Leadership by All	Staff at all levels, including Board members, actively promote and facilitate a culture of inclusion and wellbeing across the organisation
Objective 2 – Working Together to improve health and well-being for all	Our staff will actively work to reduce health inequalities
Objective 3 – Embedding a person-centred approach	Our staff use the Health Board values to deliver a person-centred approach in everything they do
Objective 4 - Being an employer of choice	We will offer equal opportunities for employment and career progression and support the health and well-being of our staff and volunteers within a fair and inclusive environment

The Pay Gap report (Appendix 2) presents an analysis of the difference in average earnings between groups of colleagues within the organisation, regardless of what role they are in. This is a useful way to measure pay equality due to its simple calculation; however, it does not measure the pay difference between people at the same pay grade, doing the same job, with the same working pattern. It also does not include any of the personal characteristics that may determine a person's pay, such as age. This year, we have also focussed on the median pay gap, which shows the typical midpoint, not just the average (mean) which can be impacted by those few outliers with significantly higher salaries. While this shows that for our 'middle' earners, the gap between earnings for male and female staff is lower, and almost non-existent between our disabled and non-disabled staff, we recognise that more work is needed to understand and address the underlying causes of the more significant gap in earnings at the higher end.

It should be noted that the headcount figures in the Pay Gap report and the workforce equality data (Appendix 1) published in the annual report are different. The figures in the workforce equality data section of the SEP report includes all staff (including bank and locum) whether they have earned money in the year or not, whereas the Pay Gap report will only include staff that have earned money in the year and where an hourly rate can be calculated.

Asesiad / Assessment

The Strategic Equality Plan Annual Report 2025/26 sets out progress made during the reporting period against the SEP 2024-2028 objectives. The report reflects the Health Board's role as both an employer and provider of services, and demonstrates the actions taken to advance equality, reduce inequalities and improve outcomes for staff, patients and communities. As we did last year, we have used an intersectional approach for the analysis of our workforce equality information as we know that people with more than one protected characteristic can experience greater disadvantage and multiple challenges.

During 2025/26, the Health Board has continued to build on the foundations established in the previous year. There has been a clear shift from awareness-raising towards more structured delivery, with early signs of cultural change and improved practice across the organisation.

The content of the annual report formed part of the Health Board's SEP assurance report submitted to Welsh Government earlier in the year, and the feedback from Welsh Government has been very positive. The Health Board has been recognised for strong leadership and governance structures, and visible leadership, which demonstrates the growing commitment to equality. The strong use of workforce data and a well-developed strategic equality plan was also highlighted.

Areas for improvement include our ongoing work to strengthen evidence of measurable and sustained impact, including clearer articulation and evidence of cause and effect between actions and improvements for protected groups.

Overall progress against all four SEP objectives is assessed as on track, with increased activity, stronger governance and improved organisational maturity in relation to equality, diversity and inclusion.

Some of the achievements outlined in the report include:

Leadership By All

There has been progress in strengthening inclusive leadership capability across all levels:

- Delivery of programmes such as Active Bystander, LEAP and the Hywel Dda Manager Programme
- Establishment of the Equality, Diversity and Inclusion (EDI) Taskforce to strengthen leadership accountability
- Continued progress against the Anti-Racist Wales Action Plan

Early impact includes increased staff confidence to challenge inappropriate behaviour, more open leadership styles and improved psychological safety within teams.

Working Together to Improving Health and Wellbeing for All

Progress has been made in reducing inequalities and improving access to services:

- Continued expansion of community outreach through the Community Development Outreach Team
- Targeted work with underserved communities, including refugees, Gypsy, Roma and Traveller communities, and people experiencing homelessness
- Strengthened partnership working and re-establishment of the Health Equity Group

This work is improving access, engagement and trust, alongside early increases in uptake of prevention and screening services.

Embedding a person-centred approach

There has been continued progress in ensuring services are inclusive and responsive to individual needs:

- Delivery of refreshed person-centred care training
- Preparation for implementation of the Welsh Health Circular on Accessible Communication and Information Standards
- Practical initiatives including learning disability support and improved identification of carers and communication needs

Staff report increased confidence in adapting care, with improvements in personalised care and accessibility for patients.

Being an Employer of Choice

The Health Board continues to strengthen an inclusive workplace culture:

- Growth and influence of staff networks
- Increased delivery of equality, diversity and inclusion training
- Continued development of a speaking-up culture through initiatives such as Working in Confidence
- Improved quality and consistency of Equality Impact Assessments

There is evidence of increased staff confidence to speak up, stronger staff voice in decision-making and improved perceptions of fairness and wellbeing support.

Key Themes

Three key themes have emerged from this year's report:

- Early signs of cultural change are emerging, reflected in increased staff confidence to speak up, challenge inappropriate behaviour, support inclusion and create psychologically safe working environments. Staff feedback and programme evaluations also indicate improved confidence amongst leaders and colleagues to address discrimination and promote inclusive practice.
- There is increasing evidence that equality, diversity and inclusion activity is translating into early impact, including improved access to healthcare services for underserved communities, increased engagement with screening and prevention programmes, stronger relationships with local communities, and improved staff confidence in delivering personalised and accessible care.
- Data remains a key limitation, with further work required to evidence long-term impact and track inequalities over time

Workforce equality data and pay gap reports:

The workforce equality report (Appendix 1) and pay gap report (Appendix 2) provide an overview of the characteristics of our workforce and highlight a number of areas where further action may be required in order to build a more inclusive and equitable workforce.

The ethnicity pay gap data shows that as an average overall, our Black, Asian and Minority Ethnic colleagues earn more than their White colleagues. However, when an analysis of difference in average pay has also been carried out by staff group and pay band this shows that, apart from Additional Clinical Services, they earn less across all other staff groups. The same analysis by Agenda for Change (AfC) pay band shows that our Black, Asian and Minority Ethnic colleagues earn less than their White colleagues for band 4, band 7, band 8a and band 8d, with the highest difference at band 8d.

There are no staff from a minority ethnic background represented at Agenda for Change band 9 and only 4 members of staff across the senior bands 8b-8d.

The gender pay gap has remained relatively static, with no significant improvement over the years, with the biggest decrease seen in 2021 and 2022 but for other years it has remained over 21%, with an increase from 22.33% in 2025 to 23.45% in 2026. The highest pay gap by staff group can be seen for Administration and Clerical, with the pay gap for Allied Healthcare Professionals decreasing for the second year, from 9.98% in 2025 to 7.98% in 2026. Male staff earn more than female staff for AfC bands 1-3, 6-7 and 9.

Last year we identified that there were limitations with the data that is available, and the analysis that was undertaken, to meet statutory requirements. Therefore, we have taken steps to address those limitations, to be able to produce more meaningful data and develop an action plan for 2026/27 to undertake a deeper dive and explore the reasons for concerning data results such as the gender pay gap and lack of representation at senior levels. This, along with the work of the EDI Taskforce data intelligence workstream, will be able to make a positive impact to enhance our understanding of the experiences of our staff, and most importantly, the actions that would have the greatest impact on eliminating discrimination.

Overall Position

The Health Board is making steady progress and is moving in the right direction. There is clear evidence of improved governance, stronger leadership accountability and increased integration of equality considerations into practice.

However, much of the impact remains at an early stage. Sustained effort is required to embed consistency, strengthen data and ensure that equality, diversity and inclusion is reflected in everyday decision-making and outcomes across the organisation.

The SEP Annual Report and supporting appendices were shared with the Staff Partnership Forum at their meeting in July 2026, and Trade Union representatives were involved in workshop discussions. Following this, the report was considered at PODCC in August 2026 where it was agreed to recommend to the Board that these are approved for publication.

Argymhelliad / Recommendation

The Board is requested to **APPROVE** the Strategic Equality Plan Annual Report 2025/26 for publication, noting that this is a consolidated report bringing together all reporting requirements established under the Equality Act 2010.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	5. Equitable 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality:	6. All Apply

Quality and Engagement Act (sharepoint.com)	
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	Not Applicable
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	3. Create people-centred employment and development opportunities that support workforce transformation, reflect the changing needs of 4. Create an inclusive culture where every voice matters, individual needs are considered and staff well-being is promoted and supported 7. Improve health and well-being by focusing on prevention and early intervention, while working in partnership to ensure everyone has equal access to care and opportunities for good health
Model Cymdeithasol ar gyfer Iechyd a Llesiant : (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing : (<i>complete for strategic change and/or significant service changes</i>)	7. All Apply
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	• Equality Act 2010 • Public Sector Equality Duties (Wales) 2011 • Health Board's Strategic Equality Plan and Objectives
Rhestr Termau: Glossary of Terms:	Included within the body of the report and appendices
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	An early draft of the report was shared with the Staff Partnership Forum at their meeting in July 2026, and Trade Union representatives were involved in workshop discussions where the findings of the workforce information and pay gap report were presented. A final

	draft report was considered at People, Organisational Development and Culture Committee (PODCC) in August 2026, and it was agreed to recommend to Board that this is approved for publication.
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Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	There will be costs associated with providing specialist training to staff in relation to meeting identified training needs on equality issues where external expertise and/or lived experience is required/recommended. While there is a dedicated budget for Business Partnerships and Inclusion and some courses will be delivered corporately and through these funds, some external training provided to individuals as an identified training need will need to be met from relevant departmental and corporate budgets.
Ansawdd / Gofal Claf: Quality / Patient Care:	There is evidence to show that generally, protected groups are disadvantaged at all stages relating to the planning, development and delivery of public sector services. The development of realistic and deliverable objectives set through an equality lens and underpinned by human rights principles, and positive progress against those objectives, will improve the quality of services delivered and patient care, not just for protected groups but for the population as a whole.
Gweithlu: Workforce:	There is evidence to show that generally, protected groups are disadvantaged when seeking employment and during their careers, facing prejudice and discrimination within exclusive working environments. Also, it is known that staff perform better when they can be themselves in the workplace. Embedding equality into core functions and HDdUHB's value base, setting objectives which engender the recruitment and retention of a diverse workforce, increasing staff knowledge and breaking down barriers faced by protected groups will lead to increased wellbeing amongst staff and can result in lower sickness absence levels, conserving valuable staff and financial resources.
Tegwch Iechyd: Health Equity:	This is an annual update report so a health equity assessment has not been completed.
Risg: Risk:	Challenges from staff or the public in relation equality and human rights can result in financial and reputational damage to the Health Board.
Cyfreithiol: Legal:	Non-compliance with the duties of the Equality Act 2010 risks the issue of a letter of non-compliance by the Equality and Human Rights Commission and legal challenges through judicial review and employment tribunals.
Enw Da: Reputational:	The SEP Objectives are designed to reduce the likelihood of reputational damage by prescribing fair and equitable treatment of staff and service users and taking action to meet the objectives. Producing an annual report on equality objectives is a requirement of the PSED. Non-

	compliance with the PSED would result in legal challenges and consequent financial and reputational damage to the organisation.
Gyfrinachedd: Privacy:	Information gathered for equality data monitoring purposes can include details on sensitive personal information, but this data is anonymised in reports and cannot be traced back to the individuals concerned. Information will already be held on Electronic Staff Records and Health Records if individuals have agreed to supply the information on a voluntary basis. An explanation of why the information is being collected and what it will be used for is included on the relevant data collection forms.
Cydraddoldeb: Equality:	There is evidence to show that generally, protected groups are disadvantaged at all stages relating to the planning, development and delivery of public sector services. The development of realistic and deliverable objectives set through an equality lens and underpinned by human rights principles, and positive progress against those objectives, will improve the quality of services delivered and patient care, not just for protected groups but for the population as a whole. An Equality Impact Assessment has not been undertaken as this is an Annual Report.



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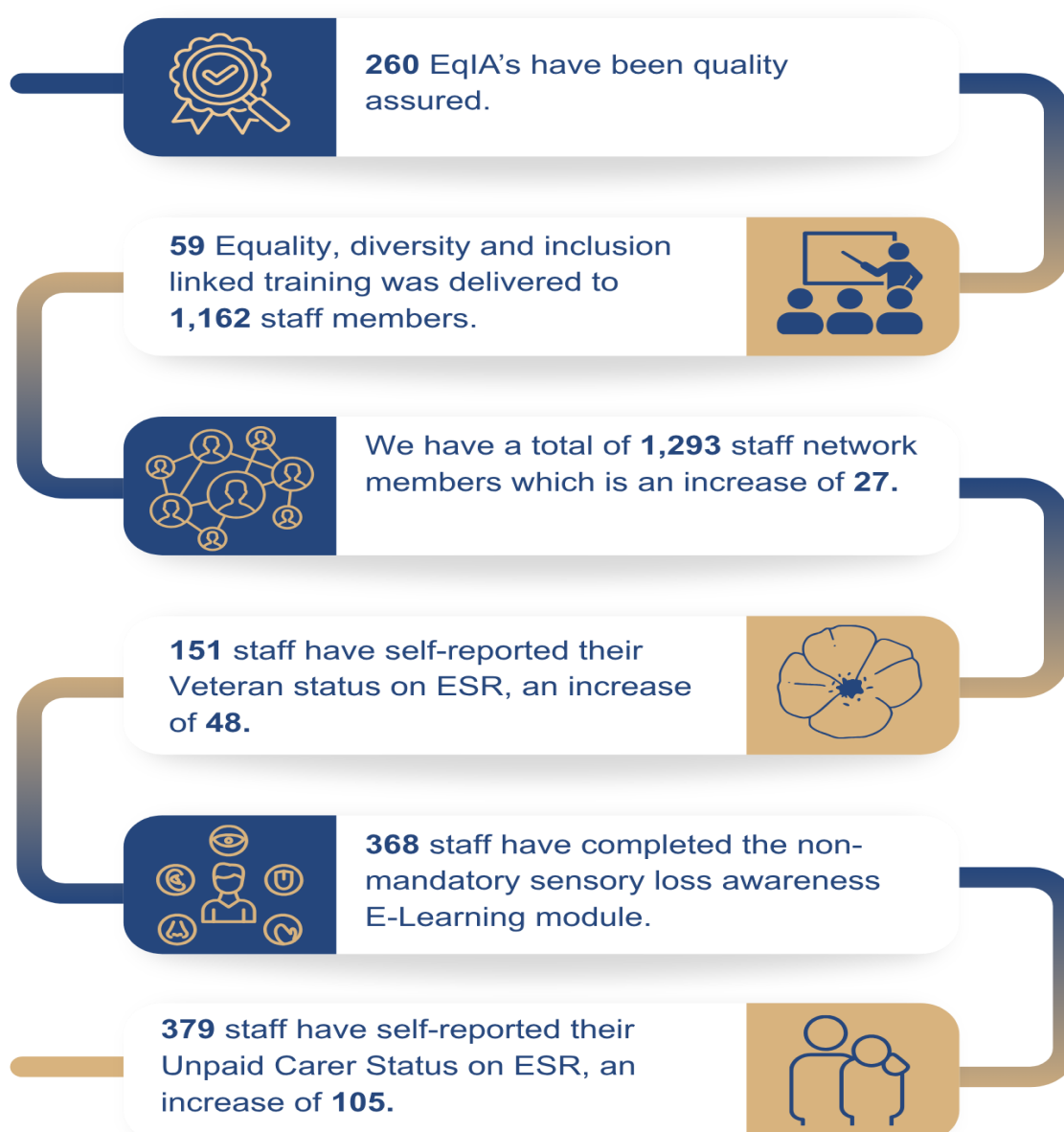
Strategic Equality Plan *Annual Report* **2025/2026**



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During 2025-2026



Introduction

Hywel Dda University Health Board (the Health Board) is dedicated to placing people at the core of all our activities. Our vision is to foster an accessible and inclusive organisational culture and environment for everyone. This encompasses our staff, those receiving care, their families and carers, as well as our partners, whether they are statutory organisations, third sector partners, or our communities. We aim to treat everyone as individuals, adopting a person-centred approach that ensures fairness, integrity, dignity, and respect for all, regardless of their background or beliefs.

The Equality Act 2010 mandates fair treatment for everyone. This legislation protects individuals from being treated less favourably due to:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief (including non-belief)
- Sex
- Sexual orientation

To ensure we treat people fairly, we must collect and utilise information about the experiences of our staff and service users. It is crucial that our services meet the needs of all groups and that we maintain fairness in the workplace. Our report includes case study examples, with fictitious names used to protect the identities of those who have shared their stories or feedback.

We employ various methods to gather and compile information about our communities and staff, including:

- Siarad Iechyd/Talking Health: Our involvement and engagement scheme that allows the public to voice their opinions on the planning, development, and delivery of local health services.
- Engagement and consultation: With staff and communities at public events and through surveys.
- Data collection: From our patient administration systems.
- Patient feedback: Including compliments and complaints about their experiences with our services.
- Staff surveys: Data from our electronic staff records and grievance reports.
- Welsh Government initiatives and national reports: Such as those from the Equality and Human Rights Commission, Older People's Commissioner, Stonewall, and others.
- Public Service Board Wellbeing Assessments: For each of the three counties.

We are continually striving to enhance the collection and reporting of equality data for those using our services. This involves adapting our existing systems to gather this data and raising awareness about its importance and how it will be used to improve services and outcomes for patients. The same applies to collecting equality data for our staff, and we are collaborating with the Welsh Government and other NHS Wales Health Boards and Trusts to improve our national information systems.

Our efforts to advance the equality agenda are interconnected with several pieces of legislation, policy drivers, and key reports, including:

- The Welsh Language (Wales) Measure 2011 – National Assembly for Wales
- Well-being of Future Generations (Wales) Act 2015
- The Welsh Language Standards (No.8) Regulations 2022 – Welsh Government
- More than just words – Welsh Government
- The Socio-economic Duty – Welsh Government
- The Armed Forces Covenant Duty – UK Government
- Anti-racist Wales Action Plan – Welsh Government
- LGBTQ+ Action Plan – Welsh Government
- Is Wales Fairer? (2023) – Equality and Human Rights Commission

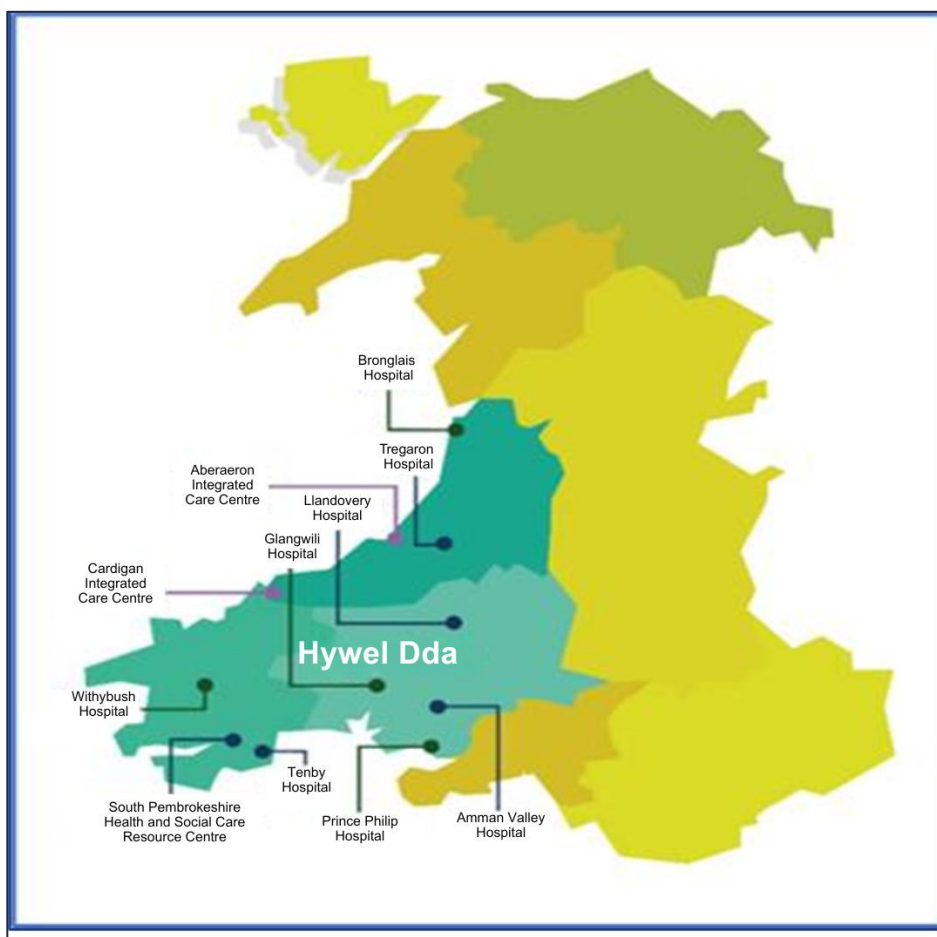
While our annual report provides an overview of the Health Board's efforts to promote equality, diversity, and inclusion, it should be read alongside other key documents listed below, with hyperlinks provided:

- [Hywel Dda University Health Board Annual Report](#)
- [Director of Public Health Annual Report](#)
- [Our 20-year strategy - A Healthier Mid and West Wales: Our Future Generations Living Well](#)
- [Our Well-being of Future Generations Act](#)
- [Elusennau Iechyd Hywel Dda Health Charities Annual reports](#)

About the Hywel Dda area

Hywel Dda University Health Board plans and provides NHS healthcare services for the residents of Carmarthenshire, Ceredigion, Pembrokeshire, and neighbouring counties. Below are some key facts about our Health Board. For more detailed information, please refer to our Health Board Annual Report 2024-2025:

- Our Health Board covers a quarter of the land mass of Wales.
- We employ approximately 13,000 staff members and have a growing number of volunteers and apprentices.
- Based on the 2021 Census, we provide healthcare services to around 383,000 residents, as well as numerous visitors to our area.
- We support 47 general practices, 47 dental practices, 97 community pharmacies, and 43 general ophthalmic practices.
- Our facilities include four main hospitals, seven community hospitals, and eleven health centres.
- We collaborate with our three local authorities and partners from the public, private, and voluntary sectors.



We recognise that many individuals within our diverse populations, including those with protected characteristics, experience socio-economic deprivation. This deprivation is a significant factor contributing to poorer health outcomes, limited access to education and employment opportunities, and the perpetuation of the cycle of deprivation.

Our goal is to break this cycle in alignment with the aspirations of the Well-being of Future Generations (Wales) Act 2015, striving to create a healthier, more equal Wales with resilient communities working together towards a better future for all.

Information on health and socio-economic factors across the three counties is available from the Public Health Wales Observatory, the Welsh Index of Multiple Deprivation, and Stats Wales. Further details about the characteristics and needs of our population can also be found in the local assessments of wellbeing published by the Public Services Boards in each local authority area.

Ceredigion Local Well-being Plan - Ceredigion County Council

Carmarthenshire Local Well-being Plan – the Carmarthenshire We Want

Well-being Assessment - Pembrokeshire County Council

Demographic information for the Hywel Dda region is available on the Office for National Statistics website. Historically, our population has experienced temporary changes, with significant increases during the summer months due to the tourism industry and transient student populations throughout the year.

We recognise the importance of continually striving to ensure that our diverse communities have opportunities to communicate their needs, receive appropriate services, and have equal opportunities for employment and career progression.

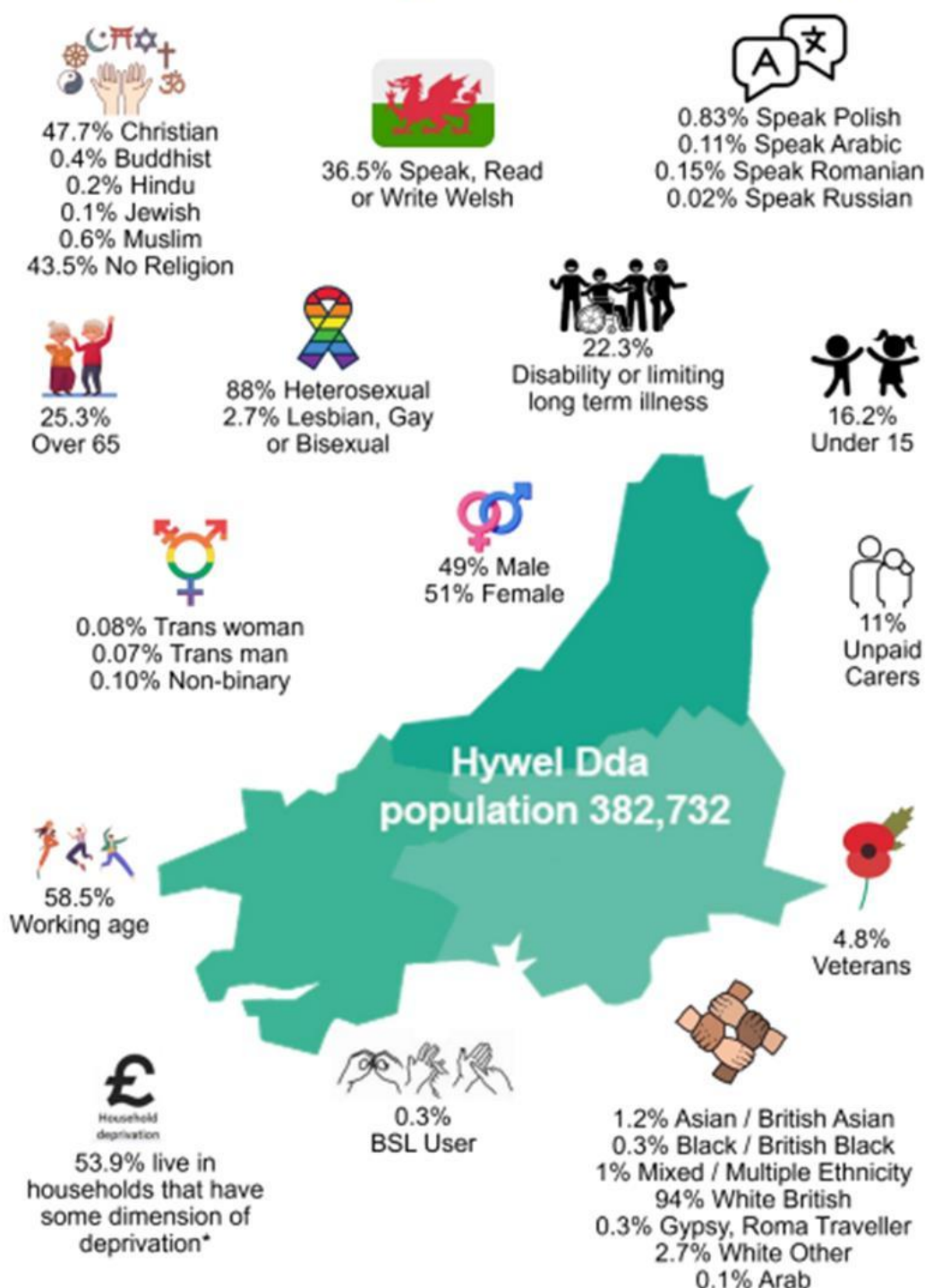
There are high concentrations of Welsh speakers in some areas across the three counties, and we are committed to providing an active offer to patients who wish to receive their services in Welsh. We aim to identify our Welsh-speaking service users and encourage our Welsh-speaking staff to register their language skills on their Electronic Staff Record (ESR). In accordance with the Welsh Language Standards (No.7) 2018 Regulations, we have an action plan in place to meet the requirements of the Standards through our Bilingual Skills Strategy. Further details can be found in our Welsh Language Annual Reports.

Appendix 1 Annual Workforce Equality Report 2025-2026, illustrates “life in Hywel Dda” across the protected groups. This information is extracted from data held on the Electronic Staff Record’s Business Intelligence database. All Health Board employees are encouraged to record and regularly update their personal data on this system to help collect more complete and accurate information about our workforce as a whole.

An overview of the population of Hywel Dda University Health Board can be found on the following page.

Our population

The infographic below provides an illustration of the characteristics of the people living in Hywel Dda and is drawn from the averages of the data for each local authority area.



*The dimensions of deprivation used to classify households are indicators based on four selected household characteristics. - Education, Employment, Health & Housing ([Household deprivation - Census Maps, ONS](https://www.ons.gov.uk/census)). Data provided by ONS Census 2021 <https://www.ons.gov.uk/census>

Our strategic equality plan and objectives 2024-2028

We have four overarching strategic equality objectives outlined in our 2024-2028 Strategic Equality Plan.

The strategic equality objectives for 2024-28 are:

- **Objective 1 – Leadership by all**
Staff at all levels, including Board Members, actively promote and facilitate a culture of inclusion and wellbeing across the organisation.
- **Objective 2 – Working Together to improve health and well-being for all**
Our staff will actively work to reduce health inequalities
- **Objective 3 – Embedding a person-centred approach**
Our staff use the Health Board values to deliver a person-centred approach in everything they do.
- **Objective 4 - Being an employer of choice**
We will offer equal opportunities for employment and career progression and support the health and well-being of our staff and volunteers within a fair and inclusive environment.

Our Strategic Equality Plan (SEP) 2024-2028 reaffirms our dedication to advancing equality, eliminating discrimination, and fostering good relations between those who share a protected characteristic and those who do not. This comprehensive plan reflects our dual role as an employer and a service provider, ensuring that our commitments extend to patients, families, carers, and the broader community.

Our Strategic Equality Plan (SEP) objectives are closely aligned with the Health Board's Wellbeing Objectives, which are interconnected with the wellbeing goals established by the Well-being of Future Generations (WFG) (Wales) Act 2015. The WFG Act is a cornerstone of our long-term strategy, 'A Healthier Mid and West Wales: Our Future Generations Living Well'.

The Health Board's long-term strategy, '*A Healthier Mid and West Wales – Healthier lives, well lived*', is structured around the following four key themes:

1. Thriving Teams,
2. Healthier Communities,
3. Great Care,
4. Positive Futures

which guide how we support our people and deliver our services. The examples provided in this annual report illustrate how the Health Board is actively embedding and promoting principles to achieve the best possible health and wellbeing outcomes for everyone.

The Health Board is diligently working to address the worsening health inequalities within our communities. The disproportionate effects on those with protected characteristics and

vulnerable individuals continue to be increasingly evident and are being further exacerbated by ongoing socio-economic pressures, political instability, and leadership changes across the UK. Conflict across the World and local tensions also contribute to these disproportionate impacts.

We are committed to mitigating these impacts and improving health outcomes for all, particularly for those most affected by external societal factors beyond their control. Our efforts include targeted initiatives and collaborations with partners and stakeholders to drive continuous improvements for the most vulnerable members of our communities.

Alongside this annual report, the Health Board regularly submits progress reports to the Welsh Government on delivery against the actions in the Strategic Equality Plan. The table below sets out the key areas of focus under each objective and shows overall progress being made. This report will then go on to highlight some of the Health Board's key achievements during 2025–2026.

Strategic Equality Plan Objective	Key areas of focus	Progress
Leadership by all	• Workforce development • Inclusive leadership and culture • Wellbeing support • Tackling discrimination • Veteran support	On track
Working together to improve health and wellbeing for all	• Reducing inequalities • Partnership working • Improving access for vulnerable groups • Listening to our population • Wellbeing and inclusion initiatives	On track
Embedding a person-centred approach	• Improving access for vulnerable groups • Raise awareness of protected characteristics • Co-productive approach • Inclusive leadership development	On track Attention required
Being an Employer of Choice	• Inclusive culture • Learning and development opportunities • Staff networks • Equitable recruitment and staff retention • Staff wellbeing • Accessible opportunities	On track

Spotlight on: Leadership by all

Our Aim

Staff at all levels, including Board members, actively promote and facilitate a culture of inclusion and wellbeing across the organisation.

Anticipated Outcome

- The Health Board recognises and values the needs and differences of all staff and service users.
- Staff, including Board members, will use their lived experiences and act as role models to create positive experiences for colleagues and service users.
- Staff and service users will stand up to racism and all forms of discrimination and are empowered to voice any concerns

This section summarises work carried out across the Health Board and outlines progress against our Strategic Equality Plan objective: Leadership by All.

Active Bystander Training

Why is this important

Evidence from workforce data continues to show that some staff experience bullying, harassment and discrimination at work, with a disproportionate impact on minoritised groups. There are also ongoing reports of discrimination from patients, the public and, in some cases, from managers.

This highlights a clear need to strengthen how staff recognise and respond to inappropriate behaviour in the moment. Without this, behaviours can go unchallenged, which risks normalising poor conduct and undermining psychological safety. The Active Bystander programme was developed by the Diversity and Inclusion Team to address this gap. It focuses on giving staff practical tools to safely challenge behaviours such as microaggressions, discrimination and inappropriate language. It also supports delivery of the Anti-Racist Wales Action Plan and the LGBTQ+ Action Plan by making inclusion a shared responsibility across the organisation.

What we have done

During 2025–2026, the Diversity and Inclusion Team designed and delivered a bespoke, in-house Active Bystander training programme. This approach allows the content to reflect real experiences within the Health Board and ensures it is relevant to our working environments.

Between April 2025 and March 2026:

- 10 Active Bystander training sessions were delivered
- 281 staff attended from a wide range of roles and departments

- Delivery included both open sessions and targeted team-based sessions (including Workforce and OD, Obstetrics and Gynaecology, Pharmacy and medical teams)

Feedback has been consistently strong:

- 100% of attendees said they would recommend the training
- A significant proportion asked for further or more advanced learning
- Increasing numbers of teams are requesting tailored sessions

In response, the Diversity and Inclusion Team has begun developing a structured delivery plan to ensure those with the greatest need for the Active Bystander training are able to receive it in a timely manner.

The impact of what we have done

The Active Bystander sessions are evaluated and feedback from attendees is used to ensure the course is effective and that the learning objectives are being achieved. 73% of attendees highlighted that they would like to attend further training on this subject and 95% indicated that they would recommend the session to others. Here are some examples of the feedback received from the programme:

Thank you for a wonderful session, very thought provoking, really useful to attend as a whole team

Very informative session and really makes you more aware and gives the confidence to intervene and act when you hear or see something that's not right

Really useful, informative session which provides strategies for intervening when we see inappropriate behaviour.

Thank you. Occasions where I have witnessed inappropriate behaviour and have or haven't intervened often play on my mind. I feel more confident managing these situations and knowing there are many different approaches that can be helpful

Early feedback shows that the training is making a practical difference. Staff report:

- Better understanding of what constitutes inappropriate behaviour
- Increased confidence to challenge behaviour safely
- Greater awareness of their role in creating an inclusive workplace

This supports a wider cultural shift towards openness and shared responsibility. It also strengthens safer ways for staff to speak up and challenge issues constructively.

The programme is helping to create the conditions needed to reduce bullying and harassment over time. However, current workforce data shows that some groups, particularly Black, Asian and Minority Ethnic staff continue to report higher levels of negative experiences. This confirms that while progress is being made, sustained and targeted action is still needed.

The longer-term impact will be measured through improvements, over time, in staff experience data, including national staff survey results.

LEAP (Leadership Engagement with Awesome People)

Why is this important

The LEAP (Leadership Engagement with Awesome People) programme was developed to strengthen leadership capability across Hywel Dda in response to clear organisational need. Evidence shows that many leaders experience low confidence, high pressure and a sense of isolation, which can impact team culture, staff wellbeing and service delivery.

The Health Board continues to operate in a complex environment, with workforce pressures linked to stress, retention and recruitment. Strong, consistent leadership is essential to address these challenges and to create a working environment where staff feel valued, respected and able to thrive.



LEAP was designed to help reset leadership culture by developing compassionate, inclusive and self-aware leaders. It supports organisational priorities, including equality, diversity and inclusion, by embedding inclusive behaviours and improving psychological safety across teams.

What we have done

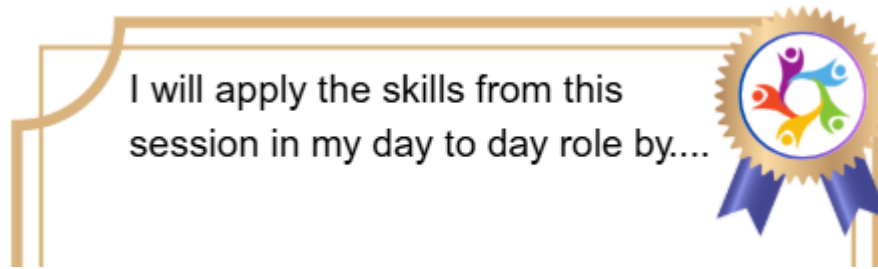
During 2025–2026, the Health Board continued to deliver the LEAP programme as a key leadership development initiative for senior staff.

- Four cohorts, consisting of 59 delegates completed their LEAP journey
- Four cohorts consisting of 66 delegates started their LEAP journey
- Since LEAP's beginning in 2023, 126 leaders have completed the LEAP programme.

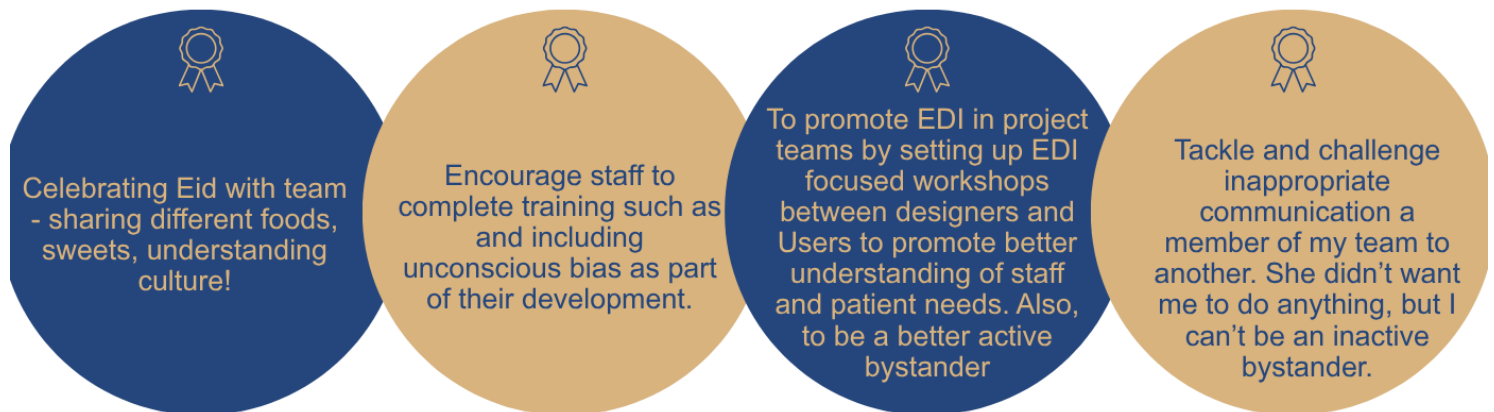
The LEAP programme combines practical learning, reflection and peer support over a 10-month period. Core areas include:

- Compassionate and values-led leadership
- Equality, diversity and inclusion
- Coaching and communication
- Strategic decision making
- Leading teams through change

The Diversity and Inclusion module, *Creating an Environment Where Everyone Can Flourish and Thrive*, remains a central component, helping leaders understand their responsibilities and foster inclusive team environments. A formal Leadership Pledge has been introduced, requiring participants to commit to specific behaviour changes. Follow-up support is also being strengthened to help leaders embed their learning in practice.



Examples of commitments made via the pledge include:



The impact of what we have done

LEAP is beginning to change how leadership is experienced across the organisation. Leaders report increased confidence, self-awareness and a clearer understanding of how their behaviour affects others. Many describe feeling more able to manage pressure, lead difficult conversations and act in line with organisational values. This is leading to visible changes within teams. Staff are more likely to speak up, raise concerns earlier and take ownership of issues rather than passing them upwards. Teams report more open communication, stronger relationships and a reduction in unresolved conflict. In some areas, there has been a clear shift from reactive, problem-focused working to more collaborative and solution-based approaches.

Leaders are also introducing more consistent ways of working, including regular team meetings, clearer communication and more structured decision-making. This has improved coordination within teams and strengthened links between services, helping issues to be resolved more quickly and effectively.

Feedback from participants supports this shift. Leaders describe becoming more confident and authentic in their roles:

- *"I don't feel like an imposter anymore. I'm clearer and more confident in how I lead."*
- *"LEAP helped me recognise I already had the skills — I just needed the confidence."*
- *"It reignited my desire to lead and reminded me of the difference I can make."*

There is also clear evidence of impact within teams. Leaders report that staff attitudes and behaviours are changing in response to their leadership:

- *“People now come to me with solutions, not just problems.”*
- *“The team talks more openly now. Issues don’t sit and build like they used to.”*
- *“Conversations are calmer and more constructive — there’s less tension.”*
- *“Staff feel more confident to speak up, even when they disagree.”*
- *“There’s a stronger sense of team — people support each other more.”*

Some feedback highlights practical changes in how teams operate:

- *“We now have regular meetings - before, we didn’t. It’s stopped things from festering.”*
- *“Communication is clearer and more consistent across the team.”*
- *“We’re working things through together rather than reacting to problems.”*

There is also evidence of improved morale and wellbeing:

- *“The team feel more positive and supported.”*
- *“I’ve created an environment where people feel valued and able to thrive.”*

While it is too early to see measurable changes in staff survey data, these early indicators suggest the programme is helping to create more psychologically safe, inclusive and supportive team cultures. LEAP is therefore contributing to the wider conditions needed to improve staff experience, retention and organisational culture over time, even though it does not directly influence these metrics.

The Hywel Dda Manager Programme

Why is this important

The Hywel Dda Manager programme was developed to strengthen day-to-day management capability across the organisation, particularly for supervisors, first-line managers and those aspiring to leadership roles.



Feedback and workforce data show that the quality of line management has a direct impact on staff experience, wellbeing and retention. Managers play a key role in shaping team culture, responding to concerns, and ensuring fair and consistent treatment of staff. Where managers lack confidence or skills in these areas, it can lead to inconsistent practice, reduced psychological safety and poorer staff experience. The programme addresses this by focusing on practical skills needed in everyday management. It places a strong emphasis on inclusive and compassionate leadership, equipping managers to recognise and challenge bias, support diverse teams and create environments where all staff feel valued and able to thrive. This is supported by the ‘Being an Inclusive Manager’ session delivered by the Diversity and Inclusion Team.

What we have done

During 2025–2026, the Hywel Dda Manager programme continued to be delivered as part of the Health Board’s wider leadership development offer. Seven cohorts have now been delivered, reaching 140 attendees. Evaluation of the programme

captured that 81% of participants reported a significant increase in their understanding of inclusive management

The programme covers key areas including:

- Managing self (resilience, wellbeing and self-awareness)
- Managing others (psychological safety, inclusive practice and conflict management)
- Coaching and performance conversations
- Developing both self and others

The 'Being an Inclusive Manager' session remains a key element of the programme. It supports managers to:

- Understand equality, diversity and inclusion in practice
- Recognise and address discrimination and bias
- Lead inclusive teams and foster a sense of belonging

As with the LEAP approach, an Inclusive Manager Pledge has been introduced to the Hywel Dda Manager Programme. Participants commit to at least one action following the session, with follow-up support from the Diversity and Inclusion Team to help embed these changes.

Examples of commitments made via the pledge include:



Participants identified further development needs, including how to be more inclusive in practice, reduce bias and better support internationally recruited staff.

The impact of what we have done

The Hywel Dda Manager programme is strengthening the consistency and quality of day-to-day management across the organisation. Managers' report increased confidence in leading people, a clearer understanding of their role, and greater awareness of how their behaviour affects staff experience. The Inclusive Manager session is a key driver of this, with both local and national evaluation showing a strong increase in knowledge and understanding of inclusive practice. Managers feel better equipped to ensure fair treatment of staff, recognise and reduce bias, and create psychologically safe environments where staff feel valued and able to thrive.

This increased confidence is translating into changes in practice. Managers are taking more consistent and fair approaches to decision-making, improving communication with their teams, and creating safer spaces for staff to raise concerns. There is also a stronger focus on understanding and supporting the needs of a diverse workforce, including internationally recruited staff. The introduction of the Inclusive Manager Pledge is helping to turn learning into action, with managers committing to practical, measurable changes in how they lead their teams.

Early feedback suggests these actions are contributing to more supportive and inclusive team environments. Managers are adopting more reflective and compassionate approaches, leading to improved relationships, better quality conversations with staff, and greater focus on wellbeing and psychological safety. While it is too early to evidence impact through staff survey data, these early indicators show progress towards a more inclusive and consistent management culture across the Health Board.

Participant feedback highlights this shift:

- *“I feel more confident in how to be inclusive in my role.”*
- *“It’s helped me think differently about bias and how it affects my decisions.”*
- *“I want to make sure my team feel safe and able to speak up.”*
- *“I need to understand more about different cultures and how to support staff better.”*
- *“It’s made me reflect on how I manage people and the environment I create.”*
- *“I’m more aware of how small behaviours can affect how included people feel.”*



The Coach Approach

Both the LEAP and Hywel Dda Manager programmes encourage a “coach approach” to support staff development and improve workplace culture. The coach approach includes:

- **Training and Development:** The Health Board has provided extensive training for managers and leaders to adopt coaching techniques in their daily interactions with staff. This includes formal training sessions and ongoing support to ensure the effective application of these skills.
- **Enhanced Communication:** By fostering a coaching culture, the Health Board aims to improve communication across all levels of the organisation. This approach encourages open dialogue, active listening, and constructive feedback.
- **Employee Empowerment:** The Coach Approach focuses on empowering employees to take ownership of their development and career progression. This involves setting personal goals, identifying areas for improvement, and creating actionable plans to achieve these goals.
- **Supportive Environment:** Creating a supportive and collaborative work environment is a key objective. The Health Board has implemented regular check-ins and mentoring sessions to provide continuous support and guidance to staff.

Anti Racism Wales Action Plan progress

Why is this important

The Anti-Racist Wales Action Plan (ARWAP) sets a national expectation for NHS organisations to actively tackle racism and deliver equitable outcomes across employment, leadership, governance and service delivery. It reflects a clear ambition for Wales to become an anti-racist nation by 2030.

Local workforce data and lived experience continue to highlight inequalities within the Health Board. While workforce diversity is increasing, disparities remain in recruitment outcomes, career progression and representation at senior levels. There are also differences in how staff and service users experience care and the workplace.

This programme of work is therefore required to move beyond awareness and into sustained, measurable change, addressing structural barriers and embedding anti-racist practice into everyday decision-making.

What we have done

During 2025-2026, the Health Board has continued to embed delivery of its local Anti-Racist Wales Action Plan across workforce, service delivery and leadership arrangements. Progress has been made across all six national focus areas, with a growing emphasis on coordination, consistency and practical delivery.

A key area of focus this year has been strengthening staff capability and awareness. Active Bystander training has expanded significantly, with ten sessions delivered to 281 staff, alongside continued promotion of anti-racist e-learning which has reached 91% compliance. These interventions are supporting staff to recognise and challenge racism

and inappropriate behaviour in the workplace. At the same time, organisational practices have been updated to reflect anti-racist principles, including the removal of outdated terminology and strengthened use of Equality Impact Assessments to inform policy and decision-making.

Governance and leadership arrangements have also been strengthened. The establishment of the Equality, Diversity and Inclusion Task Force has provided clear Board-level oversight and direction, helping to align activity across the organisation and ensure a more structured and evidence-based approach. This has been supported by improvements in how data is used, including the quality assurance of 260 Equality Impact Assessments and closer working with workforce intelligence teams to strengthen analysis and reporting.

There has been continued investment in staff engagement and experience. The Black, Asian and Minority Ethnic Staff Network has been actively supported, providing a platform for peer support, engagement and co-production. Awareness of routes to raise concerns has increased through promotion of Speak Up and Work in Confidence platforms, alongside strengthened induction arrangements that reinforce expectations around behaviour and inclusion.

In service delivery, there has been a clear shift towards more community-focused and inclusive approaches. The Community Development Outreach Team has continued to lead targeted engagement with seldom heard groups, including delivering services in community settings such as places of worship and community venues. This has improved access to vaccination, screening and prevention services, and strengthened relationships with local communities. Cultural awareness and anti-racism training for practitioners has also been delivered to support more inclusive care.

Progress has also been made in addressing workforce inequalities. Work is underway to improve fairness in recruitment processes, including reviewing job descriptions and strengthening feedback to candidates. Ethnicity pay gap reporting and Workforce Race Equality Standard data are being used to inform targeted actions, alongside the development of learning and development processes to support progression. While this work is ongoing, it provides a stronger foundation for addressing inequalities in access to opportunities.

Targeted support for specific communities has remained a priority. Partnership-based outreach with refugees and asylum seekers has expanded, providing culturally sensitive support, improving access to healthcare and building trust through consistent community engagement.

The impact of what we have done

The ARWAP programme is beginning to influence both organisational culture and service delivery. There is clear progress in building staff awareness, confidence and capability to recognise and challenge racism. Increased uptake of training and high compliance with anti-racist learning indicate that expectations are becoming more embedded across the workforce.

Staff experience is improving in key areas. There is greater awareness of reporting routes and more accessible support for those experiencing bullying, harassment or discrimination. The Black, Asian and Minority Ethnic Staff Network continues to play a central role in shaping activity, increasing visibility and providing peer support. These developments are helping to create safer spaces for staff to speak up and contribute to organisational change.

At a service level, there is evidence of more inclusive and responsive approaches to care. Community outreach models are improving access to services for seldom heard groups by delivering care in trusted settings, supporting increased engagement in prevention and screening programmes.

There are also early signs of improved organisational capability. Strengthened Equality Impact Assessment processes and improved use of workforce data are supporting more informed decision-making, while stronger leadership oversight is improving accountability and coordination.

However, workforce data continues to show that inequalities persist, particularly in relation to representation at senior levels and progression. Data quality challenges also remain, limiting full understanding of inequalities.

Overall, the Health Board has maintained momentum across a complex programme. While much of the impact is at an early stage, there is clear progress in building the foundations for long-term change. Long-term impact will be reflected through improvements in staff survey results and wider workforce and patient experience data.

Aspiring Board Members Programme

Why is this important

It is widely recognised that Boards should reflect the diversity of the workforce and communities they serve. A lack of diversity at Board level limits the range of perspectives in decision-making and can reduce understanding of the experiences of under-represented groups.

The Aspiring Board Members Programme was developed by Welsh Government to address this gap. It focuses on supporting individuals from Black, Asian and minority ethnic backgrounds to prepare for Independent Board Member (Non-Executive Director) roles within NHS Wales. This aligns with the Anti-Racist Wales Action Plan, which sets a clear expectation to improve representation and create more equitable leadership structures.

For Hywel Dda, participation in this programme supports the development of a more diverse leadership pipeline, strengthens succession planning, and helps ensure that future Board-level decisions are informed by a broader range of lived experiences.

What we have done

During 2025–2026, the Health Board actively supported the delivery of the national Aspiring Board Members Programme.

The programme provides participants with:

- Exposure to Board-level decision making
- Development in leadership, governance and strategic thinking
- Opportunities to build networks and understand wider health and care systems

Through supporting placements, the Health Board contributes directly to the development of future Board members while also benefiting from new perspectives and insights brought into the organisation.

The impact of what we have done

By supporting placements, the organisation is helping to build a pipeline of future Board members who bring broader lived experiences and different perspectives to decision-making.

There are early signs of impact at both an organisational and individual level. Participation in the programme is increasing awareness of diversity at senior levels and reinforcing the importance of inclusive leadership. It also provides an opportunity for the Health Board to reflect on its own governance practices and ensure these are inclusive and representative.

The presence of Aspiring Board Members within the organisation is helping to:

- Broaden perspectives within discussions and decision-making spaces
- Increase visibility of diverse talent and leadership potential
- Strengthen understanding of the experiences of under-represented groups

The extension of the placement reflects the value of the programme and the positive contribution participants are making. While the long-term impact will be seen through increased diversity in Board appointments over time, this programme is an important step in building a more inclusive leadership pipeline across NHS Wales.

Equality, Diversity and Inclusion Task Force

Why is this important

Workforce data and feedback continue to show inequalities in staff experience, including under-representation of some groups at senior levels, variation in progression, and differences in how staff experience the workplace. While overall workforce diversity is improving, these differences highlight the need for more focused and coordinated action. The Board recognised that existing activity was not delivering change at the pace required. A dedicated Board seminar in December 2024 brought together multiple sources of evidence, including workforce data, staff survey findings and lived experience, which highlighted persistent inequities and gaps in data quality.

In response, the EDI Task Force was established to accelerate progress, strengthen leadership accountability and ensure a more structured, evidence-based approach. The Task Force aims to move beyond isolated initiatives by bringing together leadership, lived experience and data to drive meaningful and sustained cultural change across the organisation.

What we have done

Since its establishment, the EDI Task Force has provided Board-level oversight and direction for the organisation's equality, diversity and inclusion work and brings together Board members, staff network leads and organisational partners to drive change collectively.

Three priority workstreams have been established:

- **Board Allyship** – strengthening visible leadership commitment and defining how the Board actively champions inclusion
- **Engagement and Co-production** – improving how staff contribute to shaping EDI priorities through lived experience and shared ownership
- **Data and Intelligence** – improving the quality, use and analysis of workforce data, including intersectional analysis

A key milestone during the reporting period was the “Big Conversation” staff engagement event held in November 2025. During this event:

- 41 staff attended, generating over 40 ideas for change
- Focus areas included open feedback, empowerment, communication and accountability
- The proportion of participants feeling fully empowered to promote EDI increased significantly during the session (35.6% at the start of the session to 61.5% by the end).

The outputs from this event are now being taken forward through dedicated Task and Finish groups aligned to each workstream.

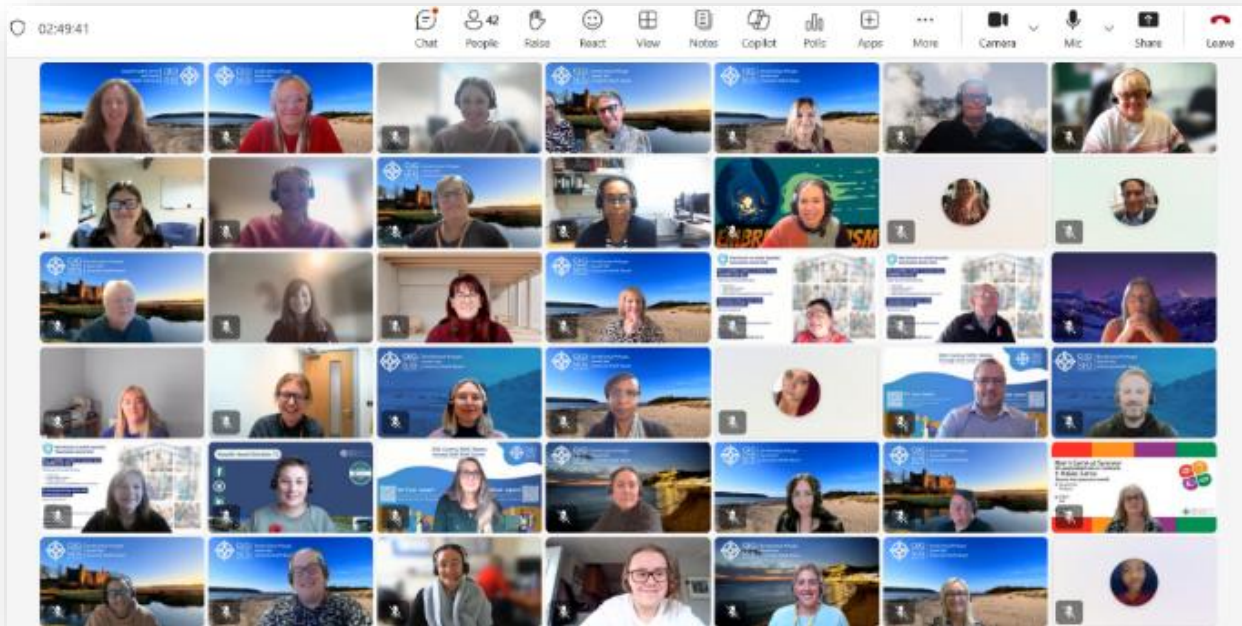
The impact of what we have done

The EDI Task Force is beginning to influence organisational culture by strengthening leadership focus, improving engagement and creating clearer direction for change. There is increased visibility of EDI at Board level, reinforcing that inclusion is a core leadership responsibility rather than a standalone initiative.

There is also growing openness in how the organisation discusses inequality. More honest conversations are taking place, supported by safer spaces for staff to share their experiences. This is helping to build trust and encourage wider engagement, particularly through the expansion of staff networks and co-production activity.

The Task Force has also highlighted important gaps in data and systems, which is driving work to improve how equality data is collected, analysed and used. This will support more targeted, evidence-based decision making over time.

Overall, the Task Force is helping to create the conditions for long-term change by aligning leadership, data and lived experience. Early indicators show increased engagement, stronger leadership commitment and a more open and accountable approach to equality, diversity and inclusion across the organisation.



Screenshot of the big conversation 2025

Spotlight on: Working together to improve health and well-being for all

Our Aim

Our staff will actively work to reduce health inequalities.

Anticipated Outcome

- We will continue to listen to our population, especially those who traditionally find it difficult to access services and often have poorer health outcomes. We will use their feedback and experience to help us when we are planning and providing services.
- The Health Board will work with partners, such as other organisations, Third Sector and communities to reduce health inequalities and remove barriers to accessing health and care services.

This section summarises work carried out across the Health Board and outlines progress against our Strategic Equality Plan objective: Working together to improve health and well-being for all.

Supporting our diverse populations

The Community Development Outreach Team (CDOT) continues to play a key role in supporting diverse communities across Hywel Dda. The team works closely with local populations to understand their needs and provides information, advice and practical support to improve access to healthcare services.



Healthcare Empowerment:

They empower individuals to access healthcare services and promote vaccine uptake.



Community Engagement:

They meet and converse with community members, encouraging participation in public engagement events.



Community Events:

In partnership, they plan and attend community events to celebrate diversity and inclusion.



Public Health Messaging:

They disseminate crucial public health information.



Interpretation Services:

They support health staff in using interpretation services to ensure patients have access to interpreters when needed, enhancing patient and clinician experiences.



Agency Connections:

They connect people with other agencies and third-sector organisations.

Over the past year, CDOT has maintained strong partnerships with third sector organisations and local authorities, delivering a range of engagement and wellbeing activities across all three counties. This work has remained particularly important in the context of ongoing cost-of-living pressures and wider social challenges, which continue to affect many individuals and communities.

Through a consistent community presence and targeted outreach, CDOT has helped ensure that support is accessible, responsive and aligned to the needs of those most at risk of inequality.

Why is this important

Many of the communities served by Hywel Dda experience barriers to accessing healthcare. These include poverty, homelessness, language barriers, low health literacy and mistrust of services. Without targeted support, these factors can lead to poorer health outcomes and reduced engagement with prevention and treatment services.

The role of the CDOT is to address these inequalities by acting as a bridge between communities and the Health Board. The team focuses on those most at risk, including homeless and vulnerably housed individuals, minority ethnic communities, Gypsy, Roma and Traveller communities, and Refugees and asylum seekers, ensuring that services are accessible, inclusive and responsive to need.

What we have done

During 2025–2026, CDOT has continued to deliver a high level of targeted outreach across all three counties, working in close partnership with local authorities, third sector organisations and NHS services.

The team has strengthened a community-based model of delivery, maintaining a consistent presence in settings such as soup kitchens, emergency accommodation, places of work, Traveller sites, Mosques, community cafés and wellbeing events. Through this approach, CDOT has specifically delivered over 70 targeted engagement activities with homeless and vulnerably housed individuals, alongside wider outreach across diverse communities.

A key focus this year has been improving access to healthcare services through practical support. This has included signposting to primary care, distributing GP registration resources, supporting navigation of Wales 111 services, and providing digital demonstrations to improve health literacy. CDOT has also facilitated access to key public health interventions, including vaccination, smoking cessation and screening programmes, working closely with specialist teams such as Hepatology and Community Immunisation.

Partnership working has been a central strength. CDOT has enabled collaboration between community organisations and NHS services, helping to establish new referral pathways, regular clinics and joint initiatives. This includes supporting community settings such as Pembrokeshire Association of Volunteer Services (PAVS) to connect with multiple NHS teams, resulting in ongoing health and wellbeing provision tailored to local need.

Targeted work has continued with specific communities. Outreach with Refugees and asylum seekers has focused on delivering multilingual information, improving understanding of NHS services and supporting access to care. Engagement with Gypsy, Roma and Traveller communities has included regular site visits, health drop-ins and vaccination delivery, helping to build trust and improve access.

CDOT has also supported wider organisational priorities by enabling participation in public consultations and service planning, ensuring that the voices of seldom heard groups are represented in decision-making.

The impact of what we have done

CDOT's work is contributing to a more inclusive and community-centred approach to healthcare delivery. Regular presence in community settings has helped build trust with individuals who are less likely to engage with traditional services, creating opportunities for earlier intervention and support.

There is clear evidence of improved access to services. Individuals have been supported to access housing, engage with vaccination programmes, and take up smoking cessation and screening opportunities.

Health literacy has increased through direct engagement, including the use of translated materials, practical demonstrations and culturally appropriate communication. This has enabled individuals to make more informed decisions about their health and better understand how to access services.

Importantly, CDOT has helped ensure that the experiences and voices of vulnerable and marginalised groups are better represented within Health Board planning and decision-making. This is supporting a shift towards more co-produced and responsive services. While this work is ongoing, it is contributing to the early identification of need, improved engagement with prevention services and a reduction in barriers to care for some of the most underserved communities. Long-term impact is expected to be reflected in improved access, outcomes and patient experience over time.



Photo taken by the Community Development Outreach Team at the Polish wellbeing café.

Case Study

The Community Development Outreach Team (CDOT) identified a group of young Unaccompanied Asylum Seeker Children (UASC) through partnership working with the local authority and ongoing community outreach activity. Multi-agency discussions highlighted that some young people had limited access to safe, structured and supportive spaces within the community.

In response, the Health Board's Arts in Health programme secured funding for a creative engagement project. CDOT supported young people to attend a graffiti art session designed to encourage participation, build confidence and create opportunities for informal conversation.

At the start of the session, one young person appeared quiet and cautious, with low expectations of what the day would involve. Through informal engagement with a local artist and community staff, the environment became more relaxed. As the session progressed, the young person began to take part in sketching and shared activities, gradually building trust and confidence. Over time, they became more comfortable engaging in conversation and began to talk more openly about their interests and experiences since arriving in the area.

The setting also created a safe and non-judgemental opportunity to share health information. Translation resources were introduced, helping to build confidence that appropriate support would be available when accessing healthcare services. The young person later described the session as one of the most positive and enjoyable information sessions they had attended.

Following this initial engagement, the young person reconnected with a local youth group facilitated by People Speak Up. This was a significant step, as they had previously experienced racism and felt isolated within the community. Since re-engaging, the young person has started to build local relationships and participate more confidently in group activities.

This case highlights how creative, community-based approaches can help reduce isolation, build trust and support access to services for young people who may otherwise be excluded.



Supporting our Gender Diverse Communities

Why is this important

National policy and recent legal developments have created increased complexity in how organisations support gender diverse individuals within both workplaces and healthcare settings. The UK Supreme Court ruling in *For Women Scotland Ltd v The Scottish Ministers* and subsequent EHRC guidance have highlighted the need for NHS organisations to carefully balance legal compliance with inclusive, person-centred care.

At the same time, feedback from staff networks and wider engagement activity shows that gender diverse staff and patients can experience barriers, including misunderstanding, inconsistent practice and lack of clarity in processes and environments. This creates a need for clear guidance, informed decision-making and ongoing staff education to ensure that care remains inclusive, respectful and safe.

What we have done

During 2025–2026, the Health Board has taken a structured and proactive approach to strengthening support for gender diverse communities, with a focus on governance, engagement and staff capability.

The Health Board has updated its LGBTQ+ Local Action Plan, working closely with staff networks to ensure that actions are grounded in lived experience and aligned with national priorities. This has strengthened clarity, accountability and the ability to monitor progress over time.

A key area of focus has also been improving staff awareness and confidence. LGBTQ+ awareness training, with a particular emphasis on trans identity and gender expression, has been commissioned and delivered during the reporting period. This has been supported by the development and promotion of practical resources to help staff use inclusive language and better understand the experiences of gender diverse individuals.

The impact of what we have done

This work is beginning to strengthen how the Health Board understands and responds to the needs of gender diverse staff and patients. There is increased awareness at both Board and operational level of the complexities involved alongside clearer recognition of the need to balance legal requirements with inclusive practice.

Engagement with staff networks has helped ensure that lived experience is central to decision-making. This has improved the relevance of action plans and strengthened trust and collaboration between staff and the organisation. It also marks a shift towards more co-produced approaches, where solutions are shaped by those directly affected.

Early feedback from training indicates that staff feel more confident in understanding gender identity, using appropriate language and supporting gender diverse colleagues and patients. This is helping to create safer, more respectful working environments and improving day-to-day interactions.

Overall, progress during this period has focused on building strong foundations, including governance, understanding and capability. While the full impact will take time to realise, these steps are supporting a more informed, inclusive and coordinated approach to meeting the needs of gender diverse communities. Long-term impact is expected to be reflected in improved staff and patient experience, including through staff survey data and feedback from LGBTQ+ communities.

Pilot Women's Health Hub Initiative

Why is this important

Women's health outcomes in Wales have historically been poorer in key areas, with many conditions under-diagnosed, under-treated or not consistently prioritised. Feedback from women has highlighted difficulties accessing timely care, particularly for menopause, menstrual health and contraception, as well as wider concerns about fragmented services and lack of continuity of care.

The Welsh Government's Women's Health Plan set out a clear commitment to address these inequalities by improving access to specialist support and bringing services closer to communities. The introduction of women's health hubs forms a key part of this response, aiming to provide more coordinated, accessible and person-centred care across the life course.

What we have done

During 2025-2026, Hywel Dda University Health Board continued implementation of the NHS Wales Women's Health Plan and successfully established a Women's Health Hub pilot based within the Sexual Health Integrated Building in Aberystwyth. The pilot has provided valuable learning to inform the future development of a wider Women's Health Hub model across the Health Board.

While a network of cluster-based Women's Health Hubs has not yet been established across Hywel Dda, significant progress has been made in laying the foundations for future implementation. This has included developing an integrated hub model, strengthening pathway design and establishing a clearer interface between primary, community and secondary care services.

A major focus during the year has been workforce development. Accredited training programmes were delivered to GPs, practice nurses, community staff, midwives and health visitors, increasing local capability in menopause care, menstrual health, contraception, coil fitting and pessary services. This work is helping to build the skills needed to deliver more women's health services within community settings and closer to home.

The Health Board has also developed a multidisciplinary approach to women's health, bringing together expertise from primary care, gynaecology, physiotherapy, psychology and bladder and bowel services. Work has commenced on developing a single point of access model, supported by virtual triage and care navigation arrangements, which will help women access the right service at the right time.

This work supports the wider "shift left" principle within the NHS Wales Women's Health Plan, aiming to move appropriate care from hospital-based services into primary and community settings wherever clinically appropriate.

The impact of what we have done

As the programme remains in the early stages of implementation, the primary impact during 2025-2026 has been the establishment of the infrastructure, partnerships, workforce capability and governance arrangements needed to support future transformation.

The Aberystwyth pilot has demonstrated strong professional engagement and provided valuable insight into how a future Women's Health Hub model could operate within Hywel Dda. Learning from the pilot is informing plans for the development of cluster-based hub arrangements and integrated women's health pathways across the Health Board.

The longer-term ambition is to improve access to women's health services, reduce avoidable referrals into secondary care, strengthen Self-Management and improve patient experience through more coordinated pathways. Future impact will be measured through the development of a dashboard that will incorporate patient-reported outcome measures (PROMs), patient-reported experience measures (PREMs), access measures and pathway performance indicators.

Overall, the work undertaken during 2025-2026 has established a strong foundation for the future rollout of a more integrated, community-based Women's Health Hub model across Hywel Dda.

Highlight

The Menopause Café is a peer support network that meets regularly via MS Teams, providing a safe and inclusive space for staff to share experiences, access support, and increase understanding of menopause. Each session forms part of the *Menopause Journey* series and features a guest speaker who provides expert insight into the stages and impacts of menopause. One session was specifically designed for partners, colleagues and managers, helping them understand the impact of menopause and how best to support those experiencing it.

Members are encouraged to engage openly by submitting questions to speakers, either in advance or anonymously during sessions. To ensure continued access to information and support, all sessions are recorded and made available on the SharePoint page as an ongoing resource for staff.

The network is open to all staff, including those who are peri-menopausal, menopausal, or supporting someone experiencing menopause at home or in the workplace.

During 2025/26, membership of the Menopause Café increased to 330 members, representing an increase of 115 people (53.5%). A total of six sessions were delivered throughout the year, reflecting the continued growth and positive impact of the network across the organisation.

Re-launch and strengthen the Health Equity Group

Why is this important

Persistent health inequalities remain across Hywel Dda, particularly for communities experiencing poverty, deprivation and wider social disadvantage. These inequalities affect access to services, experience of care and long-term health outcomes.

There is a clear need for a more coordinated and systematic approach to embedding equity across all areas of service planning, delivery and decision-making. Re-establishing the Health Equity Group provides a structure to bring together partners, align priorities and ensure that reducing inequalities is a shared responsibility across the system.

What we have done

During 2025–2026, the Health Equity Group has been re-established, with governance arrangements strengthened to provide clearer leadership and direction. The group

reconvened in October 2025 and has since supported a more coordinated, system-wide approach to tackling health inequalities.

A key area of focus has been embedding equity into prevention and service planning. This includes supporting delivery of the 20four7 prevention framework, targeting the 20% most deprived communities, and ensuring that equity is consistently considered in planning decisions.

New tools and approaches have also been introduced to strengthen this work. The development of an Equity Focused Health Impact Assessment tool is supporting services to assess how their activity may affect health inequalities. The Population Health Dashboard has improved access to data, enabling better understanding of local need and supporting more targeted interventions.

Partnership working has continued to develop through the Social Model for Health and Wellbeing programme, alongside closer alignment with related initiatives such as the Vaccine Equity Group. Training, including poverty awareness, has also been delivered to build shared understanding and capability across staff and partners.

The impact of what we have done

The re-establishment of the Health Equity Group is helping to embed equity more clearly within organisational culture and practice. There is increasing expectation that services demonstrate how they are addressing inequalities, supported by improved tools, data and governance.

The introduction of the impact assessment tool and Population Health Dashboard is strengthening decision-making. These approaches are enabling teams to better identify where inequalities exist and to target actions more effectively.

Partnership working has also improved, with stronger collaboration across health, local authorities and third sector organisations. This is supporting more coordinated responses to complex issues such as poverty and access to care.

There are early signs of a shift towards more community-focused and preventative approaches, particularly through the focus on the most deprived communities. Staff report increased awareness of the wider determinants of health and greater confidence in considering equity in their work.

While this work is at an early stage, it provides a stronger foundation for reducing health inequalities and supporting more equitable outcomes over time. Longer-term impact will depend on sustained delivery and continued alignment across programmes and partners.

Spotlight on: Embedding a person-centred approach

Our Aim

Our staff use the Health Board values to deliver a person-centred approach in everything they do.

Anticipated Outcome

- Staff will have access to training and development opportunities to enhance their knowledge of equality, diversity and inclusion.
- Staff will have an awareness and understanding of the individual needs of our service users and diverse population and strive to meet those needs.
- We will actively engage with and listen to the diverse population that we serve, and ensure their needs are at the centre of all that we do.

This section summarises work carried out across the Health Board and outlines progress against our Strategic Equality Plan objective: Embedding a person-centred approach.

Person Centred Approach training

Why is this important

Delivering equitable, high-quality care relies on staff understanding how to tailor services to individual needs rather than applying a one-size-fits-all approach. The Person-Centred Approach training supports this by reinforcing key principles of equality, dignity and respect, alongside legal responsibilities under the Equality Act and Public Sector Equality Duty.

Feedback from staff and wider organisational priorities highlight the need to strengthen understanding of unconscious bias, recognise the impact of individual experiences, and ensure that people's needs, preferences and identities are considered in all interactions. Embedding this approach from induction onwards is essential to building a consistent and inclusive culture across the Health Board.

What we have done

During 2025–2026, the Person-Centred Approach training programme has continued to be delivered as a core element of staff induction and ongoing development. 11 sessions were delivered during the reporting period, reaching 166 staff.

During this period, the EDI team completed a full refresh of the training programme. This included significant updates to both the delivery style and content to ensure that the training remains relevant, practical and aligned to current organisational priorities. The

refreshed sessions place greater emphasis on interactive learning, using case studies, group discussion and reflection to help staff apply learning in real-life scenarios.

The programme continues to cover key areas including equality legislation, protected characteristics, unconscious bias and equitable treatment. It also strengthens signposting to staff networks, support services and additional learning opportunities, helping staff understand where to access further guidance and support.

Regular evaluation continues to inform ongoing improvement of the training, ensuring that it remains responsive to staff feedback and organisational need.

The impact of what we have done

The refreshed training is helping to strengthen staff understanding of what a person-centred approach means in practice and how it applies to their role. Feedback indicates that staff are more confident in adapting their approach to meet individual needs and in recognising how unconscious bias can influence behaviour.

Evaluation data shows that a significant proportion of participants report increased knowledge, with the majority indicating that they intend to apply their learning in their daily practice. This includes improving communication, involving individuals in decisions and considering the impact of services on different groups.

The revised delivery approach has supported greater engagement, with interactive elements enabling staff to reflect on their own practice and learn from others. This is contributing to more consistent and inclusive behaviours across teams.

Embedding the programme within induction continues to ensure that new staff have a clear understanding of expectations from the outset. This supports a shared organisational approach to person-centred care.

Overall, the training is contributing to a wider cultural shift towards more inclusive, respectful and responsive care. While impact is currently based on participant feedback, it provides a strong foundation for improving both staff experience and patient care over time.

To date 75% of attendees reported that they had increased their knowledge and 94% of attendees report that they would be applying their learning daily. Feedback from participants includes:

“A good refresher session. Having been with the HB for 10 years, you can lose focus on these areas trying to get through the day-to-day”

“A reminder of the importance of being respectful, understanding and patient. New information in terms of what NHS offers that I didn't know about before.”

“I had already done this course as a part of my induction last year and I found it very valuable; it was good to have a refresher though being more established in my role.”

Accessible Communication and Information Standards (ACIS)

Why is this important

Accessible communication is essential to delivering safe, effective and person-centred care. The Welsh Government introduced the Accessible Communication and Information Standards (ACIS) to ensure that communication barriers are removed and that people can access, understand and engage with healthcare services.

The updated standards broaden the original focus on sensory loss to include a wider range of communication needs. This includes people whose first language is not English or Welsh, individuals with disabilities or neurodivergence, those with low literacy, and carers who may also require support.

Without consistent approaches to identifying and responding to these needs, patients may struggle to understand information, access services or make informed decisions. This can lead to poorer outcomes and inequalities in care.

What we have done

During 2025–2026, the Health Board has focused on preparing for the implementation of ACIS and embedding accessible communication more consistently across services.

Significant work has been undertaken to raise awareness of the new standards. A dedicated SharePoint page has been developed, providing staff with guidance, resources and accessible materials, including Easy Read and British Sign Language (BSL) content. This has been supported by wider communication activity across internal platforms and direct engagement with senior leaders and operational teams.

Governance arrangements have been strengthened through the establishment of an ACIS Stakeholders and Implementation Group. This group has brought together partners from across the organisation to review current practice, identify gaps and agree responsibilities for implementation and reporting. Workshops linked to this group have helped highlight both strong practices, such as the provision of information in alternative formats, and areas requiring further development.

Practical tools and systems have continued to be developed and refined. The Sensory Loss Aware Self-Assessment (SLASA) Checklist has been updated to align with the broader scope of the new standards and is being used to support local assessments of communication accessibility and service improvement.

There has also been continued focus on improving how communication needs are identified and recorded. Staff guidance for recording communication needs within systems such as Wales Patient Administration System (WPAS) has been widely shared, supporting more consistent documentation and visibility of patient requirements.

Alongside this, services have continued to strengthen accessible communication in practice. This includes:

- Increased use of alternative contact methods, including digital platforms, email and text
- Greater use of interpretation and translation services

- Expansion of accessible information formats, such as large print, Easy Read and audio
- Improvements to appointment systems, allowing more flexible access based on individual need

Staff awareness and capability have been strengthened through a mix of training and awareness activity. This includes neurodivergence training with a focus on communication skills, structured learning sessions to build knowledge and targeted campaigns such as Deaf Awareness Week.

The impact of what we have done

This work is contributing to a more consistent and proactive approach to accessible communication across the Health Board. Staff are increasingly recognising the importance of asking about, recording and acting on communication needs, helping to ensure that individuals receive information in a way they can understand.

There is evidence of improved accessibility in service delivery. Patients are now able to access services through a wider range of communication channels, reducing reliance on traditional methods such as telephone contact and improving access for those with additional needs.

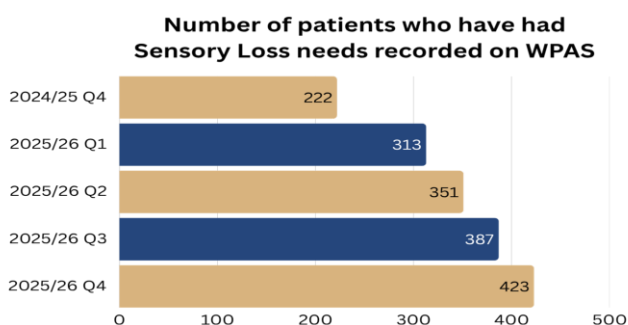
The use of tools such as the SLASA Checklist and improved data recording is beginning to support more informed decision-making. Services are better able to identify gaps in accessibility and take targeted action to address them.

Partnership working has also strengthened, with collaboration across teams, third sector organisations and service areas supporting a more joined-up approach to meeting communication needs.

Highlight

WPAS Sensory Loss Marker

The Patient Administration System for Wales (WPAS) features a sensory loss marker to highlight patients' communication needs. To promote its use, the Health Board continued to raise awareness of the WPAS Recording of Sensory Loss staff guide through our Viva and partnership forums. Through training and awareness initiatives, staff have actively collected and recorded patient communication preferences, leading to a significant increase in recording patients who have a sensory loss. As of the 31st March 2026, 423 patients were recorded on WPAS, an increase by 201 or 90.54% since 31st March 2025.



Case Study

Learning Disability Packs in Emergency Care

People with learning disabilities can face barriers when accessing emergency care, particularly in busy and unfamiliar environments. This can lead to increased anxiety and difficulties understanding what is happening during their visit.

To address this, Hywel Dda University Health Board introduced Learning Disability Packs, designed to provide clear, accessible information and reassurance during emergency care. The packs were first piloted in the Emergency Department at Glangwili Hospital. Following positive feedback, the initiative was rolled out across all acute sites in Carmarthenshire, Ceredigion and Pembrokeshire, including A&E departments and the Acute Medical Assessment Unit.

The packs include easy-read information, pictures and symbols, explanations of what will happen during the visit, and guidance on who staff are and how they can help. Patients, carers and families can request a pack on arrival, supporting timely access to information.

The Learning Disabilities Team worked closely with frontline staff to support implementation. This included awareness sessions, local promotion and embedding the packs into routine practice. The initiative also encourages the use of Health Profiles, helping staff better understand individual needs and make appropriate adjustments.

Early impact suggests the packs are helping to reduce anxiety and improve understanding for patients with learning disabilities. Staff report increased confidence in providing person-centred care, supported by clearer communication and better awareness of individual needs.

This initiative shows how simple, practical changes can make emergency care more accessible and inclusive. It supports the Health Board's wider aim to reduce inequalities and ensure that services respond to the needs of all patients.



Further information on the Health Boards introduction of Learning Disability Packs can be found [here](#).

Improving the health of veterans

Why is this important

Veterans can experience specific health needs linked to their service, including physical injury, mental health challenges and difficulties transitioning to civilian life. There is also a recognised risk that veterans may face disadvantage in accessing care if their status is not identified or understood.

The Armed Forces Covenant sets out a clear commitment that those who have served should face no disadvantage in accessing healthcare, with additional consideration given where conditions relate to military service. Embedding this principle within services is essential to ensure equitable access, consistent practice and improved outcomes for veterans and their families.

The Health Board serves approximately 382,800 people in West Wales, and the 2021 census recorded that 15,637 (4.08%) had served in the UK Armed Forces. As of March 2026, the Health Board employs 151 staff members who have declared their armed forces status.

What we have done

During 2025–2026, the Health Board has strengthened its approach to improving the health and wellbeing of veterans through a coordinated programme led by the Business, Partnerships and Inclusion team.

A key focus has been improving identification and visibility of veterans across services. This includes promoting consistent recording of veteran status within GP systems and WPAS, supported by staff guidance and targeted awareness activity. As a result, there has been a steady increase in the number of veterans identified across both primary and secondary care settings.

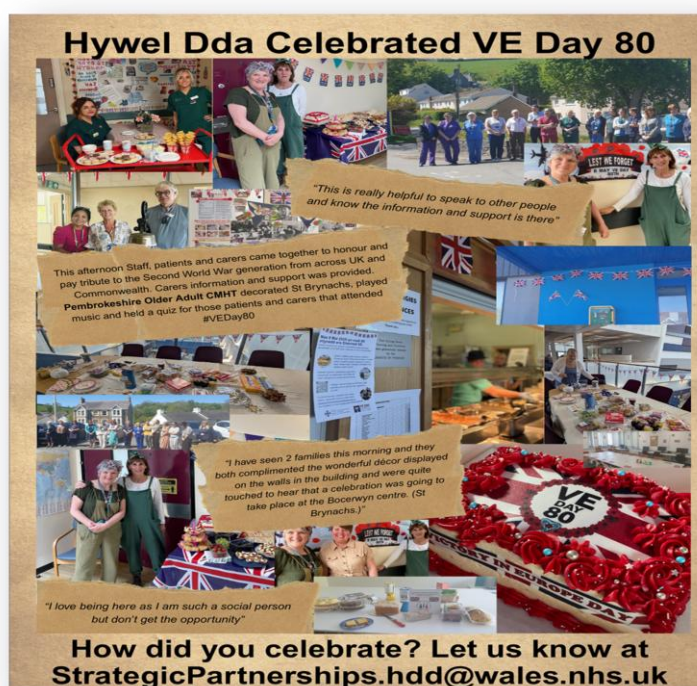
Work has also progressed to better understand veterans' needs and experiences. This includes targeted research into substance misuse and mental health pathways, alongside engagement and feedback mechanisms to capture veterans' experiences of care. Findings have helped identify gaps in awareness, consistency and access, informing ongoing service improvement.

Staff capability has been strengthened through the review and refresh of the national Armed Forces Covenant e-learning module. The updated training provides clear guidance on identifying veterans, understanding their needs, and applying priority treatment appropriately.

Partnership working has remained central to delivery. The Health Board continues to work with third sector organisations, local authorities and national partners to improve access to services and reduce disadvantage. Community-based outreach activity has increased, providing health information, signposting and practical support to veterans, including those experiencing socioeconomic challenges.

VE Day 80

2025 marked the 80th anniversary of the VE (Victory in Europe) Day. The Health Board celebrated with the nation by coming together to honour and pay tribute to veterans of the Second World War and their families through various events including Fish and Chips Day at all hospital canteens, board displays in service areas, and tea and cakes within teams and services.



Primary care has also been strengthened through increased uptake of the Health Education and Improvement Wales (HEIW) Veteran-Friendly Practice scheme, alongside improvements in planned care pathways. This includes clearer guidance for staff on managing veterans' care and applying priority treatment considerations.

The impact of what we have done

This work is improving the visibility of veterans within the health system, which is a critical first step in delivering equitable care. Increased identification and recording means that staff are better able to recognise veteran status and apply appropriate support, including priority treatment where relevant.

Staff knowledge and confidence is also improving. The refreshed training and targeted resources are helping to build a more consistent understanding of the Armed Forces Covenant and how it applies in practice.

Partnership working and outreach activity are strengthening access to support, particularly for veterans who may be less likely to engage with traditional services. This is helping to reduce barriers and ensure that veterans receive timely, appropriate care and wider support.

At an organisational level, the work demonstrates that Armed Forces Covenant principles are becoming more embedded within governance, service delivery and workforce practice. This is supporting progress towards more equitable outcomes for veterans and the wider Armed Forces community.

Highlight

Armed Forces Covenant Health Action Plan (2024–2026)

The Health Board refreshed its Armed Forces Covenant Health Action Plan outlining key priorities for 2025 – 2026. The Action Plan is a dynamic document and is coordinated by the Business, Partnerships and Inclusion team in partnership with our Armed Forces champions and is continually shaped and informed by discussions within the Armed Forces Covenant Steering Group, Armed Forces Staff Network, and various local, regional and national partnership forums. It sets out the Health Board objectives and actions in line with the Covenant, relevant accreditation schemes, and other Health Board's strategic objectives such as the Strategic Equality Objectives. The actions set out in the Action Plan are regularly reviewed and are delivered by working collaboratively with colleagues within the organisation as well as with the public and the voluntary sector partners.

The Health Board priorities for this reporting year are:



Supporting our Faith Groups - Enhancing Holistic Care and Organisational Support

Why is this important

Providing inclusive care means recognising and responding to people's spiritual, religious and cultural needs alongside their physical health. For many individuals, faith and belief are central to how they understand illness, make decisions and cope with difficult experiences, particularly at times of crisis or end of life.

There is also a clear organisational responsibility to ensure that services are respectful of different faiths and beliefs, including those who identify as non-religious. Without this, there is a risk of unmet needs, poorer experience and inequity in care. Supporting faith groups therefore forms an important part of delivering truly person-centred and equitable healthcare.

What we have done

During 2025–2026, the Chaplaincy service has continued to play a central role in supporting patients, families and staff across the Health Board. The service provides inclusive, person-centred support for individuals of all faiths and beliefs, including those with no religious affiliation.

The team has supported a wide range of faith-based needs in practice. This includes facilitating religious observance such as Ramadan, Lent, Diwali and Christmas, and ensuring that cultural and spiritual needs are considered within care planning. The Chaplaincy team also provides advice and guidance to staff on faith-related healthcare issues, helping teams respond appropriately to diverse needs.

Chaplaincy continues to contribute to wider organisational life through the delivery of reflective spaces, commemorative events and responses to significant moments. During this period, this included Remembrance activity and marking the five-year anniversary of the COVID-19 pandemic, alongside support during global and local events that impact staff and patients.

At end of life, the service works closely with multidisciplinary teams, funeral directors and registrars to support families. This helps ensure that care is delivered with dignity and respect, while also easing practical and legal processes for families and reducing pressure on clinical services.

Highlight

Key event - Remembrance Day event

On Remembrance Day, services were held across the Health Board to honour Veterans and the wider Armed Forces community, with strong staff attendance, including at Prince Philip Hospital. Thanks are extended to Euryl Howells and the Spiritual Care Team for leading the services, and to all staff who showed their support.



The service operates as part of a multidisciplinary approach, providing expertise on spiritual, cultural and social aspects of care to complement clinical practice and support holistic care delivery.

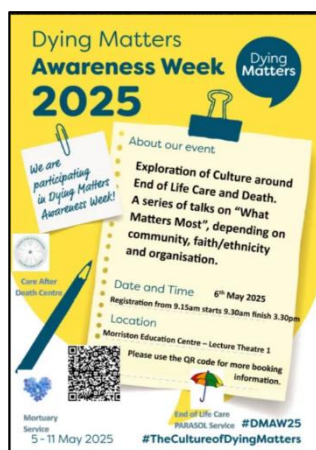
The impact of what we have done

This work is helping to ensure that care across the Health Board is more inclusive and responsive to the needs of diverse communities. Patients and families are better supported to express and meet their spiritual and cultural needs, particularly at key points such as illness, bereavement and end of life.

Staff are also benefiting from increased access to advice, guidance and reflective support. This helps build confidence in responding to faith-related needs and supports staff wellbeing, particularly during challenging periods.

The presence of Chaplaincy within multidisciplinary teams is strengthening a more holistic approach to care. By considering spiritual, cultural and social factors alongside clinical needs, services are better able to provide personalised and compassionate care.

There are early signs of a continued cultural shift towards recognising the importance of spiritual care as part of overall health and wellbeing. The service's flexibility and responsiveness also ensure that it can adapt to increasingly diverse beliefs and needs across the population. You can find further information on the health boards Spiritual Care Department through the following link: [Spiritual Care Department - here for your journey](#)



Supporting unpaid carers

Why is this important

Unpaid carers play a vital role in supporting the health and wellbeing of individuals across West Wales. Many provide significant levels of care, often alongside employment or other responsibilities, and may experience impacts on their own physical, emotional and financial wellbeing.

There is a clear system-wide responsibility to identify, recognise and support unpaid carers early, ensuring they can access timely help and continue in their caring role where they choose to do so. This work is aligned to the West Wales Strategic Plan for Unpaid

Carers 2025–2030, which focuses on two core priorities: ensuring carers are visible and valued, and that carers are supported.

What we have done

During 2025–2026, the Health Board has continued to strengthen its approach to supporting unpaid carers through partnership working, workforce development and targeted service improvements.

The Investors in Carers (IiC) scheme remains a key driver of this work. It focuses on early identification, staff training and building a network of Carer Champions across health, social care, education and the voluntary sector. During the year, significant numbers of carers have been identified and referred for support, while staff engagement with training has increased knowledge and confidence in recognising carers and signposting them to appropriate help.



Training and awareness have been a central focus. A wide range of carer awareness sessions have been delivered across multiple settings, alongside the ongoing rollout of mandatory Carer Aware e-learning for all staff. This ensures a consistent baseline understanding of the role and needs of unpaid carers across the workforce.

Examples of feedback from staff attending the carer awareness training include:

“I found the session really engaging, very helpful and informative and gained more of my knowledge about unpaid carers and how to support them.”

“Excellent presentation – Staff thoroughly enjoyed and are now confident in signposting unpaid carers for further help and support.”

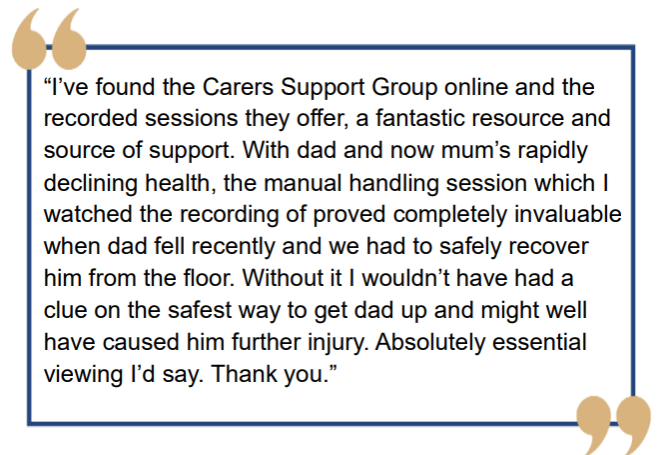
“The training was very informative and highlighted the impact that caring can have on the individual is providing unpaid caring roles.”

Since May 2023, the Carer Aware e-learning programme has been mandatory for all Health Board staff. As at 31st of March 2026, 92% of staff had completed the training, which demonstrates strong organisational engagement and providing assurance that much of the workforce has a core understanding of who unpaid carers are and why their identification and support is essential.

Partnership working has continued to strengthen support available to carers within the community. The Health Board works closely with local authorities and third sector organisations to deliver Carers Information and Support services. These services have reported increased identification and engagement with unpaid carers, with more individuals receiving advice, guidance and practical support.

Targeted support has also been developed at key points of care, particularly within hospital discharge pathways. Dedicated Carer Officers work alongside clinical teams to identify carers early; involve them in decision-making and ensure they are supported to care safely at home.

Support for staff who have caring responsibilities has also been strengthened. This includes promotion of working carer registration through ESR, delivery of line manager training, and ongoing facilitation of a Staff Carers Peer Support Network. Regular engagement and survey feedback have been used to inform improvements to organisational support.



"I've found the Carers Support Group online and the recorded sessions they offer, a fantastic resource and source of support. With dad and now mum's rapidly declining health, the manual handling session which I watched the recording of proved completely invaluable when dad fell recently and we had to safely recover him from the floor. Without it I wouldn't have had a clue on the safest way to get dad up and might well have caused him further injury. Absolutely essential viewing I'd say. Thank you."

Accessible information and signposting have been enhanced through platforms such as the Carers Support West Wales website, providing a central source of up-to-date advice and resources for carers and staff. The link to the platform is here: [Carers Support West Wales | Cymorth Gofalwyr Gorllewin Cymru](#).

The impact of what we have done

This work is improving the visibility of unpaid carers across the Health Board and wider system. More carers are being identified earlier, allowing them to access support before reaching crisis point.

Staff confidence and capability have increased, supported by training and clear guidance. This is helping to embed carer-aware practice into everyday interactions across services, ensuring carers are recognised and involved appropriately in care planning.

Partnership working and commissioned services are enabling more carers to receive timely advice, information and practical support. There is evidence of increased numbers of carers being supported, alongside improvements in wellbeing outcomes such as feeling informed, listened to and supported.

Support for working carers is also improving. Increased self-identification, peer support activity and targeted training for managers are contributing to a more open, inclusive and supportive workplace culture.

Overall, this work is contributing to a broader cultural shift. Unpaid carers are increasingly recognised as partners in care, and their needs are being considered more consistently within service delivery, workforce practice and system planning.

Spotlight on: Being an employer of choice

Our Aim

We will offer equal opportunities for employment and career progression and support the health and well-being of our staff and volunteers within a fair and inclusive environment.

Anticipated Outcome

- Staff and volunteers are encouraged to develop and progress in their roles and are supported in their health and well-being.
- Any inequalities, unfair practice and bullying and harassment are identified and addressed promptly.
- The Health Board's commitment to being an inclusive employer is visible, and staff are able to be their true selves at work.

This section summarises work carried out across the Health Board and outlines progress against our Strategic Equality Plan objective: Being an employer of choice.

Celebrating Diversity

Why is this important

Celebrating diversity helps create an inclusive workplace where staff feel recognised, respected and valued. It also improves cultural awareness, helping staff understand the experiences of colleagues and the communities they serve.

Without consistent awareness activity, there is a risk that important cultural, religious and identity-based events are overlooked. This can limit understanding and reduce opportunities to promote inclusion across the organisation.

What we have done

During 2025–2026, the Business, Partnerships and Inclusion Team has continued to deliver a coordinated programme of awareness activity.

The annual Diversity Calendar and monthly 'What's On' newsletter remain central to this approach, helping teams identify key events and encouraging engagement across the organisation.

Several awareness campaigns and events were supported during the year. These include:

- **Black History Month 2025**, promoting the theme *Standing Firm in Power and Pride*. Activity included sharing learning resources, promoting anti-racism training, and highlighting relevant materials and staff networks.

- **Pride Month 2025**, with staff attending local Pride events to increase visibility and allyship. Access to the Enfys (LGBTQ+) staff network was also expanded, enabling staff to connect using personal devices.
- **International Women's Day 2026**, promoting the theme of gender equality and collaboration. Activity included sharing local and national events, resources and opportunities for staff to engage with discussions on equity and inclusion in health and care.
- **Neurodiversity Celebration Week**, raising awareness and understanding of neurodivergence. This included sharing resources, promoting learning opportunities and supporting wider engagement through staff networks and communications.

All activity has been supported through internal communication channels, helping ensure consistent visibility across services.

The impact of what we have done

This work is helping to improve awareness and understanding across the workforce. Staff have more opportunities to engage with diversity and inclusion activity and to learn about different communities and experiences.

Participation in national campaigns such as Pride, Black History Month and International Women's Day has strengthened visibility and demonstrates the Health Board's ongoing commitment to inclusion.

The structured approach, through the Diversity Calendar and regular communications, is supporting more consistent engagement across teams and helping to embed awareness into day-to-day practice.

There are also early signs that this activity is supporting wider engagement with staff networks and learning resources, contributing to a more inclusive culture.

Supporting Pride events

Highlight

Members of the Business, Partnerships and Inclusion team alongside members of the Health Board's Enfys LGBTQ+ staff network represented the Health Board at several local Pride events, including PRIDE Cymru (Cardiff), Swansea Pride and Carmarthen.

Other speciality services, including Immunisations and vaccinations, midwifery, Community Development Outreach Team and the Wellbeing Team attended various events to promote the Health Board's commitment to LGBTQ+ communities both as an employer and as a healthcare provider. During Pride events members of the public were able to access health promotion information, discuss any matters of concern and seek advice.



Diwali Celebration Unites Cultures at Hywel Dda Health Board

On Sunday 26th October 2025, Hywel Dda University Health Board hosted its annual Diwali celebration, a vibrant and inclusive event jointly organised by the Diversity and Inclusion team and members of the Black, Asian, and Minority Ethnic Staff Network. The gathering reflected the Health Board's ongoing commitment to fostering cultural awareness and promoting inclusivity across its workforce.

Held at Glien House, the venue was transformed into a radiant celebration space, adorned with colourful Rangoli designs, flickering Diyas, and traditional decorations that beautifully captured the essence of Diwali, the triumph of light over darkness.

The evening commenced with a warm welcome and an insightful presentation on the significance of Diwali, offering attendees a deeper appreciation of its customs, symbolism, and spiritual meaning.

This year's programme featured captivating performances of classical Indian dance and music, which brought energy and joy to the room. Interactive games and a themed quiz added a lively and engaging element, encouraging laughter and connection among colleagues.

A standout moment of the evening was the multicultural feast, with staff members generously sharing homemade dishes representing a rich tapestry of cultural backgrounds. The diverse flavours and aromas celebrated not only Indian cuisine but also the broader heritage of the Health Board's community, turning the meal into a shared experience of unity and appreciation.

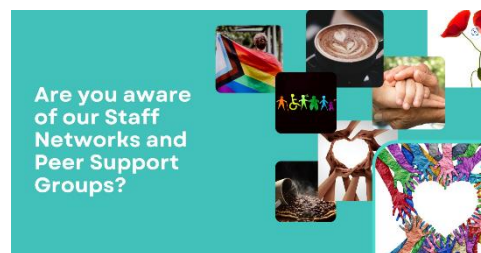
More than just a festive occasion, the 2025 Diwali celebration served as a powerful reaffirmation of the Health Board's values. By embracing cultural traditions and encouraging cross-cultural dialogue, the event strengthened interpersonal bonds and highlighted the importance of inclusivity in the workplace. It stood as a glowing example of how shared celebrations can cultivate understanding, respect, and joy among colleagues.



Staff Networks

Why is this important

Staff networks play an important role in creating an inclusive workplace where people feel supported, valued and able to contribute. They provide safe spaces for peer support, while also giving staff a voice in shaping organisational culture, policies and services.



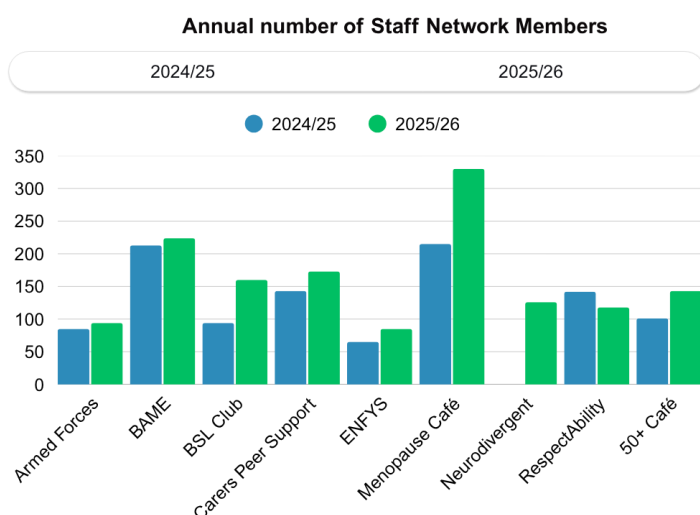
They are particularly important for groups who may experience barriers or inequality, ensuring lived experience informs decision-making and helping the organisation respond to diverse staff needs.

What we have done

During 2025–2026, the Business, Partnerships and Inclusion Team has continued to support and grow a diverse range of staff networks. These include the Armed Forces Network, Black, Asian and Minority Ethnic Network, Enfys (LGBTQ+) Network, Menopause Café, RespectAbility and Neurodivergent staff Networks and Unpaid Carers Network.

Each network provides a space for peer support, shared learning and engagement. Regular sessions have included guest speakers on topics such as wellbeing, menopause, Access to Work and health board services, shaped by feedback from members.

Membership and engagement across all staff networks have increased, with more staff getting involved in network activity and contributing to a stronger and more inclusive organisational culture.



*During 2025/26 the RespectAbility staff network made the decision to split into two separate networks and the Neurodivergent staff network was established. The RespectAbility network still meets for staff who have a chronic or long-term condition.

Networks have also played an active role in organisational engagement. This includes contributing to consultations such as the Anti-Racist Action Plan and LGBTQ+ Action Plan, ensuring lived experience informs strategic priorities.

The impact of what we have done

Staff networks are helping to create a more inclusive and supportive workplace culture. They provide safe spaces for staff to share experiences, build connections and access support.

There is evidence of increased engagement, with growing membership across networks and strong participation in events and discussions. This is helping staff feel more valued and connected to the organisation.

The networks are also strengthening organisational learning. Feedback from members is informing policy development, consultation responses and local action plans, ensuring that decisions reflect lived experience.

Importantly, networks are supporting wellbeing. By providing access to peer support, they are helping staff manage challenges both inside and outside of work, from caring responsibilities to long-term health conditions.

Overall, this work is contributing to a more open, inclusive and responsive organisation, where staff feel able to be themselves and influence change.

Case Study

Staff story

A line manager raised questions about how best to support a newly appointed apprentice joining their team. The new starter was a young Muslim man with specific faith-based needs, including time for prayer and access to culturally appropriate support. Rather than waiting for issues to arise, teams across Future Workforce, Operational Workforce, Culture and Diversity and Inclusion worked together with clinical colleagues in advance of the new staff members start date.

The health board has an established process for supporting new starters through a “buddy scheme” and a local physiotherapist volunteered to act as a point of contact, sharing a welcome pack developed specifically to meet the needs of Muslim staff. This included information on prayer space, halal food options, local mosques, and community links. The discussions also prompted wider consideration of existing prayer facilities on site and how this information could be made more visible for future new starters.

Clear communication during the induction period reassured staff that support was in place without placing the burden on the apprentice to raise sensitive issues himself. The approach helped normalise conversations about faith, culture, and inclusion as part of everyday workforce practice.

Over time, the impact extended beyond the initial onboarding. The volunteer buddy supporting the apprentice strengthened links with existing staff, including colleagues from the Black, Asian and Minority Ethnic Staff Network, and became more connected locally by attending prayer services in the area. This helped reinforce a sense of belonging, not only for the new starter but also for staff involved in supporting him.

Equality, Diversity and Inclusion Training

Why is this important

Embedding equality, diversity and inclusion into everyday practice requires staff to have the right knowledge, skills and confidence. Training helps staff understand the experiences of people with protected characteristics, challenge discrimination and provide more inclusive care.

It also supports a culture where staff feel able to respond appropriately to difference, reduce bias and improve both staff and patient experience.

What we have done

During 2025–2026, the Health Board has delivered a wide-ranging programme of Equality, Diversity and Inclusion training, combining both mandatory and specialist learning.

A total of 59 specialist training sessions were delivered, alongside broader organisational programmes, reaching 1162 staff members. Topics included:

- Cultural awareness in healthcare
- Disability awareness and reasonable adjustments
- Anti-racism for Practitioners
- Religion and belief
- LGBTQ+ inclusion
- Trans Identity and Gender Expression Training
- Neurodiversity and sensory loss
- Carer awareness and menopause

This offer is supported by a growing library of online learning resources, including recorded sessions, podcasts and guidance materials, enabling staff to access training flexibly.

Mandatory training compliance has continued to improve across key areas. As of the end of March 2026:

- anti-racism training: 93.12%
- Learning Disability Awareness: 94.27%
- Autism Awareness: 94.27%
- Carer Awareness: 91.96%
- Equality, Diversity and Human Rights: 88.27%

The impact of what we have done

There is clear evidence that training is improving staff knowledge, confidence and behaviour. Staff report better understanding of equality issues and greater confidence in applying this in their roles.

A key area of impact is increased confidence in challenging inappropriate behaviour, including discrimination, bias and microaggressions. This is supporting a more open and respectful workplace culture.

Training has also improved practical capability, with staff reporting greater confidence in making reasonable adjustments, adapting communication and responding to individual needs. This is contributing to more consistent inclusive practice.

There has been a positive impact on patient care, with staff describing increased awareness of how culture, identity and lived experience shape interactions. This is helping to build trust, improve communication and reduce barriers to care.

More broadly, the training programme is supporting:

- Greater awareness and understanding of equality and inclusion
- Improved consistency in inclusive decision making
- Stronger empathy and understanding across teams
- A more inclusive organisational culture

Feedback from staff that attended these training sessions included:

It is wonderful to see the positive change in people when it comes to understanding and supporting transgender individuals. Educating people in this area is so important, and I truly hope the powerful and compassionate message that Heath shared continues to spread and encourage even more awareness, understanding, and acceptance.

Trans Awareness and Gender Expression Training

This session was a very informative and as a staff of a diverse background I felt very emotionally affected by how patients' treatment was affected because of their religion and culture/beliefs

Cultural Awareness Training

Given my own neurodiversity, it was a pleasure to see this training delivered in a practical, easy to understand format. During the breakout room, it was clear the course had challenged how staff thought about neurodiversity- both in terms of practical understanding, reflections on their own biases and their level of empathy. Thank you so much for helping me feel seen - I look forward to the next course

Neurodiversity Training

Appreciate having a platform to go in relation to Menopause and Alan expressing this is a natural and biological transition of change. It can easily feel like you are the only one with the symptoms and effects of menopause.

Menopause Café

Listening to our staff - Speak Up and Make Meaningful Change

Why is this important

A strong speaking-up culture is essential for patient safety, staff wellbeing and organisational learning. Staff need to feel safe to raise concerns, challenge poor practice and report incidents without fear of reprisal.

Embedding psychological safety supports openness, trust and early identification of issues. Without it, concerns may go unreported, impacting both staff experience and quality of care.

What we have done

During 2025–2026, the Speak Up and Make Meaningful Change initiative has continued to support cultural change across the Health Board. This includes promoting psychological safety, strengthening communication channels and ensuring staff have clear routes to raise concerns.



Practical resources and support have been made available to staff, including guidance for staff and leaders, access to Speak Up Guardians, and links to wellbeing services, ensuring multiple routes for raising concerns.

The Health Board has also introduced and embedded the Working in Confidence platform. This provides a secure, anonymous space where staff can raise concerns, ask questions or share feedback directly with senior leaders or support teams. The platform enables two-way communication while maintaining anonymity, making it easier for staff to raise sensitive issues such as bullying or discrimination. It complements existing channels and supports a more open and responsive environment.

To further strengthen support, a member of the Diversity and Inclusion Team has joined the network of Working in Confidence Champions. This ensures that concerns relating to equality, diversity and inclusion are supported with appropriate expertise and handled sensitively.

Alongside this, Organisational Development and Relationship Managers (ODRMs) have continued to support teams through a structured culture programme. Using a bespoke culture survey aligned to seven key themes, ODRMs have worked with 77 teams and engaged over 1,500 staff. This has been supported by over 750 staff taking part in culture conversations, helping to co-produce locally relevant improvement plans based on lived experience.

The 2025 NHS Wales Staff Survey highlights continued improvement across several key areas since 2023:

- 76.4% of staff feel that reporting errors and incidents is encouraged
- 84.5% of staff say they treat patients and service users with compassion
- 73% of staff feel their immediate manager recognises the importance of emotional wellbeing
- 53% of staff feel that those involved in incidents are treated fairly

The impact of what we have done

There is evidence of a strengthening culture of openness across the organisation. More staff report feeling encouraged to speak up, and improvements in perceptions of fairness and action suggest progress towards a more just culture.

The introduction of Working in Confidence has widened access to safe and confidential reporting, particularly for sensitive concerns. This is helping to reduce barriers and increase staff confidence in raising issues.

Staff engagement activity and the use of qualitative insights, such as personal stories, are helping the organisation better understand lived experience and identify areas for improvement.

ODRM-led culture work is also supporting more localised improvement, with staff actively shaping solutions based on their experiences. This is helping embed cultural change at team level, rather than relying solely on organisational initiatives.

Overall, this work is contributing to a more transparent and supportive environment, where staff feel increasingly empowered to raise concerns and contribute to improvement.

Equality Impact Assessment (EqIAs)

Why is this important

Equality Impact Assessments (EqIAs) are essential to ensure that decisions about policies, services and service changes are fair, evidence-based and inclusive. They help identify potential impacts on different groups, including the nine protected characteristics, as well as wider factors such as Welsh language, socio-economic disadvantage and the Armed Forces community.

A robust EqIA process supports better decision making, reduces the risk of unintended inequality and ensures the Health Board meets its legal duties while improving outcomes for the communities it serves.

What we have done

The Diversity and Inclusion Team has strengthened both the quality and consistency of EqIAs across the organisation. This has been supported by an enhanced package of tools, including a revised template, updated screening process, practical guidance, video resources and an improved scoring matrix. Staff feedback on these resources has remained positive, with users reporting greater clarity and confidence.

A strong focus has also been placed on training and capacity building. EqIA training continues to be delivered across departments and is embedded within the Enabling Quality Improvement in Practice (EQIIP) programme. Plans are in place to extend this further into programmes such as STAR and leadership development programmes.

The Diversity and Inclusion team provides active support and challenge through participation in policy approval groups and service redesign steering committees. This ensures equality considerations are built into decision making at an early stage, rather than being applied retrospectively.

During 2025–2026, the Diversity and Inclusion Team supported and quality assured 260 EqIAs, reinforcing its commitment to inclusive and equitable healthcare development and decision making.

The impact of what we have done

There is clear evidence of improvement in the quality, depth and consistency of EqIAs. Assessments are increasingly informed by relevant data and include more meaningful analysis, clearer mitigation actions and stronger links to population need.

The introduction of internal auditing has been particularly important. It is supporting a more consistent standard across the organisation, reducing variation in quality and strengthening confidence in the EqlA process. It also enables continuous learning, ensuring that good practice is identified and shared, and that feedback to services is more structured and effective.

EqlAs are increasingly being used as a decision-making tool, rather than a compliance exercise. This reflects a wider cultural shift towards more thoughtful, evidence-based consideration of equality impacts.

Training and governance arrangements are strengthening accountability, while improved engagement is ensuring a broader range of voices are considered in decision making. Overall, this work is embedding equality more firmly into everyday practice and supporting more inclusive and equitable service development.

Consultation and Engagement

Why is this important

Meaningful engagement with the public, staff and stakeholders is essential to ensure that decisions about services are informed, transparent and responsive to local needs. It helps the Health Board understand lived experience, build trust and ensure that changes are shaped by the people who use and deliver services. It is particularly important to hear from people who may face barriers to accessing services or who experience poorer health outcomes.

Listening to these voices helps the Health Board understand inequalities, shape services more effectively and ensure decisions are fair, transparent and inclusive.

What we have done

During 2025–2026, the Health Board has undertaken a wide programme of engagement activity linked to major service planning and development. This has included engagement on the Clinical Services Plan, urgent and planned care developments, and the wider Healthier Mid and West Wales strategy.

A range of specific consultations and engagement activity have been delivered, including:

- Prince Philip Hospital Minor Injuries Unit (MIU)
- Primary care developments in Pontyates and St David's
- Adult mental health referral pathways in North Ceredigion
- Carmarthen Hwb and Pentre Awel schemes
- Development of a new urgent and planned care hospital

Engagement has involved close working with local authorities, third sector organisations, clinicians, elected representatives and community groups, alongside direct engagement with patients, carers and people with lived experience.

A mixed-method approach has been used to improve accessibility, including face-to-face events, community outreach, public meetings and digital platforms. Equality monitoring

has supported a better understanding of who is engaging and where further outreach is needed.

Detailed equality monitoring has been used to track participation and ensure engagement reaches individuals across protected characteristics, as well as those who may be less likely to engage. The Diversity and Inclusion Team has supported targeted outreach to under-represented groups to ensure a broader range of voices are included.

Alongside this, the Health Board has strengthened how it listens to and uses feedback. The Civica Experience system is now fully embedded across services, supported by national surveys and the Friends and Family Test. A pilot with Public Health Wales in GP-managed practices has also strengthened engagement within primary care.

The introduction of the People's Experience Framework provides a structured approach to gathering inclusive feedback, particularly from groups who may find services harder to access. Feedback is routinely reported through governance structures and is increasingly being used to inform service design and assurance processes.

The impact of what we have done

This work is helping to create a more inclusive and responsive approach to engagement. There is clear progress in moving from engagement as a one-off activity to a more continuous process of listening and learning.

Lived experience and feedback are increasingly shaping EqlAs, service planning and decision making, ensuring that proposals reflect the needs of diverse communities and consider the impact on health inequalities.

The use of structured feedback systems has strengthened a culture where listening is part of everyday practice. There is greater visibility of how feedback is used, supported by reporting through governance groups and Board structures.

The focus on reaching under-represented groups, alongside varied engagement methods, is helping to reduce barriers and include a wider range of voices. This is particularly important in understanding the needs of those who traditionally struggle to access services.

Overall, this approach is supporting more transparent decision making, improved trust with communities and greater confidence in delivering complex service change.

Recognition and Awards 2025-2026

Hywel's Applause Awards 2025

The 2025 Hywel's Applause Awards celebrates the dedication, compassion, and ingenuity across Hywel Dda University Health Board.

The Awards have several categories including the Diversity, Inclusion and Belonging award. This category recognises individuals and teams who have championed equity, representation, and meaningful change across our organisation.

Winner: Clare Pound, Data Standards Manager, Digital Services

Clare has led a transformative approach to identifying and supporting vulnerable patients, implementing system changes that are both simple and profoundly effective. Her work has delivered lasting impact, ensuring that those most in need are recognised and cared for with greater precision and empathy.

Highly commended: Jennie McClymont (Workforce Advisor) for her work organising the Health Board's Diwali event, which brought staff together to celebrate and raise awareness of cultural diversity, and the Carers Team for their work supporting carers across the organisation, including providing advice, guidance and practical support.



Looking forward to 2026/27

This report highlights the breadth of work delivered during 2025–2026 to support the Health Board’s Strategic Equality Plan 2024–2028. It shows steady progress in embedding equality, diversity and inclusion across services, workforce practice and decision-making. Our approach remains guided by four clear objectives:

- Leadership by all
- Working together to improve health and wellbeing for all
- Embedding a person-centred approach
- Being an employer of choice

A detailed action plan underpins these objectives, setting out priorities, responsibilities and outcomes. A mid-point review is currently underway. This gives us a chance to reflect on what is working, where gaps remain and where we need to strengthen our approach over the next two years.

Engagement continues to be central. Listening to staff, patients and communities’ helps ensure our work reflects real experience and meets the needs of diverse populations. This includes a focus on those who are less likely to be heard or who may face poorer outcomes.

Looking ahead, the priority is to build on this progress and move further from commitment into consistent, visible practice. This means strengthening accountability, improving how we use data and insight, and ensuring equality considerations are routinely embedded into everyday decisions.

There are also several areas of focused development for the next period. These include progressing the Equality, Diversity and Inclusion Taskforce workstream, developing a Wellbeing passport, and continuing to strengthen and support staff networks as a key part of our inclusive culture.

Creating a fair and inclusive organisation takes time. It requires continued effort, honest reflection and a willingness to challenge established ways of working. By building on the progress made so far, the Health Board will continue working towards a more equitable, inclusive and person-centred system for both staff and the communities we serve.



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University Health Board

Strategic Equality Plan Annual Report Executive Summary 2025/2026



Introduction

Hywel Dda University Health Board continues to recognise that equality, diversity and inclusion (EDI) is complex and requires sustained focus. During 2025–2026, the organisation has built on the foundations established in 2024–2025, moving from raising awareness and strengthening governance towards embedding more consistent practice and early cultural change.

This report outlines progress against the four Strategic Equality Plan (SEP) objectives:

1. Leadership by all
2. Working together to improve health and wellbeing for all
3. Embedding a person-centred approach
4. Being an employer of choice

The report reflects the Health Board's role both as a provider of healthcare and as an employer. It demonstrates continued commitment to reducing inequalities, improving access and ensuring fair treatment for staff, patients and communities.

There is now clear evidence that equality considerations are more visible within leadership, workforce practice and service delivery. Early indicators show improvements in staff confidence, engagement and access to services. However, measurable outcomes remain at an early stage and will require continued focus.

About the Hywel Dda Area

The Health Board serves approximately 383,000 residents across Carmarthenshire, Ceredigion, and Pembrokeshire, covering a quarter of the landmass of Wales. The region is characterised by a diverse population, including high numbers of Welsh speakers, socio-economically deprived communities and seasonal population fluctuations due to tourism and student migration.

The Health Board acknowledges the impact of socio-economic deprivation and other wider determinants on health outcomes and is committed to addressing these disparities. Our work is aligned to duties within other key legislation which include, but are not limited to, the Wellbeing of Future Generations (Wales) Act 2015, the Social Services and Wellbeing (Wales) Act 2024, the Armed Forces Covenant Duty.

Overall progress

Overall, the Health Board is making steady and measurable progress in delivering its Strategic Equality Plan 2024–2028. All four strategic objectives are currently assessed as on track, with clear evidence of increased activity, stronger governance and growing organisational maturity in relation to equality, diversity and inclusion.

This year has seen a shift from building awareness to more structured, evidence-based delivery. There is stronger leadership accountability through the establishment of the EDI Taskforce, alongside increased use of workforce data, equality impact assessments and lived experience to inform decision-making.

There are clear signs of progress in staff capability and culture. Training, leadership development programmes and speaking-up initiatives are improving confidence to challenge inappropriate behaviour, support inclusion and create psychologically safe environments. Staff engagement activity and survey results also point to improvements in areas such as wellbeing support and reporting concerns.

In service delivery, there is growing evidence of more inclusive and accessible care. Targeted community outreach, improvements in accessible communication, and practical initiatives such as learning disability support and carers' identification are helping reduce barriers for some of the most underserved groups.

However, the report also highlights that inequalities persist, particularly in workforce representation, career progression and data quality. While progress has been made in building the foundations for change, the full impact will take time and requires sustained, targeted action.

Overall, the organisation is moving in the right direction. The next phase will focus on embedding consistency, strengthening accountability, and ensuring that equality, diversity and inclusion are reflected in everyday decisions and outcomes across the Health Board.

Leadership by All

Progress

There has been clear progress in developing inclusive leadership at all levels. Programmes such as Active Bystander training, the LEAP leadership programme and the Hywel Dda Manager Programme have strengthened staff confidence to challenge inappropriate behaviour, lead inclusively and create psychologically safe teams. Participation has increased, with strong feedback showing improved awareness and confidence in addressing discrimination.

The establishment of the Equality, Diversity and Inclusion (EDI) Taskforce marks an important step in strengthening leadership accountability. It brings together leadership, data and lived experience to drive more focused and coordinated action.

Work to implement the Anti-Racist Wales Action Plan has also progressed. Training compliance has increased, governance has been strengthened, and there is clearer alignment between workforce data and action planning. However, workforce data continues to show inequalities in progression and representation, particularly for Black, Asian and Minority Ethnic staff.

Impact

There are early signs of meaningful cultural change:

- Staff report increased confidence to raise concerns and challenge behaviour
- Leaders are demonstrating more open and collaborative approaches
- Teams are reporting improved communication and reduced unresolved conflict
- There is greater visibility of leadership commitment to inclusion

These changes are contributing to more psychologically safe environments.

Ongoing challenges

- Workforce data continues to show inequalities in experience for some groups
- Improvements are not yet consistently reflected in staff survey outcomes

Working Together to Improve Health and Wellbeing for All

Progress

The Health Board has continued to strengthen its work with communities to reduce health inequalities and improve access to services.

The Community Development Outreach Team has expanded its reach, delivering targeted engagement with seldom-heard groups, including refugees, asylum seekers, Gypsy, Roma and Traveller communities, and people experiencing homelessness. This community-based approach is improving access to prevention, screening and wider health services.

Targeted work has also supported specific groups. This includes improving support for gender diverse individuals through updated action plans and training, introducing women's health hubs to provide more accessible and coordinated care, and strengthening partnership work to address wider health inequalities through the re-established Health Equity Group.

There are early signs of improved access, increased engagement and stronger relationships with communities. This work provides a stronger foundation for reducing inequalities over time.

Impact

This work is improving access and engagement:

- More individuals from under-served communities are accessing healthcare services
- Increased uptake of screening, vaccination and prevention programmes
- Improved health literacy and understanding of how to navigate services
- Stronger relationships and trust between communities and the Health Board

There is also improved coordination between health, local authorities and third sector partners.

Ongoing challenges

- The impact on long-term health outcomes and inequalities is not yet measurable
- Greater use of population health data is needed to demonstrate sustained change

Embedding a Person-Centred Approach

Progress

Progress continues in ensuring services are inclusive, accessible and responsive to individual needs.

The refreshed Person-Centred Approach training is improving staff understanding of equality, unconscious bias and inclusive care. Feedback shows increased confidence in adapting care to meet individual needs.

Work to improve accessible communication has also advanced. Preparation for the Accessible Communication and Information Standards, alongside practical tools such as the sensory loss marker and updated assessment checklists, is helping staff better identify and respond to communication needs.

Other initiatives, including learning disability packs in emergency care, improved support for veterans and stronger recognition of unpaid carers, demonstrate practical changes that are making services more inclusive.

Together, these actions are helping reduce barriers and improve both patient experience and access to care.

Impact

These actions are improving how services are experienced:

- Staff report increased confidence in adapting care to individual needs
- Improved recording of communication needs is enabling more personalised care
- Carers and veterans are being identified earlier and supported more consistently
- Patients are receiving more accessible information and communication

There is also a growing recognition of person-centred care as a core aspect of quality and safety.

Ongoing challenges

- Impact is primarily evidenced through staff feedback
- Limited data is available to demonstrate improvements in patient experience and outcomes

Being an Employer of Choice

Progress

The Health Board continues to build a more inclusive and supportive workplace.

Staff networks have grown and play a key role in shaping organisational culture and decision-making. Alongside this, a wide programme of equality, diversity and inclusion training has improved staff knowledge, confidence and behaviour, supporting more inclusive practice.

Work to strengthen a speaking-up culture has progressed through initiatives such as Working in Confidence and local culture programmes. Staff survey results show improvements in areas such as reporting concerns and perceptions of wellbeing support.

Equality Impact Assessments have also improved in quality and consistency, supporting more informed and equitable decision-making across services.

Impact

There is clear evidence of positive cultural change:

- Increased staff confidence in speaking up about concerns
- Improved perceptions of fairness and organisational response
- Stronger staff voice influencing policy and decision-making
- Increased sense of belonging and support through staff networks

These changes are contributing to a more open and inclusive workplace.

Ongoing challenges

- Workforce inequalities remain in areas such as progression and representation
- Data quality and disclosure continue to limit full understanding of inequality.

Key themes

1. Cultural change is emerging

There is clear progress in awareness and behaviour. Staff feel more confident and supported. However, this is not yet consistently embedded across all areas.

2. Activity has translated into early impact

Compared to 2024–2025, there is stronger evidence that actions are influencing culture, access and practice.

3. Data remains a key limitation

While progress has been made, improved data is needed to demonstrate sustained impact and track inequalities over time.

Workforce equality data insights

The Health Board publishes workforce equality data as well as pay gap reports for gender, disability and ethnicity. Some of the key insights are:

- Since we began reporting on the gender pay gap, the overall figures have remained largely unchanged—except for 2021 and 2022, when we saw a slight improvement. This year, we have also focussed on the median pay gap, which shows the typical midpoint, not just the average (mean) which can be impacted by those few outliers with significantly higher salaries. While this shows that for our ‘middle’ earners, the gap between earnings for male and female staff is lower, we recognise that more work is needed to understand and address the underlying causes of the more significant gap in earnings at the higher end.
- Medical and Dental staff have the highest levels of underreporting equality information on the Electronic Staff Record (ESR) system.
- Non-disclosure rates for equality information are half that of the NHS Wales average and are improving year on year.
- Older staff are less likely to self-report their equality information on ESR.
- Younger staff are more likely to share their sexual orientation status. This may reflect growing confidence among younger people and the impact of our efforts to be a visibly inclusive and welcoming employer for LGBTQ+ communities.
- Workforce data shows that females represent a majority in all Agenda for Change pay grades until band 9 where they become the minority and significantly under representative of the female workforce. This underrepresentation is also seen in the medical workforce in the Consultant, Specialty Doctor, Other Doctors in Training and Other Medical and Dental roles.

- There are no staff from a minority ethnic background represented at Agenda for Change band 9 and only 4 members of staff across the senior bands 8b-8d

Priorities for 2026-2028

The Health Board will continue to build on this progress over the next year.

Key priorities include strengthening the use of data and insight, progressing the EDI Taskforce workstreams, improving equality in career progression, and continuing to embed inclusive practice across all services and teams.

There is a clear focus on moving from commitment to consistent delivery. This means ensuring that equality, diversity and inclusion are part of everyday decisions and experiences for staff and the communities we serve.

Workforce Equality Information

Hywel Dda University Health Board is committed to providing outstanding patient care and we do this by ensuring we have a diverse, talented and high performing workforce.

In this section of the annual report we present an overview of our workforce equality information; the detailed data is included as Appendix 1 to this report. It should be noted that disability, ethnicity, religious belief and sexual orientation are self-reported categories on the Electronic Staff Record. As staff can reserve the right to decline the opportunity to complete equality data monitoring, we acknowledge that the data presented may not fully reflect the demographic profile of the workforce.

This section outlines comparisons between workforce equality data published as of 31st March 2026 against data published as of 31st March 2025.

Appendix 2 of this report outlines the narrative provided by the Workforce Team in respect of data presented in Appendix 1 covering Formal Disciplinary and Respect and Resolution cases.

The health board has separately published pay gap reports on disability, ethnicity and gender. The data within the pay gap reports reflect individuals who received payment during the year whilst the workforce equality data is based on all staff engaged as workers (including locum and bank staff).

Age

The 2021 Census identified between 57-60% of the population across the 3 counties being of working age (16-65 years). The majority of the workforce as of 31st March 2026 were aged between 31–60 years which accounted for approximately 71% of staff.

County	% of the population classed as of working age (16-65 years) Census 2021	% of the population classed as of working ages (16-65 years) Census 2011
Ceredigion	60%	68.5%
Pembrokeshire	57%	60%
Carmarthenshire	58.5%	60%

Source: Office of National Statistics, Census 2021

Compared to 2025, workforce information data on 31st March 2026 showed:

- The percentage of staff identifying within the age profile for the ages of 55 and below has decreased by 0.56%.
- The percentage of posts offered to candidates above 60 years is lower than the younger age groups. However, in comparison to the number of applications received from these age groups, candidates aged above 60 have a better success rate (10.63%) compared to those aged Under 24 (6.34%), 71 offers of employment were made to candidates over 60 years old.
- Around 34% of leavers are in the age bracket 16-35, 19% are in the age bracket 36-50, 36% are in the age bracket 51-65 and 11% in the age of 66 and above. The percentage of leavers per age group is proportionate to their population percentage with the exception of those aged 56 and over and those aged 26 and under where we see a comparably higher percentage of leavers.
- Analysis of the reasons why employees left the organisation shows:
 - The majority of employees aged 16-35 was as Voluntarily Resigned. The main reasons for Voluntary Resignation included: Other/Not Known, (31.36%) and Relocation, (14.69%).
 - The highest proportion of those aged 36-50 Voluntarily Resigned 35.64% of leavers in this category were shown as Other/Not Known and 10.89% left the organisation because of Work Life Balance.
 - Around 39.43% of leavers aged 51-65 were of Retirement Age. Around 11.49% opted for early retirement.

Disability

On 31st March 2026, the Health Board employed 834 staff who identified as Disabled, which accounted for 6.29% of our workforce. 9.93% of staff had not recorded their response to this characteristic on their ESR record. Based on 2021 Census data for Carmarthenshire, 23% of the population declared a limiting long-term illness. In Ceredigion 20% and in Pembrokeshire 20.3%. Whilst workforce data reflects those of working age, it is important to note that Census data captures people of all ages.

County	% of the population who are disabled under the Equality Act
Ceredigion	20%
Pembrokeshire	20.3%
Carmarthenshire	23%

Source: Office for National Statistics, Census 2021

Compared to 2025, workforce information data on 31st March 2026 showed:

- The percentage of staff identifying as not disabled has increased by 0.12%.
- The percentage of staff identifying as having a disability has increased in the reporting period by 0.92%.
- The percentage of staff preferring not to provide this information has decreased by 0.02%
- It should be noted that since 2024/25 the number of Employees having not recorded their Disability status on ESR has decreased by 1.02%, indicating an increased use of ESR for recording data.
- Of a total 76,097 applications submitted for vacancies, 3.2% (2,424) of candidates declared themselves as having a disability. Of those 2,424 applicants, 168 (6.3%) were offered employment, which is 6.3% of all offers made. 1.2% of applicants chose not to disclose whether they had a disability or not at the time of application.
- The conversion rate of shortlist to offer is 27.4% for those who have declared a disability and 28.8% for those who declared no disability on application. The overall rate for all offers in comparison to shortlist is 29.4%.
- 5% of those leaving the Health Board identified as having a disability which is less than the proportion of disabled staff (6.29%). Their top 3 reasons for leaving were:
 - Voluntary Resignation due to Other/Not Known
 - Retirement Age
 - Voluntary Resignation(s) – Promotion and Relocation.

Ethnicity

At 31st March 2026 the Health Board employed 1,353 staff who identified their ethnic group as Asian or Asian British, Black or Black British, Mixed, or any other ethnic group. This accounted for 10.20% of our workforce and an increase of 104 staff compared with 2025 data. Based on 2021 Census data for Carmarthenshire and Pembrokeshire, over 2% of the population identified as being a minority ethnic group, whereas in Ceredigion, around 3% of the population identified as being a minority ethnic group. 653 employees (4.93%) have chosen not to record their ethnicity on ESR which makes data analysis and comparisons less accurate.

County	% of the population identifying as from a Black, Asian or Minority Ethnic background
Ceredigion	Approx. 3%
Pembrokeshire	Approx. 2%
Carmarthenshire	Approx. 2%

Compared to 2025, workforce information data on 31st March 2026 showed:

- The percentage of staff identifying as White has decreased by 0.65%.
- The percentage of staff identifying as Black or Black British has increased between the reporting periods by 0.20%.
- The percentage of staff identifying as Asian or Asian British has increased by 0.43%.
- The percentage of staff identifying as having mixed ethnicity has increased by 0.09%.
- The percentage of staff identifying as from Any Other Ethnic Group has increased by 0.14%.
- Those staff whose ethnicity is not recorded on ESR has decreased by 0.21%.
- A higher proportion of candidates who are White are offered employment when compared to the percentage of candidates who apply from other ethnic minority groups.
- The success rate of ethnic minority groups in being offered the role once shortlisted is 18%, this is almost half that of white at 34%. The lowest of which is Black or Black British where 11.5% of the 1,291 shortlisted candidates are offered the role.
- 12% of those leaving the Health Board identified as being from an ethnic minority group, which is slightly higher than the proportion of Black Asian and Minority Ethnic staff (10.2%). The main reasons given by Black Asian and Minority Ethnic staff leaving the organisation include:
 - Voluntary Resignation – Other/Not Known
 - Voluntary Resignation – Relocation
 - Retirement Age

Sex

At 31st March 2026, the Health Board employed 13,262 staff of which 79.09% identified as female and 20.91% identified as male. Census data for 2021 showed the following male/female percentages

County	% of the population who identified as a Male	% of the population who identified as a Female
Ceredigion	48.9%	51.1%
Pembrokeshire	48.7%	51.3%
Carmarthenshire	48.8%	51.2%

Source: Office for National Statistics, Census 2021

- The medical and dental staff group is the only staff group where there are more males employed than females.
- Females represent a majority in all agenda for change (AfC) pay grades until band 9 where they become the minority and significantly under representative of the female workforce. This underrepresentation is also seen in the medical workforce in the Consultant, Specialty Doctor, Other Doctors in Training and Other Medical and Dental roles.
- Of a total 76,097 applications submitted for vacancies during the year 35.9% (27,285) were from male candidates compared to 63.8% (48,586) from females with 0.3% not disclosing their gender. Of the 9,033 applicants shortlisted, 30.0% were male applicants and 69.3% were female applicants. Of the total offers of employment (2,655 jobs), 25.5% (676) were male compared to 73.9% (1,963) of females. This shows that females were more successful in their applications at shortlisting and in offers of employment.
- The success rate for females from shortlisting to interview is 31.3% and 24.9% for males.
- 77.25% of those leaving the Health Board were female compared to 22.75% who were male which is broadly comparable to the proportion of females and males in the workforce. Reasons for voluntary resignation included:
 - Other/not known – Female 198/Male 62
 - Retirement Age – Female 185/Male 40
 - Relocation – Female 55/Male 35
 - Work Life Balance – Female 56/Male 13

Gender Reassignment

According to the Census 2021, 91-93% of the population across our three counties identify as being the same sex registered at birth.

County	Non-Binary	Trans Man	Trans Woman	Different to registered at birth (not specified)
Ceredigion	0.22%	0.06%	0.12%	0.14%
Carmarthenshire	0.04%	0.06%	0.06%	0.12%
Pembrokeshire	0.04%	0.06%	0.06%	0.12%

Source: Office for National Statistics, Census 2021

Statistics are not currently collected on the Health Board's Electronic Staff Record system so no further analysis of data is possible.

Marriage and Civil Partnership

According to the 2021 Census, between 43-47% of the population in our 3 counties identify as being “Married”, and around 31-38% reported as being “Single”.

County	% of the population who identify as being married	% of the population who identify as never married and never registered in a civil partnership
Ceredigion	43.1%	38.7%
Pembrokeshire	47.3%	31.8%
Carmarthenshire	47.3%	32.4%

Source: Office for National Statistics, Census 2021

Compared to 2025, workforce information data on 31st March 2026 showed:

- The percentage of staff detailing marital status information has decreased by 0.24%.
- The above decrease will be influenced by a decrease in headcount between the two years of 125.
- There are no large fluctuations in representation across marital groups between reporting periods. There has been a slight increase in civil partnerships and an equal reduction in legally separated (+/- 0.11%), a slight decrease (-0.05%) of divorced employees and a 0.03% increase in widowed employees.
- Overall leavers who have disclosed their marital status, only those declared as civil partnership or married have a higher proportion of staff leaving in the year than head count.
- A higher number of ‘Married’ employees left because of ‘Retirement Age’ compared to those who are single.
- More ‘Single’ employees left the organisation compared to the others, due to Voluntary Resignation - Other/Not Known, Relocation and to Undertake Further Education or Training. However, the percentage of single leavers is still proportionate to the percentage of single staff.

Pregnancy & Maternity

No pregnancy and maternity data was collected in the 2021 Census. However, the number of employees recorded as taking maternity and adoption leave is 627, which is 5.14% of the workforce. This is an increase of 0.54% on the data reported on 31st March 2025.

Religious Beliefs

According to the 2021 Census, around 46-48% of our counties' population are Christian, around 43-44% have no religion and 6-7% would prefer not to say. In all counties less than 1% of their population identified as Buddhist, Hindu, Jewish, Muslim, Sikh or 'other',

County	% Christian	% no religion	% did not answer	% Buddhist	% Hindu	% Jewish	% Muslim	% Sikh	% Other
Ceredigion	46.7%	43%	7.7%	0.5%	0.2%	0.1%	0.7%	0%	0.9%
Pembrokeshire	48.8%	43%	6.6%	0.4%	0.1%	0%	0.5%	0%	0.6%
Carmarthenshire	47.6%	44.4%	6.2%	0.3%	0.2%	0.1%	0.5%	0.1%	0.6%

Source: Office for National Statistics, Census 2021

- The percentage of staff identifying a specific religion or belief has risen by 0.69% compared to data reported on 31st March 2025. The workforce profile of Hywel Dda highlights that 42.81% are Christian, 18.23% reported as atheists and 17.48% preferred not to say. 7.22% of the workforce are not recorded on ESR, which makes drawing a conclusion on the data more difficult.
- 14.26% of our workforce identify as another religion (Buddhism, Hinduism, Islam, Jainism, Judaism, Sikhism, Other). All these religions are over represented in our workforce compared to the census data with the exception of Judaism.
- It is important to note that we currently do not have an option for staff to choose 'No Religion' in ESR and therefore staff that identify in this way may choose 'other' which makes up 10.51% of our workforce.
- Of a total 76,097 applications submitted for vacancies during the year 58.9% (44,798) were from Christian candidates compared to 15.4% (11,735) Islamic candidates, 8.9% (6,744) Hindu and 6% (4,571) from atheists with 5.9% not disclosing their religious belief. Of the 9,033 applicants shortlisted 29% were offered roles. Whilst proportionally a higher proportion of offers were made to those with Christian beliefs (38% of all offers made), when comparing the conversion rate by religious belief of shortlist to offer, 25% of Christian applicants shortlisted are offered, this is in line with Islam and is lower than Atheist (35% of those shortlisted are offered) and Buddhist at 29%.
- 37% of those leaving the Health Board identified as holding Christian beliefs, this is less than the proportion of Christian staff (42.8%). Conversely 4% of leavers held Islamic beliefs which is a higher proportion than the 1.7% of our workforce with this belief. The top reasons for leaving are:
 - Voluntary Resignation - Other/Not Known
 - Retirement Age
 - Voluntary Resignation – Relocation

Sexual Orientation

Data from the 2021 Census shows how the population across the three counties have identified their sexual orientation.

County	Bisexual	Gay/Lesbian	Heterosexual/Straight	Did not respond
Ceredigion	2.63%	1.5%	84.70%	10.43%
Carmarthenshire	1.02%	1.07%	89.80%	7.89%
Pembrokeshire	0.96%	1.9%	89.73%	7.92%

Source: Office for National Statistics, Census 2021

At 31st March 2026 Health Board data showed that 2.59% of staff had recorded their sexual orientation as Lesbian, Gay or Bisexual, which is a decrease of 0.02% from 31st March 2025.

Compared to 2025, workforce information data on 31st March 2026 showed:

- The percentage of staff identifying as heterosexual or straight has increased by 1.98%
- The percentage of staff choosing not to disclose this information has decreased by 3.05%.
- Those staff whose sexual orientation is not recorded on ESR has risen by 1.09% to 8.76%.
- Of a total 76,097 applications submitted for vacancies 2.3% of candidates identified themselves as lesbian, gay or bisexual (LGB) whilst 2.7% chose not to disclose their sexual orientation at the time of application. 4.3% of those who identified as LGB were offered employment. Of the 1,932 LGB+ applicants 123 (6.4%) were offered employment compared with the 3.2% conversion of heterosexual or straight applications. The success rate of LGB+ applicants from shortlisting to interview is comparable to heterosexual applicants (29.64% and 28.50% respectively).
- The highest proportion of leavers were heterosexual (74%) compared to a staff population of 81.2% with the second highest proportion not declaring a sexual orientation (12.8%) compared to a staff population of 7.10%. The proportion of leavers who were bisexual was 1.8% compared to staff population of 1.10%, the proportion of leavers who were gay or lesbian leavers was 1.5% which is the same as the staff population and the proportion of leavers who identified with an 'other' sexual orientation was 0.3% compared to a staff population of 0.2%.

Voluntary resignation – Other not known is the primary reason for leaving across most categories with the exception of those declared as bisexual, where 32% of these leavers were voluntary resignation – relocation.

Welsh Language

According to the National Population Survey 2022 published by the Welsh Government, around 48% of the Hywel Dda population are able to speak Welsh. The 2021 Census data reported significantly different profiles of Welsh Speaking across the three counties. Ceredigion has 45.3%, Carmarthenshire was slightly lower at 39.3% whilst Pembrokeshire has 17.2%.

County	% of the population who have Welsh speaking ability
Ceredigion	45.3%
Carmarthenshire	17.2%
Pembrokeshire	39.9%

Source: Office for National Statistics, Census 2021

On 31st March 2026, Health Board data recorded that:

- 34% of the workforce have Welsh language skills at foundational level or higher, which is 1% lower than that reported in 2024/25, there is an increase in headcount of an additional 408 employees at foundation level and above.
- 41% of the workforce have recorded their ability as having no Welsh language skills, which has seen an increase by 0.63% from the previous year.
- Those staff whose Welsh Language Skills are not recorded on ESR is 2% (312 employees). This has increased by 61, when compared to the headcount reported in 2024/25.

Appendix 1 – HCUHB Workforce Equality Data 2025-26 Age

Our Workforce

Headcount

	Headcount	%
<= 20 years	210	1.6%
21 to 25	832	6.3%
26 to 30	1,245	9.4%
31 to 35	1,533	11.6%
36 to 40	1,690	12.7%
41 to 45	1,591	12.0%
46 to 50	1,452	11.0%
51 to 55	1,655	12.5%
56 to 60	1,564	11.8%
61 to 65	1,097	8.3%
66 to 70	304	2.3%
>= 71 years	89	0.7%
Total	13,262	100%

1.2 Age Band Headcount by staff Group

	<= 20 years	%	21 to 25	%	26 to 30	%	31 to 35	%	36 to 40	%	41 to 45	%	46 to 50	%	51 to 55	%	56 to 60	%	61 to 65	%	66 to 70	%	>= 71 years	%	Total
Prof Scientific and Technical	1	0.2%	10	2.3%	46	10.8%	70	16.4%	78	18.3%	74	17.3%	57	13.4%	40	9.4%	31	7.3%	11	2.6%	4	0.9%	5	1.2%	427
Additional Clinical Services	114	3.8%	372	12.4%	318	10.6%	379	12.7%	343	11.5%	312	10.4%	257	8.6%	296	9.9%	295	9.9%	237	7.9%	60	2.0%	9	0.3%	2,992
Administration and Clerical	19	0.8%	62	2.5%	168	6.8%	209	8.5%	280	11.4%	304	12.3%	295	12.0%	394	16.0%	402	16.3%	241	9.8%	67	2.7%	24	1.0%	2,465
Allied Health Professionals	0	0.0%	67	7.6%	101	11.4%	144	16.3%	122	13.8%	137	15.5%	104	11.8%	92	10.4%	65	7.4%	39	4.4%	11	1.3%	1	0.1%	883
Estates and Ancillary	76	6.7%	93	8.1%	60	5.3%	83	7.3%	94	8.2%	102	8.9%	116	10.1%	107	9.4%	174	15.2%	168	14.7%	53	4.6%	17	1.5%	1,143
Healthcare Scientists	0	0.0%	13	5.8%	22	9.8%	31	13.8%	33	14.7%	29	13.0%	35	15.6%	25	11.2%	22	9.8%	9	4.0%	4	1.8%	1	0.5%	224
Medical and Dental	0	0.0%	2	0.2%	86	9.3%	113	12.2%	128	13.8%	141	15.2%	115	12.4%	127	13.7%	100	10.8%	60	6.5%	36	3.9%	20	2.2%	928
Nursing and Midwifery Registered	0	0.0%	213	5.1%	444	10.6%	504	12.0%	612	14.6%	492	11.7%	473	11.3%	574	13.7%	475	11.3%	332	7.9%	69	1.6%	12	0.3%	4,200
Total	210	1.6%	832	6.3%	1,245	9.4%	1,533	11.6%	1,690	12.7%	1,591	12.0%	1,452	11.0%	1,655	12.5%	1,564	11.8%	1,097	8.47%	304	2.4%	89	0.7%	13,262

1.3 Analysis of Pay by Age Band - Age Band Headcount and Pay Grade

	<= 20 years	%	21 to 25	%	26 to 30	%	31 to 35	%	36 to 40	%	41 to 45	%	46 to 50	%	51 to 55	%	56 to 60	%	61 to 65	%	66 to 70	%	>= 71 years	%	Total
Band 1	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	14.3%	1	14.3%	1	14.3%	1	14.3%	2	28.6%	1	14.3%	0	0.0%	7
Band 2	124	6.7%	231	12.6%	151	8.2%	164	8.9%	146	7.9%	156	8.5%	142	7.7%	155	8.4%	249	13.5%	215	11.7%	77	4.2%	31	1.7%	1,841
Band 3	81	3.2%	239	9.6%	237	9.4%	312	12.5%	279	11.2%	255	10.2%	233	9.3%	258	10.3%	291	11.7%	248	9.9%	55	2.2%	10	0.4%	2,498
Band 4	2	0.2%	35	3.2%	83	7.5%	110	9.9%	146	13.2%	131	11.8%	127	11.5%	184	16.6%	166	15.0%	91	8.2%	25	2.3%	7	0.6%	1,107
Band 5	3	0.1%	260	9.9%	388	14.8%	332	12.7%	386	14.7%	275	10.5%	237	9.0%	268	10.2%	254	9.7%	167	6.4%	48	1.8%	7	0.3%	2,625
Band 6	0	0.0%	57	2.7%	227	10.7%	295	13.9%	335	15.8%	269	12.7%	252	11.9%	285	13.4%	204	9.6%	158	7.5%	28	1.3%	12	0.6%	2,122
Band 7	0	0.0%	7	0.5%	59	4.5%	146	11.1%	171	13.0%	211	16.1%	196	14.9%	220	16.8%	176	13.4%	102	7.8%	24	1.8%	1	0.1%	1,313
Band 8a	0	0.0%	1	0.2%	13	2.7%	52	10.8%	68	14.1%	98	20.4%	88	18.3%	80	16.6%	58	12.1%	20	4.2%	3	0.6%	0	0.0%	481
Band 8b	0	0.0%	0	0.0%	1	0.7%	7	5.1%	20	14.6%	30	21.9%	29	21.2%	25	18.3%	17	12.4%	7	5.1%	0	0.0%	1	0.7%	137
Band 8c	0	0.0%	0	0.0%	0	0.0%	2	2.1%	9	9.5%	12	12.6%	18	19.0%	25	26.3%	23	24.2%	5	5.3%	1	1.1%	0	0.0%	95
Band 8d	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	3.0%	5	15.2%	16	48.5%	6	18.2%	5	15.2%	0	0.0%	0	0.0%	33
Band 9	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	7	29.2%	3	12.5%	3	12.5%	7	29.2%	4	16.7%	0	0.0%	0	0.0%	24
Consultant	0	0.0%	0	0.0%	0	0.0%	5	1.4%	27	7.7%	58	16.5%	54	15.3%	78	22.2%	58	16.5%	35	9.9%	25	7.1%	12	3.4%	352
Speciality Doctors	0	0.0%	0	0.0%	6	2.6%	24	10.4%	57	24.8%	48	20.9%	40	17.4%	24	10.4%	14	6.1%	7	3.0%	8	3.5%	2	0.9%	230
Other Doctors in Training	0	0.0%	2	0.9%	80	35.1%	74	32.5%	31	13.6%	22	9.7%	8	3.5%	3	1.3%	2	0.9%	6	2.6%	0	0.0%	0	0.0%	228
Hospital Practitioners & Clinical Assistants	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	100.0%	0	0.0%	1
Other Medical and Dental Staff	0	0.0%	0	0.0%	0	0.0%	1	1.8%	4	7.0%	6	10.5%	5	8.8%	14	24.6%	13	22.8%	8	14.0%	2	3.5%	4	7.0%	57
Other	0	0.0%	0	0.0%	0	0.0%	9	8.1%	11	9.9%	11	9.9%	14	12.6%	16	14.4%	25	22.5%	17	15.3%	6	5.4%	2	1.8%	111
Total	210	1.6%	832	6.3%	1,245	9.39%	1,533	11.6%	1,690	12.7%	1,591	12.0%	1,452	11.0%	1,655	12.5%	1,564	11.8%	1,097	8.3%	304	2.3%	89	0.7%	13,262

1.4 Average Salary by Age Band and Staff Group

	Prof Scientific & Technical	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Nursing & Midwifery Registered	Total
>=20 years	£31,516.00	£25,844.25	£25,305.82	£0	£25,120.10	£0	£0	£0	£25,662.19
21 to 25	£43,337.70	£26,835.37	£27,205.50	£34,342.26	£25,155.64	£34,477.16	£40,857.00	£33,046.82	£29,939.09
26 to 30	£46,681.31	£27,699.06	£30,812.79	£40,077.66	£25,573.19	£41,566.20	£49,890.96	£36,791.38	£35,066.53
31 to 35	£51,844.86	£27,274.13	£32,433.74	£45,487.02	£26,497.27	£48,668.11	£63,008.98	£40,073.62	£38,185.54
36 to 40	£51,946.78	£27,703.53	£36,705.24	£47,061.22	£26,943.56	£46,859.14	£87,255.05	£41,717.23	£41,652.58
41 to 45	£56,623.07	£27,865.03	£41,736.39	£51,311.49	£26,829.87	£49,038.63	£105,463.75	£44,539.18	£46,256.32
46 to 50	£54,915.60	£27,798.24	£42,469.82	£52,233.49	£26,423.51	£52,010.65	£112,268.26	£46,066.17	£46,926.96
51 to 55	£57,010.16	£28,515.77	£40,665.52	£53,942.77	£26,652.17	£53,199.18	£126,162.34	£47,396.42	£47,765.45
56 to 60	£59,061.16	£27,991.36	£38,465.96	£54,099.84	£25,987.08	£56,753.70	£133,203.02	£47,830.91	£45,348.77
61 to 65	£51,338.46	£27,686.70	£35,507.09	£50,500.30	£26,571.10	£53,078.63	£131,100.21	£47,860.66	£41,812.91
66 to 70	£54,516.36	£27,370.45	£30,721.02	£55,565.28	£27,443.77	£52,781.33	£135,445.10	£44,761.57	£46,592.26
>= 71 years	£43,865.35	£27,557.78	£31,791.58	£47,280.00	£25,117.06	£0	£133,394.61	£43,503.81	£58,245.56
Total	£53,148.52	£27,625.41	£37,618.34	£47,525.79	£26,362.03	£48,744.64	£103,135.19	£43,107.36	£42,325.03

The above table shows analysis of pay using mean annual salary as the basis and the figures shown are those for March 2026.

1.5 Contract Type and Working Pattern

Contract Type											
	Permanent	%	Fixed Term Temp	%	Locum	%	Non-Exec Director/Chair	%	Bank	%	Total
<= 20 years	140	66.7%	7	3.3%	0	0.0%	0	0.0%	63	30.0%	210
21 to 25	624	75.0%	51	6.1%	0	0.0%	0	0.0%	157	18.9%	832
26 to 30	1,010	81.1%	117	9.4%	2	0.2%	0	0.0%	114	9.2%	1,245
31 to 35	1,292	84.3%	116	7.6%	9	0.6%	0	0.0%	116	7.6%	1,533
36 to 40	1,502	88.9%	84	5.0%	8	0.5%	0	0.0%	96	5.7%	1,690
41 to 45	1,433	90.1%	71	4.5%	6	0.4%	0	0.0%	81	5.1%	1,591
46 to 50	1,334	91.9%	53	3.7%	1	0.1%	1	0.1%	63	4.3%	1,452
51 to 55	1,539	93.0%	46	2.8%	5	0.3%	1	0.1%	64	3.9%	1,655
56 to 60	1,464	93.6%	39	2.5%	2	0.1%	1	0.1%	58	3.7%	1,564
61 to 65	964	87.9%	42	3.8%	6	0.6%	2	0.2%	83	7.8%	1,097
66 to 70	241	79.3%	16	5.3%	3	1.0%	2	0.7%	42	13.8%	304
>= 71 years	67	75.3%	3	3.3%	5	5.6%	0	0.0%	14	15.7%	89
Total	11,612	87.7%	645	4.9%	47	0.4%	7	0.1%	951	7.2%	13,262

Working Pattern					
	Full Time	%	Part Time	%	Total
<= 20 years	83	39.5%	127	60.5%	210
21 to 25	471	56.6%	361	43.4%	832
26 to 30	801	64.3%	444	35.7%	1,245
31 to 35	810	52.8%	723	47.2%	1,533
36 to 40	895	53.0%	795	47.0%	1,690
41 to 45	879	55.3%	712	44.8%	1,591
46 to 50	889	61.2%	563	38.8%	1,452
51 to 55	985	59.5%	670	40.5%	1,655
56 to 60	668	42.7%	896	57.3%	1,564
61 to 65	266	24.3%	831	75.8%	1,097
66 to 70	57	18.8%	247	81.3%	304
>= 71 years	5	5.6%	84	94.4%	89
Total	6,809	51.3%	6,453	48.7%	13,262

1.6 Recruitment

Note: As the Recruitment data is extracted from Trac rather than ESR the Age Bands are reported differently to that in ESR.

	Total Number of Applications Received	Total Number of Applicants Shortlisted	%	Total Number of Applicants Offered	%
<= 20 years	739	218	29.5%	74	33.9%
20 to 24	5,477	919	16.8%	320	34.8%
25 to 29	20,476	1,575	7.7%	431	27.4%
30 to 34	18,625	1,634	8.8%	441	27.0%
35 to 39	13,190	1,341	10.2%	390	29.1%
40 to 44	8,748	1,109	12.7%	349	31.5%
45 to 49	4,522	753	16.7%	222	29.5%
50 to 54	2,383	720	30.2%	204	28.3%
55 to 59	1,268	499	39.4%	153	30.7%
60 to 64	508	223	43.9%	59	26.5%
>= 65 years	160	41	25.6%	12	29.3%
Undisclosed	0	0	0.00%	0	0.0%
Total	76,096	9032	12%	2,655	29%

Note: The figure shown as 76,096 (rather than the overall total of 76,097) of the Total Number of Applications Received and the figure shown as 9,032 (rather than the overall total of 9,033 of the Total Number of Applications Shortlisted) were due to protecting confidentiality. Any reported number with a value less than 5 has been rounded down to zero.

1.7 Leavers

	Headcount	%
<= 20 years	29	2.8%
21 to 25	105	10.0%
26 to 30	128	12.1%
31 to 35	92	8.7%
36 to 40	85	8.1%
41 to 45	62	5.9%
46 to 50	55	5.2%
51 to 55	93	8.8%
56 to 60	137	13.0%
61 to 65	153	14.5%
66 to 70	96	9.1%
>= 71 years	20	1.9%
Total	1,055	100%

1.8 Training Attendance

	Attendance / Courses Completed	%
<= 20 years	2,520	3.2%
21 to 25	7,823	9.9%
26 to 30	9,270	11.8%
31 to 35	10,386	13.2%
36 to 40	10,408	13.2%
41 to 45	8,006	10.2%
46 to 50	7,740	9.8%
51 to 55	8,643	11.0%
56 to 60	7,906	10.0%
61 to 65	4,582	5.8%
66 to 70	1,438	1.8%
>= 71 years	167	0.2%
Total	78,889	100%

1.9 Staff Involved in Formal Disciplinary Procedures

	Headcount	%
<= 20 years	0	0.0%
21 to 25	7	11.7%
26 to 30	5	8.3%
31 to 35	5	8.3%
36 to 40	4	6.7%
41 to 45	7	11.7%
46 to 50	9	15.0%
51 to 55	10	16.7%
56 to 60	3	5.0%
61 to 65	8	13.3%
66 to 70	1	1.7%
>= 71 years	1	1.7%
Total	60	100%

1.10 Staff Involved in Formal Respect and Resolution Procedures

	Headcount	%
<= 20 years	0	0.0%
21 to 25	2	2.8%
26 to 30	2	2.8%
31 to 35	6	8.5%
36 to 40	11	15.5%
41 to 45	10	14.1%
46 to 50	11	15.5%
51 to 55	10	14.1%
56 to 60	8	11.3%
61 to 65	8	11.3%
66 to 70	3	4.2%
>= 71 years	0	0.0%
Total	71	100%

1.11 Staff involved in Formal Capability Procedures

	Headcount	%
26 to 30	1	20.0%
46 to 50	1	20.0%
51 to 55	3	60.0%
Total	5	100%

Disability

Our Workforce

2.1 Headcount

	Headcount	%
Disabled	834	6.3%
Not Disabled	11,061	83.4%
Prefer Not to Answer	50	0.4%
Not Recorded on ESR	1,317	9.9%
Total	13,262	100%

2.2 Headcount by Staff Group & Disability

	Disabled	%	Not Disabled	%	Prefer Not to Answer	%	Not Recorded on ESR	%	Total
Prof Scientific and Technic	29	6.8%	366	85.7%	1	0.2%	31	7.3%	427
Additional Clinical Services	168	5.6%	2,595	86.7%	10	0.3%	219	7.3%	2,992
Administrative and Clerical	193	7.8%	2,036	82.6%	16	0.7%	220	8.9%	2,465
Allied Health Professionals	79	9.0%	729	82.6%	1	0.1%	74	8.4%	883
Estates and Ancillary	64	5.6%	896	78.4%	2	0.2%	181	15.8%	1,143
Healthcare Scientists	10	4.5%	176	78.6%	0	0.0%	38	17.0%	224
Medical and Dental	21	2.3%	724	78.0%	2	0.2%	181	19.5%	928
Nursing and Midwifery Registered	270	6.4%	3,539	84.3%	18	0.4%	373	8.9%	4,200
Total	834	6.3%	11,061	83.4%	50	0.4%	1,317	9.9%	13,262

2.3 Analysis of Pay by Disability

Disability Headcount and Pay Grade

	Disabled	%	Not Disabled	%	Prefer Not to Answer	%	Not Recorded on ESR	%	Total
Band 1	0	0.0%	4	57.1%	0	0.0%	3	42.9%	7
Band 2	114	6.2%	1,517	82.4%	8	0.4%	202	11.0%	1,841
Band 3	169	6.8%	2,119	84.8%	7	0.3%	203	8.1%	2,498
Band 4	63	5.7%	904	81.7%	5	0.5%	135	12.2%	1,107
Band 5	161	6.1%	2,201	83.9%	12	0.5%	251	9.6%	2,625
Band 6	172	8.1%	1,769	83.4%	5	0.2%	176	8.3%	2,122
Band 7	92	7.0%	1,102	83.9%	8	0.6%	111	8.5%	1,313
Band 8a	21	4.4%	425	88.4%	3	0.6%	32	6.7%	481
Band 8b	8	5.9%	124	90.5%	0	0.0%	5	3.7%	137
Band 8c	4	4.2%	85	89.5%	0	0.0%	6	6.3%	95
Band 8d	2	6.1%	30	90.9%	0	0.0%	1	3.0%	33
Band 9	2	8.3%	20	83.3%	0	0.0%	2	8.3%	24
Consultant	6	1.7%	283	80.4%	1	0.3%	62	17.6%	352
Speciality Doctors	4	1.7%	185	80.4%	1	0.4%	40	17.4%	230
Other Doctors in Training	7	3.1%	176	77.2%	0	0.0%	45	19.7%	228
Hospital Practitioners & Clinical Assistants	0	0.0%	0	0.0%	0	0.0%	1	100.0%	1
Other Medical and Dental Staff	2	3.5%	36	63.2%	0	0.0%	19	33.3%	57
Other	7	6.3%	81	73.0%	0	0.0%	23	20.7%	111
Total	834	6.3%	11,061	83.4%	50	0.4%	1,317	9.9%	13,262

2.4 Average Salary by Disability and Staff Group

	Disabled	Not Disabled	Prefer not to Answer	Not Recorded on ESR	Total
Prof Scientific & Technical	£53,129.96	£53,619.83	£55,532.00	£46,426.60	£53,148.52
Additional Clinical Services	£27,596.57	£27,582.73	£26,532.99	£28,205.22	£27,625.41
Admin & Clerical	£35,301.14	£37,913.86	£40,415.79	£36,626.95	£37,618.34
Allied Health Professionals	£45,552.29	£47,342.59	£47,280.00	£51,512.40	£47,525.79
Estates and Ancillary	£26,070.07	£26,519.88	£24,833.00	£25,773.52	£26,362.03
Healthcare Scientists	£47,564.14	£48,272.08	£0	£51,411.44	£48,744.64
Medical & Dental	£96,732.13	£101,865.96	£121,896.74	£109,834.25	£103,135.19
Nursing & Midwifery Registered	£43,145.15	£43,281.36	£43,429.25	£41,331.03	£43,107.36
Total	£39,043.29	£42,239.71	£42,465.22	£45,222.42	£42,325.03

The above table shows analysis of pay using mean annual salary as the basis and the figures shown are those for March 2026.

2.5 Contract Type and Working Pattern

Contract Type											
	Permanent	%	Fixed Term Temp	%	Locum	%	Non-Exec Director/Chair	%	Bank	%	Total
Disabled	754	90.4%	30	3.6%	1	0.1%	1	0.1%	48	5.8%	834
Not Disabled	9,659	87.3%	554	5.0%	39	0.4%	5	0.0%	804	7.3%	11,061
Prefer Not to Answer	47	94%	1	2.0%	0	0.0%	0	0.0%	2	4.0%	50
Not Recorded on ESR	1,152	87.5%	60	4.6%	7	0.5%	1	0.1%	97	7.4%	1,317
Total	11,612	87.6%	645	4.9%	47	0.4%	7	0.1%	951	7.2%	13,262

Working Pattern					
	Full Time	%	Part Time	%	Total
Disabled	402	48.2%	432	51.8%	834
Not Disabled	5,766	52.1%	5,295	47.9%	11,061
Prefer Not to Answer	27	54.0%	23	46.0%	50
Not Recorded on ESR	614	46.6%	703	53.4%	1,317
Total	6,809	51.3%	6,453	48.7%	13,262

2.6 Recruitment

	Total Number of Applications Received	%	Total Number of Applicants Shortlisted	%	Total Number of Applicants Offered	%
Disability: Yes	2,424	3.2%	614	6.8%	168	6.3%
Disability: No	72,789	95.7%	8,046	89.1%	2,316	87.2%
Disability: Undisclosed	884	1.2%	373	4.1%	171	6.4%
Total	76,097	100%	9,033	100%	2,655	100%

2.7 Shortlist to Offer

	Total Number of Applications Received	Total Number of Applicants Shortlisted	%	Total Number of Applicants Offered	%
Disability: Yes	2,424	614	25.3%	168	27.4%
Disability: No	72,789	8,046	11.05%	2,316	28.8%
Disability: Undisclosed	884	373	42.2%	171	45.8%
Total	76,097	9,033	100%	2,655	100%

2.8 Leavers

	Headcount	%
Disabled	51	4.8%
Not Disabled	855	81.1%
Prefer Not to Answer	4	0.4%
Not Recorded on ESR	145	13.7%
Total	1,055	100%

2.9 Training Attendance

	Attendance / Courses Completed	%
Disabled	2,836	3.6%
Not Disabled	40,859	51.8%
Prefer Not to Answer	168	0.2%
Not Recorded on ESR	35,026	44.4%
Total	78,889	100%

2.10 Staff Involved in Formal Disciplinary Procedures

	Headcount	%
Disabled	6	10.0%
Not Disabled	45	75.0%
Prefer Not to Answer	1	1.7%
Not Recorded on ESR	8	13.3%
Total	60	100%

2.11 Staff Involved in Formal Respect and Resolution Procedures

	Headcount	%
Disabled	11	15.5%
Not Disabled	54	76.1%
Prefer Not to Answer	1	1.4%
Not Recorded on ESR	5	7.0%
Total	71	100%

2.12 Staff Involved in Formal Capability Procedures

	Headcount	%
Disabled	4	80.0%
Not Disabled	1	20.0%
Total	5	100%

Ethnicity

Our Workforce

3.1 Headcount

	Headcount	%
Ethnic Minority Total	1,353	10.2%
Asian or Asian British	786	5.9%
Black or Black British	210	1.6%
Mixed	130	1.0%
Any Other Ethnic Group	227	1.7%
White	11,256	84.9%
Not Recorded on ESR	653	4.9%
Total	13,262	100%

3.2 Headcount by Staff Group & Ethnicity

	Asian or Asian British	%	Black or Black British	%	Mixed	%	White	%	Any Other Ethnic Group	%	Not Recorded on ESR	%	Total
Prof Scientific and Technic	8	1.9%	6	1.4%	7	1.6%	389	91.1%	7	1.6%	10	2.3%	427
Additional Clinical Services	101	3.4%	38	1.3%	28	0.9%	2,725	91.1%	26	0.9%	74	2.5%	2,992
Administrative and Clerical	28	1.1%	12	0.5%	21	0.9%	2,333	94.7%	11	0.5%	60	2.4%	2,465
Allied Health Professionals	30	3.4%	27	3.1%	6	0.7%	777	88.0%	8	0.9%	35	4.0%	883
Estates and Ancillary	46	4.0%	5	0.4%	7	0.6%	1,004	87.8%	14	1.2%	67	5.9%	1,143
Healthcare Scientists	9	4.0%	7	3.1%	2	0.9%	191	85.3%	2	0.9%	13	5.8%	224
Medical and Dental	287	30.9%	57	6.1%	24	2.6%	302	32.5%	75	8.1%	183	19.7%	928
Nursing and Midwifery Registered	277	6.6%	58	1.4%	35	0.8%	3,535	84.2%	84	2.0%	211	5.0%	4,200
Total	786	5.9%	210	1.6%	130	1.0%	11,256	84.9%	227	1.7%	653	4.9%	13,262

3.3 Analysis of Pay by Ethnicity

Ethnicity Headcount and Pay Grade

	Asian or Asian British	%	Black or Black British	%	Mixed	%	White	%	Any Other Ethnic Group	%	Not Recorded on ESR	%	Total
Band 1	0	0.0%	0	0.0%	0	0.0%	6	85.7%	0	0.0%	1	14.3%	7
Band 2	96	5.2%	21	1.1%	14	0.8%	1,621	88.1%	19	1.0%	70	3.8%	1,841
Band 3	56	2.2%	24	1.0%	23	0.9%	2,300	92.1%	23	0.9%	72	2.9%	2,498
Band 4	10	0.9%	4	0.4%	7	0.6%	1,062	95.9%	4	0.4%	20	1.8%	1,107
Band 5	252	9.6%	56	2.1%	27	1.0%	2,046	77.9%	63	2.4%	181	6.9%	2,625
Band 6	54	2.5%	36	1.7%	20	0.9%	1,927	90.8%	25	1.2%	60	2.8%	2,122
Band 7	21	1.6%	8	0.6%	8	0.6%	1,231	93.8%	11	0.8%	34	2.6%	1,313
Band 8a	9	1.9%	3	0.6%	4	0.8%	446	92.7%	7	1.5%	12	2.5%	481
Band 8b	0	0.0%	0	0.0%	1	0.7%	136	99.3%	0	0.0%	0	0.0%	137
Band 8c	0	0.0%	0	0.0%	2	2.1%	91	95.8%	0	0.05%	2	2.1%	95
Band 8d	1	3.0%	0	0.0%	0	0.0%	32	97.0%	0	0.05%	0	0.0%	33
Band 9	0	0.0%	0	0.0%	0	0.0%	24	100.0%	0	0.0%	0	0.0%	24
Consultant	107	30.4%	17	4.8%	7	2.0%	161	45.7%	21	6.0%	39	11.1%	352
Speciality Doctors	89	38.7%	25	10.9%	9	3.9%	45	19.6%	23	10.0%	39	17.0%	230
Other Doctors in Training	63	27.6%	13	5.7%	7	3.1%	36	15.8%	24	10.5%	85	37.3%	228
Hospital Practitioners & Clinical Assistants	0	0.0%	0	0.0%	0	0.0%	1	100.0%	0	0.0%	0	0.0%	1
Other Medical and Dental Staff	17	29.8%	1	1.8%	0	0.0%	26	45.6%	4	7.0%	9	15.8%	57
Other	11	9.9%	2	1.8%	1	0.9%	65	58.6%	3	2.7%	29	26.1%	111
Total	786	5.9%	210	1.6%	130	1.0%	11,256	84.9%	227	1.7%	653	4.9%	13,262

3.4 Average Salary by Ethnicity and Staff Group

	Asian or Asian British	Black or Black British	Mixed	White	Any Other Ethnic Group	Not Recorded on ESR	Total
Prof Scientific & Technical	£55,508.74	£45,091.00	£53,739.25	£53,255.27	£53,769.11	£51,813.03	£53,148.52
Additional Clinical Services	£26,389.18	£26,042.44	£28,179.69	£27,673.79	£26,970.96	£27,763.08	£27,625.41
Admin & Clerical	£34,807.30	£32,536.08	£34,778.39	£37,790.45	£36,823.65	£34,351.05	£37,618.34
Allied Health Professionals	£43,788.19	£41,208.68	£43,950.25	£48,031.98	£41,787.38	£47,049.35	£47,525.79
Estates and Ancillary	£25,142.87	£24,833.00	£24,833.00	£26,501.34	£25,028.48	£25,590.37	£26,362.03
Healthcare Scientists	£44,145.91	£41,790.46	£38,448.50	£49,287.74	£44,358.50	£51,304.67	£48,744.64
Medical & Dental	£98,570.16	£91,732.98	£96,197.37	£123,708.18	£93,400.76	£85,562.91	£103,135.19
Nursing & Midwifery Registered	£35,552.41	£36,572.29	£41,264.22	£44,435.48	£39,586.38	£37,138.11	£43,107.36
Total	£58,292.44	£51,705.88	£48,610.22	£40,316.52	£56,494.35	£47,027.20	£42,325.03

The above table shows analysis of pay using mean annual salary as the basis and the figures shown are those for March 2026.

3.5 Contract Type and Working Pattern

Contract Type											
	Permanent	%	Fixed Term Temp	%	Locum	%	Non-Exec Director/Chair	%	Bank	%	Total
Asian or Asian British	592	75.3%	111	14.1%	10	1.3%	0	0.0%	73	9.3%	786
Black or Black British	150	71.4%	33	15.7%	0	0.0%	1	0.5%	26	12.4%	210
Mixed	107	82.3%	11	8.5%	0	0.0%	0	0.0%	12	9.2%	130
White	10,103	89.8%	395	3.5%	25	0.2%	2	0.0%	731	6.5%	11,256
Any Other Ethnic Group	189	83.3%	27	11.9%	2	0.9%	0	0.0%	9	4.0%	227
Not Recorded on ESR	471	72.1%	68	10.4%	10	1.5%	4	0.6%	100	15.3%	653
Total	11,612	87.6%	645	4.9%	47	0.4%	7	0.1%	961	7.3%	13,262

Working Pattern					
	Full Time	%	Part Time	%	Total
Asian or Asian British	562	71.5%	224	28.5%	786
Black or Black British	158	75.2%	52	24.8%	210
Mixed	73	56.2%	57	43.9%	130
White	5,525	49.1%	5,731	50.9%	11,256
Any Other Ethnic Group	158	69.6%	69	30.4%	227
Not Recorded on ESR	333	51.0%	320	49.0%	653
Total	6,809	51.3%	6,453	48.7%	13,262

3.6 Recruitment

	Total Number of Applications Received	%	Total Number of Applicants Shortlisted	%	Total Number of Applicants Offered	%
Asian or Asian British	20,922	27.5%	1,287	14.2%	287	10.8%
Black or Black British	36,681	48.2%	1,291	14.3%	149	5.6%
Mixed	1,770	2.3%	194	2.2%	49	0.9%
White	13,722	18.0%	5,822	64.5%	1,979	74.5%
Any Other Ethnic Group	1,946	2.5%	206	2.2%	54	2.0%
Undisclosed	1,056	1.4%	233	2.6%	132	5.0%
Total	76,097	100%	9,033	100%	2,650	99.8%

Note: The figure shown as 2,660 (rather than the overall total of 2,655) of the Total Number of Applicants Offered was due to protecting confidentiality any reported number within the Ethnic Group sub categories of a value less than 5 has been rounded down to zero and therefore the percentage rate was 99.8% rather than 100%.

3.7 Shortlist to Offer

	Total Number of Applications Received	Total Number of Applicants Shortlisted	%	Total Number of Applicants Offered	%
Asian or Asian British	20,922	1,287	6.2%	287	22.3%
Black or Black British	36,681	1,291	3.5%	149	11.5%
Mixed	1,770	194	11.0%	49	25.3%
White	13,722	5,822	42.4%	1,979	34.0%
Any Other Ethnic Group	1,946	206	10.6%	54	26.2%
Undisclosed	1,056	233	22.1%	132	56.7%
Total	76,097	9,033	12%	2,650	29.3%

3.8 Leavers

	Headcount	%
Asian or Asian British	75	7.1%
Black or Black British	21	2.0%
Mixed	15	1.4%
White	847	80.3%
Any Other Ethnic Group	16	1.5%
Not Recorded on ESR	81	7.7%
Total	1,055	100%

3.9 Training Attendance

	Attendance / Courses Completed	%
Asian or Asian British	7,422	9.4%
Black or Black British	2,386	3.0%
Mixed	1,012	1.3%
White	61,128	77.5%
Any Other Ethnic Group	1,839	2.3%
Not Recorded on ESR	5,097	6.5%
Total	78,889	100%

3.10 Staff Involved in Formal Disciplinary Procedures

	Headcount	%
White	51	85.0%
Black or Black British	4	6.7%
Mixed	1	1.7%
Any Other Ethnic Group	1	1.7%
Not Recorded on ESR	3	5.0%
Total	60	100%

3.11 Staff Involved in Formal Respect and Resolution Procedures

	Headcount	%
White	62	87.3%
Asian or Asian British	3	4.2%
Black or Black British	2	2.8%
Any Other Ethnic Group	3	4.2%
Not Recorded on ESR	1	1.4%
Total	71	100%

3.12 Staff Involved in Formal Capability Procedures

	Headcount	%
White	4	80%
Asian or Asian British	1	20%
Total	5	100%

Sex

Our Workforce

4.1 Headcount

	Headcount	%
Female	10,489	79.1%
Male	2,773	20.9%
Total	13,262	100%

	FTE	%
Female	8,222.33	78.0%
Male	2,315.62	22.0%
Total	10,537.94	100%

4.2 Headcount by Staff Group & Sex

	Female		Male		Total	
	Headcount	%	Headcount	%	Headcount	%
Prof Scientific and Technic	337	78.9%	90	21.1%	427	3.2%
Additional Clinical Services	2,499	83.5%	493	16.5%	2,992	22.6%
Administrative and Clerical	2,013	81.7%	452	18.3%	2,465	18.6%
Allied Health Professionals	687	77.8%	196	22.2%	883	6.7%
Estates and Ancillary	605	52.9%	538	47.1%	1,143	8.6%
Healthcare Scientists	120	53.6%	104	46.4%	224	1.7%
Medical and Dental	345	37.2%	583	62.8%	928	7.0%
Nursing and Midwifery Registered	3,883	92.5%	317	7.6%	4,200	31.7%
Total	10,489	79%	2,773	21%	13,262	100%

4.3 Analysis of Pay by Sex

Sex Headcount and Pay Grade

	Female		Male		Total	
	Headcount	%	Headcount	%	Headcount	%
Band 1	5	71.4%	2	28.7%	7	0.05%
Band 2	1,339	72.7%	502	27.3%	1,841	13.9%
Band 3	2,040	81.7%	458	18.3%	2,498	18.8%
Band 4	968	87.4%	139	12.6%	1,107	8.4%
Band 5	2,303	87.7%	322	12.3%	2,625	19.8%
Band 6	1,782	84.0%	340	16.0%	2,122	16.0%
Band 7	1,103	84.0%	210	16.0%	1,313	9.9%
Band 8a	372	77.3%	109	22.7%	481	3.6%
Band 8b	102	74.5%	35	25.6%	137	1.0%
Band 8c	57	60.0%	38	40.0%	95	0.7%
Band 8d	24	72.7%	9	27.3%	33	0.3%
Band 9	11	45.8%	13	54.2%	24	0.2%
Consultants	112	31.8%	240	68.2%	352	2.7%
Specialty Doctors	89	38.7%	141	61.3%	230	1.7%
Other Doctors in Training	93	40.8%	135	59.2%	228	1.7%
Hospital Practitioners & Clinical Assistants	0	0.0%	1	100.0%	1	0.00%
Other Medical and Dental	26	45.6%	31	54.4%	57	0.4%
Other	63	56.8%	48	43.2%	111	0.8%
Total	10,489	79.1%	2,773	20.9%	13,262	100%

4.4 Average Salary by Sex and Staff Group

	Female	Male	Total
Prof Scientific & Technical	£52,282.84	£56,206.65	£53,148
Additional Clinical Services	£27,618.35	£27,657.06	£27,625.41
Admin & Clerical	£35,613.36	£45,723.52	£37,618.34
Allied Health Professionals	£47,643.73	£47,140.12	£47,525.79
Estates and Ancillary	£25,218.80	£27,379.93	£26,362.03
Healthcare Scientists	£48,838.47	£48,635.02	£48,744.64
Medical & Dental	£96,606.13	£106,963.65	£103,135.19
Nursing & Midwifery Registered	£43,043.49	£43,825.90	£43,107.36
Total	£39,750.20	£51,467.79	£41,325.03

The above table shows analysis of pay using mean annual salary as the basis and the figures shown are those for March 2026.

4.5 Contract Type and Working Pattern

Contract Type						
Assignment Category	Female		Male		Total	
	Headcount	%	Headcount	%	Headcount	%
Permanent	9,315	88.8%	2,297	82.8%	11,612	87.6%
Fixed Term Temp	437	4.2%	208	7.5%	645	4.9%
Locum	9	0.1%	38	1.4%	47	0.4%
Non-Exec Director/Chair	2	0.0%	5	0.2%	7	0.0%
Bank	726	6.9%	225	8.1%	951	7.2%
Total	10,489	100%	2,773	100%	13,262	100%

Working Pattern						
Employee Category	Female		Male		Total	
	Headcount	%	Headcount	%	Headcount	%
Full-Time	4,883	46.6%	1,926	69.5%	6,809	51.4%
Part-Time	5,606	53.5%	847	30.5%	6,453	48.7%
Total	10,489	100%	2,773	100%	13,262	100%

4.6 Recruitment

	Total Number of Applications Received	%	Total Number of Applicants Shortlisted	%	Total Number of Applicants Offered	%
Female	48,586	63.8%	6,262	69.3%	1,963	73.9%
Male	27,285	35.9%	2,710	30.0%	676	25.5%
Undisclosed	226	0.3%	61	0.7%	16	0.6%
Total	76,097	100%	9,033	100%	2,655	100%

4.7 Shortlist to Offer

	Total Number of Applications Received	Total Number of Applicants Shortlisted	% of applicants shortlisted within own group	Total Number of Applicants Offered	% of shortlisted offered within own group
Female	48,586	6,262	12.3%	1,963	31.3%
Male	27,285	2,710	9.9%	676	24.9%
Undisclosed	226	61	27.0%	16	26.2%
Total	76,097	9,033	11.9%	2,655	29.4%

4.8 Leavers

	Headcount	%
Female	815	77.25%
Male	240	22.75%
Total	1,055	100%

4.9 Training Attendance

	Attendance / Courses Completed	%
Female	62,997	79.9%
Male	15,892	20.1%
Total	78,889	100%

4.10 Staff Involved in Formal Disciplinary Procedures

	Headcount	%
Female	34	56.7%
Male	26	43.3%
Total	60	100%

4.11 Staff Involved in Formal Respect and Resolution Procedures

	Headcount	%
Female	52	73.2%
Male	19	26.8%
Total	71	100%

4.12 Staff Involved in Formal Capability Procedures

	Headcount	%
Female	4	80%
Male	1	20%
Total	5	100%

Marital Status (Marriage and Civil Partnership)

Our Workforce

5.1 Headcount

	Headcount	%
Civil Partnership	294	2.2%
Divorced	938	7.1%
Legally Separated	86	0.7%
Married	6,566	49.5%
Single	4,369	32.9%
Widowed	163	1.2%
Not Recorded on ESR	846	6.4%
Total	13,262	100%

5.2 Headcount by Staff Group & Marital Status

	Civil Partnership	%	Divorced	%	Legally Separated	%	Married	%	Single	%	Widowed	%	Not Recorded on ESR	%	Total
Prof Scientific and Technic	9	2.1%	22	5.2%	0	0.0%	223	52.2%	145	34.0%	2	0.5%	26	6.1%	427
Additional Clinical Services	107	3.6%	196	6.6%	28	0.9%	1,225	40.9%	1,267	42.3%	40	1.3%	129	4.3%	2,992
Administrative and Clerical	43	1.7%	225	9.1%	19	0.7%	1,324	53.7%	685	27.8%	38	1.5%	131	5.3%	2,465
Allied Health Professionals	11	1.2%	49	5.5%	4	0.5%	437	49.5%	322	36.5%	7	0.8%	53	6.0%	883
Estates and Ancillary	27	2.4%	91	8.0%	7	0.6%	467	40.9%	457	40.0%	22	1.9%	72	6.3%	1,143
Healthcare Scientists	2	0.9%	8	3.6%	2	0.9%	120	53.6%	72	32.1%	0	0.0%	20	8.9%	224
Medical and Dental	9	1.0%	29	3.1%	3	0.3%	601	64.8%	192	20.7%	5	0.5%	89	9.6%	928
Nursing and Midwifery Registered	86	2.0%	318	7.6%	23	0.5%	2,169	51.6%	1,229	29.3%	49	1.2%	326	7.8%	4,200
Total	294	2.2%	938	7.1%	86	0.6%	6,566	49.5%	4,369	32.9%	163	1.2%	846	6.4%	13,262

5.3 Analysis of Pay by Marital Status - Marital Status Headcount and Pay Grade

	Civil Partnership	%	Divorced	%	Legally Separated	%	Married	%	Single	%	Widowed	%	Not Recorded on ESR	%	Total
Band 1	0	0.0%	0	0.0%	0	0.0%	3	42.9%	2	28.6%	0	0.0%	2	28.6%	7
Band 2	43	2.3%	135	7.3%	12	0.7%	703	38.2%	832	45.2%	33	1.8%	83	4.5%	1,841
Band 3	102	4.1%	180	7.2%	22	0.8%	1,050	42.0%	989	39.6%	40	1.6%	115	4.6%	2,498
Band 4	19	1.7%	102	9.2%	11	1.0%	599	54.1%	313	28.3%	16	1.4%	47	4.2%	1,107
Band 5	49	1.9%	170	6.5%	6	0.2%	1,146	43.7%	963	36.7%	31	1.2%	260	9.9%	2,625
Band 6	44	2.1%	151	7.1%	14	0.7%	1,132	53.3%	638	30.1%	16	0.8%	127	6.0%	2,122
Band 7	18	1.4%	93	7.1%	10	0.8%	797	60.7%	298	22.7%	12	0.9%	85	6.5%	1,313
Band 8a	7	1.5%	35	7.3%	4	0.8%	317	65.9%	96	20.0%	3	0.6%	19	4.0%	481
Band 8b	2	1.5%	14	10.2%	3	2.2%	87	63.5%	22	24.1%	2	1.5%	7	5.1%	137
Band 8c	1	1.1%	11	11.6%	0	0.0%	65	68.4%	12	12.6%	3	3.2%	3	3.2%	95
Band 8d	0	0.0%	7	21.2%	1	3.0%	21	63.6%	4	12.1%	0	0.0%	0	0.0%	33
Band 9	0	0.0%	4	16.7%	0	0.0%	17	70.8%	1	4.2%	0	0.0%	2	8.3%	24
Consultant	1	0.3%	15	4.3%	0	0.0%	267	75.9%	38	10.8%	2	0.6%	29	8.2%	352
Speciality Doctors	2	0.9%	7	3.0%	0	0.0%	167	72.6%	39	17.0%	1	0.4%	14	6.1%	230
Other Doctors in Training	4	1.8%	2	0.9%	0	0.0%	86	37.7%	99	43.4%	1	0.4%	36	15.8%	228
Hospital Practitioners & Clinical Assistants	0	0.0%	0	0.0%	0	0.0%	1	100.0%	0	0.0%	0	0.0%	0	0.0%	1
Other Medical and Dental Staff	1	1.8%	2	3.5%	0	0.0%	42	73.7%	9	15.8%	0	0.0%	3	5.3%	57
Other	1	0.9%	10	9.0%	3	2.7%	66	59.5%	14	12.6%	3	2.7%	14	12.6%	111
Total	294	2.2%	938	7.1%	86	0.6%	6,566	49.5%	4,369	32.9%	163	1.2%	846	6.4%	13,262

5.4 Average Salary by Marital Status and Staff Group

	Civil Partnership	Divorced	Legally Separated	Married	Single	Widowed	Not Recorded on ESR	Total
Prof Scientific & Technical	£51,700.33	£47,198.70	£0	£56,298.07	£49,692.61	£90,013.00	£51,304.28	£53,148.52
Additional Clinical Services	£26,997.88	£27,595.58	£28,011.38	£27,926.40	£27,337.40	£27,205.51	£28,095.79	£27,625.41
Admin & Clerical	£31,206.29	£39,782.55	£40,824.24	£39,921.55	£33,019.00	£34,644.28	£38,232.95	£37,618.34
Allied Health Professionals	£46,950.51	£50,226.05	£55,967.33	£51,181.32	£42,683.40	£57,855.76	£46,557.75	£47,525.79
Estates and Ancillary	£25,950.09	£26,608.96	£24,833.00	£26,817.38	£25,891.15	£25,549.89	£26,162.50	£26,362.03
Healthcare Scientists	£47,280.00	£51,951.39	£43,911.29	£51,300.58	£44,652.51	£0	£48,581.63	£48,744.64
Medical & Dental	£82,112.40	£120,429.66	£141,425.61	£109,956.45	£79,873.96	£108,226.32	£96,669.51	£103,135.19
Nursing & Midwifery Registered	£42,574.67	£47,209.14	£50,697.72	£44,986.48	£40,167.84	£43,500.87	£38,726.29	£43,107.36
Total	£34,996.76	£42,179.22	£41,943.53	£46,584.77	£36,711.23	£38,306.73	£41,780.41	£42,325.03

The above table shows analysis of pay using mean annual salary as the basis and the figures shown are those for March 2026.

5.5 Contract Type and Working Pattern

Contract Type											
	Permanent	%	Fixed Term Temp	%	Locum	%	Non-Exec Director/Chair	%	Bank	%	Total
Civil Partnership	260	88.4%	15	5.1%	2	0.7%	0	0.0%	17	5.8%	294
Divorced	848	90.4%	30	3.2%	2	0.2%	1	0.1%	57	6.1%	938
Legally Separated	80	93.0%	2	0.2%	0	0.0%	0	0.0%	4	4.7%	86
Married	5,888	89.7%	301	4.6%	24	0.4%	4	0.1%	349	5.3%	6,566
Single	3,654	83.6%	246	5.6%	16	0.4%	1	0.0%	452	10.3%	4,369
Widowed	144	88.3%	7	4.3%	0	0.0%	1	0.6%	11	6.7%	163
Not Recorded on ESR	738	87.2%	44	5.2%	3	0.4%	0	0.0%	61	7.2%	846
Total	11,612	87.2%	645	4.9%	47	0.4%	7	0.1%	951	7.2%	13,262

Working Pattern					
	Full Time		Part Time		Total
Civil Partnership	141	48.0%	153	52.0%	294
Divorced	448	47.8%	490	52.2%	938
Legally Separated	47	54.7%	39	45.3%	86
Married	3,140	47.8%	3,426	52.2%	6,566
Single	2,447	56.0%	1,922	44.0%	4,369
Widowed	57	35.0%	106	65.0%	163
Not Recorded on ESR	529	62.5%	317	37.5%	846
Total	6,809	51.3%	6,453	48.7%	13,262

5.6 Recruitment

	Total Number of Applications Received	%	Total Number of Applicants Shortlisted	%	Total Number of Applicants Offered	%
Civil Partnership	1,163	1.5%	272	3.0%	87	3.3%
Divorced	1,209	1.6%	349	3.9%	102	3.8%
Legally Separated	175	0.2%	42	0.5%	15	0.6%
Married	41,417	54.4%	4,162	46.1%	1,071	40.3%
Other	1,085	1.4%	397	4.4%	141	5.3%
Single	29,971	39.4%	3,493	38.7%	1,069	40.3%
Widowed	174	0.2%	48	0.5%	16	0.6%
Unknown	767	1.0%	146	1.6%	40	1.5%
Unspecified	136	0.2%	124	1.4%	114	4.3%
Total	76,097	100%	9,033	100%	2,655	100%

5.7 Shortlist to Offer

	Total Number of Applications Received	Total Number of Applicants Shortlisted	%	Total Number of Applicants Offered	%
Civil Partnership	1,163	272	23.4%	87	32.0%
Divorced	1,209	349	28.9%	102	29.2%
Legally Separated	175	42	24.0%	15	35.7%
Married	41,417	4,162	10.1%	1,071	25.7%
Other	1,085	397	36.6%	141	35.5%
Single	29,971	3,493	11.7%	1,069	30.6%
Widowed	174	48	27.6%	16	33.3%
Unknown	767	146	19.0%	40	27.4%
Unspecified	136	124	91.2%	114	91.9%
Total	76,097	9,033	12%	2,655	29%

5.8 Leavers

	Headcount	%
Civil Partnership	21	1.99%
Divorced	89	8.44%
Legally Separated	9	0.85%
Married	493	46.73%
Single	376	35.64%
Widowed	23	2.18%
Not Recorded on ESR	44	4.17%
Total	1,055	100%

5.9 Staff Involved in Formal Disciplinary Procedures

	Headcount	%
Civil Partnership	2	3.3%
Divorced	9	15.0%
Legally Separated	1	1.7%
Married	21	35.0%
Single	24	40.0%
Widowed	1	1.7%
Not Recorded on ESR	2	3.3%
Total	60	100%

5.10 Staff Involved in Formal Respect and Resolution Procedures

	Headcount	%
Civil Partnership	2	2.8%
Divorced	7	9.9%
Legally Separated	1	1.4%
Married	39	54.9%
Single	19	26.8%
Widowed	1	1.4%
Not Recorded on ESR	2	2.8%
Total	71	100%

5.11 Staff Involved in Formal Capability Procedures

	Headcount	%
Married	3	60%
Single	1	20%
Not Recorded on ESR	1	20%
Total	5	100%

Maternity and Adoption (Pregnancy and Maternity)

Our Workforce

6.1 Headcount

	Headcount	%
Staff taken Maternity Leave & Adoption Leave	627	5.1%

6.2 Leavers

	Headcount	%
Leaving Reason due to Maternity or Adoption	0	0.0%

Religion and Belief (Including No Belief)

Our Workforce

7.1 Headcount

	Headcount	%
Atheism	2,417	18.2%
Buddhism	89	0.7%
Christianity	5,678	42.8%
Hinduism	158	1.2%
Islam	231	1.7%
Jainism	2	0.0%
Judaism	7	0.1%
Sikhism	10	0.1%
Other	1,395	10.5%
I Do Not Wish to Disclose my Religion/Belief	2,318	17.5%
Not Recorded on ESR	957	7.2%
Total	13,262	100%

7.2 Headcount by Religious Belief and Staff Group

	Atheism	%	Buddhism	%	Christianity	%	Hinduism	%	I do not wish to disclose my religion/ belief	%	Islam	%	Jainism	%	Judaism	%	Other	%	Sikhism	%	Not Recorded on ESR	%	Total
Prof Scientific and Technic	101	23.7 %	3	0.7 %	191	44.7 %	4	0.9 %	55	12.9 %	3	0.7 %	0	0.0 %	0	0.0 %	44	10.3 %	0	0.0 %	26	6.1 %	427
Additional Clinical Services	611	20.4 %	6	0.2 %	1,258	42.0 %	18	0.6 %	488	16.3 %	21	0.7 %	0	0.0 %	1	0.0 %	408	13.6 %	0	0.0 %	181	6.0 %	2,992
Administrative and Clerical	459	18.6 %	8	0.3 %	1,161	47.0 %	9	0.4 %	372	15.1 %	9	0.4 %	0	0.0 %	2	0.1 %	257	10.4 %	1	0.0 %	187	7.6 %	2,465
Allied Health Professionals	201	22.8 %	2	0.2 %	383	43.4 %	7	0.8 %	138	15.6 %	11	1.2 %	1	0.1 %	0	0.0 %	80	9.1 %	1	0.1 %	59	6.7 %	883
Estates and Ancillary	180	15.7 %	4	0.3 %	479	41.9 %	5	0.4 %	198	17.3 %	2	0.2 %	0	0.0 %	0	0.0 %	111	9.7 %	0	0.0 %	164	14.3 %	1,143
Healthcare Scientists	52	23.2 %	2	0.9 %	73	32.6 %	4	1.8 %	39	17.4 %	3	1.3 %	0	0.0 %	0	0.0 %	21	9.4 %	0	0.0 %	30	13.4 %	224
Medical and Dental	48	5.2 %	46	5.0 %	156	16.8 %	84	9.1 %	286	30.8 %	168	18.1 %	1	0.1 %	1	0.1 %	23	2.5 %	4	0.4 %	111	12.0 %	928
Nursing and Midwifery Registered	765	18.2 %	18	0.4 %	1,977	47.0 %	27	0.6 %	742	17.7 %	14	0.3 %	0	0.0 %	3	0.1 %	451	10.7 %	4	0.1 %	199	4.7 %	4,200
Total	2,417	18.2 %	89	0.7 %	5,678	42.8 %	158	1.2 %	2,318	17.5 %	231	1.7 %	2	0.0 %	7	0.1 %	1,395	10.5 %	10	0.1 %	1,395	10.5 %	13,262

7.3 Analysis of Pay by Religious Belief - Religious Belief Headcount and Pay Grade

	Atheism	%	Buddhism	%	Christianity	%	Hinduism	%	I do not wish to disclose my	%	Islam	%	Jainism	%	Judaism	%	Other	%	Sikhism	%	Not Recorded on ESR	%	Total
Band 1	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	14.3%	0	0.0%	0	0.0%	0	0.0%	1	14.3%	0	0.0%	5	71.4%	7
Band 2	357	19.4%	5	0.3%	801	43.5%	14	0.8%	289	15.7%	10	0.5%	0	0.0%	0	0.0%	193	10.5%	0	0.0%	172	9.3%	1,841
Band 3	475	19.0%	5	0.2%	1,074	43.0%	10	0.4%	414	16.6%	17	0.7%	0	0.0%	0	0.0%	335	13.4%	0	0.0%	168	6.7%	2,498
Band 4	173	15.6%	6	0.5%	496	44.8%	3	0.3%	172	15.5%	2	0.2%	0	0.0%	2	0.2%	128	11.6%	0	0.0%	125	11.3%	1,107
Band 5	527	20.1%	10	0.4%	1,110	42.3%	29	1.1%	495	18.9%	14	0.5%	0	0.0%	2	0.1%	288	11.0%	1	0.0%	149	5.7%	2,625
Band 6	455	21.4%	10	0.5%	966	45.5%	10	0.5%	340	16.0%	11	0.5%	0	0.0%	1	0.0%	217	10.2%	2	0.1%	110	5.2%	2,122
Band 7	222	16.9%	2	0.2%	654	49.8%	5	0.4%	201	15.3%	4	0.3%	1	0.1%	0	0.0%	147	11.2%	2	0.2%	75	5.7%	1,313
Band 8a	106	22.0%	3	0.6%	240	49.9%	2	0.4%	64	13.3%	4	0.8%	0	0.0%	0	0.0%	41	8.5%	1	0.2%	20	4.2%	481
Band 8b	32	23.4%	1	0.7%	74	54.0%	0	0.0%	19	13.9%	0	0.0%	0	0.0%	0	0.0%	8	5.8%	0	0.0%	3	2.2%	137
Band 8c	13	13.7%	1	1.1%	54	56.8%	0	0.0%	13	13.7%	0	0.0%	0	0.0%	1	1.1%	5	5.3%	0	0.0%	8	8.4%	95
Band 8d	6	18.1%	0	0.0%	21	63.6%	1	3.0%	2	6.0%	0	0.0%	0	0.0%	0	0.0%	2	6.0%	0	0.0%	1	3.0%	33
Band 9	2	8.3%	0	0.0%	12	50.0%	0	0.0%	6	25.0%	0	0.0%	0	0.0%	0	0.0%	3	12.5%	0	0.0%	1	4.2%	24
Consultant	21	6.0%	17	4.8%	71	20.2%	38	10.8%	101	28.7%	45	12.8%	0	0.0%	1	0.3%	10	2.8%	2	0.6%	46	13.1%	352
Speciality Doctors	11	0.5%	11	0.5%	35	15.2%	21	9.1%	71	30.9%	66	28.7%	1	0.4%	0	0.0%	2	0.9%	1	0.4%	11	0.5%	230
Other Doctors in Training	4	1.8%	16	7.0%	23	10.1%	15	6.6%	81	35.5%	52	22.8%	0	0.0%	0	0.0%	6	2.6%	1	0.4%	30	13.2%	228
Hospital Practitioner & Clinical Assistants	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	100.0%	1
Other Medical and Dental Staff	4	7.0%	1	0.2%	13	22.8%	5	8.8%	15	26.3%	2	3.5%	0	0.0%	0	0.0%	2	3.5%	0	0.0%	15	26.3%	57
Other	9	8.1%	1	0.9%	33	29.7%	5	4.5%	34	30.6%	4	3.6%	0	0.0%	0	0.0%	8	7.2%	0	0.0%	17	15.3%	111
Total	2,417	18.2%	89	0.7%	5,677	42.8%	158	1.2%	2,318	17.5%	231	1.7%	2	0.0%	7	0.1%	1,396	10.5%	10	0.0%	0	0.0%	13,262

7.4 Average Salary by Religious Belief and Staff Group

	Prof Scientific & Technical	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Nursing & Midwifery Registered	Total
Atheism	£50,923.07	£27,591.22	£37,559.16	£44,545.24	£26,657.40	£45,933.17	£113,049.07	£42,134.39	£39,133.55
Buddhism	£57,655.27	£29,096.62	£34,065.29	£41,707.50	£25,457.81	£51,897.00	£92,274.90	£45,736.26	£69,663.17
Christianity	£56,475.59	£27,555.79	£38,324.81	£48,155.03	£26,713.01	£50,724.64	£108,535.17	£44,314.30	£40,995.35
Hinduism	£61,251.00	£26,260.47	£34,203.06	£41,183.29	£24,833.00	£41,393.50	£104,668.99	£36,064.32	£73,882.48
I do not wish to disclose my religion/belief	£53,921.37	£27,600.69	£36,953.73	£48,551.69	£26,219.19	£47,799.83	£108,200.28	£41,567.29	£43,801.70
Islam	£59,358.00	£26,160.62	£47,966.38	£38,979.11	£24,833.00	£42,214.29	£87,276.51	£37,667.43	£75,007.59
Jainism	£0	£0	£0	£51,028.00	£0	£0	£88,389	£0	£77,714.43
Judaism	£0	£27,898.00	£63,733.65	£0	£0	£0	£121,264.00	£38,882.65	£59,822.62
Sikhism	£0	£0	£55,532.00	£0	£0	£0	£95,453.50	£49,487.75	£70,588.56
Other	£45,342.25	£27,758.48	£35,248.71	£49,346.15	£25,723.00	£49,911.72	£111,102.30	£43,100.65	£37,606.35
Not Recorded on ESR	£46,860.46	£28,159.07	£37,493.73	£52,016.83	£25,786.20	£50,626.90	£113,982.53	£41,572.53	£44,148.71
Total	£53,148.52	£27,626.41	£37,618.34	£47,525.79	£26,362.03	£48,744.64	£103,135.19	£43,107.36	£42,325.03

The table above shows analysis of pay using mean annual salary as the basis and the figures shown are those for March 2026.

7.5 Contract Type and Working Pattern

Contract Type											
	Permanent	%	Fixed Term Temp	%	Locum	%	Non-Exec Director/Chair	%	Bank	%	Total
Atheism	2,095	86.7%	111	4.6%	2	0.1%	0	0.0%	209	8.6%	2,417
Buddhism	62	69.7%	24	27.0%	0	0.0%	0	0.0%	3	3.4%	89
Christianity	5,107	89.9%	202	3.6%	1	0.0%	4	0.1%	364	6.4%	5,678
Hinduism	122	77.2%	25	15.8%	1	0.6%	0	0.0%	10	6.3%	158
I do not wish to disclose my religion/belief	1,955	84.3%	116	5.0%	35	1.5%	2	0.0%	210	9.1%	2,318
Islam	135	58.4%	79	34.2%	3	1.3%	0	0.0%	14	6.1%	231
Jainism	2	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2
Judaism	5	71.4%	1	14.3%	0	0.0%	0	0.0%	1	14.3%	7
Other	1,259	90.3%	52	3.7%	1	0.1%	0	0.0%	83	5.9%	1,395
Sikhism	8	80.0%	1	10.0%	0	0.0%	0	0.0%	1	10.0%	10
Not Recorded on ESR	862	90.1%	34	3.6%	4	0.4%	1	0.1%	56	5.9%	957
Total	11,612	87.6%	645	4.9%	47	0.4%	7	0.1%	951	7.2%	13,262

Working Pattern					
	Full Time	%	Part Time	%	Total
Atheism	1,325	54.8%	1,092	45.4%	2,417
Buddhism	63	70.8%	26	29.2%	89
Christianity	2,859	50.4%	2,819	49.6%	5,678
Hinduism	121	76.6%	37	23.4%	158
I do not wish to disclose my religion/belief	1,116	48.1%	1,202	51.9%	2,318
Islam	184	79.7%	47	20.3%	231
Jainism	1	50.0%	1	50.0%	2
Judaism	4	57.1%	3	42.9%	7
Other	691	49.5%	704	50.5%	1,395
Sikhism	9	90.0%	1	10.0%	10
Not Recorded on ESR	436	45.6%	521	54.4%	957
Total	6,809	51.3%	6,453	48.7%	13,262

7.6 Recruitment

	Total Number of Applications Received	%	Total Number of Applicants Shortlisted	%	Total Number of Applicants Offered	%
Atheism	4,571	6.0%	1,819	20.1%	641	24.1%
Buddhism	1,006	1.3%	119	1.3%	35	1.3%
Christianity	44,798	58.9%	4,056	44.9%	1,019	38.4%
Hinduism	6,744	8.9%	350	3.9%	67	2.5%
Islam	11,735	15.4%	655	7.3%	163	6.1%
Jainism	53	0.1%	5	0.1%	0	0%
Judaism	8	0.0%	5	0.1%	0	0%
Sikhism	258	0.3%	22	0.2%	5	0.2%
Other	2,410	3.2%	827	9.2%	264	9.9%
Undisclosed	4,514	5.9%	1,175	13.0%	460	17.3%
Total	76,097	100%	9,033	100%	2,654	100%

Note: The figure shown as 2,654 (rather than the overall total of 2,655) of the Applications Offered was due to protecting confidentiality any reported number with a value less than 5 has been rounded down to zero.

7.7 Leavers

	Headcount	%
Atheism	181	17.2%
Buddhism	14	1.3%
Christianity	397	37.6%
Hinduism	14	1.3%
Islam	42	4.0%
Other	105	10.0%
I Do Not Wish to Disclose my Religion/Belief	204	19.4%
Not Recorded on ESR	98	9.3%
Total	1,055	100%

7.8 Training Attendance

	Attendance / Courses Completed	%
Atheism	15,517	19.7%
Buddhism	805	1.0%
Christianity	31,547	40.0%
Hinduism	1,583	2.0%
Islam	2,800	3.6%
Judaism	22	0.00%
Jainism	14	0.0%
Sikhism	64	0.1%
I Do Not Wish to Disclose my Religion/Belief	13,771	17.5%
Other	8,287	10.5%
Not Recorded on ESR	4,479	5.7%
Total	78,889	100%

7.9 Staff Involved in Formal Disciplinary Procedures

	Headcount	%
Atheism	14	23.3%
Christianity	28	46.7%
I Do Not Wish to Disclose my Religion/Belief	7	11.7%
Islam	1	1.7%
Other	4	6.7%
Not Recorded on ESR	6	10.0%
Total	60	100%

7.10 Staff Involved in Formal Respect and Resolution Procedures

	Headcount	%
Atheism	12	16.9%
Christianity	32	45.1%
Hinduism	2	2.8%
Islam	1	1.4%
I Do Not Wish to Disclose my Religion/Belief	7	9.9%
Other	10	14.1%
Not Recorded on ESR	7	9.9%
Total	71	100%

7.11 Staff Involved in Formal Capability

	Headcount	%
Christianity	2	40%
I Do Not Wish to Disclose my Religion/Belief	3	60%
Total	5	100%

Sexual Orientation

Our Workforce

8.1 Headcount

	Headcount	%
Bisexual	140	1.1%
Gay or Lesbian	203	1.5%
Heterosexual or Straight	10,769	81.2%
Not Stated – Person Asked but Declined to Provide a Response	1,162	7.1%
Not Recorded on ESR	943	8.8%
Other Sexual Orientation Not Listed	25	0.2%
Undecided	20	0.2%
Total	13,262	100%

8.2 Headcount by Sexual Orientation and Staff Group

	Bisexual	%	Gay or Lesbian	%	Heterosexual or Straight	%	Not stated (Person Asked but Declined to provide a Response)	%	Other sexual orientation Not Listed	%	Undecided	%	Not Recorded on ESR	%	Total
Add Prof Scientific and Technic	7	1.6%	7	1.6%	361	84.5%	24	5.6%	2	0.5%	0	0.0%	26	6.1%	427
Additional Clinical Services	37	1.2%	45	1.5%	2,571	85.9%	152	5.1%	8	0.3%	5	0.2%	174	5.8%	2,992
Administrative and Clerical	30	1.2%	42	1.7%	2,061	83.6%	141	5.7%	5	0.2%	3	0.1%	183	7.4%	2,465
Allied Health Professionals	12	1.4%	17	1.9%	716	81.1%	79	8.9%	1	0.1%	2	0.2%	56	6.3%	883
Estates and Ancillary	9	0.8%	20	1.7%	850	74.4%	100	8.7%	4	0.3%	3	0.3%	157	13.7%	1,143
Healthcare Scientists	2	0.9%	3	1.3%	165	73.7%	23	10.3%	0	0.0%	1	0.5%	30	13.4%	224
Medical and Dental	6	0.6%	4	0.4%	546	58.8%	257	27.7%	1	0.1%	2	0.2%	112	12.1%	928
Nursing and Midwifery Registered	37	0.9%	65	1.5%	3,499	83.3%	386	9.2%	4	0.1%	4	0.1%	205	4.9%	4,200
Total	140	1.1%	203	1.5%	10,769	81.2%	1,162	8.8%	25	0.2%	20	0.2%	943	7.1%	13,262

8.3 Analysis of Pay be Sexual Orientation - Sexual Orientation Headcount and Pay Grade

	Bisexual	%	Gay or Lesbian	%	Heterosexual or straight	%	Not Stated (Person Asked but Declined to Provide a Response)	%	Not Recorded on ESR	%	Other Sexual Orientation not Listed	%	Undecided	%	Total
Band 1	0	0.0%	0	0.0%	1	14.3%	1	14.3%	5	71.4%	0	0.0%	0	0.0%	7
Band 2	23	1.2%	34	1.8%	1,470	79.8%	140	7.6%	165	9.0%	5	0.3%	4	0.2%	1,841
Band 3	29	1.2%	36	1.4%	2,139	85.6%	119	4.8%	163	6.5%	8	0.3%	4	0.2%	2,498
Band 4	13	1.2%	15	1.4%	895	80.8%	57	5.1%	124	11.2%	2	0.2%	1	0.1%	1,107
Band 5	28	1.1%	40	1.5%	2,103	80.1%	292	11.1%	156	5.9%	1	0.0%	5	0.2%	2,625
Band 6	22	1.0%	35	1.6%	1,797	84.7%	157	7.4%	106	5.0%	1	0.0%	4	0.2%	2,122
Band 7	10	1.0%	24	1.8%	1,121	85.4%	85	6.5%	69	5.3%	4	0.3%	0	0.0%	1,313
Band 8a	6	1.2%	10	2.1%	427	88.8%	16	3.3%	20	4.2%	1	0.2%	1	0.2%	481
Band 8b	3	2.2%	2	1.5%	120	87.6%	8	5.8%	4	2.9%	0	0.0%	0	0.0%	137
Band 8c	0	0.0%	2	2.1%	74	77.9%	10	10.5%	8	8.4%	1	1.1%	0	0.0%	95
Band 8d	0	0.0%	0	0.0%	30	90.9%	1	3.0%	1	3.0%	1	3.0%	0	0.0%	33
Band 9	0	0.0%	0	0.0%	19	79.2%	4	16.7%	1	4.2%	0	0.0%	0	0.0%	24
Consultant	1	0.3%	4	1.1%	213	60.5%	85	24.1%	48	13.6%	0	0.0%	1	0.3%	352
Speciality Doctors	2	0.9%	0	0.0%	144	62.6%	72	31.3%	11	4.8%	1	0.4%	0	0.0%	230
Other Doctors in Training	2	0.9%	0	0.0%	118	51.8%	77	33.8%	30	13.2%	0	0.0%	1	0.4%	228
Hospital Practitioner & Clinical Assistants	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	100.0%	0	0.0%	0	0.0%	1
Other Medical and Dental Staff	1	1.8%	0	0.0%	29	50.9%	12	21.1%	15	26.3%	0	0.0%	0	0.0%	57
Other	0	0.0%	1	0.9%	68	61.3%	26	23.4%	16	14.4%	0	0.0%	0	0.0%	111
Total	140	1.1%	203	1.5%	10,768	81.2%	1,162	8.8%	943	7.1%	25	0.2%	21	0.2%	13,262

8.4 Average Salary by Sexual Orientation and Staff Group

	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not Stated (Person Asked but declined to Provide a Response)	Other Sexual Orientation	Undecided	Not Recorded on ESR	Total
Prof Scientific & Technical	£52,571.80	£42,006.94	£53,598.70	£55,116.88	£73,776.57	£0	£46,860.56	£53,148.52
Additional Clinical Services	£27,886.36	£26,986.61	£27,567.18	£28,150.05	£30,281.98	£25,767.20	£28,095.63	£27,625.41
Admin & Clerical	£31,602.57	£38,096.21	£37,714.06	£37,745.11	£42,515.50	£31,085.79	£37,277.59	£37,618.34
Allied Health Professionals	£42,485.94	£40,736.41	£47,334.61	£48,727.12	£55,532.00	£39,398.00	£52,188.93	£47,525.79
Estates and Ancillary	£24,833.00	£25,439.25	£26,602.32	£25,658.36	£24,833.00	£24,833.00	£25,827.49	£26,362.03
Healthcare Scientists	£47,280.00	£39,444.00	£48,622.42	£48,235.97	£0	£39,263.00	£51,527.35	£48,744.64
Medical & Dental	£86,849.40	£127,603.00	£100,279.97	£106,146.85	£62,117.00	£95,702.00	£115,226.63	£103,135.19
Nursing & Midwifery Registered	£42,937.07	£44,890.28	£43,597.23	£39,174.61	£47,479.22	£46,358.50	£41,021.20	£43,107.36
Total	£38,262.41	£39,433.64	£41,569.40	£49,556.88	£41,422.05	£40,911.27	£44,564.99	£42,325.03

The above table shows analysis of pay using mean annual salary as the basis and the figures shown are those for March 2026.

8.5 Contract Type and Working Pattern

Contract Type											
	Permanent	%	Fixed Term Temp	%	Locum	%	Non-Exec Director/Chair	%	Bank	%	Total
Bisexual	117	83.6%	6	4.3%	0	0.0%	0	0.0%	17	12.1%	140
Gay or Lesbian	185	91.1%	2	1.0%	0	0.0%	0	0.0%	15	7.4%	203
Heterosexual or Straight	9,501	88.2%	515	4.8%	10	0.1%	4	0.0%	730	6.8%	10,769
Not Stated (Person Asked but Declined to Provide a Response)	913	78.6%	81	7.0%	33	2.8%	2	0.2%	133	11.4%	1,162
Not Recorded on ESR	850	90.1%	34	3.6%	4	0.4%	1	0.1%	54	5.7%	943
Other Sexual Orientation Not Listed	23	92.0%	1	4.0%	0	0.0%	0	0.0%	1	4.0%	25
Undecided	14	70.0%	5	25.0%	0	0.0%	0	0.0%	1	5.0%	20
Total	11,612	87.6%	645	4.9%	47	0.4%	7	0.1%	951	7.2%	13,262

Working Pattern					
	Full Time	%	Part Time	%	Total
Bisexual	84	60.0%	56	40.0%	140
Gay or Lesbian	134	66.0%	69	34.0%	203
Heterosexual or Straight	5,599	52.0%	5,170	48.0%	10,769
Not Stated (Person Asked but Declined to Provide a Respond)	529	45.5%	633	54.5%	1,162
Not Recorded on ESR	440	46.7%	503	53.3%	943
Other Sexual Orientation Not Listed	10	40.0%	15	60.0%	25
Undecided	13	65.0%	7	35.0%	20
Total	6,809	51.3%	6,453	48.7%	13,262

8.6 Recruitment

	Total Number of Applications Received	%	Total Number of Applicants Shortlisted	%	Total Number of Applicants Offered	%
Bisexual	1,155	1.5%	206	2.3%	58	2.2%
Gay or Lesbian	644	0.8%	184	2.0%	56	2.1%
Heterosexual or Straight	72,057	94.7%	8,139	90.1%	2,320	87.4%
Other	133	0.2%	25	0.3%	9	0.3%
Undecided	71	0.1%	17	0.2%	7	0.3%
Undisclosed	2,037	2.7%	462	5.1%	205	7.7%
Total	76,097	0%	9,033	100%	2,655	100%

8.7 Shortlist to Offer

	Total Number of Applications Received	Total Number of Applicants Shortlisted	%	Total Number of Applicants Offered	%
Bisexual	1,155	206	17.8%	58	28.2%
Gay or Lesbian	644	184	28.6%	56	30.4%
Heterosexual or Straight	72,057	8,139	11.3%	2,320	28.5%
Other	133	25	18.8%	9	36.0%
Undecided	71	17	23.9%	7	41.2%
Undisclosed	2,037	462	22.7%	205	44.4%
Total	76,097	9,033	12%	2,655	29%

8.8 Leavers

	Headcount	%
Bisexual	19	1.8%
Gay or Lesbian	16	1.5%
Heterosexual or Straight	783	74.2%
Not Stated (person asked but declined to provide a response)	135	12.8%
Other sexual orientation not listed	3	0.3%
Undecided	3	0.3%
Not Recorded on ESR	96	9.1%
Total	1,055	100%

8.9 Training Attendance

	Attendance / Courses Completed	%
Bisexual	1,115	1.4%
Gay or Lesbian	1,279	1.6%
Heterosexual or Straight	64,088	81.2%
Not Stated (person asked but declined to provide a response)	7,603	9.6%
Other sexual orientation not listed	164	0.2%
Undecided	211	0.3%
Not Recorded on ESR	4,429	5.6%
Total	78,889	100%

8.10 Staff Involved in Formal Disciplinary Procedures

	Headcount	%
Gay or Lesbian	3	5.0%
Heterosexual or Straight	46	76.7%
Not Stated (person asked but declined to provide a response)	4	6.7%
Not Recorded on ESR	7	11.7%
Total	60	100%

8.11 Staff Involved in Formal Respect and Resolution Procedures

	Headcount	%
Gay or Lesbian	1	1.4%
Heterosexual or Straight	57	80.3%
Not Stated (person asked but declined to provide a response)	9	12.7%
Not Recorded on ESR	4	5.6%
Total	71	100%

8.12 Staff Involved in Formal Capability Procedures

	Headcount	%
Bisexual	1	20%
Heterosexual or Straight	3	60%
Not Stated (person asked but declined to provide a response)	1	20%
Total	5	100%

Welsh Language

Our Workforce

9.1 Headcount by Staff Group

	0 – No Skills	1 – Entry	2 – Foundation	3 – Intermediate	4 – Higher	5 – Proficiency	Not Recorded on ESR	Total
Add Prof Scientific and Technic	142	103	42	22	44	78	1	432
Additional Clinical Services	1,023	584	240	238	232	283	20	2,620
Admin & Clerical	860	701	273	225	178	245	16	2,498
Allied Health Professional	360	179	80	59	65	131	5	879
Estates and Ancillary	498	198	71	53	65	114	42	1,041
Healthcare Scientists	81	45	16	14	24	36	2	218
Medical & Dental	552	106	32	15	7	30	83	825
Nursing & Midwifery Registered	1,679	821	353	288	307	483	82	4,013
Total	5,195	2,737	1,107	914	922	1,400	251	12,526
%	41%	22%	9%	7%	7%	11%	2%	100%

9.2 Leavers – Welsh Language Skills 2025/26

	Primary Headcount	%
Not Recorded / NA	143	13.55%
0 – No Skills / Dim Sgiliau	440	41.71%
1 – Entry / Mynediad	182	17.25%
2 – Foundation / Sylfaen	73	6.92%
3 – Intermediate / Canolradd	60	5.69%
4 – Higher / Uwch	60	5.69%
5 – Proficiency / Hyfedredd	97	9.19%
Total	1,055	100%

9.3 Hires – Welsh Language Skills 2025/26

	Primary Headcount	%
Not Recorded / NA	201	15.27%
0 – No Skills / Dim Sgiliau	617	46.85%
1 – Entry / Mynediad	176	13.36%
2 – Foundation / Sylfaen	84	6.38%
3 – Intermediate / Canolradd	73	5.54%
4 – Higher / Uwch	61	4.63%
5 – Proficiency / Hyfedredd	105	7.97%
Total	1,317	100%

Appendix 2 – Formal Respect and Resolution, Disciplinary and Capability Narrative

Analysis has been undertaken of the equality data for all formal cases in regard to Respect & Resolution, Disciplinary and Capability cases and a summary has been provided in this section.

This analysis indicates an overall increase in activity, consistent with the continued emphasis on encouraging staff to raise concerns and speak up. There were 60 formal disciplinary cases, 71 Respect & Resolution cases, and 5 capability cases recorded in 2025/26.

As in previous years, the Workforce Team continues to promote early resolution and informal approaches, although informal activity is not fully captured corporately. The relatively low number of capability cases (5) should be considered when interpreting trends, as small numbers limit statistical reliability. Overall, the data suggests that case volumes are concentrated within mid-career staff groups, broadly aligning with workforce composition.

The Workforce team continues to encourage a compassionate approach to its processes and where necessary every effort is made to address concerns and conduct issues in an informal manner to encourage learning from events and a compassionate approach to such matters.

Respect and Resolution

The 2025/26 data demonstrates that there is a continued increase in the use of the Respect & Resolution process, indicating a positive cultural shift toward staff feeling more able and willing to raise concerns. Respect and Resolution cases remain the most frequently utilised of the formal employee relations processes, with a total of 71 cases recorded during the reporting period.

The distribution of cases continues to reflect the organisation's workforce profile, with activity concentrated predominantly within mid-career age groups. The highest proportion of cases is observed within the 36–40 age band, with no cases recorded among those aged 20 and under. This pattern suggests that case volumes are largely influenced by workforce composition and the increasing complexity of roles and interpersonal dynamics that can arise as staff progress through their careers, rather than age acting as a determining factor in itself.

A notable feature of the data is the higher proportional involvement of disabled staff within Respect and Resolution cases. Staff with a declared disability, who make up approximately 6.3% of the workforce, account for 15.5% of cases. This trend was present in 2024/25 but is now more clearly defined.

This pattern may reflect a number of factors, including the possibility that disabled staff experience additional workplace barriers or challenges that lead to concerns being raised more frequently. These may relate to working conditions, access to adjustments, or broader aspects of workplace inclusion. It may also indicate a greater likelihood of disabled staff engaging with formal processes where issues arise. Importantly, the data does not indicate that disability is the cause of the concerns raised, and it may reflect a more open culture and improved confidence in raising concerns, but it does highlight the importance of ensuring that inclusive practices and early support mechanisms are consistently applied across the organisation.

In terms of ethnicity, the distribution of Respect and Resolution cases is broadly proportionate to the workforce profile, with the majority of cases involving staff who identify as White. There are no clear or consistent trends indicating disproportionate representation among minority ethnic groups within this process. This suggests that, overall, the Respect and Resolution framework is being accessed in a way that reflects the diversity of the workforce, and there is no indication from the data that ethnicity is a contributing factor in the raising of concerns or in the processes themselves.

From a gender perspective, female staff account for approximately 73% of Respect and Resolution cases. While this appears high in isolation, it is broadly reflective of the overall workforce profile, where the majority of employees are female. The data may also suggest a greater propensity for female staff to engage with formal mechanisms for raising concerns, potentially reflecting differing approaches to conflict resolution or willingness to utilise organisational processes. However, there is no evidence to suggest that gender itself is a significant driver of cases beyond this proportional representation.

Analysis of marital status shows that married staff represent the largest group within Respect and Resolution cases, followed by those who are single. This mirrors the general workforce distribution and does not indicate any disproportionality linked to marital status. Similarly, there are no discernible trends in relation to religion and belief or sexual orientation, with case distribution broadly aligned to workforce demographics and no evidence that these characteristics have contributed to the concerns raised.

Overall, the Respect and Resolution data suggests that while most characteristics are proportionately represented, the higher involvement of disabled staff warrants ongoing attention. This should be considered within the wider context of workplace experience and the need to ensure that organisational practices are inclusive and responsive to individual needs.

Disciplinary

The number of disciplinary cases in 2025/26 (60 cases) shows broad consistency with the previous year, suggesting that the use of formal disciplinary processes remains stable. This indicates that there has been no significant escalation in conduct-related issues, and that thresholds for entering formal disciplinary processes have remained consistent. This stability is generally a positive indicator, reflecting controlled and proportionate use of formal procedures within the organisation.

The distribution of cases demonstrates a similar pattern to Respect and Resolution, with activity concentrated within mid- to late-career age groups. The highest proportion of cases is observed within the 51–55 age band, although overall the spread of cases reflects the workforce age profile. As with previous years, there is no evidence of a significant or consistent age-related disproportionality.

As with Respect and Resolution, disabled staff are proportionately more represented within disciplinary cases, accounting for 10% of cases compared to approximately 6.3% of the workforce i.e. 6 cases of the 60 raised. This overrepresentation is likely to be influenced by a combination of factors, including the impact of long-term health conditions on attendance and performance, as well as the increased level of engagement with formal organisational processes that disabled staff may experience. It may also reflect situations where earlier intervention or adjustments could have mitigated the escalation of issues. The data does not suggest that disability itself is a causal factor in conduct-related issues and given in context we should not be alarmed rather be mindful of this trend and reinforce the importance of consistent and proactive support.

Ethnicity data indicates that the majority of disciplinary cases involve staff who identify as White, which is consistent with overall workforce composition. However, there are some indications of slight overrepresentation among Black and Mixed ethnicity staff when compared to their respective proportions within the workforce. While these differences are based on relatively small numbers, they highlight an area that would benefit from continued monitoring to determine whether this represents an emerging trend or statistical variation. When considered alongside wider workforce data, including recruitment and contract patterns, it may reflect broader structural factors rather than issues directly related to the disciplinary process itself.

The gender profile of disciplinary cases shows a more balanced distribution than that seen in Respect and Resolution, with approximately 57% of cases involving female staff and 43% involving male staff. Given the predominantly female workforce, this suggests that male staff may be proportionately more represented within disciplinary processes, although the difference is not substantial. This may reflect differences in role types, working environments, or exposure to situations that give rise to conduct-related issues, rather than any systemic bias in the application of processes.

Marital status within disciplinary cases shows that single staff represent the largest group, followed by married staff, which again reflects the underlying workforce profile. There is no evidence of any disproportionate impact associated with marital status. Similarly, the distribution of cases across religion and belief and sexual orientation aligns with workforce demographics, with no clear trends indicating unequal treatment or impact.

In summary, disciplinary cases in 2025/26 are broadly proportionate across most characteristics, although the data highlights areas, particularly disability and some aspects of ethnicity, where continued monitoring and further qualitative understanding would be beneficial.

Capability

Capability cases remain very low in number, with only five formal cases recorded during 2025/26. and this stability is itself a positive indicator, suggesting that formal performance management processes are used only where necessary.

Given the low numbers recorded any analysis must be treated with caution, as small numbers can significantly distort proportional representation and limit the ability to draw firm conclusions.

The age profile of capability cases shows a concentration within the 51–55 age group, which may reflect the intersection of longer service, cumulative workplace demands, and the potential impact of health conditions over time. However, given the small number of cases, this does not constitute a definitive trend.

The most notable feature of the capability data is the high proportion of cases involving disabled staff, with four of the five recorded cases relating to individuals with a declared disability. While this appears disproportionately high, it is important to recognise that this reflects a very small number of individuals. The pattern is likely to be influenced by the relationship between long-term health conditions and sustained performance, as well as the extent to which appropriate adjustments and support mechanisms are in place. It may also indicate opportunities to strengthen early intervention and ensure that managers are effectively supported to manage performance in the context of disability.

Ethnicity data suggests that the majority of capability cases involve White staff, with a smaller proportion involving Asian staff. While this represents a higher proportional involvement for Asian staff compared to their workforce representation, the very small number of cases means that this finding cannot be considered statistically reliable and should instead be viewed as a prompt for continued observation over time.

The gender distribution indicates that the majority of cases involve female staff, which is consistent with the overall workforce profile. Similarly, marital status data shows that most individuals involved are married, again reflecting the broader workforce demographic rather than indicating any causal relationship.

There are no discernible patterns in relation to religion and belief or sexual orientation within capability cases, although again this is influenced by the very small dataset.

Overall, the capability data does not indicate systemic inequality but does highlight areas where further qualitative analysis would be valuable. In particular, the interaction between disability, health, and performance management requires careful consideration to ensure that processes remain supportive, fair, and focused on enabling staff to succeed.

Overall Position

Across all three processes, the 2025/26 data indicates that most demographic groups are represented in a way that broadly reflects workforce composition. Variations that do exist, particularly in relation to disability and, to a lesser extent, ethnicity, appear to reflect the interaction between workforce characteristics and organisational processes rather than clear evidence of inequity. The data reinforces the importance of continued monitoring, alongside deeper qualitative exploration, to ensure that any emerging themes are understood and addressed appropriately.



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Pay Gap Report for Disability, Ethnicity & Gender

Reporting Period 01 April 2025 - 31 March 2026

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Introduction

Hywel Dda University Health Board is committed to providing outstanding patient care and we do this by ensuring we have a diverse, talented and high performing workforce.

We are working hard to create an inclusive and compassionate culture and to ensure that equality is considered throughout the employee life cycle.

This report provides an overview of our data but should be read alongside our Strategic Equality Plan Annual Report which includes information on the actions that we have taken to promote diversity and inclusion in the workplace.

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 came into force on 06 April 2017 and requires employers with more than 250 employees to publish annual data on their gender pay gap. Although public sector organisations in Wales are exempt from these regulations, NHS Wales has agreed to work to publish its own gender pay data in line with the regulations using reports designed to meet the requirements in Electronic Staff Register Business Intelligence (ESRBI).

Alongside our Gender Pay Gap, we are publishing our Ethnicity and Disability Pay Gap. Hywel Dda University Health Board is committed to ensuring that our pay practices are transparent, fair and equitable. It should be noted that the data within this report is based on staff who have earned money during the reporting period. The figures may vary from those reported within the Workforce Equality Data chapter of our Strategic Equality Plan Annual Report which includes staff engaged as workers and employees and will include bank and locum staff.

What is the Pay Gap?

The pay gap is the difference in average earnings between group of colleagues within the organisation, regardless of what role they are in.

The pay gap is useful in measuring pay equality due to its simple calculation; however, it does not measure the pay difference between people at the same pay grade, doing the same job, with the same working pattern. It also does not include any of the personal characteristics that may determine a person's pay, such as age.

We aim to look at the pay differences between men and women, our Black, Asian & Minority Ethnic and white colleagues, and those identified as having a disability and those who do not.

Gathering the Information

The following data was produced using the ESRBI report. The report includes all employees (those with a contract of employment) who have earned money in the reporting period whereby an hourly rate can be calculated. Agency workers and contracted staff are excluded from the report on the basis that they will form part of the headcount of the agency/company that provides them, and not the employer to which they are on assignment.

All pay gap data provided in this report was obtained through the national Pay Gap dashboards via the ESR Business Intelligence report as of 31 March 2026. The data includes staff on Agenda for Change, staff on non-Agenda for Change terms and conditions. Clinical Excellence Awards for medical staff are included in both ordinary and bonus pay calculations.

Agenda for Change and Medical and Dental pay evaluation ensures that jobs are evaluated and not the post holder. Some of our employees are appointed on a fixed rate salary such as our apprentices, whilst other staff groups are employed on a band which includes salary progression through a national scale.

Regulatory Requirements for Gender Pay Gap

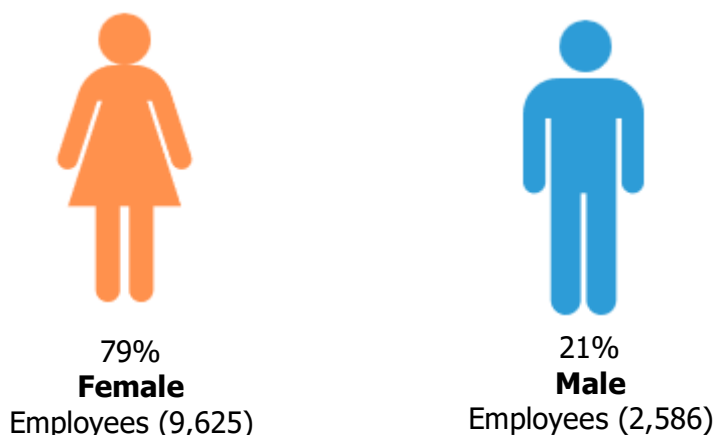
According to the Regulations, this report presents the following:

1. Average gender pay gap as a mean average
2. Average gender pay gap as a median average
3. Proportion of males/females when divided into four groups, ordered from lowest to highest pay
4. Average bonus gender pay gap as a mean average
5. Average bonus gender pay gap as a median average
6. Proportion (ratio) of males/females receiving a bonus payment

Gender Pay Gap

Our Workforce

The calculations used within this report are based on a total of 12,211 employees as at 31 March 2026. Analysis of our internal equality data indicates our gender split is:



Rates of Pay

The gender pay gap is defined as the difference between the mean or median hourly rate of pay of females and males.

The mean gender pay gap is the difference between the average hourly earnings of females and males.

Gender	Ave Hourly Rate
Male	£27.98
Female	£21.42
Difference	£6.56
Pay Gap %	23.45%

The average hourly rate of pay is calculated from a specific pay period, in this case March 2026. The hourly rate is calculated for each employee based on 'ordinary pay', which includes basic pay and allowances such as unsocial enhancements.

The figures above shows that the mean hourly rate for a male is £27.98 compared to £21.42 for female staff members; males received on average £6.56/hour more than females, a pay gap as a mean average of 23.45% (the 2025 figure was 22.33%).

The median hourly pay gap is the difference between the midpoints in the ranges of hourly earnings between men and women and excludes payments of overtime but includes enhancements for shifts and weekend working.

Gender	Ave Hourly Rate
Male	£21.19
Female	£19.62
Difference	£1.57
Pay Gap %	7.42%

As a median average, males received £1.57/hour more than females, a pay gap at a median of 7.42% (the 2025 figure was 6.64%).

Yearly Comparison of our Mean Gender Pay Gap

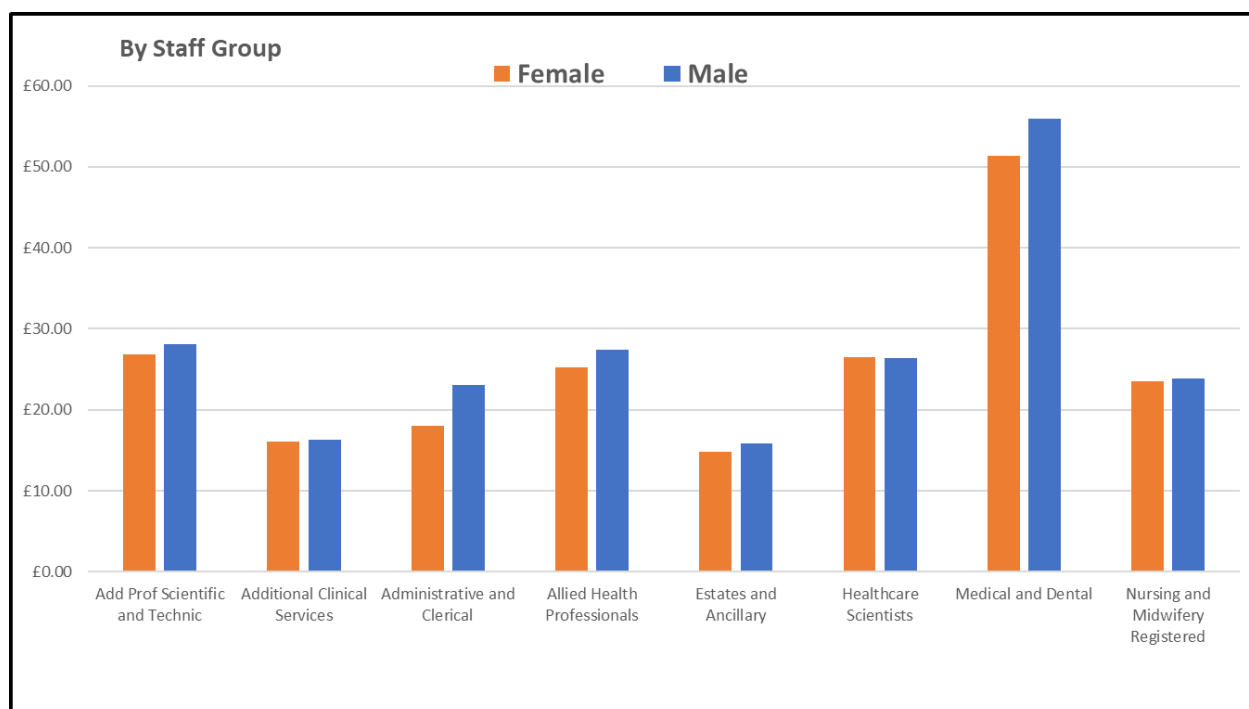
Our first Gender Pay Gap report was published in 2018, where there was a difference of 22.88% between the average earnings of male and females. Since then, we have seen fluctuations in the gender pay gap with the lowest mean pay gap reported in 2021 (17.60%). In 2026, the percentage mean pay gap has risen 1.12% since 2025 and is currently 23.45%.

Year	Average Hourly Rate		Difference	% Pay Gap
	Male	Female		
2018	£19.86	£15.12	£4.74	22.88%
2019	£20.09	£15.48	£4.61	22.90%
2020	£21.06	£15.87	£5.19	24.65%
2021	£20.63	£17.01	£3.62	17.60%
2022	£21.67	£17.56	£4.11	18.95%
2023	£22.49	£17.49	£5.00	22.24%
2024	£23.89	£18.85	£5.04	21.11%
2025	£26.06	£20.24	£5.82	22.33%
2026	£27.98	£21.42	£6.56	23.45%

Our median pay gap has also fluctuated since 2018 with the lowest pay gap reported in 2021 at 0.69%. In 2026 the median pay gap is currently 7.42%. which is a 0.78% increase since 2025 but a 0.22% decrease since 2018.

Year	Median Hourly Rate		Difference	% Pay Gap
	Male	Female		
2018	£14.70	£13.58	£1.12	7.64%
2019	£15.24	£13.96	£1.27	8.37%
2020	£16.54	£14.45	£2.09	12.64%
2021	£15.66	£15.55	£0.11	0.69%
2022	£16.27	£16.13	£0.14	0.86%
2023	£17.12	£15.89	£1.23	7.20%
2024	£18.37	£17.37	£1.00	5.46%
2025	£20.28	£18.94	£1.35	6.64%
2026	£21.19	£19.62	£1.57	7.42%

By Staff Group



Males have a higher average hourly rate in all the staff groups except Healthcare Scientists:

- Additional Professional Scientific and Technical
- Admin and Clerical
- Allied Health Professionals
- Estates and Ancillary
- Medical and Dental
- Nursing and Midwifery
- Additional Clinical Services

Administration and Clerical have the highest percentage gender pay gap of 21.73% (£5.01 per hour), followed by Medical and Dental with a pay gap of 8.21% (£4.59 per hour).

The pay gap for Allied Healthcare Professionals fell again from 9.98% last year to 7.98% this year (£2.19 per hour).

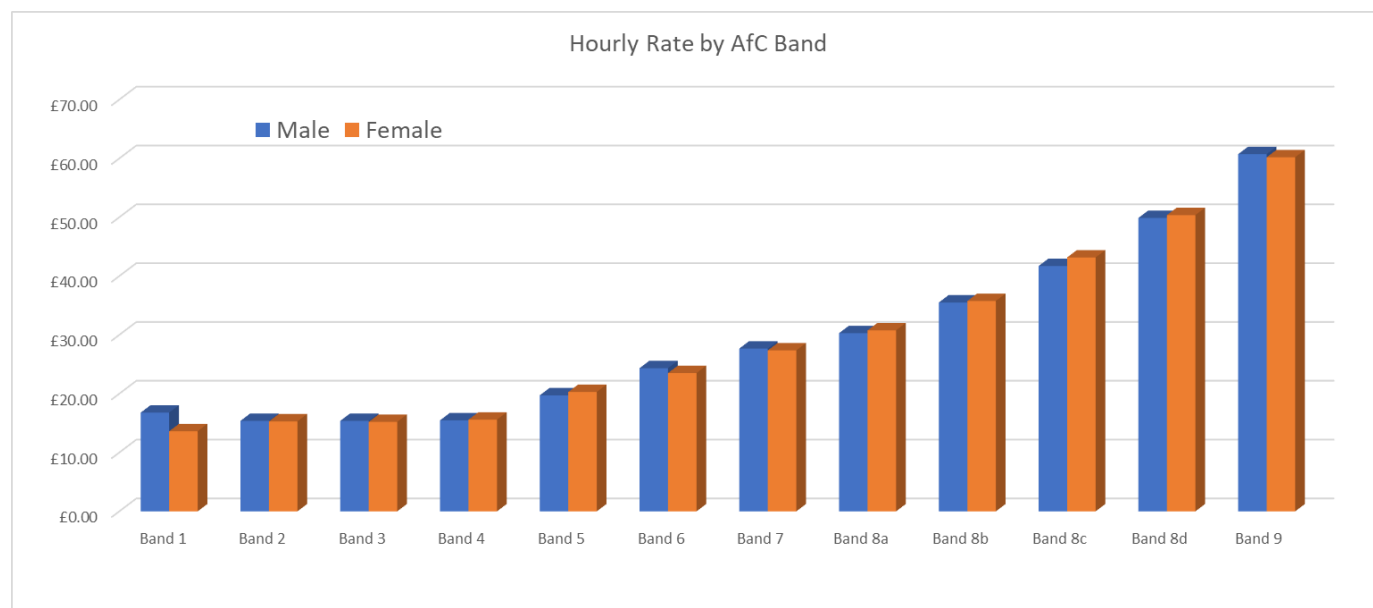
The male average hourly rate for Medical and Dental was £4.59 higher than females (the 2025 figure was £1.54). This is an average hourly pay gap of 8.21%, which is higher than the previous year (the figure was 3.04%).

By pay band

This is the third year that we have provided gender pay gap data by Agenda for Change (AfC) pay bands, showing that:

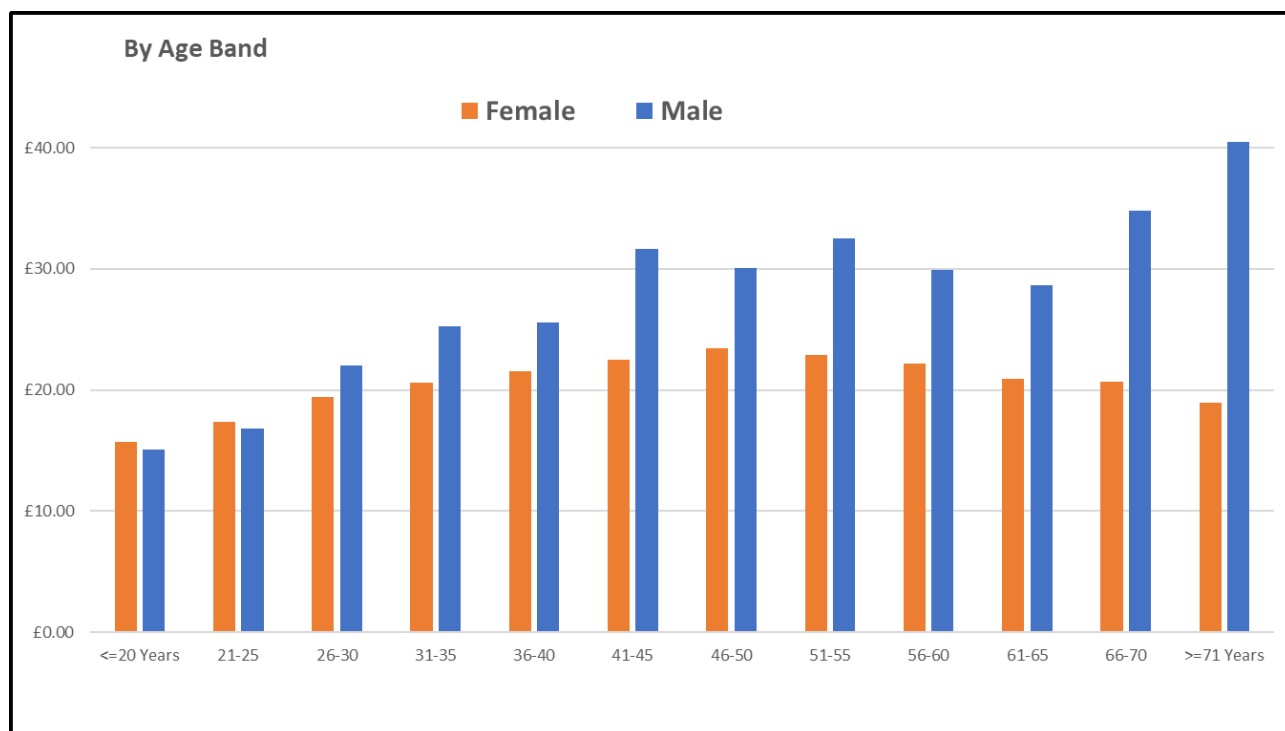
Males have a higher hourly rate than females for AfC pay bands 1-3, 6-7 and band 9, where the highest difference is band 1 at 18.86%, band 6 at 3.40% and band 7 at 1.13%.

Females have a higher average hourly rate than males for bands 4-5, & 8a – 8d, where the highest difference is band 8c with a negative pay gap of -3.49% & band 5 at -2.89%.



Pay Band	Male	Female	Difference	Gap
Band 1	£16.78	£13.62	£3.16	18.86%
Band 2	£15.38	£15.30	£0.09	0.56%
Band 3	£15.38	£15.21	£0.17	1.10%
Band 4	£15.47	£15.59	-£0.12	-0.77%
Band 5	£19.72	£20.29	-£0.57	-2.89%
Band 6	£24.34	£23.51	£0.83	3.40%
Band 7	£27.67	£27.36	£0.31	1.13%
Band 8a	£30.29	£30.77	-£0.48	-1.58%
Band 8b	£35.51	£35.76	-£0.26	-0.72%
Band 8c	£41.71	£43.16	-£1.45	-3.49%
Band 8d	£49.88	£50.37	-£0.48	-0.97%
Band 9	£60.72	£60.20	£0.53	0.87%

By Age Band



Females aged 25 years of age and under have a higher average hourly rate than males of the same age. In other age bands, males have a higher average hourly rate than females of the same age.

There is a pay gap of 53.12% (£21.48 per hour) for those aged 71 years and over, and a pay gap of 40.69% (£14.17 per hour) for those aged 66 - 70 years old.

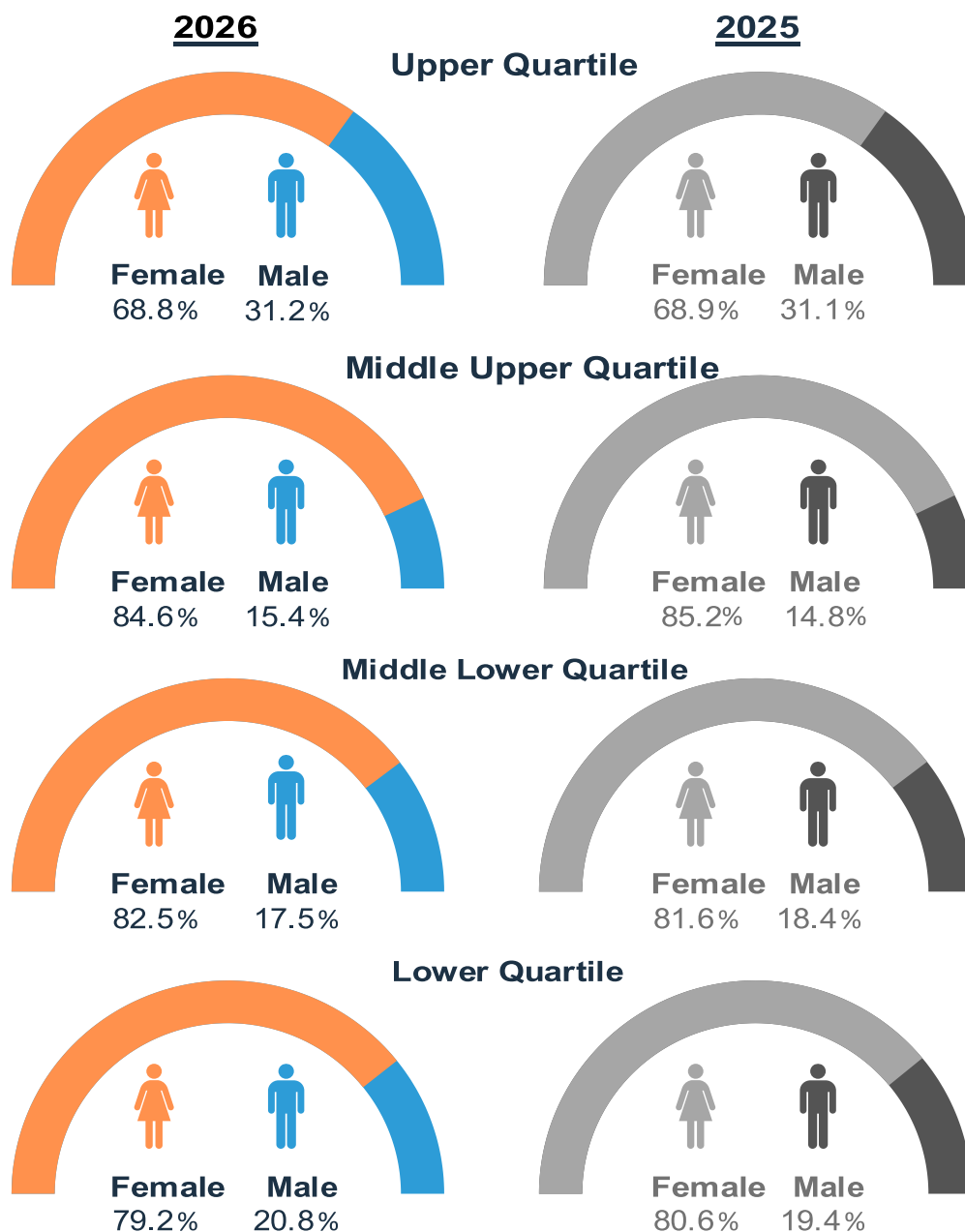
Pay Quartiles

Quartiles are calculated by ranking pay for all colleagues from lowest to highest, and splitting into four groups, showing the percentage of males and females in each group.

Quartile	Hourly Rate Range (from)	Hourly Rate Range (to)
Upper	£25.58	and over
Middle Upper	£19.65	£25.58
Middle Lower	£15.66	£19.64
Lower	up to	£15.66

Pay Quartiles Split

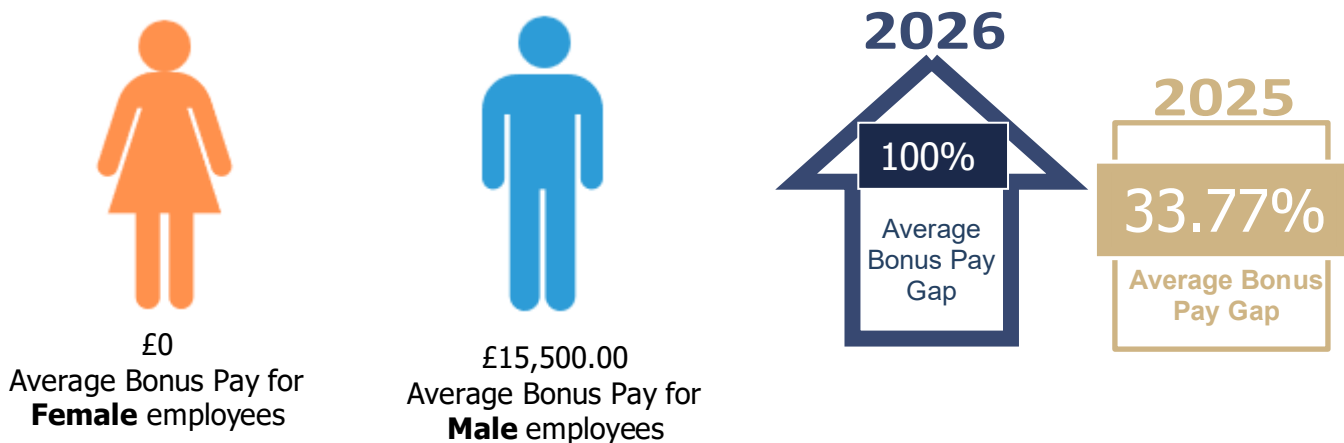
The infographics below shows the proportion of males and females divided into four pay band quartiles.



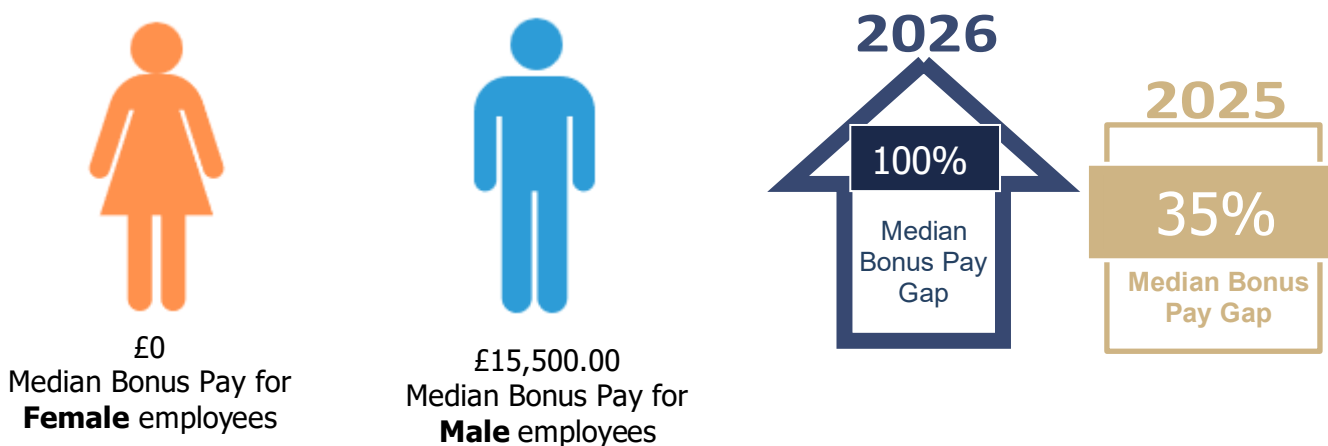
Females were over-represented in the middle two quartiles (83% and 85%) and underrepresented in the upper quartile (69%), compared to the proportion of women in the workforce (79%).

Bonus Payments

Consultants receive payments called 'Clinical Excellence Awards'. Although contractually these are classed as a bonus.

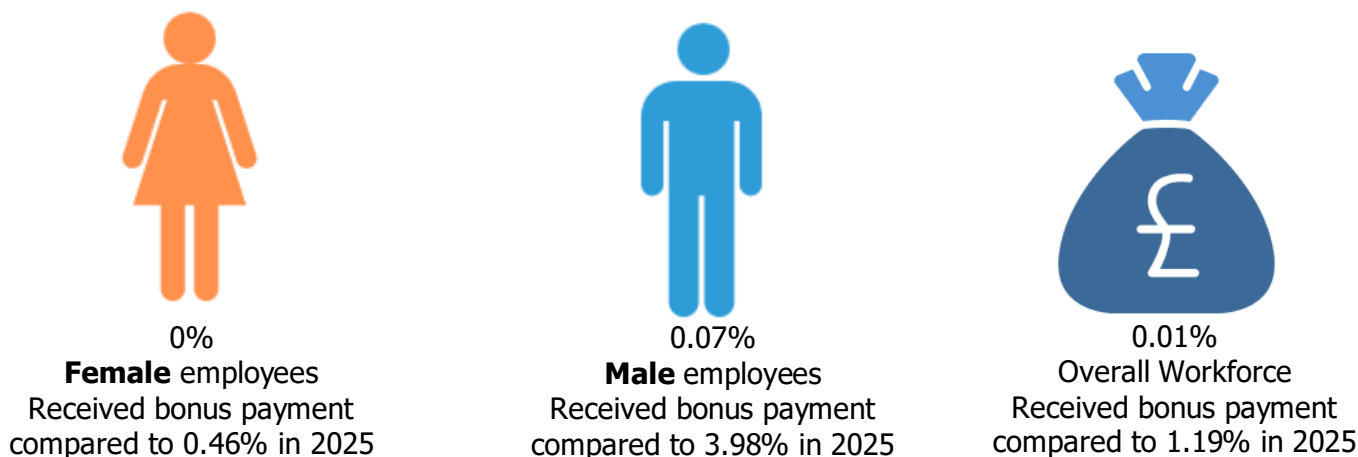


Male bonus pay as an average was £15,500.00 higher than females (2025 was £1,378.44). This equates to a 100% average bonus pay gap, which is higher than the previous year, although the numbers involved are now extremely small.



Male median bonus pay was £15,500.50 higher than females (2025 was £1,458.61). This equates to a 100% median bonus pay gap, which is higher than the previous year, although the numbers involved are now extremely small.

Staff Receiving a Bonus



Disability Pay Gap

Yearly Comparison of our Mean Disability Pay Gap

This is the fifth year that we are voluntarily publishing our information on our disability pay gap. This helps us to be more open and transparent about our people. Although not required, reporting pay differences between disabled and non-disabled colleagues is encouraged as a means of improving inclusion and to tackle inequality in the workplace.

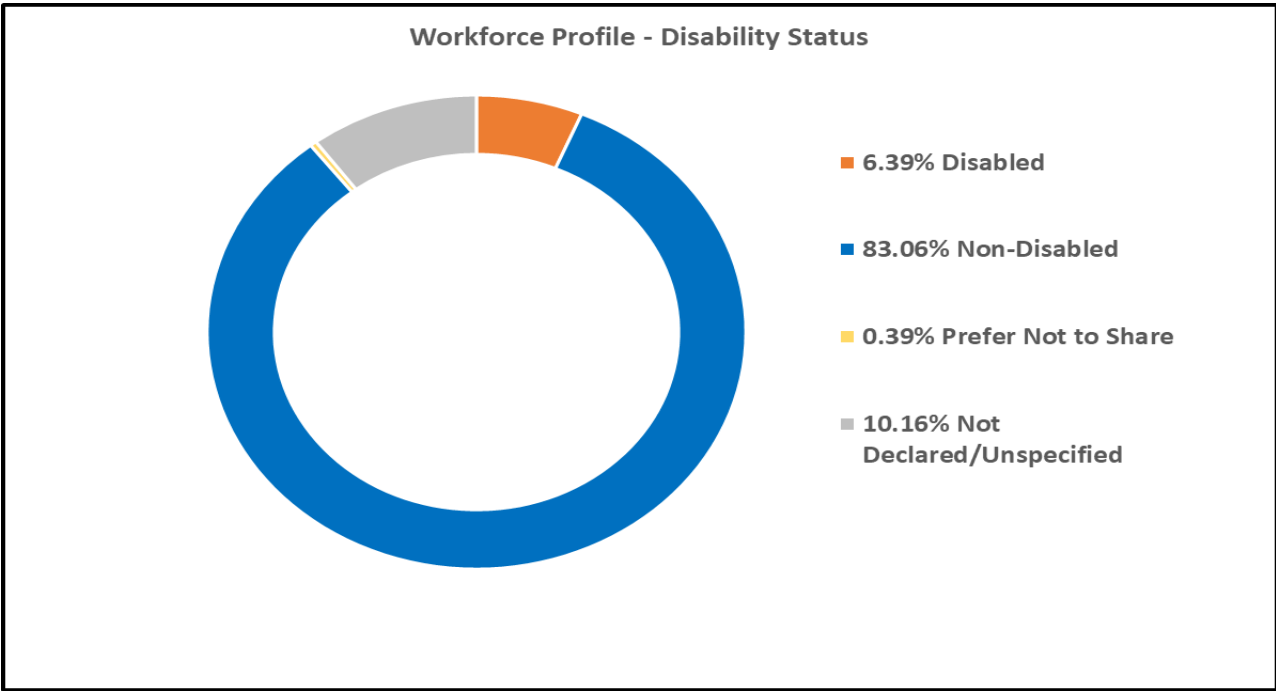
Over the past five years, the average and median disability pay gap has been:

Year	Average Hourly Rate		Difference	% Pay Gap
	Non-Disabled	Disabled		
2022	£18.05	£16.76	£1.29	7.15%
2023	£18.22	£16.78	£1.44	7.90%
2024	£19.69	£18.09	£1.60	8.13%
2025	£21.34	£19.55	£1.79	8.39%
2026	£22.61	£20.56	£2.05	9.07%

Year	Median Hourly Rate		Difference	% Pay Gap
	Non-Disabled	Disabled		
2022	£16.03	£15.07	£0.96	5.99%
2023	£16.05	£16.09	-£0.04	-0.25%
2024	£17.80	£17.17	£0.63	3.54%
2025	£18.94	£18.85	£0.09	0.48%
2026	£19.64	£19.62	£0.02	0.10%

We hope that publishing these reports will also encourage more people to share their disability information in order for us to better understand our workforce and remove barriers that may be impacting their day-to-day lives.

According to the Office for National Statistics, around 21.1% of people in Wales and the Hywel Dda area have some form of disability that affects their daily lives. Analysis of our internal equality data indicates our workforce profile as:



The 6.39% disabled percentage represents 780 staff, and the 85.01% non-disabled percentage represents 10,142 staff.

6.39% of our workforce have shared with us that they have a disability, which is considerably lower than the percentage of disabled people in Wales and the Hywel Dda area (21.1%), however it is an increase on 5.53% of our workforce in 2025 and 4.45% in 2024.

The percentage of people that preferred not to share this information was 0.39%, which is a decrease since last year (0.42%).

10.16% of people have not declared this information on ESR, which is a decrease since last year (11.22%) and is better than the NHS Wales average of 15.6%.

The above indicates a growing confidence in sharing this information.

To get a more accurate understanding of our disability pay gap, we need more colleagues to share their diversity data and this continues to be an organisational aim. As a result, our pay gap is likely to fluctuate as more people share this information.

Rates of Pay

The mean disability pay gap is defined as the difference between the average hourly rate of pay of our disabled and non-disabled colleagues.

Disability	Ave Hourly Rate
Non-Disabled	£22.61
Disabled	£20.56
Difference	£2.05
Pay Gap %	9.07%

The average hourly rate of pay is calculated from a specific pay period, in this case March 2026. The hourly rate is calculated for each employee based on 'ordinary pay', which includes basic pay and allowances such as unsocial enhancements.

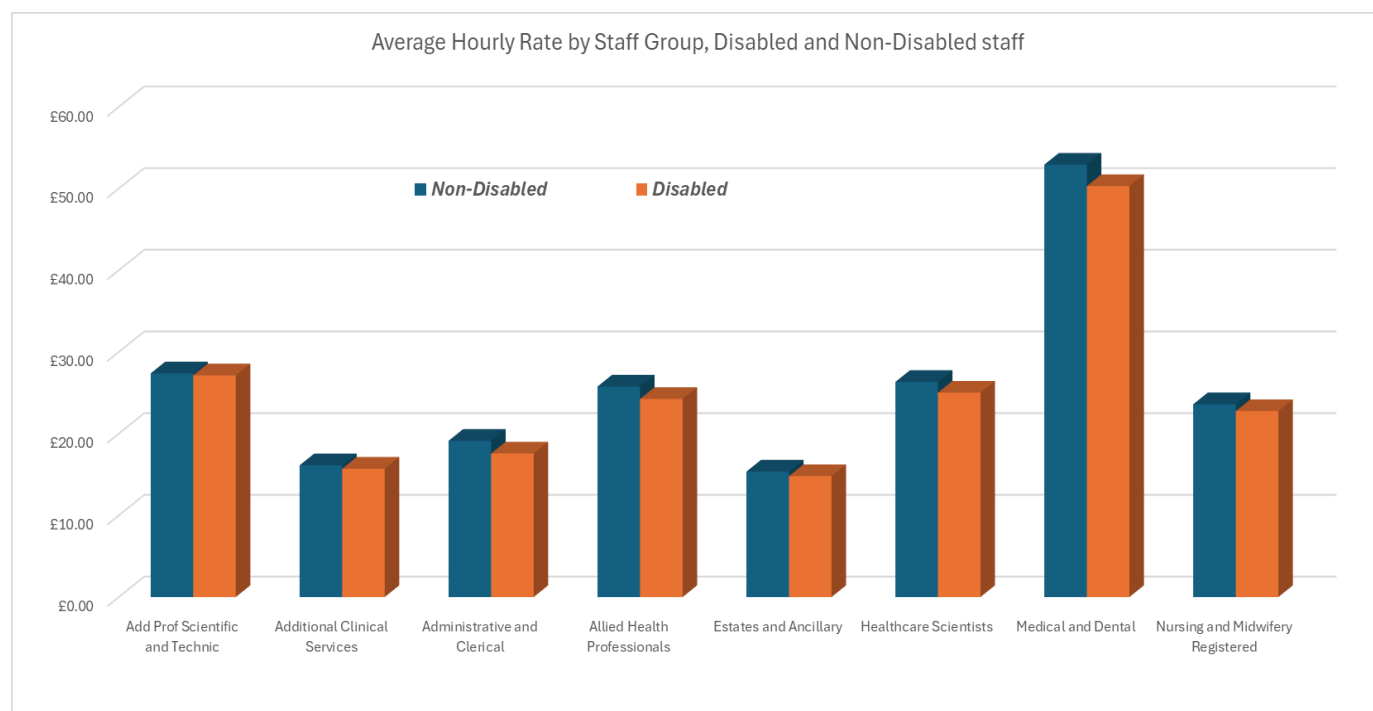
The figures above shows that the mean hourly rate for colleagues identifying as having a disability is £20.56 compared to £22.61 for non-disabled colleagues; our colleagues identifying as having a disability received on average £2.05/hour less than non-disabled colleagues, a pay gap as a mean average of 9.07%.

The split by gender was:

Male	Ave Hourly Rate
Non-Disabled	£27.38
Disabled	£20.75
Difference	£6.63
Pay Gap %	24.21%

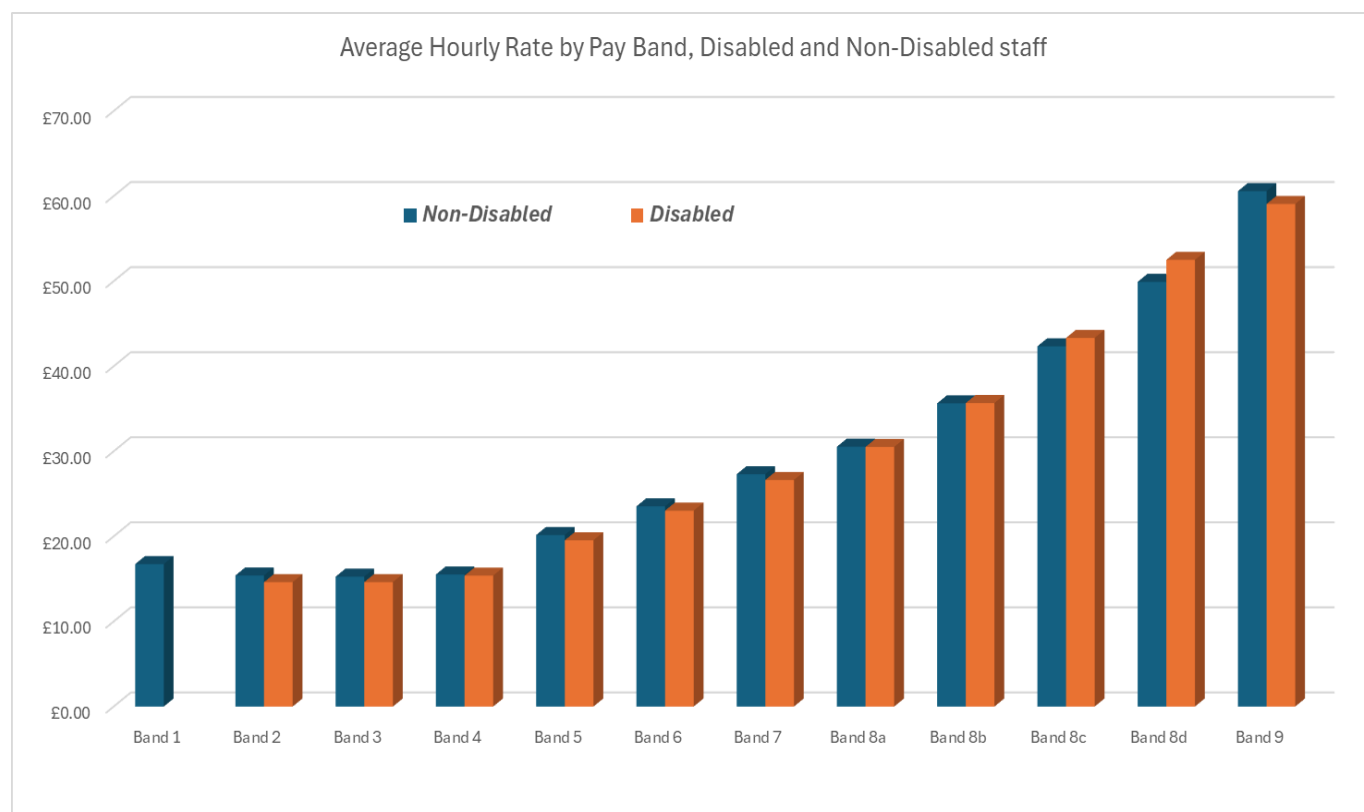
Female	Ave Hourly Rate
Non-Disabled	£21.38
Disabled	£20.51
Difference	£0.87
Pay Gap %	4.07%

By Staff Group



Further analysis of the information by staff group has highlighted that non-disabled staff have a higher average hourly rate of pay in all staff groups.

By Pay Band



Further analysis of the information by AfC pay bands shows that disabled staff have a higher average hourly rate of pay than non-disabled staff in bands 8c and 8d. For all other bands non-disabled staff have a higher average hourly rate of pay. It should also be noted that there are no disabled staff at band 1.

Pay Quartiles

Quartiles are calculated by ranking pay for all colleagues from lowest to highest, and splitting into four groups, showing the percentage of disabled staff and non-disabled staff in each group. The percentage of staff by disability in each of the quartiles is:

Quartile	Disabled?			
	No	Not Declared / Unspecified	Prefer Not To Answer	Yes
Lower	83.2%	8.7%	0.4%	7.6%
Middle Lower	82.9%	10.4%	0.4%	6.3%
Middle Upper	83.3%	9.3%	0.3%	7.1%
Upper	82.8%	12.1%	0.5%	4.6%

Ethnicity Pay Gap

Yearly Comparison of our Mean Ethnicity Pay Gap

This is the fifth year that we are voluntarily publishing our information on our ethnicity pay gap. This helps us to be more open and transparent about our people. Although not required, reporting pay differences between Black, Asian & Minority Ethnic and White colleagues is encouraged as a means of improving inclusion and to tackle inequality in the workplace.

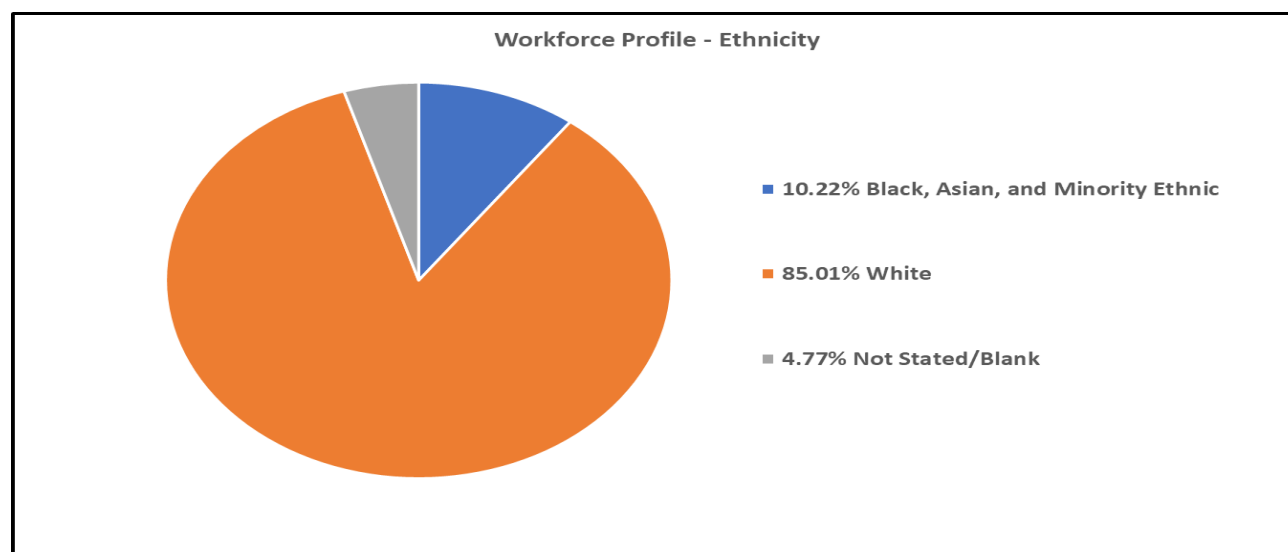
Over the past five years, the average and median ethnicity pay gap has been:

Year	Average Hourly Rate		Difference	% Pay Gap
	White	Black, Asian & Minority Ethnic		
2022	£17.63	£28.01	-£10.38	-58.88%
2023	£17.76	£26.62	-£8.86	-49.89%
2024	£19.10	£27.61	-£8.51	-44.55%
2025	£20.44	£28.89	-£8.45	-41.34%
2026	£21.57	£30.63	-£9.06	-42.00%

Year	Median Hourly Rate		Difference	% Pay Gap
	White	Black, Asian & Minority Ethnic		
2022	£15.53	£24.07	-£8.54	-54.99%
2023	£15.58	£21.53	-£5.95	-38.19%
2024	£17.00	£22.64	-£5.64	-33.18%
2025	£18.62	£22.26	-£3.64	-19.55%
2026	£19.62	£23.37	-£3.75	-19.11%

We hope that publishing these reports will also encourage more people to share their ethnicity information in order for us to better understand our workforce and remove barriers that may be impacting their day-to-day lives.

According to the Office for National Statistics, 6.2% of the population of Wales and around 2.79% of the Hywel Dda population identify as being from a Black, Asian and Minority Ethnic background. Analysis of our internal equality data indicates our workforce profile as:



The 10.22% Black Asian and Minority Ethnic percentage represents 1,248 staff, and the 85.01% white percentage represents 10,380 staff.

10.22% of our workforce identify as being from a Black, Asian and Minority Ethnic background, which is significantly higher than the percentage of the Hywel Dda population (2.79%) and is also an increase on 9.41% reported last year and 7.81% the previous year showing a steady increase in the diversity of our workforce.

4.77% of employees have not provided this information on ESR or have left this section blank. This is a decrease from 4.9% last year and 4.94% the previous year indicating an increasing confidence in sharing this information. It is also significantly less than the NHS Wales average for ethnicity information not recorded (9.8%).

To get a more accurate understanding of our ethnicity pay gap, we need more colleagues to share their diversity data and this continues to be an organisational aim. As a result, our pay gap is likely to fluctuate as more people share this information.

Rates of Pay

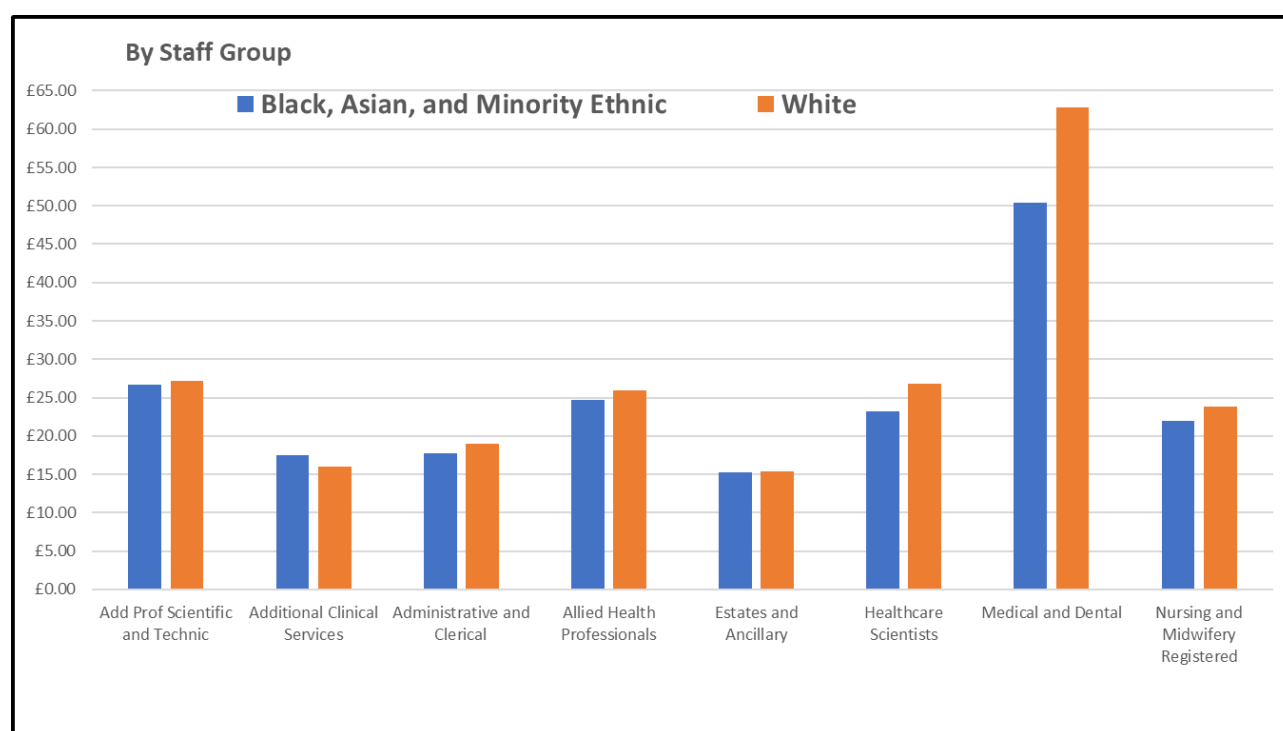
The mean ethnicity pay gap is defined as the difference between the average hourly rate of pay of our Black, Asian & Minority Ethnic and white colleagues.

Ethnicity	Ave Hourly Rate
White	£21.57
Black, Asian, and Minority Ethnic	£30.63
Difference	-£9.06
Pay Gap %	-42.00%

The average hourly rate of pay is calculated from a specific pay period, in this case March 2026. The hourly rate is calculated for each employee based on 'ordinary pay', which includes basic pay and allowances such as unsocial enhancements.

The figures above show that the mean hourly rate for our Black, Asian & Minority Ethnic colleagues is £30.63 compared to £21.57 for white colleagues; our Black, Asian & Minority Ethnic colleagues received on average £9.06/hour more than white colleagues, a negative pay gap as a mean average of -42.00%. However, it is important to note that while the pay gap is useful in measuring pay equality, it is calculated using average hourly rates and it does not measure the pay difference between people at the same pay grade, doing the same job, with the same working pattern. As you will see demonstrated by the data below, while there will be Black, Asian & Minority Ethnic colleagues who have a higher hourly rate, which increases the average overall, for most staff groups, white colleagues earn more than our Black, Asian & Minority Ethnic colleagues.

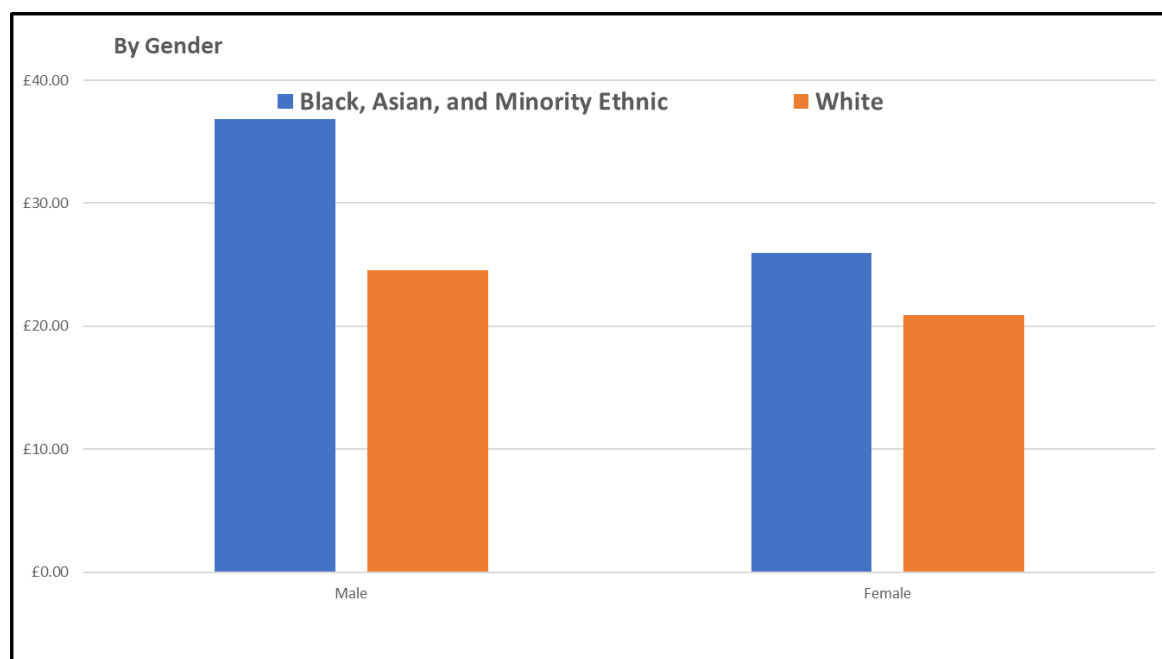
By Staff Group



Further analysis of the information by staff group has highlighted that there is a negative pay gap for Black, Asian & Minority Ethnic colleagues working in Additional Clinical Services. This means that Black, Asian & Minority Ethnic colleagues within this staff group earn more than white colleagues.

In all other staff groups there is a pay gap whereby white colleagues earn more than our Black, Asian & Minority Ethnic colleagues. This is most significant in the Medical and Dental staff group with a pay gap of £12.36 per hour (19.68%).

By Gender



The figures show that the mean hourly rate for our Black, Asian & Minority Ethnic male colleagues is £36.85 compared to £24.55 for white male colleagues; our Black, Asian & Minority Ethnic male colleagues received on average £12.30/hour more than white male colleagues, a negative pay gap as a mean average of -50.10%.

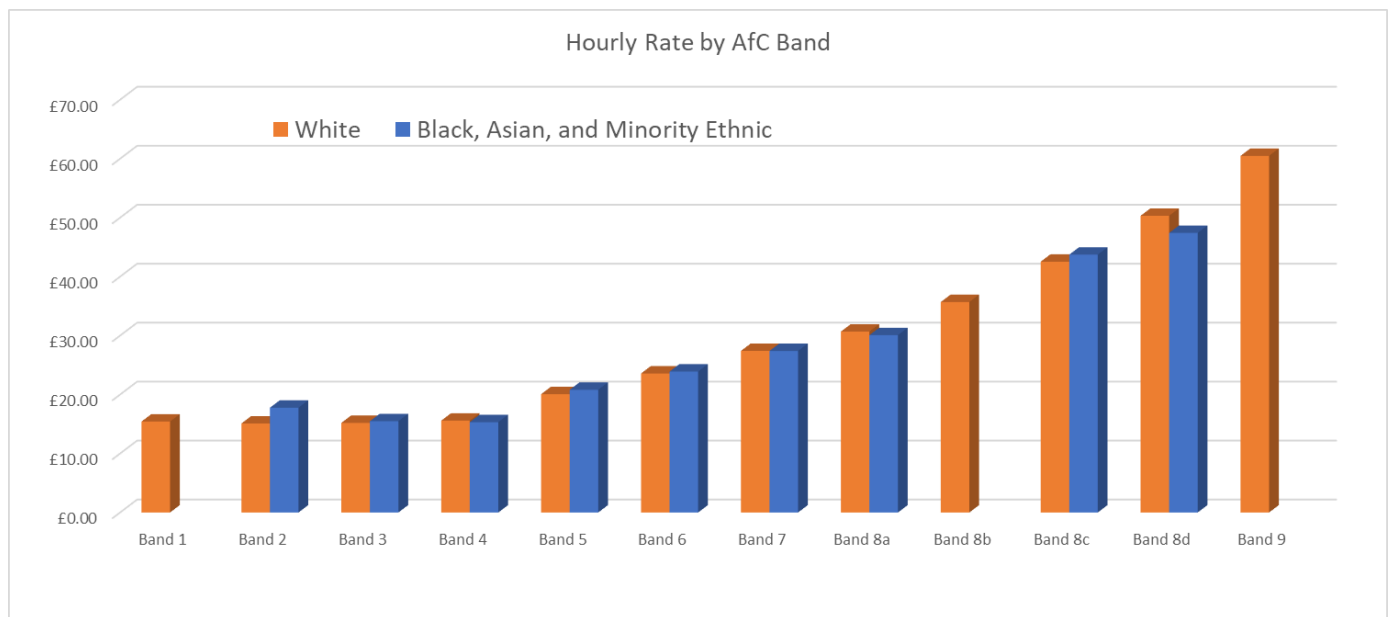
The mean hourly rate for our Black, Asian & Minority Ethnic female colleagues is £25.96 compared to £20.91 for white female colleagues; our Black, Asian & Minority Ethnic female colleagues received on average £5.05/hour more than white female colleagues, a negative pay gap as a mean average of -24.15%.

By Pay Band

This is the third year that we have provided ethnicity pay gap data by Agenda for Change (AfC) pay bands, showing that:

The AfC pay bands where Black, Asian & Minority Ethnic colleagues have a lower average hourly rate than their white colleagues are band 4 (1.65%), band 7 (0.04%), band 8a (1.96%) and Band 8d (5.78%) and the highest gap is seen for band 8d (5.78%). The highest negative pay gap, where Black, Asian & Minority Ethnic colleagues have a higher average hourly rate than their white colleagues is for band 2 with a negative pay gap of – 17.70%.

It should also be noted that there are no Black, Asian & Minority Ethnic colleagues represented at band 1, band 8b and band 9, but we have seen representation at band 8d since last year.



Pay Band	White	Black, Asian, and Minority Ethnic	Difference	Gap
Band 1	£15.42			
Band 2	£15.10	£17.77	−£2.67	−17.70%
Band 3	£15.20	£15.48	−£0.28	−1.86%
Band 4	£15.58	£15.32	£0.26	1.65%
Band 5	£20.07	£20.81	−£0.74	−3.69%
Band 6	£23.58	£23.91	−£0.33	−1.39%
Band 7	£27.41	£27.40	£0.01	0.04%
Band 8a	£30.68	£30.08	£0.60	1.96%
Band 8b	£35.70			
Band 8c	£42.54	£43.73	−£1.19	−2.81%
Band 8d	£50.32	£47.41	£2.91	5.78%
Band 9	£60.48			

Pay Quartiles

Quartiles are calculated by ranking pay for all colleagues from lowest to highest, and splitting into four groups, showing the percentage of Black, Asian and Minority Ethnic staff and White staff in each group. The percentage of staff by ethnicity in each of the quartiles is:

Quartile	Ethnicity		
	Black, Asian & Minority Ethnic	Not Stated / Black	White
Lower	4.8%	3.2%	92.0%
Middle Lower	7.6%	3.9%	88.5%
Middle Upper	11.2%	5.1%	83.7%
Upper	17.2%	6.9%	75.9%

Actions to support an Inclusive Workplace

We continue to make efforts to address any pay gaps within our workforce. Pay gaps are still present in the Health Board, and the gender pay gap has increased slightly since last year.

Our Strategic Equality Plan and Objectives 2024 - 2028 for the Health Board states that we *“will work together to achieve our objectives and create a fairer, more equitable and inclusive environment for all. Within the theme of being an employer of choice and the associated objective, we are developing our understanding of the issues impacting on pay gaps, in particular gender, disability and ethnicity and continue to analyse and report on pay gap data and will use this to take action to address identified issues.”*

An Equality Diversity and Inclusion Task Force has been established to accelerate our work to eliminate discrimination and foster an inclusive and equitable environment within our organisation. With support from the Health Board's Quality Improvement team, the Task Force has adopted a quality improvement approach, to achieve system-wide change.

In addition, we are committed to taking the following actions:

Data analysis:

- In addition to the analysis of bonus payments received by staff, we will include overtime and unsocial hours payments (for evening and weekend working).

Recruitment:

- Encourage those who need reasonable adjustments to come forward during recruitment drives.
- Volunteers and those on work experience who require reasonable adjustments will also be encouraged to come forward.
- Continue the Pathway 4 programme, which is a work experience programme for individuals with additional learning needs to access work experience opportunities to suit their needs.
- Actively support Appointing Managers to ensure awareness regarding reasonable adjustments, providing one to one support if required.
- Identify how we can encourage people to apply for roles and development opportunities in sectors where there are greater pay gaps.
- Continually review and monitor policies and processes to ensure there is no bias in the starting salaries of new employees.
- Implement recruitment practices which include ensuring mixed gender panels for selection and remuneration purposes.
- Continually review and monitor policies and processes to ensure accessibility for all.
- Audit/observation of recruitment/selection processes to ensure fair and kind processes.

Employee experience:

- Progress our evidence towards achieving 'Disability Confident Leader - Level 3' whereby the Health Board will actively promote and show disabled people that we are leading the way in getting businesses to become a more inclusive workplace.
- Continue to reinforce our health board values through senior leaders and managers, to develop a working environment that fosters diversity and does not tolerate bias towards people with a protected characteristic, even if it is unconscious.
- Cultural intelligence training.
- NHS staff survey 2025 results highlighted 3 lowest scoring themes:

- Staff engagement
- Patient safety
- Morale

As such actions have been recommended focussed on

- Local ownership and application
- Staff experience
- Act on burnout as a system risk, not an individual issue
- Staff involvement in change
- Protect and scale what is working
- Continue the success of programmes to raise awareness of individual needs including learning disabilities, disability, dyslexia, ASD, ADD/ADHD. For example Autism Wales allowed the Health Board to deliver its 'Introduction to Autism' online training session via the Health Board's electronic staff record system and this is now mandatory for all staff. As of March 2026, 94% of Health Board staff are compliant with the Autism Awareness competency on ESR; [the highest compliance of all Health Boards across Wales].
- Roll out a programme of bite size learning sessions remain ongoing on a broad variety of topics e.g. sensory loss awareness, carer awareness etc. that are open to all Health Board staff.
- Support a climate of disclosure, whereby employees feel comfortable to disclose their equality information (e.g. disability which is not reported by over 10% of employees) and request any additional organisational support they may need.
- Continue to increase promotion and recognition of the Health Board's staff networks, including our networks for Black, Asian and Minority Ethnic staff, those with a disability, long term condition or are neurodivergent and our Menopause cafe.
- Continue to explore and understand the reasons why our Black, Asian & Minority Ethnic employees consider leaving/leave the organisation by using the exit interview process.
- Adopt the recommendations outlined in the Welsh Government's Anti-racist Wales Action Plan and as a result of the annual Workforce Equality Standard reports and align these with our cultural development plan.

Career progression:

- Continue to work with other NHS organisations and partners to learn from best practice and explore opportunities to develop joint activities e.g. apprenticeship, work experience and volunteering programmes.
- Work in conjunction with the Black, Asian and Minority Ethnic Staff Network to enhance our understanding of the experiences of minority ethnic staff and the actions which could be taken to support them to enhance and develop their careers.
- Explore how we can better support female employees and encourage the next generation of female leaders.
- Continue to foster a culture of continuous professional development (CIPD) with clear pathways to support career progression for all staff. Progression frameworks for Agenda for Change Bands 2-4 are currently in development, aimed at addressing and overcoming barriers to CPD, promoting engagement, and enhancing progression opportunities.