**INFORMATION APPENDIX: CURRENT STATUS OF EQUALITY OBJECTIVE DELIVERABLES AND MEASURES OF SUCCESS**

**Table 1: Equality Objectives: Year 1 deliverables**

All activities with a current RAG rating of Amber have plans in place. It should be noted that we are only 4 months into delivery, so some activities have not started yet and others are in early stages of delivery.

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| **Amplifying the voices of people more likely to have a poorer experience of care or have difficulty accessing care** |
| **Activity** | **Deliverables 2022/23** | **RAG rating July 2022** |
| Increasing range of feedback we receive from people more likely to have poor care or have difficulty accessing care | Continue developing equality monitoring across information collection from people and how we can disaggregate this  | Amber |
| Further develop targeted campaigns/ activities to increase feedback from specific groups (e.g. Because we all care) | Green |
| Consider additional tools needed to gather feedback from some groups  | Green |
| Develop approach and expectations for local teams in proactive outreach/ gathering of feedback from specific groups of people | Green |
| Ensuring we use feedback well and countering epistemic injustice | Test how much feedback from people in different equality groups has an impact on our regulatory action through Single Assessment Framework piloting work | Not started – starting from Sept 22 |
| Encouraging providers and local systems to respond to people more likely to have poor care |  Test through Single Assessment Framework piloting workConsider communications to raise expectations | Green |

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| 1. **Using data to understand and respond to equality risks**
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| Strategic development: | Evaluate “equity by design” approach | Not started – Starting from Sept 22 |
| Testing and building data requirements | Build equality risks data required evidence for providers, ICSs and LAA for single assessment framework and test as part of regulatory model development | Green |
| Hearing from frontline staff in providers about equality | Deliver revised approach to WRES and expand to other workforce equality issues in NHS Trusts and to other sectors | Green |
| Using evidence to ensure CQC decision making is fair | Integrate equality monitoring into IOM2Deliver recommendations of GP Inequalities report | Green |
| **Working with others to improve equality of access, experience and outcomes** |
| National joint working | Look at priorities for developing other improvement coalitions on equality/ health inequalities-based aligning with Strategy theme on accelerating improvement  | Green |
| Actions arising from Chief Execs of Arm’s Length Bodies meeting on tackling inequalities | Amber |
| Building improving equality/ tackling inequalities into joint work through Memoranda of Understanding | Deliver small action plan – Align with wider work on Memoranda of Understanding | Green |
| Build our own capacity to escalate issues to others and respond to recommendations from others | Embed research and development priorities into relevant CQC Research and Development priorities. Test in regulatory model pilots – including different approaches. Align with MOU development work | Amber |
| **Using our independent voice to reduce inequalities** |
| Strategic development | Delivery of tackling inequalities priorities in Independent Voice plan | Green |
| Delivery of tackling inequalities priorities in Research & Development plan | Amber |
| Tackling inequalities in local areas | Develop communication about role of ICSs in reducing inequalities in ICS nationally, including potential joint work with EHRC and NHSEI | Amber |
| National reporting | Develop inequalities theme in State of Care | Green |
| Using findings to improve how we address inequalities in our own regulation | Develop narratives about addressing inequalities within strategy themes on safety and improvement | Green |

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| **Our Inclusive Future** |
| Inclusive Leadership and Accountability | Introduce the second cohort of Reverse Mentoring targeted at our Senior Leaders and Black and minority ethnic and/or disabled colleagues. | Amber  |
| Develop and introduce the “Inclusive Leadership Pathway” (ILP). The ILP has been designed for disabled and/or Black and Minority Ethnic colleagues. It includes stretch projects, funded learning, and coaches. | Green |
| Procure, design and develop an inclusive Leadership Programme. Everybody will be exemplars of our behavioural framework, our cultural principles and our values. Diversity and inclusive leadership will be a golden thread running through the programme. | Green |
| Inclusive Policies and Practices | QI project underway examining our recruitment process and areas which may need improving. Under the project scope includes piloting Independent Panel Members (IPMs) in the shortlisting process of all recruitment panels at Grade A and above. As well as evaluating the success of IPMs. | Not started – Starting from Sept 22  |
| Review and update comms and our offer to disabled candidates to discuss any required reasonable adjustments for all parts of the recruitment process. | Green |
| Begun a QI project to improve the experience of disabled colleagues acquiring reasonable adjustments. | Green |
| Ensure our internal and external recruitment campaigns and job adverts are inclusive and demonstrate our commitment to improving the representation of disabled colleagues at senior grades. Review how effective diversity job websites have been to attract diverse talent at our Grade A and Executive advertised roles. | Not started – Starting from Sept 22 |
| Refresh and update Academy’s Mentoring program and promote places for Black and minority ethnic and/or colleagues with disabilities. | Green |
| Inclusive Cultures  | Achieve Disability Confident Level 2 Q2 2022 (completed) and work towards any actions necessary to achieve level 3 by March 2023 | Green |
| Work towards any actions necessary to achieve Carer Confident employer level 1 by March 2022 and level 2 by March 2023. | Green |
| Develop a rhythm of showcasing and reporting on D&I data more frequently throughout the year to encourage local action from colleagues across the organisation. | Not started –Starting from Sept 22 |
| Build and implement the “Living Library” and Academy’s “Confidence with Difference” learning as tools to raise awareness of different experiences between colleagues in the organisation. | Not started – Starting from Sept 22  |
| Develop a “Share and Declare” PowerBI dashboard and campaign targeting different directorates at a time, in order to encourage colleagues to self-report so we can highlight the importance of having accurate ESR data.  | Green |
| Inclusive Engagement | Introduce an accessibility working group to identify and remove accessibility barriers within CQC. | Green |
| Transform the Freedom to Speak Up Ambassador roles in the organisation and introduce Colleague Support Officers (CSO). Develop working relationships between the new CSO roles and our Network Chairs, D&I Coordinators and Wellbeing Leads, in order to integrate CSO roles into Equality Networks and directorates. | Work underway to implement new roles |

**Table 2: Equality Objectives: Measures of success July 2022**

* Measures of success for each equality objective were published in July 2021, within [our Equality Objectives](https://www.cqc.org.uk/about-us/our-strategy-plans/our-equality-objectives-2021-2025).
* Many of the measures were designed to align with strategy indicators and supplementary data points to make collection and analysis more streamlined.
* Many of these are baseline figures, so a commentary on performance will only be possible in future years.
* Figures given are for 2021/22 unless otherwise stated.
* Ranges applied for RAG rating sentiment indicators: 50% or below agreement= red, 51-75% agreement =Amber, Above 75%=green

Please note the following caveats (for more information please see Table 3 at the end of the document):

* Not all data is yet available to assess the equality objectives, with more objective data being absent. This means there is an emphasis on the views of people, services and stakeholders.
* As we have undertaken extensive engagement to articulate our strategic intent providers and stakeholders may be feeding back based on what we plan to do, rather than actual delivery. We may therefore see results temporarily decline from high baselines as we begin to implement our strategy but before it is fully realised.
* Some data is based on low sample sizes this year, and others are unweighted (i.e. the stakeholder survey). They may, therefore, not be fully reliable and shifts in results next year for these indicators will therefore need to be treated with caution.

# **Overarching measures of meeting the needs of people more likely to have poor care**

These measures are taken from our Annual Awareness survey. They are not included in measures of success for specific equality objectives but are relevant across all objectives.

* **63%** of the public (n=1000) and 63% of those more likely to have poor care (n=326) agreed CQC does what they want as a regulator of health and social care. (8% of the public disagreed).
* **71%** of the public (that were aware of CQC n=569) and 69% of those more likely to have poor care agreed CQC does what they want as a regulator of health and social care
* Those that have chosen a care home, carers and those aged 55+ were more likely to have a negative perception of CQC. We will do more work to understand the concerns of these groups.

**Table 2: Measures of success**

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| **Equality Objective** | **Reference** | **Measures** | **Performance data** | **RAG rating** |
| 1. **Amplifying the voices of people more likely to have a poorer experience of care or have difficulty accessing care**
 | 1.1 | Feedback from people (including those more likely to have poor care) that we use in our regulation | **15%** of all inspections were triggered by information of concern, including whistle blowing, complaints and concerns shared by people, care staff and other stakeholders. Of those inspections that have a recorded risk trigger (not regulatory history), **49%** are triggered by information of concern[[1]](#endnote-2). Note: While only a relatively small proportion of our inspections were triggered by information shared by people, this is because we have focused a lot of our activity on thematic inspections and our internal processes do not systematically record this. Not currently measuring whether this information is from people more likely to have poor care. **48-81%** of people involved in different types of engagement activity to develop our approach were people more likely to have poor care[[2]](#endnote-3). | Amber |
| 1.2 | People, including those more likely to have poor care, say it is easy to share information with us.  | **84%** of the public who have shared information with CQC say it was easy to do this (n=67). For those more likely to have poor care (n=21), 70% agreed it was an easy process to share compared to 93% of those less likely to have poor care (n=43)[[3]](#endnote-4).  | Amber |
| 1.3 | Assessment and review outputs include the views of people – including those more likely to have poor care | Not currently measured – however of those who have used CQC information to understand standards of care they expect to receive, **91%** of those more likely to have poor care agreed (n=33) that CQC's information about the standards of care they can expect focuses on what matters to them and their loved ones. This is higher than the **85%** of those less likely to have poor care (n=62) though based on small numbers[[4]](#endnote-5). | Too early |
| 1.4 | Operational colleagues say we give appropriate weight to people’s experiences of care | We are not collecting this yet but will ask this on our next survey  | Too early |

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| **Equality Objective** | **Reference** | **Measures** | **Performance data** | **RAG rating** |
| 1. **Using data to understand and respond to equality risks**
 | 2.1 | Data items in risk models relating to equality risks | Risk models for our new approach are not finalised yet. However, **13/ 34** quality statements in our new regulatory model are directly related to equality risks, compared to 8/27 Key lines of enquiry for health services and 10/21 key lines of enquiry for adult social care in our existing model[[5]](#endnote-6). Development of our new approach based on “required evidence” for each quality statement is also likely to increase data items related to equality risks.  | Too early |
| 2.2 | Data on equality risks that triggers regulatory action | We are not measuring this yet. | Too early |
| 2.3 | Use of information on equality risks in the reports we publish about our assessments | We are not measuring this yet. | Too early |
| 2.4 | Services, local stakeholders and operational colleagues who say we maintain an up-to-date picture of quality of services, and in local systems, through a range of information | **45%** of local stakeholder survey respondents (n=159) agree with this (7% disagreed, 23% neither agreed nor disagreed and 25% did not know)[[6]](#endnote-7) [This is an aggregation of the figures below] We asked local stakeholders whether CQC maintains an up to date picture of quality using a range of information for the following sectors; * Adult Social Care (n=53) 68% agreed
* Primary Medical Services (n=53) 32% agreed
* Acute Services (n=53) 36% agreed

**82%** of services (n=17,768) say CQC maintains an up to date understanding of quality at their service using a range of information (4% disagreed)[[7]](#endnote-8)Not yet measured for operational colleagues. | Red (local stakeholders) / too early (other groups) |
| **Equality Objective** | **Reference** | **Measures** | **Performance data** | **RAG rating** |
| **Working with others to improve equality of access, experience and outcomes** | 3.1 | Local stakeholders say our work has sufficient focus on reducing inequalities in access, experience and outcomes for people using services | **78%** of services (n=17769) agree with this (17% of services neither agreed nor disagreed[[8]](#endnote-9)). Information not collected yet for local stakeholders.  | Green (services)/ Too early (other groups) |
| 3.2 | Volume of feedback about people's experiences of care from our strategic partners and stakeholders that we can act on | We are not measuring this yet | Too early |
| 3.3 | The number of people, services and local stakeholders who say we act quickly where services fail to improve safety | **52%** of the public that are aware of CQC [[9]](#endnote-10)(n=589), **72%** of services [[10]](#endnote-11)(n=17,723) and **66%** of local stakeholder survey respondents (n=53)[[11]](#endnote-12) say we act quickly where services fail to improve safety (3% of services and 19% of local stakeholders disagreed). Of the public, those that have chosen a care home, those aged 55+ were more likely to have a negative perception.  | Amber |
| 3.4 | Strategic partners and other stakeholders say they have taken action to address safety concerns following information we have shared with them from our regulatory activities. | **74%** of our strategic partners and other stakeholder survey respondents[[12]](#endnote-13) (n=125) say this | Amber |

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| **Equality Objective** | **Reference** | **Measures** | **Performance data** | **RAG rating** |
| **3 continued** | 3.5 | Our commitments with other organisations to tackle inequalities in access, experience and outcomes as measured through revised memoranda of understanding | Only one Memorandum of understanding/ Joint working agreements has been updated and published since the Equality Objectives came into place. This refers to joint working on equality issues[[13]](#endnote-14). | Green |
| 3.6 | Evidence of our response to recommendations made by others concerning inequalities in access, experience and outcomes. | We are not measuring this yet, but are in process of setting up a system to track recommendations to CQC | Too early |
| **Equality Objective** | **Reference** | **Measures** | **Performance data** | **RAG rating** |
| **Using our independent voice to reduce inequalities** | 4.1 | Services and local stakeholders that say our work has encouraged them to reduce inequalities in access, people feeling safe, care (and treatment) meeting people's needs, overall experience and satisfaction, and health and care outcomes | **88%** of services (n=17733) say our work has encouraged them to reduce inequalities in access, experience and outcomes for people who use, or need to use, their services[[14]](#endnote-15) (9% of services neither agreed nor disagreed). This question will also be asked of local stakeholders, but this information is not collected yet. | Green (services)/ too early(other groups) |
| 4.2 | Number of services, local stakeholders and our operational colleagues who say our work has sufficient focus on reducing inequalities | **78%** of services (n=17769) say our work has sufficient focus on reducing inequalities in access, experiences and outcomes for people using services (17% of services neither agreed nor disagreed)[[15]](#endnote-16). This question will also be asked of local stakeholders and our operational colleagues | Green (services)/ too early (other groups) |
| 4.3 | The amount of content in our national reports about addressing inequalities in access, experience and outcome from using care services. | In the first year of the Equality Objectives to date (from 1st August 2021) we, we have published 10 national reports, 5 had a main focus on inequalities and a further 3 had some content on inequalities. In the previous full year, we published 23 national reports, 7 had a major focus on inequalities and a further 13 had some content[[16]](#endnote-17).  | Green |
| 4.4 | Evidence that learning from our independent voice work develops our own approaches to regulating to reduce inequalities, for example through changing our methods | Reports which have influenced our regulatory approach to reducing inequalities include Out of Sight report and Maternity safety, equity and engagement | Too early |

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| **Equality Objective** | **Reference** | **Measures** | **Performance data** | **RAG** |
| **5. Our inclusive future: delivering on our diversity and inclusion strategy for our workforce** | 5.1 | By March 2025 we will have increased representation of colleagues from Black and minority ethnic groups/ communities at all levels of CQC to at least match the economically active population levels and increase the proportion of colleagues from Black and minority ethnic groups/ communities progressing from application to shortlisting to offer, for all internal and external recruitment. | The Workforce Race Equality Standard (WRES) Annual Report 2021 shows representation of Black and Minority Ethnic colleagues across CQC has increased by 1 percentage point in 2021 to 13.8% (the economically active population is 13%). This includes minor increases to representation of Black and Minority Ethnic colleagues at Grade A and Executive Grades (by +0.5% for grade A and +1.2% for Exec grades). The Workforce Race Equality Standard (WRES) Annual Report 2021 indicates that Black and Minority Ethnic colleagues are less likely to be appointed from shortlisting compared to white colleagues. The figure has got worse compared to last year’s report which was 1.088 (this year 1.432). The figure is now outside the ‘non-adverse’ range (the non-adverse range is between 0.80-1.25, meaning any figure outside of this is significant). | Amber |
| 5.2 | By March 2022, colleagues from Black and minority ethnic groups/ communities will experience equal opportunities for career progression, promotion and development; as measured by internal recruitment outcomes, access to funded learning opportunities and survey data. | Black and Minority Ethnic colleagues are more likely to access the Individual Learning Request (ILR) process. The figure (0.667) has significantly improved on 2020’s figure of 1.467. This is due to both an increase of applications from colleagues with a Black or Minority Ethnic background and a decrease in applications from colleagues with a white background. Based on headcount, Black and Minority Ethnic colleagues were more likely to submit an ILR this year than in 2019-20 (18.4% of applications were from Black and Minority Ethnic colleagues compared to 9.2% for the previous year). There is little difference in having an ILR approved between the groups (85% for white, 84% for Black and Minority Ethnic people).Black and Minority Ethnic respondents (38.2%) are less likely to believe that CQC provides equal opportunities for career progression or promotion than white respondents (51.7%). Black and Minority Ethnic respondents’ score has improved from 2020’s report (taken from the November 2019 People Survey) whereas the equivalent score for white respondents saw a minor decrease. | Amber |
| 5.3 | Year-on-year reduction in the proportion of colleagues from Black and minority ethnic groups/ communities reporting that they have personally experienced discrimination of any form. | The Workforce Race Equality Standard (WRES) Annual Report 2021 indicates Black and Minority respondents are more likely to experience discrimination from managers, team leaders or other colleagues (11.5%), than white respondents (4.9%). This figure has increased since last year’s report and has resulted in the gap widening between Black and Minority Ethnic and white colleagues and their experiences. | Red |
| 5.4 | Improve disability, ethnicity, sexual orientation, religion and belief declaration rates in Electronic Staff record to target of 95% | Current Figures as of June 2022 (vs Nov 2021)Disability 94.6% (Nov 2021: 94%, increase of +0.6%)Ethnicity 91.5% (Nov 2021: 91%, increase of +0.5%)Sexual Orientation 84.5% (Nov 2021: 84%, increase of +0.5%)Religion 65.3% (Nov 2021: 64%, increase of +1.3%) | Green |
| 5.5 | Improve representation of disabled colleagues in Exec and C, D and E roles to 7.5% | The Workforce Disability Equality Standard (WDES) Annual Report 2021 indicates disabled colleagues are proportionately represented at the Grades C, D and E (8.2%) and this is an improvement (+1.8%) on the previous year’s report. However, they continue to be underrepresented in our Exec grades (3%), where there is also a higher number of “Not Stated” self-reporting of disability. This was a slight decrease (-0.1%) from the previous year. | Amber |
| 5.6 | Increase likelihood of disabled applicants being appointed from shortlisting | The Workforce Disability Equality Standard (WDES) Annual Report 2021 shows the figure for disabled candidates’ likelihood of being appointed from shortlisting compared to non-disabled candidates has improved since 2020 report from 1.38 to 1.20. The difference in relative likelihood of being shortlisted is within the ‘non-adverse’ range (the non-adverse range is between 0.80-1.25, meaning any figure outside of this is significant).  | Green |
| 5.7 | Reduce gap between disabled colleagues and non-disabled colleagues who say that they have experienced bullying or harassment | The 2021 Workforce Disability Equality Standard (WDES) Annual Report shows 16.9% of disabled colleagues had reported experiencing bullying, harassment or abuse from other CQC staff compared to 7.1% of non-disabled colleagues. However, all figures have improved since the 2020 report (-3.1% for disabled colleagues, -1.9% for non- disabled colleagues). | Green |
| 5.8 | Reduce gap between disabled colleagues and non-disabled colleagues who say that we provide equality in career progression and that their contributions to CQC are recognised | The 2021 Workforce Disability Equality Standard (WDES) Annual Report shows 37.4% of disabled colleagues believe that CQC provides equal opportunities for career progression or promotion compared to 53.2% of non-disabled colleagues. The figure has declined since the 2020 report (-2.6%) whereas the equivalent figure for non-disabled respondents has increased (+1.1%). | Red |
| 5.9 | Improve percentage of colleagues who have had reasonable adjustment requests met from 51% to 100% by March 2022 | The 2021 Workforce Disability Equality Standard (WDES) Annual Report shows CQC made appropriate reasonable adjustments to 67% of disabled colleagues to enable them to carry out their work. The figure has improved since the 2020 report (+16.1%). | Green |
| 5.10 | Achieve Disability confident employer level 3 by March 2023 | We have received our Disability confident employer level 2 award and are on track for level 3.  | Green |
| 5.11 | Achieve Carers Confident employer level 1 by March 2022 and level 2 by March 2023. | Carer Confident employer level 1 was achieved prior to March 2022 and on track for level 2 by March 2023.  | Green |

**Table 3: Caveats or limitations of data**

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| **Evidence sources** | **Overview** | **Caveats or limitations** |
| Annual Awareness Survey | Computer Assisted Telephone Interviews which lasted approximately 15 minutes. This was conducted between December 2021 and January 2022.This was a nationally representative sample of 1000 adults in terms of English region, age, ethnicity and gender. The sample also includes at least 100 responses from CQC’s key sub-groups (carers, recent healthcare users, people with long-term health conditions, and those aged 65+) to allow for meaningful comparisons |  |
| Annual Provider Survey | The Annual Provider Survey is sent to all providers (Registered Manager or Nominated Individual for all registered locations). The survey ran from November to December 2021.Received a response rate of 36.9%.Results from the Annual Provider Survey have been weighted to ensure the responses are representative of the population we surveyed.  | Findings from the annual provider survey showed a high level of positivity. To help us understand what was driving the answers, and whether the results are appropriate to use as a baseline, we are exploring why providers responded the way they did. |
| Annual Stakeholder Survey | The Annual Stakeholder survey was sent to 980 organisations whom CQC has worked with over the past year. This was made up of; * Arms length bodies
* Commissioners of health and care
* Other regulatory bodies
* Integrated Care System leads
* Other commissioning groups
* Other public representatives
* Professional Associations
* Statutory public representatives.

There survey ran from December 2021 to February 2022 (extend a month due to Covid).There was a 23% (227/980) response rate | Low response rates overall and per stakeholder group. Due to low response rates, we were unable to weight the results. Unweighted results are reported which means that the survey results are not representative of the population surveyed and are therefore findings of the groups that responded.  |
| CRM data | System data on our performance |  |
| Internal monitoring- Public engagement log 2021/2022 | Log of insight / co-production undertaken by the Public Engagement Team between 1st April 2021 till 31st March 2022 | Identifying whether co-production/insight that has informed CQC’s definition of quality was undertaken retrospectively therefore there could be some errors.The log reflects work the Public Engagement Team have conducted. This log does not capture coproduction activity that the team is not made aware of.  |

**References in tables**

1. CRM data [↑](#endnote-ref-2)
2. Public engagement insight log 2021-2022 [↑](#endnote-ref-3)
3. Annual Awareness Survey: Dec 2021-Jan 2022 [↑](#endnote-ref-4)
4. Annual Awareness Survey: Dec 2021-Jan 2022 [↑](#endnote-ref-5)
5. Desktop comparison of published assessment frameworks [↑](#endnote-ref-6)
6. Annual stakeholder survey [↑](#endnote-ref-7)
7. Annual provider survey Nov-Dec 2021 [↑](#endnote-ref-8)
8. Annual provider survey Nov-Dec 2021 [↑](#endnote-ref-9)
9. Annual Awareness Survey: Dec 2021-Jan 2022 [↑](#endnote-ref-10)
10. Annual provider survey Nov-Dec 2021 [↑](#endnote-ref-11)
11. Annual stakeholder survey [↑](#endnote-ref-12)
12. Annual stakeholder survey [↑](#endnote-ref-13)
13. Desktop review of published Joint working agreements: https://www.cqc.org.uk/about-us/our-partnerships/joint-working-agreements [↑](#endnote-ref-14)
14. Annual provider survey Nov-Dec 2021 [↑](#endnote-ref-15)
15. Annual provider survey Nov-Dec 2021 [↑](#endnote-ref-16)
16. Desktop review of publications on CQC website [↑](#endnote-ref-17)