Moorfields Eye Hospital NHS Foundation Trust

NHS

Equality, Diversity and Inclusion

Annual Report 2022

Contents:

1. Introduction and context

Since 2020 the development and delivery of health services have become ever more challenging. The Covid pandemic highlighted health inequalities suffered particularly by the poor and most vulnerable who at the same time were often the frontline workers providing vital services right across the economy. Black, Asian and other visible ethnic minority communities were disproportionately affected in Covid mortality rates. Within the trust, the Covid pandemic acted as a significant catalyst for change and innovation in how we deliver care. New service models and an expansion of remotely provided care introduced during the pandemic gave us the opportunity to redesign parts of our network and processes, providing a strong foundation for how we plan to operate in future.

The global reaction to the murder of George Floyd in the summer of 2020 and the resurgence of the Black Lives Matter movement further underlined how race affects life chances differently. The discrimination experienced by women, those with disabilities and LGBTQ+ communities have also been highlighted, alongside sometimes hostile reaction to the implications these issues raise for society. As a trust, this has further reinforced our commitment to ensure we create an inclusive environment for patients, volunteers and colleagues

Over the last year the consequences of Brexit, the war in Ukraine, the sharp rise in energy costs and the cost-of-living crisis have all emphasised how inequality remains a major challenge for the UK.

Reflecting this environment in which the trust operates, the Moorfields Strategy 2022-2027 sets out our motivation, our purpose and the values that underpin how we work. The strategy brings together all aspects of the organisation's work across clinical care, research and education and applies to NHS and commercial services, both in the UK and internationally, building on the previous five year 'Vision of Excellence'. Along with listening to feedback from patients, carers and staff, four important factors that shaped the new strategy: the Covid pandemic, system-oriented working, digital opportunities and the new integrated centre for advancing eye health.

1.1. Our motivation

Our motivation is what inspires all of us day-to-day and our strategy is firmly rooted in this belief. The experience of losing sight or having serious disturbances of vision is distressing and can be isolating and costly for those affected. Putting people with sight loss or disturbed vision at the centre of care is essential if we are to support their needs.

1.2 Our purpose

Working together to discover, develop and deliver excellent eye care, sustainably and at scale

1.3. Our values

- **Excellence** is at the heart of Moorfields' purpose and history. It is also fundamental to our future as we innovate at the forefront of eyecare, delivering the best care and experience.
- **Equity** means everyone can expect that we will do our best for them – our patients, staff and system partners – providing appropriate, accessible, excellent and sustainable care based on clinical need. Everyone can be confident their voice is listened to in decisions about their care.
- **Kindness** means we are friendly and considerate – treating everyone with respect and going out of our way to reassure and give confidence.

These values enable Moorfields to deliver our purpose. Getting equality, diversity and inclusion right is a vital part of this.

2. Delivering the trust's equality obligations

Setting a national standard, the current NHS England and NHS Improvement (NHSEI) equality objectives consider the equality and health inequality impacts of COVID-19 and the key lessons learned, capability, information, internal

workforce, patient access and information, system workforce, Integrated Care Boards and system landscape. See: https://www.england.nhs.uk/about/equality/objectives-for-22-23-and-23-24/

This approach is also reflected in the work at Moorfields – responding to change, meeting regulatory obligations, and shaping next steps as detailed below.

2.1. Leadership and Governance

Senior leadership is in place with the Director of Workforce and Organisation Development as the lead for all equality, diversity and human rights issues working with the Chief Nurse and Director of Allied Health Professionals.

The Equality, Diversity and Human Rights steering group is the strategic group for equality, diversity and inclusion (EDI). Its remit is to provide focus, leadership, and coordination for achievement of corporate delivery on the equality, diversity and human rights agenda, as relating to our patients and our staff.

The group ensures that the Trust is responding appropriately to equality legislation and national requirements, ensuring the better use of both workforce and patient equality monitoring data, including data from ESR and staff surveys, to target improvements.

The Group is chaired by the Chief Executive and reports to the People and Culture Committee (for staff issues), the Quality and Safety Committee (for patient issues) and the Board on progress in compliance to equality and human rights legislation, through implementation of the Trust's Equality Objectives, the Equality Delivery System, the Workforce Race Equality Standard, the Workforce Disability Equality Standard, the gender pay gap, the Accessible Information Standard and any subsequent national requirements ensuring that our services are inclusive in terms of outcomes for our patients, access, patient experience and employment practices.

Further, since the development of the Moorfields' Strategy 2022-2027, an excellence delivery unit has been established to provide strategic governance and oversight of the various programmes that will enable the strategy to be realised. The Working Together Programme Board, which is Co-Chaired by our Chief Nurse and Director for Allied Health Professionals and our Director of Workforce and OD, also provides delivery assurance of the strategic priorities as they relate to EDI and health inequalities. See section 2.2. for further information.

To increase capacity and ensure appropriate subject matter expertise is in place to drive the EDI agenda, the trust has introduced new roles into the organisation. These include: an Organisational Development (OD) Consultant, who is the professional lead for EDI as it relates to staff experience within the trust; an EDI Manager, who is responsible to the OD Consultant; and an EDI Co-Ordinator.

2.2. Strategic Priorities

The Equality Act 2010 is the overarching legislation, developed as a means of streamlining and simplifying previous laws related to equality. It covers the nine 'protected characteristics' of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion/belief, sex and sexuality, which cannot be used as a reason to treat people unfairly. The Act also challenges organisations and individuals to consider the 'intersectionality' between the protected characteristics and the consequences for life chances.

A key component of the Act is the PSED which requires public authorities and those who exercise public functions to have 'due regard' to the need to eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunity between different groups and foster good relations between different groups. To demonstrate this, organisations are expected to publish their equality objectives every four years.

The trust has clearly articulated a set of strategic priorities, which are governed via EDHR and the Working Together Programme Board, which ultimately report to the Board.

In April 2022, the following EDI strategic priorities were agreed at EDHR:

- Increase the diversity of our leadership and management teams

- Build a strong and positive culture of inclusion
- Improve the collection, reporting and transparency of our EDI data

Reflecting our duty to reduce health inequalities, the Working Together Programme has agreed the following strategic priorities:

- Implement Patient Experience Strategy
- Enhance our approach to Accessible Information Standards
- Improve digital accessibility to ensure equitable patient access
- Making better use of routine health data
- Review outpatient attendance and non-attendance

See Appendix A and B for further information.

2.3. Workforce Disability Equality Standard (WDES)

The WDES was introduced in 2017 and mandated in 2018, and is a set of ten indicators which enable the comparison of the workplace and career experiences of disabled and non-disabled staff. In the first wave of COVID-19, NHSE, in partnership with NHS Employers, undertook a survey about impact of the pandemic on the workplace experience of disabled staff. The results highlighted how longstanding concerns were reinforced by the pandemic including (i) those shielding due to a long-term condition or disability often felt a lack of support from their manager or employer, (ii) senior leaders were not visible in demonstrating their commitment to workplace disability equality and lack of communication or information about the WDES. This national evidence highlights that many disabled staff continue to experience inequalities in the workplace when compared to their non-disabled colleagues. This is consistent with our trust data, see Appendix C.

This demonstrates the continued need to take robust action, with monitoring and evaluation, to ensure progress takes place and that ongoing work programmes support positive change.

2.4. Workforce Race Equality Standard (WRES)

The WRES was introduced in 2015 and aims to ensure employees from Black, Asian and Minority Ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. It recognises that a motivated, included, and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety. The first phase of the WRES focused on understanding the challenge of workplace race equality so that leaders could recognise the changes that need to be made. The next phase focuses, through communications and engagement, on changing the deep-rooted cultures of race inequality and learning more about the importance of equity, to build capacity and capability to work with race. Continuous embedding of accountability is designed to ensure key policies have race equality built into their core, so that eventually workforce race becomes everyday business.

See Appendix D for our trust data.

2.5. Gender Pay Gap (GPG)

Since April 2017 all organisations with more than 250 employees are expected to report annually on the mean gender pay gap (calculated as the percentage difference between the average hourly salary for men and women), the median gender pay gap (calculated as the percentage difference between the mid-point hourly salary for men and women), the bonus gender pay gap, the proportion of males and females in each pay quartile and action to address the gap.

In October 2021 Moorfields reported that in 2020 our mean gap of 19.03 per cent and a median gap of 17.67 per cent. For more details see:

https://www.moorfields.nhs.uk/sites/default/files/uploads/documents/Gender%20Pay%20Gap%20Reporting%20-%2031st%20March%202020%20Snapshot%2003.10.21.pdf.

Our 2021 data showed that the mean gap had marginally increased to 19.80 per cent and our median gap to 17.95 per cent. This report is due to be published shortly. Our 2022 GPG is under analysis.

Whilst not formally required to do so, we have undertaken some Ethnicity Pay Gap (EPG) analysis. In 2020 the mean EPG was 16.34 per cent, reducing to 15.48 per cent in 2021. Our 2022 EPG will be included in our 2022 GPG report.

2.6. Supporting Staff Networks

Fundamental to demonstrating the trust's commitment to delivering its strategic priorities and responding to the issues raised by the WDES and WRES data and the Staff Survey is the support for the BAME, Disabled and LGBTQ+ staff equality networks. With Executive sponsors and, as noted above, dedicated admin support from the EDI team, the networks meet a minimum of three times a year with a key responsibility for raising awareness about the needs of different groups of staff. The terms of reference for the networks have recently been reviewed to create one common model outlining the best structure to ensure they are all sustainable and appropriately resourced. In addition, the leadership has been refreshed with all three appointing new co-chairs in the last three months. In 2021 and 2022 the networks led celebrations of National Inclusion Week, as well as key awareness days and months including Pride, Black History Month, and International Day of Persons with Disabilities. The organisation's commitment is to increase the voice and influence of the networks on trust matters, including sharing WRES and WDES data and getting feedback on draft action plans.

2.7. Accessible Information Standards (AIS)

The AIS directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. Organisations have had to comply with the Standard from August 2016 onwards. Among the work Moorfields has undertaken to demonstrate its compliance are the following initiatives:

- Installed the NHSE AIS e-learning package onto Insight (our in-house training system) to increase staff awareness Assessed additional training needs for staff
- Developed system flags to identify patients and/or carers who require information in a different format
- Reviewed existing policy and practice around use of email and text messages for patient appointments
- Installed a new hearing loop system at our City Road site
- Run a digital inclusion project for those that need more support accessing our systems
- Run a communications campaign to raise staff awareness about this with sight loss and AIS needs

To build on this work, there is a specific AIS project to further enhance our compliance, respond to patient feedback, and to ensure we become an exemplar, noting our patient demographic and speciality.

2.8. Improving Patient Experience

We are committed to continually improving patient experience, which in turn has the potential to positively impact health inequalities.

As part of this commitment, we are developing a new Patient Experience Strategy. And we are also implementing the National Patient Safety Strategy, which focusses on maximising the things that go right and minimising the things that go wrong. This has included the formal launch of the Patient Safety Incident Response Framework (PSIRF) and a "Safer September" campaign to promote World Patient Safety Day and create a culture of continuous learning and improvement.

We are also engaging our patients in helping us to develop Patient Experience Principles, in order to elevate patient experience and incorporate our values of excellence, equity and kindness across the whole patient pathway.

2.9. Addressing Health Inequalities

Identifying, monitoring and review of health inequalities as a means for addressing their underlying predisposing factors, is a key NHS priority, further galvanised following the pandemic. Its requirements are enshrined in primary

legislation, embedded in operational guidance, and integral to the NHS contract. From a health care provider perspective, our duty of care is to ensure equitable availability and access to services and outcomes of care provided.

In support of this, we are implementing a project to make better use of routine health data arising from trust operational activity and provision of health care as a means for generating health information and intelligence for multiple purposes to meet NHS requirements for action on inequalities and the Trust's strategic objectives and core values. The proposed approach will concurrently report on:

- activity and performance for operational purposes
- outcomes (effectiveness and safety) for clinical purposes
- variations and potential inequalities (disparities) in service provision and outcomes – from a public health perspective

This will serve to identify and quantify at high organisational level, any disparities across our Network or within Clinical Services, and in doing so:

- Inform further specific deeper scrutiny, review, and action to address any disparities that are found to be unwarranted.
- Provide the basis for a strategic and responsive plan for monitoring and addressing disparities in the services provided by Moorfields.

To further enhance our use of patient data to help inform our approach to addressing health inequalities, we have commenced a project to review out-patient (OPD) attendance and non-attendance. This project will review out-patient attendances (New and Follow-Up) across the trust network using routine activity data collections. It will report on pre-existing attendance levels up to 2019-20 establishing an organisational baseline from which to assess the impact of recent changes to service organisation and delivery. In the first instance this will be for the high-volume clinical services with attendance presented by clinical risk and patient profile. The findings and recommendations of this review will inform an approach for ensuring regular organisational monitoring and review of OPD attendance and all types of non-attendance for any variations across the Trust Network, to inform deeper scrutiny and action to address any that are found to be unwarranted.

3. Equality Delivery System (EDS)

Originally launched in 2011, through collaboration and co-production and recognising the impact of COVID-19, the EDS has been updated earlier this year. Its main purpose remains to help NHS systems and organisations, in discussion with their partners and populations, review and improve their performance for people as described by the 'protected characteristics' and help demonstrate 'due regard' to the PSED. It is aligned to NHS England's Long-Term Plan and its commitment to an inclusive NHS that is fair and accessible to all. See Appendix Four for further detail.

In 2019 a group of key equality champions undertook a mock assessment using the then current EDS2 tool with its four goals (of better health outcomes, improved patient access and experiences, a representative and supported workforce and inclusive leadership). This concluded that the Trust was 'undeveloped' for two outcomes, 'developing' for thirteen and 'achieving' for three. In conclusion the following headline issues were noted:

- Outcomes for eyes are excellent, but there are questions of equitability (beyond the eye to see the whole person and understand the context of the communities and places they come from)
- The infrastructure of sites, for example the use of aids and signs for wayfinding, is often poor and needs improving
- More thought is needed about how to build in 'Making Every Contact Count' to service delivery to signpost patients, their families and carers to other health, social care, and voluntary and community sector services, as well as supporting themselves, to improve health and wellbeing
- The organisation collects a lot of data but needs to use it more to understand patients and staff better and develop services.
- There is a need to hear more from patients and partners to help prioritise work on what's important

The content of this report demonstrates work is underway against a number of the headline issues identified, which complements work which pre-dates the scope of this report, including the introduction of Patient Experience Co-Ordinators.

4. Recommendations and next steps

This report demonstrates the trust's commitment to continually improving the experience of our patients, volunteers, and colleagues through the lens of EDI. Building on the foundations that are now in place, it is recommended that:

- Review and enhance the Equalities and Health Inequalities Analysis toolkit as one of the key tools to integrate EDI within the fabric of the organisation. This will include the provision of training and support.
- Continue the good progress on maturing, growing, and supporting Staff Networks and ensuring under-represented and diverse staff feel empowered and have a voice.
- Continue the celebrations and commemorations of EDI events and conversations, which have been successful.
- Undertake an EDI audit to ensure compliance and identify further areas for improvement.
- Undertake a self-assessment regarding our maturity against the new EDS model.
- Build leadership capacity and capability to authentically lead EDI in their delivery areas, embedding EDI as a golden thread in the delivery of operational performance.
- Ensure we appropriately resource our key projects to deliver against our strategic priorities.

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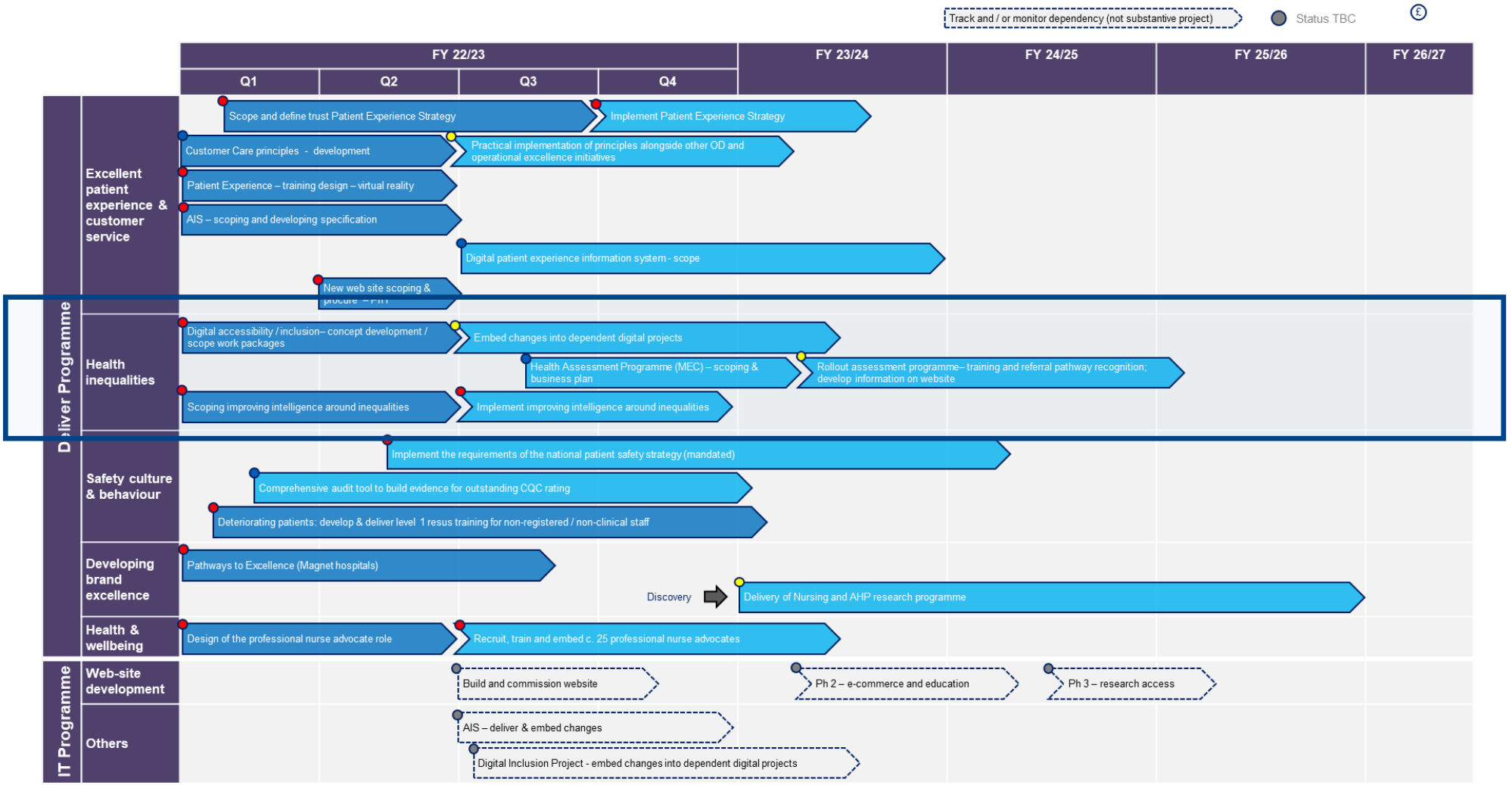
Appendix A: EDI Strategic Priorities

Objective	Why?	How?	Measures
Increase the diversity of our leadership and management teams	• WRES data shows a lack of Black, Asian and Minority Ethnic representation at Band 8a+ • WDES data shows colleagues with disabilities are under-represented at all Bands (versus the national economically active population) • ESR data shows that 2.4% of people identify as LGBTQ+	• De-biasing recruitment • Mutual mentoring and / or Career Sponsorship	• WRES indicators 1, 7 and 9 • WDES indicators 1, 5 and 10 • Increase in LGBTQ+ representation • Maintain gender representation • Equivalent to London economically active for the majority of Bands: Women 46%, BAME 36%, Disabled 12%, LGBTQ+ 5-7% (estimated)
Build a strong and positive culture of inclusion	• Staff Survey data shows the workforce does not feel the Trust is as inclusive as it could be and that incidences of bullying, harassment and discrimination remain too high	• Active Bystander training • Re-launch Bullying and Harassment Pathway • Leadership Academy Programme • Galvanising Staff Networks • Launch the Health Passport and supporting infrastructure, including a reasonable adjustments policy	• Staff survey (SS) Q21c – 'I would recommend my organisation as a place to work'; SS Q18 – 'I think that my organisation respects individual differences (e.g., cultures, working styles, backgrounds, ideas, etc.); SS Q8b & c – 'The people I work with are understanding and kind to one another' and 'The people I work with are polite and treat each other with respect'; SS Q14a & c – 'In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work' • WDES Indicator 8 • Increased membership across Staff Networks
Improving the collection, reporting and transparency of our EDI data	• EDI data reporting is currently driven by national and legal requirements and is inconsistently and infrequently reviewed • The declaration rates for 'protected characteristics' are higher in the Staff Survey than on ESR, suggesting concerns about doing so when not via an anonymous channel	• Create a standard suite of EDI measures • Create campaigns to build trust and understanding in how ESR data is stored and used, and why it is important • Publish EDI objectives	• EDI reports are regularly reviewed and inform insight and action • Declaration rates improve –particularly for disability and LGBTQ+ • Good awareness of EDI objectives across the Trust

Appendix B: Health Inequalities Priorities



Appendix C: Workforce Disability Equality Standard

			National		MEH		
WDES Indicator			**2020**	**2021**	**2020**	**2021**	**2022**
1	Representation	Disabled	3.4%	3.7%	2.0%	2.2%	2.2%
		Non-Disabled	73.5%	74.9%	90.4%	93.2%	93.7%
2	Relative likelihood of non-disabled applicants being appointed from shortlisting across all posts compared to disabled applicants		1.2	1.1	1.31	1.5	1.7
3	Relative likelihood of disabled staff entering the formal capability process compared to non disabled staff		1.54	1.94	**	**	**
4a	Percentage of disabled staff experiencing harassment, bullying or abuse from:						
4.1	Patients/Service users, their relatives or other members of the public	Disabled	33.8%	31.6%	35.2%	38.2%	37.8%
		Non-Disabled	26.8%	25.2%	24.2%	24.9%	26.2%
4.2	Managers	Disabled	19.8%	18.6%	26.1%	28.0%	28.3%
		Non-Disabled	13.0%	10.7%	13.8%	15.0%	14.7%
4.3	Other colleagues	Disabled	26.8%	25.7%	33.6%	33.6%	35.8%
		Non-Disabled	18.1%	16.8%	21.6%	20.9%	22.6%
4b	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	Disabled	47.8%	49.6%	56.7%	55.3%	57.9%
		Non-Disabled	46.6%	48.0%	48.4%	50.7%	54.6%
5	Percentage of staff believing that trust provides equal opportunities for career progression or promotion	Disabled	51.9%	51.5%	40.6%	42.8%	40.1%
		Non-Disabled	58.0%	57.6%	53.4%	50.8%	48.8%
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work,	Disabled	32.0%	31.3%	36.4%	39.0%	42.7%
		Non-Disabled	23.0%	23.0%	22.3%	27.4%	28.4%
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled	37.2%	39.2%	45.5%	51.3%	36.6%
		Non-Disabled	47.9%	50.5%	53.6%	56.5%	48.3%
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.		72.4%	76.6%	66.3%	66.3%	62.5%
9a	The staff engagement score for Disabled staff, compared to non-disabled staff.	Disabled	6.60	6.70	7.10	7.00	6.5
		Non-Disabled	7.10	7.20	7.40	7.40	7.2
9b	Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?	Yes/No	92.80%	NK	Yes	Yes	Yes
10	Board representation	Disabled - Voting	2.80%	3.60%	0.0%	6%	6.3%
		Disabled - Non	3.80%	3.90%	0.0%	0%	20.0%
		Disabled - Exec	3.30%	3.80%	0.0%	0%	8.3%
		Disabled - NED	2.70%	3.60%	0.0%	11%	11.1%

** Data is not reported as sample size is below 10, in line with advice received from WDES implementation team

Appendix D: Workforce Race Equality Standard

			National		MEH		
WRES Indicator			**2020**	**2021**	**2020**	**2021**	**2022**
1	Percentage of BME staff	Overall	21.0%	22.4%	52.6%	53.0%	54.4%
		VSM	6.8%	9.2%	0.0%	0.0%	0.0%
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		1.61	1.61	1.26	1.24	1.38
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		1.16	1.14	1.19	0.91	0.76
4	Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff		1.14	1.14	1.22	0.73	1.11
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12months	BME	30.3%	28.9%	28.3%	29.2%	29.4%
		White	27.9%	25.9%	22.6%	23.6%	26.5%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12months	BME	28.4%	28.8%	28.5%	31.5%	31.8%
		White	23.6%	23.2%	22.5%	24.9%	25.4%
7	Percentage of staff believing that trust provides equal opportunities for career progression or promotion	BME	71.2%	69.2%	48.2%	45.3%	41.7%
		White	86.9%	87.3%	57.1%	56.4%	56.1%
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader of other colleagues	BME	14.5%	16.7%	12.5%	15.6%	17.3%
		White	6.0%	6.2%	13.4%	7.8%	8.2%
9	BME board membership		10.0%	12.6%	15.0%	15.0%	14.3%

The action plans for both WDES and WRES can be found at:
https://www.moorfields.nhs.uk/sites/default/files/uploads/documents/WDES%20and%20WRES%202022%20-%20final%20report%20and%20action%20plans.pdf

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Appendix E – Patient demographic data (for period 1st April 2021-31st March 2022)

Gender	Unique Patients (Total)	% Unique Patients (Total)	Unique Patient (Outpatients)	Unique Patient (Admissions)	Unique Patient (A&E)
Female	159137	51.98%	141819	17470	25695
Male	146949	48.00%	130183	15775	24453
Unknown	39	0.01%	29	1	13
Grand Total	**306125**	**100.00%**	**272031**	**33246**	**50161**

Ethnicity	Unique Patients (Total)	% Unique Patients (Total)	Unique Patient (Outpatients)	Unique Patient (Admissions)	Unique Patient (A&E)
African	12441	4.06%	11200	1060	2462
Any other Asian background	8678	2.83%	7970	776	1317
Any other Black background	3771	1.23%	3491	241	519
Any other ethnic group	56297	18.39%	43281	4605	18963
Any other mixed background	1257	0.41%	1093	96	257
Any other White background	13158	4.30%	10851	1003	3542
Bangladeshi	4386	1.43%	3783	400	1023
British	61377	20.05%	56217	5962	8575
Caribbean	9983	3.26%	9419	872	1283
Chinese	1763	0.58%	1511	164	423
Indian	18167	5.93%	17290	1949	1915
Irish	2591	0.85%	2406	290	324
Not stated	105160	34.35%	96887	15214	8644
Pakistani	4928	1.61%	4583	467	697
White and Asian	529	0.17%	494	42	71
White and Black African	559	0.18%	526	35	67
White and Black Caribbean	775	0.25%	724	69	79
NULL	305	0.10%	305	1	0
Grand Total	**306125**	**100.00%**	**272031**	**33246**	**50161**

	Unique Patients (Total)	% Unique Patients (Total)	Unique Patient (Outpatients)	Unique Patient (Admissions)	Unique Patient (A&E)
Disability	**1318**	**0.43%**	**1302**	**162**	**42**
Dementia (D)	695	0.23%	687	96	15
Disability registered (DIS)	184	0.06%	178	20	12
Learning Disability (LD)	424	0.14%	422	44	15
DIS/LD	12	0.00%	12	2	0
D/LD	3	0.00%	3	0	0
None Listed	304807	99.57%	270729	33084	50119
Grand Total	**306125**	**100.00%**	**272031**	**33246**	**50161**

Summary:	306,125 Unique patients found from 669,314 patient contacts 160 CCG or other recognised areas (including Scottish Health Boards, Welsh LLBs and Overseas Territories) 17 Ethnic groups Identified 1318 patients identified with either a Learning Disability (LD), Dementia (D) or Registered Disabled (DIS) - Includes three patients with both Learning Disability and Registered Disabled (DIS), and twelve patients with Dementia and Registered Disabled

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Appendix F: Workforce demographic data (as at 31st March 2022)

Gender			
Staff Group	**Female**	**Male**	**Grand Total**
Add Prof Scientific and Technic	176	71	247
Additional Clinical Services	271	105	376
Administrative and Clerical	571	238	809
Allied Health Professionals	40	11	51
Estates and Ancillary	3	31	34
Healthcare Scientists	34	24	58
Medical and Dental	166	198	364
Nursing and Midwifery Registered	365	70	435
Grand Total	**1626**	**748**	**2374**
Percentage	**68.49%**	**31.51%**	**100.00%**

Ethnicity								
	Asian	**Black**	**Chinese**	**Mixed**	**Not Stated**	**Other BME**	**White**	**Grand Total**
Add Prof Scientific and Technic	102	12	9	3	23	4	94	247
Additional Clinical Services	103	93	1	16	54	33	76	376
Administrative and Clerical	172	136	5	28	130	31	307	809
Allied Health Professionals	9	7	0	1	6	0	28	51
Estates and Ancillary	3	7	0	1	4	4	15	34
Healthcare Scientists	13	1	0	4	6	3	31	58
Medical and Dental	105	5	22	20	39	31	142	364
Nursing and Midwifery Registered	85	131	12	17	43	43	104	435
Grand Total	**592**	**392**	**49**	**90**	**305**	**149**	**797**	**2374**
Percentage	**24.94%**	**16.51%**	**2.06%**	**3.79%**	**12.85%**	**6.28%**	**33.57%**	**100.00%**

Age Band							
Staff Group	<26	26-35	36-45	46-55	56-65	66+	Grand Total
Add Prof Scientific and Technic	18	103	71	29	21	5	247
Additional Clinical Services	33	102	110	94	34	3	376
Administrative and Clerical	57	213	206	186	120	27	809
Allied Health Professionals	9	18	9	11	4		51
Estates and Ancillary	1	2	7	13	11		34
Healthcare Scientists	2	16	18	15	7		58
Medical and Dental		113	120	82	36	13	364
Nursing and Midwifery Registered	5	35	87	195	98	15	435
Grand Total	**125**	**602**	**628**	**625**	**331**	**63**	**2374**
Percentage	**5.27%**	**25.36%**	**26.45%**	**26.33%**	**13.94%**	**2.65%**	**100.00%**

Disability					
No	Not Declared	Prefer Not To Answer	Unspecified	Yes	Grand Total
2219	60	**15**	**27**	53	2374
93.47%	2.53%	0.63%	1.14%	2.23%	100.00%

Sexual Orientation						
Bisexual	Gay or Lesbian	Heterosexual or Straight	Not stated (person asked but declined to provide a response)	Other sexual orientation not listed	No Category Selected	Grand Total
19	41	1447	838	4	25	2374
0.80%	1.73%	60.95%	35.30%	0.17%	1.05%	100.00%