Equality counts

Equality information for CQC in 2013

January 2014

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

Our purpose is 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 we encourage them to make improvements.

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

Our principles

- We put **people who use services** at the centre of our work.
- We are **independent, rigorous, fair and consistent**.
- We have an **open and accessible** culture.
- We work **in partnership** across the health and social care system.
- We are committed to being a **high-performing organisation** and apply the same standards of continuous improvement to ourselves that we expect of others.
- We promote **equality, diversity and human rights**.

CONTENTS

FOREWORD

This equality information report, Equality counts, sets out how we have started to promote equality and tackle inequality for people who use health and social care services and for people who work for the Care Quality Commission. We publish this report as one of our duties under the Equality Act 2010. But promoting equality is more than a duty. It is at the centre of our purpose. This is why we have agreed that one of CQC's principles is to promote equality, diversity and human rights.

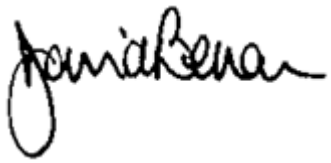
Our purpose is to make sure that *everyone* receives safe, effective, compassionate, high quality care, and we intend to deliver it. But we will only achieve this through our commitment to promote equality, diversity and human rights across all sectors through our new inspection approach. We're therefore creating an approach where inspectors have the tools, knowledge and skills that they need to promote equality and address inequality when they find it.

We also know that in an inclusive and just staff culture, people work to their best. This is why promoting equality within CQC is just as important as promoting equality in our regulatory work. We need to recognise the talents of all our staff and to model the best behaviour around equality. The work we do to improve, for example, the experience of our disabled staff, Black and minority ethnic staff, lesbian, gay and bisexual staff or staff with caring responsibilities, matters. We cannot expect the services we regulate to take notice of our judgements on equality and human rights unless we model a diverse workforce and a proactive culture at CQC that values equality and human rights for our own staff.

This report shows what we have to do to tip the balance to promote equality and diversity. It shows that discrimination and disadvantage are real and limit people's lives. You can read the facts and figures and read people's stories.

You can see both the progress we have made and what remains to be done to achieve the positive CQC culture we want. We are working on it.

We will make sure that services provide people with safe, effective, compassionate, high quality care. Fundamental to our goal is that people experience equality when using health and social care services.



David Behan
Chief Executive

SUMMARY

In 2013, we redefined CQC'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 tested 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 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 (table 1).

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 1: Diversity profile of 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 place.

INTRODUCTION

> *CQC's new strategy and approach is about being on the side of people who use services. Providers that deliver high quality care, demonstrating equality and upholding people's human rights, will be rated highly... those who don't, will not.*
>
> **Paul Bate, Director of Strategy and Intelligence**

This report provides information about equality in our workforce and for people who are affected by our regulatory policies and practices. It provides us with useful information to develop our work in promoting equality and human rights – both in our regulatory functions and as an employer. Under the Equality Act 2010, we have a duty to publish:

- 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, pregnancy and maternity, race, religion and belief, sex and 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 employment status, social class, geography (for example, people in rural isolated communities) or homelessness status. However, these grounds are outside the scope of this report.

The information about our workforce is based on data held on 30 September 2013. The main groups of people affected by our policies and practices are those who use health and social care services and those who provide such services.

This report updates our previous report *Equality matters*, which we published in January 2013.

In 2012, we published our Equality Objectives for CQC. Much of the work described in this report relates to work undertaken to meet these objectives and highlights specific progress against each objective. There have been significant changes since the equality objectives were published. We have a new three-year strategy, a new approach to regulation, a new Executive Team and Board. We have also appointed Chief Inspectors of Hospitals, Adult Social Care and Primary Care. Whilst our equality objectives are still relevant to our work, we plan to review them to ensure that they are the best objectives for our future plans. We aim to have new objectives in place for April 2014.

CQC's approach to equality is based on people's rights, including those set out in the Equality Act 2010, but also those enshrined in the Human Rights Act 1998 and human rights treaties ratified by the UK Government, such as the UN Convention on the Rights of People with Disabilities and the UN Convention on the Rights of the Child.

Before April 2014, we will also consult on our Human Rights-based approach to regulation, inspection and monitoring of care services. This will give more details about our strategy for embedding human rights, including equality, into the way we regulate services, and will also influence our new Equality Objectives.

SECTION 1:
Equality in our policies and practices

1.1 Work that cuts across equality characteristics

In the following sections, we outline some of the main issues faced by people who use health and social care services in relation to the 'protected characteristics' under the Equality Act 2010, and we describe the action that we have taken during 2013, through our policies and practices, to address these issues. Some of our work to promote equality is relevant to all equality characteristics.

During the past year, this work included:

- ✓ Engaging with other partners in the health and social care sector on equality and human rights, for example through the Department of Health's Equality Act 2010 implementation group, the Inspectors and Ombudsmen's Equality Forum and the adult social care sector leadership work on equality, led by Skills for Care and continuing work with the Equality and Human Rights Commission through our memorandum of understanding.

- ✓ Engaging with CQC's eQuality Voices group on developing our equality and human rights work. eQuality Voices is a group of people who use services and people with unpaid caring responsibilities who provide us with independent views, support and challenge about our work.

- ✓ Delivering an action plan to follow up the findings of our evaluation of equality and human rights in our inspection work. This takes a new approach and is focused on peer learning and sharing good practice at a national level, supported by specialist advice, guidance and development from our central Equality and Human Rights team and a network of equality leads in our Operations directorate.

- ✓ Including a specific objective on equality in the individual objectives for inspection staff across the country (approximately 1,100 staff). This has led to a wide range of actions at a local level.

- ✓ Developing our human rights approach in our new inspection model and testing this in the first wave of NHS acute hospital inspections, ensuring that key equality topics are included in standard lines of enquiry and that inspectors have the tools and methods they need.

> *The role and work of eQuality Voices demonstrates the value of direct experience in the work of CQC. Over the past year, eQuality Voices members have been involved in a wide range of topics, applying their extensive equality and human rights expertise to issues of most importance to people who receive health and social care services. I've also been impressed by CQC staff who have sought to work constructively and meaningfully with the group. On a personal note, the group and Bren, as my co-chair, have been very supportive of me during a tough time. I am very proud of them and looking forward to building on what the group – and CQC – have achieved.*
>
> **Kay Sheldon, Non-Executive Director of CQC and Co-Chair of eQuality Voices group**

CQC monitors and inspects health and social care providers under regulations that include specific reference to avoiding unlawful discrimination (under Regulation 9 of the Health and Social Care Act 2008 Regulated Activities Regulations 2009) and ensuring that providers deliver care and treatment to people with due regard to their age, sex, religion, sexual orientation, race, cultural and linguistic background and disability (Regulation 17 of the same regulations). These requirements are sub-clauses of wider regulations so it is not possible to ascertain precisely how much regulatory action we have taken on equality (table 2).

However, all the other clauses in Regulation 17 – Involving and respecting service users – support equality through the need to ensure dignity, privacy and independence for every person using the service and enabling people to make, or participate in making, decisions relating to their care and treatment.

Table 2: Inspection activity around Regulation 17 in 2012/13

Type of service	Number of services inspected meeting Reg 17	Number of services inspected not meeting Reg 17	% of services inspected not meeting Reg 17
Residential homes	8,683	487	5%
Nursing homes	3,264	430	12%
Home care agencies	4,225	125	3%
Community social care	1,240	37	3%
NHS hospitals	221	21	9%
NHS community healthcare	169	13	7%
NHS mental health, learning disability & substance misuse services	125	9	7%

Source: CQC, *The state of health care and adult social care in England 2012/13*

Where services do not meet standards for Regulation 17, we set compliance actions and we monitor whether they take action to meet the standard. If they do not, we may take enforcement action.

Between 1 October 2012 and 30 September 2013, we found 48 services did not comply with Regulation 17, leading us to take enforcement action (table 3).

Table 3: Enforcement action around Regulation 17 in 2012/13

Type of service	Number of services where CQC took enforcement action under Regulation 17
Acute hospitals	1
Mental health hospitals/hospitals for people with a learning disability	2
General practitioners	0
Dentists	2
Care homes	36
Home care agencies	3
Other social care services	4
Total	**48**

Source: CQC data

Table 4 on the next page shows the number of incidents by types of abuse for safeguarding incidents reported as notifications to CQC. If one incident covered more than one type of abuse, it will have been recorded for both types of abuse, so the total figure does not indicate the total number of incidents. While the number of discriminatory incidents may appear to be low, taking action on other types of abuse, such as neglect, physical abuse and psychological or emotional abuse, may also contribute to equality for older people and disabled people.

There are a number of actions that CQC may take in response to these notifications, including holding a management review to decide whether services meet our requirements and discussion with local safeguarding teams as part of multi-agency procedures. CQC is committed to taking appropriate regulatory action to ensure that both children and adults are safeguarded from abuse in the services that we regulate.

Table 4: Number of safeguarding incidents, by type of abuse, January to August 2013

Notifications - type of abuse	Total incidents
Discriminatory	31
Financial / material	99
Neglect	1,210
Physical	454
Psychological / emotional	449
Sexual	62
Unspecified	653

Source: CQC data

We also ensure that the rights of people detained under the Mental Health Act 1983 are upheld (which includes their rights to equality under the Mental Health Act Code of Practice).

Our Mental Health Act annual report includes more details about this area of our work.

> *[eQuality Voices is] a really good opportunity to independently look at the equality and human rights work of CQC through the views and experiences of a diverse range of people. The group has provided both challenge and support through a positive relationship with the CQC team. As a Co-chair it has been a real privilege to work with Kay and the group, and a very proud moment in my life.*
>
> **Bren McInerney, Co-chair, eQuality Voices group**

1.2 Gender equality (including pregnancy and maternity)

Background

Women make up 51% of the population in England and accounted for 56% of acute hospital inpatient episodes. There are a number of reasons that may contribute to this difference, including the differing age profile of men and women and women's use of inpatient maternity services (Hospital Episode Statistics 2012-13, Health and Social Care Information Centre).

Men make up 49% of the population and accounted for 48% of the mental health and learning disability trust inpatient episodes.

Of the applications made under the Deprivation of Liberty Safeguards in 2012-13, 48% were for men and 52% were for women. Of these applications, 47% were granted for men, and 53% were granted for women.

There is no data available relating to the gender profile of people using regulated social care services. However, due to the longer life expectancy of women, we know that in many services, such as care homes for older people, more women are using services than men.

Providing appropriate health services for men and women includes providing single-sex services in line with national requirements, for example on inpatient wards. In 2012-13 in England, there were 3,741 cases of healthcare providers breaching single sex accommodation requirements. Of these breaches, 58% occurred in the London region. Overall, there is a pattern of breaches, which peak in December and January and are at the lowest in August. This is possibly linked to winter pressures (NHS England, *Mixed sex accommodation data 2012-13*).

The Department of Health policy requires that separate bathrooms are available for male and female patients. Respondents to the national inpatient survey were asked if they ever used the same bathroom or shower area as patients of the opposite sex. The proportion who said that they did not have to use the same bathroom or shower area as patients of the opposite sex has increased from 84% in 2011 to 86% in 2012. This leaves 13% who said they did have to use the same bathroom or shower area as patients of the opposite sex, down from 15% in 2011, and 1% who did so because it had specific bathing equipment that they needed, down from 2% in 2011, (CQC National Inpatient Survey 2012).

While there are obvious differences in the health needs of men and women, the evidence does not suggest a clear trend of either gender experiencing worse health than the other. However, both genders may find that their health needs are not met: men are less likely to use their GP and women have specific concerns about maternity services (Equality and Human Rights Commission, 2010, *How Fair is Britain?*).

Gender can also interact with other equality characteristics, such as race, to create different patterns of disadvantage. For example, the difference in the ability to speak English, to understand and to be understood in a care setting differs between males and females in England (figure 1).

Figure 1: Proficiency in English by general health by sex for people aged over three years

Men	Women
Cannot speak English well:	**Cannot speak English well:**
42% of people who cannot speak English well are men (1.2% all men)	58% of people who cannot speak English well are women (1.6% all women)
Cannot speak English at all:	**Cannot speak English at all:**
32% of people who cannot speak English at all are men (0.2% all men)	68% of people who cannot speak English at all are women (0.3% all women)

Source: ONS Official Labour market statistics from 2011 census, table DC2303EW

There may be a variety of reasons for these differences, including country of origin and cultural expectations that women do not engage with other people outside of their communities. Whatever the reason, this means that there will be language barriers for them and for the people providing care. There are also gender differences in people's ability to read in their first language, which can mean that women are less able to gain information about health and social care through translated written materials.

Meeting our equality objectives 1: Responding appropriately when providers do not meet the equality aspects of the essential standards

In 2012, we undertook a structured evaluation of equality and human rights in our inspection work. This evaluation also looked at the best approaches for improving how we regulate for equality and human rights in inspections. To deliver these actions during 2013, we have:

- ✓ Launched a national project to share case studies highlighting good practice around equality and human rights in inspections.
- ✓ Provided 'top tips' for compliance managers on how to develop equality and human rights practices in their teams.
- ✓ Introduced a standard objective for all inspectors, registration assessors and their managers around equality.
- ✓ Worked on embedding equality into the new framework for inspecting NHS acute hospitals and the lines of enquiry for inspectors to follow, which we began to test in September 2013.
- ✓ Delivered a range of action through local teams to support this objective, such as regular reflection on equality in staff supervision sessions and team learning activities. For example, one team is arranging a learning set with equality staff from its local council.
- ✓ Provided a quarterly bulletin on equality and human rights for CQC staff.

Pregnancy and maternity

Maternity services differ from other health services because pregnancy is not an illness – it is a normal life event. There were 694,241 live births in England in 2012. The number of stillbirths fell to 3,558 in 2012 from 3,811 in 2011 (a fall of 6.6%). The number of stillbirths is an indicator within the NHS outcomes framework 2012/13 for reducing deaths in babies and children in England.

In 2012, the average number of available maternity beds was 7,856 and an average of 4,645 were occupied, which is an occupancy rate of 59% (ONS statistics).

Our specific work on equality on the grounds of gender

We have:

- ✓ Agreed that in our future model of acute hospital inspections, we will always inspect maternity services on our regular inspections.
- ✓ Indicated our intent to include mothers as one of the groups that we will focus on in our inspections of GP services.
- ✓ Produced supporting information for our inspectors regarding elimination of mixed sex accommodation.
- ✓ Introduced two development programmes for CQC staff: the 'Springboard' development programme for women and the 'Navigator' development programme for men.
- ✓ Continued to monitor against the Quality and Risk Profile indicator regarding breaches of single sex accommodation in hospitals.
- ✓ Involved women's groups in our SpeakOut network. For example, Womencentre in Huddersfield.

> *To understand the quality of a service we must understand how the service responds to equality and human rights issues. In our development of the acute inspection model, we have tried to give inspectors the tools they need to help them to do this. This includes having specific lines of enquiry that enable us to focus our attention on issues that matter to people, and making sure that equality and human rights are woven through the inspection framework. We are also using innovative engagement methods to gather views and experiences from seldom heard groups through Regional Voices and SpeakOut.*
>
> **Sarah Bartholomew, Head of Regulatory Design**

1.3 Race equality

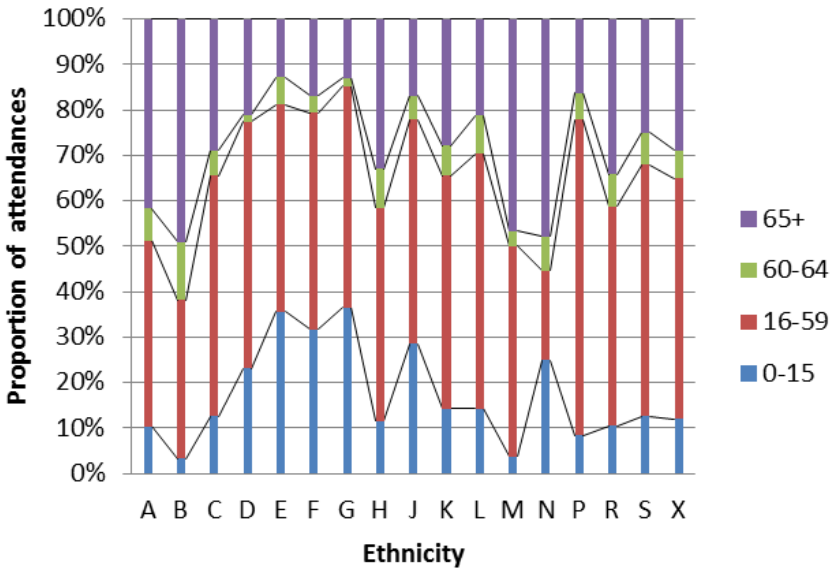
Background

Although White British people make up 84% of the population, (ONS, Mid year statistics 2012), they represent only 73% of the hospital inpatient episodes in NHS acute trusts (Hospital Episode Statistics). People of mixed heritage, Indian, Bangladeshi, Black African and Chinese people also had a lower number of acute hospital inpatient episodes than may be expected from their population sizes, whereas people from other Asian or Asian British backgrounds, other Black backgrounds and 'other ethnic backgrounds' had higher numbers of inpatient episodes than may be expected. This suggests that some people from Black and minority ethnic communities may be using acute hospital inpatient services more often, but that the same is not true across all Black and minority ethnic communities.

There are a number of health conditions that are more likely in certain communities, for example, Black or south Asian people are more likely to develop diabetes and high blood pressure, and associated health conditions such as kidney problems. These health inequalities will have an impact on the use of some health services by Black and minority ethnic (BME) communities. The inequalities also show the importance of our regulatory work in some services regarding race equality. In particular, the development of our inspection model in primary medical services in the future may be able to have a positive impact on race equality, as many of these health inequalities can be addressed in primary care.

White British people represent 72.5% of the inpatient episodes in mental health and learning disability trusts, which is proportionately lower than might be expected. However, Gypsies and travellers, people of 'other mixed race', Bangladeshi people and 'other Black' people have attendance levels that are proportionately higher than expected from their percentage of the population. There are also differences by age between and within ethnic groups. For example, in figure 2, groups B (Irish) and M (Chinese) appear to have a larger proportion of attendances made by older people and fewer by children than other groups.

Figure 2: Proportion of mental health trust hospital attendances by ethnicity and age, England 2012-13



Source: Hospital Episode Statistics for 2012-13

White British people represent 65% of accident and emergency admissions. The white Gypsy and traveller group represents 5% of admissions, which is disproportionate in terms of population size. However, this may be due to Gypsies and travellers not being registered with a GP where they are living, and therefore needing to use accident and emergency instead, rather than any increased susceptibility to accidents.

People with a main language other than English who could not speak English well, or not at all, had a lower proportion of 'good' general health (65%) than those with English as their main language (80%), or those with a main language other than English who spoke English well or very well (88%) (ONS).

It is almost 10 years since the David Bennett Inquiry report made the crisis in BME mental health a national issue and brought to light the discrimination in mental health services that has led to higher numbers of Black people being diagnosed as schizophrenic, over-represented among people who are sectioned and picked up by the police under mental health law, despite BME people having similar rates of mental ill health as other ethnic groups.

The report from the Schizophrenia Commission The Abandoned illness (2012) states that, while efforts have been made to improve outcomes for BME people using mental health services, people from African-Caribbean and African backgrounds still experience greater dissatisfaction with mental health services than their White counterparts.

The Commission was told by BME people involved in their research that:

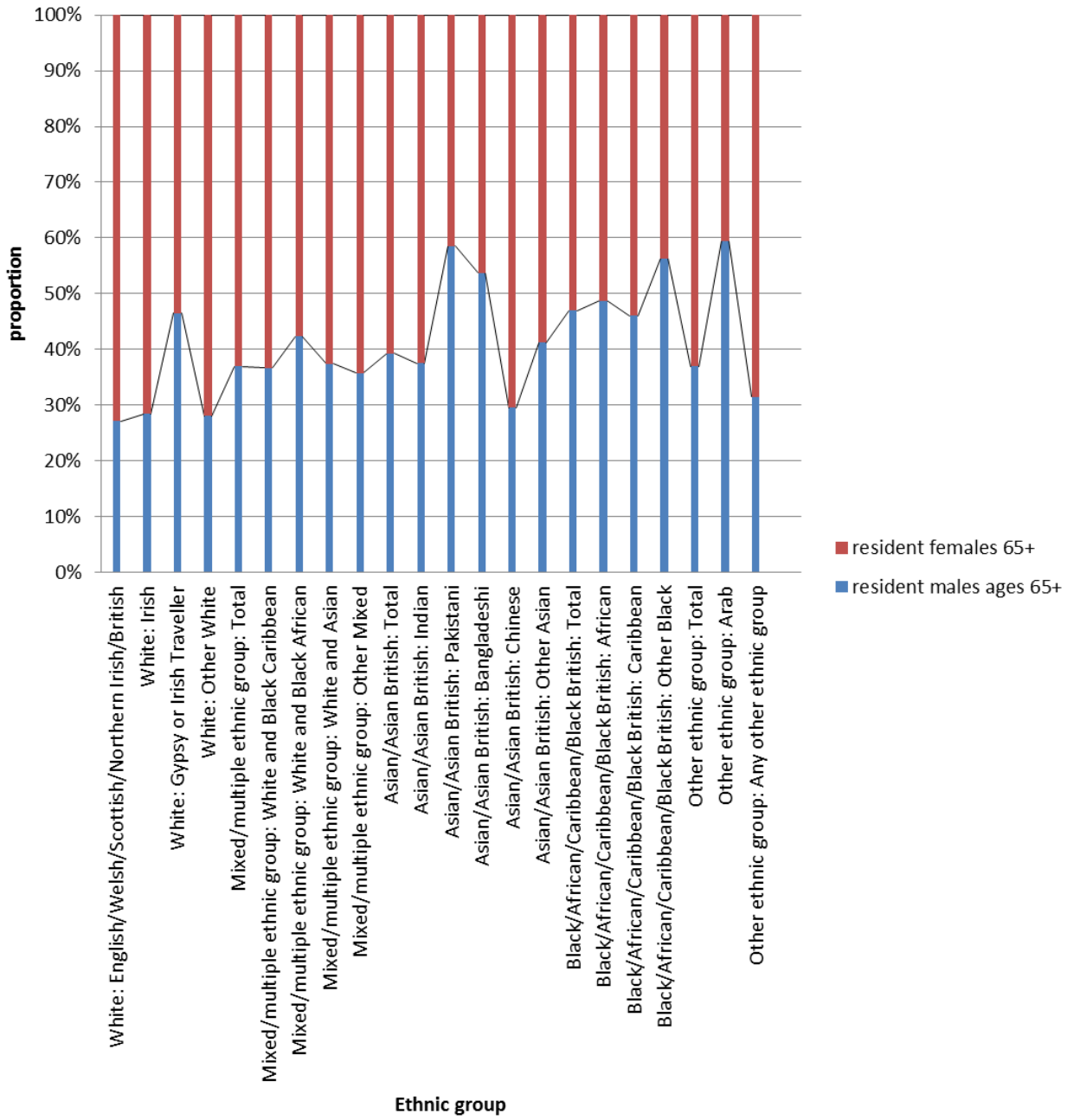
- Too much treatment involves coercion under the Mental Health Act, over-emphasis on medication and not enough talking treatments.
- There is a lack of understanding of specific cultural issues affecting different populations.
- The stigma and shame of seeking help hinders the delivery of any kind of support.
- There is a lack of recognition of ethnic differences and ignorance of the very real problems affecting people from BME communities. Treating everyone as though they are the same is wrong; diversity needs to be acknowledged and respected.

The Commission concluded that people from African-Caribbean and African backgrounds are more likely to be given a diagnosis of schizophrenia or psychosis. They are more likely to be admitted to hospital under section, to have police involvement in their admission and they are heavily represented in locked and secure forensic units. They are more likely to be detained under forensic sections. Black people are less likely to receive psychological therapy and more likely to complain of being restrained and forcibly medicated.

Although there is no specific data relating to the ethnicity of people using specific types of adult social care, statistics relating to people living in communal establishments show that there are differences in the proportion of men and women aged 65 and over from different ethnic groups who are living in communal establishments (figure 3).

A communal establishment is an establishment providing managed residential accommodation and includes several types of services that we regulate such as care homes. Considering people aged over 65, a higher proportion of Black and Asian people living in communal establishments are men, compared to white and other ethnic groups. This may have implications about how gender sensitive care is planned and provided for Black and minority ethnic older people, such as considerations about the gender of care workers in care homes.

Figure 3: Proportion of people aged 65 and over by ethnic groups by gender living in communal establishments 2012-13



Source: ONS 2011 census table DC2117EWla

Case study 1: Achieving race equality through inspection work

Our inspectors found that the availability of interpreting services was poor for people using an acute hospital in an area with a high ethnic minority population. The service improved after inspectors included this finding in an inspection report. This meant that people with English as a second language had access to information about their care and treatment in their own language through interpreters.

We inspected a care home for older people in London. One older man from a minority ethnic community was not having his cultural needs met and was not settling into the care home well. The inspector found the care home was not meeting the regulation that includes having regard to the cultural background of people using the service. Following this, the care home manager negotiated with the local council for the man to attend a day service specifically for people from his community twice a week. The man is now much happier and has settled into the care home.

Our specific work on equality on the grounds of race

We have:

- ✓ Continued our focus on inequality for Black and minority ethnic (BME) people using mental health services, including work led by CQC's staff Race Equality Network.
- ✓ Started thematic work on mental health emergencies, which will include some work around inequalities in relation to race. This work will be carried out in 2014.
- ✓ Consulted with a wide variety of groups including Gypsies and travellers and BME people who use mental health services about our new plans for inspecting health and social care services.
- ✓ Indicated our intent to include how GP services meet the needs of BME groups with poor access to primary care, such as Gypsies and travellers, in our future inspections of these services.
- ✓ Engaged with a wide variety of groups from BME communities on a range of topics through our Speak Out network and eQuality Voices, including less often heard groups such as Gypsies and travellers and refugees and asylum seekers.
- ✓ Provided all our main publications in six languages, and translated reports and other publications on request.
- ✓ Provided interpreters for inspectors on request, so that they can gather the views of people who speak languages other than English on inspections.
- ✓ Provided demographic information to hospital inspection teams, so that they know the ethnicity profile of the local area when planning an inspection.
- ✓ Supported community organisations to carry out focus groups to gather the views of specific communities about hospitals before inspections.

Meeting our equality objectives 2: Involving a diverse range of people who use services in our work

During the year we have:

- ✓ Continued to support and engage with the SpeakOut Network, a national network of over 90 groups, which helps communities that are often not heard to have a stronger voice about health and social care matters that affect their communities. Groups invite their communities to get involved in our projects to gain views on regulation and our methods and guidance. The SpeakOut network is managed on our behalf by the School of Social Work at the University of Central Lancashire and is an example of how statutory organisations can effectively engage with marginalised and disadvantaged groups. The network includes groups of disabled people, older people, people from Black and minority ethnic communities, Gypsies and travellers, faith groups, lesbian, gay and bisexual people's groups, groups of transgender people and groups of homeless people. For example, this year, SpeakOut groups have been involved in our strategy review, in the development of our new inspection model and in planning our thematic inspections around services for people with dementia. We have launched a new training programme for members of SpeakOut, which includes short courses and an online training package about influencing health and social care services.
- ✓ Worked through Regional Voices to develop how we communicate with people with a learning disability through their existing networks and to reach young people and children using mental health and community services for our pilot inspection programme of these services, which starts in 2014.
- ✓ Worked with the Race Equality Foundation to reach out to people in BME communities as part of our thematic review of services for people with dementia.
- ✓ Held 13 community focus groups as part of the first group of new NHS acute hospital inspections. These focus groups have sought to reach out to a wider range of communities and have been run through local Councils for Voluntary Services, Regional Voices and Speak Out groups. The events have been developed for a range of equality groups, for example, Black and minority ethnic people, people with a learning disability and Jewish women, to test our ability to reach some of these groups when finding out about the quality of local hospital services.
- ✓ Developed our Experts by Experience programme to enable people to get involved in our work, for example, by being members of inspection teams for hospitals, care homes and other services. In particular, this year we have focused on developing a programme for children and young people so that they can be Experts by Experience in relation to health and social care services used by children. We work with a Children and Young People's advisory group of 16 young people, which meets regularly to develop this work.

  Experts by Experience are supported through voluntary sector organisations, under contract with CQC. One of their major roles is to talk to people using services during our inspections, so it is important that we have a diverse pool of Experts by Experience. During the coming year, we will work with support organisations to develop equality monitoring and outreach to fill any gaps in the diversity profile of our pool of Experts by Experience.
- ✓ Supported the eQuality Voices group, comprised of 20 people who use health and social care services to act as a 'critical friend' in the development of our equality and human rights work, including monitoring progress on our equality objectives.

As part of eQuality Voices monitoring work, the group decided to look at CQC's existing structures around the diversity of involvement in three specific areas: the Experts by Experience programme, SpeakOut Network, and the new inspection regimes.

The group thought that a positive development was the expansion of the Experts by Experience programme, and particularly the involvement of children in this area. The new inspection regimes enable us to maximise the knowledge gained from reviewing the present structures and methods of involvement. The new inspection regimes have a considerable focus on Experts by Experience, and it is important to celebrate the programme of children and young people in the new regime, along with the current specialist Experts by Experience.

The group also suggested some additional groups of people that we are not currently reaching through the SpeakOut Network.

Bren McInerney a member of the working group said: "The group decided what areas it wished to look at and then worked alongside the CQC lead to provide both challenge and support on how CQC assured us, and itself, on the inclusive approach to involvement."

Nigel Thompson, CQC's link with this working group said: "The group provided CQC with an independent and fresh look at what we were presently doing, and what we needed to do for the future. This invaluable and open insight allows us to further improve our inclusive approach to involvement within the CQC."

1.4 Disability equality

> *The only way we can really tackle equality and human rights issues is to make sure they are part of the way we work every day. Each time we think about improving quality we need think about what that means to different people. This means more than just using the equality and diversity prompts to plan and conduct an inspection, it means thinking with our teams about how we relate and respond to people around us whether we are out inspecting, in meetings or having a conversation in the office.*
>
> **Debbie Ivanova, Head of Regional Compliance, CQC South region**

Background

Disability includes physical and sensory impairments, learning disabilities and mental health conditions.

Disabled people make up a significant percentage of the population: Data from the ONS 2011 Census indicates that more than 9.5 million people have a limiting long-term illness or impairment. We know that disabled people are likely to use health and social care services more frequently than non-disabled people, though the equality monitoring data in health is not as well developed for disability as it is for race, gender and age.

In relation to disabled people's use of social care services, in March 2013, there were 462,910 places in care homes in England (CQC data). A large proportion of people using regulated social care services would also have protection under disability discrimination law – even if many of these people (particularly older people) may not self-identify as disabled people. For example, 278,072 care home places have been identified as being for people with dementia.

Disabled people can have different experiences of how health and social care services are delivered.

Some disabled people using care services can experience discrimination and in some cases, abuse, as Winterbourne View demonstrated, where staff were found to have abused residents with learning disabilities. This led to South Gloucestershire's Safeguarding Adults Board commissioning a Serious Case Review, which was launched in August 2012 and the resulting Serious Case Review report made recommendations for preventing abuse in the future. Subsequently, the Department of Health published a report in December 2012 Transforming care: A National response to Winterbourne View Hospital and the Winterbourne View Review Concordat: Programme of Action, which set out actions for health and local authority commissioners working together with national bodies, including the care Quality Commission, to transform care and support for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging.

The need for generic health services to address the needs of disabled people is recognised in a number of recent strategies. In the Department of Health's fourth annual report on the End of Life Care Strategy (2012), it highlights the implementation of the National Institute for Health and Care Excellence (NICE) Quality Standard for end of life care for adults, which stresses the importance of ensuring that

treatment and care, and the information given about it, is culturally appropriate and accessible to people with physical, cognitive or sensory impairment or learning disabilities (End of life care strategy: Fourth annual report). In October 2012, The Royal College of General Practitioners and the Royal College of Psychiatrists published guidance designed to support Clinical Commissioning Groups (CCGs), with local authorities and learning disability partnership boards, to commission health services in ways that achieve better health outcomes for people with learning disabilities (Improving the Health and Wellbeing of People with Learning Disabilities: An Evidence-Based Commissioning Guide for Clinical Commissioning Groups).

Although some people using mental health services do not identify as disabled people, mental health is included in the definition of disability in the Equality Act 2010. Many people using inpatient services in mental health and learning disability trusts would almost certainly have protection under disability discrimination law – there were 1.4 million inpatient attendances in these trusts in 2012-13.

We have a particular role in ensuring that the rights of people detained under the Mental Health Act 1983 are protected. The total number of people subject to detention or Community Treatment Order (CTO) restrictions under The Mental Health Act at the end of the year has remained similar to the number during 2011/12, as the decrease in people subject to detention in hospital is offset by an increase in people subject to a CTO. On 31 March 2013, this was 22,207 people, 60 fewer than in the previous year.

Of the number of people subject to the Act:

- 16,989 people who were inpatients were detained in hospital (a decrease of 514 or 3%). This corresponds with a reported fall in the number of available NHS beds.
- 5,218 people were subject to a CTO (an increase of 454 or 10%).

These figures include detentions and CTOs for both NHS and independent sector providers (Health and Social Care information Centre, Key facts: Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, England - 2012-2013, Annual figures [NS], Table 8 Patients detained under the Mental Health Act 1983 and patients on Community Treatment Orders by Mental Health Act 2007 mental category at 31 March, 2013).

Disabled people can also experience double discrimination or multiple disadvantage if they also have other protected characteristics.

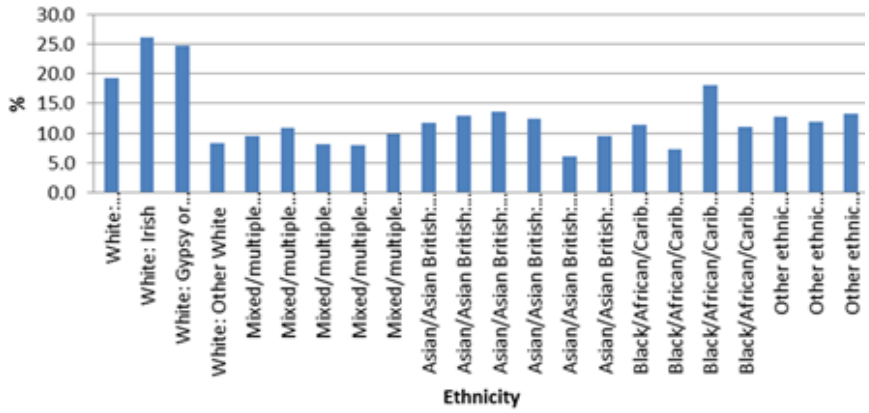
Disability and harassment

Mental health is the most common cause of disability. If you experience low mental wellbeing over a long period of time, you are more likely to develop a mental health problem (MIND). Research has suggested that there may be an association between harassment and poor mental health. Some evidence suggests that lesbian, gay and bisexual and transgender people, Gypsies and travellers and asylum seekers, who are perhaps more likely than other groups to face hostility and misunderstanding, are all more likely to experience poor mental health (EHRC report, How fair is Britain chapter 9).

Disability and ethnicity

In some ethnic groups, a higher proportion of the population are disabled people. For example, approximately 25% of people in both White Irish and White Gypsy and traveller groups are disabled people (figure 4).

Figure 4: Proportion of population by ethnicity in England whose activities are affected by disability (Census 2011)



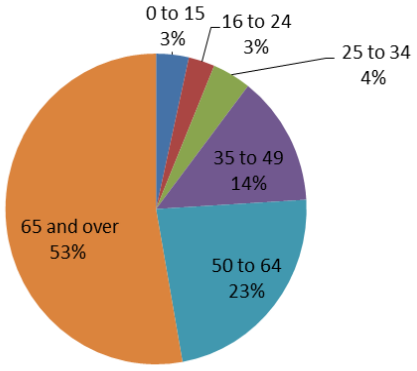
Source: ONS Census table DC3205EWr - Long-term health problem or disability by ethnic group

Disability and age

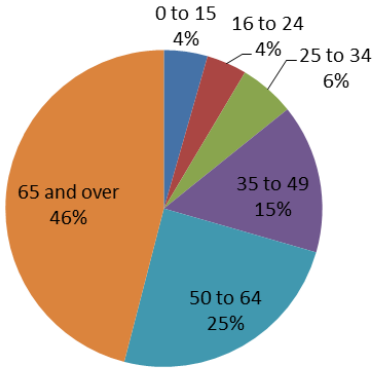
Of the 9.4 million people who are affected by long term health conditions or disability, 4.3million are affected a lot and 4.9 million are affected a little. There is a strong link between age and disability; people aged over 65 make up over half of the people in England whose day to day activities are limited a lot by disability and almost half of those whose activities are limited a little (figure 5). These charts may not only relate to levels are impairment but also to levels of support provided to people of different age groups, as people are less likely to say that their day to day activities are limited by disability if they have their access and support needs met.

Figure 5: Proportion of disabled people by age band (Census 2011)

Day-to-day activities limited a lot

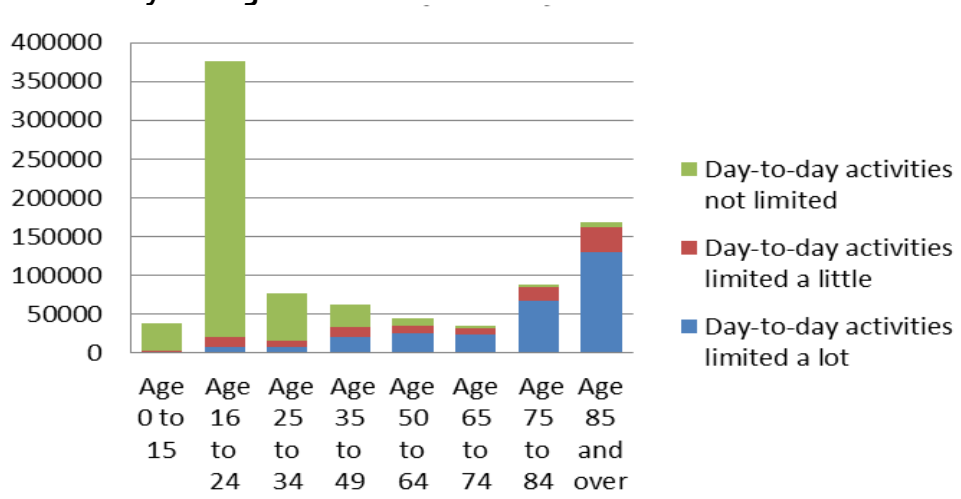


Day-to-day activities limited a little



Source: ONS Census 2011, Long term health problem or disability by health by sex by age

Figure 6: Residents of communal establishments in England (including care homes) by degree of disability and age



Source: ONS Table DC3304EWla, Long-term health problem or disability by general health by age - communal establishment residents

Figure 6 illustrates how the degree of limitation to day-to-day activity increases for people as they age. It is perhaps unsurprising that there are far fewer disabled people in the younger age ranges, as these figures will include university halls of residence and hostels, for example. However, the chart does show the significant number of people aged 85 and over living in communal establishments compared to those aged 65 to 84.

Meeting our equality objectives 3: Increasing the uptake of our accessible information

CQC's Accessible Communications function has made significant progress in 2013, to make sure that we communicate in an accessible and easy way so that people can understand what we say. The General Social Care Council said in its 2012 learning report on involving people that CQC's accessible communications policy "is an excellent example of how the work of regulators can be made accessible to people who use services and their carers". We have continued to build on this success in 2013 and keep publishing our information in easy read, large print, audio, British Sign Language video and six community languages.

We are able to regularly review the uptake of accessible information though both data on information requests and web downloads, and through advice from people who use services and others, for example through the SpeakOut Network and eQuality Voices.

We have worked with partnership organisations, such as the Challenging Behaviour Foundation and the Mental Health Foundation to consult on alternative versions. Our Accessible Communications Officer also consulted with CQC's Learning Disability Advisory Group and the eQuality Voices group on easy to read materials and publications. By producing high quality accessible information we encourage people to use it more.

In May 2012, to increase the uptake of inspection reports in alternative formats, we added a link to each provider profile page on our website to invite people to request an alternative format of that provider's latest inspection report. This makes it easier for people to request an alternative format so they can use the findings from our inspections in a way they understand.

We also supply interpreters to help our inspectors gather the views and experiences of people who use services during inspections, or at CQC events and workshops. To promote this service, our Accessible Communications Officer has presented at induction training workshops for inspectors and featured in an internal video to increase awareness of accessible communications by CQC staff. Access to the interpreting service has greatly helped our inspectors to gather real insight into the thoughts of people who use services:

"Using the interpreter enabled me to communicate effectively with the residents and gain their feedback about the service." (CQC Inspector, September 2013).

In August 2013, we updated the computer software that inspectors use to write inspection reports so that a 'flag' is raised when they start a report for a service for people with a learning disability, which tells them that an easy to read version of their report is required.

The Public Communications team has also been actively promoting the use of easy read and audio mp3 versions of our leaflets about standards people should expect from social care services. We have been working with local councils to encourage them to give people our information when they attend adult social care initial screening and needs assessments, and at subsequent review meetings. We aim to enlist the support of all 150 local authorities. Initially, we are working to establish pilot programmes with 20 authorities. This work should help to raise awareness of our publications in alternative formats and encourage people who use services to use them.

Last year, eQuality voices monitored how we made accessible information available both internally and externally. They used a range of methods including: mystery shopping calls to our National Customer Service Centre, using the website and looking at the information available to order. The group concluded:

"There was a very quick response to a web-based issue about letting people know that CQC reports were available in different formats by including a contact on the website with a hyperlinked email address. Over the coming months this was superseded by including a button on every page to order documents in different formats that met individual need (translation, easy read, Braille, MP3 etc). Mystery shopping calls to the call centre proved very useful and informative. We saw a variation of how different individuals were spoken to, but on the whole their questions were very professionally well handled.

Looking at the targets that the Communications team were set, we felt as a team they were challenged significantly and they met each challenge really well, making a significant input into how CQC can be perceived by those trying to contact it. Information is power to people looking for and providing care – the quality of the information and the availability of it in relevant formats is key to CQC as an organisation meeting its mission statement. We believe, given the right challenges, the Communications team will progress its work on equality and human rights significantly to help embed the new fundamentals not only within CQC as an organisation, but also in the wider arena. EQuality Voices will remain the critical friend to the Communications Team for the journey."

Accessible publication downloads from CQC's website

From 1 September 2012 to 31 August 2013 there were almost 70,000 downloads of publications in accessible format from our website. These figures do not include BSL video and Audio MP3 format, as these are streamed rather than downloaded.

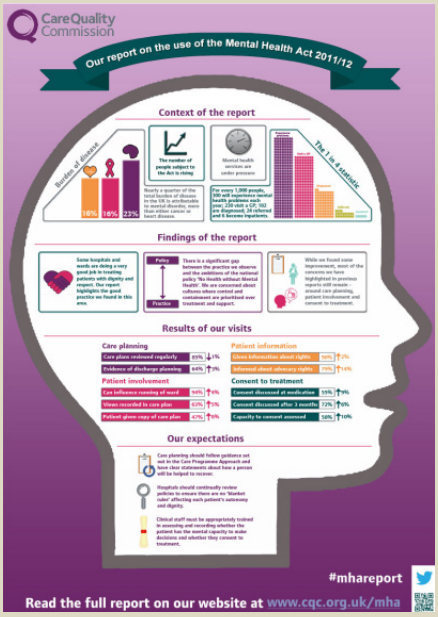
During the year our accessible communications team also received 324 specific requests for Braille, audio, BSL video, easy read, language translation, large print and interpreting services. Between July 2013 and October 2013, we sent out 2,354 easy read booklets about CQC and the standards that people can expect from care services. The demand for booklets about care homes and home care increased from seven requests in July to 487 in October, which is a result of our work to promote the booklets with local authorities.

Downloads from CQC's website in accessible formats 2012-13

Easy read	**61,414** requests (91.2%)
Large print	**5,021** requests (7%)
Translations into other languages	**1,331** requests (1.8%)

Case study 2: Our annual report on the Mental Health Act

When we published our report into the use of the Mental Health Act in January 2013, we saw that 1,160 downloads (17.1%) were of the easy to read version. On the day of publication, we received positive feedback from social media sites such as Twitter, from a range of charities and from those interested in mental health, as we produced alternative formats and an infographic for visual learners.



"@CareQualityComm so impressed with your efforts to make this report fully accessible- a truly great example of what best practice looks like"

"So pleased to see an easy- read version of the #mhareport has been produced. great example, @CareQualityComm"

"Well done to @CareQualityComm for making their Mental Health Act report readable & producing in accessible formats too. #mhareport"

Our specific work on equality on the grounds of disability

We have:

- ✓ Carried out a national survey of people who received community mental health services in 58 NHS trusts between July and September 2012. The report was published in September 2013.
- ✓ Planned a thematic review of services for people with dementia, which started in December 2013.
- ✓ Continued to deliver work in response to the Winterbourne View investigations and inquiries, such as introducing a tougher test before new providers of services for people with a learning disability can register with CQC.
- ✓ Produced guidance for compliance inspectors on how to communicate with people, with specific sections about communicating with people with sensory impairments, and people with learning disabilities.
- ✓ Provided face-to-face training to every member of CQC staff around issues for people with dementia, including using a rights-based perspective and good practice in communicating with people with dementia.
- ✓ Continued our communications work to produce an easy to read version of inspection reports for services specifically for people with a learning disability. All our key publications are available in large print, Braille, audio and sign language, and easy read summary versions. All other reports and publications can be reformatted for people on request.
- ✓ Provided posters in a range of languages about listening events for NHS acute hospital inspections and set a minimum standard of venue accessibility for these events. We ask people to contact us with their access requirements before a listening event and have also supplied interpreters and speech-to-text facilities at listening events on request.
- ✓ Focused on human rights issues in our annual report on our monitoring of the Mental Health Act.
- ✓ Indicated our intent to include how GP services meet the needs of people with long term conditions and people with mental health conditions, in our future inspections of these services. The majority of these people will be covered by disability equality law.
- ✓ Monitored our equality objectives through the eQuality Voices group, particularly our objectives on disability equality, accessible communications and monitoring the Mental Health Act.
- ✓ Involved disabled people in some of our ongoing development work for the new inspection model, such as our Adult Social Care external co-production group.
- ✓ Issued two Warning Notices between December 2012 and August 2013, where we took enforcement action under Regulation 17. These were to NHS and independent mental health services (see table 3 on page 11 of this report).

1.5 Equality on grounds of sexual orientation

Background

There is very little monitoring data about the sexual orientation of people using health and social care services.

However, in 2012 the ONS Integrated Household Survey (IHS) study found that 1.5% of adults in the UK identified as gay, lesbian or bisexual.

Of those, 2.6% of adults aged 16 to 24 identified as such, compared to only 0.4% of those aged 65 and over. Of those asked, 1.5% of men said they were gay while 0.7% of women identified with being lesbian or gay (table 5).

Table 5: Sexual identity: by gender, January to December 2012

Gender	% men 2012	% women 2012	% total 2012
Heterosexual/straight	93.2	93.7	93.5
Lesbian/gay	1.5	0.7	1.1
Bisexual	0.3	0.5	0.4
Other	0.3	0.3	0.3
Don't know/refusal	3.5	3.8	3.6
No response	1.2	1.0	1.1

Source: The ONS Integrated Household Survey (IHS)

Despite this lack of monitoring, it is recognised that lesbian, gay and bisexual (LGB) people face health inequalities and often face discrimination or unsuitable services when using health and social care services, and that there are particular equality issues for some groups, such as older LGB people.

Stonewall raised these issues in its report LGB in Later Life (2011). They found that three in five LGB people are not confident that social care and support services, such as paid carers or housing services, would be able to understand and meet their needs; more than two in five are not confident that mental health services would be able to understand and meet their needs; and one in six are not confident that their GP and other health services would be able to understand and meet their needs. Therefore, our work to develop inspection of primary medical care, such as GPs, may be able to have an impact on equality for LGB people if we can drive improvements to give LGB people greater confidence in using these services.

The impact of the fear of discrimination is made clear in a document produced for care providers by Age UK and Opening Doors Camden, Supporting older LGBT people – a checklist for social care, which begins by saying "Many older LGBT people are scared of growing old and needing care."

In 2012, the National End of Life Care Programme published *The route to success in end of life care - achieving quality for lesbian, gay, bisexual and transgender people,* (see the NHS Improving Quality website).

Our specific work on equality on the grounds of sexual orientation

We have:

- ✓ Consistently moved up the Stonewall Workplace Equality index rankings over the last three years, having been a Stonewall champion since 2009. This assessment covers not only our practice as an employer but also issues such as our engagement with LGB communities, how we provide services and our policies around equality on the grounds of sexual orientation. We aim to reach the top 100 in the Index. Rankings are released in January following an application in the previous September, so the 2014 ranking relates to our work in 2013.

Year	Ranking	Moved
2010	353	
2011	252	101
2012	157	95
2013	133	24
2014	111	22

- ✓ Involved LGB people's groups in our SpeakOut Network.
- ✓ Involved individual LGB people in our eQuality Voices group.
- ✓ Started work to look at ensuring that lesbian, gay and bisexual (LGB) people receive appropriate support when they are living in care homes. This work is in partnership with Age UK, Stonewall, the care homes' trade associations and CQC's SpeakOut network, and will continue into 2014.
- ✓ Made it clear in our information for the public that we are interested in hearing from LGB people about their experiences of health and social care. We know that specifically mentioning sexual orientation gives LGB people increased confidence to tell us about their experiences.
- ✓ Attended Manchester Pride for the first time in 2013; colleagues from our staff Lesbian, Gay, Bisexual and transgender Equality Network were joined by members of the SpeakOut group, OLGA (Older Lesbian, Gay Bisexual and Trans Association). They spoke to many people about CQC's work, and encouraged people to tell us about their experiences of care.

Case study 3: ensuring equality for people using adult social care services who want same sex relationships

A small care home for people with a learning disability had a discriminatory policy on sexuality, which stated that the service would not allow people to have same sex relationships. Our inspections are based on meeting the needs of people using the service; we could not identify anyone using the service who was currently affected by the policy, but we were concerned that the provider may be breaching the Equality Act 2010. The inspector contacted the service's commissioning authorities, who then asked the provider to change the policy, which they did. Commissioners have a duty to avoid unlawful discrimination, including when they are contracting with other providers, such as care homes, to supply services.

Meeting our equality objectives 4: Embedding equality in our Mental Health Act functions

During January to March 2013, CQC Mental Health Act Commissioners from two regions piloted an equality monitoring formal methodology during their visits to patients who are detained under the Mental Health Act. This was the first time that we have tried monitoring some protected characteristics, such as sexual orientation, on Mental Health Act visits.

We analysed almost 30 monitoring forms that were returned, and also considered qualitative feedback from Commissioners on the tool regarding applicability and acceptability of the forms for people who are detained. The results of the pilot were shared at the eQuality voices meeting in May 2013.

At this time, the transformation programme in CQC confirmed that a new model of regulating and monitoring mental health service providers would be developed by December. We decided that this was an ideal opportunity to embed equality monitoring into the new methodology, rather than as a separate exercise. We will evaluate this in practice, amend if required and then roll out for use more widely from April 2014 onwards.

The eQuality Voices Mental Health Act Monitoring Group has been set up to help embed equality, diversity and human rights principles in CQC's approach to its responsibilities under the Mental Health Act. The group consists of three members of eQuality Voices and includes people with direct experience of detention under the Mental Health Act.

The group has highlighted issues related to:

- The form and content of CQC's draft guidance about equality monitoring during Mental Health Act visits and of its draft equality monitoring form, including the diversity and range of experience represented by visitors, and has suggested appropriate amendments.
- Gaps in equality, diversity and human rights data in the last Mental Health Act Annual Report and the need for action to address these.
- The importance of CQC looking at people who use services as whole people, not just at individual protected characteristics, as part of its responsibilities under the Act.
- The need for CQC to focus more fully on the equality, diversity and human rights of people subject to Community Treatment Orders.
- Shortfalls in the focus on equality, diversity and human rights in the new mental health model that CQC is building, related, for example, to the five key questions that CQC has developed for assessing future standards, and the importance of rectifying these.

1.6 Equality on the grounds of religion and belief

Background

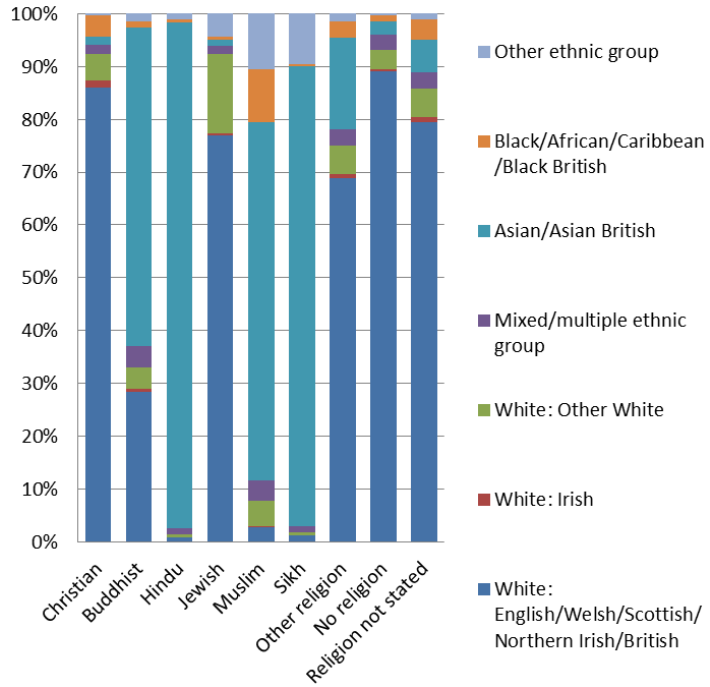
There is very little centrally collated monitoring data about the religions and beliefs of people using health and social care services. We expect providers to ask people using services about religion and belief as part of care planning and then to respond appropriately in terms of meeting any religious or ethical requirements in the way that they provide care and treatment. However, this information is not centrally recorded in datasets available to others, for example Hospital Episode Statistics.

Census data shows that residents in care homes in England are predominantly from a White background. However, as figure 7 shows, this does not mean that they all observe the same religious beliefs. It is important that assumptions are not made about a person's religion based on appearance, and that people are given the choice and are helped to observe the customs of their religions, for example regarding their clothing, their choice of food, and prayer.

Although a high proportion of people in England (59%) state that they are Christian (ONS mid 2012 figures), it is important for providers of health and social care not to make assumptions about the religion of people based upon ethnicity. For example, although 68% of people of Muslim faith are from the Asian/Asian British ethnic group, 32% are not: 10% are from the Black African/Caribbean British group for example, and this is particularly relevant to delivering care appropriate to people's individual religious background. Food preparation and choice is an example where this would be important to consider.

The Equality and Human Rights Commission has produced guidance on religion and belief in health and social care and people's rights under equality legislation, and gives particular examples of where discrimination could take place in health and social care.

Figure 7: Religion by ethnic group – Census 2011



Case study 4: Patients' religion and belief in hospital

Before inspecting an NHS acute hospital trust, we looked at a range of information that we held about it. As a result of this, inspectors focused on equality and diversity when checking several regulations and whether the trust was meeting them. They found that although patients' religious and cultural needs had been properly assessed, the trust needed to improve how staff communicated this information when the patients moved between wards.

Our specific work on equality on the grounds of religion and belief

We have:

- ✓ Engaged with faith groups through our SpeakOut network and at listening events for inspections of NHS acute hospitals, including Orthodox Jewish groups and groups of people with ethical beliefs, such as Vegetarians for Life.
- ✓ Looked at issues about religion and belief during inspections of health and social care services, for example around food and meals and meeting people's spiritual and belief needs when they are terminally ill.
- ✓ Provided a room for prayer and quiet reflection in our London offices.

1.7 Age equality

Background

The ONS population statistics for mid-2012 show differences in age profiles between men and women. In mid-2012, the population of England was 53,493,729, of which 49.2% were male, and 50.8% were female.

- 10.1 million people (18.9% of the population) were aged between 0 to 15, of which, 51.2% were male and 48.8% were female.
- More than 9 million people (16.9% of the total population) were aged over 65, of which, 44.8% were male and 55.2% were female.

We know that older people use inpatient hospital services more than other adults: 16.9% of people in England are older people (aged 65 or over).

In 2012-13, older people accounted for:

- 36.9% of acute hospital inpatient attendances
- 37.4% of inpatient attendances in mental health and learning disability hospitals, and
- 21.2% of Accident and Emergency (A&E) episodes.

Children aged between 0 to 15 represent 18.9% of the population.

In 2012-13, children accounted for:

- 21.1% of A&E attendances, of which, 55.5% were males and 44.5% were females
- 11.9% of acute hospital attendances, of which, 54% were males and 46% were females
- 13.3% of mental health trust attendances, of which 55.6% were males and 44.3% were females.

As people's life expectancy rises, there are changing trends in the age of death, with more deaths in people aged 85 and over, and proportionately fewer in people aged 65 to 84. People in the older age group have a greater likelihood of frailty and multiple long-term health conditions, so are more likely to need the health and social care services that we regulate.

Older people also make up the majority of people using CQC-regulated social care services. Our data at March 2013 showed that there were 398,497 places in care homes designated for older people. This was 81.3% of all places in care homes where the age range is known.

Meeting our equality objectives 5: Ensuring staff have the tools and training that they need around equality

CQC already has a training tool that we make available to staff to use in practical discussions about equality and human rights – the 'Equally Yours' board game. All teams used this two years ago, and we have used this as part of the induction programme for all new staff since then. We also provide equality and human rights e-learning, which all staff must complete, including new staff joining CQC. It is also available as a resource for staff to refresh their knowledge.

As part of the development of the CQC Academy, which provides training and learning for our staff, we are committed to carrying out equality impact assessments of all training and learning offered. Equality and human rights will be at the forefront of the planning and we continue to learn from feedback from the staff survey, staff forums and any other sources so that we continuously improve our commitment to equality and human rights principles, best practice and ways of working.

We are developing a peer learning approach to informal learning about equality and human rights for inspection staff. This involves collecting examples of good practice from inspectors about how to look at equality and human rights issues during inspections, and sharing this nationally through our staff intranet and through regional equality and human rights leads.

A sub group of eQuality Voices has been monitoring our progress on this objective. Its members include people with direct experience of using the learning, development and tools on inspections, as they are Experts by Experience and are involved in inspection teams themselves, for example in the first wave of NHS acute hospital inspections.

The monitoring sub group remains generally supportive of the new approach to inspecting acute hospitals, which includes having larger inspection teams that involve more Experts by Experience, and they feel that getting 'the voice of people who use services' into inspections is essential to applying equality and human rights principles.

The group feels that the reference material for the first wave of inspections did contain plenty references to the principles of equality and human rights, but their experience of inspections to date does not make them confident that these principles are applied consistently in practice. Much depends on how inspection team members understand and apply equality and human rights. It is right that more clinical staff are involved in inspecting hospitals as clinical issues are key, however, this can lead to a focus on issues in the questions 'is the service caring?' and 'is it responsive?', such as pressures on staff availability, staff grading, and referral and waiting times, rather than issues that relate to patients as individuals, including equality issues. The group recognise that it is early days in the development of the new model, as the new regulations and guidance are not yet fully in place, but they are keen that we start work to meet the training needs of inspection teams around equality and human rights.

Our specific work on equality on the grounds of age

We have:

- ✓ Undertaken a themed inspection programme of the quality of care provided to older people in their own homes, following the inquiry by the Equality and Human Rights Commission into the human rights of older people using home care services. We inspected a sample of 250 home care services providing care to more than 26,000 people. As well as having an impact on the services that we inspected, we produced a national report *Not just a number*, which included recommendations around key themes: late or missed calls, continuity of care workers, supporting staff, care planning and safeguarding and safety.
- ✓ Published two reports about dignity and nutrition on older people's wards in hospitals and in care homes, *Time to Listen in NHS hospitals* and *Time to listen in care homes* following a series of inspections on this theme carried out in 2012.
- ✓ Published an updated position statement and five-year action plan for older people and people with dementia.
- ✓ Produced guidance for compliance inspectors on how to communicate with people, including a specific section on communicating with people with dementia.
- ✓ Indicated our intent to include how GP services meet the needs of people aged over 75 with complex health needs in our future inspections of these services. We will also include how GPs meet the needs of children.
- ✓ Provided face-to-face training to every member of CQC staff around issues for people with dementia, including using a rights-based perspective and good practice in communicating with people with dementia. Though this is also a disability equality issue, it also has a major impact on age equality.
- ✓ Launched a thematic review of admission to hospitals from care homes in April 2013. It is our first thematic review to focus primarily on adult social care providers and will draw together existing information to present a detailed picture of emergency hospital admissions, A&E attendances and non-attendance at outpatient appointments from care homes.
- ✓ Involved children and young people in consultations about our new ways of working and our corporate strategy.
- ✓ Carried out a themed inspection programme of the transition arrangements for children with complex health needs who move from children's health services to adult services.
- ✓ Launched a programme of children looked after and safeguarding (CLAS) reviews to look at the quality and effectiveness of the arrangements that health care services have made to ensure children are safeguarded and how health services promote the health and wellbeing of looked after children and care leavers.
- ✓

1.8 Equality for transgender people

Background

There is little data about the size of the transgender population or how many transgender people use health and social care services.

However, The Gender Identity Research and Education Society (GIRES) estimate that around 1% of the population is 'gender variant' to some degree, although not all will seek medical treatment. The number of people seeking treatment is increasing at around 11% each year. The Trans Mental health and wellbeing study published by GIRES in September 2012 focuses on issues that affect transgender people and their health.

- 70% of the participants were more satisfied with their lives since transitioning and only 2% were less satisfied.
- 85% were more satisfied with their body since undertaking hormone therapy, 87% were more satisfied after non-genital surgery and 90% after genital surgery.
- 45% used mental health services more before transition, 18% more during, and none used mental health services more post-transition.
- 74% felt that their mental health had improved as a result of transitioning.

The Government has been working on a cross-government transgender plan and engaging with transgender people about their health issues.

The Equality and Human Rights Commission have analysed commissioning and provision of gender identity services and looked at best practice.

Our specific work on equality for transgender people

We have:

- ✓ Systematically reviewed the intelligence that we hold on each gender identity clinic in England and fed this information back to the inspector responsible for each service.
- ✓ Engaged and involved transgender people in our consultation on the strategic review.
- ✓ Involved transgender people in our eQuality Voices group, and SpeakOut network, and as Experts by Experience.

Meeting our equality objectives 6: Improving the information we hold on risks to equality in the organisations we regulate

As a stated objective in our business plan, the Intelligence Directorate has been exploring some of the opportunities and challenges involved in improving the equality information and intelligence that we hold about health and social care providers. In 2013, we analysed the equality information that we hold, the gaps in this information and the potential opportunities to address some of those gaps.

We identified the data that we hold, or could develop, that would help us better understand people's experiences around human rights and equalities and determine the risks to their care.

We are developing the analysis to enable us to share information, including the national census, for both local and national level reporting. We have developed a 'demographic tool' that informs inspection teams about the population in a local area, across all the protected characteristics.

We have also explored new data sources such as data on unlawful discrimination shared through our relationship with the Equality and Human Rights Commission.

We plan to develop our equality data about care services in 2014, including using data sets to look at differences in health outcomes for equality groups such as people with a learning disability who use acute hospital services. We can then analyse these data sets to highlight services within health trusts where the differences might be larger for particular groups of people, to help prioritise what we look at on inspections.

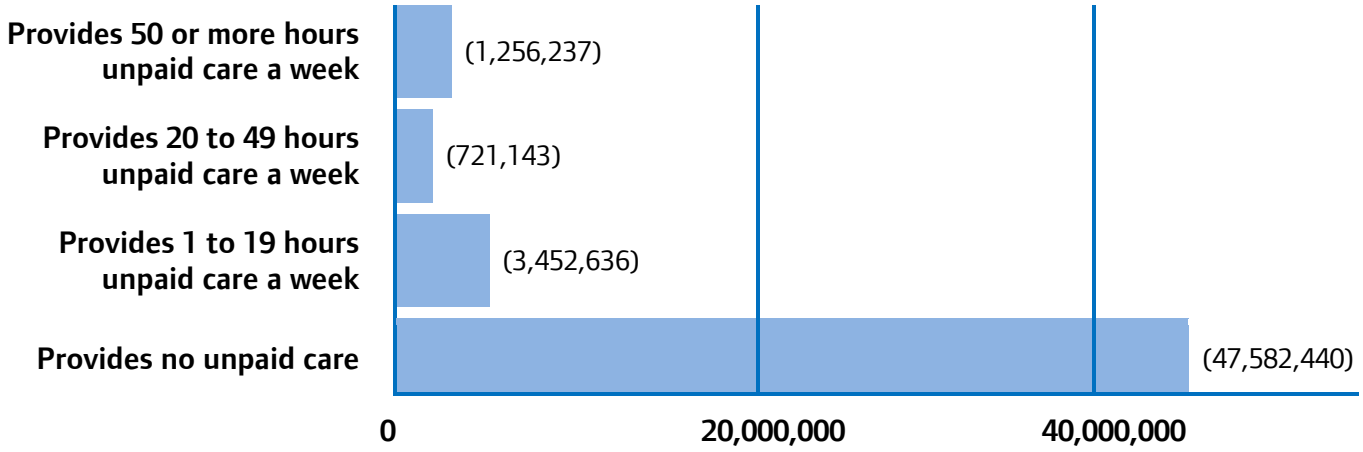
A final area to highlight is our focused qualitative work to better understand what our information can tell us about people's experiences that are difficult to find through national datasets, for example from services for transgender people.

1.9 Equality for carers

Background

At the time of the 2011 census, figures showed that the total number of people providing unpaid care in England was 5,430,016 (10.3% of the population). Of these people, 1,256,237 (2.4%) provided more than 50 hours of unpaid care each (figure 8).

Figure 8: Number of unpaid carers by time spent caring in England (2011 Census)



Source: ONS Census 2011

There are 166,363 young carers in England (Census 2011). One in 12 young carers is providing care for more than 15 hours a week. Around one in 20 misses school because of their caring responsibilities. Young carers are 1.5 times more likely than their peers to be from Black, Asian or minority ethnic communities, and are twice as likely to not speak English as their first language. Young carers are also 1.5 times more likely than their peers to have a special educational need or a disability (Children's society report *Hidden from View-the experiences of young carers in England*).

Being an older carer can have a significant impact upon your health. In a survey of the experiences of older carers carried out by the Princess Royal Trust for Carers in 2011, the report *Always on Call, Always Concerned* stated that more than one in eight people aged over 60 is providing care to somebody they know and almost 70% of the older carers said caring had a negative impact on their physical health. A third (34.2%) reported cancelling a treatment or operation for themselves because of their caring responsibilities and half (49.8%) said that their health had got worse in the last year

Our specific work on equality for people with caring responsibilities

- ✓ We work with Experts by Experience who are carers; they are an important part in our inspections.
- ✓ We consult carers on how we develop our work, for example through the eQuality Voices group and SpeakOut Networks.
- ✓ We carry out some specific work to gather the views of carers about health and social care services, such as partnership working with Regional Voices, Carers Together (Hampshire), Carers Trust (South East region) and the relatives and residents association.
- ✓ Organisations representing carers are involved in some of our ongoing development work of the new inspection model, such as our Adult Social Care external co-production group.
- ✓ Some colleagues have told us that they have caring responsibilities as well as working for CQC. We are working with some volunteers to explore ways in which CQC can support them. We have recently developed a survey for people who have requested support, so they can tell us about their experience.

Case Study 5: Using inspections to ensure that carers have an appropriate voice

We inspected a care home for older people and found that it did not adequately involve people's family carers in planning their care. Our inspectors judged that the care home was not meeting the regulations in this area of care. As a result of our inspection, the provider took action to make sure that people's carers were more actively involved in planning their care.

SECTION 2:
Equality in our workforce

2.1 CQC staff profile

The staff profile shown in table 6 is based on a snapshot of all members of staff working for CQC at 30 September 2013. We also show data from 30 September 2012 to compare how the profile of staff has changed.

To follow good practice in data protection and ensure personal privacy, we have combined some categories so that there are at least 10 people in each category. This helps to protect the anonymity of staff.

The overall number of CQC staff increased from 2,018 on 30 September 2012 to 2,133 on 30 September 2013. In 2013, we collected fresh equality monitoring information from every member of staff, and explained the purpose of this work in communications to staff. The results of this monitoring exercise have largely increased the overall percentage of staff who have stated their sexual orientation from 53.3% in 2012 to 77.1% in 2013. The percentage of staff where religion and belief is known increased from 40.1% in 2012 to 66.7% in 2013.

Gender

Women make up 68.8% of CQC's workforce, very similar to last year's figure of 69%. Many employees join CQC from other health and social care employers, which, as a sector, traditionally employs more women than men.

Ethnicity

The monitoring update project has also helped to reduce some of the percentages in previously used non-standard categories, such as 'White unspecified', therefore reducing the percentage of staff who identify as 'White other' from 16.3% to 5.9%. Looking only at clearly defined categories (White Irish, Mixed Race, Asian and Asian British, Black and Black British and Chinese), the percentage of Black and minority ethnic staff has increased from 11.6% to 12.3%. There have been slight rises in the percentage of Black and Black British, Asian and mixed race staff and a larger rise in White Irish staff – though this has been offset by a fall in staff in 'any other ethnic group', which might be caused by the monitoring update work. The proportion of staff whose ethnicity is not known has decreased from 10.7% to 7.4%.

Disability

There was a large increase in the number of staff who indicated that they are disabled people – up from 110 in 2012 to 165 in 2013, representing a percentage increase from 5.5 to 7.2% of staff identifying as disabled people. This increase may include staff joining CQC and existing staff who have acquired an impairment and have updated their information through the equality monitoring update project.

However, the number of CQC staff identifying as disabled people (7.2%) is still low compared to the estimated 13% of public sector workers that are disabled people and the number of disabled employees in the UK workforce overall (10.5%) (Office for National Statistics, *Labour market status of disabled people,* May 2013).

However, the percentage of staff whose disability status is 'not known' also increased from 4.9% in 2012 to 9.4% of staff in 2013. Some of these will be new starters who have not completed monitoring, where the percentage of 'not known' is even higher (see table 7). However, some disabled staff may be reluctant to declare that they are a disabled person for a number of reasons. We hope to continue to address these reasons by promoting good practice in supporting disabled staff, such as through our reasonable adjustments survey, the recruitment equality audit and supporting the Disability Equality Network.

Sexual orientation

We do not know the sexual orientation of 22.9% of our workforce, a decrease from 45.7% last year. Of the staff whose sexual orientation is known, lesbian, gay and bisexual staff make up 5.6%, which is a slight increase on 5.2% last year.

Religion and belief

We do not know the religion and belief of 33.3% of our workforce. However, following the monitoring update this is down from 59.9% last year. Christians make up 63.9% of the staff whose religion is known; in 2012 this figure was 70.4%. Where religion is known, the percentage of atheists has risen from 8.7% to 18.6% and for non-Christian religions the figure has decreased from 8% to 6.9%.

Age

The proportion of people aged under 25 who work for CQC is lower than in the national population. This may be because the majority of our job roles are in inspection, which require significant relevant experience. Both the number and percentage of staff under 25 have decreased in the past year, for the second year running. Some of this change will be caused by existing staff turning 25, as the percentage of staff aged 26 to 30 has increased. The percentage of staff aged 41 to 50 has decreased by 1.8%. Though the overall number of staff in this age range has increased, it is a smaller increase in number than the increase in other age ranges.

Carer status

In the 2013 staff survey, 37% of staff indicated that they had some caring responsibilities: 23% of employees had caring responsibilities for children, compared to 27% in 2012, and 3% of staff had primary care responsibilities for an adult aged 18-65; 7% had primary care responsibilities for an adult aged over 65 and 11% had secondary caring responsibilities.

Table 6: CQC staff profile

Gender	Number of staff Sept 2013	% total staff Sept 2013	Number of staff Sept 2012	% total staff Sept 2012	Change in staff % from 2012
Female	1,536	68.8	1,393	69.0	-0.2
Male	697	31.2	625	31.0	0.2
Total	**2,233**		**2,018**		

Age	Number of staff Sept 2013	% total staff Sept 2013	Number of staff Sept 2012	% total staff Sept 2012	Change in staff % from 2012
Under 25	52	2.3	64	3.2	-0.9
26-30	225	10.1	185	9.2	0.9
31-35	259	11.6	226	11.2	0.4
36-40	236	10.6	222	11.0	-0.4
41-45	287	12.9	266	13.2	-0.3
46-50	376	16.8	370	18.3	-1.5
51-55	414	18.5	375	18.6	-0.1
56-60	284	12.7	228	11.3	1.4
61+	100	4.5	82	4.1	0.4
Total	**2,233**		**2,018**		

Ethnicity	Number of staff Sept 2013	% total staff Sept 2013	Number of staff Sept 2012	% total staff Sept 2012	Change in staff % from 2012
White - UK	1,650	73.9	1,221	60.5	13.4
White - Irish	45	2.0	33	1.6	0.4
White (not UK or Irish - includes White unspecified)	132	5.9	328	16.3	-10.4
White total	1,827	81.8	1,582	78.4	3.4
Mixed race (dual heritage) total	26	1.2	23	1.1	0.1
Asian and Asian British total	89	4.0	79	3.9	0.1
Black and Black British total	106	4.8	91	4.5	0.3
Any other ethnic group (including Chinese)	19	0.9	27	1.3	-0.4
BME total (mixed race, Asian and Asian British, Black and Black British, Chinese and Irish people)	274	12.3	235	11.6	-0.8
Not known	166	7.4	216	10.7	-3.3
Total	**2,233**		**2,018**		

Disabled person	Number of staff Sept 2013	% total staff Sept 2013	Number of staff Sept 2012	% total staff Sept 2012	Change in staff % from 2012
No	1,862	83.4	1,809	89.6	-6.2
Yes	161	7.2	110	5.5	1.7
Not known	210	9.4	99	4.9	4.5
Total	**2,233**		**2,018**		

Sexual orientation	Number of staff Sept 2013	% total staff Sept 2013	Number of staff Sept 2012	% total staff Sept 2012	Change in staff % from 2012
Lesbian, gay or bisexual	95	4.3	56	2.8	1.5
Heterosexual	1,626	72.8	1,020	50.5	22.3
I do not wish to disclose my sexual orientation	248	11.1	162	8.0	3.1
Not known	264	11.8	780	38.7	-26.9
Total	**2,233**		**2,018**		

Religion and belief	Number of staff Sept 2013	% total staff Sept 2013	Number of staff Sept 2012	% total staff Sept 2012	Change in staff % from 2012
Atheism	277	12.4	71	3.5	8.9
Christianity	953	42.7	571	28.3	14.4
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism)	102	4.6	64	3.2	1.4
Other	158	7.1	104	5.2	1.9
I do not wish to disclose my religion/belief	373	16.7	96	4.8	11.9
Not known	370	16.6	1,112	55.1	-38.5
Total	**2,233**		**2,018**		

2.2 Staff joining CQC

Table 7 shows the monitoring data for 383 new members of staff who joined CQC between 1 October 2012 and 30 September 2013. This overall figure was up very slightly from 375 staff who joined CQC in the previous year.

To follow good practice in data protection and ensure personal privacy, we combined some categories so that there are at least 10 people in each category. This helps to protect anonymity of staff monitoring data.

Gender

Males made up 36% of new starters, but represent only 30% of in-post staff – this is a statistically significant difference.[1] Recruitment is contributing to a slow change in the overall gender balance in the workforce towards a more equal number of men and women.

Ethnicity

The percentage of new staff whose ethnicity is unknown is high at 34.5%, which is higher than the 'unknowns' for disability and sexual orientation. This makes analysis somewhat approximate. However, the percentage of new starters who said that they were from non-White backgrounds, as a percentage where ethnicity is known, is 14.8%, compared to an overall workforce percentage of 9.7%. So recruitment of people from non-White UK backgrounds may be similar to or higher than these groups in the workforce overall. However, this does not mean that BME people fare equally well in recruitment with their White UK counterparts, as this depends on the proportion of BME people who apply to CQC (see page 62).

Disability

Of the 383 new starters in the year, 20 were disabled people. If 'not knowns' are discounted, this represents 6.1% of new starters, lower than the overall workforce figure for disabled staff where disability status is known (7.9%), though this difference is not statistically significant. If we are going to increase the overall percentage of disabled staff, we need to recruit a higher percentage of disabled people in the future.

Sexual orientation

Of the new staff that declared their sexual orientation, 24 (8.5%) identified as lesbian, gay or bisexual. This percentage is higher than lesbian, gay and bisexual people in the workforce overall (5.6%). It may be that some of the work to become an employer of choice for LGB people, such as our Stonewall Diversity Champion work, is starting to have an impact.

Religion and belief

Of the staff joining during the year who stated their religion, 70.4% were Christians. This is higher than the equivalent percentage of Christians in the overall workforce (63.9%). The percentage of new starters who practise other religions or are atheists was lower than in the overall workforce, though these differences were not statistically significant.

[1] All the analytical results described as 'statistically significant' are the result of chi-square contingency tests, which are useful for detecting correlations between two categorical variables.

Age

The profile of staff who joined CQC in the year is younger than the overall staff profile. As in the previous, there is a higher percentage of new staff in all age groups up to age 40 compared to existing staff. Individuals aged under 26 made up 7% of starters, but make up only 1.7% of in-post staff, which is a statistically significant difference. However, this year a higher percentage of staff aged 51and over joined CQC, up from 19.7% to 24%, although this is, unsurprisingly, still lower than the percentage of staff in this age group in the workforce as a whole.

Meeting our equality objectives 7: Ensuring a diverse workforce at CQC

Early in 2013, we decided that we would aim to attain a 'Diversity in Business Award' as an optional addition to the Investors in People Award. We commissioned an independent firm to undertake a 'diagnostic' to show us where we needed to improve our practice to meet DiBA standards.

One area identified was that we needed to monitor equality in recruitment more effectively and to take action as a result of the monitoring. We have launched a project to audit our recruitment policy, practices and outcomes for equality, working in partnership with our three staff equality networks covering race, disability and sexual orientation and gender identity. The recruitment audit will be complete in early 2014.

In the meantime, the Race Equality Network has continued work to encourage more Black and minority leaders in CQC as one of its priorities, including for example, holding a question and answer session with prominent Black leaders as part of Black History Month.

We have also supported CQC staff to attend the Calibre, Shine and Stonewall Leadership programmes for Black and minority ethnic, disabled and lesbian, gay and bisexual staff who want to move into leadership positions.

Table 7: Staff joining CQC from 1 October 2012 to 30 September 2013

	Total new staff during the year	% new staff during the year	% total staff at 30 September 2013	% new staff in previous year
Gender				
Female	242	63.2	68.8	60.0
Male	141	36.8	31.2	40.0
Total	**383**			
Ethnicity				
White (including White Irish and White other)	214	55.9	81.8	48.3
Black and minority ethnic people (Black, Asian, Mixed race and any other group)	37	9.7	10.9	14.4
Not known	132	34.5	7.4	37.3
Total	**383**			
Disabled person				
No	304	79.4	83.4	89.1
Yes	20	5.2	7.2	5.6
Not known	59	15.4	9.4	5.3
Total	**383**			
Sexual orientation				
Lesbian, gay or bisexual	24	6.3	4.3	3.5
Heterosexual	260	67.9	72.8	65.6
I do not wish to disclose my sexual orientation	18	4.7	11.1	12.5
Not known	81	21.2	11.8	18.4
Total	**383**			

	Total new staff during the year	% new staff during the year	% total staff at 30 September 2013	% new staff in previous year
Religion and belief				
Atheism	32	8.4	12.4	2.1
Christianity	174	45.4	42.7	48.8
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism) plus other	41	10.7	11.7	8.0
Do not wish to disclose	36	9.4	16.7	14.1
Not known	100	26.1	16.6	26.9
Total	**383**			
Age				
Under 25	26	6.8	2.3	6.1
26-30	67	17.5	10.1	16.0
31-35	45	11.8	11.6	13.6
36-40	42	11.0	10.6	14.9
41-50	111	29.0	29.7	29.9
51+	92	24.0	35.7	19.7
Total	**383**			

2.3 Staff leaving CQC

Table 8 shows the profile from monitoring data for 101 staff who left CQC between 1 October 2012 and 30 September 2013. This overall figure was down from 141 in the previous year and 175 in the year before that, showing that overall staff retention rates are improving. To follow good practice in data protection and ensure personal privacy, we combined some categories so that there are at least 10 people in each category. This helps to protect anonymity of staff monitoring data.

Gender

Retention of male staff has decreased slightly since last year; men now make up 39.5% of leavers compared to 36.9% last year. As 36.8% of staff joining CQC were men (table 7) and men make up only 31.2% of the overall workforce, this suggests a slightly higher turnover of male staff, though the number of men leaving compared to women is not statistically significant.

Ethnicity

The number of BME staff leaving CQC is in line with expected numbers; BME staff make up 10.9% of all staff and 9% of staff leaving CQC.

Disability

Twelve per cent of staff leaving were disabled people, which is higher than statistically expected because only 7.2% of the overall workforce are disabled people. We may need to find out the reasons for these figures, which suggest lower retention of disabled staff. It is important to note that there may be factors other than disability discrimination that have caused or contributed to this difference. For example, there is a higher proportion of disabled staff in older age groups, so the number of disabled staff retiring might be higher than the number of non-disabled staff.

Sexual orientation

Of the staff who left CQC, 7.2% were lesbian, gay or bisexual, which is higher than expected because LGB staff make up only 4.3% of total staff, though these figures are not statistically significant. Again, work may be needed to find out the reasons for these figures, which may suggest lower retention of LGB staff.

Religion and belief

Of the staff who left CQC who had completed monitoring on religion and belief, 70.9% were Christians, which is higher than the percentage in the workforce overall. Where religion is known, 12.8% were atheists, which is lower than might be expected from overall figures. While these differences are not statistically significant, the difference could be age-related in that more people approaching retirement might be Christians rather than atheists.

Age

The 'leaver rate' is unsurprisingly higher among older staff because of retirement. Staff aged over 50 make up only 37% of staff in-post, but 49% of leavers. Compared to previous years, the retention of younger staff has improved; 12.4% of staff are under 30, and this age group makes up 10.2% of staff leaving CQC compared to 18.5% last year. This may be due to better support for younger staff at CQC or fewer external job opportunities.

Table 8: Staff leaving CQC from 1 October 2012 to 30 September 2013

Publishable data - no category <10	Total number of staff leaving CQC	% staff leaving	% total staff	% staff leaving in previous year
Gender				
Female	101	60.5	68.8	63.1
Male	66	39.5	31.2	36.9
Total	**167**			
Ethnicity				
White (including White Irish and white other)	125	74.9	81.8	59.6
Black and minority ethnic people (Black, Asian, Mixed Race and any other group)	15	9.0	10.9	12.1
Not known	27	16.2	7.4	28.3
Total	**167**			
Disabled person				
No	134	80.2	83.4	87.9
Yes	20	12.0	7.2	N/A
Not known	13	7.8	9.4	6.6
Total	**167**			
Sexual orientation				
Lesbian, gay or bisexual	12	7.2	4.3	N/A
Heterosexual	97	58.1	72.8	54.6
I do not wish to disclose my sexual orientation	13	7.8	11.1	8.5
Not known	45	26.9	11.8	36.2
Total	**167**			

Publishable data - no category <10	Total number of staff leaving CQC	% staff leaving	% total staff	% staff leaving in previous year
Religion and belief				
Atheism	11	6.6	12.4	N/A
Christianity	61	36.5	42.7	24.8
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism) and other	14	8.4	11.6	9.2
Do not wish to disclose/not known	81	48.5	33.3	63.1
Total	**167**			
Age				
Under 30	17	10.2	12.4	18.5
31-35	13	7.8	11.6	9.2
36-40	13	7.8	10.6	7.1
41-45	19	11.4	12.9	13.5
46-50	28	16.8	16.8	N/A
51-55	28	16.8	18.5	9.2
56-60	26	15.6	12.7	17.7
61 and over	23	13.8	4.5	17.8
Total	**167**			

2.4 Staff profile by pay grade

This is the second report that we have been able to publish in relation to pay grade and equality following the Job Evaluation and reward project that brought all CQC staff onto a unified grading system in 2012.

The overall totals in these tables are slightly different to previous tables. This is because 23 staff are outside the normal grading structure (nine staff were outside the normal grading structure last year).

The majority of staff (57.5%) are in pay band B. This is because band B includes all inspectors, who make up a large group in our workforce.

We are unable to present data on the profile by pay grade for staff with caring responsibilities as we cannot store this data on our electronic staff record system, which is a nationally procured system used in the NHS, so amending the system is out of our control.

Pay grade by gender

Table 9a on the next page shows the distribution of female and male staff in each pay band. This data is not an equal pay audit; it is not looking at equal pay for equal work but at distribution of staff across pay bands by gender.

There is a higher proportion of male staff (7.8%) compared to female staff (5.5%) in the lowest pay grade (band G), though this difference is not statistically significant.

A higher proportion of men are in executive grades than women (3.1% of male staff compared to 2.1% of female staff), though this difference is not statistically significant.

The only pay band where there is a statistically significant difference in gender distribution is pay band C, where there are more men than would be expected from the overall gender ratio in CQC. This may be related to the types of roles that fall in band C, for example, analyst roles, where there tend to be a higher number of men.

Table 9a: Pay grade by gender

	Description of band	Pay range outside London	Female	% female staff in this pay band	Male	% male staff in this pay band	Total	% total staff in this pay band
Band G	Administrative support positions	£14,948 - £16,059	84	5.5	53	7.8	137	6.2
Band F	Most administrative positions	£18,988 - £21,109	117	7.7	46	6.8	163	7.4
Band E	More complex administrative positions	£22,018 - £24,442	42	2.8	15	2.2	57	2.6
Band D	Technical: Supervisory, team leaders, first-line management, advisory positions	£24,745 - £27,876	78	5.1	46	6.8	124	5.6
Band C	Professional: Policy development, middle management positions, more complex advisory positions	£29,442 - £33,835	85	5.6	68	10.0	153	6.9
Band B	More complex, broad middle management positions: Inspectors, Senior specialists, Senior policy, professional and advisory leads	£36,966 - £43,784	911	59.6	359	52.7	1,270	57.5
Band A	Senior management positions: Complex specialist, professional and policy lead positions	£49,490 - £58,580	180	11.8	73	10.7	253	11.5
Exec 1, 2, 3	Heads of function, deputy directors, executive directors	£70,000 +	32	2.1	21	3.1	53	2.4
Total staff			**1,529**	**100.0**	**681**	**100.0**	**2,210**	**100.0**

Pay grade by ethnicity

We have combined some categories to protect the anonymity of individual staff. Because there is at least one Black or minority ethnic (BME) member of staff in each pay band, and the ethnicity for some staff in each band is 'not known', it is not possible to determine the ethnicity of an individual member of staff from this data, so we have included all the figures, including categories with less than 10 staff.

A higher percentage of non-BME staff are in the lowest grade (band G). One reason may be that many band G posts are based at our customer service centre in Newcastle upon Tyne – a city with a low BME population.

For the inspector band (band B), there are similar percentages of BME staff (55.5%) and non-BME staff (58%).

In band A, White British staff make up 12.5% compared to 7% of BME staff. Although the percentage of BME staff has risen in this band since 2012, so has the percentage of White British staff, and there is still a statistically significant difference. Only 0.7% of BME staff are at executive grades (an increase from 0.5% last year), compared to 2.6% of White British staff (a decrease from 2.9% last year).

This means that while BME people make up 12.3% of CQC staff overall, only 7.5% of Band A positions and 3.8% of executive grade positions are filled by BME staff.

CQC is committed to recruiting more BME staff to higher management grades; page 46 outlines current work on career progression for BME staff.

Table 9b: Pay band by ethnicity

Pay band	Non-BME staff	% Non-BME staff	BME staff (White Irish, mixed race, Asian and Black/Black British/Chinese)	% BME staff	Ethnicity not known	% not known	Total staff	% total staff in this pay band
Band G	110	**6.2**	11	**4.0**	16	10.4	137	6.2
Band F	124	**7.0**	27	**9.9**	12	7.8	163	7.4
Band E	44	**2.5**	8	**2.9**	5	3.3	57	2.6
Band D	93	**5.2**	21	**7.7**	10	6.5	124	5.6
Band C	109	**6.1**	34	**12.4**	10	6.5	153	6.9
Band B	1,034	**58.0**	152	**55.5**	84	54.6	1,270	57.5
Band A	222	**12.5**	19	**6.9**	12	7.8	253	11.5
Exec 1, 2, 3	46	**2.6**	2	**0.7**	5	3.3	53	2.4
Total staff	**1,782**	**100**	**274**	**100.0**	**154**	**100.0**	**2,210**	**100.0**

Pay grade by disability

There were no statistically significant differences between disabled and non-disabled staff across pay bands. A higher percentage of disabled staff are in band B than would be expected: 69.8% of disabled staff are in this band compared to 56.4% of non-disabled staff, but this is not statistically significant. There are fewer disabled staff in grades below B than might be expected – only around 20% of disabled staff are in these grades compared to around 30% of non-disabled staff. These figures are similar to last year.

Disabled staff are under-represented at management grades, though this is also not statistically significant. The three disabled staff in executive grades only represent 5.7% of staff in executive grades. In band A, there are only 13 disabled staff out of 253, representing 5.1% of staff at this grade, whereas in CQC overall, 7.2% of staff are disabled people.

Table 9c: Pay band by disability

Pay band	Non-disabled staff	% Non-disabled staff	Disabled staff	% disabled staff	Not known	% not known	Total staff	% of total staff in this pay band
Band G	113	6.1	6	3.8	18	9.2	137	6.2
Band F	145	7.8	6	3.8	12	6.2	163	7.4
Band E	49	2.6	4	2.5	4	2.1	57	2.6
Band D	106	5.7	7	4.4	11	5.6	124	5.6
Band C	130	7.0	9	5.7	14	7.2	153	6.9
Band B	1,047	56.4	111	69.8	112	57.4	1,270	57.5
Band A	221	11.9	13	8.2	19	9.7	253	11.5
Exec 1, 2, 3	45	2.4	3	1.9	5	2.6	53	2.4
Total staff	**1,856**	**100.0**	**159**	**100.0**	**195**	**100.0**	**2,210**	**100.0**

Pay grade by sexual orientation

To protect the anonymity of individual members of staff we have grouped the pay bands into those below band B, band B and those above band B. There is a higher percentage of lesbian, gay and bisexual (LGB) staff in the higher pay bands than heterosexual staff: 22.1% of LGB staff are in band A or executive grades compared to only 13% of heterosexual staff, though this gap has closed slightly since last year when the equivalent figures were 23.6% and 10.0%. This difference is still statistically significant.

However, the impact of this in relation to LGB equality may be affected by how confident LGB senior staff are to 'come out' and we do not collect data on whether staff at different grades are 'out' at work. The number of LGB staff below band B is also lower than would be expected – and this is also statistically significant.

Table 9d: Pay band by sexual orientation

Sexual orientation	Number of staff below band B	% staff below band B	Number of staff in band B	% staff in band B	Number of staff above band B	% staff above band B	Total staff	Total %
Lesbian, Gay or Bisexual	17	17.9	57	60.0	21	22.1	95	100.0
Heterosexual	488	30.2	918	56.8	210	13.0	1616	100.0
Not known/do not wish to disclose	129	25.9	295	59.1	75	15.0	499	100.0
Total staff	**634**	**28.7**	**1,270**	**57.5**	**306**	**13.9**	**2,210**	**100.0**

Pay grade by religion and belief

To protect the anonymity of individual members of staff, we have grouped the pay bands into: those below band B, band B and those above band B. Only 4.9% of staff practising non-Christian religions are in band A and above, which is lower than would be expected from the overall staff profile, for example 16.3% of atheists and 13.4% of Christians are in these pay bands. This difference is statistically significant. The low number of Christians below band B is also statistically significant. There are more staff practising non-Christian religions than would be expected in pay bands below B, with 38.2% falling into this pay band compared to 25% of Christians and 30.1% of atheists. This is statistically significant.

Table 9e: Pay band by religion and belief

Religion	Number of staff below band B	% staff below band B	Number of staff in band B	% staff in band B	Number of staff above band B	% staff above band B	Total staff	Total %
Atheism	83	30.1	148	53.6	45	16.3	276	100.0
Christianity	237	25.0	586	61.7	127	13.4	950	100.0
Buddhism, Hinduism, Islam, Judaism, Sikhism	39	38.2	58	56.9	5	4.9	102	100.0
Other	58	36.9	82	52.2	17	10.8	157	100.0
Not known	217	29.9	396	54.6	112	15.5	725	100.0
Total staff	**634**	**28.7**	**1,270**	**57.5**	**306**	**13.9**	**2,210**	**100.0**

Pay grade by age

Younger workers are concentrated in the lower pay bands, with only 7.7% of staff aged under 25 in band B or higher. However, at the same date last year, over three quarters of staff aged under 25 years were in the lowest two pay bands and this has decreased to around 23%, though this is still a statistically significant difference. The change from last year is due to an increase in younger staff in pay bands E to C, which increased from nine members of staff to 36. The overall profile has changed slightly from last year: at 30 September 2012 15.9% of all staff were in the lowest two pay bands compared to 12.4% at the same date in 2013.

In contrast, 86.8% of staff aged over 50 are in band B and above, compared to 71.4% of all staff at 30 September 2012. However, there are no statistically significant differences between staff aged 26-50 and staff aged over 50 in respect to pay band A or executive grades.

Table 9f: Pay band by age

	Under 25 years	% staff under 25 years	26-50 years	% staff 26-50 years	Over 50 years	% staff over 50 years	Total	% total staff in this pay band
Band G	1	1.9	128	9.3	24	3.1	153	6.9
Band F	11	21.2	94	6.8	19	2.4	124	5.6
Band E	3	5.8	46	3.3	8	1.0	57	2.6
Band D	13	25	122	8.8	28	3.6	163	7.4
Band C	20	38.5	93	6.7	24	3.1	137	6.2
Band B	4	7.7	712	51.6	554	71.2	1,270	57.5
Band A	0	0.0	152	11.0	101	13.0	253	11.5
Exec 1, 2, 3	0	0.0	33	2.4	20	2.6	53	2.4
Total staff	**52**	**100.0**	**1,380**	**100.0**	**778**	**100.0**	**2,210**	**100.0**

2.5 Equality in recruitment

This is the first year that we have been able to report equality in recruitment. CQC uses the NHS Jobs website for the majority of recruitment exercises, which enables us to monitor equality of applicants for job roles. The tables on the following pages show data on:

- applicants and shortlisted candidates for 1 October 2012 to 30 September 2013 using data taken from NHS jobs website, and
- successful applicants for 1 November 2012 to 31 October 2013 using data taken from our electronic staff records (similar to the 'new starters' data in 2.2).

The need to use two data sets means that although the comparison between applicants and shortlisted candidates is straightforward, the comparison between applicants/shortlisted candidates and successful applicants can only ever be an approximation. This is because:

- The two data sets do not directly correspond with each other because of the time delay between applications and appointments. We have made some allowance for this by using two different periods for the data – assuming that it may take one month between shortlisting and appointment. However, the time delays will vary considerably between individual recruitment exercises.
- People in the 'undisclosed' category at application stage may be in a different category at appointment stage, and vice versa.
- We do not know how many individuals have applied for more than one role.
- Some recruitment exercises on NHS Jobs were for more than one role, whereas others may not have resulted in a successful appointment, for example, if no candidates were deemed suitable for appointment.

Another limiting factor in this data is that some posts – particularly very senior posts – are not recruited through NHS Jobs but through external recruitment agencies. CQC does not receive equality monitoring from these recruitment exercises in a consistent format that can be added to the main data set.

For future years, we will explore whether we can make a better link between the equality monitoring on NHS Jobs and successful applicants. We will also look at how we can ensure better reporting of equality monitoring when we use external agencies.

We are not able to present data on the recruitment for staff with caring responsibilities, as we are not able to collect or store this data on the NHS Jobs system or our electronic staff record system, which are both nationally procured systems used in the NHS, so amending the system is not in our control.

Recruitment by gender

In theory, if men and women had the same 'success rates', the percentage of applications, shortlisting and starters in the last three columns in table 10a, should be the same. There were significant but not very large differences among recruitment pools with respect to gender. Males made up 41% of the total applicants, but only 38% of those that were shortlisted and did not start work, and only 36% of those that started work. By contrast, females made up 59% of the total applicants, with 62% being shortlisted but not starting work, and 64% actually starting work.

This suggests that women are slightly more successful than men at securing jobs with CQC. Looking at the first columns in table 10a, if men and women were equally successful, the percentage of applicants shortlisted would be the same, but only 18.3% of men were shortlisted compared to 21.4% of women and only 3.36% of male applicants were appointed compared to 4.19% of female applicants. However, we must be careful about drawing any conclusions about whether sex discrimination is taking place as there might be other factors that explain the lower success rates for men, for example, more men may apply for a certain type of role that tends to attract a higher number of applicants. We can investigate this further in our recruitment audit.

Table 10a: Recruitment by gender

Category	Applied 01.10.12 to 30.09.13	Shortlisted 01.10.12 to 30.09.13	Starters 01.11.12 to 31.10.13	% applications shortlisted	% applications appointed		% applications	% shortlistings	% starters
All	8,239	1,661	316	20.2%	3.84%		100.00%	100.00%	100.00%
Male	3,366	617	113	18.3%	3.36%		40.80%	37.15%	35.76%
Female	4,845	1,039	203	21.4%	4.19%		58.81%	62.55%	64.24%
Undisclosed	28	5	0	17.9%	0.00%		0.34%	0.30%	0.00%

Recruitment by disability

In theory, if disabled and non-disabled people had the same 'success rates', the percentage of applications, shortlisting and starters in the last 3 columns, should be the same. We can see from table 10b that 22.4% of disabled applicants are shortlisted compared to 19.8% of non-disabled applicants. However, only 2.2% of disabled applicants are appointed compared to 3.36% of non-disabled applicants. This is a statistically significant difference.

This suggests that whilst disabled people are at least as successful at getting shortlisted, they are less successful than non-disabled people in getting appointed to jobs at CQC. CQC operates the 'guaranteed interview scheme' for disabled candidates that meet the essential criteria for the role, which might explain why disabled people do not appear to have disadvantage at shortlisting stage. We will do further work in our recruitment equality audit to identify why disabled shortlisted candidates are less successful than non-disabled candidates at securing jobs with CQC. However, it should also be noted that the higher percentage of successful applicants where disability status is 'undisclosed' may have an impact on these figures.

Table 10b: Recruitment by disability

Category	Applied 1.10.12 to 30.9.13	Shortlisted 1.10.12 to 30.9.13	Starters 1.11.12 to 31.10.13	% applications shortlisted	% applications appointed		% applications	% shortlistings	% starters
All	8,239	1,661	316	20.2%	3.84%		100.00%	100.00%	100.00%
Disabled person	540	121	12	22.4%	2.22%		6.55%	7.28%	3.80%
Not disabled person	7,598	1,504	255	19.8%	3.36%		92.22%	90.55%	80.70%
Undisclosed	101	36	49	35.6%	48.51%		1.23%	2.17%	15.51%

Recruitment by ethnicity

Again, if people across all ethnic groups had the same 'success rates', the percentage of applicants shortlisted and appointed should be the same across all ethnic groups. We can see that White candidates were the most successful group in getting shortlisted from their job applications – the percentage of shortlisted candidates who are White was higher than the percentage of applicants who are White – in contrast to all the other ethnic groups. The ethnic group least successful in reaching the shortlisting stage was Asian candidates, with only 14.4% being shortlisted compared to 22.1% of White people. These differences were statistically significant. The lower percentage of Black candidates appointed was also statistically significant.

Comparisons of the percentage of applicants successfully appointed is made more complex by the higher numbers of successful appointees whose ethnicity was 'undisclosed'. However, the figures indicate that White candidates are also most successful, with candidates from Asian and Black backgrounds and 'other ethnic groups' being less successful.

However, we must be careful about drawing any conclusions from this data about whether race discrimination is taking place as there may be other factors that explain the lower success rates for candidates from some ethnic groups. For example, more people from one group may apply for a certain type of role that tends to attract a higher number of applicants. We will do further work in our recruitment equality audit to identify why there are differences in success rates for people from different ethnic groups applying for jobs with CQC.

Table 10c: Recruitment by ethnicity

Category	Applied 01.10.12 to 30.09.13	Shortlisted 01.10.12 to 30.09.13	Starters 01.11.12 to 31.10.13	% applications shortlisted	% applications appointed		% applications	% shortlistings	% starters
All	8,239	1,661	316	20.2%	3.84%		100.00%	100.00%	100.00%
White total	5,651	1,250	177	22.1%	3.1%		68.59%	75.26%	56.01%
Asian total	956	138	12	14.4%	1.26%		11.60%	8.31%	3.80%
Mixed total	163	28	4	17.2%	2.45%		1.98%	1.69%	1.27%
Black total	1,186	195	18	16.4%	1.52%		14.39%	11.74%	5.70%
Other ethnic group total	136	27	0	19.9%	0.00%		1.65%	1.63%	0.00%
Undisclosed	147	23	105	15.6%	71.43%		1.78%	1.38%	33.23%

Recruitment by age

Table 10d shows that success in securing job roles at CQC increases with age. This is perhaps not surprising as, with age, people gain both essential experience and skills required for jobs and more experience in how to be successful in job applications, for example, people improve their job applications and interview techniques through experience. So, while only 11.3% of applicants aged under 25 were shortlisted, 20.6% of applicants aged 26 to 49 years old and 22.1% of applications aged 50 and over were shortlisted.

The percentage of applicants successfully appointed also rises with age. The lower success rates at both stages were statistically significant for applicants aged under 25. To protect anonymity, we have not shown this data in smaller age bands. However 13% of people aged 65 to 69 and 33% of people aged over 70 were successful in obtaining posts, compared to the average of 3.84%.

Table 10d: Recruitment by age

Category	Applied 01.10.12 to 30.09.13	Shortlisted 01.10.12 to 30.09.13	Starters 01.11.12 to 31.10.13	% applications shortlisted	% applications appointed		% applications	% shortlistings	% starters
All	8,239	1,661	316	20.2%	3.84%		100.00%	100.00%	100.00%
Under 25	690	78	16	11.3%	2.32%		8.37%	4.70%	5.06%
26-49	5,844	1,205	225	20.6%	3.85%		70.93%	72.55%	71.20%
50 and over	1,698	375	75	22.1%	4.42%		20.61%	22.58%	23.73%
Undisclosed	7	3	0	42.9%	0.00%		0.08%	0.18%	0.00%

Recruitment by religion and belief

Table 10e shows that, in relation to religion and belief, atheists are the most successful group of applicants to get to the shortlisting stage with 23.5% of applications being shortlisted compared to 19.9% for Christians and 16.1% for non-Christian religions and 'other'. This difference is statistically significant. There is probably a large overlap between applicants from non-Christian religions and Asian applicants, so the low success rate for this group might have been anticipated from the ethnicity results in table 10c. However, it is interesting that Christian applicants were more successful in securing jobs than atheist applicants despite their lower success rate in reaching the shortlisting stage. This could be related to age, as a higher percentage of younger staff identify as atheists.

Table 10e: Recruitment by religion and belief

Category	Applied 01.10.12 to 30.09.13	Shortlisted 01.10.12 to 30.09.13	Starters 01.11.12 to 31.10.13	% applications shortlisted	% applications appointed		% applications	% shortlistings	% starters
All	8,239	1,661	316	20.2%	3.84%		100.00%	100.00%	100.00%
Christianity	4,531	903	144	19.9%	3.18%		54.99%	54.36%	45.57%
Atheism	1,163	273	22	23.5%	1.89%		14.12%	16.44%	6.96%
Non-Christian religions including 'Other'	1,650	265	28	16.1%	1.70%		20.03%	15.95%	8.86%
Undisclosed	895	220	122	24.6%	13.63%		10.86%	13.25%	38.61%

Recruitment by sexual orientation

Table 10f shows that over 5% of lesbian, gay and bisexual candidates are successful at obtaining posts compared to under 3% of heterosexual candidates. However, these figures should be treated with caution due to the low total numbers of lesbian, gay and bisexual candidates compared to those in the 'undisclosed category' – 19 LGB people were appointed during the period compared to 92 'undisclosed'. It is interesting that the percentages shortlisted do not vary greatly between lesbian, gay and bisexual people and heterosexual people, and these are the figures that are taken from the comparable data set. This suggests that either LGB people are more successful at interview stage than their heterosexual peers or that the errors in using the two data sets are too large when comparing a much smaller group (LGB people) to a much larger group (heterosexual people).

Table 10f: Recruitment by sexual orientation

Category	Applied 01.10.12 to 30.09.13	Shortlisted 01.10.12 to 30.09.13	Starters 01.11.12 to 31.10.13	% applications shortlisted	% applications appointed		% applications	% shortlistings	% starters
All	8,239	1,661	316	20.2%	3.84%		100.00%	100.00%	100.00%
Lesbian, gay and bisexual total	363	79	19	21.8%	5.23%		4.41%	4.76%	6.01%
Heterosexual	7,321	1,459	205	19.9%	2.80%		88.86%	87.84%	64.87%
Undisclosed	555	123	92	22.2%	16.58%		6.74%	7.41%	29.11%

2.6 Grievance, disciplinary and bullying and harassment issues

We have committed to a zero-tolerance approach to bullying and harassment. During the year, we have delivered two major projects to act on this commitment:

- An independent review of bullying and harassment in CQC commissioned by our Chief Executive, David Behan. This review was carried out by Sarah Hunter. We published the report on both our public website and our staff intranet.
- The introduction of a network of Dignity at Work Advisers (see page 68).

We measure our progress on removing bullying and harassment by asking staff a number of questions in our annual staff survey.

- In 2013, 60% of staff said that they felt CQC was committed to an environment that was free from bullying and harassment, up from 50% last year.
- 23% of staff said that they had witnessed bullying and harassment at work in the last year, down from 35% the previous year.
- 14% said that they had personally been bullied or harassed at work, down from 21%.
- 8% said that they had faced discrimination at work, down from 15%.

While the overall figures are improving, they show that we still have some way to go before we meet our aspiration of all staff being free from bullying and harassment and being confident about CQC's approach to this.

Of those who had personally experienced bullying, harassment or discrimination:

- Only 24% had reported bullying or harassment, which was down from 31% last year.
- Only 21% of staff who reported bullying or harassment were satisfied with how this was dealt with, which was down from 25% last year.
- Only 31% of staff who experienced discrimination reported it (a new question this year).
- Only 6% of staff who reported discrimination were satisfied in how this was dealt with (a new question this year).

These figures show that our new approaches to bullying and harassment – such as introducing Dignity at Work Advisors four months before staff completed the 2013 staff survey – were not making an impact by the date of the survey. In fact, reporting rates were lower this year. We need to keep our approach to bullying, harassment and discrimination under review to ensure that it is having the desired effect. The figures also show that we need to improve our response to staff who report discrimination.

However, the number of bullying and harassment cases that become formal grievances increased this year. For the year ending 30 September 2013, there were 14 formal grievance cases taken by staff – the same as last year. Of these cases, nine related to bullying or harassment compared to two cases last year. It is not possible to give equality monitoring data for these cases due to their small number.

This year, there were eight Employment Tribunal cases, down from 12 cases last year. Four claimants cited discrimination in their claim – the same as last year. Of these four, two were withdrawn by the employee, one was dismissed by the judge and the other one is pending.

It is important that, as well as dealing with bullying and harassment more effectively when it takes place, our work aims to reduce the incidence of bullying, harassment and

discrimination. Worked planned for 2014, such as learning for staff who manage people on 'unconscious bias' and the development of the action plans for equality in recruitment, reasonable adjustments and engagement with carers should have a positive impact on this.

This year, there were 13 disciplinary cases, down from 16 last year. It is not possible to give equality monitoring data for these cases due to their small number.

Meeting our equality objectives 8: Ensuring CQC staff are treated equally

In both 2012 and 2013, CQC commissioned GFK, the independent company undertaking our staff survey, to provide a report that analysed the results for each question by equality characteristics. For the 2012 survey, we picked out the questions where there were the biggest 'gaps' between equality groups and their comparators (e.g. disabled staff and non-disabled staff) and early in 2013 we engaged with staff on these issues to develop key priorities for action. We will repeat the consultation process for the 2013 results. Key issues from the 2012 survey were:

- Overall, disabled staff reported the least positive experiences of working at CQC. A lower percentage of disabled staff thought that CQC was an equal opportunities employer, compared to non-disabled staff, linked with a lower percentage of disabled staff feeling that they are treated with fairness and respect, having the equipment and technology to carry out their role and having a good work-life balance. When talking to disabled staff, the two themes of the results came through strongly: the need for line managers to be more consistent about supporting disabled staff and improving the way CQC handles requests for reasonable adjustments.
- Staff aged 55 and over were generally less positive about their experience working at CQC.
- There was a lower percentage of staff with caring responsibilities who were able to achieve a good work-life balance and who thought CQC was an equal opportunities employer and that they were treated with fairness and respect. When talking to staff with caring responsibilities it was clear that we need to engage these staff better to improve their working experience at CQC.
- Survey results for Black and minority ethnic staff were more mixed, with BME staff reporting more positive outcomes than their White UK colleagues in some areas (being proud to work for CQC, having resources to carry out their role and being able to strike a good work-life balance). However, in some areas, BME staff reported less positive experiences, such as whether CQC is an equal opportunities employer, career progression and reward and support from line managers. From discussing with BME staff, career progression is seen to be a key issue.
- The experience of lesbian, gay and bisexual staff was also mixed, with a higher percentage of LGB staff thinking CQC is an equal opportunities employer than their heterosexual colleagues. However, LGB staff were less confident about the future of CQC and fewer thought that CQC leaders were sufficiently visible, compared to their heterosexual colleagues.

Many of these findings corresponded with the results of the independent diagnostic we commissioned in relation to the Diversity in Business awards standard (see page 46).

In response, working with staff equality networks, we have:

- Carried out a further survey of disabled staff and staff with caring responsibilities specifically around reasonable adjustments and support requests, and will develop an action plan from this.
- Started a recruitment equality audit (see page 46).
- Started specific engagement with staff with caring responsibilities.
- Started planning some learning, specifically for staff who manage people, about 'unconscious bias'.

Also, in April 2013, CQC launched the Dignity at Work scheme. This forms part of the Bullying and Harassment policy in which 24 members of staff have been fully trained to undertake the role of a Dignity at Work Advisor. Each advisor has a pen picture on our internal intranet site and we regularly promote their role through the internal CQC 'team brief'. The advisors send monitoring quarterly data to Human Resources to ensure that we are analysing any trends and looking at ways to resolve identified concerns within a particular area or equality group. We are also using staff survey results and the current organisational change programme to review the dignity at work programme on an on-going basis.

In January 2014, we held a workshop with staff to review the Bullying and Harassment policy to make it fit for purpose, as current feedback suggests that the policy is not helpful and could be more explicit.

2.7 Programmes and policies to address equality for staff

Our progress in relation to programmes and policies on workforce equality is outlined in our equality objectives that relate to ensuring a diverse workforce at CQC, ensuring staff are treated equally and learning and development around equality for staff (see pages 46, 67 and 34).

The following comments about our progress are from the Chairs of CQC's three staff equality networks.

This is a significant year for CQC. We've set a new strategic direction and changed our leadership team. We are now changing the way we inspect, changing our culture, and taking on extra and new responsibilities, all at the same time. It is clear that equality is a core value for CQC. Our strategy for 2013-2016, Raising standards, putting people first, clearly identifies equality as one of the principles through which we carry out our work. We've seen progress in terms of strengthening the voice of people, particularly those who are in vulnerable circumstances, through our new approach to inspections. The new listening events, which are a new feature of our inspection regime, are drawing in more people from the community to share their experiences about the care they receive. The work we do with the SpeakOut groups continues to make a significant difference for people.

One aspect where we need urgent improvement as an organisation is the whole area of inclusion. There is evidently a lack of staff from minority background at senior levels in the organisation. At the moment, neither our executive team nor the board is representative of the community it serves. The Race Equality Network continues to raise this as an area that needs to be addressed. One of the things that CQC can do to attract candidates from minority backgrounds is ask recruitment agencies to find, encourage and target candidates from these backgrounds.

The Race Equality Network is working with senior leaders to implement CQC's strategic objectives, by contributing to the work on the thematic review on emergency mental health care; building the Academy to ensure it meets the needs of all staff, including those from minority groups; encourage and participate in the end-to-end audit of our recruitment process as part of making CQC an excellent employer; support CQC develop how we access leadership and culture in the organisations we regulate.

These are exciting times for CQC. The Race Equality Network believes CQC is moving in the right direction and we are committed to contributing our part to 'raise standards and put people first'. We have been, and want to continue to be, a platform for implementing strategy.

Segun Oladokun, Chair, CQC Race Equality Network

CQC's policy in equality and human rights is good with regard to the outward facing agenda, service provision and what providers need to do. However, there are issues that need to be addressed that relate to staff: whilst we have all the right policies and procedures in place, their interpretation by managers is patchy. This has been borne out through a number of issues raised by the network on people's behalf, especially those that relate to reasonable adjustments.

We could improve by ensuring that managers understand their role in managing staff with a disability. The evidence seems to indicate that managers follow the medical model of disability and look at the limitations of the perceived illness/disability rather than what can be done to elevate the issue and follow the social model.

The group is willing to help facilitate organisational learning to support the improvements needed and become involved in the changes at the beginning of the process rather than at the end in an organisational conscience capacity. The Disability Equality Network therefore welcomes the opportunity to be involved in projects to make CQC a better place to work for disabled staff – such as the staff survey on reasonable adjustments and learning for managers on unconscious bias."

Chris Thurlow, Chair, Disability Equality Network

CQC must work harder to raise the status of its equality networks and keep listening to and learning from them. Our network members bring to CQC their lifetime experiences of facing the challenges of discrimination and of living diverse lives. We mustn't waste their talents. As David Behan has said, 'only the people in the organisation can make it better.'

We value the new work on strengthening our ability to address equality and human rights in our inspections and look forward to improvements in the lives of people who use services as a result.

Pauline O'Rourke, LGBT Equality Network Chair 2009-2013

Published January 2014

How to contact us

Call us on: **03000 616161**

Email us at: **enquiries@cqc.org.uk**

Look at our website: **www.cqc.org.uk**

Write to us at: **Care Quality Commission**
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Follow us on Twitter: **@CareQualityComm**

Read more at: **www.cqc.org.uk**