Ethnicity Pay Gap Reporting 2024 - 2025

1.0 Introduction

1.1 The National Health Service (NHS) is one of the largest employers in the United Kingdom, with a workforce that reflects the diversity of the nation it serves. Despite this diversity, evidence suggests that disparities in pay persist across ethnic groups within the NHS. The ethnicity pay gap—defined as the difference in average hourly pay between employees from different ethnic backgrounds—has become an increasingly important issue in the context of equality, diversity, and inclusion. Addressing this gap is not only a matter of fairness but also critical for fostering trust, improving staff morale, and ensuring the NHS remains an exemplar of equitable employment practices.

1.2 This paper explores the current state of the ethnicity pay gap within The Princess Alexandra Trust (PAHT), examining the data, implications for workforce equality, and the steps being taken to address it. By analysing available data and policy initiatives, the discussion aims to highlight both progress and challenges, while considering the broader social and organizational impact of pay disparities. Ultimately, understanding and closing the ethnicity pay gap is essential for achieving the NHS's commitment to equality and for delivering high-quality care in a truly inclusive environment.

2.0 Background and Context

2.1 The NHS was founded on principles of universal access and equality, but workforce equality has evolved over decades. Early diversity initiatives focused on recruitment and pay equity became a formal agenda much later, influenced by the Equality Act 2010, which provided the legal basis for tackling discrimination, including race and ethnicity.

2.2 The ethnicity pay gap reporting remains voluntary, creating inconsistencies in transparency. At PAHT we understand the value of transparency, and we aim to reduce inequality across the board, through all our policies and practical steps. It is also included in our plan for the NHS High Actions Improvement Plan 2023.

2.3 NHS People Plan and Workforce Race Equality Standard (WRES) are key initiatives aimed at improving representation and reducing disparities. Pay gaps impact morale, retention, and progression opportunities, it undermines the NHS's commitment to equality and can affect patient care indirectly through workforce dissatisfaction.

3.0 Terminology and how to read the data

- **Mean ethnicity pay gap** – the difference between the mean (average hourly earnings, excluding overtime) of relevant staff from different ethnic backgrounds

- **Median ethnicity pay gap** – the difference between the median (the difference between the midpoints of hourly rates of earnings, excluding overtime) of relevant staff from different ethnic backgrounds

- **Mean bonus gap** – the difference between the mean bonus paid to staff from different ethnic backgrounds (bonus pay exclusively made up of local and national consultant

clinical excellence awards, discretionary points and the welcome bonus for our international Nurses)

- **Pay distribution by ethnicity**– the proportion of relevant staff in the lower, lower middle, upper middle and upper quartile pay bands by ethnicity

3.1 How to read the data:

- A positive percentage (e.g. 1.0%) indicates that white employees have higher ordinary pay or bonuses than ethnic minority employees.
- A negative percentage (e.g. -1.0%) indicates that ME employees have higher ordinary pay or bonuses than white employees.

4.0 Ethnicity Profile of the Trust

4.1 The table and chart shows the ethnicty profile for all staff employed at PAHT as at March 2025.

4.2 When reviewing the information, it is useful to understand the overall numbers of ME and white staff in the workforce. As of 31 March 2025, the ethnic profile of staff represents 46% for ME staff (43% previous year), and 51% classed as White (54% previous year). Staff who have not stated their ethnicity represents 3%, which remains the same as last year.

Ethnicity	Headcount	%
BME	1901	46%
Not Stated	115	3%
White – British & white other	2141	51%
Grand Total	**4157**	

Table 1

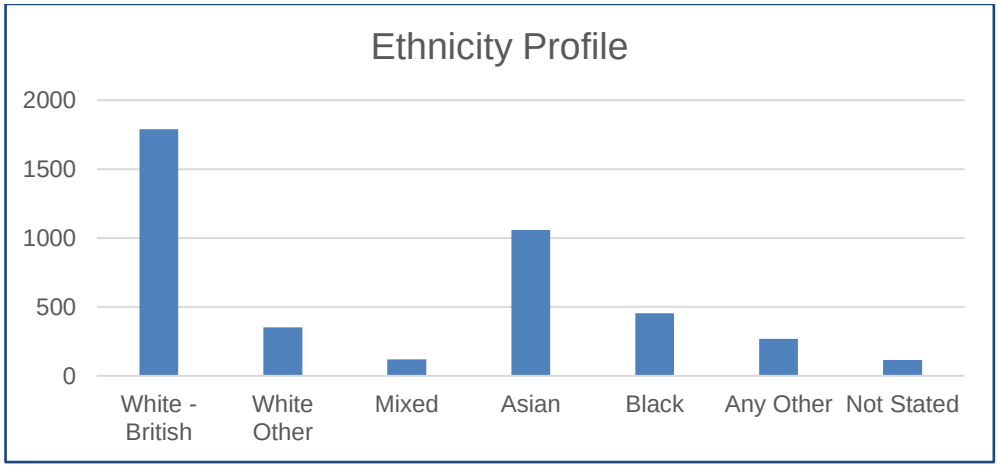

Chart 1

5.0 Mean and Median Basic Pay by Ethnicity

5.1 Table 2 provides the overall mean ethnicity pay gap between ME and white staff is -14.69% (in favour of ME) and median pay gap is -20.32% (in favour of ME).

Ethnicity	Mean Hourly Rate	Median Hourly Rate
BME	25.42	21.94
Not Known	28.4	23.07
White	22.16	18.23
Diff White - BME Gap	-14.69%	-20.32%
Diff White - BME Gap	-£3.26	-£3.71

Table 2

5.2 Table 3 provides the corresponding number of staff within each ethnic group by pay band or grade excluding medical and dental staff.

Band/Grade	BME	White	Not Stated	Grand Total
Band 1	2	10	2	14
Band 2	175	366	17	558
Band 3	192	404	13	609
Band 4	39	226	3	268
Band 5	573	200	10	783
Band 6	259	300	14	573
Band 7	129	259	12	400
Band 8 - Range A	55	124	4	183
Band 8 - Range B	20	45	2	67
Band 8 - Range C	4	17	1	22
Band 8 - Range D	3	17	1	21
Band 9	3	11	0	14
VSM	1	7	0	8
NED	4	5	1	10
Grand Total	1459	1991	80	3530

Table 3

5.3 Table 4 illustrates the ethnicity pay gap breakdown for medical and dental staff only. Mean gap: 7.75% (in favor of White) Median gap 11.15% (in favour of white).

Ethnicity	Mean Hourly Rate	Median Hourly Rate
BME	40.55	36.53
Not Known	44.24	45.29
White	43.96	41.12
Diff White - BME Gap	7.75%	11.15%
Diff White - BME Gap	£3.41	£4.59

Table 4

5.4 Table 5 provides the corresponding number of staff under medical and dental only within each ethnic group by pay grade.

Band/Grade	BME	White	Not Stated	Grand Total
Foundation Year 1	40	12	3	55
Foundation Year 2	38	12	2	52
Specialty Registrar	80	38	3	121
Trust Grade	71	10	7	88
Career Grade Doctor	78	13	4	95
Consultant	135	65	16	216
Grand Total	442	150	35	627

Table 5

6.0 Mean and median bonus pay by ethnicity (Medical and Dental Terms and conditions and international nurses)

7.1 Chart 3 illustrates the international nursing scheme that PAHT run during the last year, which was only applicable to ME staff.

7.2 Chart 4 illustrates the CEA payments, demonstrating that ME staff had favourable payments when compared to white staff.

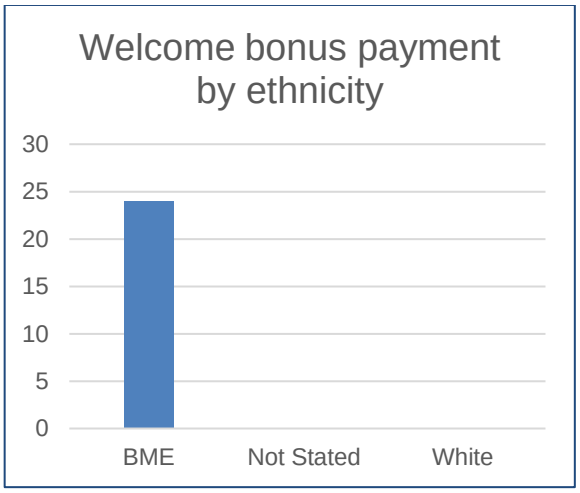

Chart 3

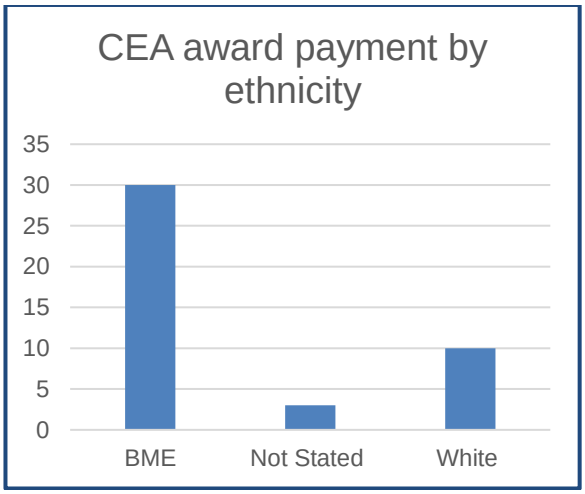

Chart 4

7.0 Pay distribution by ethnicity

6.1 Chart 2 shows the proportion of ethnic staff in each quartile.

6.2 Staff are allocated into each quartile based on their hourly rate of pay and does not differentiate full time from part-time hours – it only considers salary paid and banding.

6.3 Lower quartile is our lowest pay quartile, and upper quartile is our highest pay quartile as per the requirement. Job roles included in each quartile are as follows:

- Lower quartile – roles include domestics porters, HCA and clerical staff

- Lower middle quartile – roles included staff nurse
- Upper middle quartile – roles include manager, F1, F2 doctors and specialists
- Upper quartile – consultants, senior managers, heads of service and directors

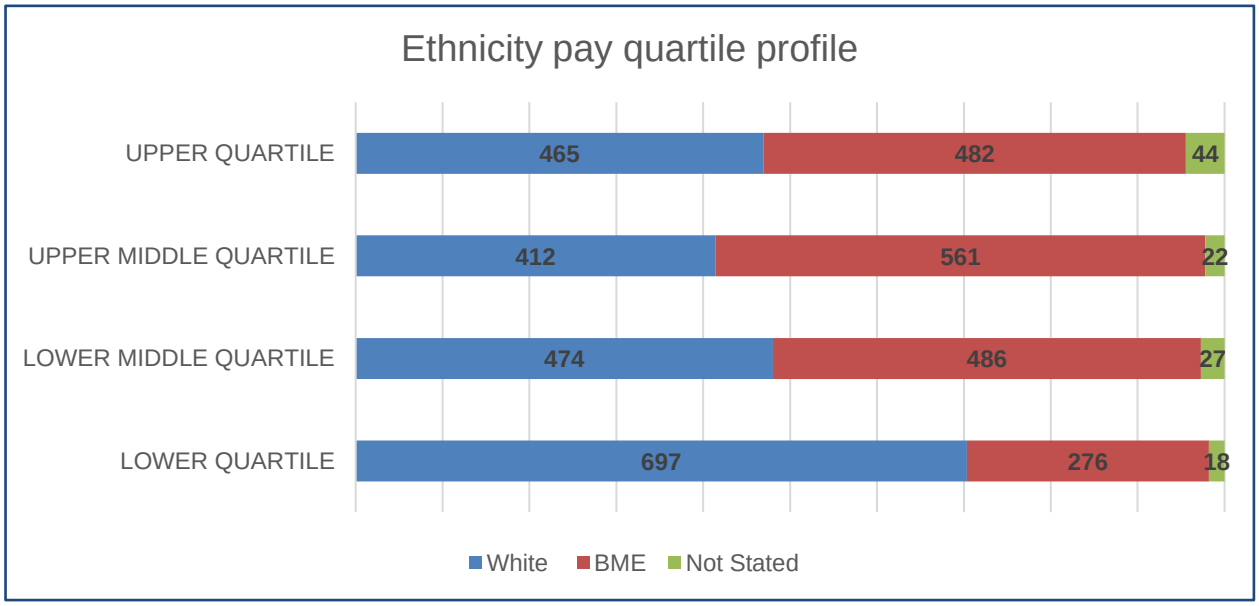

Chart 2

8.0 Patterns and insights

8.1 The data from PAHT clearly shows a concentration of ME representation at Band 5 roles at 73.2% which far exceeds Trust average (41.3%). That indicates a strong presence of ME in roles such as nursing, which is not surprising given the international recruitment drive for the past few years.

8.2 However, what the data also points out to is that without proportionate progression into Bands 6-7 and beyond, this concentration may signal a progression bottleneck.

8.3 Analysing ME concentration at Band 6 (45.2%), which is slightly above overall average, suggest partial progression from Band 5.

8.4 However when looking at Band 7 (32.3%) the data dips below average, pointing to the limited transition into first-line leadership or specialist posts.

8.5 at Higher bands (8A-9) the representation ranges between 12-30% and at VSM is 12.5% which indicates structural barriers to senior leadership roles for our ME staff.

8.6 We also may have a possible concern around our entry-level (Band 1-4) as it ranges around 14-15% suggesting that either, role-type allocation, or labour market/recruitment dynamics are affecting entry level representation. Considering most of our staff are Harlow home-based, and the composition of the population/community around Harlow is 83% white, it may be labour market dynamics around the postcode.

8.7 There is also a clear over representation of ME under medical and dental terms and conditions driven by the labour market. However, despite over representation, there is still a pay gap favouring white staff.

9.0 Conclusion

9.1 Our efforts to address the ethnicity pay gap will require a focus on a few factors. The role of bias shapes on who gets promoted, training opportunities and career outcomes.

9.2 To ensure equality of opportunity for ME staff and increasing representation in the upper quartiles, we will:

- Review our current practices;
- Monitor opportunities for promotion;
- Promote career progression routes;
- Provide leadership training and targeted professional development;
- Target succession planning;
- Implement the NHS debias recruitment programme targeting ME staff;
- Introduce mentorship programmes.

9.3 Appreciating that there is still work to be done to eliminate those systemic barriers and ensure that pay and career advancement are fair for all ME groups.

9.4 Our EDI Strategy & Delivery Plan features the East of England (EoE) Anti -racism Strategy, that sets out the work we are doing to address the activity mentioned above in tackling discrimination, to create equity and equality of opportunity for ME staff.

9.5 Our ambition is to create an inclusive culture that fosters diversity of thought and experience**.**

9.6 To achieve equity, ME staff must have opportunities to progress to senior posts**,** proportionate to their representation in the Trust and we will aim to achieve that through our policies and action plan (Appendix 1)

10.0 Recommendation

10.1 Board is requested to discuss this paper and approve for publication.

Appendix 1
Ethnicity Pay Gap Actions 2025- 2026

Area and Objective	Action	Outcome and impact	Lead	Timescales	Where will this be reported / monitored
To improve the underrepresentation of BME staff in non-clinical senior managers posts band C to VSM.	Provide a clear brief to recruitment consultants and executive search firms	More diverse candidate shortlists to improve representation of BME staff in the non-clinical roles.	Head of People – Recruitment & Retention	On going	Divisional Resourcing meetings
	Implementing fair and inclusive practices across	Ensure a fair recruitment	Head of People –	On going	

	all HR employee relation processes and implement NHSE De bias Recruitment practices.	process for BME Staff.	Recruitment & Retention		
	Enhance communications to Staff for Trust's Ready-to-Manage, Coaching, ICB and NHS Leadership Academy Programmes.	Employees are given equal access to development programmes for career progression. Promotion of NHS development programmes that are tailored to minority groups.	Head of OD & Learning	On going	People Committee
	Monitor the outcomes of WRES Action Plan – recruitment, training, promotion discrimination, bullying and harassment.	WRES actions are having a positive improvement on the progression of BME Staff.	Head of EDI	On going	People Committee
	Monitor outcomes form the from the EoE Anti- racism Strategy	Activity to address systemic racism is having a positive effect in addressing barriers for BME staff.	Head of EDI	On going	People Committee
	Through the REACH staff networks run focus groups to monitor feedback on perceptions of career progression and promotion amongst BME staff.	Increase employee knowledge and confidence with regards to access to development programmes, career paths and opportunities.	Head of EDI Chair of the REACH Staff Network	April 2026	People Committee