CareQuality Commission

The state of health care and adult social care in England 2015/16

EQUALITY IN HEALTH AND SOCIAL CARE

STATE OF CARE

Equality in health and social care

Key points

- We continue to see variation in the access, experience and outcomes for people in equality groups using health and social care services.
- The link between equality for staff working in services and the quality of care is now well-established. Providers need to reduce the difference in experiences and outcomes for their staff and to learn from best practice, such as through the NHS Workforce Race Equality Standard.
- People in particular equality groups are more likely to get their specific needs and preferences met if they are involved in planning their own care and the service delivers more personalised care.
- Action on equality also needs to be taken at a service level. This requires leaders to embed equality into working practices to achieve good quality care for all, including those who are often less-considered by services such as lesbian, gay, bisexual and transgender people using adult social care services.
- Good practice in equality means that services are more likely to be rated good or outstanding for being responsive.
- Equality in health and social care cannot be achieved by providers alone. The whole system needs to be involved, including through commissioning and joint working such as Sustainability and Transformation Plans.

Introduction

We know that equality of access, experience and outcomes in health and social care services is very important – providers cannot meet the needs of their communities without this.

This is why equality runs throughout our work. Our examples of good practice and significant findings throughout the year are reflected in this chapter. We also consider how equality issues affect staff working in health and social care services.

The chapter meets our statutory duties under the Equality Act 2010 to report on what we know about equality for groups that are affected by our statutory functions. The Act covers eight protected characteristics related to service provision: age, disability, gender, gender reassignment, pregnancy and maternity, race, religion and belief, and sexual orientation.

There are some challenges in reporting progress on equality. For example, data collection for different equality groups is inconsistent in national health datasets. Despite these limitations, through our inspections and analysis we have been able to identify examples of good and poor practice in equality, which in turn encourages improvement in the quality of care.

Addressing equity of experience from board to ward

Mersey Care NHS Foundation Trust, Liverpool

We inspected Mersey Care NHS Foundation Trust and rated it as good in October 2015.

We found that the trust was committed to equality across all protected characteristics and was piloting the use of a human rights-based approach. The trust was using the NHS Equality Delivery System effectively. It had an equality and human rights steering group, chaired by a non-executive director. Coordinators were in place across the trust to oversee how local action plans were implemented for each service. There had been visible effects on frontline services, for example:

- The trust had been awarded a Navajo Merseyside and Cheshire LGBT Charter Mark for recognition of its approach to lesbian, gay, bisexual and transgender (LGBT) people.
- A human rights-based approach in older people's services had resulted in developing a person-centred assessment tool incorporating the values of human rights law. We saw this being used on the ward.
- People had good access to interpreting services. The dietary requirements of people were met, with a choice of food available that was appropriate to different religious and cultural needs.
- There was an active learning disability advisory group that promoted the involvement of people using the service and used human rights principles. The group had produced a booklet about human rights for people with a learning disability, written by people with a learning disability.
- The trust had been improving its recording of incidents of discrimination for both people who use the service and staff.

Good practice in equality

Responsiveness

Good practice in equality means that services are more likely to be rated good or outstanding for being responsive. We have found that these services:

- understand the needs of people using – or likely to use – their services
- enable people to regularly discuss how their service is developed
- develop the service to address any unmet needs
- empower staff to be innovative in responding to different needs.

Personalisation of health and care services is the foundation for achieving equality, as it helps people to have control over how services meet their needs, preferences and aspirations. As well as personalisation, responsive services tackle institutional barriers to equality – for example, giving people equal access to services, providing interpreting services, and helping people to feel equally safe and 'at home' when services are delivered in a shared environment such as a care home or inpatient ward.

In larger services, such as hospitals, many providers rated good or outstanding for being responsive promoted a culture that understands the needs and preferences of different groups. They did this through, for example, strong patient engagement and encouraging staff to innovate in how they meet people's needs and preferences. This was similar to many of the GP practices rated good or outstanding for being responsive.

Leadership

We have found that good leadership is needed to continually improve equity in the delivery of services and to support staff to do so. In all services, it is necessary to move beyond a tick-box approach – for example when staff attend equality training but there is no follow-up afterwards.

Leadership of equality at a system level is also very important. For example, in our most recent Mental Health Act report, we reported on the importance of providers working alongside commissioners in the local implementation of new guidelines to monitor and address long-standing inequalities in the experiences of Black and minority ethnic (BME) groups using mental health services. One issue that providers and commissioners need to tackle together is higher rates of detention for people from BME groups.

Equality in adult social care: addressing people's diverse needs

We collect information about the work carried out by adult social care services to meet the needs of people with particular equality characteristics. We do not currently collect equivalent data for healthcare services. We looked at information returned to CQC from April 2015 to March 2016 by 9,076 adult social care services.

Although we have seen some examples of good practice in adult social care during the year, comparison with equivalent evidence from last year suggests that the amount of work on equality for people who use services is, at best, relatively static. There may be a widening gap between policy and putting this into practice in residential services.

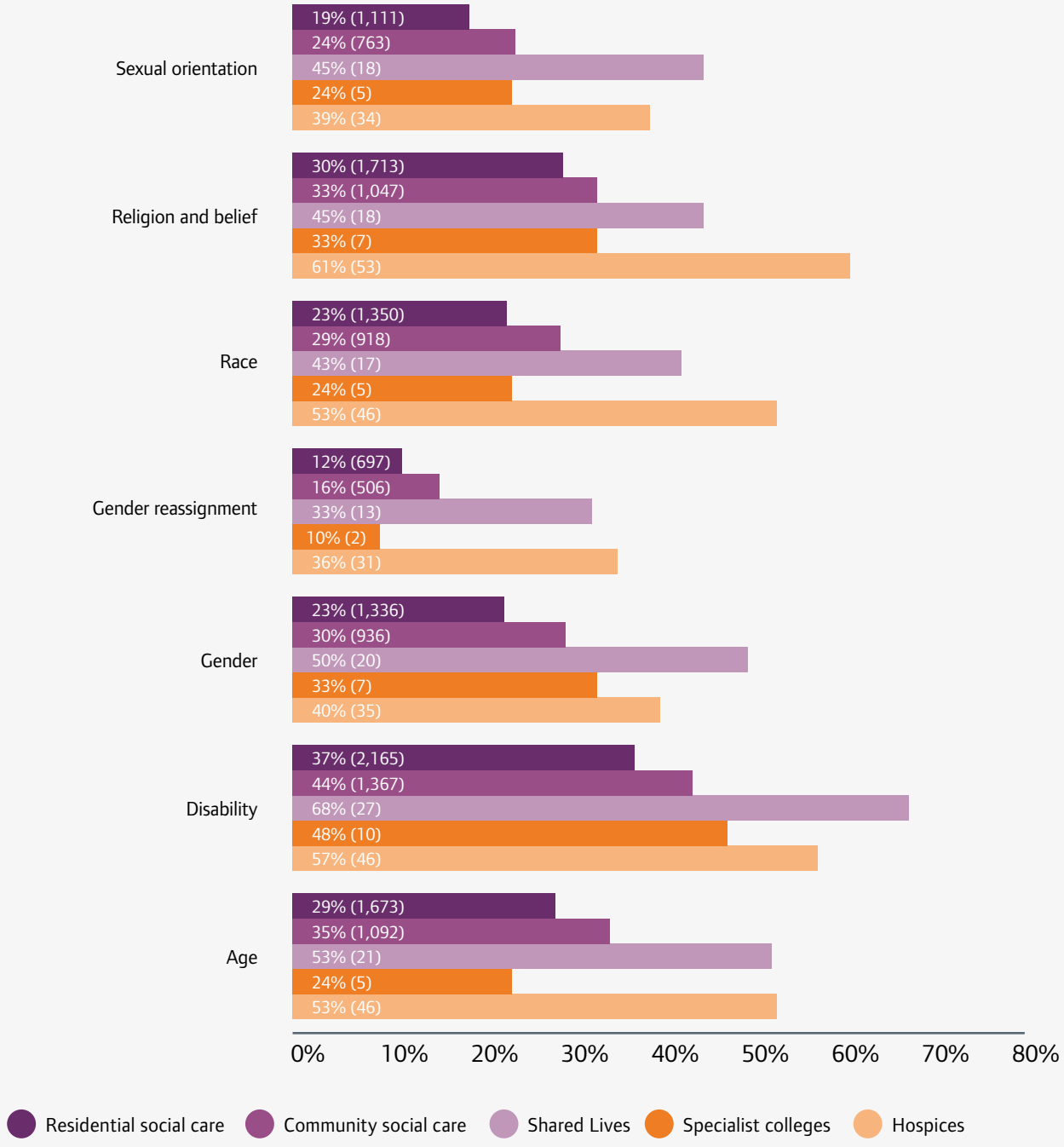
We found that 99.6% of services had policies covering equality and diversity. However, the percentage of services that said they had carried out work in the last year to meet the needs of people with particular equality characteristics was much lower, at 45.3% of services overall. This was a drop from 53.7% in the previous six months. A particular change was found in residential services, where the numbers saying 'yes' to this question dropped from 58% in 2014/15 to 43% in 2015/16. It should be noted that these figures were based on provider information returns sent ahead of inspections, so the sample of providers in each year would have been different.

The percentage of services reporting that they had carried out work on equality in the last 12 months varied by service type and protected characteristic

from 10% to 68% (figure 2.36). All service types, except hospices, had carried out most work around equality for disabled people, and the least work around gender reassignment and sexual orientation.

In our inspections, we found that staff often found it difficult to engage with people using their service around issues of sexual orientation.

Figure 2.36 Percentage of adult social care services that reported they had carried out work on equality in the previous 12 months, by service type and protected characteristic, April 2015 to March 2016



Source: CQC provider information returns

Equality work in adult social care

Shadon House Dementia Resource Centre, Tyne and Wear

Shadon House is an assessment and respite service providing residential care for older people, some of whom live with mental health conditions or dementia. We rated the service outstanding in June 2016, including a rating of outstanding for being responsive. We found that:

- The service's vision was to "improve people's health, wellbeing and quality of life; give people choice and control; help them make a positive contribution; maintain personal dignity and respect; and keep them free from discrimination and harassment".
- Staff were committed to upholding people's human rights, treating everyone with respect and dignity and tailoring care to the individual.
- People received advice on a range of advocacy services that were specific to their needs.
- The service worked closely with a local arts charity to deliver stimulating creative projects for older people with communication difficulties – musicians, storytellers, poets and writers used people's experience and local culture as a focus.
- The building had been customised to meet the needs of people living with dementia, with decoration and large signs to help people orientate themselves.
- All staff members had been trained in equality and diversity issues. They were able to access detailed information about a wide range of religious and cultural beliefs and traditions.
- There was a culture of mutual respect between people using the service, their families, staff and professionals.

Equity of access: the role of providers

There are many ways that providers can ensure equity of access to their own services, and help people in different equality groups to access other health and social care services. The availability of services is a separate issue that may result from national policy or commissioning issues that are outside the control of providers.

We have found that providers rated good or outstanding for being responsive actively identify the needs and preferences of people currently using their services, as well as those who may need to use them in the future – through identifying unmet needs. For example, at the Tavistock and Portman NHS Foundation Trust, community mental health practitioners from the largest refugee communities in the area had been employed to help reach out to their communities. Examples included producing leaflets in local languages for Somali and Congolese people, and providing refugee outreach projects for children and their parents, sports clubs, and mental health awareness sessions.

Primary medical services

Registering with a GP practice and using GP services is the cornerstone of the NHS, as it helps people access a range of other health services.

We analysed the 2015 GP patient survey results for different equality groups and found that Gypsies and Irish Travellers, Pakistani and Bangladeshi people were less likely to say that they found GP practice receptionists to be helpful compared with people from other ethnic groups. The percentage of people saying they found receptionists to be helpful rose with age group from the 18 to 24 group to the 75 to 84 group (with a slight decrease after this age for the 85 and over group).

These results mirror national reports by the Equality and Human Rights Commission (EHRC) and Doctors of the World which indicate that people from some groups are finding it difficult to register with a GP practice, particularly refugees and vulnerable migrants, Gypsies and Travellers and homeless people. GP practices have only a limited degree of discretion, under the GP contract and regulations, about whether to register the person. Practices may only decline to register a patient if they have reasonable grounds to do so. These grounds must not be related to equality characteristics. CQC has produced guidance to GP practices on the entitlements of refugees and asylum seekers, and the British Medical Association has clarified its guidance on GP patient registration.

However, in our inspections we found a number of examples of good practice that were improving equity of access to primary medical services for these groups, such as:

- A GP practice providing support for a local programme offering sanctuary to refugees and asylum seekers to help ensure people's access to health care, and an outreach service for two local Traveller communities, targeting young families.
- Travellers represented on a patient participation group at a GP practice and good engagement with the Traveller community. Positive outcomes included high rates of immunisation for Traveller children.[b]

Hospital services

We have little evidence on equity of access to hospital services, as surveys and inspections focus on people who are already using hospitals.

Although we can compare population data with hospital use, it is difficult to draw conclusions from this about equity of access because there are a large number of factors that may influence patterns of access. RightCare data provides good evidence about variation in access to a range of health services based on geography and deprivation, but this does not cover other equality characteristics.

We can, however, use the 2015 NHS inpatient survey to look at differences in how well people are directed to or referred to other services after a stay in hospital.[b, c] We found that:

- People with a mental health condition were significantly less likely to say that hospital staff discussed other services with them before discharge in both the 2014 and 2015 surveys. And in 2015, people with a learning disability and people from a range of BME groups were still significantly less likely to say that they had been asked about equipment and adaptations before leaving hospital, compared with other people.
- In 2014, people with a learning disability and people from Asian and Asian British backgrounds were significantly less likely to say that hospital staff discussed with them whether they needed any health and social care services after leaving hospital, compared with other people. In 2015, there were no significant differences in answers to this question for people in these groups. This could represent an improvement but would need to be observed over a longer period of time before we could be certain.

Specialist secondary services

Some equality groups need to access specialist secondary services. For example, transgender people need to access gender identity clinics (GICs). Referrals to GICs are increasing rapidly – in October 2015, there were almost twice as many people waiting for a first appointment at a GIC compared with the year before. Transgender people can also face difficulties accessing other types of services, particularly inpatient mental health services arranged on a single-sex basis.

Adult social care

As we say in part 1 of this report, the number of people eligible for local authority funded adult social care has fallen. This has a particular effect on equality groups that are more likely to use adult social care, for example older people and disabled

Footnote:

b For further detail, see the annex to this chapter at www.cqc.org.uk/stateofcare

c Note that when analysing some surveys at the level of respondents' protected characteristics, some groupings may involve small numbers which result in very wide confidence intervals or potentially skewed results

people. The EHRC has highlighted spending on social care for older people as an important challenge to whether Britain is a fair country.

In 2014/15, only 9.6% of adults receiving long-term social care support from local authorities were from a BME background, which is lower than the population percentage in England (14.6%). This could be due to factors such as:

- Differences in need – while 17% of people in White ethnic groups are aged over 65, only 5% of people in BME groups are in this age range. However, the prevalence of disability is higher in some BME groups, so the level of need is not easy to compare from population data alone.
- Greater difficulties in accessing appropriate care due to information barriers – the 2014/15 survey of people who use adult social care services showed that people from BME groups were more likely than people from White ethnic groups to have tried to find information, but were also more likely to say that they found it fairly or very difficult to find information or advice.

Equally good experience when using services

People from different equality groups perceive their experiences of health and social care in different ways – both positively and negatively – depending on a range of factors.

The 2015 NHS inpatient survey showed that age is an important factor in how people perceive their experiences of hospital care. Sample sizes may have some influence on differences between groups, but the following points are worth considering:

- Younger people (aged 16 to 35) were significantly less likely to report being treated with dignity and respect than older people (aged 66 to 80). They also reported significantly less confidence and trust in both nurses and doctors.
- People with a mental health condition were significantly less likely to say that they were treated with dignity and respect while in hospital, compared with people with no long-term condition.

Gender identity clinics

West London Mental Health NHS Trust and Tavistock and Portman NHS Foundation Trust

During the year, we inspected the largest gender identity clinic in England for adults (part of West London Mental Health NHS Trust) and the only service for those aged under 18 (part of Tavistock and Portman NHS Foundation Trust). In both services we found very skilled and specialist staff who were highly committed to their roles and we received a lot of positive feedback from people using the services. Both services had taken positive steps to raise understanding of transgender issues within the local community, for example with religious leaders and in schools.

But we also found some access issues:

- Long waiting times were a significant issue for people using the gender identity clinic at West London Mental Health NHS Trust, and at times inefficiencies in administration contributed to the challenges faced by people waiting for appointments or attending the clinic.
- There was geographical inconsistency around the age that young people could transfer from young people's gender identity services into adult services, and also around processes, for example deciding when young people needed to be reassessed.
- People who used these services could be particularly anxious about the risks of complaining about a scarce service that can be hard to access.

- These results were similar to last year. They show that the self-reported experience of inpatient care continues to be poorer for certain groups of people.
- A number of groups were less likely to say that they received enough emotional support from hospital staff during their stay, including younger people, Muslim people, people with a mental health condition, and Asian, Asian British, and Chinese people.

In the 2015 NHS maternity services survey, there were some differences in the support people received around childbirth:

- Asian, Asian British, Black, Black British and Arab people were more likely than people from White ethnic groups to report being given the information or explanations they needed during their care in hospital after birth.
- Respondents from White ethnic groups were the least likely to report being given consistent advice about feeding their baby. This is an interesting pattern, as it differed from many other health and social care surveys, which show that people in BME groups are less likely than people in White ethnic groups to say that they are given adequate information. There could be some learning from maternity services around good communication to people from a range of ethnic groups.

In the GP patient survey, there were similar findings to the NHS inpatient survey around patient experience and age. Positive responses increased with age, with a slight decrease for the oldest age group for questions on confidence and trust in nurses, doctors treating the person with care and concern, and overall experience of using the GP surgery.

People from Pakistani, Bangladeshi, Chinese and White non-UK ethnic backgrounds were also less likely to say that doctors and nurses treated them with care and concern and were less likely to have confidence and trust in nurses. People from all these groups were significantly less likely to report a good overall experience of using a GP surgery compared with White British people. Muslim, Sikh and Hindu people reported a poorer overall experience of GP surgeries than Christian people.

Involvement and person-centred care

People in particular equality groups are more likely to get their specific needs and preferences met if they are involved in planning their own care and the service delivers more personalised care.

For example, in adult social care we found that many residential services rated good or outstanding for being responsive had achieved this through focusing on person-centred services in care planning, and through regular discussions with people using the service and local groups representing diverse communities. These discussions included what types of activities they would individually like to do, and creating their own care plans. Often these improvements did not take many resources, just thought and attention.

In the analysis of patient surveys for our review *Better care in my hands*, we found that:

- Women who use maternity services were particularly positive about being involved in their own care.
- Disabled people and people with long-term conditions were consistently less likely to say that they were involved in their own care than those without long-term conditions. This was across a range of surveys: A&E, inpatient, maternity and cancer care. We hope that the new NHS Accessible Information Standard will help to improve this in future years.
- People from BME groups were also less likely to say that they felt involved in their own care (including in GP practices) in a range of surveys, as were lesbian, gay and bisexual (LGB) people.
- Older people were more likely to say they were involved in their health care than younger people, but this decreased again for people aged over 75.

Equality of outcomes

Health outcomes

This year, the EHRC reported that some health inequalities are improving. There has been a decrease in the difference in mortality rates for men and women, and an improvement in infant mortality rates for White, Pakistani, Bangladeshi, African and African Caribbean children.

However, some inequalities are not improving – including the poorer health of disabled people, higher levels of mental ill-health among people from LGB and BME groups, lower life expectancy for people with a serious mental illness and over-representation of people from BME groups detained under the Mental Health Act. Gypsies and Travellers have a persistently poor health status and higher mortality rate. In our analysis of the GP patient survey responses, we found that Gypsies and Irish Travellers were significantly less likely to say that they felt confident managing their own health, compared with any other ethnic group.

Lower life expectancy for people with a learning disability, including a high number of avoidable deaths, has been a concern for a number of years. We welcome the learning disability mortality review launched by NHS England as part of the *Five Year Forward View*. Our review of how NHS trusts investigate and learn from deaths will also have a particular focus on deaths of people with a learning disability. To fulfil one of our equality objectives, we have introduced a set of questions for acute hospital inspection teams to help them consistently consider the quality of care for people with a learning disability.

A review by Public Health England and Lancaster University of 30 CQC acute trust-wide inspection reports and 61 reports on specific acute hospitals (from April and November 2015) (not yet published) showed that the majority of comments about care for people with a learning disability in our inspection reports were positive (78%) and the proportion of positive comments increased as ratings increased. This suggests that hospitals that provide better care overall are also likely to provide better care to people with a learning disability.

Another concern about equality in health outcomes is the poorer health status of some newly arrived migrants. This can be addressed not only by providing better access to primary care, but by improving care in settings such as immigration removal centres.

Quality of life outcomes

How people rate their quality of life and their satisfaction with services provides important information about outcomes from using social care services. The 2015 adult social care survey showed that:

- People from White ethnic groups were significantly more satisfied with the care and support services they received, than people from BME groups.
- People aged under 65 were more satisfied with care and support services than those aged 65 and over. This contrasted with some of the age-related findings from health settings, where younger people tended to be more dissatisfied than older people, but it was in line with our ratings of care services. As reported in the adult social care chapter of this report, domiciliary care agencies and residential care homes for people with a learning disability (mostly people aged under 65) were more likely to be rated good or outstanding compared with equivalent services for other people (mostly older people).

The role of the local care system

Responsibility for improving equality does not lie solely with providers. Others in the health and social care system, such as commissioners and oversight bodies, play an important role.

Clinical commissioning groups (CCGs) have a responsibility to commission services to meet the needs of their local communities. Their progress in this can be tracked by looking at the Equality Delivery System (EDS2) reports that they produce.[d]

There is some progress. We could find gradings for more CCGs than last year, and a higher proportion were either achieving or excelling in commissioning services to meet the needs of their populations (figure 2.37). However, there is considerable room for improvement. Almost four out of five CCGs were not able to show that they were 'achieving' the commissioning of services to meet the needs of different equality groups. There is no national system in place for adult social care commissioners to benchmark and develop their commissioning of services to meet the needs of local communities. The Local Government Association does, however, organise an equality peer challenge award based on the Equality Framework for Local Government. This is voluntary and not specific to adult social care.

Our report *My diabetes, my care* found that people who attended structured diabetes education courses felt it improved their ability to manage their condition. People with a learning disability and people from BME groups were more likely to have Type 2 diabetes than others, yet many courses did not meet the needs of these groups of people. Where CCGs were tailoring outreach and education programmes to the needs of people from BME groups and people with a learning disability, and were delivering personalised care and support, this was having positive outcomes.

Our pilot reviews of the quality of care in a place (in North Lincolnshire and Salford) found that their health and wellbeing boards (HWBs) had developed approaches to ensure that partners valued equality, diversity and inclusion and that equality objectives had been set.

It is too early to comment on the impact on equality of Sustainability and Transformation Plans or the developing new models of care that cross

Footnote:

d EDS2 is designed to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance related to the Equality Act 2010. For further details: https://www.england.nhs.uk/about/gov/equality-hub/eds/

Improved care in response to findings

Yarl's Wood Immigration Detention Centre, Bedford

We first inspected Yarl's Wood Immigration Detention Centre in 2015. We re-inspected the service in March 2016 and found improvements in healthcare services in response to our previous findings, including:

- staffing improvements to better match, assess and meet the needs of people at the centre
- new care pathways, particularly to meet people's long-term health, sexual health and mental health needs – for example with better input from mental health professionals, mental health assessments by trained staff, mental health awareness training for staff, and referrals to specialist teams
- better care for pregnant women
- feedback from patients noting improvements in staff attitudes and in how care is delivered.

traditional provider boundaries. However, there is an expectation that these will reduce health inequalities and therefore improve equality of outcomes, and will be designed to promote person-centred care – improving equality of access and experience is also fundamental to the success of these new initiatives.

Workforce equality

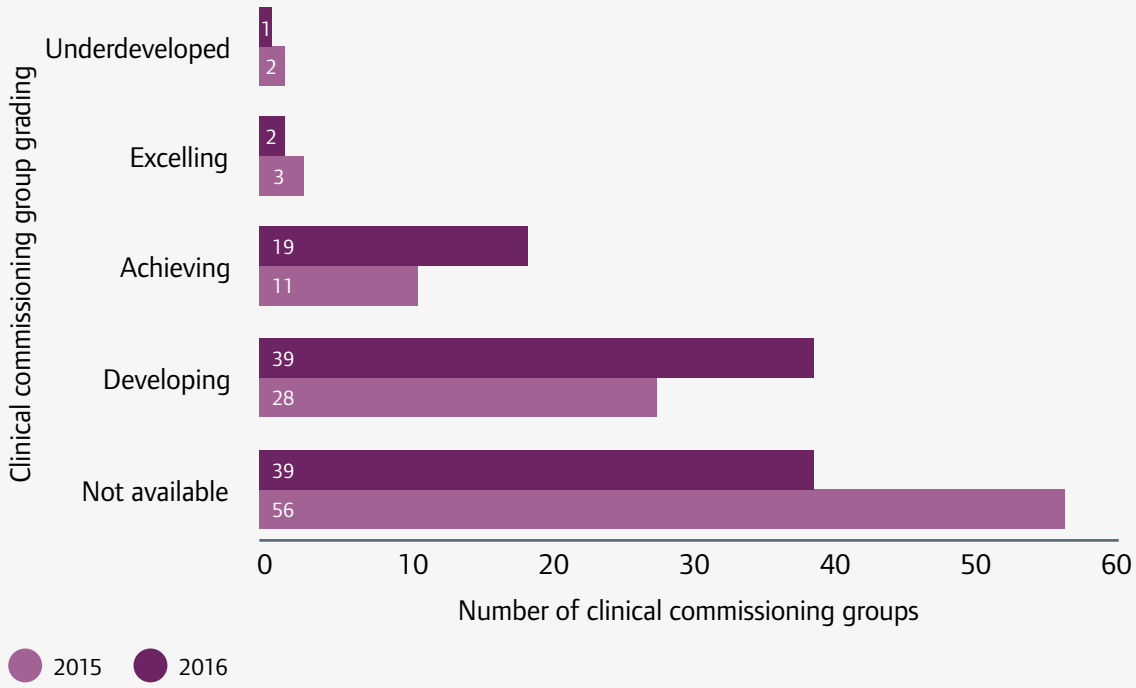
The link between staff equality and the quality of care is now well-established. Workforce equality in the NHS is gaining greater attention due to the NHS Workforce Race Equality Standard (WRES). We are considering workforce race equality in all our inspections of NHS trusts and independent healthcare organisations and our findings contribute to our ratings for being well-led. We are also using the WRES in CQC to look at race equality in our own workforce.

Diversity in the health and social care workforce

Workforce profiles change relatively slowly, so there is little change compared with last year. This year:

- Nearly two in five (38%) of NHS medical staff, 15% of NHS non-medical staff and 20% of adult social care staff are from BME backgrounds. This compares with 11% of the UK workforce being from BME backgrounds.
- Staff from BME groups are still under-represented in management roles – they hold only 10% of NHS non-medical and 13% of adult social care management jobs.
- Women make up 82% of the adult social care workforce and 81% of the NHS non-medical workforce, compared with 47% of the UK workforce. However, only 44% of NHS medical staff are female.

Figure 2.37 Clinical commissioning group gradings: how well services are commissioned, procured and designed to meet the needs of local communities, July 2015 and May 2016



Source: 100 clinical commissioning group websites

- Women are under-represented in health and social care management roles – men make up 19% of NHS non-medical staff, but fill 30% of management roles. The difference is not so large in adult social care – where men are 18% of the workforce and 22% of managers.
- These broad categories mask some differences between grades within roles. For example, nurses from BME groups are more likely to be in the lower grade posts (for example band 5, which accounts for 66% of Asian or Asian British nurses, 57% of Black or Black British nurses, and only 46% of White nurses). They are also less likely to be in the highest grade posts (bands 8 or 9, which account for 1% of Asian or Asian British nurses, 31% of Black or Black British nurses and 5% of White nurses). Female NHS managers are more likely to be in lower grade management roles than their male management colleagues.

The King's Fund report *Making the difference: diversity and inclusion in the NHS* has found that levels of reported discrimination vary significantly by type of trust, location, gender, age, ethnicity, sexual orientation, religion and disability status.

Staff experience

From our analysis of the NHS 2015 staff survey results, we found that:

- Staff from BME groups were more likely than staff from White ethnic groups to experience bullying and harassment from other staff across all types of trust. However, the picture was much more mixed around staff experiencing bullying and harassment from members of the public. This is similar to the analysis of the 2014 results carried out by NHS England.
- The indicators with the largest difference between staff from BME groups and staff from White ethnic groups, across all types of trust, were those relating to personal experience of discrimination and belief that the trust provides equality opportunities. This was also the case last year. For example, in 2015, 14% of staff from BME groups working in acute trusts said that they had experienced discrimination, compared with 6% of staff from White ethnic groups.
- There has been some improvement in mental health trusts, as there was a fall in the number of trusts where staff from BME groups were reporting a worse experience of bullying and harassment from other staff.
- These differences are not inevitable. On each indicator, there were some trusts where staff from BME groups responding to the survey reported the same or better outcomes than their colleagues from White ethnic groups. NHS England is using the 2014 analysis to identify good practice that other trusts can learn from. We encourage providers to use the advice and resources on the national WRES team to improve.[e]

Footnote:

e For further detail, see the annex to this chapter at www.cqc.org.uk/stateofcare

Equality-led approach to end of life care commissioning

Central Manchester CCG

In our end of life care review, *A different ending*, Central Manchester CCG stood out as an example of good practice in commissioning to meet the needs of the local population. The CCG has made equality a central part of its approach to end of life care by:

- embedding equality analysis into its decision-making processes, including considering people who are homeless, Gypsies and Travellers and migrant workers, as well as those with protected equality characteristics
- setting up yearly equality performance monitoring
- taking action as a result of equality analysis – for example, adding whether people's gender identity differed at birth into the development of the Electronic Palliative Care Coordination System
- working with Macc, Manchester's voluntary and community sector support organisation, to respond to feedback from patients and advocates – for example, commissioning a care home project to make sure that frail, older people with non-cancer diagnoses have access to the right end of life care services
- delivering training to staff in care homes to enable them to be more confident in discussing people's preferred place of death and advance care planning, and to deal with a crisis more effectively – as a result, admissions to hospital have reduced by 68%
- commissioning the Manchester Pathway (MPath) service to reduce A&E attendances and hospital readmission for homeless people, so that people who are likely to be approaching the end of their lives are identified earlier.

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