**Equality counts:**

**Equal**

**Equality Information from the Care Quality Commission in 2013**

**Summary**

In 2013, we redefined the Care Quality Commission’s purpose: to make sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and to encourage them to make improvements. We also agreed that one of our principles is to promote equality, diversity and human rights.

**Our equality objectives**

We have made progress on our equality objectives during the year. Our work around accessible communications and involving a diverse range of people in our work is particularly strong. We have also made progress in our objectives around regulating health and social care providers for equality, improving the information that we hold about the risks to equality, and looking at equality in our Mental Health Act functions, although there is still more to do in these areas. We have also developed a programme to ensure that staff are treated equally, which includes work on preventing bullying and harassment, and again, there remains more work to be done in this area. We also need to continue our work to ensure that we have a diverse staff profile and that all staff receive the learning and development that they need relating to equality, diversity and human rights.

We will be reviewing our equality objectives early in 2014. This will enable us to focus on outstanding areas for improvement and to make sure that these objectives align with our overall corporate strategy, which has changed since we published our current equality objectives.

**Equality in our work to regulate health and social care services**

We know from data and research that some equality groups, such as older people and disabled people, rely on health and social care services more than others. We also know that there are some differences in how people access and use services, for example, by ethnicity and gender. Some people with particular equality characteristics also rely on more specialised services, for example, people with a learning disability and transgender people who use gender identity clinics.

We also know from research that the experiences of some people are different when they use health and social care services – for example, when people with a learning disability use inpatient acute health services, when Black and minority ethnic people use mental health services, and when lesbian, gay and bisexual people use GP services or live in care homes.

We need to bear these differences in mind when planning, delivering and evaluating our programmes of regulation.

In this report, we use census data to look at the differences between groups of people with more than one equality characteristic; for example, differences in the proportion of older men and women from different ethnic groups living in communal establishments such as care homes.

During the year we have:

* Developed our human rights approach to embed equality and human rights into our new model of regulation and have started to test this in our inspections of NHS acute hospitals.
* Supported inspection staff through a network of equality leads and a new peer learning initiative about equality and human rights, and by setting a new individual objective for all inspectors to look at equality in their work.
* Continued to take action where we find providers do not meet regulations that support equality and human rights. We made over 1,100 judgements that health and social care services did not meet the regulation concerning involvement, respect and equality, and we required them to take action to improve. We took legal action to enforce this regulation for 48 services.
* Engaged with people who use services on how we regulate providers in relation to equality, for example, through our SpeakOut Network and eQuality Voices group.
* Engaged with other partners to improve equality in the health and social care sector, including the Department of Health, NHS England, the Equality and Human Rights Commission, organisations in the voluntary and community sector and those representing providers.
* Carried out themed inspection programmes to tackle specific equality issues; for example, we completed our work on dignity and nutrition for older people, we started themed inspections looking at the transition arrangements for young people with complex health needs from children’s health services to adult services, and we started work on how we can ensure lesbian, gay and bisexual people who live in care homes receive appropriate services.

Next year, we will continue to develop our approach to how we regulate to ensure equality in different types of health and social care services. For example, we have started to develop how we can ‘track’ patients who are at greater risk of receiving poor care in NHS acute hospitals – such as people with a learning disability. In our document *A fresh start for the regulation and inspection of GP practices and GP out-of-hours services*, we have outlined our early thinking about focusing our inspections on six specific groups of people – five of which relate to equality groups: older people with complex health needs, people with long term conditions and people with mental health conditions (many of whom are disabled people), mothers, children and young people, and people in vulnerable circumstances with poor access to primary care – such as gypsies and travellers, homeless people and people with a learning disability.

**Equality in our workforce**

This year we have improved our equality monitoring data by asking each member of staff to update their personal equality information. This has expanded what we know about the profile of our staff, especially in relation to sexual orientation and religion and belief, enabling us to analyse the data and identify statistical significances.

Our diversity profile in a number of areas is good, for example in relation to recruiting older staff and the number of lesbian, gay and bisexual staff in middle and senior management positions. Other areas have improved slightly over the year, such as the overall percentage of disabled staff and staff from Black and minority ethnic (BME) backgrounds.

**Table: Diversity profile of Care Quality Commission (CQC) staff**

|  |  |  |
| --- | --- | --- |
| **Equality group** | **% CQC staff:  adjusted to allow for individuals where monitoring information is not known**  **Total staff = 2,223** | **% CQC senior management (head of function level and above) adjusted to allow for individuals where monitoring information is not known**  **Total staff = 53** |
| Women | 68.8% | 60.4% |
| Black and minority ethnic staff (census categories as Black/Black British, Asian/ Asian British, Mixed Race, white Irish) | 12.3% | 3.7% |
| Disabled staff | 7.9% | 6.3% |
| Lesbian, gay and bisexual staff | 5.6% | Not shown as numbers too low |
| Staff aged under 25 | 2.3% | – |
| Staff aged over 50 | 35.7% | 37.8% |
| Staff from non-Christian religious beliefs | 6.9% | Not shown as numbers too low |
| Staff with primary caring responsibilities for children | 23% \* | Not collected |
| Staff with primary caring responsibilities for adults | 10% \* | Not collected |

\* from CQC staff survey, not staff records – not possible to adjust for unknowns

The detailed analysis suggests some areas where we need to focus our work:

* The number of disabled staff in CQC is still low at 7.9%, compared to the overall percentage of disabled people employed in the UK workforce, which is10.5% *(Labour market status of disabled people, May 2013, Office for National Statistics).*
* The low percentage of BME staff in management positions; while BME people make up 12.3% of CQC staff overall, only 7.5% of Band A management positions and 3.8% of executive grade positions are filled by BME staff.
* The low percentage of staff from non-Christian religions in management positions; while 13.9% of CQC staff are in Band A or executive grade posts, only 4.6% of staff from non-Christian religions are in these posts.

For the first time, we are able to present recruitment data in this report. Although the quality of the data can be improved, the analysis to date shows that we need to look further at:

* The lower success rate of shortlisted disabled applicants being appointed to jobs.
* The lower success rates for Asian applicants being shortlisted and appointed.
* The lower success rates for Black shortlisted candidates being appointed.
* The lower success rates for applicants from non-Christian religions being shortlisted and appointed.

We are carrying out a recruitment audit to look at the reasons for some of these findings.

Our 2013 staff survey identifies that although levels of bullying, harassment and discrimination are decreasing, we still have further work to do to reach our goal of zero tolerance in this area. Fourteen per cent of staff said that they had been bullied or harassed during the year and 8% said that they had experienced discrimination.

During the year we have worked on a number of initiatives relating to equality for staff:

* Following an independent review of bullying and harassment commissioned by our Chief Executive, David Behan, we developed a programme of work around this issue. We have now recruited and trained a group of staff to act as Dignity at Work Advisors.
* We analysed the responses to the 2012 staff survey from staff in different equality groups and consulted with staff about the reasons why the responses varied between these groups and their comparators, for example, between disabled staff and non-disabled staff. We also commissioned an independent report about whether we would meet the Diversity in Business Award standards. We have developed a programme of work in response to these two analyses, including an audit of equality in our recruitment practices, work on reasonable adjustments for disabled staff and a project to engage with staff with caring responsibilities. This work will continue into 2014 and will expand to include learning about unconscious bias for CQC managers.
* We continued to support our staff equality networks – the Disability Equality Network, Lesbian, Gay, Bisexual and Transgender Equality Network and the Race Equality Network – which all make an extremely valuable contribution to our equality work.
* We continued to work with others to reach our goal of making CQC a good place to work for a diverse workforce, for example through membership of the Business Disability Forum, Employers for Carers, Mindful Employer Scheme and Stonewall Diversity Champions. Our ranking on the Stonewall Employers Index rose this year from 133rd place to 111th.