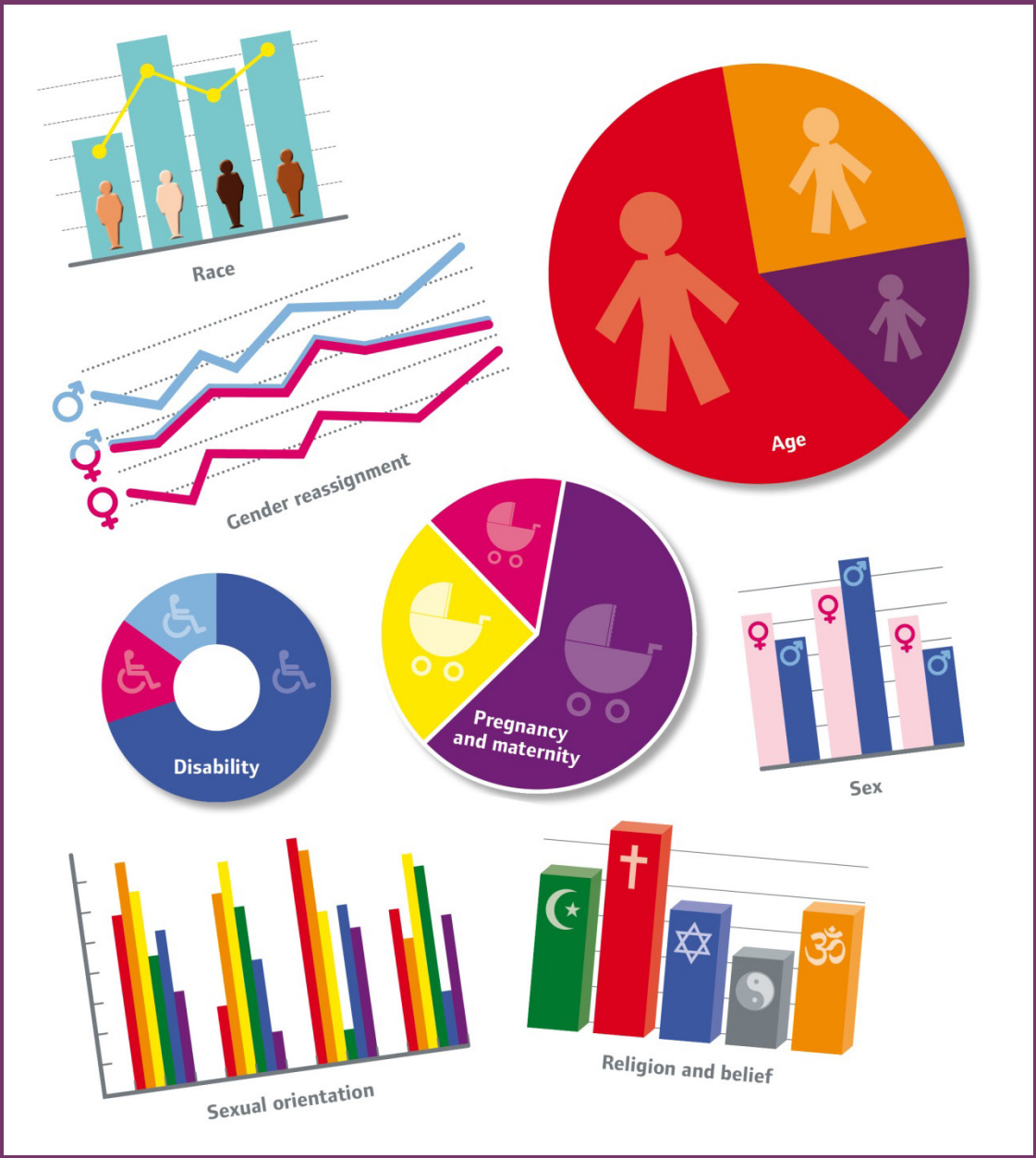
Care Quality Commission

# Equal measures

## Equality information report for 2014




March 2015

## The Care Quality Commission is the independent regulator of health and adult social care in England.

### Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

### Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.


Published March 2015

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# Foreword

Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high quality care and we encourage care services to improve.

Over the past 18 months in CQC, we have been radically redesigning the way we regulate health and social care services, which has involved changing the way we inspect services and changing the way we are organised. Central to these changes has been the promotion of a human rights approach to our work, which includes equality and diversity as a key pillar.

What are the arguments for this approach?

Firstly, the link between how an organisation engages with its staff, how it cares for them and values them impacts on the care of people who use services. Michael West's research has been influential. Roger Kline's work *Snowy White Peaks* carries this argument further when he sets out that organisations that demonstrate equality and diversity deliver high quality care.

The first argument is one of effectiveness. Diverse organisations and healthy organisations are effective organisations.

The second argument is unashamedly and unequivocally one of morality. Health and care services are there to support all members of our communities. Unfair discrimination on any basis is wrong.

The third argument is that a lack of diversity is not helpful in the development of strong teams. Safe, high quality health and care is dependent on strong teams. Strong teams thrive on difference.

Finally, where services do not reflect the diversity of the community they serve they can become 'disconnected' from the 'assets' or strengths of the community.

This report looks at how CQC inspects services and what we have learned about equality, diversity and human rights. It is also a self-assessment on how we, as an employer, promote equality and diversity.

Everyone should experience good care when they use health and social care services. In our *State of health care and adult social care in England* report for 2013/14, we found unacceptable variation in care in England between different types of providers and within the same type of providers.

In this annual equality report, we have focused on variation in care specifically for older people and younger people, and differences on the grounds of disability, ethnicity, religion and belief, sex, sexual orientation and gender identity.

We have identified that there is still too much variation in people's access, experience and outcomes in many health and social care services on these grounds.

We expect 'well-led' services to address equality and inclusion for staff because there is increasing evidence of strong links between staff equality and high quality care for people using services.

We will be objective and independent in these assessments and 'tell it as it is' – so that we are always on the side of people who use health and social care services.

We expect health and social care providers to address equality issues linked to being 'well-led', so we must model this behaviour ourselves. Individuals work at their best in an inclusive and just culture. There is evidence that diversity in teams helps them perform better. We need to harness the different wisdom and experiences that a diverse workforce can bring.

In 2014, we launched CQC's new values: excellence, caring, integrity and teamwork. Putting these values into action in everything that we do will make the biggest difference to building a diverse workforce where every member of staff feels valued and has an equal opportunity to be the best that they can be. Our values and behaviours will have a positive impact on our regulatory work and help to improve the health and social care services that people receive.

In this report we describe the progress that we have already made and the remaining challenges that we face. We are determined to meet these challenges. We set out our next steps in tackling these challenges, including our new Equality Objectives.

Whether you are someone using health or social care services, a member of the public, a provider, a member of CQC staff or someone with an interest in equality and inclusion, I hope that you find this report helpful and that you will work with us to achieve our common goal: that **everyone** has safe, effective, compassionate, high quality health and social care services

**David Behan**
Chief Executive

# Summary

## Equality for people using health and social care services

Across England, there is too much significant variation in the quality of care that people receive – variation linked to equality characteristics. This variation in quality ranges from people's ability to access health and social care, their experiences when they use care services and the outcomes from using services.

CQC's work over the last year, including our new approach to inspecting and rating services, along with published research and analysis of data such as Hospital Episode Statistics, confirms that this situation persists.

## Equality for staff working in health and social care

There is also still too much variation in the experience of staff on equality grounds. In particular, there is increasing evidence of a link between discrimination experienced by staff and the quality of care provided. For staff in both health and social care, some equality groups are less likely to be promoted and more likely to experience bullying and harassment.

We therefore welcome the introduction of an NHS Workforce Race Equality Standard as the right step to start addressing this important challenge.

## Our work with regard to equality in health and social care

Addressing inequality is at the heart of CQC's purpose to make sure health and social care services provide people with safe, effective, compassionate, high quality care and encourage care services to improve.

We expect providers to take seriously their responsibilities to provide safe, high quality care **for everyone** and we will assess this during inspections. This year, we published our human rights approach to regulation, which incorporates equality into all aspects of our regulatory approach, such as the new key lines of enquiry.

We have further developed our regulatory practice around equality by improving our inspection methods, providing learning and development opportunities for all our staff and gathering better equality information about providers. We have engaged more with diverse groups of people and we have looked at particular equality issues in our thematic reviews and inspections.

## Equality in our own workforce

We also take our responsibilities seriously regarding equality for our own staff. Just as we expect service providers to address equality for their staff, we know that we need to address equality for CQC staff in order to live up to our organisational values:  excellence, caring, integrity and teamwork.

The results from our staff survey indicate progress. More employees than before across all equality groups would recommend CQC as a good place to work. Employee satisfaction (measured by the 'employee engagement 'index) shows no difference between Black and minority ethnic (BME) staff and non-BME staff – and is higher for lesbian and gay staff than for heterosexual staff. We are very proud to have reached the Top 100 in the Stonewall Workplace Equality Index for the first time in the history of CQC.

But we still need to do more to achieve our ambition of having no difference in employment outcomes for staff based on their equality characteristics. In particular, BME staff and disabled staff are still less likely to consider CQC as an equal opportunities employer, compared with other groups, and remain under-represented at CQC's senior and middle management grades. And disabled staff are still more likely to say that they have personally experienced bullying, harassment or discrimination, compared with other staff.

## Our work in 2015/16 and beyond

We want to go further in achieving change in equality for people who use health and social care, and for our own staff.

We will build on and develop our human rights approach to regulation and inspection. We will develop a new People Strategy. We will work with others, such as the NHS Equality and Diversity Council and the Equality and Human Rights Commission to bring about change. We will prioritise our new Equality Objectives 2015-17 to:

**Objective 1:** Deliver learning and development for all CQC staff by March 2016 to address unconscious bias. This will help to promote equality, diversity and inclusion in our regulatory work, in employment at CQC and in our wider relationships with colleagues.

**Objective 2:** Include race equality for staff (through the NHS Workforce Race Equality Standard) as a factor in our judgements about whether hospitals are well-led.

**Objective 3:** Improve our regulatory insight and action about the safety and quality of mainstream health services for people with a learning disability or dementia, or those experiencing mental ill-health.

**Objective 4:** Help our inspectors to pursue key lines of enquiry and to make consistent and robust judgements about particular aspects of equality. We will focus on adult social care services meeting the needs of lesbian, gay and bisexual people and people with a sensory impairment, and look at the transition of young disabled people into adult services.

**Objective 5:** Work towards having no difference in the employment outcomes for our staff or potential recruits because of age, disability, ethnicity, gender, gender reassignment, religion or belief or sexual orientation.

We will be measuring our progress in relation to employment, starting by using the new NHS Workforce Race Equality Standard. Our staff equality networks will also continue to provide valuable advice to CQC, and we will maintain a zero tolerance approach to bullying and harassment in the workplace with the support of our Dignity at Work advisors programme.

As the quality regulator for health and adult social care services in England, CQC is committed to working with providers, commissioners, people who use services, and our own staff to encourage the improvements needed for everyone to receive good care – no matter who they are.

We expect providers to meet the needs of all people who use their service, and take action to ensure equality for their staff, as this will improve the quality of the care that they provide.

# Introduction

*"A central part of CQC's purpose is to encourage providers to improve. Ensuring that people are not disadvantaged because of their age, gender, disability, sexual orientation, ethnicity, or belief is an important part of this. Similarly within CQC, our Equality Objectives show the steps we will take to promote diversity across our organisation and support people to bring the best of their talents and knowledge to the organisation."*

**Paul Bate, Executive Director of Strategy & Intelligence**

The Equality Act 2010 requires that CQC reports each year on:

- Information relating to CQC's employees who share a relevant protected characteristic.
- Information relating to people other than employees who share a relevant protected characteristic and who are affected by our policies and practices.

The protected characteristics in the Equality Act 2010 are:

- Age
- Disability
- Gender reassignment
- Race
- Religion and belief
- Pregnancy and maternity
- Sex
- Sexual orientation
- In addition, marital and civil partnership status is a protected characteristic in relation to employment.

We recognise that people can face discrimination or disadvantage on other grounds, such as caring responsibilities, employment status, social class, geography or homelessness status. However, these grounds are outside the scope of this report.

Publishing this report gives us the opportunity to look closely at evidence that helps us fulfil our role to promote equality, diversity and human rights – both in our regulatory functions and as an employer. We have also built on issues raised in our previous reports *Equality matters* (2013) and *Equality counts* (2014).

We also hope that the report is useful to everyone who is interested in equality, diversity and inclusion for people who use health and adult social care services.

# Section 1: EQUALITY FOR PEOPLE USING HEALTH AND SOCIAL CARE

Across England, people using health and adult social care services are still not receiving equally good care – because of who they are. In this section, we outline some of the ongoing variations in quality of care for people in different equality groups in 2014/15, focusing on new evidence over the last year and our own work.

## Hospitals

**The frequency of use of hospital services, across all types of NHS trusts, varies by ethnicity, gender and age**. For the first time, we have analysed 14.5 million NHS hospital inpatient 'episodes 'and 83.5 million outpatient appointments where age, sex and ethnicity of the patient was known. See the separate Annex 1: Analysis of Hospital Episode Statistics document published alongside this report.

Some of this variation in use is what we would expect, explained by differences in the health profile and needs of different groups. For example, females in middle age (25-50) make more use of outpatient services compared to men, largely due to antenatal, postnatal and gynaecological appointments, and there is a pronounced upswing in elective and emergency admissions as people grow older.

But not all variation can be explained this way. For example, cancellations are disproportionately high for some ethnic groups, and 'did not attends' (DNAs) are most common among young to middle-aged adults (18-50), especially among men in this age range. Looking at ethnicity reveals some complexities – for example, the age-related upswing in emergency admissions starts at age 65-69 for White British women, not until age 70-74 for women of White Irish origin, but starts at the very young age of 25-29 for women of Pakistani origin.

More work is needed to understand if these variations reflect differences in need and behaviours, or in the accessibility or quality of services for these groups. The overall figures can also mask potential inequalities in particular services. For example, despite the upswing in elective admissions for older people, the Royal College of Surgeons recently concluded in a report that age discrimination is still a factor in decisions whether to refer older people for certain types of surgery.[1]

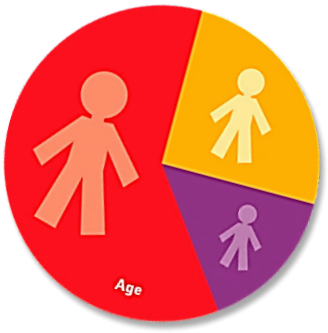
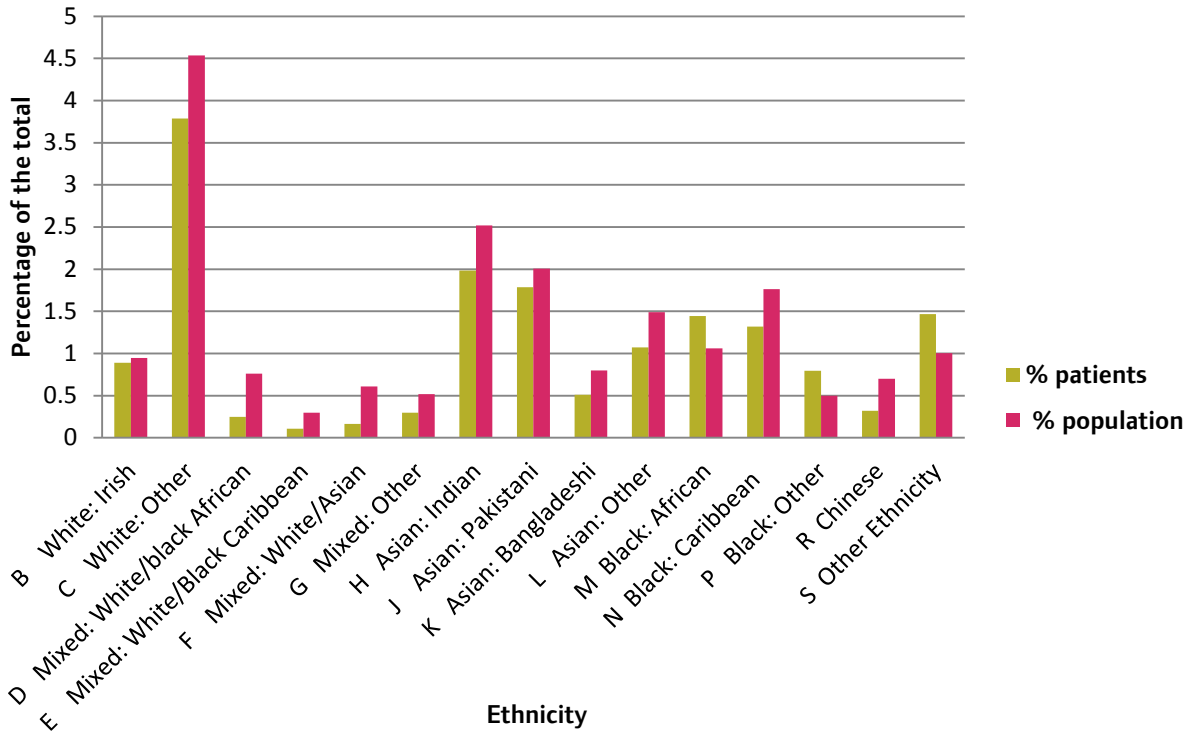


Figure 1 shows the proportions of elective inpatient admissions to ethnic group, other than White British (representing 81% of the population and 84% of elective admissions). This shows some overall variation based on ethnicity, which again could be due to health profile, need or access issues.

**Figure 1: Comparison of proportions of acute hospital elective inpatient admissions to the population by ethnic groups (except for White British)**




Source: HES figures, 2013/14, and population figures from Census 2011.

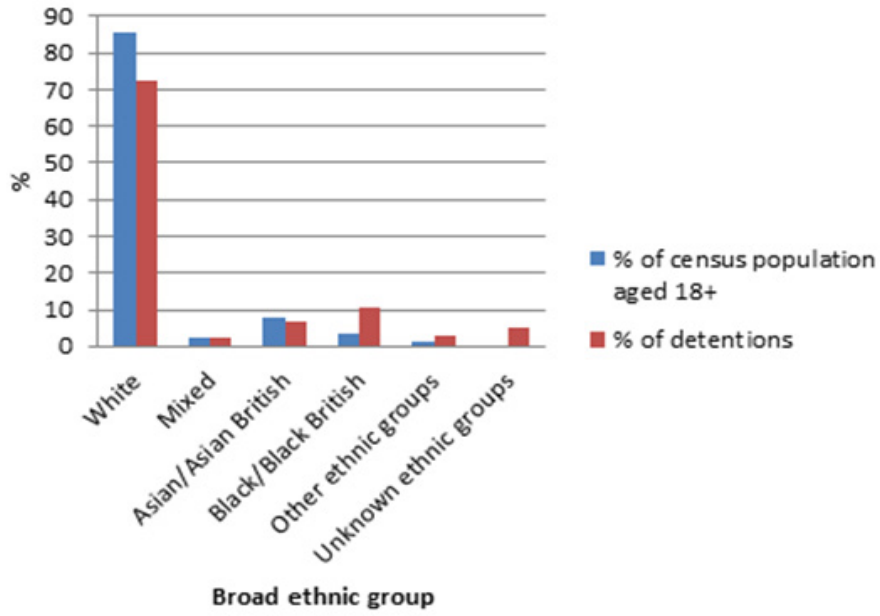
**People who have dementia have poorer outcomes in acute hospitals compared to those without dementia.** People with dementia are protected under the disability provisions of the Equality Act 2010. In 2014, we published a review of the care of people with dementia as they move between care homes and acute hospitals. We found that the variation in how hospitals and care homes assess, plan, deliver and monitor care increases the risk of poor care for people with dementia and that a person with dementia is likely to experience poor care at some point along their care pathway.[2] Despite some improvements, people who have dementia also continue to have poorer outcomes in acute hospitals compared to those without dementia, including higher mortality rates and longer stays in hospital, compared to matched patients without dementia.[3]

In 2014, we carried out a survey of health-based places of safety for people detained under section 136 of the Mental Health Act.[4] We found that too many providers operate policies that exclude **young people** from all of their places of safety. In many cases, this leaves the police with little choice but to take a vulnerable young person in their care to a cell in a police custody suite.

Although 82% of the English population is White, in 2013/14 only 72% of all people detained in hospital under Mental Health Act 1983 (as amended by the Mental Health Act 2007) were patients in the White ethnic group (figure 2). Between 2012/13 and 2013/14, there has been little change in the over-representation of **people detained under the Mental Health Act** in some minority ethnic groups, particularly the Black and Black British group.[5]


Our new inspections are picking up variation in how well acute hospitals are responding to people's needs based on equality characteristics. For example, physical access for disabled people, accessible communication and information, faith-related needs and issues of consent relating to capacity. (see Appendix B).

**Figure 2: Comparison of the proportion of detentions in 2013/14 by ethnic groups with the proportion of the census adult population (mid-2012)**




Source: HSCIC Annualised MHMDS file 2013/14; Table 10b of the experimental data tables.

# Primary medical services

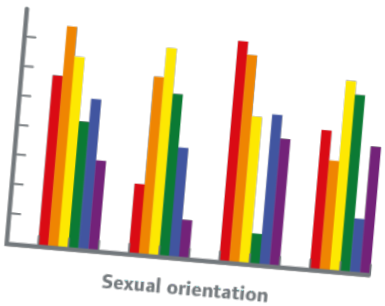
*"We should not forget that our whole methodology is based on ensuring that people who may be 'disenfranchised' and therefore not equal - people with mental health issues, people who are more vulnerable because of their circumstances and people with long term conditions – have the care they require."*

**Inspection Manager, Primary Medical Services & Integrated Care Inspectorate**

**GPs are often not routinely involved in the care of children with complex health needs.** In 2014, we published a report of our themed inspection that looked at how the health needs of young disabled people with complex needs are met when they become adults. We found that despite general practice being the single service that does not change during the transition from children's to adult services, GPs needed to be more involved at an earlier stage in planning for transition. This means that there can be a lack of continuity when young people with complex needs move to using adult health services.[6]

The outcomes and access to preventative services are often poorer for **people with a learning disability** than for the general population when using primary health services. A 2013 Department of Health review found that although many GP services for people with a learning disability had improved since 2010, there were still concerns, including delays in diagnosis and treatment, lack of communication and information, and poor quality health checks.[7] The final report of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD), also published in 2013, found that 84% of people dying prematurely had sought medical attention in a timely way. However, 41% had problems with investigations and 33% died with undiagnosed significant illness.[8]

**Some lesbian, gay and bisexual people feel that their GP surgery is not meeting their needs.** There is only small-scale recent research about the experiences of lesbian, gay and bisexual (LGB) people using GP services, but it showed that 20% felt their needs as a lesbian, gay or bisexual person were not met. Although based on a small sample, the findings are in line with other studies carried out in the past five years.[9] A 2013 survey of transgender people found that 60% of respondents thought that their GP could improve their services for transgender patients.[10]



# Adult social care

Many people using social care services do so over an extended period and receive services where they live – whether this is in their own homes or a residential setting such as a care home. This means that social care affects all aspects of a person's life, so paying attention to equality is especially important.

Research published this year indicates that White British people had a better understanding of the social care system than **South Asian** people, and that the language needs of South Asian people were not usually met in mainstream social care services.[11] And, while there is a lack of recent evidence, in a large-scale survey in 2010, 60% of **lesbian, gay and bisexual people** were not confident that social care services could meet their needs.[12]

There is also evidence that around half the older people living in care homes have some degree of **visual impairment** and three quarters have **hearing loss** but that this is often overlooked, sometimes due to discrimination based on age or on disability, such as the person having dementia.[13] In our new inspections of adult social care services, we have found some variable practice in relation to consent to care and treatment where people need assistance to make decisions, or where they lack capacity to make a decision (see Appendix B).

In 2014, as part of our new approach to regulating social care services, we asked service providers two questions about equality – one relating to equality policies and the other relating to work to achieve equality in practice (see Appendix A). This analysis shows that:

- Although a high percentage of adult social care services have equality policies in place, far fewer have taken specific action in the past 12 months to ensure equality for people using their services. The percentage taking action was lowest in residential care services (42%). Some of these providers may have taken action on equality in previous years. However, common types of work to address equality include providing learning and development for staff, which needs to be repeated for new members of staff, and development work to improve the service for people, which will also need to be reviewed over time.
- Across all types of adult social care services, the most frequent work carried out around equality was to ensure that services met the needs of people in relation to disability and religion or belief, followed by age and race. However, providers also need to take a proactive approach to equality on the grounds of sexual orientation, so that lesbian, gay and bisexual people feel confident using their services.[14] We last looked at how many providers had carried out work on equality, using a different methodology, in our *State of health and adult social care* report for 2010/11. We found then that work on sexual orientation and gender reassignment lagged behind work on other equality characteristics. Appendix A shows that this is still the case, although there has been a slight increase in the percentage of providers who reported work relating to sexual orientation (from 17% to 21%) and a greater improvement regarding gender reassignment (from 4% to 16%) since 2010/11.

# What has improved in health and social care?

Despite this persistent variation in quality of care for people, some areas of practice around equality are improving:

- In relation to gender, since 2010 all providers of NHS-funded care have been expected to eliminate mixed-sex wards, except where it is in the overall best interest of the patient. Between 2012/13 and 2013/14, incidences of breaches of mixed sex accommodation have reduced by 27%.[15]
- A report published in 2014 on our first comprehensive inspections of GP out-of-hours services also saw many services responding to the needs of certain patient groups who have mobility issues or feel vulnerable because of their condition, such as older people and people with long-term conditions. They responded by offering transport services or making home visits.[16]
- The NHS recognises the importance of equality in health care. One of the principles of the NHS Constitution is that: "The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status". NHS England has developed the Equality Delivery System (EDS2)[17] to help NHS healthcare providers to drive improvements in equality by responding to the needs and circumstances of each patient and by providing workplaces that are free from discrimination and that support the diverse talents of staff. NHS England is making the EDS2 mandatory through the NHS contract from April 2015, which may lever further improvement.

There is currently a lack of NHS monitoring data for disability, sexual orientation, religion and belief. We therefore welcome the work of the NHS Equality and Diversity Council to develop appropriate data collections in health services around all protected characteristics in order to provide intelligence to improve services.


# Section 2: EQUALITY FOR STAFF WORKING IN HEALTH AND SOCIAL CARE SERVICES

There is now strong evidence that, in health and social care, a diverse workforce in which the contributions from all staff are valued is linked to good patient care.[18] Put simply, a diverse – and equally valued – workforce has an impact on the quality of care.

But we know that the workforce in health and social care is not diverse in relation to some equality characteristics. For example:

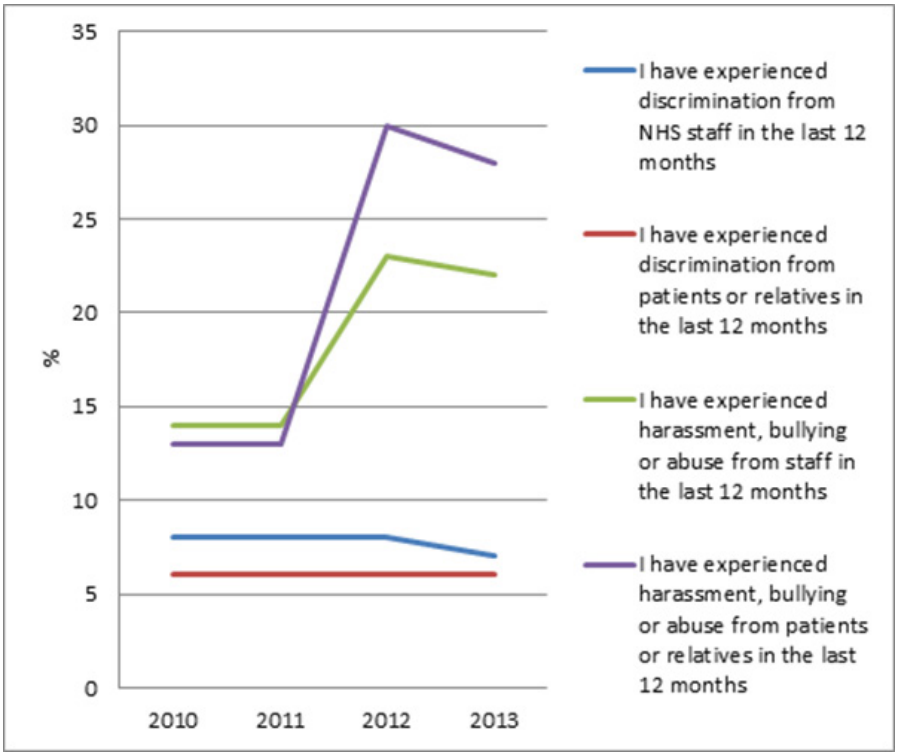
- Only 2% of all social care staff – and only 1% of care staff and 1% of registered managers – say that they are disabled people.[19]
- Other analysis has focused on the lack of Black and minority ethnic (BME) staff at higher management and leadership levels. In England, BME people make up 15% of the population and 17% of the NHS workforce, but only 6% of the most senior non-medical grade posts. In London, the contrast is starker, as BME people make up 39% of the population and 45% of NHS staff, but only 14% of the most senior non-medical posts.[20] There is also under-representation of BME staff in social care management. In England, 68% of care workers are White and 82% of registered care home managers are White. In London, only 31% of care workers are White, while 56% of registered managers are White.[21]

There is also evidence that discrimination still exists for staff working in health and social care. NHS staff surveys show that despite a decrease from 2012 to 2013, the proportion of NHS staff experiencing bullying, harassment or discrimination remains significant (figure 3).*

Staff in some equality groups are more likely to experience discrimination. In 2013, whilst 7% of NHS staff overall said that they had personally experienced discrimination from colleagues or managers on the past 12 months, there was a large difference between the percentage of White staff (6%) and non-White staff (14%) who said this. In addition, 13% of disabled staff, 12% of gay male staff and 11% of lesbian staff also said that they had personally experienced discrimination from managers and colleagues.[22] BME staff, lesbian and gay staff and disabled staff were also more likely than their peers to say that they have experienced harassment, bullying and abuse from managers or colleagues.


* It should be noted that not all bullying and harassment may be related to equality. The bullying and harassment question format changed slightly in 2012, which may explain the sudden increase in percentage for these two questions.

**Figure 3: Percentage of NHS staff experiencing discrimination, bullying or harassment between 2010 and 2013 (from NHS staff survey)**




Recent research also shows that the NHS recruitment processes disproportionately favour White applicants. In addition, BME staff are more likely to be subject to disciplinary procedures and to have lower morale than non-BME staff.[23]

The outcome of lack of access for BME staff to senior jobs or promotion, or the experiences of being bullied and harassed, may be that the health and social care service loses these staff. This will have an adverse impact on staff and poorer outcomes for people who use services.

During our inspections, we see that good staff engagement makes a huge difference to the quality of services. We therefore believe that treating all staff working in health and social care with equality, dignity and respect is vital in order to improve these services. We commend the NHS Equality and Diversity Council's recent decision to prioritise race equality for staff through the introduction of the NHS Workforce Race Equality Standard into the NHS standard contract from April 2015.[24] We will contribute to improving race equality for NHS staff by using this standard as an indicator in our assessments of whether NHS organisations are well-led.

# Section 3: OUR WORK WITH REGARD TO EQUALITY IN HEALTH AND SOCIAL CARE

*"Asking questions about discrimination and protected characteristics on my inspections provides good evidence of equality. All of the staff we spoke with at a recent inspection could clearly explain how they would recognise and report abuse. They understood that racism or homophobia were forms of abuse and gave us examples of how they valued and supported people's differences."*

**Inspector, Adult Social Care Directorate**

## Improving equality for people through new style inspections

Over the last year, we have changed our approach to inspection. We published our explicit *Human rights approach to regulation* alongside our new handbooks for providers, which explains how we incorporate equality and human rights principles into inspections.[25]

During our inspections, we always ask five key questions: is the service safe, effective, caring, responsive, and well-led? Inspectors use a set of key lines of enquiry (KLOEs) that directly relate to these five questions to ensure a consistent approach. These KLOEs include our human rights principles of fairness, respect, equality, dignity, autonomy, rights to life and rights for staff.

We tested and reviewed the new inspection methods for acute hospitals between September 2013 and March 2014 and for adult social care from June to October 2014. We found that to capture robust evidence of equality and human rights issues through our inspections depends on two factors in particular: the awareness and skills of inspection teams and the evidence that comes into CQC from providers, patients, members of the public and staff. We will work to improve our approach for both of these factors going forward.

Appendix B gives some examples of equality issues that we are picking up in our new inspection approach. As our new approach develops, we will also be better able to comment about equality in health and social care at a national level. Our Equality, Diversity & Human Rights Team, part of CQC's Policy & Strategy Unit, continues to lead on our approach to assuring equality, valuing diversity and promoting human rights across CQC's regulatory policy and practice.

## In 2014, we have improved our regulation for equality by:

- ✓ Consulting publicly on our human rights approach to regulation, which includes equality. The final version was published in September 2014 alongside appropriate information on regulating for equality in our new provider handbooks, including equality impact assessments for each handbook.
- ✓ Developing and continuing to review our inspection methodology and guidance for inspectors for all sectors to ensure it is aligned with our human rights principles, including our key lines of enquiry and ratings descriptors, to help our inspection teams focus on equality.
- ✓ Ensuring that the new fundamental standards were aligned and cross-referenced with the Equality Act 2010 by liaising with the Department of Health on changes required to regulations.
- ✓ Improving our intelligence about equality before inspections, including easy access to demographic information about local areas, information about the Equality Delivery system for NHS inspections and equality information from adult social care providers. We are now developing better information about race equality for staff working in NHS trusts, as part of our commitment to looking at staff equality in our assessments of whether NHS trusts are well-led.
- ✓ Continuing to monitor the effectiveness of our pre-inspection intelligence and our inspection practice in picking up equality issues. This included working with Public Health England on an external evaluation of how well our inspections of NHS hospital trusts in 2014 addressed issues for people with a learning disability; the interim report was published in February 2015.
- ✓ Testing equality-related learning and development for inspectors and managers to help them focus on equality in inspections, and securing £450,000 of funding for learning and development on equality and human rights for all CQC staff in 2015/16.
- ✓ Introducing equality and human rights in our themed work, such as the reviews of mental health crisis care, end of life care, transition to adult services and dementia care.
- ✓ Developing Equality Objectives to improve our regulatory insight, actions and judgements where we want to make a difference around specific equality issues.

# Engaging and involving a diverse range of people

We have a well-established programme of engagement through our SpeakOut network – a national network of more than 100 community groups that was created to support us in our regulatory functions. Through this network, we have been able to hear and learn from the views and experiences of communities including disabled and non-disabled people (including those under 18 and over 65), the lesbian and gay community, transgender people, people from Jewish, Somali, Muslim, South Asian, Bengali, and Eastern European communities, gypsy and travellers groups, people with substance misuse issues, refugees and asylum seekers, homeless people and women experiencing domestic violence or living in refuge.

The range of this engagement since January 2014 has included:

- 491 people from a range of equality groups involved in pre-inspection focus groups and engagement activities.
- 42 focus groups held about the proposed changes to our regulatory framework and the new rating system.
- 23 individual interviews with people who use mental health services and 25 narrative interviews to help define what 'good' care looks like in maternity, accident and emergency, surgery and outpatients units.

> *"This was one of the best things I have ever done as an inspector at this inspection focus group. It really did make me think and has influenced the way I have planned this massive inspection. I had certainly never thought about some of the issues the women raised. You can do all the training in the world but hearing their stories is by far the most powerful."*
>
> **Inspector, Acute Hospitals Directorate**

We evaluated the work of SpeakOut between January and September 2014. This showed that we engaged significantly with groups covering the protected characteristics, including Black and minority ethnic communities and older people aged from 65 up to late 70s. We also developed our engagement with gypsies and travellers, homeless people, those who misuse substances and children and young people, and we improved female-to-male participant ratios. However, we still need to do more work to engage with people on the autism spectrum, lesbian, gay, bisexual and transgender communities, people in prison and armed forces personnel.

*"The contribution of insightful members of the group has supported and made active changes to the new inspection regime, and what this will actually mean in practice. Personally, it is a real privilege to be Co-Chair the eQuality Voices group, with people with remarkable talents and skills, and to maintain the balance of challenge and support, without fear or favour, to CQC. Only by doing this in equal and fair measures can we deliver better services for all, and particularly the people and communities whose voices are often seldom heard."*

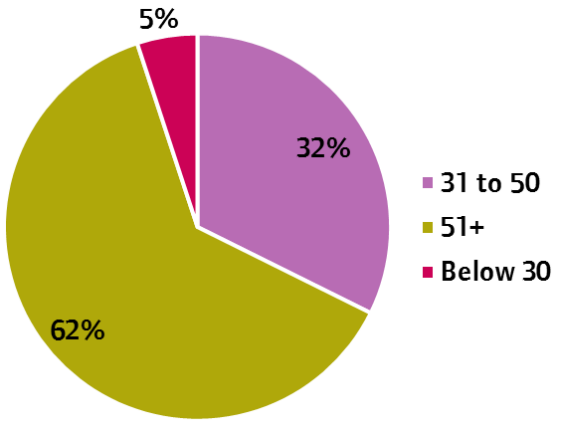
**Bren McInerney and Victoria Jones Co-chairs of eQuality Voices**

eQuality Voices is a group of people who use services whose role is to help shape and monitor our equality work. During the year, eQuality Voices have helped us to shape the definitions of the principles in our human rights approach, identified priorities for our work on equality and diversity, and advised us on our thematic work.

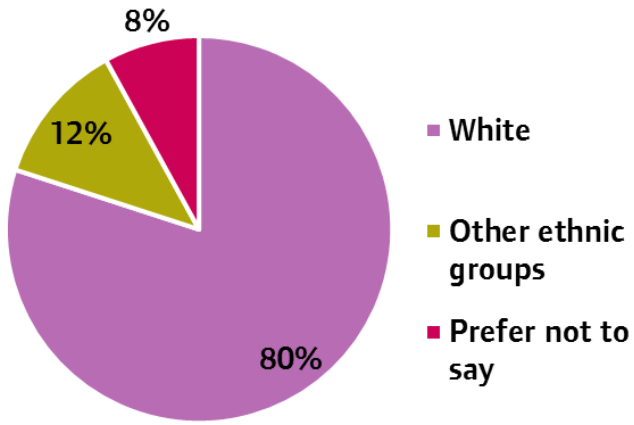
Finally, our Experts by Experience programme includes people who have a personal experience of using health, mental health and social care services, with diverse equality characteristics (figure 3). They participate in our inspection programme by visiting services, running focus groups, and talking with people who use services on inspection visits and by telephone. In 2013/14, 502 Experts by Experience worked with us and, since October 2013, we have been testing our new inspection approach with them. They have been involved in inspecting 1,202 services, three quarters of which were adult social care services.

**Figure 3: Diversity profile of CQC's Experts by Experience**

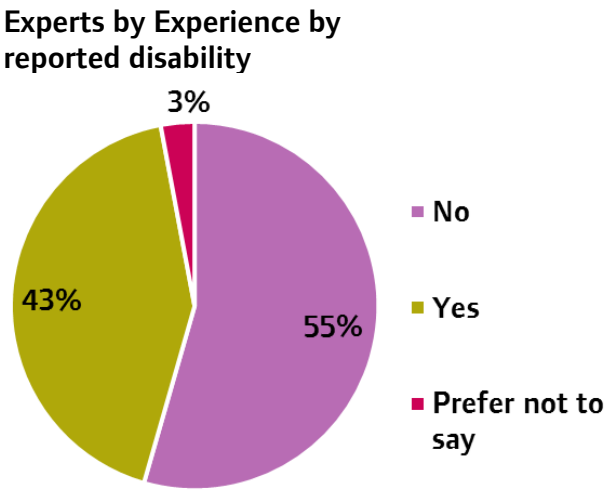
**Experts by Experience by proportion in different age groups***

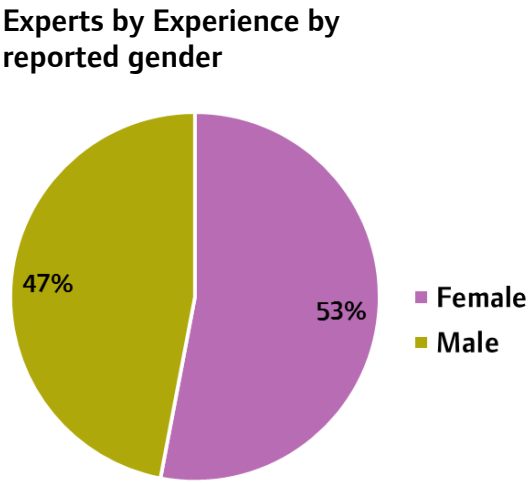



**Experts by Experience by ethnic groupings***




* Some groupings have been adjusted to reflect different monitoring categories used by the support organisations that we contract with to recruit and support Experts by Experience.




# Making our information accessible

Our accessible communications function has continued to support the organisation with information provided in easy read, large print, audio, British Sign Language video, six core community languages and other accessible formats. We publish all information on our website. During the period September 2013 to October 2014:

- People downloaded 26,253 easy read documents, 1,966 large print versions and 1,029 translations of documents into languages other than English. This was lower than last year's 61,414 downloads – probably because of a major publicity drive about CQC's website in 2013, which has not been repeated in 2014. Also, once people have downloaded the accessible information, they may not need to download it again the following year.
- We also translated into easy read, and other formats, the annual State of care report as well as the publication on our human rights approach, and we produced new easy read, Braille, large print and audio questionnaires for people who use services to support the consultation on our new inspection approach. We supplied 2,905 paper copies of easy read documents (an increase of 23% on last year) through our online publication request service. Stakeholder engagement campaigns with audiences such as local authorities have been partly responsible for the increased activity in accessible communications.
- We handled 306 specific requests for Braille, audio, British Sign Language video, easy read language translation, large print and interpreting services. Though the annual figure was down from 324 requests in 2013, one area of growth that increased by a third on last year has been the supply of interpreters to help our inspectors gather the views and experiences of people who use services. This reflects our greater emphasis on listening to the voices of people who use services to inform our judgements.

# Section 4: EQUALITY IN OUR WORKFORCE

*"As part of our individual objectives, we promote and incorporate the values and behaviours of the organisation in all we do. We ensure that the principles of equality are understood and that people are reminded to, and do, treat each other with dignity and respect, both personally and professionally."*

**Head of Inspection, Adult Social Care Inspectorate**

Alongside our regulatory activity, we also take seriously our responsibilities regarding equality for our own staff. Just as we expect service providers to address staff equality, we know that we need to address equality for CQC staff in order to live up to our organisational values of excellence, caring, integrity and teamwork.

This year, for the first time, we are proud to have become one of the Top 100 employers in the Stonewall Workplace Equality Index, which measures the work of employers to tackle discrimination and create inclusive workplaces for their lesbian, gay and bisexual employees.

The results from our staff survey indicate other progress. More employees than before across all equality groups would recommend CQC as a good place to work. This year, our employee engagement index (EEI), a combined measure across four survey questions, showed no difference between Black and minority ethnic (BME) and non-BME staff, and our lesbian and gay staff both have a higher EEI than their heterosexual peers. And, while 12% of CQC staff still said that they had experienced bullying or harassment from other staff, this compares favourably with 22% reported in the latest NHS staff survey.[26] Other headlines from the results of our staff survey are given in Appendix C.

Over the last year we have refreshed our organisational values through extensive consultation with staff, including the staff equality networks, to reflect the culture of inclusivity we aspire to.

However, we still need to do more to achieve our ambition of having no difference in employment outcomes for staff based on their equality characteristics.

BME staff are less likely to consider that CQC is an equal opportunities employer compared to other groups (56% of BME staff compared to 77% of non-BME staff). BME staff are also more likely to say that they have experienced discrimination (13%). Our analysis of our workforce shows that BME staff are not proportionately represented in the upper pay bands within CQC and, from our conversations with BME staff, we know this to be a major contributing factor to these survey results.

Our disabled staff, and staff with caring responsibilities, are also significantly more likely to say that they have personally experienced bullying, harassment or discrimination, compared to other staff (27% and 23% respectively). Disabled staff were also the equality group most likely to say that they had experienced discrimination at work – with 22% of disabled staff reporting this compared to 9% of all staff. The EEI for disabled staff is lower than for non-disabled staff, and disabled staff remain under-represented at all pay bands.

To address these challenges, we have developed a new People Strategy to create an inclusive organisation, which will enable us to:

- Create an environment where the contribution of every employee is valued and where discrimination and bullying are not tolerated.
- Promote equality and inclusion in our work, employment practices, training and through our suppliers.
- Deliver attraction strategies that are inclusive, helping us to secure talented people from diverse backgrounds.
- Support people's different needs and requirements, where we can.
- Create opportunities for a variety of working patterns and make sure people's non-work time is respected.
- Deliver and exceed our statutory equality duties, ensuring that at each stage of the employee lifecycle our policy and practice is lawful and that it advances equality of opportunity.

Led by our Human Resources team, this work will continue to focus efforts on the engagement levels of particular groups of staff. For example, our participation in the Disability Equality Standard performance review process will help us to improve the experience of disabled staff at CQC. We will also focus on how we improve around under-represented equality groups, particularly at senior management levels, and will use the new NHS Workforce Race Equality Standard to measure our progress.

To create a high performing organisation, CQC promotes inclusion through three specific networks. Each has a member of the Executive Team as its sponsor:

- **Disability Equality Network:** CQC is improving its approach to employing and supporting disabled staff, as part of valuing and encouraging the very best from our diverse workforce. To do so, we are working with the Business Disability Forum to review our performance against the Disability Equality Standard. This will provide an independent and rigorous analysis of how well we are currently doing. Our Disability Equality Network is closely involved in this work.

*"CQC has a number of initiatives in place that relate to the disability agenda and the network wanted to capture this and benchmark ourselves. The network, with the support of CQC, has completed its first disability standard submission. We are awaiting feedback from the assessment to allow the group to challenge and work with CQC in moving forward with regard to the disability agenda."*

**Chris Thurlow, Chair, CQC Staff Disability Equality Network**

- **Lesbian, Gay, Bisexual, Transgender (LGBT) Equality Network:** 'Reaching out', the annual report for CQC's LGBT network, highlights the substantial amount of work and achievements in 2014. The network held more meetings with groups inside and outside of CQC and promoted the work of both CQC and the network. LGBT History month enabled people to explore the role of an 'Authentic Role Model', and the committee invited the Chief Executive of Stonewall, Ruth Hunt, and Paralympic medal winner, Claire Harvey, to talk about the people who inspired them. The network has contributed to the development of staff policies and the changes made in response to consultation have benefitted all staff – not just LGBT staff. In partnership with CQC's leadership, the LGBT network developed a definition of the term 'partner' and also influenced the wording of CQC's adoption policy, which has helped CQC to recognise that all families are different.

*"This is one of the things I feel most proud about as Chair, that our group is not inwardly focused. We have proved this by encouraging the holistic view, inviting everyone to our events and encouraging a more open culture within the organisation. This year's AGM presentation was not just about intimacy and older LGBT people; it was about intimacy and older people full stop."*

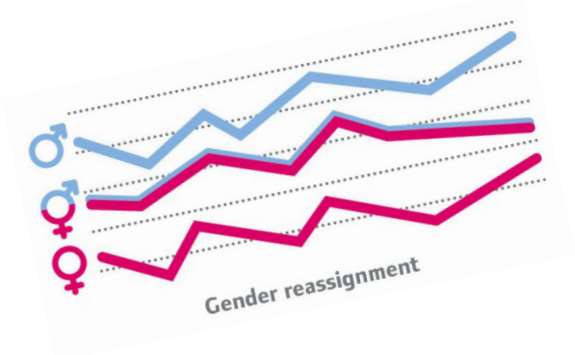
**John Scott, Chair, CQC LGBT Equality Network**

- **Race Equality Network:** The Race Equality Network saw much change and development in 2014, building on positive projects from previous years. A new team updated the group's terms of reference, launched a new logo – developed through a competition – and revamped its intranet page, which now holds recorded audio sessions and other presentations. Black History Month events were a great success. Most offices held some functions, and the network raised around £500 for Médecins Sans Frontières, which was donated for Ebola aid relief. During these events, there were talks from inspirational people along with leading academics.

*"At our AGM, we agreed that it would be very beneficial to increase the number of events being celebrated and recognised within CQC, as our network is for all ethnicities, cultures and/or religious beliefs. We have consequently had our first World Aids day celebrations, and will be holding commemorative and remembrance sessions for World Holocaust Remembrance Day in January. We will be celebrating further cultural events throughout next year. We rounded off the year with a closed 'reflections' session with CQC's Chief Executive and Chair, creating a safe environment for a small group of people to share their stories. This is a huge step in terms of engagement between the top of the organisation and the network and an extremely positive demonstration of the commitment of both our Chief Executive and Chair to understand the experiences of people in their organisation, which all helps to build a better organisation."*

**Keira Liburd, Chair, CQC Race Equality Network**

Our staff equality networks continue to provide valuable advice to CQC, and we will maintain a zero tolerance approach to bullying and harassment in the workplace with the support of our Dignity at Work advisors programme.

# Section 5: OUR WORK IN 2015/16 AND BEYOND

We have made good progress over the last year, but we still have more to do to achieve equality for people who use health and social care, and for our own staff.

Embedded in our wider programme of work on equality and diversity, including the human rights approach to regulation and inspection and our new People Strategy, are our new Equality Objectives from April 2015 to March 2017.

### Objective 1

Deliver learning and development for all CQC staff by March 2016 to address unconscious bias. This will help to promote equality, diversity and inclusion in our regulatory work, in employment at CQC and in our wider relationships with colleagues.

### Objective 2

Include race equality for staff (through the NHS Workforce Race Equality Standard) as a factor in our judgements about whether hospitals are well-led.

### Objective 3

Improve our regulatory insight and action about the safety and quality of mainstream health services for people with a learning disability or dementia, or those experiencing mental ill-health.

### Objective 4

Help our inspectors to pursue key lines of enquiry and to make consistent and robust judgements about particular aspects of equality. We will focus on adult social care services meeting the needs of lesbian, gay and bisexual people and people with a sensory impairment, and look at the transition of young disabled people into adult services.

### Objective 5

Work towards having no difference in the employment outcomes for our staff or potential recruits because of age, disability, ethnicity, gender, gender reassignment, religion or belief or sexual orientation.

We published our last set of Equality Objectives for CQC in 2012. Much of the work described in this report relates to work undertaken to meet these objectives, and Appendix D cross-references the current objectives with the progress outlined in this report. We have developed our new Equality Objectives to reflect the significant changes to our regulatory approach. During 2014, we consulted with CQC staff and stakeholders, including people who use services (through our eQuality Voices group), to develop the new objectives, based on CQC's new approach and focused on where change is needed. We have now published full information about each new equality objective on our website.

We know that health and social care services will only provide good quality care for all people if attention is paid to equality – and so we must also pay attention to this in regulation. The continued delivery of our human rights approach, based on embedding equality into our mainstream regulatory strategy, policy and practice, will help us to do this over the next few years.

Similarly, we know that CQC will only be an excellent organisation if we value diversity, inclusion and equality for our staff. Our new People Strategy therefore has an increased focus on achieving this.

We will also work with others, such as the NHS Equality and Diversity Council and the Equality and Human Rights Commission where this will help us to fulfil our purpose: to make sure that health and social care services provide **everyone** with safe, effective, compassionate and high-quality care.

# Conclusion

This report outlines what we know about equality and how we have responded to it. Our new approach is enabling us to regulate for equality much more effectively than before and we aim to continuously improve how we do this. We expect providers to demonstrate that they are:

- Meeting the needs of all people who use their services, paying particular attention to groups of people who may currently be receiving a poorer quality of care.
- Taking action to ensure equality for their own staff, which will improve the quality of the service that they provide.

As the quality regulator for health and adult social care services, we are committed to working with providers, commissioners, people who use services, and our own staff to encourage the improvements needed for **everyone** to receive good care – no matter who they are. We are equally committed to ensuring equality for our own staff.

# Appendix A: Analysis of equality questions in adult social care provider returns

We sent over 7,000 provider information forms to adult social care providers between August and November 2014 and the results in this report are based on the responses received as of 22 December 2014.

**Table 1: Equality policies in adult social care services**

| Service type | Total no. respondents | No. with equality policy in place = 'Yes' | % with equality policy in place |
|---|---|---|---|
| **Residential care** | 3,179 | 3,153 | 99 |
| **Community services** | 1,097 | 1,087 | 99 |
| **Shared Lives schemes** | 20 | 20 | 100 |
| **Hospices** | 53 | 50 | 94 |
| **Specialist colleges** | 15 | 15 | 100 |

**Table 2: Work undertaken on equality in adult social care services in the last 12 months**

| Service type | Total no. respondents | In the last 12 months have you done any specific work to ensure your service meets the needs of the people with protected characteristics = Yes | % = 'Yes' |
|---|---|---|---|
| **Residential care** | 3,179 | 1,320 | 42 |
| **Community services** | 1,097 | 422 | 38 |
| **Shared Lives schemes** | 20 | 20 | 100 |
| **Hospices** | 53 | 36 | 68 |
| **Specialist colleges** | 15 | 13 | 87 |

**Table 3: Coverage of equality characteristics across all adult social care service types (for services that have equality policies)**

| Do the policies cover meeting the needs of people with protected characteristics under these specific areas? | Yes | No | Blank | % Yes |
|---|---|---|---|---|
| Age | 4,252 | 56 | 56 | 97 |
| Disability | 4,269 | 40 | 55 | 98 |
| Gender | 4,248 | 57 | 59 | 97 |
| Gender reassignment | 3,726 | 551 | 87 | 85 |
| Race | 4,255 | 50 | 59 | 98 |
| Religion/belief | 4,253 | 52 | 59 | 97 |
| Sexual orientation | 4,199 | 100 | 65 | 96 |

**Table 4: Work undertaken by adult social care services to meet the needs of people with protected characteristics**

| If you have done some work, which groups does this cover? | Yes | No | Blank | % Yes |
|---|---|---|---|---|
| Age | 1,194 | 1,138 | 2,032 | 27 |
| Disability | 1,549 | 868 | 1,947 | 35 |
| Gender | 1,014 | 1,272 | 2,078 | 23 |
| Gender reassignment | 686 | 1,583 | 2,095 | 16 |
| Race | 1,049 | 1,246 | 2,069 | 24 |
| Religion/belief | 1,254 | 1,098 | 2,012 | 29 |
| Sexual orientation | 927 | 1,368 | 2,069 | 21 |

# Appendix B: Equality issues identified through inspection

During 2014, our inspections, focus groups and engagement with the public highlighted a range of equality issues, as well as how providers are addressing them. These are some examples.

## Access, communication and information

We found that some NHS acute hospitals needed to improve how they enabled disabled people to access their services – including both environmental access and communication. For example, we saw:

- A lack of hearing loops in reception areas, affecting patients' privacy.
- Badly designed bathrooms and lack of equipment, restricting access and denying people adequate personal care.
- People with a learning disability, people with a visual impairment and those whose first language was not English being unable to make choices about food or find their way around a building because information and signage was not clear and accessible.
- A lack of facilities, such as lifts and access to wheelchairs, in hospital car parks, which resulted in people being stressed and late for appointments.

For people whose first language was not English, the provision of interpreting services, how staff used them and the translation of information varied between hospitals. Some hospitals used an interpreter when required, while others had access to interpreters but didn't routinely use them; some staff and managers knew how to use the translation and interpreting services available, while others used family members to interpret in hospitals.

We found examples of NHS trusts that employed midwives who could speak particular languages to meet the needs of women from different ethnic backgrounds, so they could be fully included in their care.

**Extracts from NHS acute hospital inspection reports**

✓ "Translation facilities were, in general, not used, as a number of staff could communicate with patients in their first language."

✗ "We were told by a number of managers and staff that it was not a problem to make people understand when their first language was not English. Patients often brought with them a member of the family who could speak English."

*"The transition between the care home, hospital and back to the care home can be distressing and stressful for older people with dementia from minority ethnic communities. Especially for those without any other family and who are unable to articulate their cultural needs or their distress or where language is a barrier. We try to stay with them when they go to hospital but often we can't."*

**Manager of care home for African-Caribbean elders with dementia**

We found a number of examples where people were enabled to have equal access regardless of their age, language, ethnicity, disability or sexual orientation. For example, we saw that some people were able to understand their care plan as it was available in large print, or easy words and pictures. Some people could check themselves in for an appointment using a seven language self-check in desk. We also saw a same sex couple who were looking at ways of starting a family, and their GP, who had been "delightful, open and helpful", had researched the subject, given support and advice and made a referral in a non-judgemental way.

**Extract from a GP inspection report**

✓ "A GP realised that the patient was registered blind and could not read the documents and instructions regarding his cancer care and treatment. The GP phoned the hospital to pre warn them so they could meet him when he arrived and offer support. The GP also phoned him regularly to explain instructions, medicines side effects and options."

Despite national policy on eliminating mixed sex accommodation, a minority of hospitals were still in breach of these conditions. For example, in one hospital we found two units where people's privacy and dignity were compromised and a general mixed ward that lacked separate bathroom facilities.

## Food, faith and religion

We all want food that we can enjoy, that is appropriate to our customs and beliefs and that keeps us well. In adult social care inspections, we nearly always report on positive and negative points about nutrition and hydration. Our inspectors look at people's dietary needs and wishes and whether this information is recorded in their care plans, and if staff had knowledge and awareness of any needs for culturally-appropriate food and drink. By observing mealtimes, our inspectors are able to see people's experiences, especially people who are unable to speak to us verbally.

Inspections also look at people's faith and their wish to worship. For people in hospital, inspection reports give examples of access to faith support. For example, in one hospital an Islamic Imam was available 24 hours a day and Muslims used the Sanctuary daily for prayers.

**Extract from an adult social care inspection report**

✗ "Much of the information that was on display was not accessible for people. For example, the menus were written in small black writing on a dark red piece of paper and no pictures had been used to support people's understanding."

**Extract from NHS acute hospital inspection report**

✓ "Patients' spiritual needs were met by the chaplaincy team who had 11 chaplains representing Christian, Roman Catholic, Muslim, Hindu and Sikh faiths. There was a team of volunteers who worked closely with the chaplaincy team to provide pastoral support for patients."

## End of life care

We found variation in how people's end of life wishes were recorded, depending on the circumstances, the type of service the person was using, how ill they were and the involvement of their family.

We saw services that provided care and support to people of different cultural backgrounds, faiths and ages at the end of their life. Examples included access to a multi-faith room with washing facilities, and a chapel and chaplaincy team that represented different faiths and used different languages. In one example, a hospital had improved its care for parents who had a stillborn baby. The care was carried out in a Christian tradition, but had been adopted by the Imam, enabling appropriate support to Muslim families during and after the death of a child.

An evaluation of our engagement work found that we have less evidence about people's experiences of intensive, palliative and end of life care. We will look at this during our thematic review on end of life care during 2015.

**Extract from an adult social care inspection report**

✓ "Care plans recorded people's end of life care wishes. For example, one person had stated: 'I would like to live as normal a life as possible. I do not want to be alone.'"

## Capacity and consent

We found some examples of capacity and consent issues that compromised people's dignity and posed a risk to their rights. The experiences of some people with mental health needs or dementia showed that this led to poor quality care.

For example, one hospital used a security guard to 'manage' a person if they needed one-to-one care because they were confused, had dementia or 'may be aggressive'.

In another example, two people who lacked mental capacity due to their critical illness were restrained by using hand mittens to prevent them dislodging medical devices. There was no documentation within the nursing or medical records regarding consent. One further example showed that medication was given to a person covertly in their food and the decision-making process about the person's mental capacity had not been completed.

We also found, in both hospitals and adult social care, that DNAR decisions were not always recorded. Guidelines on DNACPR decision-making from the Resuscitation Council UK, British Medical Association and Royal College of Nursing were revised in October 2014, and emphasise the importance of this.[27]

**Extract from an NHS acute hospital inspection report**

X "There was a low level of compliance in completing 'do not attempt cardiopulmonary resuscitation' (DNAR) forms."

## Equality for health and social care staff

We carried out a small-scale evaluation of the way we have been looking at race discrimination of staff in NHS acute hospitals. The evaluation showed that we are currently not consistent around this issue and that it would be useful to hold some focus groups, where appropriate, for Black and minority ethnic staff during an inspection, which could feed into our assessments of whether trusts are well-led. We have set an equality objective to address this, linked to the new NHS Workforce Race Equality Standard.

## Going forward

The report of the interim analysis by Public Health England and Improving Health and Lives (IHAL), published in February 2015[28], indicated that around half of our published inspection reports for NHS trusts addressed issues for people with a learning disability (see page 19). We aim to improve this next year by ensuring that all inspections of NHS acute hospitals focus on care for people with a learning disability across all the core services included in inspections.

Our new approach to inspections looks at many equality issues. However, it is too early to tell if our new methodology is sufficiently robust to assess all the equality aspects of safety and quality in a consistent way and to see what improvement providers are making in response to issues raised.

Looking at the inspection reports published under our new approach to date, we know that we need to do more to report on the quality of service experienced by particular equality groups such as lesbian, gay and bisexual people. We know that we need to improve consistency in reporting on some key issues, such as race discrimination of staff and the access, experience and outcomes for people with dementia or a learning disability using acute and primary health services. We will address these in the coming year, including through our new Equality Objectives.

# Appendix C: Summary of workforce data

Management information forms the foundation for our workforce planning. It informs how we plan to improve ways of working, not just for what we can measure against the protected characteristics, but more widely for all our staff – from determining our attraction strategy to promoting CQC as an employer of choice throughout the employee lifecycle.

## Workforce profile

The grading of jobs for CQC staff ranges from bands E, F and G (support and administrative posts), C and D (technical and professional posts), band B (inspectors and team leaders), band A (senior and professional managers), together with the executive grades 1, 2 and 3 (heads of function, director and executive director).

**Please note:** Figures below relate to CQC staffing at the end of September 2014, the 2013 figures relate to staffing at the end of September 2013. See the separate Annex 2: CQC staff workforce statistics at September 2014 for full statistical tables.

### Age

When comparing the age patterns of staff in CQC to the general workforce in England (referred to as 'the general workforce'), we found statistically significant differences in the proportion in different age groups. Under-25s are under-represented in CQC's workforce; only 3% of the workforce is under 25 compared to 14% in the general workforce. Staff aged 46-55 are over-represented in the workforce at 34%, compared with 24% in the general workforce.

However, when we compared the age breakdowns of the workforce at the end of September 2014 with the same period in 2013, the proportion of staff aged under 25 increased from 2% to 3%, which is a statistically significant increase.

Age groups were not proportionally represented across pay bands. Younger staff were over-represented at lower pay bands and under-represented in higher bands. This is not surprising, as staff with more experience are more likely to be in higher pay bands.

### Disability

Comparing CQC and the general workforce in 2014, there are statistically significant differences in the proportion of disabled staff. Only 7% of CQC staff are disabled, while 14% of employed staff are disabled in the general workforce. There have been no significant changes in this since last year. Disabled people are over-represented in band B (67% of CQC staff compared to 52% of overall staff) but are under-represented in band F.

## Ethnicity

Comparing the ethnicity patterns of CQC staff and the general workforce, there are no statistically significant differences for Mixed-Race, Asian and Asian British ethnicities. Black and Black British populations are over-represented in CQC (5% in CQC compared to 2% in the general workforce). White staff and 'any other' ethnic groupings (including Chinese) were under-represented in CQC compared to the general workforce.

Comparing the staff ethnicity profile of September 2014 with September 2013, there were no significant changes for most ethnic groups. However, the total of White ethnicity groups (i.e. the sum of all White groups: White UK, White Irish, White) increased from 81% to 84%, which was a statistically significant increase, while staff with "unknown" ethnicity dropped from 8% to 5%.

As of 30 September 2014, staff from BME backgrounds were not proportionally represented in the upper pay bands (executive levels 1, 2 and 3 and band A). BME staff were over-represented at bands C and F.

## Religion

Comparing staff religion and belief for CQC and the general workforce, Christians are statistically under-represented in CQC (44% of CQC's workforce) compared to the general workforce (59%). The share of the workforce that records their religion as "Not known" is the same in CQC and the general workforce. In 2014, all religions were proportionally represented in CQC across all pay bands.

When we compared the breakdown of religions in the workforce between 2013 and 2014, we found no significant changes for Atheism, Christianity, Non-Christian religions "Other" and "Not known" groups. There was a significant decrease in the "I do not wish to disclose my religion/belief" group between 2013 and 2014 from 18% to 16%.

## Sexual orientation

Comparing the breakdown of the workforce between 30 September 2013 and 30 September 2014, there were no significant changes in the proportions of heterosexual, lesbian, gay and bisexual, and "unknown" sexual orientations. In 2014, 73% of staff said they were heterosexual, 4% stated they were lesbian, gay or bisexual and 22% said "unknown".

In 2014, heterosexual, lesbian, gay and bisexual and "unknown" orientations were proportionally represented across all pay bands.

## Gender

Comparing CQC gender patterns to the general workforce, males are significantly under-represented in CQC and females are over-represented (69% working at CQC, compared to 46% in the general workforce). This is due to the nature of our work and employment backgrounds of employees – women are over-represented in the health and social care workforce as a whole.

When comparing gender patterns of the CQC workforce between 2013 and 2014, we found no statistically significant changes in the share of male and female staff.

# Staff survey – findings relating to diversity

Our annual staff survey provides us with comparable data year on year, which can be been broken down by equality characteristics.

All business areas within CQC have used the staff survey results as a key source of information for the positive assurance they are able to give about people management. The results have also clarified their priorities for staff engagement and development.

The headings below indicate the greatest differences between particular staff groups and their peers in the results of the staff survey carried out in August 2014.

## Gender

Male employees are more positive than female staff about receiving the right training and development to do the job: feeling able to balance work and home life and perceiving morale to be good in CQC. Female employees are more positive than their male counterparts that activity as a result of the last staff survey led to improvements; that CQC is committed to being a high-performing organisation and that CQC's work with people who use services improves standards of care. But female staff are less positive than male staff about feeling able to balance work and home life.

## Ethnicity

When it comes to overall engagement, there is no difference between Black and minority ethnic (BME) and non-BME employees, with both groups having an employee engagement index (EEI) of 65. BME employees are more positive than non-BME staff about their personal morale, the wider morale of CQC staff and feeling proud to work for CQC. However, BME staff are less positive than non-BME staff that CQC is an equal opportunities employer; that CQC promotes equality, diversity and human rights and that CQC has a strong commitment to equality and diversity in its regulatory functions.

## Religion/belief

At the overall level, there is limited difference between the religious groups in terms of their employee engagement. Since 2013, there has been an increase in the EEI across atheists but no change across the largest religious group of Christians.

## Age

In line with findings in both the 2012 and 2013 staff surveys, the relative level of engagement with CQC decreases as age increases: those in the 'younger' age groups continue to be the most engaged.

Taking into account the year-on-year changes, there is still an identifiable 'engagement gap' between the youngest and oldest CQC employees.

Also, in line with previous years, younger workers remain more positive overall and are more likely to agree that they have adequate resources to carry out the role; to feel that CQC prioritises health and safety and that they are able to strike the right balance between work and home life. However, they are less positive about whether they receive six and 12-month performance and development review discussions with their line manager; their team being committed to producing quality work and the reasons behind organisational changes being clearly communicated.

The groups of older employees are more likely to believe that CQC employees display the employee values and behaviours; they have regular one-to-one performance and development discussions with their line manager and they understand the reasons why organisational changes are made. They are less positive than younger staff that CQC prioritises health and safety, not so satisfied with the overall reward package and less able to strike the right balance between work and home life.

Across all age groups, there has been a positive shift and increase in the number of employees who would recommend CQC as a good place to work.

## Disability

In 2014, there has been encouraging further progress as the EEI across disabled employees has risen from 59 to 61 and has risen across non-disabled staff from 64 to 65. However, the gap (61 versus 65) is still one of the most notable across the different employee groups and suggests that there is still further room for improvement across disabled staff in CQC.

Again, in line with the results from last year, disabled employees are less positive than non-disabled staff about feeling that they are treated with fairness and respect in CQC; they are less likely to report that they can strike the right balance between work and home life and are less satisfied with their overall reward package. Disabled staff are slightly more likely than non-disabled staff to understand the reasons why organisational changes are made; believe that changes are effectively implemented in CQC and believe that CQC is committed to being a high performing organisation.

### Sexual orientation

Findings show that lesbian, gay and bisexual employees are more positive than their peers in their perceptions of CQC's commitment to creating an environment that is free from bullying and harassment, in believing that communications across different parts of CQC are effective and that CQC is an equal opportunities employer. However, lesbian, gay and bisexual staff are less positive than their peers about accessing learning and development opportunities in CQC; ensuring that everyone has a six-month and 12-month performance and development review discussion with their line manager, and that CQC priorities health and safety.

## Staff survey results for questions relating to bullying, harassment and discrimination

Table 5 on the next page shows the staff survey results for key questions relating to bullying, harassment and discrimination for particular equality groups. The questions in CQC's staff survey are slightly different from those in the NHS staff survey. We will review this for future surveys to see if we can enable better benchmarking – for example, in relation to the NHS Workforce Race Equality Standard, which uses questions from the NHS staff survey.

The leadership of CQC is committed to taking a zero tolerance approach to bullying and harassment in the workplace. The bullying and harassment policy outlines how it is handled.

In summer 2013, CQC commissioned an independent report looking into bullying and harassment in the workplace. Dignity at Work advisors are now trained and able to talk through issues of bullying and harassment with any member of staff.

**Table 5: staff survey results for key questions relating to bullying, harassment and discrimination for particular equality groups.**

| | Number of respondents | % since July 2013, I have been bullied and/or harassed at work | % since July 2013, I have experienced discrimination at work | % believe that CQC is an equal opportunities employer | % agreeing that they are treated with fairness & respect in CQC |
|---|---|---|---|---|---|
| All staff | 1,960 | 12 | 9 | 73 | 69 |
| Women | 1,324 | 12 | 9 | 72 | 68 |
| BME staff | 230 | 13 | 13 | 56 | 67 |
| Disabled staff | 183 | 27 | 22 | 60 | 52 |
| LGB staff | 113 | 16 | 12 | 81 | 74 |
| Staff 16-25 | 72 | 5 | 5 | 91 | 89 |
| Staff 56+ | 287 | 12 | 6 | 67 | 67 |
| Staff with non-Christian religious beliefs | 87 | 15 | 14 | 69 | 77 |
| Staff with caring responsibilities for children | 479 | 11 | 9 | 70 | 67 |
| Staff with caring responsibilities for adults | 178 | 23 | 12 | 62 | 57 |

# Appendix D: Progress on our current Equality Objectives

| Equality Objective 2012-2014 | Progress |
|---|---|
| **1.** Responding appropriately when providers do not meet the equality aspects of the essential standards. | See page18-19 and Appendix B. |
| **2.** Involving a diverse range of people who use services in our work. | See page 20-22. |
| **3.** Increasing the uptake of our accessible information. | See page 22. |
| **4.** Embedding equality in our Mental Health Act functions. | This work has been incorporated into our work on developing equality in our new approach, covered in section 3. |
| **5.** Ensuring staff have the tools and training that they need around equality. | See section 3. A major achievement was work with the Equality and Human Rights Commission to secure funding for learning and development for inspection teams and other CQC staff around building knowledge and confidence around equality and human rights, which will be delivered in 2015-2016. |
| **6.** Improving the information we hold on risks to equality in the organisations we regulate. | See page 19. |
| **7.** Ensuring a diverse workforce at CQC. | See section 4 and Appendix C. |
| **8.** Ensuring CQC staff are treated equally. | See section 4 and Appendix C. |

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