



Department
of Health

Culture Change in the NHS

Applying the lessons of the Francis Inquiries

Equality Analysis

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Equality Analysis

Prepared by
The Department of Health, Quality Improvement Team

Equality Analysis

Introduction

1. People want to have confidence that the care they need now, or will need in the future, can support a diversity of needs and aspirations. This means we need to consider the needs of all people, especially those who might traditionally be excluded or who find it difficult to access services and support.
2. Changes to landscape, culture and evidence also mean that consideration of the needs of all people who may access care should be an ongoing process, which is reviewed to reflect both the progress made by organisations and any new or ongoing issues that evidence may have brought to light. Reviewing equality considerations ensures that people can remain confident that the care they need now, or in the future, can support a diversity of needs and aspirations.

Responsibility of the Department of Health to tackle inequality

3. The Department of Health is committed to promoting equality, diversity and human rights and reducing inequalities in health. In its role, it seeks to be an effective champion for all, by:
 - setting national direction and supporting delivery in ways that promote equality and tackle inequalities in health that arise from disadvantage and discrimination;
 - taking action to support people to maximise their health, wellbeing, independence, choice and control; and
 - supporting all the people who work in the health and care system and in the Department of Health to deliver these goals, recognising the value of their differences in the contribution they make.
4. The Equality Act 2010 encourages public bodies to understand how different people will be affected by their activities so that policies and services are appropriate and accessible to all and meet different people's needs. By understanding the effect of their activities on different people, and how inclusive public services can support and open up people's opportunities, public bodies are better placed to deliver policies and services that are efficient and effective.
5. In order for the Department of Health to be compliant with equalities legislation, it needs to demonstrate how it has paid due regard to section 149 of the Act and the three aims of the Public Sector Equality Duty, which are to:
 - eliminate discrimination and other conduct prohibited under the Equality Act 2010;
 - advance equality of opportunity between people who share a protected characteristic and people who do not; and
 - foster good relations between people who share a relevant characteristic and those who do not.
6. The Duty covers the following protected characteristics: age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; and sexual orientation.

Culture Change in the NHS – applying the lessons of the Francis Inquiry one year on

Background

7. *Patients First and Foremost*,¹ published in March 2013, set out the initial response of England's health and social care system to the Public Inquiry into the events at Mid Staffordshire NHS Foundation Trust. It detailed key actions that the health and care system would take to ensure that 'patients are the first and foremost consideration of the system and everyone who works in it' and to restore the NHS to its core values.

8. *Hard Truths: The Journey to Putting Patients First*² was published in November 2013 and set out a full response to the Inquiry, including responses to each of the 290 recommendations that were made. As part of *Hard Truths: The Journey to Putting Patients First*, an Equality Analysis³ was undertaken to assess the impact of the responses on groups with protected characteristics, identifying where further equalities work could be undertaken.

9. *Culture Change in the NHS – applying the lessons of the Francis Inquiries* was published in February 2015 and provides key information on the action taken to address each of the 290 recommendations. This report is the accompanying Equality Analysis and both reports are being undertaken within the context of the original responses made in *Hard Truths: The Journey to Putting Patients First* and its accompanying Equality Analysis.

10. *Culture Change in the NHS – applying the lessons of the Francis Inquiries: Equality Analysis* provides an update to *Hard Truths: The Journey to Putting Patients First: Equality Analysis* and therefore focuses predominantly on new data on protected characteristics that has become available since November 2013. The report also provides evidence of how new policies referenced in the document have considered equalities issues in their development. The document also sets out the further equality work that various organisations have undertaken as part of their commitments in the *Hard Truths: The Journey to Putting Patients First: Equality Analysis*. The document also looks at how evidence has been gathered through stakeholder engagement to give those with protected characteristics, who are often under-represented, a voice. This will ensure that the potential impact of the progress and changes delivered on people who share protected characteristics can be identified and mitigated against as needed.

Evidence and engagement

11. The publication of *Hard Truths: The Journey to Putting Patients First* has been followed by a great deal of action to take forward the measures outlined in response to the 290 recommendations made in the Inquiry. To inform *Culture Change in the NHS – applying the lessons of the Francis Inquiries*, the Department of Health gathered information on the impact these changes had. This was achieved through stakeholder engagement and communication with local health providers and communities. This process was undertaken

¹ Department of Health (2013) *Patients First and Foremost: The Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report.

² Department of Health (2013) *Hard Truths: The Journey to Putting Patients First. The Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry*. www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response.

³ Department of Health (2013) *Hard Truths: The Journey to Putting Patients First. The Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry. Equality Analysis*. www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response.

using a variety of media and platforms, on the basis that this would be an innovative and effective way of talking to patients and members of the public whose voices don't normally get heard. An event with the WeNurses Twitter community was held, using this large online social platform to create an 'open invitation' event to allow as many people as possible from all different backgrounds, roles and locations to have their voices heard equally. This forum provided an opportunity for the Department of Health to hear about experiences from people who would not usually get the chance to speak up and talk about their experience of delivering care, giving a stronger voice to staff across the entire health and care system.⁴

12. Stakeholder engagement was also undertaken with organisations across the health and social care landscape to build a basis of evidence on the impact of *Hard Truths* from a front-line and first-person perspective. This involved contacting NHS, health and community organisations and listening to their 'stories' and experiences of where staff, leaders and patients felt changes had been made following the Public Inquiry and the *Hard Truths* response, as well as what more they felt could be changed to ensure continuous improvement. This was an 'open' request for stories using the Department for Health Connecting program.

13. In order to further inform this analysis, we engaged with those organisations who had committed to undertaking further equality work in *Hard Truths: The Journey to Putting Patients First: Equality Analysis*. These commitments were outlined in Annex A of that document, and the progress made on each of these is included in the Equality Assessment – New Policy section of this document.⁵

14. In order to further inform this analysis we have also reviewed and considered a range of relevant research available online (see footnotes for specific documents).

Equality assessment – new policy

15. *Culture Change in the NHS – applying the lessons of the Francis Inquiries* has been designed with the specific aim of reviewing the progress made against the measures identified in *Hard Truths: The Journey to Putting Patients First*.⁶ All the measures identified in the report strive to improve outcomes for all. This accompanying Equality Analysis seeks to provide an update on the concerns raised last year around people sharing protected characteristics, and to identify what organisations have done and are doing to ensure any negative impacts identified in the *Hard Truths* Equality Analysis are being minimised or eradicated a year on. Each of the commitments to further work identified in the *Hard Truths* Equality Analysis will be covered, by organisation, along with additional work undertaken across the wider community of health and social care organisations in England. This Equality Analysis also provides an assessment of the new policies which are included in the progress report; namely stronger incentives to financially reward organisations that are open and safe and increasing transparency around the funding of complaints advocacy, and how equalities issues have been considered in developing these policies.

16. The NHS is founded on a common set of principles and values that bind together the communities and people it serves. These principles and values are brought together within a single document, the NHS Constitution, which is applicable to all people who are eligible to

⁴ The Francis Effect – Towards 'Hard Truths' One Year On. <http://www.wecomunities.org/tweet-chats/chat-details/315>

⁵ See Annex A of Department of Health (2013) *Hard Truths: The Journey to Putting Patients First: Equality Analysis*. www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response.

⁶ Department of Health (2013) *Hard Truths: The Journey to Putting Patients First. The Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry*. www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response.

use the NHS. In order to update the NHS Constitution, the Department of Health is consulting across a range of areas, including:

- recommendations made in Sir Robert Francis QC’s Public Inquiry;
- fundamental standards;
- mental health;
- Armed Forces covenant;
- named GP; and
- transparency.

17. As an enduring document, the NHS Constitution seeks to reinforce equality, with a specific focus on protected characteristics. As such, the opening principle of the NHS Constitution states that: ‘The NHS provides a comprehensive service, available to all, irrespective of gender, race, disability, belief, gender reassignment, pregnancy and maternity or marital and civil partnership.’ As such, any changes made to the NHS Constitution are applicable to each user, with equal regard. As part of the update, we are looking to further reflect equality through a specific focus on reinforcing a parity of esteem between physical and mental health. The proposed update will be reflected as an NHS Principle – one of seven core values that guide the NHS in all that it does.

18. In *Hard Truths* the Government undertook to consult on proposals about whether a Trust should reimburse a proportion or all of the NHS Litigation Authority’s compensation costs when they have not been open about a safety incident. We therefore plan to release the consultation alongside *Culture Change in the NHS: applying the lessons of the Francis Inquiries*.

Update on equalities issues identified in *Hard Truths: The Journey to Putting Patients First: Equality Analysis*

19. In *Hard Truths* and the accompanying Equality Analysis of 2013, the Care Quality Commission committed to further equality work on several measures that would help to prevent problems in the health and care system. This included a commitment to include patient involvement in the ratings of hospitals, and further equality work to consider how seldom-heard groups would be involved in this. Since this commitment, the Care Quality Commission has consulted (April and June 2014) on how it could change the way it regulates, inspects and rates care services. In July 2014, the Care Quality Commission also published a consultation on guidance for providers meeting the fundamental standards and on Care Quality Commission enforcement powers.⁷ These consultations provided an opportunity for seldom-heard groups to provide their feedback on proposals and for patient involvement in the process. Following the closure of the two consultations, the Care Quality Commission is considering the responses and will publish its new guidance prior to April 2015.

20. As part of the Chief Inspector of Hospitals’ ‘call to action’ to draw patients and clinicians into expert inspection teams, a commitment was also made to consider how patients with protected characteristics could be included in expert inspection teams. Under the leadership of the Chief Inspectors of Hospitals, General Practice and Adult Social Care, the Care Quality Commission has put in place specialist inspection teams that subject providers to greater scrutiny. These teams now routinely involve expert inspectors and people with experience

⁷ Care Quality Commission (2014) *Guidance for providers on meeting the fundamental standards and on CQC’s enforcement powers: Consultation*. www.cqc.org.uk/sites/default/files/20140725_fundamental_standards_and_enforcement_consultation_final.pdf.

of receiving services, including those with protected characteristics. Since April 2014, all inspections of acute NHS Trusts have used the new methodology. In April 2014, the first new-style inspections also started in 200 general practices and also in adult social care. The use of these inspections and a ratings system is vital in giving patients and members of the public from all backgrounds equal access to fair, balanced and easy-to-understand assessments of how well a provider is performing. By involving service users in these inspections to a greater degree, the Care Quality Commission is ensuring greater patient involvement in the process.

21. The Care Quality Commission also committed to continuing to consider the impact of equalities on the development of fundamental standards for health and social care providers, and this has been undertaken through several channels. From January 2014 to April 2014, a public consultation was run to ask for views on changes to the Care Quality Commission registration requirements, in order to introduce fundamental standards of safety and quality for care.⁸ The public nature of this consultation provided an opportunity for seldom-heard voices to contribute to the development of fundamental standards, and also allowed issues of concern to be highlighted and accommodated in the final regulations. An Impact Assessment was also undertaken on the review of the Care Quality Commission registration requirements and this concluded that the costs would not impact service users or any specific groups, while the benefits of improved quality of care through more effective regulation would be realised by users of health and social care services equally.⁹ This assessment also concluded that the policy will not disproportionately affect any one demographic or social group; however, as more generally the users of healthcare services tend to be people from older age groups, lower income distribution and those with disabilities or long-term conditions these groups may benefit at a greater level proportionally.

22. The Department of Health and the Care Quality Commission have also made significant progress on their commitment, made in *Patients First and Foremost* and *Hard Truths: The Journey to Putting Patients First*, to introduce a new statutory Duty of Candour on providers of health and adult social care. The Duty of Candour came into force in November 2014 for health service bodies, while it is intended that a new set of Care Quality Commission registration requirements will come into force in April 2015 for all Care Quality Commission registered providers, which will include the Duty of Candour. This means that, from April 2015, the Duty of Candour will apply to all Care Quality Commission-registered providers. An Impact Assessment was also undertaken on this, which concluded that the benefits of improved quality of care through increased openness and transparency will be realised by users of health and social care services equally. The introduction of the Duty of Candour will therefore not disproportionately affect any one demographic or social group.¹⁰ It also concluded that, in general, the users of healthcare services tend to be people from older age groups, lower income distribution and those with disabilities or long-term conditions and so the introduction of the Duty of Candour will provide an opportunity for these groups to have a greater voice and understanding when things go wrong in their healthcare.

23. The Department of Health and the Care Quality Commission have also made significant progress in taking forward the legislative requirement for providers to undertake the necessary checks to ensure that all directors exhibit the correct types of personal behaviour, technical competence and business practices required for their role. These 'fit and proper person' tests will apply to all Care Quality Commission-registered health and social care providers and, although directors of health and social care organisations are likely to be impacted as

⁸ Department of Health (2014) *Requirements for registration with the Care Quality Commission: Response to consultation*. www.gov.uk/government/consultations/fundamental-standards-for-health-and-social-care-providers.

⁹ Department of Health (2013) *Review of CQC registration requirements: Impact Assessment*. www.gov.uk/government/uploads/system/uploads/attachment_data/file/274721/FS_impact-assessment.pdf.

¹⁰ Department of Health (2013) *Duty of Candour on Providers: Impact Assessment*. www.gov.uk/government/uploads/system/uploads/attachment_data/file/295625/DoC_impact-assessment.pdf.

they will face additional scrutiny over their suitability to become or remain directors of these organisations, there will be no cost impact on service users. Those directors who are found to be unfit for the role will also face costs associated with being removed from their role. An Impact Assessment of this legislation concluded that the benefits of improved quality of care through better assurances on the quality and performance of directors of health and social care providers will be realised by users of health and social care services equally and will not disproportionately affect any one demographic or social group. As the general users of healthcare services tend to be people from older age groups, lower income distribution and those with disabilities or long-term conditions, they are therefore most likely to benefit from the greater scrutiny of the directors leading the services they are accessing.¹¹ Responses to the consultation on strengthening corporate accountability in health and social care also raised concerns about the proposed requirement for directors to be physically and mentally fit to take on the role – and in particular that this might impact on the appointment of service users with disabilities or mental health conditions to Board-level positions. The draft regulation provides that this applies in relation to the relevant position, which will enable the provider to qualify the conditions for service user positions, so as to avoid any adverse impact on those applicants with disabilities.¹²

24. As part of *Hard Truths: The Journey to Putting Patients First*, the Department of Health and NHS England agreed to work together to publish data on patient safety in the key areas that matter most in terms of risk of harm. The Department of Health and NHS England also agreed to consider whether equality data could and should be collated as part of this. Over the past 12 months, these two organisations have worked together with the Health and Social Care Information Centre, the Care Quality Commission and Public Health England to develop a new comparison website tool ‘My NHS’, which allows health and social care organisations to see how their services compare with those of others. Trusts’ Safety Thermometer data is also now more readily accessible through NHS Choices. NHS England has also increased the frequency for publishing ‘never events’ data and has extended the list of specialty outcomes data published for doctors. The data on patient safety on NHS Choices is not collected alongside comprehensive demographic data or data in relation to protected characteristics, so we cannot display or analyse it from an equalities perspective. However, this commitment to transparency will make it easier for people to compare hospitals so that they can make more informed choices and hold local hospitals to account.

25. In *Hard Truths: The Journey to Putting Patients First*, Health Education England outlined how it was introducing a process to ensure that all students entering NHS-funded clinical education programmes were assessed against the values set out in the NHS Constitution. This process also aimed to support NHS organisations in implementing an evidence-based approach to recruiting for values for NHS employees. *Hard Truths: The Journey to Putting Patients First: Equality Analysis* included a commitment to look at how equalities issues are considered as part of recruitment. Since this Equality Analysis was published, equality and diversity has been an important part of Health Education England’s values-based recruitment programme. The Equality and Diversity Assessment, due to be published in early 2015, has shown that values-based recruitment can be seen to positively affect potential equality issues relating to the protected groups (including race, gender, disability, age, sexual orientation and religion) because of the following:

- values-based recruitment promotes evidence-based, best-practice recruitment methodology on the basis of job analysis and ‘job fit’ rather than any of the protected characteristics.

¹¹ Department of Health (2014) *Fit and Proper Persons Requirement for Directors: Impact Assessment*. www.gov.uk/government/uploads/system/uploads/attachment_data/file/296084/Impact_assessment.pdf.

¹² Department of Health (2014) *Fit and Proper Persons Requirement for Directors: Impact Assessment*. www.gov.uk/government/uploads/system/uploads/attachment_data/file/296084/Impact_assessment.pdf.

- values-based recruitment is a non-cognitive assessment, which evidence has shown, unlike cognitive assessments, does not discriminate between subgroups.
- The VBR programme promotes individual, face-to-face, structured interviews to assess values, which can positively affect those who may struggle in a competitive group environment and allows the recruiter to make reasonable adjustments where required.
- It is a prerequisite that the values-based recruitment framework and core requirements are conducted with respect to employment law and local Human Resources and equality and diversity policies to ensure any impact on protected groups is taken into consideration and action taken.
- The values recruited for are those of the NHS Constitution, which are values developed with patients and the public, and are ones which are considered accessible to all and appropriate for all groups. Engagement with patients and the public has shown that these are the expectations wanted from NHS staff providing healthcare to them.
- The values-based recruitment programme has reviewed the resources included in the framework using 16 evidence-based evaluation criteria, one of which is 'fairness and widening participation'. Use of these evaluation criteria will also be encouraged in local assessment of values-based recruitment methodologies, which will support a standardisation of recruitment processes with respect to equality and diversity.

26. Health Education England has also committed to conducting future work that will follow up on the evaluation of values-based recruitment methods, including, in particular, stakeholder views from the recruiting managers, those being recruited and patients from the protected groups. This will be conducted as both local organisation evaluations of values-based recruitment methods and as part of the longitudinal study, commissioned by the Department of Health, to look into the longer-term benefits of values-based recruitment.

27. Health Education England, Skills for Care and Skills for Health also committed to considering the needs of staff with protected characteristics when examining how the 'Care Certificate' can be introduced into regulated health and care settings. They have duly assessed the Certificate's impact on equality and diversity, and people sharing a protected characteristic. The Care Certificate builds on, and replaces, the Common Induction Standards and National Minimum Training Standards, which were developed with extensive engagement. The Care Certificate is not a prerequisite to employment, and, having gone through a fair and open selection process, the new healthcare assistant or social care support worker would only then be expected to demonstrate he or she meets its 15 standards. In addition to this, 'Equality and Diversity' is one of the 15 standards that new healthcare assistants and social care support workers will need to meet in order to achieve the Care Certificate.

28. We know that certain groups continue to face discrimination when using health services. Most organisations recognise that embedding equality in every part of the NHS needs strong leadership and positive engagement with staff. NHS Employers has already taken action to encourage this through the Personal, Fair and Diverse campaign, which highlights the small things that individual 'champions' can do as part of their day job to help to deliver a more inclusive workplace environment and services for patients. NHS Employers and the Social Partnership Forum, in line with their commitments to further equality work in *Hard Truths: The Journey to Putting Patients First: Equality Analysis*, have also considered the needs of staff with protected characteristics in developing guidance on staff engagement and partnership working.¹³ In the last year the Personal, Fair and Diverse campaign has also developed a

¹³ Social Partnership Forum (2014) *SPF Guidance on Staff Engagement and Partnership Working*.
www.socialpartnershipforum.org/media/32850/spf-guidance-on-staff-engagement-and-partnership-working.pdf.

free app and has begun working with various other parts of the public sector – including the Fire and Rescue Service and the Local Government Association in their review of the Equality Framework for Local Government – to promote diversity and inclusion through their campaign.¹⁴

29. The progress made by all these organisations in undertaking the further equality commitments identified in *Hard Truths: The Journey to Putting Patients First: Equality Analysis* is clear from the work that has been undertaken over the past year, and there is also positive evidence of organisations taking additional steps to ensure equality across England’s health and social care system. However, the progress made above also shows us that there is always more that can be done and this is supported by recent evidence and research published over the last 12 months. This document will therefore provide information about the equality issues that have been identified relating to each of the protected characteristics over the past year, as well the continuous longer-term evidence that remains relevant to England’s health and social care system.

Disability

30. People with disabilities use health and care services more often than people who do not have a disability. However, there is continuous evidence to suggest that they routinely struggle to access appropriate care and support; because of this many disabled people experience less favourable health outcomes.¹⁵ Recent evidence reports that some groups of disabled people, such as those with learning disabilities, also face safety issues, for example delays and omissions of treatments and basic care. The main barriers to better and safer hospital care have been reported to be the invisibility of this group of patients within hospitals, owing to a lack of effective flagging systems, and a lack of staff knowledge and understanding of the specific vulnerabilities of this group, including the reasonable adjustments to services that these patients may need.¹⁶ These problems are a matter of significant concern and the introduction of the ‘name above the bed’ system is one of the ways in which these barriers can begin to be tackled, with more still to be done.

31. It is important that people with disabilities are treated fairly and this is vital for an effective health service. Many of those who fall under one of the other protected characteristics and also have a disability report that they have had negative experiences of healthcare in the past year.¹⁷ In addition, a number of people with disabilities, including those who are older and are both disabled and from the lesbian, gay, bisexual and transgender community, report that they are not accessing the health and social care services they need.¹⁸ The introduction of additional information to the NHS Choices site, where a large amount of data is now available in one place to a larger audience, has increased transparency and the level of information available to the whole of society including these groups that often struggle to access the services they need. The ‘Friends and Family Test’, which was introduced in 2013, also asks patients whether they would recommend hospital wards, Accident and Emergency departments and maternity services to their friends and family if they needed

¹⁴ www.nhsemployers.org/campaigns/pfd-campaign.

¹⁵ Sir Michael, J. (2008) *Healthcare for All: Report of the Independent Inquiry into Access to Healthcare for People with Learning Disabilities*. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_106126.pdf.

¹⁶ Tuffrey-Wijne, I., Giatras, N., Goulding, L., Abraham, E., Fenwick, L., Edwards, C. and Hollins, S. (2013) Identifying the factors affecting the implementation of strategies to promote a safer environment for patients with learning disabilities in NHS hospitals: a mixed-methods study. *Health Services and Delivery Research*, 1(13).

¹⁷ Stonewall (n.d.) *Stonewall Health Briefing: Disability*. www.stonewall.org.uk/documents/disability_1.pdf.

¹⁸ Stonewall and YouGov (2010) *Lesbian, Gay and Bisexual People in Later Life*. www.stonewall.org.uk/documents/lgb_in_later_life_final.pdf.

similar care or treatment.¹⁹ The test provides near real-time information to drive improvements to service delivery and so far nearly five million responses have been collected. By providing an opportunity for every patient in these wards and departments to be able to give quick feedback on the quality of the care they receive, hospitals gain a better understanding of the needs of their patients, which enables improvements for patients including those who fall under one or more of the protected characteristics. An NHS England review of the first six months of the Friends and Family Test found that 85 per cent of NHS Trusts used it to improve patient experience and 78 per cent reported that it had increased the emphasis placed on patient experience in their Trusts.²⁰

32. It is important that all patients, their carers and families are listened to and that their views are considered and responded to. There has been consistent evidence that people with hidden disabilities, such as learning disabilities, often experience health inequalities and poor NHS provision, leading to avoidable harm and avoidable premature death. One of the main barriers to better and safer care has been reported to be a lack of consistent and effective carer involvement and misunderstanding by staff of the carer role, alongside a lack of clear lines of responsibility and accountability for the care of each patient with learning disabilities.²¹ The introduction of having a named doctor and/or nurse responsible for each patient is one of the ways that greater consistency in terms of patient and carer knowledge can be facilitated.

33. There also remains evidence of disabled NHS employees experiencing difficulties with accessing the support they need. In the 2013 NHS staff survey 16 per cent of NHS staff (35,744) classified themselves as having a longstanding disability and, of this number, 15 per cent did not feel that their employer had made adequate adjustments to enable them to carry out their work. This compared with 40 per cent of those classifying themselves as having a longstanding disability, who felt that their employer had made reasonable adjustments. Overall, this suggests that there is further work for employers to do.²²

Sex

34. Men and women share many similar health risks; however, the use of health services continues to form a different pattern for men and women. For example, men make up 49 per cent of the population and accounted for 48 per cent of the mental health and learning disability Trust inpatient episodes. In comparison, women make up 51 per cent of the population in England and accounted for 56 per cent of acute hospital inpatient episodes.²³ We also know that more women continue to use social care services than men,²⁴ with women making up two-thirds of the population that suffer from dementia, and women being twice as likely as men to be disproportionately affected by post-traumatic stress disorder, self-harm and eating disorders.

¹⁹ NHS Choices: NHS Friends and Family Test. www.nhs.uk/NHSEngland/AboutNHSservices/Pages/nhs-friends-and-family-test.aspx.

²⁰ Department of Health (2015) *Culture Change in the NHS – applying the lessons of the Francis Inquiries*.

²¹ Tuffrey-Wijne, I., Giatras, N., Goulding, L., Abraham, E., Fenwick, L., Edwards, C. and Hollins, S. (2013) Identifying the factors affecting the implementation of strategies to promote a safer environment for patients with learning disabilities in NHS hospitals: a mixed-methods study. *Health Services and Delivery Research*, 1(13).

²² NHS Staff Survey 2013. www.nhsstaffsurveys.com/Page/1019/Latest-Results/Staff-Survey-2013-Detailed-Spreadsheets/.

²³ Care Quality Commission (2014) *Equality counts: Equality information for CQC in 2013*. www.cqc.org.uk/sites/default/files/documents/edhr_annual_report_january_2014final.pdf.

²⁴ Care Quality Commission (2013) *Equality matters: Equality information for CQC in 2012*. www.yhsccommissioning.org.uk/docs/CQCEqualityMatters.pdf. Care Quality Commission (2014) *Equality counts: Equality information for CQC in 2013*. www.cqc.org.uk/sites/default/files/documents/edhr_annual_report_january_2014final.pdf.

35. There is evidence that there is stigma around certain illnesses that impacts the likelihood of women accessing services. Women are also more likely to live with long-term mental health problems and to suffer from violence.²⁵ Stigma and not being taken seriously were two of the main reasons why women with mental health problems and HIV had not sought help, or had encountered ignorance and prejudice when accessing healthcare provisions.²⁶

36. The NHS continues to employ a significantly higher number of women than men. In the 2013 and 2012 NHS Staff Surveys, 78 per cent of respondents classified themselves as female and 22 per cent classified themselves men.²⁷ A recent report has also identified that, although these figures are reflected in the lower levels of the organisation, there remain a smaller number of women at a senior leadership level compared with their male counterparts across both the NHS and the civil service.²⁸

37. Although men and women have different health needs, there is no evidence to suggest a clear trend in either gender receiving worse healthcare than the other; however, there is evidence to suggest that both genders may find instances where their health needs are not met. For example, we know that women have specific concerns about maternity services and men are less likely to use their GP.²⁹

Race

38. There is evidence to suggest that some groups experience significantly higher levels of ill health than the rest of the population and, as result, make more use of health services. For example those from black or South Asian communities are more likely to develop diabetes, high blood pressure and health conditions that are linked to this, such as kidney problems.³⁰ The higher propensity of certain communities to experience illnesses that require higher levels of care will therefore have an impact on the amount that these communities use health services.³¹

39. There are also differences between and within ethnic groups that affect both the types of service use and health inequalities.³² For example, in the Irish and Chinese communities older people are more likely to use mental health services than older people from any other groups; however, Irish and Chinese children have fewer admissions to mental health services than any other groups, suggesting that mental health issues are more likely to present themselves at different ages within different community groups. There is also significant

²⁵ Maternity Action and Women's Health & Equality Consortium (WHEC) (2014) *Women's voices on health: Addressing barriers to accessing primary care*. www.maternityaction.org.uk/wp/wp-content/uploads/2014/05/Access-to-Primary-Care-report-FINAL.pdf.

²⁶ Women's Health & Equality Consortium (2014) *'I am more than one thing': A guiding paper by Imkaan, Positively UK and Rape Crisis England and Wales on women and mental health*. www.whec.org.uk/wordpress/.

²⁷ NHS Staff Survey 2013. www.nhsstaffsurveys.com/Page/1006/Latest-Results/2013-Results/. NHS Staff Survey 2012. www.nhsstaffsurveys.com/Page/1037/Past-Results/Staff-Survey-2012-Detailed-Spreadsheets/.

²⁸ Hay Group (2014) *Women in Whitehall: Culture, leadership, talent*. www.gov.uk/government/publications/women-in-whitehall-culture-leadership-talent. Kline, R. (2014) *The 'snowy white peaks' of the NHS: A survey of discrimination in governance and leadership and the potential impact on patient care in London and England*. www.hsj.co.uk/Journals/2014/04/09/w/n/j/The-snowy-white-peaks-of-the-NHS.final.docx.pdf.pdf.

²⁹ Equality and Human Rights Commission (2010) *How fair is Britain? Equality, human rights and good relations in 2010*. www.gov.uk/government/publications/how-fair-is-britain-equality-human-rights-and-good-relations-in-2010-the-first-triennial-review.

³⁰ Care Quality Commission (2014) *Equality counts: Equality information for CQC in 2013*. www.cqc.org.uk/sites/default/files/documents/edhr_annual_report_january_2014final.pdf.

³¹ Care Quality Commission (2014) *Equality counts: Equality information for CQC in 2013*. www.cqc.org.uk/sites/default/files/documents/edhr_annual_report_january_2014final.pdf.

³² Care Quality Commission (2014) *Equality counts: Equality information for CQC in 2013*. www.cqc.org.uk/sites/default/files/documents/edhr_annual_report_january_2014final.pdf.

evidence that people from African-Caribbean and African backgrounds are three times more likely to be mental health patients than the rest of the population, and that these groups experience significantly greater dissatisfaction with mental health services than their white counterparts.³³

40. There are also some groups of people who have very low levels of health and wellbeing, in particular gypsies and travellers, asylum seekers and refugees.³⁴ These groups have reported experiences of outright rejection and prejudice, as well as problems with inconsistent information about what services are available to them.³⁵ To begin to address this disparity the Care Quality Commission has introduced the SpeakOut network and eQuality Voices group to allow consultation and engagement with a wide variety of groups, including gypsies, travellers, black, minority and ethnic communities and refugees, on a range of health topics. This is an ongoing process and alternative communication methods must continue to be used to facilitate a positive impact on equality for different groups.

41. One of the main barriers to engaging with individuals from black, minority and ethnic groups that is repeatedly identified is communication. This ranges from an inability to communicate due to language barriers, to a lack of recognition of ethnic difference and ignorance of the problems facing communities, leading to their issues being dismissed.³⁶ There is also evidence that a lack of confidence around healthcare professionals' ability to handle health issues that stem from within black, minority and ethnic communities constitutes a barrier to getting help, for instance with issues relating to female genital mutilation.³⁷ To begin to address and improve ways that people are engaged in their care, various healthcare providers in areas with a high ethnic population have begun to produce copies of leaflets in multiple languages. More broadly, the Care Quality Commission's new inspections process has already begun to identify cases of poor interpreting services for people in acute hospitals in areas of high minority populations. Improvements to services have been fuelled by addressing these issues in the Care Quality Commission's inspection reports, leading to people with English as a second language receiving better information, in their native language, on their care and treatment through translators.

42. The NHS continues to employ a disproportionately small number of people from black, minority and ethnic communities, in comparison with the wider social make-up of British society.

³³ Care Quality Commission (2014) *Equality counts: Equality information for CQC in 2013*. www.cqc.org.uk/sites/default/files/documents/edhr_annual_report_january_2014final.pdf.

³⁴ Care Quality Commission (2014) *Equality counts: Equality information for CQC in 2013*. www.cqc.org.uk/sites/default/files/documents/edhr_annual_report_january_2014final.pdf.

³⁵ Maternity Action and the Women's Health & Equality Consortium (WHEC) (2014) *Women's voices on health: Addressing barriers to accessing primary care*. www.maternityaction.org.uk/wp/wp-content/uploads/2014/05/Access-to-Primary-Care-report-FINAL.pdf.

³⁶ Department of Health (2012) *The Mandate: Equality Analysis*. www.gov.uk/government/uploads/system/uploads/attachment_data/file/213134/Full-EA-Mandate-v11.pdf. Care Quality Commission (2014) *Equality counts: Equality information from CQC in 2013*. www.cqc.org.uk/sites/default/files/documents/edhr_annual_report_january_2014final.pdf.

³⁷ Maternity Action and the Women's Health & Equality Consortium (WHEC) (2014) *Women's voices on health: Addressing barriers to accessing primary care*. www.maternityaction.org.uk/wp/wp-content/uploads/2014/05/Access-to-Primary-Care-report-FINAL.pdf.

2013 NHS staff survey results

Classification given by respondents	Percentage (%) of total respondents
White British	82%
White other	3%
Asian British	7%
Black British	4%
White Irish	2%
Chinese	1%
Mixed ³⁸	0%

43. Research has also found that there is a correlation between reported discrimination against black, minority and ethnic staff in the workplace and several areas of the patient experience.³⁹ This has been supported by a range of evidence that higher levels of staff engagement and positive experience links to better patient experience, producing benefits for the NHS.⁴⁰ The most recent NHS Staff Survey in 2013 recorded that a small number of staff have experienced discrimination at work in the last 12 months and the biggest reason reported for this was on the basis of their ethnic background.⁴¹

44. There is significant evidence that the way healthcare staff are treated and the diversity in healthcare leadership makes a decisive difference to healthcare and to the wellbeing of patients in healthcare settings. At a senior level there is evidence of a continuing gap between the composition of Boards of NHS bodies and the rest of the workforce and local population.⁴² Organisations across the health and care sector have acknowledged this evidence and are committed to understanding and addressing this problem.

Sexual orientation

45. Evidence shows that a third of gay and bisexual men who have accessed healthcare services in the last year have had a negative experience related to their sexual orientation. Gay and bisexual men were also reported as less likely than other patients in general to feel they were treated with respect and dignity all of the time across key health services.⁴³ This was also the case for lesbian and bisexual women, half of whom reported having

³⁸ This data is calculated on the basis that there are a range of sizes of organisation responding and therefore if there are less than 11 respondents on any question a score of 0 is recorded to ensure the data remains anonymous. This is why this figure is 0% for number of respondents.

³⁹ Dawson, J. (2009) *Does the experience of staff working in the NHS link to the patient experience of care? An analysis of links between the 2007 acute trust inpatient and NHS staff surveys*. Aston Business School. www.gov.uk/government/uploads/system/uploads/attachment_data/file/215457/dh_129662.pdf.

⁴⁰ Social Partnership Forum (2014) *SPF guidance on staff engagement and partnership working*. www.socialpartnershipforum.org/media/32850/spf-guidance-on-staff-engagement-and-partnership-working.pdf.
Dawson, J. (2009) *Does the experience of staff working in the NHS link to the patient experience of care? An analysis of links between the 2007 acute trust inpatient and NHS staff surveys*. Aston Business School. www.gov.uk/government/uploads/system/uploads/attachment_data/file/215457/dh_129662.pdf.

⁴¹ NHS Staff Survey 2013. Briefing Note. www.nhsstaffsurveys.com/Caches/Files/NHS%20staff%20survey_nationalbriefing_2013_FINAL.pdf. The percentage of staff that experienced discrimination at work from colleagues or patients and their relatives or carers was 11.6 per cent in 2013 and 11.9 per cent in 2012.

⁴² Kline, R. (2014) *The 'snowy white peaks' of the NHS: A survey of discrimination in governance and leadership and the potential impact on patient care in London and England*. www.hsj.co.uk/Journals/2014/04/09/w/n/j/The-snowy-white-peaks-of-the-NHS.final.docx.pdf.

⁴³ Stonewall (2012) *Gay and Bisexual Men's Health Survey*. www.stonewall.org.uk/documents/stonewall_gay_mens_health_final.pdf.

negative experiences in the health sector over the 12-month period prior to a 2008 survey.⁴⁴ This negative experience extends across accident and emergency, hospital inpatient and outpatient settings; for example, the percentage of gay and bisexual men who felt they were treated with respect and dignity was lower than in the general population for all of these areas.⁴⁵

46. Research has found that gay and lesbian staff in the NHS continue to experience hostility and discrimination at work.⁴⁶ This makes it harder for them to perform well in their jobs. Staff who are fully able to be themselves at work are more likely to enjoy going to work as well as feel more confident and therefore be more productive. This is something that Health Education England has begun to tackle both by introducing values-based recruitment and by making ‘Equality and Diversity’ one of the 15 requirements for success in achieving the Care Certificate.

Age

Children and young people

47. The 2013 document *Hard Truths: The Journey to Putting Patients First: Equality Analysis* highlighted that children, young people and their families often struggle to get their voices heard and to be involved in decisions about their own health.⁴⁷ The reports of the Children and Young People’s Health Outcomes Forum, and its response to the Francis Inquiry report, have helped to focus attention on the safety of children and young people in health services and have prompted significant action.⁴⁸

48. NHS England is leading on a range of work to improve children and young people’s patient safety. The initial focus, highlighted in the NHS Outcomes Framework, is the recognition of and response to clinical deterioration in children and young people.⁴⁹ In addition, a related focus for maternity services and newborn care is the reduction of full-term babies that need to be admitted into neonatal care. The programme focusing on clinical deterioration includes: work to reduce avoidable harm and death caused by sepsis; an aggregate review of investigations into deterioration incidents in children to develop examples of good practice; and a resource to promote safety by working in closer partnership with children, young people and families.

49. NHS England also has a number of business plan objectives relating to safeguarding children and young people, which is a vital element of the safety agenda. These include delivery of the Child Protection – Information Sharing system, which will help the NHS give

⁴⁴ Stonewall (2008) *Prescription for Change: Lesbian and bisexual women’s health check 2008*. www.stonewall.org.uk/documents/prescription_for_change.pdf.

⁴⁵ Stonewall (2012) *Gay and Bisexual Men’s Health Survey*. www.stonewall.org.uk/documents/stonewall_gay_mens_health_final.pdf.

⁴⁶ Stonewall (2012) *Sexual Orientation: A guide for the NHS*. www.stonewall.org.uk/documents/stonewall_guide_for_the_nhs_web.pdf.

⁴⁷ Department of Health (2013) *Hard Truths: The Journey to Putting Patients First. The Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry. Equality Analysis*. www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response. *NHS National Patient Safety Agency and National Reporting and Learning Service (2009) Review of patient safety for children and young people*. www.nrls.npsa.nhs.uk/resources/?entryid45=59864.

⁴⁸ *Report of the Children and Young People’s Health Outcomes Forum 2013/14*. www.gov.uk/government/uploads/system/uploads/attachment_data/file/307011/CYPHOF_Annual_Report_201314_FORMAT_V1.5.pdf. Children and Young People’s Health Outcomes Forum Report for the Secretary of State for Health :Response to the Francis inquiry report https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307307/CYPHOF_Francis_report_-_final_23_Oct_13.pdf

⁴⁹ NHS Outcomes Framework 2013/14 <https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014>

a higher level of protection to vulnerable children who present in unscheduled healthcare settings. The rollout of Child Protection – Information Sharing system to first-wave sites in London and the northwest of England started in October.

50. NHS England has established a children and young people’s patient safety expert group and supports the Maternity, Children and Young People’s Strategic Clinical Network to address specific safety elements relevant to children and young people. It has also commissioned a new paediatric patient safety thermometer, which measures medication omissions, skin integrity, deterioration and pain as a tool for local improvement.

51. Children are often at the greatest risk of medication errors. The Department of Health is now funding the development, led by the Royal College of Paediatrics and Child Health, of a one-stop, web-based resource, Paediatric Care Online UK, based on an American model. It will provide an online decision support tool, a quality improvement network to improve medicine safety and reduce harm from paediatric medication errors, and development of good practice guidelines.

52. NHS England has also commissioned the Healthcare Quality Improvement Partnership to lead on an 18-month development project for a national information system and database to support national child death overview panels.

53. For those cases where children and young people need to be admitted to hospital for mental health treatment, the Mental Health Act 2007 introduced new provisions that took effect in April 2010, to help to ensure that patients under the age of 18 are accommodated in an environment that is suitable for their age. The Children and Young People’s Mental Health and Well-Being Taskforce, announced in July 2014, will consider age-appropriate care and issues relating to the safety and outcomes of young people with mental health conditions. The Taskforce will publish its findings in spring 2015.

54. The Children and Young People’s Health Outcomes Forum has identified culture as a key focus of its work programme for 2014–15. It highlights the importance of engaging with children and young people – both at the level of their individual involvement in clinical decisions and their participation to inform strategy and service improvement.

55. Significant work is being done at a national level to engage with children and young people. NHS England intends to roll out the Friends and Family Test to all areas, including children and young people, by 2015. The Care Quality Commission has begun a survey of the experiences of children and young people in inpatient and day-care settings. This survey will cover a number of areas identified as key gaps by the Forum, such as staying on an age-appropriate ward, feeling safe, and the provision of information about their condition in a way that the child or young person can understand.

56. There is also recent evidence to suggest that the availability of data focusing on transition, integration and age-appropriate care needs to be improved in order to ensure health and wellbeing outcomes for children and young people are monitored and action is taken where needed.⁵⁰ Research into the transition to adult services by children and young people with complex physical health needs also found the system to be ‘fragmented, confusing ... and difficult to navigate’.⁵¹ The Department of Health and NHS England have begun to address this by bringing together patient safety data on NHS Choices, while Healthwatch England has developed a toolkit and resources for staff on how to work with and engage children, young people and their families.

⁵⁰ *Report of the Children and Young People’s Health Outcomes Forum 2013/14*. www.gov.uk/government/uploads/system/uploads/attachment_data/file/307011/CYPHOF_Annual_Report_201314_FORMAT_V1.5.pdf.

⁵¹ Care Quality Commission (2014) *The State of Health Care and Adult Social Care in England*, p.22. www.cqc.org.uk/content/state-care-2013-14.

Older people

57. Older people are more likely to use health and social care services than the rest of the population.⁵² They can be especially vulnerable as they are likely to be multiple service users and evidence shows that this means they are the most likely to suffer problems with coordination of care and delays in transitions between services.⁵³ For example, 40 per cent of older people over 65 in hospital suffer from dementia.⁵⁴ They are also physically frailer and continue to have limited personal autonomy in unfamiliar settings.

58. Research also suggests that a shift towards more coordinated care around the full range of an individual's needs, as well as preventative care and support for independent living are vital to supporting older people.⁵⁵ There is also evidence that poor communication with patients, service users and their carers, and ageism and other misperceptions of older people, all result in this group suffering from poorer health outcomes.⁵⁶

59. In order to mitigate these factors, the Department of Health has supported the development of guidance on the 'responsible clinician', produced by the Academy of Medical Royal Colleges, so that every patient in a hospital ward has a named doctor and named nurse responsible for their care during their stay. The new arrangements for the Care Quality Commission inspections and regulations also include a commitment to cooperate in the sharing of information. In addition, the General Medical Council and the Nursing and Midwifery Council have established operational protocols with the Care Quality Commission, which include information sharing. The introduction of the Friends and Family Test has also provided an opportunity for service users, including older people, to provide feedback.

Other identified groups

Gender reassignment (including transgender)

60. Data indicated that health outcomes were poor for transgender and transsexual people in the 2013 *Hard Truths: The Journey to Putting Patients First: Equality Analysis*, and research undertaken has found no further literature produced over the last 12 months. The previous limited evidence suggested that transgender and transsexual people avoid accessing routine healthcare because they anticipate prejudicial treatment from healthcare professionals. People felt that being transgendered or transsexual adversely affected the way that they were treated by healthcare professionals and that clinicians often lack information to treat transgender and transsexual people effectively.⁵⁷

61. It was also identified in the 2013 *Hard Truths: The Journey to Putting Patients First: Equality Analysis* that measures being introduced to ensure that staff are supported and well trained will be central to addressing these issues and to ensuring good outcomes for transgender and transsexual people. Health Education England committed to considering this further as it developed proposals to support improvements to continuous development and

⁵² Care Quality Commission (2014) *Equality counts: Equality Information from CQC in 2013*. www.cqc.org.uk/sites/default/files/documents/edhr_annual_report_january_2014final.pdf.

⁵³ The King's Fund (2014) *Making our health and care systems fit for an ageing population*. www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population.

⁵⁴ Care Quality Commission (2014) *Cracks in the Pathway*. www.cqc.org.uk/sites/default/files/20141009_cracks_in_the_pathway_final_0.pdf.

⁵⁵ The King's Fund (2014) *Making our health and care systems fit for an ageing population*. www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population.

⁵⁶ Age UK (2013) *End of Life Evidence Review*. www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/Age%20UK%20End%20of%20Life%20Evidence%20Review%202013.pdf?dtrk=true.

⁵⁷ Whittle, S., Turner, L., Combs, R., Rhodes, S. (2008) *Transgender EuroStudy: Legal Survey and Focus on the Transgender Experience of Health Care*. www.ptc.org.uk/pdf/eurostudy.pdf.

appraisals. This was progressed through the consultation and development of values-based recruitment and further plans to follow up on the evaluation of values-based recruitment methods through stakeholder views from the recruiting managers, those being recruited and patients from the protected characteristic groups. ‘Equality and Diversity’ has been included as one of the 15 standards that new healthcare assistants and social care support workers will need to meet as part of the Care Certificate.

Religion or belief

62. Health inequalities for people of different religions or beliefs are not well understood, but some minority ethnic groups consistently report lower satisfaction with health and social care services than the rest of the population.⁵⁸ In recruitment terms, it is important that the ethnic composition of the health and care workforce reflects the communities it serves. All staff should receive diversity training that includes knowledge to enable them to develop an empathy with the religions and beliefs of people who may need care. The work that Health Education England has undertaken on values-based recruitment and the inclusion of ‘Equality and Diversity’ as one of the standards that new healthcare assistants and social care support workers will need to meet as part of the Care Certificate are the main ways that this is being addressed.

63. Previous research has shown that certain groups face considerable access issues, which can lead to poorer health outcomes. For instance, older Muslim and Sikh women, particularly those with poor English language skills, appear to suffer heavy burdens of ill health, disability and also caring responsibilities. These women are also often in a weak position to negotiate religiously appropriate support from statutory services.⁵⁹ Organisations across the health and social care system have begun to address this by ensuing pamphlets are available in different languages so that those people who might face barriers to understanding what will take place during visits to health services and appointments are better informed.

Pregnancy and maternity

64. A longstanding problem identified with maternity services in the *Hard Truths: The Journey to Putting Patients First: Equality Analysis* was about disrespectful behaviours experienced by patients, and in particular by ethnic minority patients.⁶⁰ Recent findings from a project to address safety on maternity wards also included the need for more coordinated working between staff at all levels, from senior leaders and front-line staff to midwifery and obstetrics teams, in order to ensure safer maternity services.⁶¹

65. The Department of Health has implemented a range of measures to improve health outcomes for pregnancy and maternity. This includes giving people who are expecting a

⁵⁸ Care Quality Commission (2013) *A New Start: Consultation on changes to the way CQC regulates, inspects and monitors care services – Equality and human rights duties impact analysis*. www.cqc.org.uk/sites/default/files/documents/20130616_eia_a_new_start_consultation_final.pdf.

⁵⁹ Allmark, P., Salway, S. and Piercy, H. (eds.) (2010) *Life and Health: An evidence review and synthesis for the Equality and Human Rights Commission's Triennial Review 2010*. Centre for Health and Social Care Research, Sheffield Hallam University. www.equalityhumanrights.com/uploaded_files/triennial_review/triennial_review_life_health_omnibus.pdf.

⁶⁰ Allmark, P., Salway, S. and Piercy, H. (eds.) (2010) *Life and Health: An evidence review and synthesis for the Equality and Human Rights Commission's Triennial Review 2010*. Centre for Health and Social Care Research, Sheffield Hallam University. www.equalityhumanrights.com/uploaded_files/triennial_review/triennial_review_life_health_omnibus.pdf.

⁶¹ The Health Foundation (2010) Snapshot: Safer maternity services: Experiences and learning from our ‘improving the safety of maternity services’ programme. www.health.org.uk/public/cms/75/76/313/591/Snapshot%20Safer%20Maternity%20Services.pdf?realName=FhZP8W.pdf.

baby a choice about where and how they give birth, and assigning women a single, named midwife who will oversee their care during and after their pregnancy. There has also been a commitment to making sure that women who have postnatal depression and women who have suffered a miscarriage, stillbirth or the death of a baby get more support from the NHS. The Friends and Family Test, which was introduced in 2013, also asks patients whether they would recommend hospital wards, Accident and Emergency departments and maternity services to their friends and family if they needed similar care or treatment.⁶² Since April 2014, it has been used for all women who use NHS-funded maternity services, with more than 440,000 maternity patients responding. The value of this can be seen in an NHS England review of the first six months of the Friends and Family Test, which found that 85 per cent of NHS Trusts are using it to improve patient experience and 78 per cent reported that it had increased the emphasis placed on patient experience in their Trusts.⁶³

⁶² NHS Choices: NHS Friends and Family Test.
www.nhs.uk/NHSEngland/AboutNHSservices/Pages/nhs-friends-and-family-test.aspx.

⁶³ Department of Health (2015) *Culture Change in the NHS – applying the lessons of the Francis Inquiries*.