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NHS
Barts Health
NHS Trust

Gender, Ethnicity & Disability Pay Gap Report

2024 / 2025

Summary report covering data from the period 1st April 2024 – 31st March 2025. This report provides our annual Gender Pay Gap and Ethnicity Pay Gap trends, as well as our Disability Pay Gap snapshot.

Executive Summary:

1. Purpose

The purpose of this report is to present our Gender Pay Gap (GPG) and Ethnicity Pay Gap (EPG) and Disability Pay Gap (DPG) position for 2025. This report covers a snapshot of GPG data from March 2025, covering our GPG submission for the 2024/2025 period (unless otherwise stated) and is legally required to be published no later than the statutory date of 30 March 2026[1].

2. What is the Gender Pay Gap and Ethnicity Pay Gap?

The GPG highlights the disparity in average pay between women and men across a workforce. If women do more of the less well-paid jobs within an organisation than men, the gender pay gap is usually bigger. As a measure, it captures any pay inequalities resulting from differences in the sorts of jobs performed by men and women and the gender composition of the organisation by seniority. It does not mean that two people doing the same job, get different pay. This is the ninth year of Barts Health publishing its Gender Pay Gap data.

As in previous years, our EPG is also reported here. The EPG measures the difference in average pay between White staff and those from Black, Asian, and Minority Ethnic (BME) backgrounds. The DPG refers to the difference in average pay between disabled and non-disabled employees.

Although EPG and DPG reporting is not a statutory requirement, the NHS England EDI Improvement Plan recommends that all Trusts analyse pay gap data by protected characteristic and put in place improvement plans. Plans should be in place for sex and race by 2024, disability by 2025, and all other protected characteristics by 2026.

Barts Health NHS Trust (Barts Health) has reported EPG data since March 2020, and this is the first year that we are reporting our DPG data.

While we provide separate snapshots for the GPG, EPG, and DPG, we recognise that many factors, such as flexible working, caring responsibilities, and socio-economic background may intersect with different protected characteristics, creating compounding layers of disadvantage.

Therefore, at the end of this report, we present an integrated, intersectional action plan that takes a holistic approach to pay equity. Our aim is to address structural and cultural drivers of pay inequality, to ensure equal opportunities for all staff, regardless of individual background or circumstances.

3. Context

Barts Health is one of the largest Trusts in the country and one of Britain's leading healthcare providers. With a diverse workforce of over 20,000 staff, in addition to volunteers, students, and contractors, pay gap data provides a valuable insight into the challenges of inclusion and diversity across our entire workforce.

Like most Trusts in the country, Barts Health has a workforce that is predominantly female. Our current workforce diversity information shows that female workers make up approximately

[1] The gender pay audit obligations are outlined in The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017.

69% of our workforce and approximately 31% are male. According to data from the period this report covers, 29% of our staff are White, 26% are Asian, 22% are Black, 3% are from a mixed heritage background and 9% were from 'other' ethnic backgrounds. The ethnicity of 11% of our workforce is unknown.

One of our key aspirations as part of our WeBelong inclusion strategy is to ensure fair and equal progression for all staff. Closing our gender, ethnicity and disability pay gaps is a key driver of this ambition. We are providing this report to offer full transparency on our current position, to highlight where improvement is needed, and to support both our statutory obligations and strategic ambitions.

Many of the inequality gaps highlighted in this report are not unique to Barts Health; they are widespread across the NHS and society. By continuing to publish the extent of our own inequalities, we hope to give further recognition to this agenda and be open with our own challenges as a positive step towards addressing them.

4. Summary of Key Trends and Actions for the Next 12 Months

We are proud that over the past year, Barts Health has made progress in reducing pay disparities, particularly in relation both our median and mean EPG. However, significant challenges remain. The data highlights persistent structural inequalities, including underrepresentation of women and Global Majority colleagues in the highest pay quartiles, a high median and mean EPG, and significant variation in hourly pay by ethnicity which requires attention.

To address these challenges, we are implementing a comprehensive, intersectional action plan that focuses on six key themes:

- Governance: To ensure strong leadership, accountability, and oversight in driving pay equity.
- Data & Insight: To build a deeper understanding of the root causes of pay disparities across our workforce.
- Recruitment: To create fair, inclusive, and accessible pathways into the organisation for all.
- Career Progression: To enable equitable opportunities for development and advancement at every level.
- Culture: To foster an inclusive, respectful, and supportive working environment
- Engagement: To centre the voices and experiences of our staff in shaping meaningful change.

These actions are underpinned by our WeBelong Inclusion Strategy and our recently refreshed Barts Health People Strategy, which places inclusion and equity at the heart of our strategic priorities. Our commitment is clear: to close our pay gaps, we must go beyond compliance and embed fairness into every aspect of our organisational culture.

5. How is the Gender Pay Hap changing at Barts Health?

Overall, the median Gender Pay Gap (GPG) has shown improvement from when we first started reporting. Since first reporting in 2017, the median hourly pay gap of 13.3% between male and female colleagues has reduced to 3.3% in March 2025. This means that for every £1 that the median man earned, the median woman earned £0.97. This is an improvement of 1.5 percentage points from the previous year (4.8% in March 2024). The median pay gap is calculated by separately listing men and women across the entire workforce in increasing salary order and counting up to the "middle" person in each of the lists. This avoids skewing the figure with the highest and lowest salaries.

Following fluctuations between 2017 and 2021, our mean GPG has since been improving for four consecutive years between March 2021 and March 2025. In March 2025, the mean pay gap was 14.7%, which means that for every £1 the average man earned, the average woman earned £0.85. This is an improvement of 2.2 percentage points from the previous year (16.9% in March 2024). The mean is calculated by adding up all the salaries or bonuses for men or women and dividing it by the total number of people in each group.

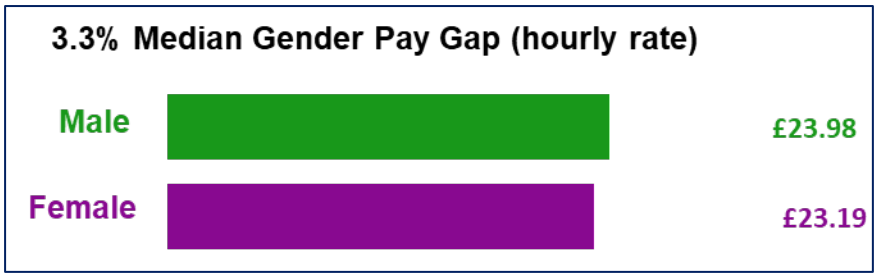

Fig.1

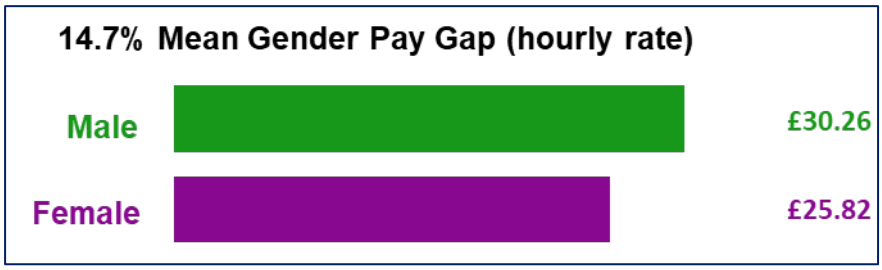

Fig. 2

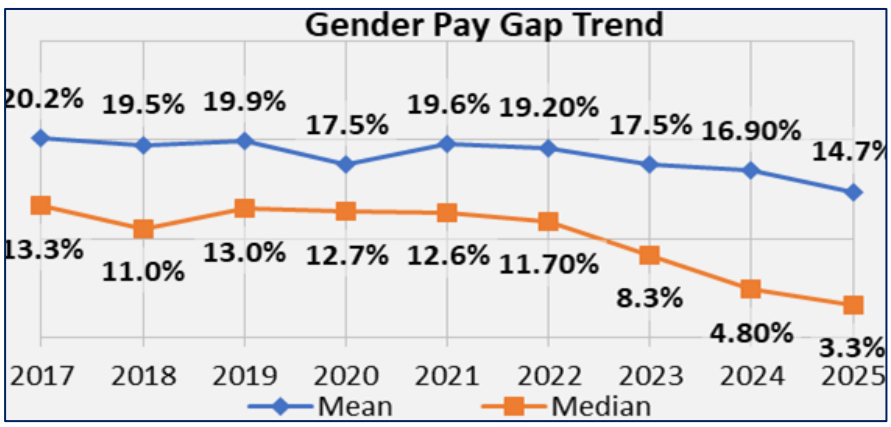

Fig. 3

The median helps give a picture of the middle and is less impacted by outliers (i.e., people in roles that are banded much higher, or lower). An improvement could indicate that the distribution of roles/pay across some parts of the organisations is becoming fairer. The mean is more impacted by higher salaries. The proportion of males is higher in some higher hourly rate staff groups (e.g. doctors) which will impact on GPG as this staff group is predominantly in the top quartile.

6. Bonus Gender Pay Gap Data: March 2017 – March 2025

The GPG data requirement also looks at the difference between bonus payments received by men and women. For Barts Health, the main payment that would normally fit the description of bonus, per gender pay gap reporting, is the Clinical Excellence Award (CEA), which has now been replaced by the National Clinical Impact Award Scheme. Only legacy awards (pre-2018) continue to be paid following the most recent consultant contract, meaning that those earning the bonus will continue to do so until they retire or leave the organisation. As a result, this is not influenceable. In 2024/25, 24% of female consultants received a CEA payment compared to 34% of male consultants. The significance of reporting against this metric is somewhat diminished compared to previous years, as it reflects a closed scheme with a fixed recipient group. However, for transparency, we will continue to note these figures in our reports going forward.

Our median bonus GPG is currently 27.1%, which means that for every £1 that the median bonus earning man earned, the median woman earned £0.73. Our mean bonus GPG is currently 35.5%, which means that for every £1 that the average bonus earning man earned, the average woman earned £0.65. There was an decrease in the median CEA in 2021 following the decision to allocate the local CEA funding equally to all eligible consultants. Since this scheme has ended the median has returned to the pre-covid levels.

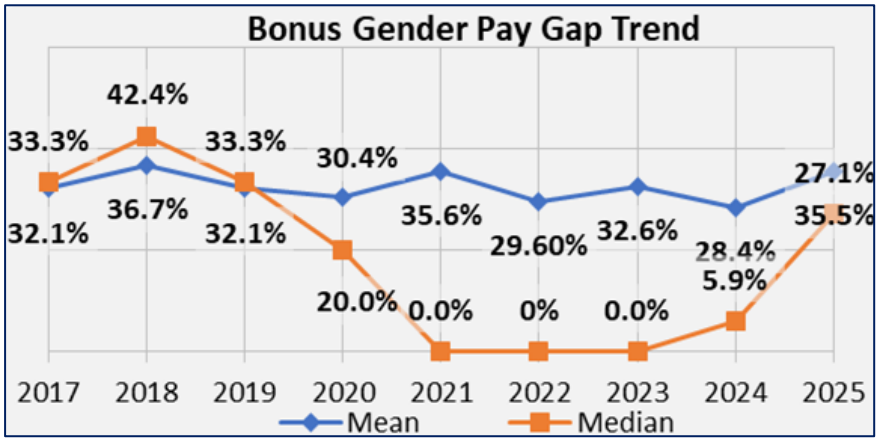

Fig. 4

7. Gender Pay Gap: Benchmarking Against Similar Trusts

2025 data is not yet available for all 10 large acute trusts in London for benchmarking purposes, as the 2025 position is not due to be published until March 2026. We instead present complete figures from the March 2023/24 snapshot which is the latest complete comparison of data from relevant trusts (see Table 1 and 2 below). We can therefore only benchmark retrospectively, until the 2025 data from all other trusts is published.

Benchmarking against similar NHS Trusts shows that Barts Health ranks among the top two trusts in relation to the median GPG, and the bottom four trusts in the region in relation to the mean GPG. It should be noted that these figures are based on snapshots from 2 years ago so comparisons should be used with caution. Moreover, while national benchmarking data can provide useful context, it is important to that ensure comparisons are made on a like-for-like basis, considering structural differences such as insourcing, which can significantly impact pay gap data.

Trust	Median Gap %
Imperial College Healthcare NHS Trust	2.1%
Barts Health NHS Trust	4.8%
University College Hospital NHS Trust	7.0%
• St George's University Hospitals NHS Foundation Trust • Guy's & St Thomas' NHS Foundation Trust	8.6%
Royal Free London NHS Foundation	13.0%
Homerton University Hospital Foundation Trust	13.3%
King's College Hospital	14.1%
Lewisham And Greenwich NHS Trust	15.3%
Barking, Havering and Redbridge University Hospitals NHS Trust	19.2%

Table 1. Median GPG: National Benchmarking

Trust	Mean Gap %
Imperial College Healthcare NHS Trust	10.6%
St George's University Hospitals NHS Foundation Trust	11.6%
Royal Free London NHS Foundation	12.2%
Guy's & St Thomas' NHS Foundation Trust	12.4%
University College Hospital NHS Trust	14.0%
King's College Hospital	16.2
Barts Health NHS Trust	16.9%
Homerton University Hospital Foundation Trust	20.1
Lewisham And Greenwich NHS Trust	21.8%
Barking, Havering and Redbridge University Hospitals NHS Trust	22.4%

Table 2. Mean GPG: National Benchmarking

Note: *Large London Acute used with NEL Acutes included. (Workforce 5,000+). Source: https://gender-pay-gap.service.gov.uk/ Figures for March 24 reflect those submitted for 2024-25. Figures for March 25 (25-26 reporting year) are not available yet.*

8. Proportion of Males and Females in each Pay Quartile

To give an overview of where women and men are distributed in terms of seniority, the proportions of male and female employees are split between four quartiles – lower, lower middle, upper middle and upper pay bands, representing increasing seniority. The proportion of women and men in these quartiles are summarised in Figure 5 below:

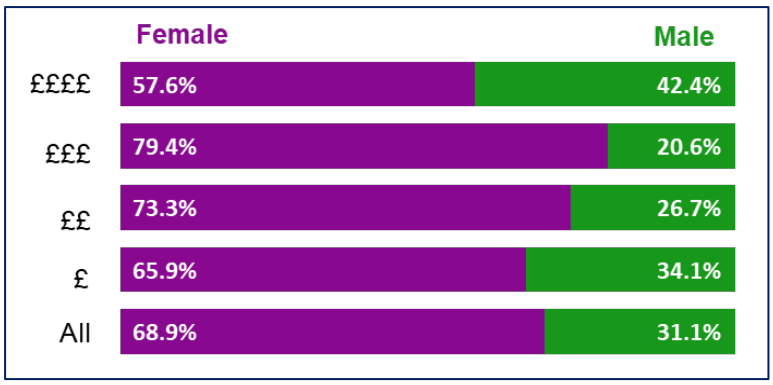

Fig.5

Highest Pay Quartile (££££): The proportion of women in the upper pay quartile has slightly reduced by 0.3 percentage points from 57.9% in March 2024 to 57.6% in March 2025. Also, an 11.3% gap exists between the trust gender profile (68.9% female) and the proportion of women in the highest pay quartile (57.6%). This gap has reduced by 0.1 percentage point since the previous year (11.4%). Whilst we are pleased that this representation gap is closing, men continue to be disproportionately represented in our workforce at the higher levels of pay. At the top pay decile 42.4% of the workforce is male, despite men only accounting for 31.1% of the total workforce.

Upper Middle (£££): 79.4% of upper middle quartile positions are filled by women. This represents an improvement of 0.9 percentage points from the previous year (78.5%). Compared to the overall Trust gender profile (68.9% female), women are overrepresented in the upper middle pay quartile, however representation significantly drops in the highest pay quartile where women are underrepresented. This suggests that there continues to be a 'glass ceiling' for women between the upper middle and highest pay quartile.

Lower Middle (££): Women are overrepresented in the lower pay quartile (73.7%) compared to the trust gender profile (68.9%).

Lowest Pay Quartile (£): In the lowest quartile, men and women are broadly distributed in an equitable way when compared with the overall trust gender profile. However, men are slightly overrepresented in this quartile (34.1%) relative to their overall presence in the workforce (31.1%).

9. Proportion of Males and Females in each Pay Quartile

The staff group and band charts at Figures 6 and 7 below, reflect the historical, and still prevalent, gender roles of the hospital workforce. Understanding where gaps exist can help identify what is working well, and where structures exist that reinforce inequality.

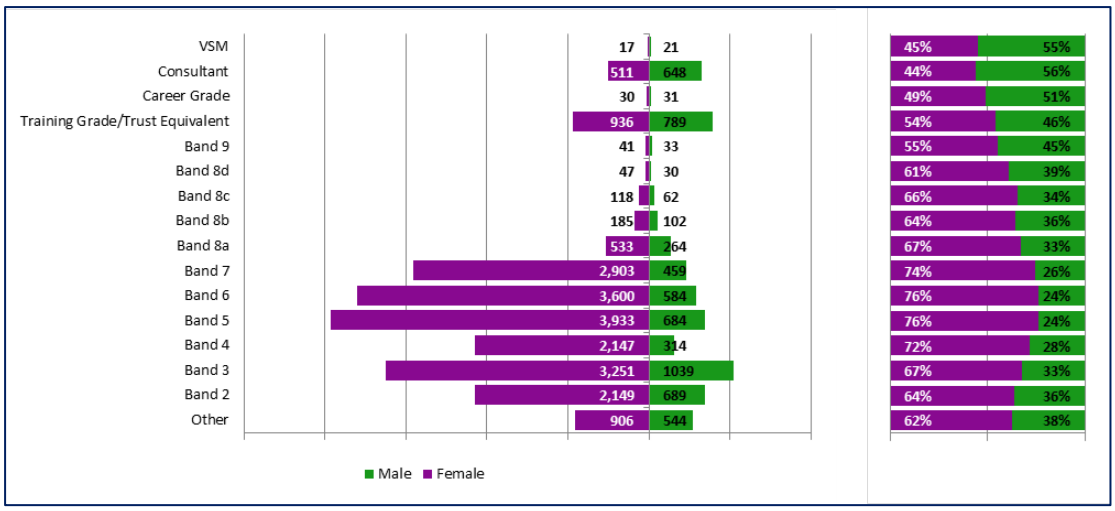

Fig.6

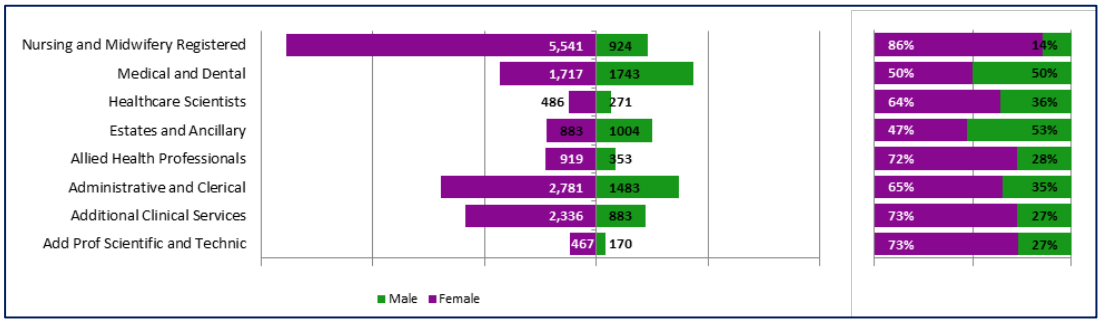

Fig.7

The level of female representation varies by band and staff group. It is important that the Trust understands the drivers of this variation, to ensure that our interventions can be targeted appropriately. Key insights within the March 2025 data include:

- Female staff account for 68.9% of our overall workforce. They are therefore underrepresented in all bands at 8a and above, and overrepresented in bands 4 to 7. The greatest disparities are within the Consultant and Very Senior Manager (VSM) workforce, where women make up only 44% and 45% of those groups, respectively. However, it is worth noting that despite these disparities, the proportion of women in Consultant and VSM roles has improved compared to the previous year, rising from 43% to 44% in Consultant roles and from 40% to 45% in VSM roles, between March 2024 to March 2025. This is a promising trend; we will therefore continue to embed career progression and inclusive recruitment interventions to help sustain and build on this progress.

- The highest proportion of women are in Nursing and Midwifery roles (86%), followed by Additional Clinical Services (73%), Additional Professional, Scientific & Technical (73%), and Allied Health Professional (72%) roles.

- The Nursing and Midwifery staff group remains predominately female (86%), consistent with previous years. This profession predominantly has a low-mid banding structure that

may provide structural barriers to progression and therefore remains a challenge for achieving gender pay equity within the Trust.

- The gender distribution among medical and dental staff is now balanced at 50% male and 50% female. While this parity within this professional staff group is promising, there is still more work to be done to ensure that the level of female representation within this workforce segment is proportionate to the overall trust gender profile (68.9% female).

10. Ethnicity Pay Gap Information (March 2025)

This is the sixth year that Barts Health are reporting their Ethnicity Pay Gap (EPG) data. As presenting ethnicity pay gap data is not currently a statutory requirement, we are not currently able to benchmark against other organisations. The ethnicity pay gap is an emerging focus of this report, and further data collection and analysis will be undertaken to investigate the underlying factors contributing to pay inequalities across different ethnic groups.

Our March 2025 snapshot shows a significant median EPG of 20.6%, which means that for every £1 that the median white colleague earned, the median BAME colleague earned £0.79. This is an increase of 1.9 percentage points since the previous year (18.7%). This disparity echoes findings in our annual Workforce Race Equality Standard (WRES) data, which consistently shows that there are disparities between White and BME colleagues in relation to career progression. The actions we are taking to reduce inequalities between ethnicities are further detailed in our 2025 WRES Report, which is available separately on our Trust website.

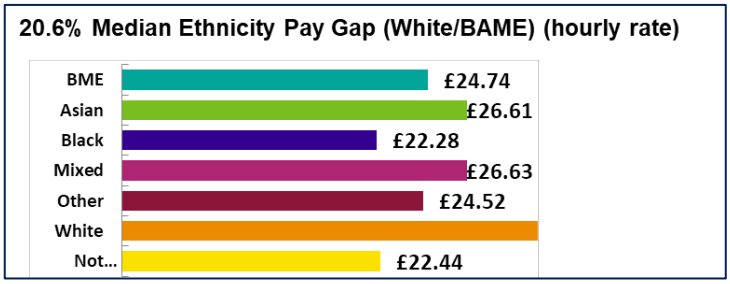

Fig.8

There is also a significant mean ethnicity pay gap of 19.5% between White and BME staff. This means that for every £1 that the average White person earned, the average BME person earned £0.80. There has been no change since the previous year.

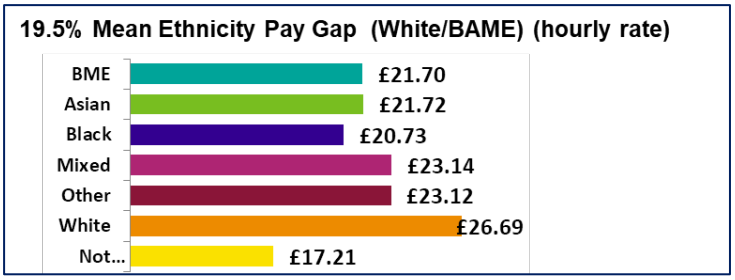

Fig.9

To provide an overview of how employees from different ethnic backgrounds are distributed across different levels of seniority, the proportion of employees from different ethnic groups within each quartile is summarised in Figure 10 below. 42% of the highest earners in the Trust are White, while staff from Black, Asian, or Mixed heritage backgrounds account for 44% of the highest earners. Compared to the overall Trust gender profile (29% White), White colleagues are overrepresented in the highest pay quartile, while BME colleagues are unrepresented.

The proportion of Asian and Mixed colleagues in both the upper and upper middle pay quartiles has remained static compared to the previous year. However, we are pleased that the proportion of Black colleagues in the upper pay quartile has increased from 14% in March 2024 to 16% in March 2025. Whilst this progress is encouraging, it is recognised that Black colleagues remain the most underrepresented group in the highest pay quartile when compared to the overall Trust ethnicity profile, where 22% of staff are known to be Black. This highlights the need for more focused interventions to support Black colleagues to progress into senior roles.

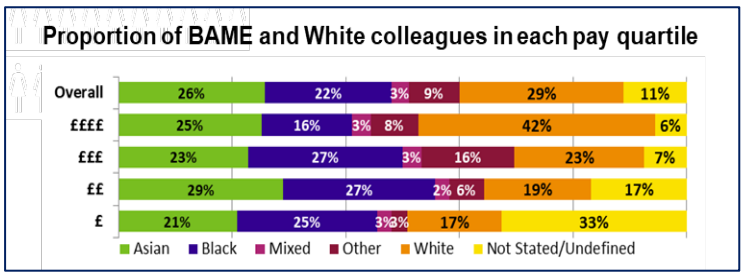

Fig.10

In March 2025, a continued variation in pay by ethnicity is evident across the top 20 most represented ethnic groups at Barts Health, as shown in Table 3 below. Bangladeshi colleagues remain the group with the lowest median pay (£17.96/hour), highlighting a persistent challenge that reflects broader socio-economic disparities and potentially occupational segregation. Chinese colleagues have the highest median pay, at £31.19/hour. White British colleagues also continue to be amongst the highest earners, consistent with previous years.

The overall disparity between the highest and lowest paid groups remains significant. This variation in median hourly pay underscores the importance of analysing ethnicity pay gap data in greater detail to identify and address specific inequalities.

Ethnicity	Mean pay by hour (£)	Median pay by hour (£)	Count
R Chinese	£ 36.36	£ 31.19	247
P Black or Black British - Any other Black background	£ 33.62	£ 29.91	307
A White - British	£ 32.45	£ 29.00	4091
C White - Any other White background	£ 31.70	£ 27.78	1271
PC Black Nigerian	£ 29.17	£ 27.00	451
H Asian or Asian British - Indian	£ 31.37	£ 26.68	1962
PA Black Somali	£ 29.51	£ 26.53	141
G Mixed - Any other mixed background	£ 28.91	£ 25.99	172
S Any Other Ethnic Group	£ 29.49	£ 25.93	524
SC Filipino	£ 24.01	£ 23.49	1321
M Black or Black British - Caribbean	£ 25.97	£ 22.63	929
N Black or Black British - African	£ 23.92	£ 22.52	2546
CY White Other European	£ 23.61	£ 21.83	209
D Mixed - White & Black Caribbean	£ 26.05	£ 21.16	203
B White - Irish	£ 23.81	£ 20.14	309
J Asian or Asian British - Pakistani	£ 22.52	£ 19.98	718
L Asian or Asian British - Any other Asian background	£ 21.36	£ 19.42	905
PD Black British	£ 24.03	£ 18.74	245
Z Not Stated	£ 22.83	£ 17.97	2429
K Asian or Asian British - Bangladeshi	£ 21.40	£ 17.96	1400

Table 3.

On 6 August 2025, the NHS Race and Health Observatory announced the commissioning of the first-ever independent, comprehensive review into ethnicity pay gaps across the NHS in England. Led by the University of Surrey, the 18-month study will examine differences in pay, career progression, pension contributions, and cumulative earnings between ethnic groups, explore the structural and systemic factors that drive racial pay inequalities, and issue evidence-based recommendations to reduce and ultimately eliminate them.

As part of our continued commitment to race equality, Barts Health will implement the recommendations from this national review to address the underlying causes of our own EPG, dismantle barriers to progression for underrepresented ethnic groups, and work towards achieving pay equity for colleagues from all ethnic backgrounds.

11. Disability Pay Gap Information (March 2025)

This is the first year that Barts is reporting Disability Pay Gap (DPG) data. As such, a snapshot is provided below, however no previous data is available for comparison. We are also not currently able to benchmark against other organisations, as reporting DPG is not currently a statutory requirement.

Initial findings show that there is a median disability pay gap of 5.5% between non-disabled and disabled staff (see Figure 11). This means that for every £1 the median non-disabled person earned, the median disabled person earned £0.95. There is also a mean DPG of

7.6% (see Figure 12), which means that for every £1 that the average non-disabled person earned, the average disabled person earned £0.92.

An important caveat is that Electronic Staff Record (ESR) disability declaration rates remain low, and we know from NHS Staff Survey data that these figures do not fully reflect the true number of staff with a disability or long-term health condition.

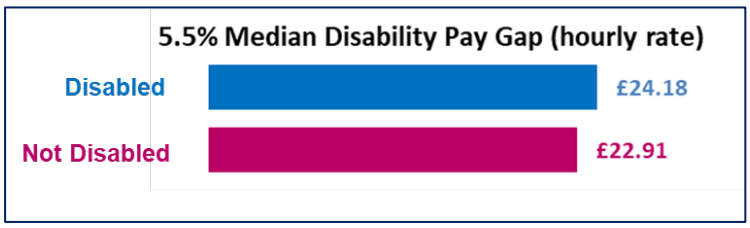

Fig.11

Fig.12

12. Closing the Gaps: Our Commitments to Pay Equity in 2025 and Beyond

We are proud that in the last 12 months both our median and mean GPGs have continued to reduce, building on the improvements that we made in the previous year. Despite this progress, we recognise that there is still significant work required, to reduce our gender, ethnicity and disability pay gaps, and ensure that we achieve pay equity for all people across our organisation. The key challenges that we need to address are:

- We have a significantly high median EPG, which has worsened over the last 12 months.
- We have a significantly high mean EPG, which has shown no improvement over the last 12 months.
- Despite continued improvements in our mean GPG position, benchmarking against similar NHS Trusts shows that Barts Health ranks among the bottom four trusts in the region in relation to the mean GPG.
- Women and Global Majority colleagues are underrepresented in the highest pay quartile, while men and White colleagues are overrepresented.
- There is a continued variation in pay by ethnicity, with Bangladeshi colleagues remaining the group with the lowest median pay.

We cannot underestimate the scale of the challenge ahead; however, we are confident that, through a strategic and delivery focused approach, we can make real progress in closing our pay gaps and creating a fairer, more inclusive workplace for all.

Some of the key strategic actions that we will take over the next five years to create a more inclusive and equitable organisational culture are set out in our WeBelong Inclusion Strategy and our recently refreshed Barts Health People Strategy, which has inclusion and equity embedded as a golden thread. A detailed breakdown of the actions that we will take over the next 12 months is provided in the table in section 13 below.

We remain firmly committed to taking an intersectional approach to addressing our pay gaps, recognising that individual experiences cannot be understood through single characteristics alone. Factors such as gender, ethnicity, disability, socio-economic background, caring responsibilities, and flexible working status etc. often intersect in ways that create compounding layers of disadvantage. We are therefore determined not to lose sight of the people behind the data, and we will continue to actively engage with our staff networks and local communities to better understand the lived experiences of our people and deliver interventions that truly achieve meaningful and sustainable change.

We also recognise that while this report provides valuable insight, it is only part of the picture. To truly understand and address the underlying structural and cultural drivers of our pay gaps, we need to dig deeper. We will therefore work in close partnership with our People Analytics team to ensure regular, detailed analysis of pay gap data, at a more granular level that will help us to better target our interventions. This will not be a one-off, annual exercise, but rather an ongoing process that continuously informs our decisions and actions. Our approach will be underpinned by strong governance, robust and measurable action plans, and clear senior leadership accountability.

We are proud of the progress we have made, but we know we cannot afford to stand still. As we look ahead, we remain steadfast in our commitment to fairness, inclusion, and equity, and to building a workplace where every colleague has equal opportunities to thrive and succeed

13. GPG and EPG Action Plan: 2025/26

Theme	What actions will we take over the next 12 months?
Governance	• We recently refreshed the chairing of our Pay Equity Task and Finish Group, appointing a Hospital People Director and a co-chair from the BME Network to lead its work. We will continue to review and expand the membership of the group to ensure a more intersectional, joined-up, and coordinated approach to addressing our Gender Pay Gap (GPG), Ethnicity Pay Gap (EPG), and Disability Pay Gap (DPG). • We will continue to review and refresh key policies to ensure that they do no create or compound structural inequalities.
Data & Insight	• We will continue to analyse data to understand pay gaps by protected characteristic, with a particular focus on gender, ethnicity and disability pay gaps over in the next 12 months. We will put in place an improvement plan in line with the recommendations in the NHS Equality, Diversity, and Inclusion Improvement Plan. • We will continue to analyse data by professional group to identify 'pinch points' where representation begins to drop off, to ensure that interventions can be targeted at the appropriate level across our different professional groups. • We will continue to conduct root cause analysis to better understand the drivers of the variation in pay by ethnicity to ensure that interventions can be designed and tailored appropriately. • We will explore and implement measures to track social mobility indicators within our recruitment processes, to help ensure we are attracting and appointing a diverse range of candidates from different socio-economic backgrounds. • Whilst exercising caution with data from Trusts that have undergone insourcing, we will continue to track our pay gap data against that of other Trusts and embed learning and best practice from those that have successfully reduced their pay gaps. • We will conduct more granular pay gap analysis, including intersectional data (e.g., gender, ethnicity, disability, socio-economic background, caring responsibilities, flexible working).
Recruitment	• We will transform our recruitment processes to remove bias from decision making, including ensuring that all interview panels for senior roles (8a+) include an objective inclusion ambassador, implementing a more values based inclusive recruitment approach and rolling out our refreshed inclusive recruitment training which is now live and available to all hiring managers. • Due to current productivity challenges, permanent opportunities may be limited. We will therefore take a more robust and inclusive approach to acting-up and secondment opportunities, using refreshed internal talent management processes to ensure fair and equitable access. This approach will accelerate internal development and build the readiness of our diverse talent pipeline for senior roles when they arise. • We will bolster our role as an anchor institution, through providing inclusive local employment opportunities such as Project SEARCH. • We will expand recruitment via non-traditional routes, e.g. apprenticeships, as part of our broader efforts to widen access and participation for underrepresented groups.

	• We will explore digital solutions, including Artificial Intelligence (AI), to improve and simplify the application process, with a particular focus on enhancing accessibility for neurodiverse candidates. • Where possible, we will advertise senior posts internally before external advertisement and strongly encourage staff from under-represented staff groups to apply.
Career Progression	• We will develop a robust talent management and succession planning framework, that is integrated into our annual appraisal cycle, ensuring that all colleagues have equal opportunities to be considered for senior roles. • We will refresh our Inclusive Career Development Offer, including delivery of bespoke leadership development programmes targeted specifically at underrepresented staff groups (e.g. Pave Your Path Programme for disabled colleagues). • By driving appraisal compliance, we will continue the roll out of scope for growth career conversations across the organisation, which have now been embedded into the appraisal framework. • We will conduct a detailed analysis of representation disparities at various levels and across different staff groups within the BAME categorisation. We will use this data to inform development of targeted interventions and monitor the impact of current initiatives on specific groups, especially focusing on the underrepresentation of Black and Bangladeshi colleagues in senior roles.
Culture Change	• We will continue to bolster our senior leadership development offering, for example through delivery of biannual senior leadership conferences, and build compassionate and inclusive leadership capability at every level of our organisation. • We will enhance the focus on respect and civility within teams to foster an inclusive culture where racism, sexism and discrimination of any kind is not tolerated. • We will continue to roll out our civility-focused training offer, including Cultural Intelligence (CQ) and Active Bystander training, targeting delivery in known hot-spot areas. • We will ensure fair and equitable access to flexible working opportunities, and actively challenge entrenched negative perceptions of flexible and part-time working, to prevent these from becoming barriers to career progression.
Communication & Engagement	• We will work in partnership with our Staff Networks, to continue to engage with our people through listening circles and focus groups to gather insights on barriers to progression and what more we can do to improve the impact of current initiatives. • We will increase the frequency of inclusive career development roadshows, to ensure that all colleagues are aware of the suite of career development opportunities that are available to them and to encourage colleagues from unrepresented staff groups to apply for senior roles when they become available.