CQC's Equality Objectives for 2019–21

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Care Quality Commission

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

Introduction

Our role is to make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and treat everyone with respect and dignity. This means that focusing on equality is central to our work.

CQC is legally required under the Equality Act 2010 to set equality objectives at least every four years. We have chosen to set objectives every two years, to reflect the pace of development within CQC and the health and social care sector, and because we are ambitious to work for change on equality.

Our equality objectives for 2017-19 have helped us to make sure that we consider equality in our regulatory work and for our staff. We are building on this previous work with our new objectives. We have chosen similar topics but changed the activities that we will deliver, based on our experience. In the section “why this objective?” we also summarise work carried out to date.

To develop our new objectives for April 2019 to March 2021, we have:

- Reviewed evidence of inequality in health and social care and in the CQC workforce.
- Gathered ideas from CQC staff, external organisations, health and social care providers and people who use services, including feedback on the impact of our objectives over the last two years. We then engaged with these groups to help set priorities, by considering the impact of the inequality, the unique ability of CQC to make a difference and whether the issue has been neglected.
- Developed ‘logic models’ for each selected topic, to help make sure that the activities that we will carry out will lead to the positive impacts on equality that we want to achieve. These contain more detail than the information in this document, such as lists of outputs and assumptions.

- Looked at the costs and benefits for carrying out the objectives, based on reasonable assumptions at this early stage of our work. Our equality objectives do not add new requirements for providers of health and social care. We will continue to look at the cost of implementing the activities for CQC and for others, especially providers of health and social care services. We will also continue to look at the monetary benefits to the health and social care system that the activities will achieve – as well as the wider benefits to people using health and social care services.
- Used guidance from the Equality and Human Rights Commission about selecting and prioritising equality objectives and making them specific and measurable.[1]

[1.] Equality and Human Rights Commission, Objectives and the Equality Duty – a guide for public authorities, 2011, revised 2014.

Our five objectives for 2019–2021 are:

1. Confident with difference – person-centred care and equality

2. Accessible information and communication

3. Equality and the well-led provider

4. Equal access to care and equity of outcomes in local areas

5. Continue to develop a diverse CQC workforce with equal opportunities for everyone and a culture of inclusion

Objective 1: Confident with difference: Person-centred care and equality

Why this objective?

There is strong evidence that person-centred care is the cornerstone of good equality practice – and good care – but that leadership is needed to make person-centred care a reality for people in some equality groups.

We have focused in the past two years on improving how we look at person-centred care for people in lesbian, gay, bisexual and transgender (LGBT) communities in adult social care and mental health services. This work has led to increased confidence in inspectors asking questions about LGBT equality and then including this in inspection reports. For example, between November 2017 and November 2019, we mentioned care quality for transgender people in eight NHS trust mental health inspection reports (50% of reports) and 473 adult social care reports (4% of reports). We are currently widening this work to look at equality for faith groups.

Skills for Care have told us that their work 'Confident with difference' shows a lack of knowledge and confidence in social care managers and staff across a range of equality issues, rather than conscious discrimination. Despite our progress, not all CQC colleagues are confident to ask questions of providers about LGBT equality and equality more widely. There are also challenges in that we need to make our inspection reports shorter, while maintaining important content around equality.

The impact we want to make

People who use services will receive better quality care because services that are confident with difference are more able to meet their needs.

Our aims for 2019–2021

- Our regulation assures more people using services that they will experience frontline care delivery across all sectors that is confident with difference.
- We ensure that CQC colleagues are confident with difference so that they can play their part in delivering this objective.
- We use the evidence we gather on this topic in our national reports and information to encourage improvement beyond the regulation of individual services.

The activities we will carry out

- Develop a set of principles for what confident with difference looks like.
- Conduct research and engagement to find out how confident with difference CQC colleagues are when they are carrying out regulatory tasks, such as inspections.
- Analyse inspection reports to see where we demonstrate attention to equality issues in person-centred care and where we do not, looking for key themes.
- Comparing the principles with the analysis and engagement, we will explore the most effective ways we can build confidence with difference for CQC staff and use this information to develop some or all the following actions. We will also learn from others about effective interventions, for example Skills for Care.
- Develop a communications plan to promote being confident with difference.
- Develop and deliver learning for senior leaders and managers on confidence with difference.
- Develop and deliver learning for inspection colleagues on confident with difference in a range of ways, for example, webinars, lunchtime learning, team meetings, opportunities for ongoing support and reflection, and a focus on report writing.
- Develop and implement supporting guidance or information for providers and CQC colleagues.

- Consider how we can best support Experts by Experience and CQC Specialist Advisors to be confident with difference. Specialist Advisors and Experts by Experience are paid to help us on our inspections but they are not permanent CQC staff.
- Recruit and support existing and new equality leads to be ambassadors for confident with difference work.
- Align our development work with other information on different people's experience of care, for example using data from patient surveys.
- Use our increasing regulatory findings from this work in 'independent voice' products

The outcomes we expect

In the short term: (first year)

- CQC colleagues and providers are clearer about our expectations around providers being confident with difference and start to increase their focus on this.
- CQC colleagues' confidence in looking at this in regulation increases through learning, access to improved methods and local support from ambassadors.

In the medium term: (end of two years)

- We pay more attention to whether providers are confident with difference in regulatory activity (for example monitoring and inspection)
- There is better reporting on confident with difference in inspection reports and what we publish.
- A consistent and sustainable approach is embedded.
- We expand on good practice such as case studies to develop the work.

In the long term: (after two years)

- All CQC colleagues are confident with difference and in communicating this to providers.

- Providers are more confident with difference, including when they engage with us.
- Improved CQC reporting on person-centred care and equality to drive improvement.

Objective 2: Accessible information and communication

Why this objective?

Millions of people in England have a disability or sensory impairment that affects how they communicate or receive information. In the UK, there are:

- 11 million people with hearing loss, of which, 900,000 are severely or profoundly deaf.
- Almost two million people living with sight loss, with 360,000 registered as blind or partially-sighted and 250,000 deafblind.
- 1.5 million people with a learning disability.
- More than 350,000 people with aphasia (difficulties finding and using the right words, and sometimes understanding words, for example after a stroke).

When people can't understand information, and don't get the support they need to communicate, it can stop them:

- getting a correct diagnosis
- attending appointments
- receiving safe and effective care or treatment
- being treated with dignity and respect
- being listened to and involved in their care.

All publicly-funded health and social care providers must now meet the Accessible Information Standard (AIS). This aims to improve the lives and life expectancy of people who need information to be communicated in a specific way. Services that meet the AIS are also likely to save money.[2]

[2]. NHS England, Accessible information standard: Notes on costs of meeting individuals' needs, 2016

We've committed to considering how well providers meet the AIS as part of our regulation, as it is implicitly included in the Health and Social Care Act regulations. We introduced the standard into our regulation in November 2017 and already many inspections cover the standard. We now we want to develop our work. We want to help ensure that providers consistently deliver the benefits of the AIS to everyone who needs this. We also want to make sure that we set a good example by improving how we communicate with people who need accessible information or communication methods.

The impact we want to make

Impact 1: Disabled people's health and care needs and rights are met because health and social care services put people's information and communication needs and rights at the centre. Services take a person-centred approach and proactively engage with disabled people to do this.

Impact 2: CQC is fully accessible for all disabled people and accessible communication and information is business as usual for us.

Our aims for 2019–2021

- We know which health and social care services most need to improve in delivering the AIS, so we can focus our regulatory work on the AIS more effectively.
- We consider what we can do beyond embedding the AIS into 'inspect and rate' activity to drive improvement, for example, by using enforcement and publishing information about progress nationally on the AIS.
- CQC becomes more accessible in our communication, for example in developing our telephony system and digital programmes.

The activities we will carry out

Impact 1:

- Pull together research on gaps in services meeting AIS, including engagement with key voluntary and community sector (VCS) organisations of disabled people and other disabled people (for example Experts by Experience) to help focus improvement activity.
- Work on developing an action plan with other national organisations to drive improvement on AIS in a time limited frame, including VCS organisations of disabled people.
- Develop a CQC action plan based on research and contribute to the joint plan.
- Engagement with providers to gather and share best practice – testing first in Yorkshire and Humber and the North East.
- Raise the issue nationally – including fulfilling our commitment to reporting on how the AIS is working for people with a learning disability made in the Learning Disabilities Mortality review (LeDeR) annual report.

Impact 2:

- Ensure that we include a requirement for developing accessible communications when we tender out contracts for CQC telephony and other communications.
- Ensure that CQC digital development meets agreed standards of accessibility, in line with legal duties under the Equality Act to make information accessible.

The outcomes we expect

In the short term: (first year)

- Health and social care providers recognise their responsibility to act on people’s information and communication needs and start to increase their focus on this.
- All CQC staff recognise their responsibility to include looking at people’s information and communication needs in regulation.
- Organisations in the health and social care sector (including commissioners) commit to working together to drive

improvement on accessible information and communication with clear timeframes in place.
- CQC commits to making itself accessible to everyone with a clear timeframe that sets out progress.

In the medium term: (end of two years)

- Health and social care providers act to meet the AIS and ensure that their staff understand how to assess and meet disabled people's information and communication needs.
- CQC staff ensure that the AIS is covered in inspections and all other relevant regulatory activity.
- CQC drives improvement on accessible information and communication for disabled people using health and social care services through our publications and work with other organisations.
- CQC's contact centre becomes fully accessible and digital developments maximise accessibility.

In the long term: (after two years)

- Our regulation contributes to all health and social care services meeting the AIS.
- CQC, providers, disabled people's organisations and sector stakeholders move

Objective 3: Equality and the well-led provider

Why this objective?

The link between equality for health and care staff and providing good quality care is now well established. For example, there is a link between patient satisfaction and results of the NHS staff survey on issues such as workplace discrimination. Other research shows that good workforce equality practice has financial benefits to healthcare organisations, so it has a positive impact on the use of resources.

The equality aspects of the well-led key question are now better developed in our assessment frameworks for both health and social care services. As well as improved prompts to gather evidence of workforce equality, inspectors are also prompted to look for evidence that providers take account of equality characteristics for people using their services, for example when engaging with them to gather feedback and to develop services.

We have built knowledge and experience of regulating equality under the well-led key question in hospitals – through our work on the Workforce Race Equality Standard (WRES). Our work on WRES has been established for four years and involves developing intelligence and inspection methods, staff learning, appointing and using specialist advisors on inspections and working with other national bodies, such as NHS England, to align our approach to the WRES.

Through our regulation we have had some successes in helping trusts to pay attention to workforce equality issues. CQC inspections are regarded as one of the strongest levers for the WRES. However, we can sometimes miss where there are race equality issues within specific trust services, if we do not have information from staff working in those services. There have also been some challenges in applying the WRES in a way that works well for independent hospitals.

The forthcoming Equality Delivery System 3 (EDS3) and the Workforce Disability Equality Standard (WDES) are also mandatory for all NHS providers to develop their equality programmes but these are not yet embedded in our regulation as well as the WRES.

We have done less work to look at leadership on equality and workforce equality in primary medical services and adult social care services. We need to develop this work to reflect the very different scale of these services compared to NHS trusts.

The impact we want to make

Gaps in workforce inequalities in NHS trusts have improved because of better implementation of the workforce race and disability equality standards (WRES and WDES) and the NHS Equality Delivery System (EDS3). Inequalities for patients needing NHS hospital services have improved through good use of EDS3.

Reduced inequalities for both staff and people using services in primary medical services and adult social care through good leadership of these services.

Our aims for 2019–2021

- We measure the impact we have made by including the WRES in our regulation of NHS and independent hospitals. We plan how to develop this work.
- We consider equality and inclusion, for patients and for staff, more widely in regulating whether NHS trusts are well-led, especially through our engagement with trust Boards and using established equality improvement initiatives such as Equality Delivery System (EDS3) and the forthcoming Workforce Race Equality Standard (WDES).
- When inspecting how well-led GP practices and adult social care services are, we look at workforce equality and how providers plan to meet needs of people in equality groups using their services.

The activities we will carry out

- Establish a group to design and deliver this objective.
- Develop an evaluation project plan to review the impact of our regulatory work on the implementation of the WRES by NHS and independent hospitals.
- Engage with NHS England and NHS Improvement, providers, CQC specialist advisors and NHS trust equality and diversity leads and champions as part of the evaluation.
- Develop existing methodology and CQC staff learning to support EDS3 and WDES being implemented through our regulation of NHS trusts. In particular, consider how we can use the ‘monitor’ part of our operating model to strengthen our work on equality and well-led in hospitals.
- Develop methodology to help our staff include questions about equality when they inspect whether GP practices and adult social care services are well-led.
- Develop and implement methodology to support our regulation of the WRES in the Independent Healthcare sector, aligning with NHS England on this.
- Establish links with NHS England/NHS Improvement regional improvement teams to coordinate work on improving equality in NHS trusts that are in special measures – including through wider CQC and NHS England/NHS Improvement regional engagement.

The outcomes we expect

In the short term: (first year)

- We evaluate our regulatory work on WRES and make recommendations on what needs to be improved.
- We consider WRES and equality more broadly as part of our ‘monitor’ work programme in NHS trusts, including joint work with NHSI on trusts in special measures.
- We start to implement relevant methodology and learning to support WDES and EDS3 in hospital regulation including

acute, mental health, community and ambulances and for the WRES in independent hospitals.
- We develop methodology and learning to help inspectors consider equality in their review of whether GPs and adult social care services are well-led.

In the medium term: (end of two years)

- We deliver an action plan based on recommendations from the WRES evaluation which includes our work in regulating independent hospitals.
- Equality including the WRES is fully embedded in our dialogue with NHS trusts, leading to improvements in NHS workforce equality and patient experience.
- We have implemented relevant WDES and EDS3 methodology in regulating NHS trusts including acute, mental health, community and ambulances.
- CQC colleagues in adult social care and primary medical services directorates feel confident in asking questions on workforce equality.
- Our adult social care and GP practice inspection reports increasingly include equality issues in well-led.

In the long term: (after two years)

- We have improved CQC’s well-led regulatory framework or equivalent.
- WDES and EDS3 is fully embedded in the way we regulate NHS trusts.
- Adult social care, GP practices and independent hospitals have a well-led inspection approach that is inclusive of the principles that underpins the WRES, adapted so it is suitable for these sectors.
- We can see that workforce inequalities in the services that we regulate and inequalities for patients are reducing due to better use of EDS3. We can measure this through looking at national data such as NHS staff and patient surveys or by feedback from providers about the impact of EDS3 in their trusts.

Objective 4: Equal access to care and equity of outcomes in local areas

Why this objective?

People using health and social care services often need to use more than one service, known as a ‘pathway of care’. However, people in some equality groups may have difficulty accessing some services or care pathways, which could lead to poorer health outcomes for them.

People will only receive good care if these inequalities in access and outcomes are tackled. These issues can only be solved at a ‘local system level’ and considering commissioning, joint working, population health approaches and care pathways – covered in the NHS Long Term Plan.

We are starting to look more at local systems, which provides us with an opportunity to consider equality issues about access to care.

There are longstanding issues with access to preventative and appropriate mental health services for some people from Black and minority ethnic (BME) groups. This lack of access may contribute to higher rates of compulsory detention under the Mental Health Act for some groups. This is an issue of national concern that we could also explore through looking care in local areas.

The impact we want to make

Local areas are better able to meet the health and social care needs of the whole of their local population through an increased focus on inequalities in access and outcomes. People from BME groups with mental health issues are more likely to receive appropriate care which avoids compulsory detention through better local joint working.

Our aims for 2019–2021

- We encourage local areas to consider the needs of people in equality groups through our work at a local area level, including aligning with the NHS Long Term Plan actions on inequality.
- We look at some specific systematic issues of inequality that are national priorities, for example by developing intelligence that local CQC teams can use on access and outcomes for people from BME groups who need to use mental health services.

The activities we will carry out

- Find and use existing indicators about inequalities in access and outcome when we develop CQC area level analytics products. Consider developing new indicators where these do not exist but could be developed from existing data, with a focus on mental health issues for people from BME groups.
- Add local area goals for inequalities (when set through the NHS Long Term Plan processes) into area level analytics products.
- Develop, pilot and refine supporting tools for CQC engagement leads for Integrated Care Systems to use around inequalities in access and outcomes.
- Develop supporting tools for engagement meetings with NHS trusts to use around inequalities in access and outcomes in local areas – embed into equality objective 3 work around NHS trust engagement on equality and the well-led provider.
- Look at how our local system review methodology captures local system responses to inequalities in access and outcome – including access to mental health services for people from BME groups.
- Look at using what we publish to report nationally on how local areas are working to reduce inequality.

- Develop and deliver an engagement plan to inform providers, integrated care system leaders and local voluntary and community sector organisations about this work.

The outcomes we expect

In the short term: (first year)

- People leading provider organisations and Integrated Care Systems are aware that CQC will consider their role in tackling inequalities in access. They start to increase their focus on this.
- Providers recognise their responsibility to act to reduce inequalities in local areas and start to increase their focus on this.
- Providers are aware that we will consider improving access and outcomes for people from BME groups using mental health services as a specific national issue that needs addressing at an area level. They start to increase their focus on this.

In the medium term: (end of two years)

- Integrated Care Systems pay greater attention to actions and goals to reduce inequalities in the NHS Long Term Plan through our engagement with them.
- Providers take action to support local area plans to narrow inequalities in the way they provide access to and deliver services.
- Providers and Integrated Care Systems take action to improve access and outcomes for people from BME groups using mental health services with a focus on providing care that reduces the likelihood of being detained under the Mental Health Act.

In the long term: (after two years)

- Leadership of Integrated Care Systems perform better in their activities to tackle inequalities in line with the NHS Long Term Plan commitments.
- Providers make a stronger contribution to local area commitments to reduce inequalities.
- Services for people from BME groups who need mental health care improve in local areas, so more people receive appropriate preventative services. This will result in reducing detention under the Mental Health Act.

Objective 5: Continue to develop a diverse CQC workforce with equal opportunities for everyone and a culture of inclusion

Why this objective?

As the regulator, we assess provider organisations on the way they meet people’s diverse needs and how they pay attention to their workforce equality. In doing so, we set and monitor expectations for the sector.

It is essential that we invest energy in getting this right for our own workforce, so that we can benefit from a diverse staff and in doing so, set an example to those we regulate and ensure high-quality care.

Over the past two years we have strengthened our approach to staff equality and inclusion. We have carried out a programme of work to improve the experience of disabled staff. We commissioned Roger Kline to look at inequalities in recruitment outcomes for BME staff at CQC and have started to implement the recommendations of his report. We are participating in the national WRES experts programme. We have moved up 40 places in the Stonewall Index which measures equality for lesbian, gay, bisexual and trans staff. Two new staff equality networks have started up, a carers’ equality network and a gender equality network, to complement existing networks looking at race, disability and LGBT+ equality. Equality network chairs now attend CQC Board meetings.

<u>The impact we want to make</u>

We have a culture in CQC which brings about a sense of safety and enables individuals to flourish in an environment which values difference and doesn't create barriers. We will eliminate discrimination, advance equality of opportunity and foster good relations between CQC colleagues. In doing this we will positively impact collaborative working, innovation and diversity in CQC teams.

Our aims for 2019-2021

- We equip our leaders, managers and teams to create a culture of safe, open dialogue and 'respectful enquiry' where we are all confident with difference.
- We ensure equal opportunities for all in our recruitment processes and approach.
- We improve the quality of our data on CQC workforce diversity to have a stronger evidence base for change.

The activities we will carry out

- **Data**: Implement a campaign to improve equality monitoring levels in CQC electronic staff records (ESR) and participation in people surveys and feedback forums. Use improved workforce data to develop aspirational representation targets for senior levels in CQC. Continue to benchmark ourselves against standards such as the Workforce Race Equality Standard (WRES), Stonewall and Workforce Disability Equality Standard (WDES).
- **Leadership**: CQC Board will develop a shared vision for inclusion and agree leadership commitments. Introduce an inclusion module in the new Shaping our Future Leaders programme which is a learning programme for staff moving into management roles.
- **Recruitment and Talent**: Implement key recommendations from Roger Kline report 2017 to eliminate bias from CQC recruitment process and guidance. Implement independent panels for all CQC senior recruitment. Continue roll out of CQC talent management strategy.
- **CQC staff equality networks**: Implement a policy of protected time for network chairs. Rolling attendance for a CQC network chair at all Board meetings. Continue to provide support and development to networks to help drive change.
- **Culture**: Engage CQC in a 'big conversation' on our inclusion vision and strategy. Develop a communications and engagement plan on diversity and inclusion. Embed diversity

and inclusion in wider organisational development projects and programmes.

The outcomes we expect

In the short term: (first year)

- Improved communications and diversity and inclusion issues and activities are more visible within CQC.
- CQC staff equality networks are supported, valued and recognised as critical partners to help develop a more diverse and inclusive organisation.

In the medium term: (end of two years)

- Improved reporting rates for protected characteristics on our ESR system provides robust data on workforce representation within CQC.
- Improve CQC rankings and outcomes on existing and future benchmarking tools such as WRES, Stonewall and WDES.
- Inclusive leadership embedded in CQC management development programmes.
- Improved diversity of candidates at shortlisting and interview stage of recruitment.
- CQC Managers have an increased awareness and understanding of diversity and inclusion.

In the long term: (after two years)

- CQC can use data and insight to better inform decisions and actions and continuously improve.
- All leaders and managers in CQC role model inclusive behaviours.
- Increased representation at senior levels of CQC, particularly an increase in staff from BME groups.
- Open dialogue and respectful enquiry are the norm across teams at CQC.

Cross-cutting work

Our cross-cutting work brings common elements together to deliver the overall programme more efficiently. It does not add additional activities to the work.

The impact we want to make through our cross-cutting work

Good awareness of equality objectives by different internal and external stakeholders levers greater change.

Potential of qualitative and quantitative data to drive improvement is maximised.

CQC colleagues are confident with difference in both their regulatory roles and in their relationships with other organisations.

<u>Our aims for 2019-2021</u>

- CQC colleagues are confident with difference and understand what this means for their role in both CQC staff equality and inclusion and when they deliver regulatory work.
- Indicators and qualitative intelligence enable us to monitor equality in health and social care at service, provider and area levels.
- People who use services tell us their experiences of accessing and using services so that we can both use these to help assess quality of care and to help us develop the equality objectives.
- Health and social care providers are aware of our objectives and this helps to drive change.
- The way that we develop regulatory methodology about our objectives is consistent and efficient.

The activities we will carry out

- Design and deliver plans for public engagement, provider engagement and other stakeholder engagement to raise awareness of the objectives. To include engagement activities for specific objectives and consider how we capture the experiences of people using services about equality objective topics.
- Plan CQC staff engagement to raise awareness of objectives and to point to useful resources and opportunities to contribute.
- Develop a stakeholder engagement plan to help develop the Equality Objectives development.
- Review relevant indicators at a provider level for objectives 1-3 and potential for development of indicators, link also to development of indicators for objective 4 at an area level in EO1 – EO3.
- Review information gathered from providers through provider information returns.
- Develop the Equality and Human Rights learning needs analysis to consider any new requirements – including roles of Line Manager in supporting learning in their teams and managers and senior leaders being confident with difference. Develop learning for key teams on equality objectives so teams are prepared to embed them into their work – Policy, CQC Academy and operating model groups.
- Identify cross-cutting methods development work – where it would be more effective to take a combined approach to embedding the objectives, for example in our programme of work to make our inspections more efficient.

The outcomes we expect

In the short term: (first year)

- Clear, realistic plan for engagement enables clarity over timings and resources.

- Develop intelligence data sets (including Provider Information Requests) in a consistent way that considers requirements for all objectives.
- Integrate a clear plan for learning and development requirements into existing equality, diversity and human rights learning needs analysis.
- Smarter and simpler way of applying required policy and methods changes for Equality Objectives across all sectors.

In the medium term: (end of two years)

- Deliver engagement, intelligence, policy and methods and learning and development elements of plans.

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