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Tackling workforce inequalities in health and adult social care

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Institute for Employment Studies

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Foreword

The case has long been made that there is a connection between workforce discrimination and care quality in health and social care. When there are issues of discrimination, there is an impact on teamwork. Staff are less likely to speak up about safety or care quality issues or if they do, their views may not be heard or acted on. Staff experiencing discrimination are more likely to leave their jobs. This impacts on staff availability and continuity of care for people. This is why we have an interest in workforce equality as the care quality regulator.

We know from data such as the NHS Workforce Race Equality Standard (WRES), and importantly from people's own testimonies, that workforce inequalities such as racism persist in health and social care. This new research clearly demonstrates that racism and other types of discrimination has an impact on the health and wellbeing of staff and team culture, which in turn affects quality of care for people using services. So, everyone interested in care quality needs to take workforce equality seriously as a key quality and safety issue.

We have been considering workforce equality in our regulation of NHS Trusts since the start of the WRES in 2015. We are becoming more confident at using our range of regulatory levers for improving workforce equity. We have introduced a "Workforce equality, diversity and inclusion" quality statement into our assessments of services. Where necessary and possible, we are more frequently using the Health and Social Care Act regulations to bring about change on workforce inequalities. So why did we need this research now?

Firstly, nearly all the existing evidence relates to NHS trusts. So, we wanted to map workforce inequalities in all care settings that we regulate, including care homes, GP practices and dental surgeries. Secondly, we wanted to develop more direct evidence of the causes and effects of inequalities. This includes the impacts on both staff and care quality. Thirdly, we wanted to increase our understanding on key issues. For example, how individuals may experience discrimination in multiple ways. Also, what works to tackle discrimination and advance equity. This will help us regulate better.

To meet these aims, we centred the research on an in-depth survey of staff working in health and social care. This is supported by interviews with providers and their representative bodies as well as an extensive literature review. This was followed by workshops with inspectors and other colleagues in CQC to help the research team make tailored recommendations for our regulation.

The findings of the research cover the types of workforce inequalities experienced and the impact of discrimination based on more than one characteristic, sometimes called intersectionality or combined discrimination. It then examines the conditions driving these

inequalities and its effects on both staff and care quality. The final section looks at how to reduce workplace inequalities. A key finding in this section is that engagement of senior leaders in workforce equality is highly valued by staff as effective for tackling workforce inequalities. However, is not reported as one of the most commonly undertaken initiatives. So, whilst the findings should be of interest to anyone concerned with care quality, we urge those of us in senior leadership positions to study this report particularly carefully. And to take the action needed to progress workforce equality in our organisations, for the benefit of both staff and people who use health and care services.

Julian Hartley, Chief Executive of Care Quality Commission

Joyce Frederick, Director of Policy and Strategy, Care Quality Commission

Executive summary

CQC commissioned research on workforce inequalities in the health and adult social care sector to understand the role of systemic, institutional, and interpersonal discrimination and the best ways to tackle these through regulation. The study was conducted by the Institute for Employment Studies, in collaboration with IFF Research.

The main aims of the research were to identify:

- effective methods to evidence workforce inequalities beyond the use of established datasets,
- effective approaches that health and care providers can use to address these workforce inequalities and how these can be assessed through regulation,
- and, how to use CQC's regulatory impact mechanisms to achieve desired change.

The study was designed using a mixed-methods approach, combining an evidence review, an employee voice survey, and organisational case studies. This collection of primary data is a departure from usual CQC research practice of working with secondary sources. This provides new evidence that brings the experiences of staff working in the health and adult social care sector to of the forefront of the findings and recommendations.

The research findings are divided into three sections – mapping the incidence and behavioural manifestation of workforce inequalities, exploring the underlying causes and their impact on staff as well as people who use health and care services, and finally, identifying effective practices for addressing or reducing workforce inequalities.

Insights from the literature review, employee voice survey and provider case studies were synthesised and then discussed with senior CQC stakeholders and inspectors. This process informed tailored recommendations aligned with CQC's eight regulatory impact mechanisms.

Mapping workforce inequalities

- The survey found that race/ethnicity inequalities were most frequently experienced and/or observed, followed by sex or gender, physical disability/condition, nationality, and mental health condition/illness-related inequalities.
- Of the 646 survey respondents, 41% reported having personally experienced and/or observed race/ethnicity-related inequalities, while 32% reported sex or gender related unequal treatment, 22% reported physical disability/condition, and 18% reported mental health condition/illness and nationality-related inequality.

- There was a high incidence of combined discrimination or intersectional discrimination, which is when a person is discriminated against because of a combination of two or more protected characteristics. More than two-thirds of survey respondents reported experiencing and/or observing two or more types of inequalities.
- Race/ethnicity was the most common intersecting characteristic, most commonly reported, along with nationality inequality by 20% of survey respondents. This was closely followed by race/ethnicity inequality combined with gender, religion, and physical or mental health conditions or illness inequalities, respectively.
- Unequal treatment at work manifested in the form of microaggressions, social exclusion, and lack of access to opportunities.
- People experiencing physical disability/condition-related inequality were more likely to report social exclusion, unfair treatment at work and limited access to opportunities, highlighting concerns around workplace accessibility and broader inclusion issues.
- Low pay is an important axis of inequality and discrimination, with significant over-representation of ethnic minority and international migrant staff in low-paid jobs.
- Managers or team leaders were reported as the most common source of discriminatory behaviour for those experiencing inequalities due to physical disability/condition (77%), mental health condition/illness (67%), and gender (60%).
- Colleagues and peers were the most common source of unequal treatment reported by those experiencing and/or observing race/ethnicity inequalities (61%).
- the higher incidence of discrimination by managers or team leaders may not necessarily indicate more personal or interpersonal discrimination but may reflect broader systemic inequalities and institutional discrimination shaped by organisational policies or culture.

Causes and effects of workforce inequalities

- Over half of survey respondents identified attitudes of leaders/managers, attitudes of staff/colleagues, and organisational culture as the main drivers of workplace inequalities. These were followed by wider inequality issues in the UK, within organisational systems and the fear of speaking up.
- Only one-quarter or less of respondents across race/ethnicity, gender, physical disability/condition, and mental health condition/illness reported making a formal complaint.
- The majority of survey respondents chose not to make formal complaints, preferring instead to raise issues informally with colleagues or supervisors. This was largely due to concerns that no action would be taken or a fear of being perceived as troublemakers.

- More than 80% of survey respondents reported feeling upset or distressed due to experiencing inequalities, and over half said they had considered leaving their job as a result.
- Implicit bias and subtle racism were found to negatively affect careers, particularly in areas such as recruitment, progression and workplace experiences. Over 60% reported that inequalities hindered their career progression and promotion opportunities, while more than 75% reported a negative impact on their work environment and relationships.
- Generally, experiences of workforce inequalities were seen to have a negative impact on the quality of services, the quality of care, and the quality of interactions with people using services.
- There is a two-way relationship between the attitudes of people using services toward ethnic minority staff and the quality of care and services provided. More than 40% of respondents experiencing and/or observing race/ethnicity inequalities reported poor interactions with patients/people using services, which negatively affected the quality of care and quality of care and services delivered.
- The report also identifies sector-specific challenges and contextual factors across acute care, adult social care, primary care, dentistry, community and mental health care.

Good practices for reducing workforce inequalities

- Establishing robust complaints/grievance procedures and securing senior leadership engagement were identified to be the two most effective initiatives to reduce workforce inequalities, reported by 54% and 45% of survey respondents respectively. However, these initiatives were available to only 31% and 28% of survey respondents.
- In contrast, the most common approaches, such as staff training and celebrating diversity, were available to 77% and 59% of survey respondents, but were considered less impactful or effective.
- Adopting an intersectional approach to equality, diversity, and inclusion (EDI) efforts is crucial for fostering effective behaviour change.
- Presence of staff networks, diversity at senior leadership and board levels, effective EDI data gathering and sharing, and improved grievance and ‘speaking up’ practices were noted as positive examples in the case study organisations.
- Systemic and institutional racism are significant barriers to tackling workforce inequalities because they are deeply ingrained and often operate in subtle, hidden ways, making them difficult to identify and challenge.

Recommendations

Key recommendations emerging from the research are:

1. **Set clear measurable EDI targets** to track and demonstrate progress.

2. **Encourage the collection and use of EDI data for all providers**, including demographic data on complainants and the categorisation of discrimination data.
3. **Adopt a proportionate and flexible approach** to setting expectations around workforce equity, tailored to the size and scale of each provider.
4. **Upskill inspectors to assess and identify signs of workforce inequality**, by recruiting inspectors who have lived experienced of inequality to enhance diagnostic capabilities, creating a specialised group of 'super users' who specialise in EDI and/or inspections, developing EDI resources, and using fully observational techniques and indirect questioning to gain a deeper understanding of staff culture.
5. **Hold providers accountable for addressing workforce inequalities** by clearly defining where responsibility lies for addressing workforce inequalities and outlining consequences for inaction. Enforcement-focused measures may be necessary to ensure compliance with legislative and regulatory standards.
6. **Support clear accountability structures** to ensure senior leadership is responsible e for EDI and ensure employee voices plays a clear role in the assessment process to understand workers' experiences of senior leadership engagement.
7. **Encourage providers to take a proactive approach to workforce equality** by implementing strategies that support individuals at risk.
8. **Promote an open, honest, collaborative approach with providers** to improve workforce equity. Progress should be framed as an opportunity, with dedicated learning resources available. Accountability should reflect both actions taken and progress made, balancing the directive and relational aspects of regulatory mechanisms.
9. **Establish supportive peer networks** for inspectors that encourage the sharing of best practice.
10. **Strengthen the evidence linking workforce inequalities to care quality and equity** for people using health and care services. This may involve examining how workforce inequalities manifest across the different sectors regulated by CQC, identifying sector-specific differences, and highlighting the downstream impacts on people using services, including clinical outcomes.
11. **Facilitate the identification and sharing of good practices on workforce EDI**. CQC should take a leadership role in highlighting and sharing evidence-based interventions that promote workforce equity.
12. **Use CQC's national, independent voice to promote cross-sector collaboration** with other regulatory bodies to advance EDI efforts.
13. **Emphasise an inspection approach centred on a lived experience** to inform assessments and drive wider system change through evidence-based practice.
14. **Encourage alternative approaches to increase staff knowledge of EDI and reducing bias**, moving beyond standard training sessions and diversity celebrations. Survey findings indicate that these are perceived as less effective in

addressing workforce inequality compared to disciplinary procedures and senior leadership engagement.

1 Introduction

The Care Quality Commission (CQC) is England's independent regulator of health and social care. CQC is committed to tackling health inequalities between different groups of people. These health inequalities are often a result of avoidable, unfair and systematic differences in the use of health and care services and their outcomes.

The State of Care report, CQC's annual assessment of health and social care in England, has found pervasive and persistent inequalities in the access and quality of care experienced by people using health and care services. These health inequalities are mirrored by inequalities, discrimination, and exclusion among staff who work in the health and adult social care sector. Workforce inequalities can negatively impact quality care and equity for people using services, as well as the wellbeing and human rights of staff involved.

The health and adult social care (HASC) sector workforce represents wide diversity along categories of gender (80% are women), nationality (80% are British), race and ethnicity (while 77% are white on average, in London, 68% are from black, Asian, or other minority ethnic groups), highlighting significant regional variations across England (Skills for Care, 2023). Black and minority ethnic workers continue to be overrepresented in frontline care roles with higher risks to their mental and physical health and wellbeing, while they remain underrepresented in senior leadership and management roles compared to white colleagues (TUC, 2021).

Since 2015, there has been a growing emphasis on ensuring equal access to career opportunities and fair treatment in workplace experiences within NHS Trusts, driven by the NHS Workplace Race Equality Standards (WRES) and the Workplace Disability Equality Standards (WDES). In addition, mandatory gender pay gap reporting by employers with 250 or more employees has been in place since 2017, serving as another important initiative for workforce equality. However, employers in many areas within the HASC sector, particularly smaller employers are exempt from these requirements, highlighting an opportunity to encourage good practice more widely.

In 2021, CQC published its strategy for the changing world of health and social care. The strategy aimed to make regulation more relevant to the way care is delivered, more flexible to managing risk and uncertainty, and faster and more proportionate in the way CQC responds to the changing health and care environment. As the independent regulator, CQC seeks to accelerate improvements in the quality of care, particularly through better coordination of services within Integrated Care Systems.

However, data alone is not enough to address workforce inequalities. Meaningful engagement with service providers and staff, cultural shifts and a better understanding of

what interventions are effective – and when and where they should be applied – are all essential. Through its Workforce Equality Risk and Oversight Group (WEROG), CQC is working to implement recommendations from the Inclusive Britain report, the Messenger review, and other CQC workplace equality reviews. The goal is to embed workforce equality into its regulatory framework and to use enforcement powers to drive meaningful change.

In this context, CQC commissioned the current research to identify effective ways of tackling workforce inequalities through regulation. This study was designed and conducted by the Institute for Employment Studies and IFF Research.

Research aims

The research aims to build upon existing evidence about workforce inequalities. CQC seeks to address gaps in its organisational knowledge on:

- effective methods to evidence workforce inequalities beyond the use of established datasets;
- effective approaches that health and care providers can use to address these workforce inequalities and how these can be assessed through regulation; and
- how to use its regulatory impact mechanisms to achieve the desired change.

To achieve these aims, the study focused on three key areas of research, with several lines of enquiry explored within each area. These are as follows:

A. Develop an evidence-led understanding of workplace inequalities and connection to service users' experiences beyond the established datasets.

Lines of enquiry:

- How systemic, institutional, and interpersonal discrimination manifest and have an impact on staff and quality of care.
- How structural and institutional operations and practices have an impact on inclusion and discrimination.
- How workforce inequalities and issues around race and racism as well as other forms of discrimination can be understood.
- Which critical factors are the driving conditions for workforce inequalities.
- Identify examples of good practice where employers in regulated organisations of different types have successfully advanced equality in their workplace cultures.
- The connection between workforce inequalities and service delivery and the quality and outcomes for people using services.

B. Devise effective strategies for health and care providers to address workforce inequalities and determine how CQC can assess these within regulation.

Lines of enquiry:

- What are the most effective regulatory approaches for tackling systemic workforce inequalities.
- How can regulation be used to look beyond dominant cultures to understand the experiences of non-dominant cultures.
- How can CQC ensure workers from all equality groups can feel empowered to raise concerns, helping to better understand workforce inequalities.
- Key measures of success.

C. Propose how CQC can use existing regulatory impact mechanisms to achieve the desired change.

Lines of enquiry:

- How to build the evidence into the assessment framework and how to effectively use impact mechanisms to accelerate improvement in workforce equity.
- How to support CQC staff to make robust judgements about a service, provider or local system, with a consistent approach to interpreting and recording evidence.
- How to engage with providers and their staff on their assessment of workforce equality, specifically identifying issues around race and racism.

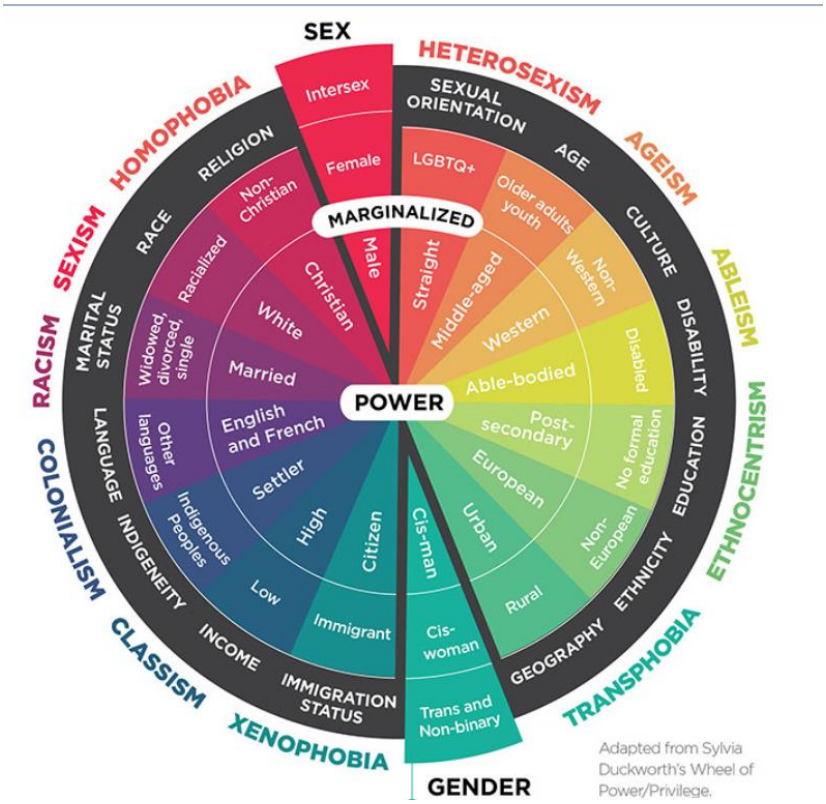
Conceptual framework

The study applies an **intersectionality lens** to understand how power dynamics and socio-identity markers intersect to shape the lived experiences of discrimination, exclusion, and marginalisation. Intersectionality recognises that people's experiences are influenced by the interaction of different social factors, such as race/ethnicity, class, sex, gender identity, sexual orientation, geography, age, disability/ability, migration status, religion, and indigeneity.

While each of these identity markers can create an advantage or disadvantage on its own, intersectionality promotes an understanding of how multiple layers of disadvantage combine to shape more complex experiences of prejudice and discrimination.

Figure 1.1 illustrates the operations of this intersectional framework, showing how power and marginalisation are experienced across multiple, intersecting axes of inequality – in visible, invisible and hidden ways. These inequalities are perpetuated through systemic, institutional and interpersonal discrimination and stereotyping, which prevents people from having a voice in organisational spaces.

Figure 1.1 Intersectional identity markers



Source: Canadian Institute of Health Research, Gender and Health, Issue 3 Part 1, 2021

Intersecting discrimination and exclusion are maintained within interdependent systems of power and oppression such as patriarchy, colonialism, imperialism, racism, homophobia, and ableism. These are reinforced through institutional policies and everyday practices.

Underpinning this research is a three-dimensional view of power relations. This study views unequal power relations as manifesting in multiple *forms* (hidden, visible, or invisible power), operating at many *levels* of decision-making and authority (interpersonal, organisational, or systemic power), and shaping different *spaces* for participation and action (closed, invited, or claimed spaces).

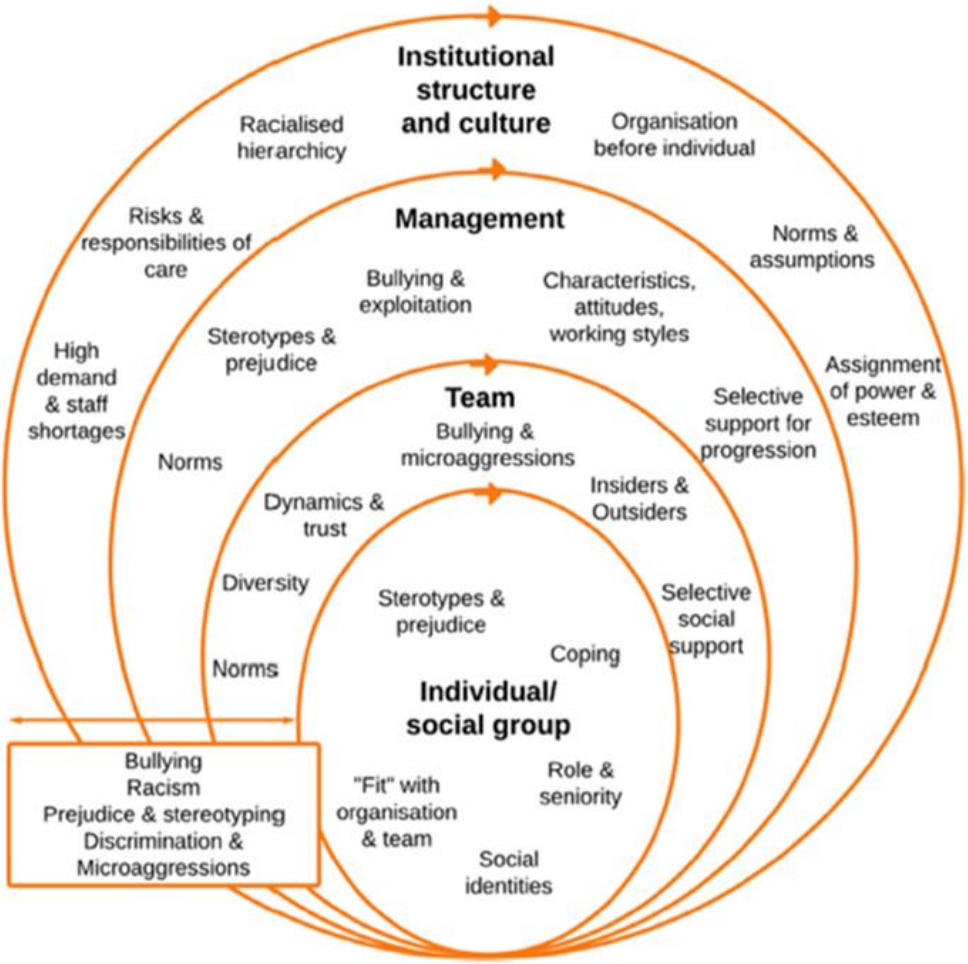
Multiple structural features influence the employment landscape of the HASC sector. These include:

1. changing immigration laws and systems;
2. increased funding pressures;
3. growing demands of a rapidly ageing population;
4. acute staff shortages;
5. recruitment, retention, and pay challenges of an increasingly diverse and international workforce; and

6. focus on place-based approaches, integrated care systems and joined up service since the Health and Care Act of 2022.

Woodhead et al. (2022) provide a useful conceptualisation of the factors reinforcing inequalities within healthcare organisations (see Figure 1.2). Bullying, racism, discrimination and microaggressions are an outcome of these factors perpetuated by conditions and actors at different levels beginning with the individual, extending to teams and management, and finally embedded within institutions and structures that perpetuate the 'inequality regimes' at play.

Figure 1.2 Factors shaping and maintaining race inequalities in healthcare



Source: Woodhead et al, 2022

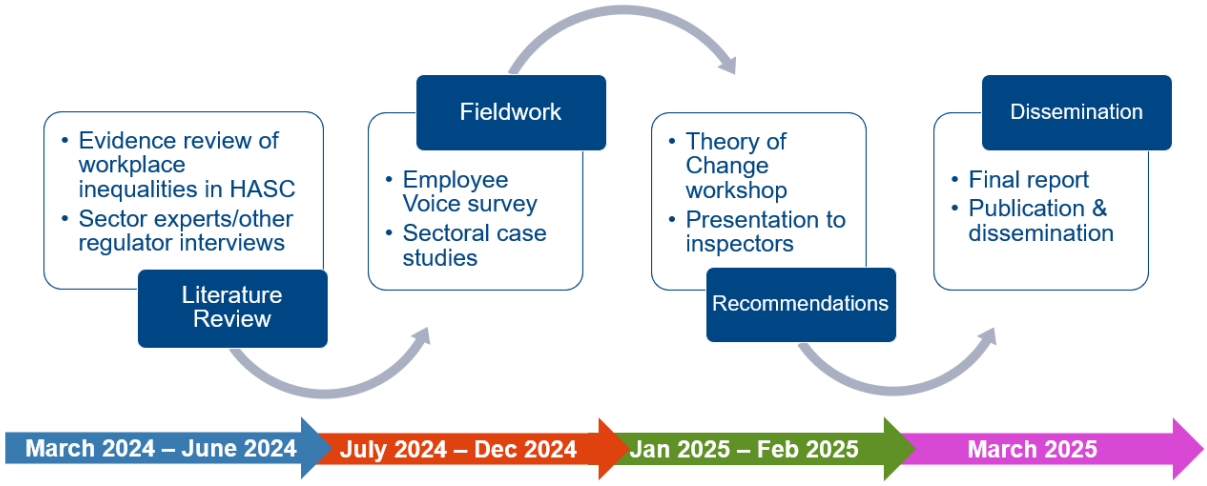
As identified in the findings of this report, these structural factors shape the manifestation of systemic, institutional, and interpersonal discrimination and workforce inequalities.

Methodology

The research adopted a mixed-methods study design, combining an evidence review, employee voice survey, and organisational case studies. This focus on collecting primary data marked a shift from CQC's usual research practice of working with secondary sources, enabling the development of new evidence beyond established datasets. It enabled the voices of staff in health and adult social care to be a central focus of the findings, helping to answer research questions, where existing datasets could not provide adequate answers.

Figure 1.3 outlines the different components of the research methods used, along with their timelines. A detailed description of each research component and its methodology is provided in Appendix A.

Figure 1.3 Research methodology and timeline



Source: IES, 2025

Evidence review and expert interviews

The literature review examined existing studies on workforce discrimination, harassment, stereotyping, and bullying behaviours within the HASC sector, as well as identifying regulatory theories and mechanisms that effectively influence workplace policies and behaviours. Appendix A details the research questions and study inclusion criteria.

Expert interviews with regulatory and sector body experts in EDI and workforce regulation were conducted to understand how other regulators support health and social care providers in addressing workforce inequalities most effectively. The list of regulatory bodies interviewed is provided in Appendix D. The insights gained from these interviews contribute to the final recommendations for CQC.

Employee voice survey

The employee voice survey gathered insights from health and adult social care employees about workforce inequalities, including their personal and work characteristics, personal and/or observed experiences of inequalities, and information on interventions aimed at addressing these issues. From a total of 832 responses received, 646 responses were included for analysis after data cleaning. A complete respondent profile is available in Appendix B.

The report presents descriptive statistics on the survey responses. Further statistical analysis of differences and disaggregating findings into smaller groups was not feasible due to the small response rates on many questions. Due to the survey sample being a small proportion of all HASC employees, these findings are not directly generalisable across the whole workforce. However, they do provide value due to the richness of insights gathered from the voices of staff directly.

Organisational case studies

Case studies of health and social care providers were developed to highlight good practices relating to workforce equality and EDI. The research team spoke with senior staff and employees to collect data on the available EDI infrastructure, culture and ways of working, management practices, and leadership at an organisational level to identify examples of good practices in tackling workplace discrimination and inequality.

Due to challenges with provider engagement and availability, the research team was able to secure the involvement of only two organisations as case studies. These were the East London NHS Foundation Trust, representing mental health and community care, and Buckinghamshire NHS Foundation Trust, representing acute care. For the remaining sectors that CQC regulates, the researchers employed a combination of secondary literature review and interviews with stakeholders from umbrella organisations, trade associations, and relevant reference groups.

Thematic Analysis

The data from the evidence review, expert interviews, employee survey and provider case studies were synthesised and thematically analysed to draft recommendations for CQC. This approach allowed the research team to triangulate findings to minimise bias and overreliance on any one data source or set of findings.

This mixed methods approach allowed the research to provide a comprehensive understanding of the range of issues and experiences of staff working in the HASC sector despite limitations from the survey sample. It also yielded insights into broader sector-specific, labour market and policy contexts that influence experiences of workforce inequalities, as well as adoption of EDI policies, practices and initiatives to tackle these issues.

The final recommendations were reviewed and refined through consultation with CQC senior stakeholders and inspectors in two online workshops, to evaluate their feasibility and practicality in the assessment context.

Structure of the report

This report is structured into distinct chapters, each addressing different research themes. Each chapter combines the evidence from the literature review, expert interviews, employee voice survey, and sectoral and case study interviews. The broad scope of this research is reflected in each chapter through a discussion of sectoral insights and comparison of similarities and differences between the six sectors regulated by CQC.

Chapter 2 focuses on the main findings from mapping workforce inequalities across the HASC sectors and sub-sectors that CQC regulates. It places strong emphasis on intersectionality by examining the combined axes along which inequalities were reported.

Chapter 3 discusses the causal conditions and impact of workforce inequalities on staff and patients or people who use services, providing a deeper insight into the structural and systemic factors driving workforce inequalities in health and adult social care.

Chapter 4 outlines the key themes and findings related to addressing workforce inequalities. It presents examples of good practices for tackling inequalities and highlights what employees consider to be effective EDI initiatives. Finally, chapter 5 presents recommendations for the CQC regulatory framework, for assessment and regulation and for engaging providers. Chapter 6 concludes the report.

2 Mapping workforce inequalities

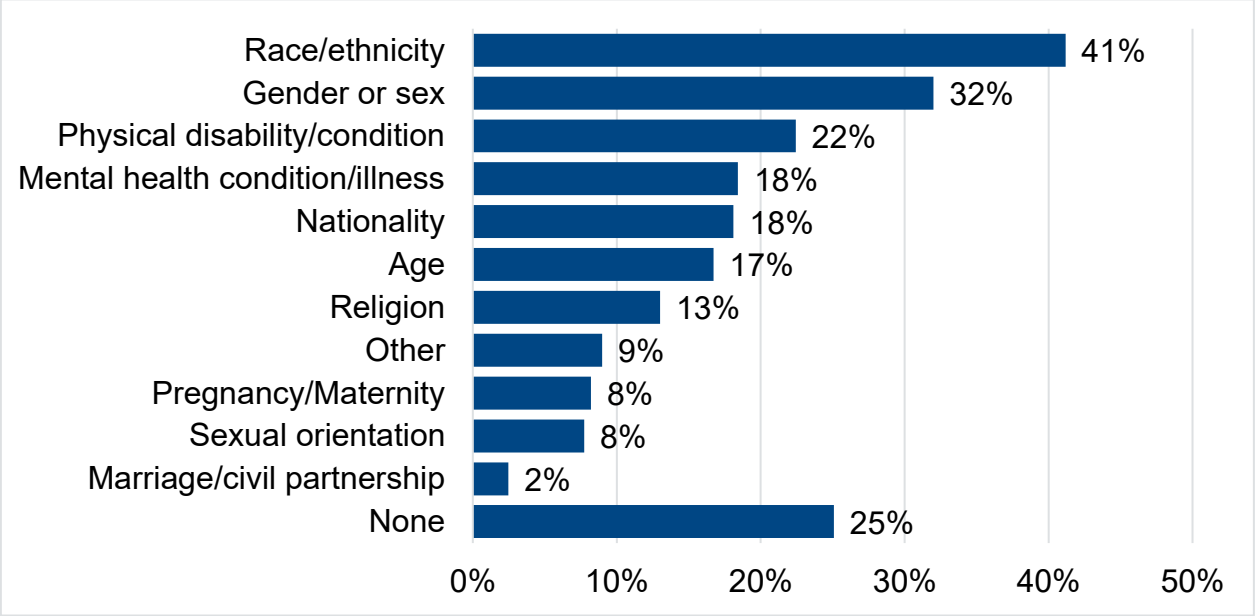
This chapter maps the nature, incidence, and experience of workforce inequalities among staff working in health care and social care settings. It presents key findings: the types of inequalities most prevalent and frequently experienced, the nature of intersectionality and combined discrimination, the manifestation of behaviours resulting in inequalities, impact of low pay, and the role of managers, team leaders and colleagues as a source of unequal treatment at work.

Key finding 1: incidence of inequalities

The survey found that race/ethnicity inequalities were most frequently experienced and/or observed, followed by sex or gender, physical disability/condition, nationality, and mental health condition/illness related inequalities.

As Figure 2.1 shows, 41% of respondents reported having personally experienced and/or observed race/ethnicity-related inequalities. This was followed by unequal treatment due to gender identity or sex (32%), physical disability/condition (22%), mental health condition/illness (18%) and nationality (18%).

Figure 2.1 The proportion of respondents who observed and/or experienced inequalities by inequality type



Source: IES, 2024

The explanatory note in Appendix A on Methodology provides a detailed discussion on the issue of gender identity and sex. Both sex and gender were addressed separately in the survey to assess the distinct experiences of discrimination based on sex (male or female) versus those experienced by trans individuals or people with non-binary gender identities. However, due to lack of a clear definition between these terms and the common use of 'gender inequality' to refer to discrimination against women who are assigned female at birth, some respondents appear to have interpreted both terms as referring primarily to discrimination against women or misogyny. A review of open-text responses in the survey confirmed this interpretation.

Figure 2.1 presents the combined frequency of respondents selecting sex or gender as the inequality they experienced and/or observed, after accounting for overlaps. This figure captures the full spectrum of inequality, including misogyny and discriminations experienced by men or women, as well as those experienced by individuals with trans and non-binary gender identities. However, the graphs in the rest of the report present the data for sex and gender separately, while acknowledging that these categories may still reflect similar experiences of discrimination across both binary and non-binary gender experiences.

A deeper analysis for the top four inequalities – race/ethnicity, sex/gender, physical disability and mental health conditions – are discussed below.

Racism

Survey findings presented in Figure 2.1 align with existing literature and interview findings, which indicate that race/ethnicity-related unequal treatment is widely reported within the HASC sector workforce. Ethnic minority healthcare staff frequently report experiencing stereotyping, discrimination and bullying from patients and colleagues. This inequality persists even in more diverse regions, such as London (Kline, 2014).

The survey found that race/ethnicity inequalities were both experienced and/or observed at a higher rate by Asian (61%), black (68%) and other ethnicities (77%) compared to white respondents (26%). This suggests that personally experiencing racism probably makes it more likely that one will observe racism towards others. The higher incidence of experiencing and/or observing race-related inequalities was reported across all managerial levels, employment types and roles, as well as across various sub-sectors. Combined with the finding that senior leadership engagement on workforce equity is vital (as discussed in chapter 3), this data emphasises that it is important for people from diverse racialised backgrounds to be involved at more senior levels in an organisation if the organisation wants to tackle racism.

Race inequalities pose significant risks for the health and wellbeing of staff as demonstrated by studies on the experience of ethnic minority workers during the COVID-19 pandemic. These studies highlighted higher rates of infection and related deaths among ethnic minority staff during the pandemic, who were more likely to work in high-risk settings due to feeling that they could not challenge or influence decisions (Hussein, 2022a; Hussein, 2022b, Rhead et al. 2024).

This situation of race inequalities among staff mirrors the disproportionate rates of infection, mortality and the need for intensive care among people from ethnic minority backgrounds who use health services, highlighting a clear link between workforce inequalities and health inequalities.

Gender inequalities

Gender inequalities were the second most frequently reported in the employee voice survey and also commonly highlighted in the literature. Gender discrimination can encompass inequalities between men and women, as well as those experienced by individuals who identify as trans or non-binary. Interestingly, gender-based discrimination is often prevalent against females, even in female-dominated fields like obstetrics and gynaecology (Hussein et al, 2023). This aligns with survey findings for this research, where 25% of respondents who reported not experiencing or observing any inequalities included a higher proportion of male respondents.

Hussein et al. (2023) note that perpetrators of gender discrimination are often other female colleagues, either in higher-ranking roles or prominent members of the midwifery team, who undermine the plans of female doctors compared to their male counterparts. Frustration over sexist stereotyping was present, with female doctors being disproportionately mistaken for nurses or secretaries. Additionally, they also reported being discouraged from pursuing more competitive specialities, such as surgery.

The State of the Adult Social Care and Workforce report (2023/24) by Skills for Care (2024b) indicates that only 21% of staff are men, a modest 2% increase from the 2022/23 report. In the employee voice survey, 75% of those who reported having experienced and/or observed sex or gender related inequalities were female, while less than 15% were male. The remaining respondents preferred not to disclose their sex.

Cross-sector analysis from sectoral interviews and organisational case study interviews also highlights significant gender imbalances in certain areas, especially the unequal representation of women in senior positions or higher-paid positions. The adult social care workforce report shows that even though a small group of men work in this sector, the large majority of men occupy senior management positions (Skills for Care, 2024b).

> *"The higher up the ladder you go in social care, the more men get managerial roles…men are sped up the ladder into managerial roles, in a way that is disproportionate to the number of men who work in social care."* - 9th December 2024, interview with senior staff member from The Care Workers Charity

Signalling gender norms and prejudice in the workforce, interviewees shared that women are often expected to take on tasks perceived as more nurturing, which may in practice be more difficult, while men are typically required to take on manual tasks, such as heavy lifting.

Disablism

Inequalities and discrimination based on physical disability or long-term health conditions were the third most commonly reported by survey respondents (22%), followed by inequalities due to mental health conditions or illness (18%). Despite the underrepresentation of disabled individuals in the HASC workforce, issues of disablism are a prominent issue as highlighted in the literature. These include challenges related to disclosure, stereotyping and stigma around disability, as well as concerns over career progression, health and wellbeing (Lindsay et al, 2023).

Sector-level interviews highlighted that job roles requiring more physical demands were more challenging for individuals with disabilities and could negatively impact their physical health. In addition, financial insecurity in some underfunded sectors, such as the GP sector and adult social care, mean many employers are reluctant to allocate budgets for making reasonable workplace adjustments for those who need them.

> *"People with physical disabilities can find it harder to have a career in the [adult social care] sector because it can require a lot of physical work which some may find challenging."* - 4th October 2024, interview with adult social care sector expert from Care England

This lack of organisational support for disabled colleagues can widen the disability gap in employment by creating barriers to accessing work. It makes addressing disability-related inequalities and discrimination more complex for employers, particularly in sectors that are already facing funding and capacity challenges.

Nationality inequality

Unequal treatment due to nationality discrimination was reported by 18% of survey respondents. This finding aligns with literature on how migrant healthcare staff are heavily relied upon and typically over-represented in the workforce, particularly in social care settings (Turnpenny & Hussein, 2022). Known as the '*migrant in the market'* model, this reliance on international migrant labour is sustained by migrants' willingness to accept low pay and difficult working conditions in exchange for easier entry into the UK labour market (ibid). However, due to small number of survey respondents, further disaggregation of data by nationality was not possible.

There have been concerns around employers exploiting international workers, as they are more likely to accept the opportunity to live and work in the UK and overlook the conditions of their employment, for example, working a higher number of unsociable hours. This is further exacerbated by the restrictions of the Health and Care Worker visa, which ties the visa holder's right to live and work in the UK to a specific employer (Citizens Advice, 2024). This creates a power imbalance between employer and employee, increasing the risk for employees attempting to enforce their rights at work and limiting their ability to leave an exploitative job.

Modern slavery has been reported within the social care sector and is believed to be linked to these recruitment and retention issues. Providers often rely on quick recruitment

methods through agencies, which can involve limited transparency and potential exploitation of migrant workers (Emberson & Trautrims, 2018). A short note on modern slavery and the literature on this issue is included in Appendix C.

Sector interviews conducted for this research noted that migrant workers face additional challenges in getting registered in the UK within their professions, as their international qualifications are often not recognised as transferrable. Migrant staff educated overseas often struggle to have their certifications recognised or accredited in the UK, often leaving them to work in roles where they are overqualified.

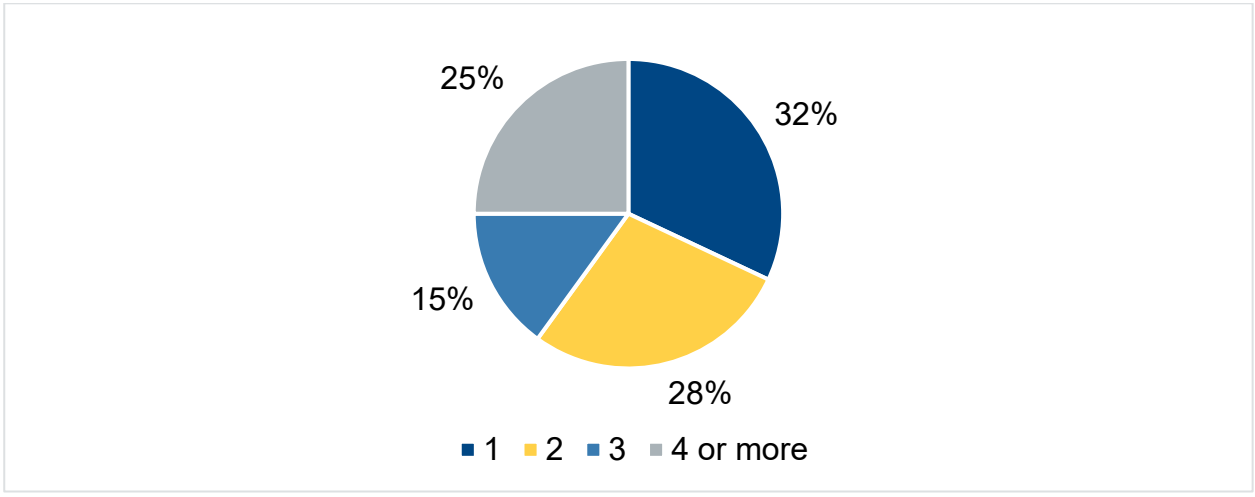
Key finding 2: combined discrimination or intersectionality

The survey revealed a high prevalence of combined discrimination and intersecting inequalities.

Combined discrimination or intersectional discrimination is where a person is discriminated against because of a particular combination of two or more protected characteristics. Over two-thirds of survey respondents reported experiencing and/or observing two or more types of inequalities, as shown by Figure 2.2. This highlights the prevalence of combined discrimination within the HASC workforce, which exacerbates the impact of inequalities.

The importance of intersectionality in the healthcare context is highlighted by Samra and Hankivsky (2020), who explain that '…experiences of marginalisation cannot be dissected one social category at a time…' (pg. 848). Considering intersectionality during medical training, they show that healthcare workers now operate in multicultural environments, making it essential to 'analyse their privileges, practices, and pedagogy to advance social justice' (pg. 848).

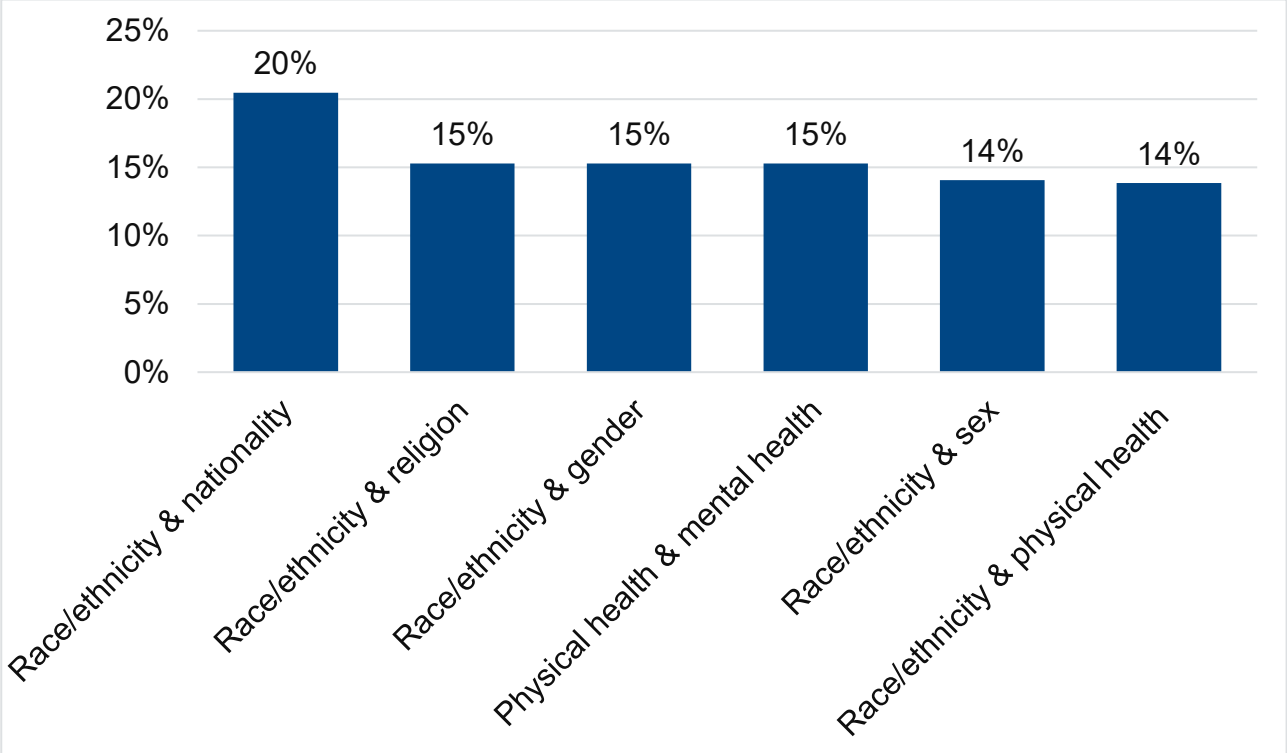
Figure 2.2 Percentage of respondents who experienced and/or observed multiple inequalities



Source: IES, 2024

Figure 2.3 illustrates the incidence of the top two intersecting inequalities reported by survey respondents. Race/ethnicity intersecting with nationality was the most common, reported by 20% of respondents. This was closely followed by race/ethnicity intersecting with unequal treatment on account of gender, and then religion, and physical or mental health conditions or illness. We discuss the intersections of ethnicity and nationality and ethnicity and gender in some detail further in this section.

Figure 2.3 The most commonly combined inequalities experienced and/or observed



Source: IES, 2024

Ethnicity and nationality

In line with the literature on migration status, nationality emerged as an important social identity marker. Rhead et al. (2021) highlight that there needs to be more research looking into the intersections between ethnicity and migration status and how this impacts workplace inequalities.

It is important to note that in the literature, different ethnicities are often grouped together when making comparisons. For example, white groups are compared with all other ethnic groups, despite there being different experiences and influences affecting individuals within each group.

Ethnicity, gender, and nationality

The intersection of gender and ethnicity is a commonly researched and discussed area in the literature. Gesing, Pant and Burbage (2022) argue that it is problematic to treat race

and gender as two mutually exclusive categories, as doing so would overlook the intersection and fail to recognise the compounded impacts of discrimination.

Similarly, Rosette et al. (2018) explain that 'being both female and black is more than the sum of being a member of either category' (pg. 3). Even when the number of women in the workforce increases, the proportion of black women often rises by the smallest amount (General Dental Council, 2021). Despite an overall increase in women progressing in healthcare, an intersectional lens reveals that white and Asian women progress at a faster rate than black women, particularly in dentistry (Fleming et al., 2022).

Further, gender combines with race and nationality to shape the experiences of migrant women from ethnic minority backgrounds. For example, while men make up a higher proportion of the overall migrant worker population (with entry and settlement dynamics differing by gender), migrant women make up a higher proportion of the care worker population (Hussain, 2017; Turnpenny and Hussein, 2022).

Ethnic minority and migrant women workers are twice as likely to work in low-paid, insecure and high-risk jobs and to be classified as key workers compared to white women (Hussein, 2022a). They also tend to experience higher levels of discrimination compared to white women and men from ethnic minority backgrounds. These women often feel vulnerable and overwhelmed by having to defend their identities against both racism and sexism, making them less confident in challenging these behaviours (Hussein et al, 2023).

Other intersecting inequalities

Despite the importance of an intersectional approach, only half the papers included in the evidence review mentioned intersectionality or took an intersectional lens in their analysis.

For instance, female healthcare workers with multiple intersecting social identity markers experience deskilling, downward job mobility, bullying and harassment, reduced social support and increased likelihood of disciplinary action (Hussein, 2022b). Family and care responsibilities often impact access to career opportunities, promotions, and training for women compared to their counterparts without any dependents (Hussein, 2022a).

Sector interviews for this research confirmed that employers often hold preconceived notions about young women, assuming they may start families soon and need time off, which makes them less likely to be offered job roles, as illustrated by the quote below.

> *"Even down to recruiting, if you've got a young female who might be of childbearing age, you'll find that, you know, it'll be the older [person] who perhaps has already had a family who might be preference. Nobody will explicitly say that."* - 15th November 2024, interview with sector expert in General Practice

The intersectionality of disability with other social identity markers is underreported (Lindsay et al., 2023). The survey findings point to race/ethnicity intersecting quite often with mental and health conditions and physical disability (see Figure 2.3). Female survey

respondents more frequently reported physical disability/condition and mental health condition/illness inequalities.

Age emerged as another axis of intersectional discrimination with age-related inequalities being experienced and/or observed increasing with age in the survey. Younger age groups more commonly reported mental health conditions/illness as well as nationality inequalities, reflecting the wider societal shifts such as the rise of mental health concerns among young people in the UK and the increasing likelihood of younger people migrating to the UK in search of work or educational opportunities.

Religion, which is sometimes closely linked to particular ethnicities or nationalities, also emerged as an axis of combined discrimination as reported in Figure 2.3 by 15% of respondents. Inequality based on religion was more commonly reported by individuals outside the white, black and Asian ethnic categories. This suggests a need for further research to disaggregate the experiences of various minority ethnic groups and specific nationalities.

Key finding 3: types of unequal behaviours at work

Microaggression, unfair treatment at work, exclusion, and lack of access to opportunities were the most commonly reported behavioural manifestations.

Figure 2.4 shows the range of behaviours that survey respondents experienced or observed across the top four most prevalent inequality types – race/ethnicity, gender, physical disability/condition and mental health condition/illness.

Microaggressions were experienced at a higher rate across all four inequalities, with over 50% of respondents reporting such incidents. These are not typically isolated incidents but are more likely to be experiences that accumulate over time, potentially contributing to larger, more significant issues. The subtle nature of microaggressions make them difficult to prove and can leave victims feel confused about the experience itself (Estacio and Saidy-Khan, 2014).

Exclusion, bullying, harassment and unfair treatment at work were the next most commonly experienced behaviours. The literature confirms that the HASC sector workforce has an over-representation of ethnic minorities, who often experience bullying and harassment as a result of structural and institutional racism (Hussein, 2022a; Woodhead et al., 2022).

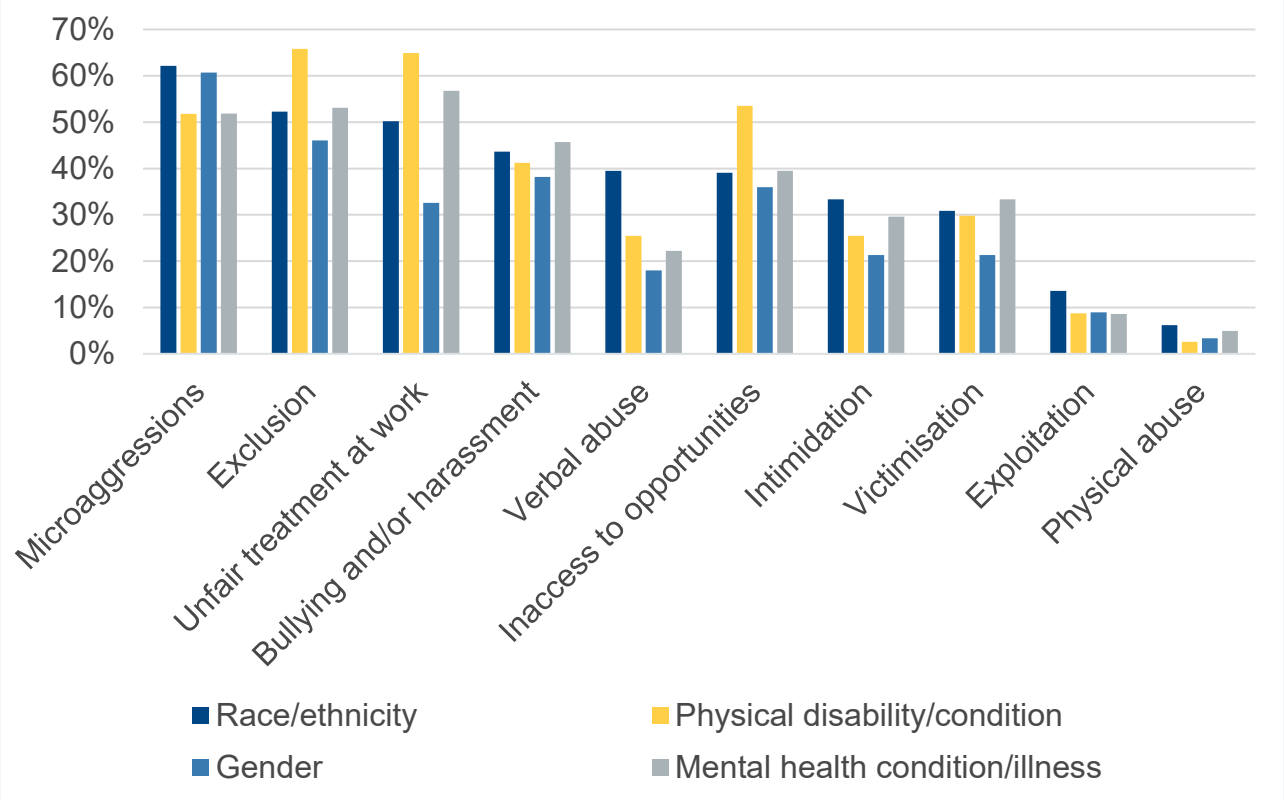
People experiencing unequal treatment due to physical disabilities/conditions were more likely to report exclusion and unfair treatment at work (two-thirds of respondents) (see Figure 2.4). Discrimination in access to opportunities was also higher among those with reported physical disability or conditions compared to other types of inequality. This may suggest concerns related to accessibility at work and broader inclusion issues.

Findings from the survey align with a systematic review that found both individual-level and institutional-level disablism were prevalent in the healthcare sector, which may

discourage individuals with disabilities from entering the sector, leading to under-representation (Lindsay et al, 2023). There was often fear of stigma associated with disclosing a disability, along with challenges navigating the bureaucracy involved in disclosure.

Exclusion was also a common behaviour experienced by more than 50% of respondents reporting inequalities related to mental health condition/illness, and 45% of those experiencing or observing gender inequalities reporting the same. Bullying was more commonly experienced/observed in cases of gender inequalities compared to unfair treatment at work.

Figure 2.4 Behaviours experienced and/or observed associated with inequalities by the four most prevalent inequality types



Source: IES, 2024

Key finding 4: pay and inequalities

Low pay is an important axis of inequality and discrimination.

There is a significant over-representation of ethnic minorities in low-paid jobs and sectors (Kline, 2014; Hussein, 2022b; Hussein et al, 2023), while they remain underrepresented in senior management roles and higher-pay bands (Hussein, 2022a). Within the HASC sector and across pay bands and occupations, racial minorities and migrant groups follow

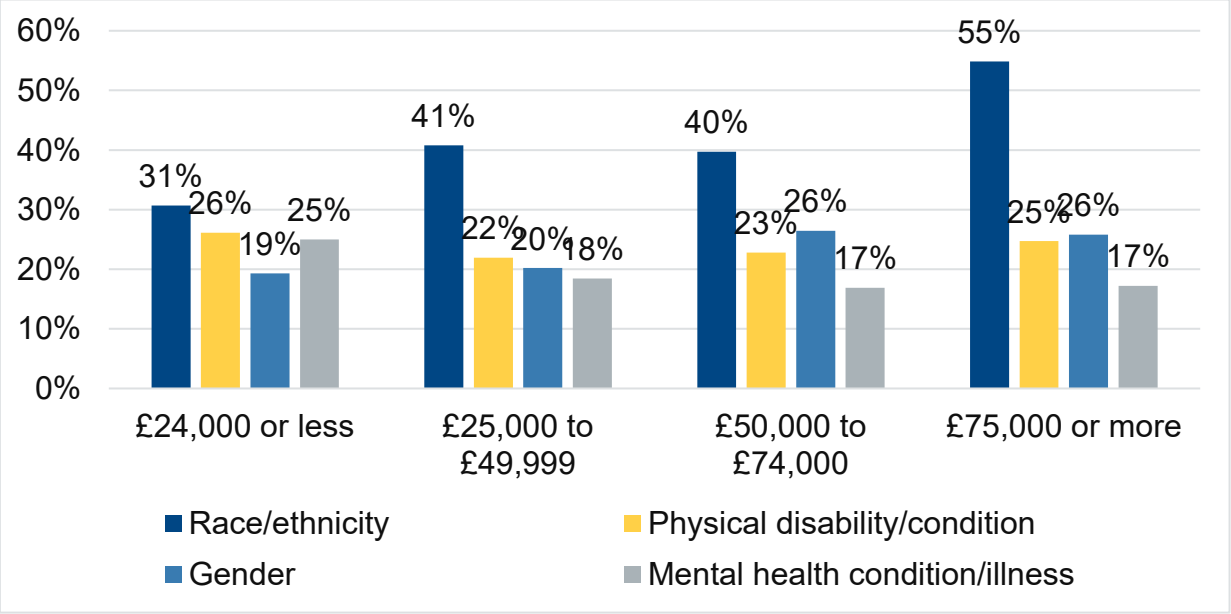
employment patterns that are linked to a gendered or racialised division of labour (Hussein, 2022b).

Socio-economic disadvantages and caring responsibilities are push factors that drive ethnic minorities to accept low-paid jobs (Hussein, 2022b). Staff belonging to minority groups are also more likely to be in supporting roles, which typically come with lower salaries. Additionally, the gender pay gap is more pronounced within certain ethnic groups (Hussein, 2017; Hussein, 2022b). This is linked to historical segregation in employment, which has shaped the selection of certain groups into certain types of occupations. It is also attributable to the 'care deficit', or the increasing marketisation and outsourcing of care, which often disproportionately affects minority groups.

Racial discrimination and ethnicity pay gaps exist across all sectors of the HASC (NHS, 2024a). Ethnic minority workers are more likely to be employed in private social care, which is often characterised by insecure contracts, fragmented work and low pay. This highlights the issue of 'poverty pay' (that is payment below the national minimum wage) within the social care sector (Hussein, 2017; 2022a). These poor wages can be attributed to the low value society gives to the care of older people.

Figure 2.5 shows the top four reported inequalities against respondents' income. Interestingly, the proportion of respondents who experienced and/or observed race inequalities actually increased as the salary scale increased. This may suggest that race discrimination is more pronounced at senior levels. For example, one report highlighted significant gaps in diversity at the most senior board level of NHS trusts, with only 8% of board members coming from a black or ethnic minority background (Kline, 2014).

Figure 2.5 Percentage of respondents' income by the four most common observed and/or experienced inequality types



Source: IES, 2024

Further analysis showed that, while the number of survey respondents is too small to disaggregate and report statistically, white and Asian respondents appear to earn higher salaries compared to those identifying as black. White respondents also tended to occupy management roles more compared to respondents from ethnic minority groups.

Interviewees noted that pay equity is not always practised, particularly between genders, with male and female staff often being remunerated differently. Female staff who were self-employed typically earned lower wages, and pay disparities tend to accumulate over time, as illustrated in the quote below.

> *"It's pretty clear that women are being downtrodden - I'm not entirely convinced that women are being given all the pay they earn."* - 6th December 2024, interview with adult social care sector expert

International migrant staff working in pay bands lower than their qualification levels contribute to a domino effect on pay equity within health and social care. The quote below highlights the impact of nationality inequalities on pay inequities.

> *"What happened before was whatever experience you had [internationally], you would go to the bottom of the band and you know, it is already difficult to stand out."* – 2nd December 2024, NHS Trust Staff Member

Key finding 5: source of unequal treatment at work

Managers, team leaders, and colleagues/peers are the most common sources of unequal treatment at work.

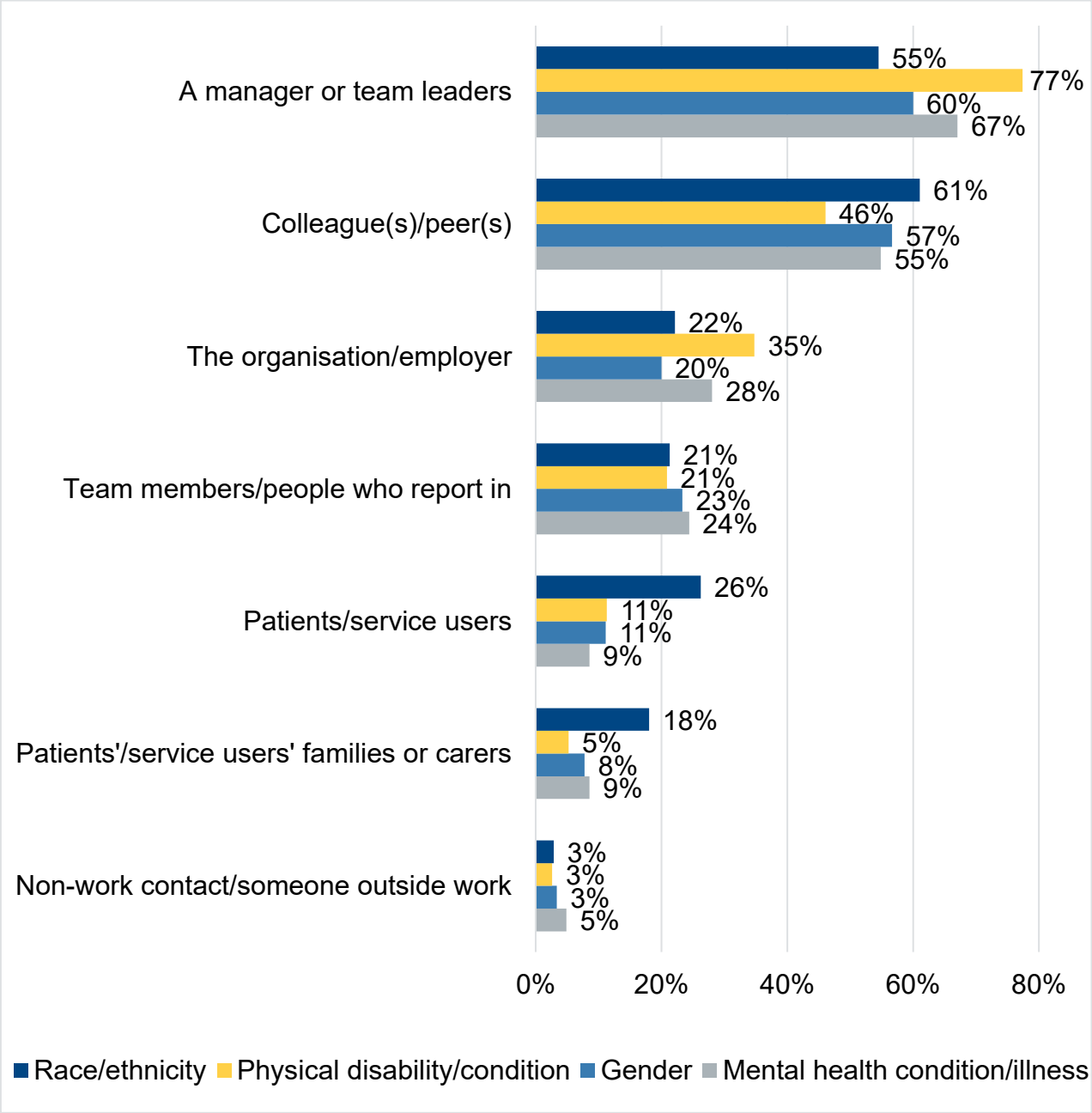
The literature review identified a gap in evidence regarding the source of the discrimination, harassment or bullying within the HASC workforce. A few of the studies indicated this behaviour often came from colleagues (Estacio & Saidy-Khan, 2014; NHS, 2023a, Hussein et al., 2023) or leadership (Pung & Goh, 2017; Emberson & Tantrims, 2018; Hussein, 2022b), with additional papers reporting these behaviours from patients (Smart, 2021; Hussein, 2022b).

Findings from the survey align with the literature, showing the most common source of discriminatory behaviour was managers or team leaders, followed by colleagues or peers (see Figure 2.6). Managers as the source of unequal treatment were reported across all the top four inequalities, but this was most common for those with physical disability/condition (77%).

It is important to note that the higher incidence of discriminatory behaviours from managers or team leaders does not necessarily indicate greater individual bias or discrimination. These actions are likely a reflection of wider systemic inequalities and institutional discrimination, where managers are acting in line with organisational policies or culture. In this context, managers may be more 'messengers' of entrenched institutional discrimination than individual perpetrators.

Interestingly, the organisation or employer was less frequently reported as a source of inequality in Figure 2.6, except for those experiencing physical disability/condition-related inequalities (35%). This may be due to the lack of employers offering workplace adjustments to accommodate disabled workers, which can exacerbate feelings of inequality within the workplace.

Figure 2.6 Sources of inequalities by the four most common inequalities



Source: IES, 2024

Experiencing discrimination from users of health care services or the families of users was much higher for staff reporting race/ethnicity-based inequality compared to other inequality types. These findings are supported by sectoral interviews, and by the literature, which indicates that racially marginalised groups are more likely to experience discriminatory behaviour from people who use services (Palmer et al, 2019). This discrimination often manifests as overt or covert bullying from people using social care services (Hussein, 2022a).

> *"Racist attitudes are reported by care workers from colleagues, managers and families of people who draw on care. Sometimes it is brushed off when it comes from patients (e.g. being racist/sexist/homophobic) and not treated seriously."*- 9th December 2024, interview with sector expert in adult social care sector

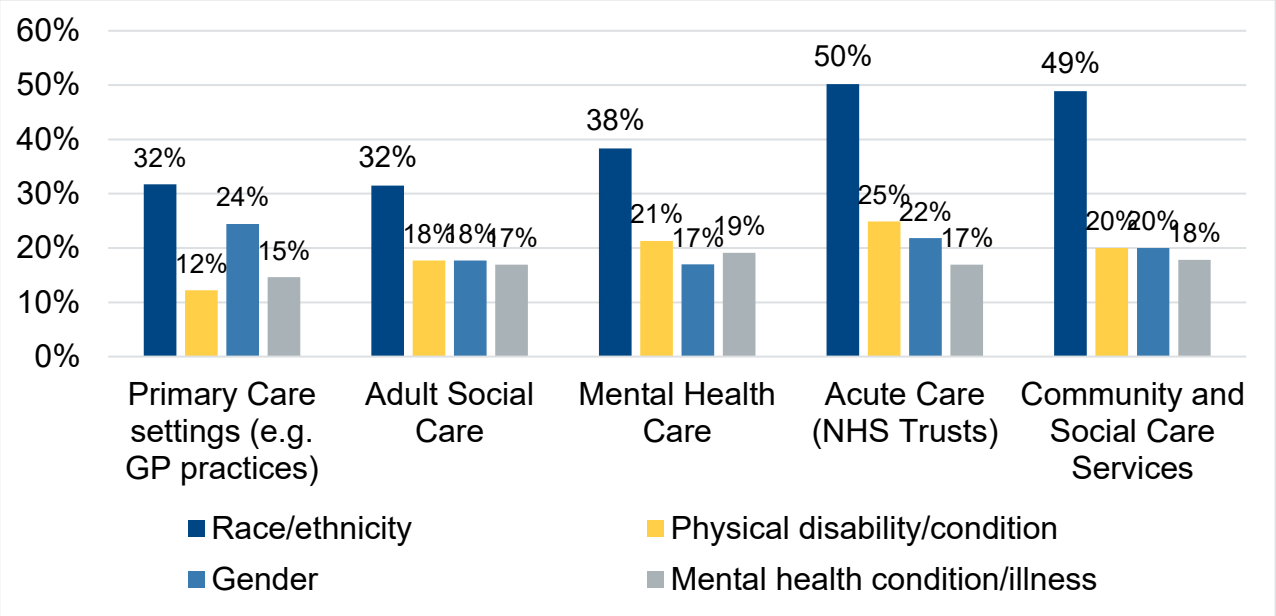
Abuse by people using services is often overt and rooted in broader societal patterns of discrimination and prejudice. The proportion of individuals admitting racial prejudice in the UK has remained at least 25% for the last 30 years (Kelley et al., 2017 as cited in Smart, 2021). Hostility was reported to be greater amongst older and less qualified individuals and this was said to contribute to the racial abuse often suffered by healthcare workers in the UK.

In addition, trends of lower patient satisfaction levels when served by black and ethnic minority staff were observed in the NHS Staff Management and Health Service Quality Survey (2011). Similar levels of lower satisfaction were also reported in more recent surveys (DDAG, 2021).

Sector Insights

- Some inequalities appear more common in different settings. Figure 2.7 shows the sectoral differences from the employee voice survey.
- Acute care reported the highest prevalence of experiences and/or observation of race/ethnicity inequalities (50%) and physical disability/health condition (25%).
- Community and social care services reported the highest prevalence of experiences and/or observation of nationality-related inequalities (23%).
- Mental health care reported the highest prevalence of experiences and/or observation of mental health condition/illness-related inequalities (19%).
- Primary care settings such as GP practices reported the highest prevalence of experiences and/or observation of gender (24%) and age-related inequalities (19%).

Figure 2.7 The prevalence of the four most common inequality types across HASC sectors



Source: IES, 2024; Note: Numbers in dentistry were too small to be disaggregated

Adult social care

Previous research from the Equality and Human Rights Commission (EHRC) found that workers in adult social care from ethnic minority groups experience inequalities at particularly high rates, including in recruitment and promotion (EHRC, 2022). They are more likely to occupy roles with poorer working conditions, are underrepresented in senior management positions and higher pay bands (over £70k per year) and appear less likely to access non-mandatory training (ibid; Skills for Care, 2024b).

Ethnic minority workers are more likely than white British colleagues to be on zero-hours contracts or in bank roles without fixed hours (Care England, 2024; EHRC, 2022). Workers on these kinds of contracts feel more isolated from their colleagues, are usually paid less, have less agency (for example, being able to afford time off) and experience poorer working conditions (EHRC, 2022).

Almost all frontline workers in adult social care are paid close to minimum wage, and low pay across the sector is a structural issue, rather than simply an issue of pay equity between employees. Sector-level interviewees suggested that some providers may pay overtime in cash, and staff could be working more hours than they should. The situation was described by one expert as follows:

> *"Some years ago, I attended a conference where one of the speakers said that in social care what we've effectively got is poor people looking after even poorer people. That stuck in my head and made me think that a key part of the experience of inequality is poverty itself, and I*

can't help but wonder whether we don't pay enough attention to that issue." - 13th May 2024, interview with senior member of staff from the Race Equality Foundation

- However, staff from ethnic minority groups appear more at risk of being in vulnerable financial circumstances. Research by Care England found that adult social care workers from ethnic minority groups were significantly less likely to say they can usually or always pay their bills (51.7%) compared to white colleagues (62.4%). Workers who identified as black African, black Caribbean and black British were even less likely to say they could do this (47.3%) (Care England, 2024).
- Staff from ethnic minority groups may also be less likely to receive the Government financial support they are entitled to, are more likely to be financially excluded compared to white people, and to use non-traditional credit products (Care England, 2024). Evidence further suggests this is mediated by intersectional characteristics. For example, international migrant staff in this sector appear to be particularly vulnerable to inequalities, and even exploitation (Skills for Care, 2024b). When unfair treatment occurs, international workers may be reliant on their employer to stay in the UK, making it risky to speak up. Some may not even realise they are being treated unfairly, as they may have previously worked under systems with different regulations.

Dentistry

Staff demographics in the dental sector have changed over time to become more diverse. However, inequalities still persist, especially for those with intersecting minoritised characteristics.

Black dentists remain significantly underrepresented, making up approximately 2% of UK dentists (Lala et al., 2021). However, the overall proportion of dentists from any minority ethnic group in 2021 (29%) is higher than the proportion of the UK population from a minority ethnic group (14%), driven by high representation of people from an Asian ethnic group (23% of UK dentists) (ibid). Applicants from an Asian ethnic group have a 37% acceptance rate for dental degrees, compared to only 19% for people from a black ethnic group (Anim-Somuah and Mills, 2024). This demonstrates the need for data that breaks down the 'black, Asian and minority ethnic' (BAME) category further (Lala et al., 2021, Diversity in Dentistry Action Group, 2021).

The number of women in dentistry has increased, with the total number of female dentists exceeding that of men between 2013 and 2021 (Fleming et al, 2022). Although this increase in women occurred across all ethnic groups, the increase was smallest among black women (ibid), and during this period there was a slight decrease in the number of male black dentists in the UK (ibid).

Gender pay equity appears to be a particular issue, with women's pay per hour for a procedure under the NHS pay system being lower than that for men (General Dental Council, 2024). Sector experts suggest women were more likely than men to see patients who take longer to work with (for example, due to dental phobias), reducing the number of

procedures they can complete in a day and consequently their daily pay. They also suggested women may feel less confident negotiating their pay or contract in the private sector.

> *"[Women] are paid the same as a guy to do the same procedure, but that procedure might take four or five times longer for a nervous patient. If it takes [a woman] five times longer to do that filling, [they're] going to see five times fewer patients, and therefore [their] pay will be very different"* - 6th January 2025, interview with sector expert in dentistry

Sector experts reported younger women may face discrimination during recruitment, as practice owners may try to avoid recruiting staff who could take maternity leave. Employees who take maternity leave in private practices may receive less maternity pay compared to those working in the NHS. Private practice is also an increasingly common model in dentistry compared to other health and social care sectors (Nuffield Trust, 2023). Overall, women also appear more likely to work part time, and less likely to be in senior hospital roles or to own their own practice (General Dental Council, 2024).

Although there have been efforts to gather more data on equality and diversity, the dental workforce is one of the least understood parts of the health and care system in England (NHS, 2024b). For example, there is no data on the equality characteristics of the workforce beyond dentists. The British Dental Association has been leading on efforts to improve data gathering and reporting on workforce characteristics in the sector. Interviewees reported that organisations and groups have been set up to provide support to those in dentistry, such as informal social media support groups, and Confidental, a charity helpline for dentists. Confidental has recently expanded to provide support to all staff members within the dental sector, including dental nurses and admin staff.

Primary care

- Racial inequalities appear to be widespread in primary care, particularly in experiences of discrimination and harassment. Previous research of primary care providers in London found racism was the most common root of harassment and discrimination, with 30% of primary care workers from an ethnic minority group reporting being bullied, harassed or discriminated against by patients and 18% from other staff (NHS/HEE, 2022).
- Those from a black ethnic background were most likely to report these experiences. Most incidents involved less overt behaviour, such as underhand comments, making it more difficult for workers to challenge the behaviour. This contributed to a feeling of being in a hostile environment.
- The research also reported the impact on retention, with 12% of primary care staff from ethnic minority groups considering leaving their role in the past year after experiencing discrimination or harassment. This was disaggregated as 27% of staff from black ethnic groups and 15% of staff from Asian ethnic groups (NHS/HEE, 2022).

Mental health care

- In comparison to other NHS settings, the mental health sector is considered to be performing slightly worse in terms of racial equality for staff (Nuffield Trust, 2021). Staff in support roles may experience inequalities at higher rates and, while available data is limited, there are indications that support staff in the mental health sector are more likely to be male and/or black compared to staff in the wider NHS (Nuffield Trust, 2021).
- Support staff in this sector appear to be significantly more at risk of racial discrimination from patients, patient relatives or colleagues (48%) compared to staff in other roles within NHS mental health services (43%) (Nuffield Trust, 2021). They also appear to experience discrimination to a greater extent than similar workers in other sectors. There is also evidence of an ethnicity pay gap in favour of white staff across those in support roles across the NHS (ibid).
- Although the evidence on the ethnicity progression gap is mixed, ethnic minority workers in NHS mental health services are underrepresented in higher pay grades compared to their white counterparts (Think Ahead, 2023). In 2016–2020, staff from ethnic minority groups also experienced a decrease in access to in-work training compared to their white counterparts (ibid).
- Though evidence is limited, previous research suggests that slightly more mental healthcare staff reported as disabled (6%) compared to staff in roles outside mental health (4%). This is still below the proportion of employed working-age adults in the UK with a disability (19%) (Nuffield Trust, 2021). Mental health trusts also have the highest proportion of disabled staff who reported that their employer had made adequate adjustments (77%), and are more likely to have a slightly higher proportion of disabled board members than providers in other settings. However, this number remains relatively low at 3% (Nuffield Trust, 2021).

Of the survey respondents in this research who worked in mental health care, 19% reported experiencing and/or observing inequalities related to mental health conditions or illness, which was higher than for any other healthcare setting. It is not possible to confidently ascertain from this data the exact reasons behind this finding. It could be due to people with lived experience of mental health issues being more likely to work in this sector (so the prevalence of people who might face discrimination on this ground is higher), or due to people working in mental health care being more aware of issues around mental health conditions or illnesses, or due to higher discrimination on the grounds of mental health within mental health services. Further research is required to understand the factors shaping the incidence of mental health inequalities within the mental health services workforce.

Acute care

Race inequalities and gender discrimination are noted to be particularly prevalent in acute care services. Staff from ethnic minority groups are more likely to be placed in riskier

conditions that white colleagues. Ethnic minority workers had higher rates of COVID-19 infection and deaths compared to white staff during the pandemic, and were more likely to be deployed to COVID-19 wards. They also reported feeling they could not challenge or change these rota decisions (EHRC, 2022, Hussein, 2022a; Hussein, 2022b).

Rhead et al. (2024) have shown that NHS staff from ethnic minority backgrounds were exposed to more harassment and discrimination, and lacked access to Personal Protective Equipment (PPE) compared to their white counterparts during the pandemic.

On gender discrimination in acute care settings, a 2023 report found that almost one in three female surgeons (30%) working in the NHS had been sexually assaulted in the preceding five years (Begeny et al., 2023). The same study also found that 29% of female surgeons interviewed had experienced unwanted physical advances at work, more than 40% had received uninvited comments about their body and 38% experienced sexual "banter" at work (ibid). The publication of the report was called a '#MeToo moment for surgery' and led the Royal College of Surgeons to introduce new measures to reduce such incidents occurring in the future.

Data also suggests that ambulance staff are often victims of unwanted sexual behaviour. The 2023 NHS Staff Survey found that reports of sexual misconduct were highest among ambulance workers, with more than 27% reporting sexual harassment from the public and just over 9% from colleagues (NHS, 2024a). Nurses and maternity care staff were also among the worst affected groups, with 11% of this group indicating that they had experienced unwanted sexual behaviour.

"Sometimes when my colleagues go to the community, if they're somebody from the global majority they still receive abuse from the patient." – 9th December 2024, interview with worker in the acute care sector

3 Causes and effects of workforce inequalities

This chapter examines the conditions that drive workforce inequalities as well as the impact this has on staff, their career and patient interactions. It covers aspects of formal and informal reporting, the role of implicit bias and subtle racism, and the bi-directional effect of discriminatory behaviour between service providers and those who use services.

Key finding 6: conditions driving workforce inequalities

More than one-half of survey respondents identified individual attitudes of leaders/managers, individual attitudes of staff/colleagues, organisational culture, wider inequality issues in the UK and within organisational systems and fear of speaking up as the driving conditions for workforce inequalities.

Figure 3.1 The conditions that give rise to inequalities according to all respondents

Source: IES, 2024

Figure 3.1 presents respondents' views on the conditions that drive inequalities, with the most common driver being individual attitudes of leaders or managers (77%). This was also the most common response across all sub-sectors and was most frequently selected by those working in community and social care settings than any other sector.

66% felt that inequalities were the result of individual attitudes of staff or colleagues. This was more frequently reported for those experiencing or observing religion and nationality-related inequalities, by older workers, by male respondents, and by those working in mental health care settings. Organisational culture was the third most common choice among survey respondents and was slightly higher for individuals who reported experiencing and/or observing age or gender-related inequality. This option was also selected by a higher proportion of female respondents those working in HASC for over 15 years, and those working in community care settings.

Lastly, 57% of respondents mentioned inequalities within organisational systems followed by a fear of reporting or speaking up (54%). The top six factors chosen by survey respondents point to a dynamic interaction of structural, institutional and interpersonal factors in driving workforce inequalities. They collectively suggest that systemic, cultural and attitudinal issues simultaneously exist and intermingle to reinforce workforce inequalities in the sector.

> *"There are also… are some really, really bad people out there that are delivering care when they shouldn't and they treat their staff very poorly, discriminating against all sorts of different characteristics."*- 9th December 2024, interview with senior member of staff from The Care Workers Charity

Wider inequalities within the UK were identified as another factor by 59% of survey respondents and was higher for religion and race/ethnicity-based inequalities. It was also selected most by younger respondents (18–30 years old), those working in mental health care or primary care, those from ethnicities other than white, and those with less than five years of service.

Other conditions driving inequalities identified by more than one-half of respondents were inequalities within organisational systems (57%) and fear of whistleblowing or speaking up (51%), while 41% of respondents identified an absence of tangible and measurable actions taken to improve EDI within their organisation as a driver of inequalities. For example, one study observed the impact of institutional racism on recruitment with processes favouring white workers (Hussein, 2022; Hussein, 2022a).

Inequalities within organisational systems were selected more often by those working in mental health care and by respondents from ethnic groups other than white. Additionally, the absence of tangible and measurable actions taken to improve EDI was reported by a higher proportion of female respondents.

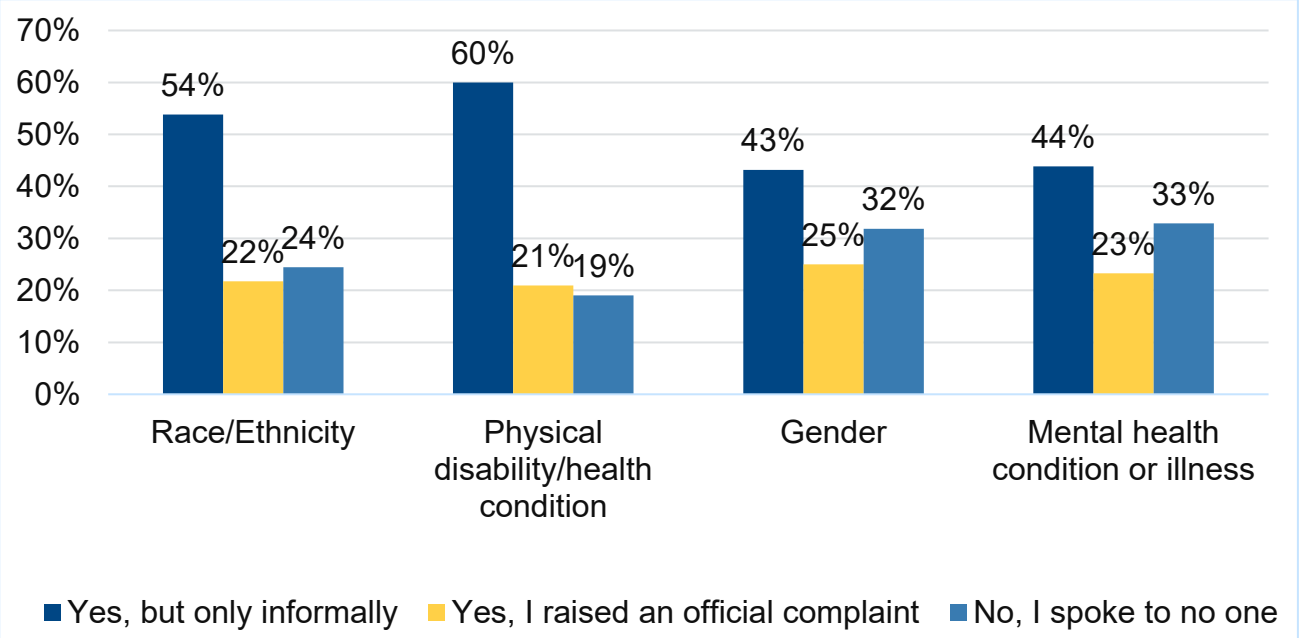
Key finding 7: reporting of unequal treatment

Most survey respondents did not make formal complaints, preferring to discuss the issue informally with colleagues or supervisors. This was due to a belief that no action would be taken or a fear of being perceived as troublemakers.

The literature highlights challenges in reporting racism in the workplace. Research by Kline and Warmington (2024) found that UK-trained staff are more likely to raise an issue as compared to colleagues who trained in other countries. Moreover, of those who reported an issue, only a minor proportion were taken seriously and provided with a resolution, and many left their jobs as a result of discrimination (ibid).

Similarly, a report from the British Medical Association (2025), surveying doctors in 2021 revealed that 91% of female doctors experienced sexism, but almost half of them felt they could not report it. This reluctance to report highlights a significant issue, where female staff may feel unsafe at work and at greater risk of sexual abuse. These findings are reflected by the respondents of the employee voice survey as noted in Figure 3.2 across the top four commonly reported inequalities.

Figure 3.2 Reporting unequal treatment



Source: IES, 2024

As the figure indicates, the incidence of formally reporting a complaint was much lower (between 21–25%) compared to informal reporting, which refers to mentioning or sharing the incidence of unequal treatment to colleagues or superiors. Around one-third to one-fifth of respondents across inequality types said they did not formally report unequal

treatment or discriminatory behaviour (physical disability/condition 19%, race/ethnicity 24%, gender 32%, mental health condition/illness 33%).

Further analysis of the data revealed that the most common reasons for not formally reporting included feeling no action would be taken, being perceived as a troublemaker, and not believing anything would change as a result of reporting.

It is interesting to note that the manager was the most common place respondents reported, despite Figure 2.6 identifying managers or team leaders as the most common source of unequal treatment at work. While this could explain the overall under-reporting of workforce inequalities, it is not possible from the current data to draw meaningful connections between the attitudes of managers and the choice to report to them. The literature points to the absence of support from management and colleagues as a key factor influencing the decision to report, although this is not always present (Turnpenny & Hussein, 2022).

It is also notable that the most common expectation among respondents was that complaints would not be taken seriously. Among those who had experienced unequal treatment due to race or ethnicity, the most common outcome reported was that no action was taken. Additionally, the fear of whistleblowing or speaking up as reported by 54% of respondents in Figure 3.1, highlights the importance of changing organisational culture and developing robust grievance resolution procedures.

Not being able to report mistreatment was also a common theme from sector level interviews. Within dentistry, primary care and adult social care, where organisations are often small, research participants noted that staff were more likely to simply leave if they faced challenges in the workplace. This was especially the case when there was no clear person to report to or if there were no appropriate procedures in place to deal with their concerns.

> *"[There is] difficulty in reporting and whistle blowing and you can get similar issues within dental practises because it's a smaller, more difficult environment. A lot of the time people won't whistle blow, they'll just leave."* – 6th January 2025, interview with senior member of dental sector

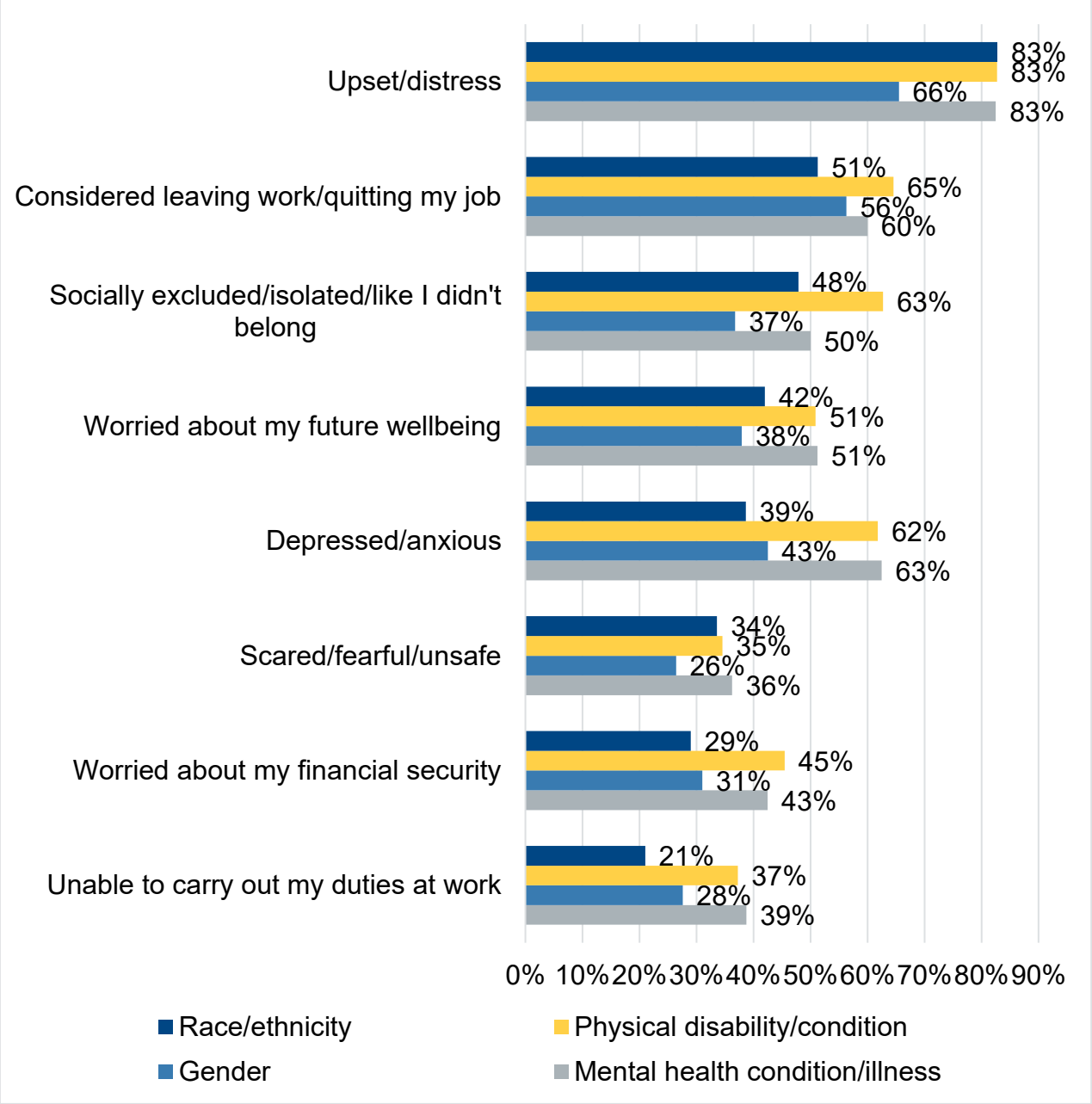
Key finding 8: impact of inequalities on self

Over 80% of respondents of employee voice survey reported feeling upset or distressed as a result of experiencing inequalities, with more than 50% reporting having considered leaving the job.

Less literature focuses on the emotional and psychological impact of inequalities, with more emphasis often placed on the career impact, such as progression and wage disparities. However, some studies do highlight mental distress and health concerns arising from race/ethnicity inequalities (Rhead et al., 2021; Hussein et al., 2023) and

ableism (Lindsay et al., 2023). The employee voice survey asked respondents about the impact of inequalities on oneself. These findings are reported in Figure 3.3 below.

Figure 3.3 Impact of inequalities on self against the four most common inequalities (% agree or strongly agree)



Source: IES, 2024

The most commonly reported personal impact was feelings of upset or distress, which was reported by over 80% of those experiencing inequalities of race/ethnicity, physical disability/condition and mental health condition/illness.

Those experiencing or observing physical and mental-health related inequalities reported significantly higher rates of depression and/or anxiety, concerns about financial security, and being unable to carry out duties at work, with over 60% affected. In contrast, these issues were reported at a much lower rate (around 40%) for those facing race or gender-related inequalities.

Interestingly, feelings of social exclusion, isolation or not belonging were much more commonly reported by those experiencing or observing physical disability/condition inequality (63%) compared to other inequality types, particularly gender (37%). While it is difficult to pinpoint the exact reasons behind this, it could be hypothesised that peer support may act as a protective factor against feeling isolated for women, as they are more likely to have other women in their immediate work networks. In contrast, individuals with disabilities may have fewer opportunities to connect with supportive peers or other disabled colleagues, potentially contributing to a sense of isolation. The literature confirms that negative workplace experiences can significantly harm the health and well-being of disabled staff (Lindsay et al, 2023). This highlights the need for further investigation.

When further analysing differences based on demographic characteristics, a few noticeable differences emerged. Female respondents reported being unable to carry out work duties slightly more often, while a higher number of male respondents reported experiencing depression and/or anxiety.

The literature supports the idea that experiencing negative treatment at work significantly impacts the mental and emotional wellbeing of staff, particularly for those from ethnically minoritised groups (Hussein, 2022a). Studies vary in the way this impact is expressed and reported. One study looking at the impact of racial discrimination on junior doctors found it led to psychological distress, leaving participants feeling undermined and lacking confidence at work (Hussein et al, 2023). However, it did not identify evidence of mental health symptoms. In contrast, a London-based study found that experiencing discrimination was associated with higher anxiety or depression (Rhead et al, 2021).

Racial inequality was also found to affect the mental health of primary care staff, with one contributing factor being the disproportionate rate at which ethnic minority doctors face fitness-to-practice hearings (Atewologun et al., 2019). Data submitted to the General Medical Council identified that doctors referred to such hearings were more often trained overseas, or black and ethnic minority staff.

Similarly, a study of migrant nurses observed that demeaning comments about their competency and microaggressions in the workplace had negative consequences on their emotional well-being (Estacio & Saidy-Khan, 2014). Study participants reported feelings of inferiority as a result of working with racially abusive colleagues. This aligns with research that suggests that, even in the absence of external barriers, the internalisation of discrimination can occur. This internalised discrimination impacts cognitive function, planning, and decision-making, which further negatively affects patient care and outcomes (Hussein et al, 2023).

Key finding 9: impact of inequalities on career

Implicit bias and subtle racism were found to result in negative career impacts, particularly in areas such as recruitment, progression and workplace experiences.

Much of the literature focuses on the impact of workforce inequalities on career experiences. This includes discriminatory recruitment practices that limit access to employment, as well as both direct and indirect effects on career progression and relationships at work.

Recruitment

There is evidence suggesting that recruitment processes tend to favour white British workers, with white applicants being more likely to be hired, while minority ethnic applicants are more likely to receive less favourable responses (Hussein, 2022a; Hussein, 2022b). Furthermore, applicants with visible social markers, such as Muslim names, are disproportionately affected by implicit bias during the recruitment process (Hussein, 2022b).

Stereotypes about women, especially from different ethnicities, influence hiring and leadership decisions. Role congruity theory suggests that women may face barriers in getting hired in certain fields where occupational norms still lead to gender segregation (Rosette et al., 2018). Women are also less likely to be recruited if employers consider there is a possibility they may have children, which has consistently impacted women's career progression (Freeman et al, 2023).

Progression

Woodhead et al. (2022) found that discriminatory behaviour experienced by ethnically minoritised groups within London NHS Trusts directly and indirectly affected their progression. These negative experiences contributed to feelings of fatigue and resignation, which further hindered their professional growth and development.

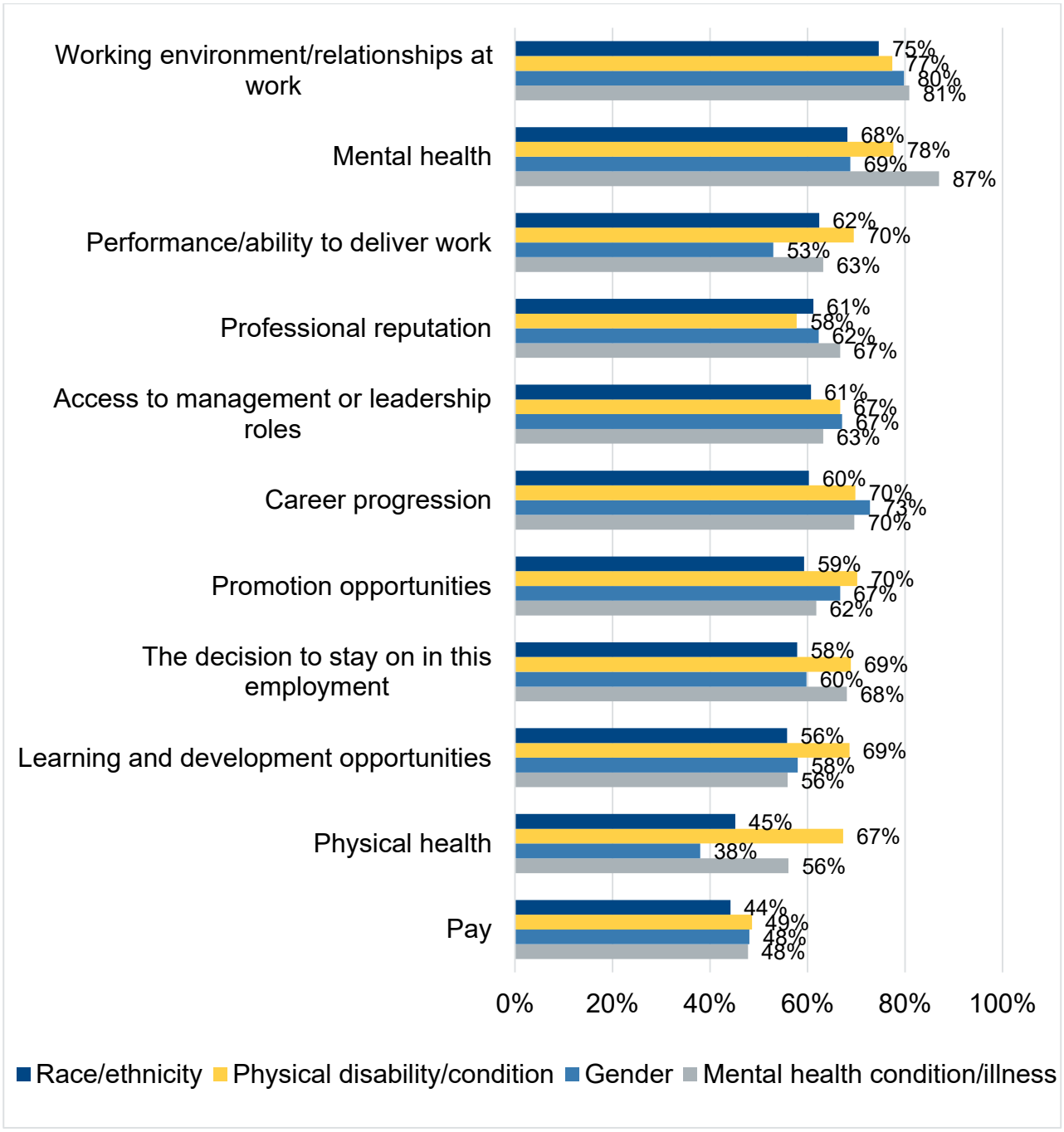
A racialised hierarchy was also maintained by resistance from other groups toward staff from minority backgrounds occupying more senior roles. Workplace culture, therefore, played a key role in shaping inclusion and exclusion processes, influencing decisions to stay or leave. In some cases, individuals voiced their preference for working in environments with other minority group colleagues, as they felt these workplaces were more supportive. However, in these situations, white colleagues reported feeling excluded from these ‘cliques’, highlighting their discomfort with an experience they were less familiar with (ibid).

Effects of discrimination, marginalisation and exclusion faced by migrant workers often materialise in the form of detrimental effects on their career trajectory. For example, nurses reported experiencing subtle racial bias by being denied opportunities to develop their knowledge and skills so they could progress (Estacio and Saidy-Khan, 2014). Ethnic minorities and women continue to be disadvantaged when it comes to senior roles. Leadership positions are more likely to be occupied by staff who are white and male. Data

suggests that the proportion of ethnic minority staff decreases as the seniority of dental staff roles increases (Diversity in Dentistry Action Group, 2021).

The survey findings reflect these experiences, as shown in Figure 3.4, with 60% or more of respondents experiencing and/or observing the top four inequality types reporting a negative impact on their career progression and promotion opportunities.

Figure 3.4 Impact of inequalities on career by the four most common inequalities reported (% agree or strongly agree)



Source: IES, 2024

For those experiencing and/or observing inequalities due to gender, career progression was a particular concern, with 73% reporting a negative impact. In contrast, for those facing inequalities related to physical health, the highest impact was identified as performance/ability to deliver work.

Work experiences and relationship with colleagues

A review of international nurses being treated unfairly found that they were targeted by their supervisors and given unequal work distribution and unfavourable timetables (Pung & Goh, 2017). Instances of unfair treatment extended beyond individual-level issues, with these nurses feeling mistrusted and isolated from healthcare teams as a whole, sometimes fearing for their job security. Similarly, previous CQC research highlights the negative experiences at work that the maternity workforce from black and Asian backgrounds report, on account of race inequalities and stereotypes (Smith, 2024).

Studies also highlight the rise of subtle and hidden forms of racism, which differ from the more overt racism, for example, using social exclusion and unfriendliness to make individuals feel unwanted and unwelcome, without resorting to direct bullying. Thus, discrimination, racism and unfair treatment, particularly toward migrant care workers with black, Asian and other ethnicities such as Chinese, is rarely overt or direct. Instead, it takes the form of grievances or microaggressions rooted in racial bias (Turnpenny and Hussein, 2022).

The findings from the employee voice survey are consistent with the literature, highlighting the impact of inequality on the working environment or work relationships. As shown in in Figure 3.4, more than 75% of respondents reported experiencing or observing this impact across all the top four inequality types.

Perhaps unsurprisingly, the impact on mental health was very high for those who experienced and/or observed inequalities due to a mental health condition or illness (87%). The decision to remain in employment was a common impact for inequalities due to physical health/disabilities and mental health conditions/illness (69% and 68% respectively) (refer Figure 3.4). This may be linked to the availability and accessibility of support (or lack of) within the workplace.

Key finding 10: impact on people who use health services

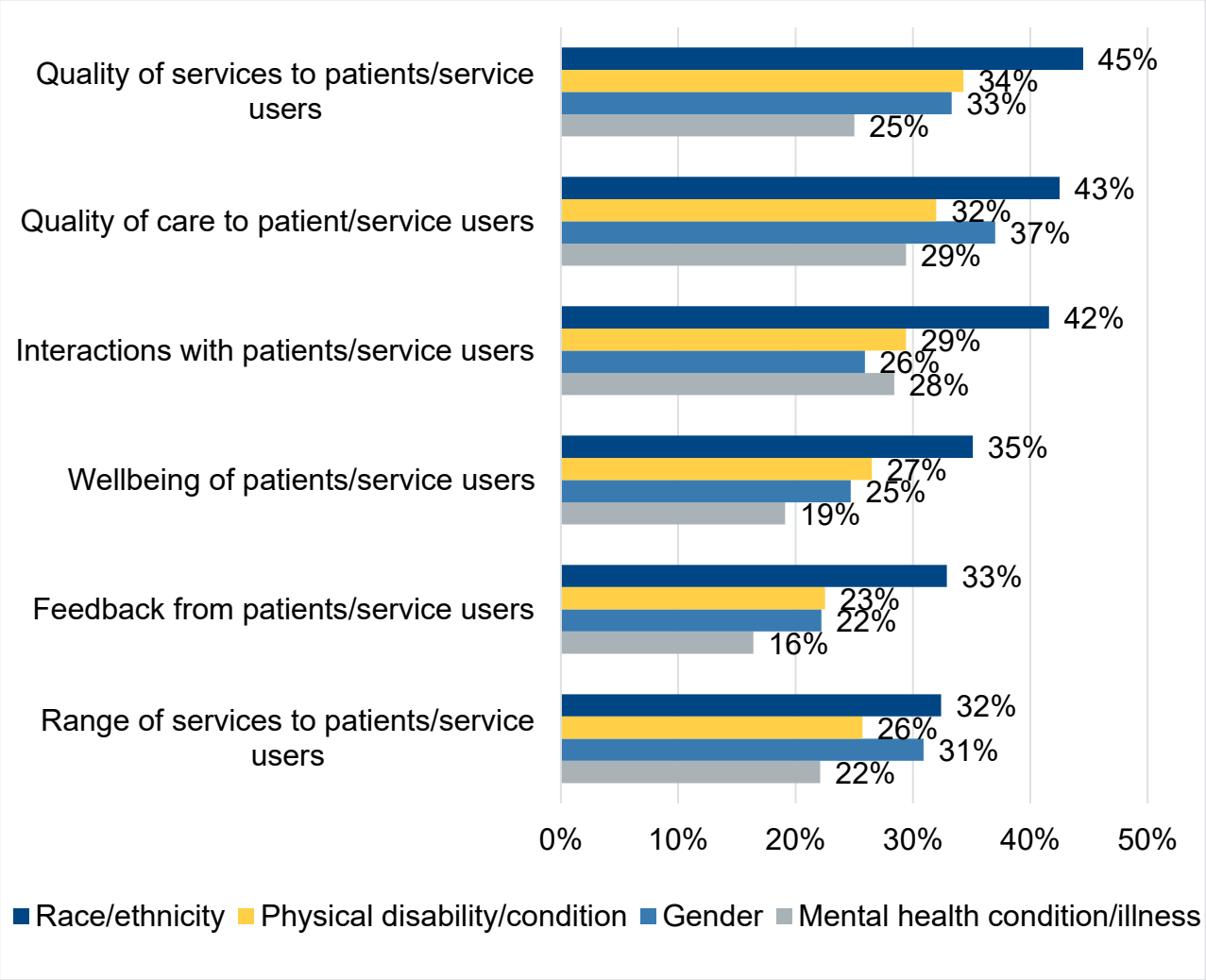
There is a two-way relationship between the attitudes of people using services toward ethnic minority staff and the quality of care and services provided.

There is a gap in the literature regarding how workforce inequalities affect patient care. When patients are mentioned in literature, the focus tends to be on the mistreatment of staff by patients. Examples of racial prejudice by patients include refusing services from migrant nurses and showing a preference for non-immigrant nurses, reflecting underlying assumptions about competency (Estacio and Saidy-Khan, 2014).

Pung and Goh's review (2017) found similar experiences, with international nurses facing rejections from patients or caregivers of patients. These service users had lower levels of trust in the skills of staff due to their ethnicity. The resulting discrimination and exclusion were reported to lead to feelings of loneliness, alienation and social disengagement among migrant nurses.

Ethnic minority healthcare staff experience racism from both service users and colleagues and often lack organisational support to managing racism (Hamed et al., 2022). Some healthcare workers also hold negative racial stereotypes of patients, perceiving ethnic minority healthcare service users as 'difficult'. As a result, racial biases in favour of the majority group are often reflected in medical decisions.

Figure 3.5 Impact of inequalities on patient care by the four most common inequalities (% agree or strongly agree)



Source: IES, 2024

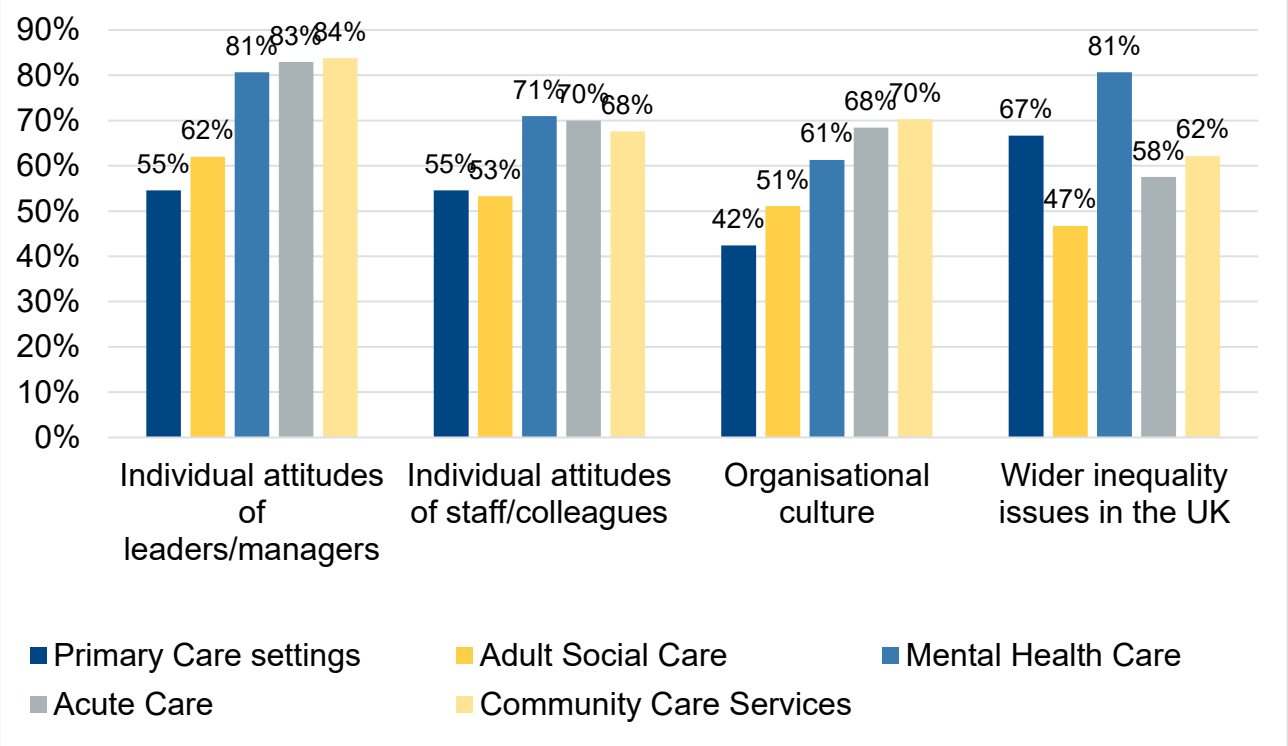
Findings from the employee voice survey shown in Figure 3.5 highlight the impact of workforce inequalities among health and social care staff on the quality of care provided to patients or users of healthcare services. One-quarter of respondents reported poor interactions with patients/service users, with 42% of those who experienced and/or observed ethnic inequalities selecting this response category. A negative impact on the quality of services to, and care of patients/service users was also commonly reported across the top four inequality types.

Sector Insights

Figure 3.6Recruitment and funding challenges are impacting all sectors within health and social care (NHS, 2023). In addition, many staff members across all sectors are experiencing high workloads to ensure core services are delivered. This combination of factors is hindering both organisational and individual efforts to tackle inequalities. This section provides insights into each sector within the HASC.

Figure 3.6 shows how the most common conditions driving inequalities differ by sectors. Wider inequality issues in the UK were more commonly identified as a key driver in mental health care and primary care settings compared to other sectors. In contrast, the individual attitudes of leaders or managers were seen as a more critical factor within community care services and acute care settings.

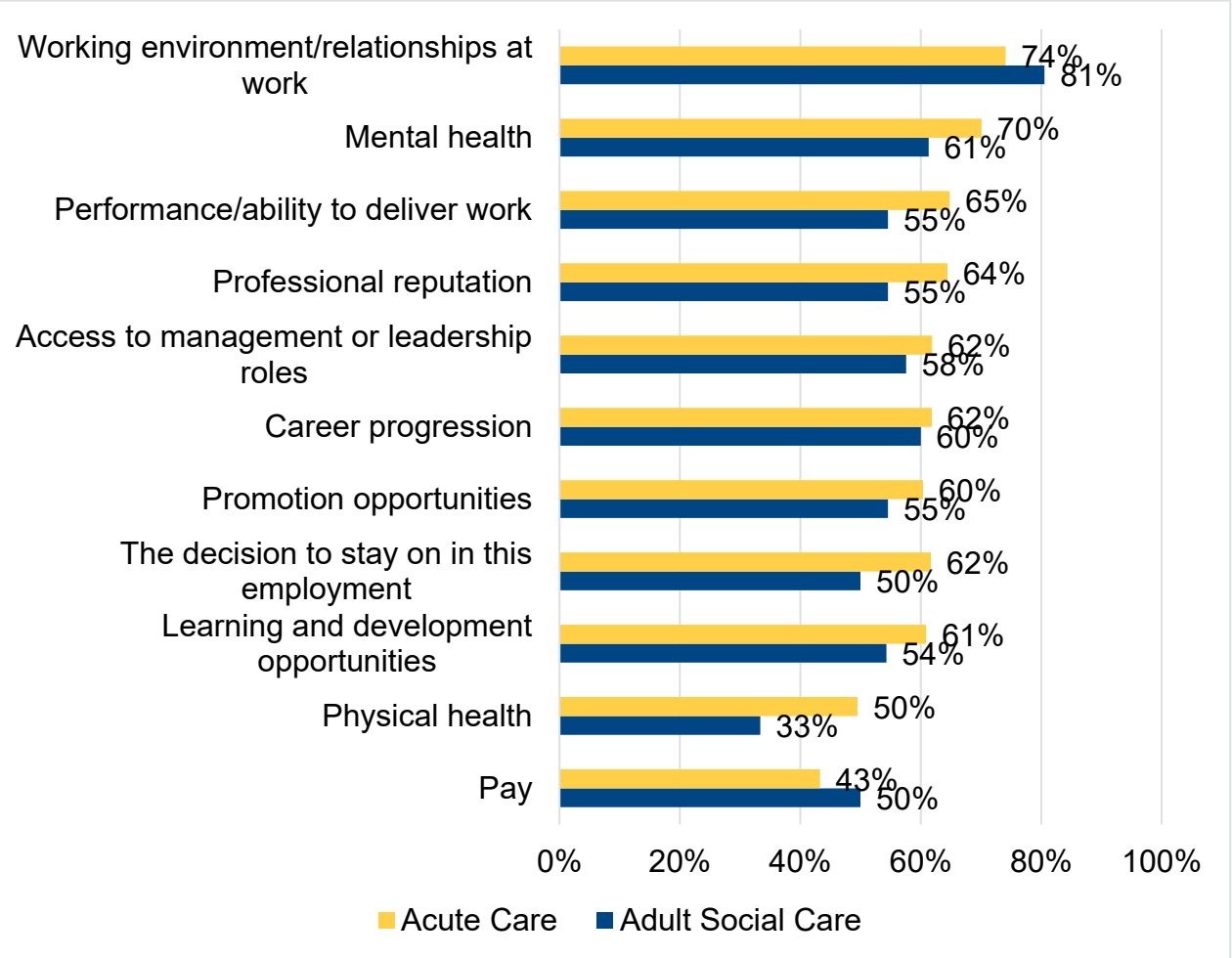
Figure 3.6 The most common conditions for inequalities by sector



Source: IES, 2024; Note: numbers in dentistry were too small to report disaggregated analysis

Figure 3.7 below shows the differences between respondents from the acute care and adult social care sectors regarding impact on their careers where the data could be reported. Two areas where adult social care respondents report more negative impacts than their acute care counterparts are working relationships and pay. While insights can be drawn from the sections on acute care and adult social care, the survey could not explore the underlying reasons behind these sectoral differences.

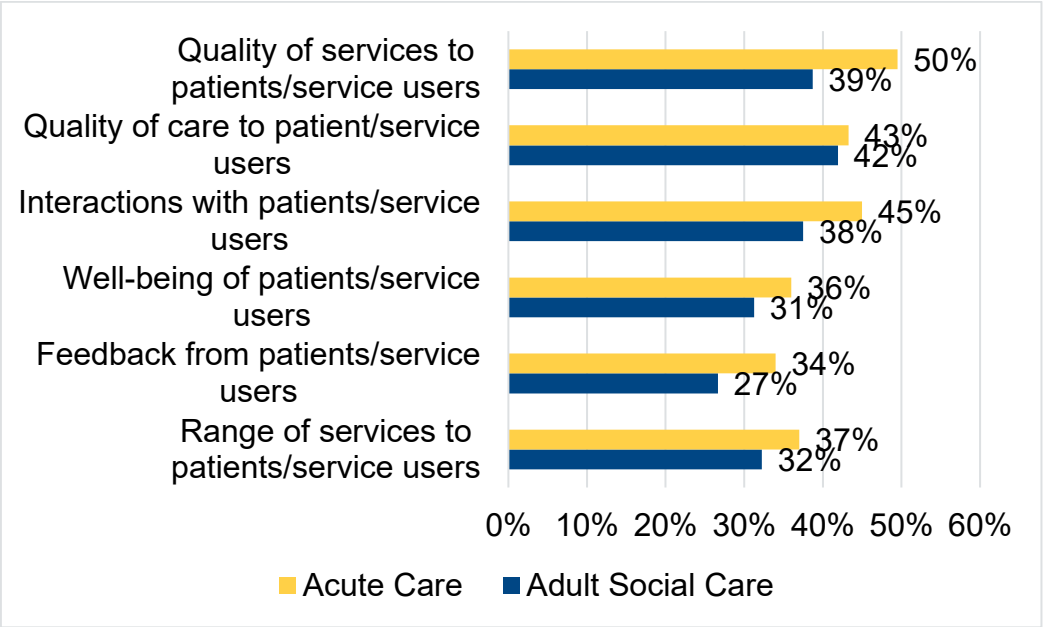
Figure 3.7 Impact on career for acute and adult social care for race/ethnicity inequality (% agree or strongly agree)



Source: IES, 2024

As with the impact on self and career, only limited analysis of sectoral differences could be made for impact on patients or service users due to small respondent numbers. Figure 3.8 illustrates the differences between acute and adult social care in terms of the perceived impact on patients of race/ethnicity-based inequalities. The negative impact on patients was more commonly reported within acute care settings, where one-half of respondents felt that the quality of services provided was impacted. On the other hand, this was slightly lower among respondents working in adult social care (39%).

Figure 3.8 Impact on patients for acute and adult social care for race/ethnicity inequality (% agree or strongly agree)



Source: IES, 2024

Adult social care

The 2024 CQC State of Care report highlighted that while the demand for social care has continued to rise, particularly for individuals discharged from hospital, the supply of care services has not always kept pace (CQC, 2024).

Social care work has been devalued, resulting in the sector being underfunded and understaffed (Care England, 2023; Skills for Care, 2024a). Low pay is a significant issue within adult social care, making staff more vulnerable to poor treatment, as the consequences of losing their job can be far more detrimental.

Sector experts suggest the 'hidden' nature of domiciliary care means home care workers may be vulnerable to experiencing inequalities. Domiciliary carers travel to clients to provide care in their own homes. This means inequalities between how different employees are treated may be less visible to others around them, or during inspections or assessments. Working alone in the community may also expose home carers to a higher risk of discrimination or abuse from patients or patients' relatives, especially staff from minoritised groups.

CQC and other organisations have identified that some employers are recruiting internationally with the intention of exploiting international workers for cost-saving purposes. Recent changes to the visa system for social care workers have made recruiting internationally easier (CQC, 2023). While many employers use the system to successfully recruit internationally in good faith, some may take advantage of workers by

using threats related to their visa, or even through debt bondage (Beels, 2023; CQC, 2023).

CQC has also received reports of some providers engaging (intentionally or not) in human trafficking and modern slavery, exploiting victims through financial, physical, sexual or psychological abuse, racial or religious discrimination, and threats or blackmail (CQC, 2023). The 2024 CQC State of Care report highlighted that in 2023 to 2024, 106 referrals were made to partner agencies regarding concerns about modern slavery and labour exploitation (CQC, 2024). This was nearly three times as many as the previous year (ibid). The Department of Health & Social Care (2024) has since redirected and extended a funding pilot to support activity tackling exploitative practices in international recruitment.

> *"[Some international recruitment] is close to modern slavery. They [adult social care staff] are being told they have to pay back some of the fees associated with bringing them over. [They get] very poor treatment in terms of actually getting the hours of work, so there is a lot of issues with discrimination and poor treatment of people that come over here by themselves, they are very removed from the family… from their safety network and are being taken advantage of."* - 9th December 2024, interview with senior member of staff from The Care Workers Charity

Prior research suggests that staff awareness of their employment rights is low in the adult social care sector, especially in outsourced roles (EHRC, 2022). This can particularly affect international recruits, who may be less familiar with UK law and systems or experience language barriers. Domiciliary carers and outsourced workers may also be vulnerable, as they are often isolated from their colleagues and managed remotely (EHRC, 2022).

Reports in the literature review suggest these combined conditions can make raising concerns feel riskier for workers in lower paid roles within adult social care (EHRC, 2022). Many employees fear losing their job if they speak out and some also report witnessing others who raised concerns being victimised.

There are also fewer opportunities to raise concerns in adult social care compared to healthcare, where anonymised feedback mechanisms such as NHS surveys exist. Employees also lack confidence that their concerns will be heard or acted upon if they speak up (EHRC, 2022).

Some experts suggest that a negative atmosphere in some adult social care settings fosters inequalities and unfair treatment. Bullying or unkind behaviour may become normalised, especially for new staff. Younger workers, in particular, may lack the experience to recognise what constitutes unacceptable workplace behaviour (The King's Fund, 2024).

Dentistry

Many dental practices operate on a small-scale and/or are run independently from the NHS. Like GP practices and some independent social care providers, sector experts noted that small practices may lack dedicated or specialist EDI resources and private providers may not offer staff the same level of EDI training as provided in the NHS. This reflects previous research reporting that stakeholders feel effective EDI training should be a priority for the dental sector, particularly leaders (Diversity in Dentistry Action Group, 2021).

> *"In a general [dental] practice, you wouldn't have the nurses do [EDI training]. There's no requirement for any of the dentists to do it. So EDI hasn't taken priority over clinical matters and general matters of governance."* - 6th January 2025, interview with sector expert in dentistry

Sector experts reported low morale across the sector relating to pay, which may contribute to, or exacerbate inequalities. Staff can feel overloaded by the volume of work, and feel care is not delivered well as a result.

Sector experts describe how staff in certain roles, particularly dental nurses, feel especially undervalued compared to their colleagues. The low rate of pay for dental nurses means they are paid close to minimum wage, despite being exposed to the same level of risk at work as dentists, who are paid significantly higher.

Primary care

Sector experts reported that GP practices find resourcing EDI initiatives especially challenging. Many primary care providers are experiencing particularly intense funding shortages, with a unique and complex funding structure to navigate. Where GP practices operate similar to businesses, they may have additional factors to consider when deciding what to resource.

As with other small organisations without dedicated EDI staff, GP practices may struggle to allocate resources towards addressing workforce inequalities, often requiring shifts from other areas. Staff responsible may also struggle to keep up to date with current EDI best practice. Some organisations have been working to reduce this burden by providing guidance and promoting collaboration. However, experts noted the fragmented nature of the sector, with many small and relatively independent providers, which makes co-ordination challenging.

Sector experts suggested that due to the small size of typical GP practices, workers' experiences of inequalities may be more influenced by the attitude of individual partners or managers within the practices, and the personal relationships they form. With small workforces, staff may have fewer internal routes for raising grievances or complaints, especially if these complaints relate to people in positions of authority.

"I think the main concern I have with the GP sector is it's made-up of a lot of tiny providers who are owned by partners generally, but each kind of partnership has their own kind of policies and procedures. So although there is national guidance out there, it's the partners who will decide how they do things within the practise." - 15th November 2024, interview with sector expert in General Practice

One in four staff from black backgrounds working in primary care settings like GP practices have considered leaving or quitting their job due to racial discrimination (Health Education England, 2022). Practices struggle to identify unacknowledged inequalities (such as pay gaps) or staff outcomes through data when staff numbers are small; this can place more burden on those who feel they have been treated unfairly to raise issues themselves. It can also be more difficult to address hidden forms of discrimination with small staff numbers. With fewer staff members, individual incidents may be viewed as personal conflict rather than being linked to broader patterns influenced by a protected characteristic such as race or disability.

Mental health care

Similar to other areas of the health and social care sector, mental healthcare is experiencing significant challenges with recruitment and retention (NHS Confederation, 2024). The structure of training and rigid progression routes, especially for mental health nurses, can present challenges for people from non-traditional backgrounds trying to join the workforce (Centre for Mental Health, 2024). There is some evidence that high training costs and preconceived notions about who works in mental health care may deter potential candidates from pursuing a career in this field (Think Ahead, 2023).

Workforce inequalities can harm retention or make recruitment more difficult when roles are left unfilled. This can also make it more difficult for remaining staff. Vacancy rates in mental healthcare vary across the country, with the highest vacancy rates in 2024 in the Southeast of England (British Medical Association, 2025)

Mental healthcare is unique in the diversity of services operating outside the NHS or on its periphery. This range includes private in-patient care facilities, other private companies offering outpatient therapies, self-employed counsellors, charities, community interest groups, and local authorities. The extent of this variation means it can be more difficult to co-ordinate efforts across the sector and settings outside the NHS may not be considered when developing policies (Centre for Mental Health, 2024).

Acute care

Acute care is less cohesive than other sectors discussed, with structural factors influencing staff experiences being more diverse and wide-ranging.

One structural issue that frames the experience of staff working in acute care is the UK's lack of critical care capacity, exacerbated by the COVID-19 pandemic. Official data indicates that UK critical care capacity lags behind most other developed countries, with

less than half of the average number of beds per capita than OECD nations (British Medical Association, 202). The sector's inability to deal with the demands placed on it extends beyond the number of available hospital beds to staff levels, meaning that a depleted workforce is left to deal with patient numbers beyond its capacity to treat in a timely manner (ibid). This context frames the experience of staff working within the sector, increasing the likelihood that workforce issues are deprioritised by senior staff, who have less time available and are more focused on issues directly linked to patient care.

Another structural factor impacting the sector is a lack of recognition of overseas qualifications, leading to a concentration of international nurses in the lower pay bands. Workers we spoke to in the sector expressed frustration that nurses moving to the UK from overseas had to start at a lower level than their prior experience or ability warranted, only because their prior qualifications were not recognised.

As many as 25% of international nurses who had recently started working in England felt their previous professional knowledge and experience was not recognised and described it as "heart-breaking" to start at a low pay band after decades of experience (University of Huddersfield, 2023). This contributes to the underrepresentation of international nurses in higher pay bands and presents a particular challenge for staff retention in the sector, as well as raising questions about the use of resources to retrain international staff.

Interviewees highlighted this issue in the context of nursing within acute care as follows:

> *"Internationally educated nurses (IENs) often arrive with a master's degree. However, when they apply for a module in UK educational institutions as NMC-registered nurses, they are required to complete a level 6 course before progressing to level 7. This lack of recognition for degrees from other countries creates additional barriers and hurdles for the career progression of IENs."* - 6th December 2024, interview with NHS Trust Staff Member

Cross-sectoral challenges

Across sectors, the characteristics of different settings or providers present unique challenges.

Small or independent providers, such as GP or dental practices and independent social care providers, face greater challenges to identifying and evidencing inequalities; as with smaller workforces it becomes more difficult to collect comprehensive data and identify patterns of discrimination or inequities. Unlike larger providers or NHS trusts, they may also lack specialist staff working on EDI issues.

> *"The larger providers (often due to requirements stipulated by funding sources) are much more likely to be in line [with EDI requirements], whereas the smaller SMEs [small to medium enterprises] depend on individual priorities of the smaller management team."* - 4th October 2024, interview with adult social care sector expert from Care England

The location of a provider may also impact the working conditions for staff. In some areas of the UK, it can be more difficult to recruit for health and social care roles which can result in a more challenging overall environment for staff who remain (Care England, 2023). Sector experts suggest that providers in areas with high levels of deprivation may experience this more acutely, which is exacerbated by greater funding constraints and higher local demands for services (Atewologun et al., 2019; CQC, 2022).

This disparity in experience is particularly pronounced for small-scale providers with small catchment areas, such as GP or dental practices, where demand for services can vary greatly between providers in close proximity (CQC, 2022). Some previous research suggests staff working in rural areas can experience feelings of exclusion (Anim-Somuah and Mills, 2024), though sector interviews suggest this can affect staff from ethnic minority groups in any area that is predominantly white.

Experts highlighted how a dispersed workforce presents additional challenges, particularly where staff are spread across multiple locations, with varying local needs. For example, domiciliary care workers or district nurses (who often work away from their colleagues) are often less visible, making it easier for unfair treatment, harassment or bullying to go unnoticed. This makes them particularly vulnerable to harassment or discrimination from patients or patient relatives/carers, especially when caring for patients in their own homes.

Providers outside the NHS have greater autonomy, allowing more flexibility in shaping workforce policies, such as pay banding, and types of non-clinical training. As a result, staff in these settings are often more reliant on strong leadership to ensure fair and effective practices are implemented.

4 Reducing workforce inequalities

This chapter synthesises insights from the literature review, employee voice survey, sector and expert interviews, and employer case studies to present findings on effective strategies for addressing workforce inequalities in the HASC sector. In particular, it emphasises the need to tackle systemic and institutionalised forms of discrimination, the importance of adopting an intersectional approach to EDI, the significance of cross-sectoral collaboration among health regulators, and the necessity of evaluating the effectiveness of specific interventions.

Key finding 11: effectiveness of different EDI initiatives

Establishing robust complaints/grievance procedures and securing senior leadership engagement are seen to be the two most effective initiatives to reduce workforce inequalities but are the least prevalent in workplaces as compared to commonly used approaches such as staff training or celebrating diversity, which are often considered less impactful.

There is generally an understanding that awareness of the barriers that prevent positive workplace experiences is an important first step to be able to tackle them (Hussein, 2022a). However, most of the literature focuses on interventions employed within the NHS. Examples of these interventions include:

- Intersectionality training and reflexivity skills training for medical students to make them aware of how their social identity shapes their experiences and approach to patient care (Samra and Hankivsky, 2020).
- Social diversity in medical recruitment panels and faculty to help improve representation for historically marginalised groups (ibid).
- Better signposting to support services such as counselling and reporting services as well as awareness training and policies to help reduce experiences of workplace inequalities (Hussain et al., 2023).
- Overcoming isolation and exclusion in rural English settings by ‘claiming ground’ whereby migrants actively network with local residents, participate in events and use local services, and help create a sense of belongingness in the area (Spiliopoulos, Cuban & Broadhurst, 2021).

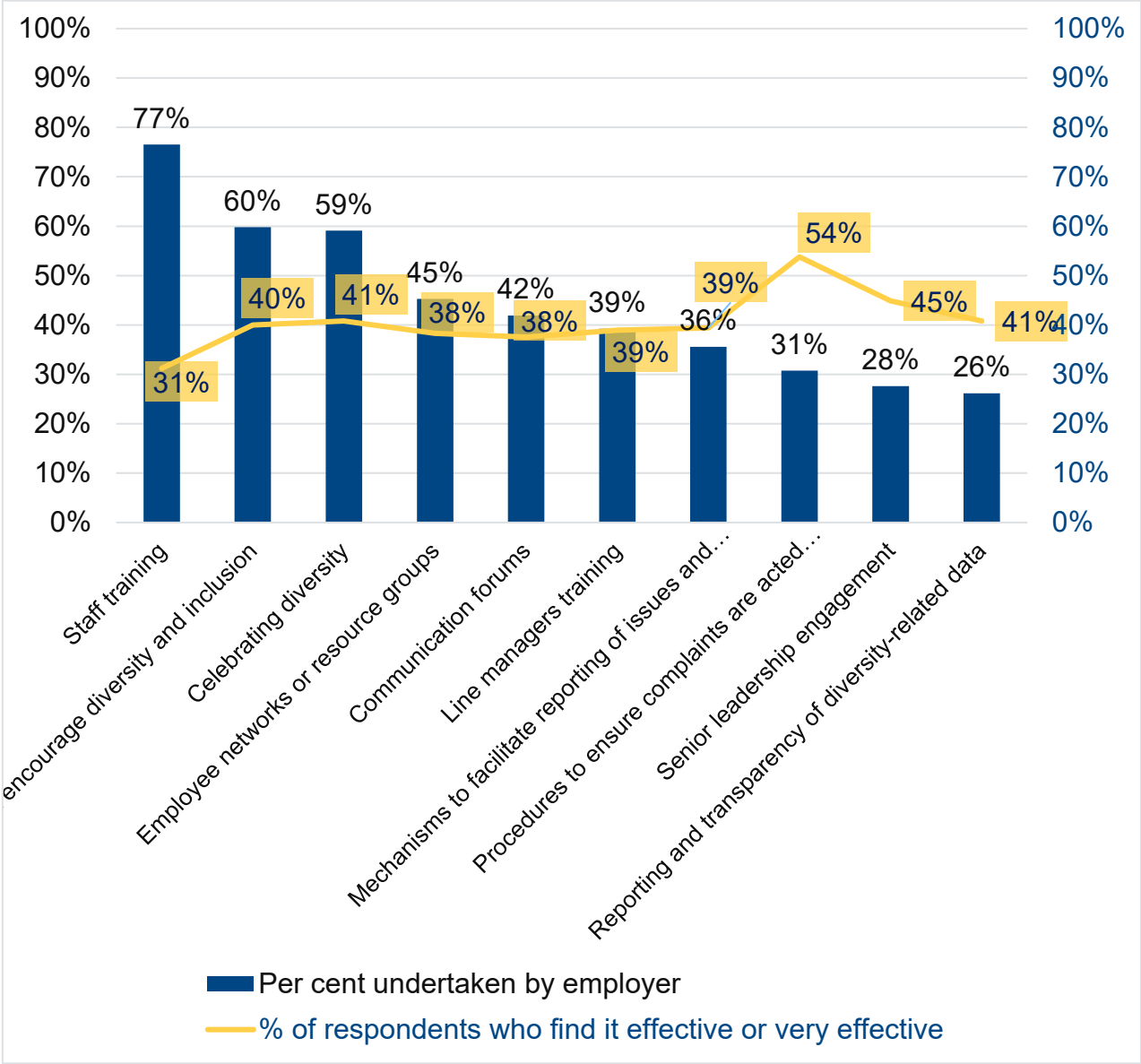
Unconscious bias training can be helpful in raising awareness of how inequalities are reproduced but it is not sufficient on its own to drive meaningful change in behaviour. Despite this evidence, 77% of survey respondents reported that their employers provided

staff training on EDI as shown in Figure 4.1, and unsurprisingly only 31% considered this to be an effective or very effective intervention.

The most interesting finding from Figure 4.1 is that while staff training was the most commonly implemented initiative, it was regarded as the least effective. In contrast, the three least commonly implemented initiatives (procedures to ensure that complaints were acted upon/followed up on, senior leadership engagement and reporting and transparency of diversity-related data) were seen as the most effective.

More than one-half of survey respondents (54%) felt that ‘procedures to ensure complaints are acted upon and/or followed’ was the most effective way of tackling inequalities. However, this was only available in 31% of respondents’ organisations. Similarly, 45% of respondents felt that senior leadership engagement was most effective in reducing inequalities, but only 28% reported this was prevalent in their organisation.

Figure 4.1 Prevalence of initiatives to reduce inequalities and their effectiveness



Source: IES, 2024

The least prevalent initiative was 'reporting and transparency of diversity-related data' which was reported by only 26% of respondents. However, it was seen to be more effective than other measures like staff training, employee networks or resource groups, communication forums, and line manager training. Additionally, while 60% of respondents reported that celebrating diversity and encouraging diversity and inclusion was prevalent in their organisation, only 40% actually found it to be effective.

These findings suggest that more needs to be done to shift EDI efforts from mandatory or tick box exercises towards genuine commitment and action on tackling discrimination, prejudice and inequality.

Sectoral analysis of these EDI initiatives, as illustrated in Table 4.1 below, showed staff training to be most widely prevalent across all sectors regulated by CQC. Senior leadership engagement was marginally higher in primary care settings such as GP practices (36%), but this might be explained by the small number of staff in these settings and the small number of survey respondents from this sector. Respondents from adult social care reported the highest proportion of procedures in place to ensure complaints are acted upon/followed up (43%) as compared to only 23% of respondents working in acute care having access to these procedures. Over one-half of the respondents who worked in mental health care services reported that employee resource groups were utilised within their workplace.

Table 4.1 Prevalence of the most common interventions to reduce inequalities by sector

	Primary Care settings	Adult Social Care	Mental Health Care	Acute Care (NHS Trusts)	Community Care Services
Staff training	64%	***82%***	***79%***	***76%***	***76%***
Policies that encourage diversity and inclusion	***64%***	***60%***	52%	***58%***	***59%***
Senior leadership engagement	***36%***	25%	31%	24%	29%
Celebrating diversity	36%	***55%***	***79%***	***62%***	***56%***
Procedures to ensure complaints are acted upon/followed up	32%	***43%***	28%	23%	26%
Employee networks or resource groups	28%	44%	***55%***	46%	44%

Source: IES, 2024; Note: numbers in dentistry were too small to be disaggregated

Key finding 12: adopting an intersectional approach

An intersectional approach to EDI is crucial for fostering effective behaviour change.

Samra and Hankivsky (2020) call for 'complex thinking' to dismantle power structures and challenge cultural norms within the medical field. Complex thinking suggested here does not mean complicated or difficult to do. Rather, it encourages employers to take a systemic view of EDI issues and avoid adopting easy or tick box actions that may be less effective. The authors propose the use of an intersectional framework in healthcare settings that can help improve diagnostic biases and protect against systemic biases.

Guidance from the Chartered Institute of Personnel and Development (CIPD) suggests that for an EDI strategy to be effective, it must extend beyond legal compliance. The CIPD outlines a list of intersecting characteristics that should be considered when adopting an

intersectional approach. These include, ‘accent, age, caring responsibilities, colour, culture, visible and invisible disability, gender identity and expression, mental health, neurodiversity, physical appearance, political opinion, pregnancy and maternity/paternity and family status and socio-economic circumstances’ to take an intersectional approach (Ali, 2022).

An intersectional approach is particularly effective when trying to identify and understand instances of structural inequality. For example, the increased risk of serious harm faced by ethnic minority groups during the COVID-19 pandemic can only be fully understood through an intersectional lens. Considering a range of intersecting factors revealed that this heightened risk was not direct, but the result of several mediating factors, such as socio-economic circumstances, working environments and lack of access to healthcare (Scottish Government, 2022).

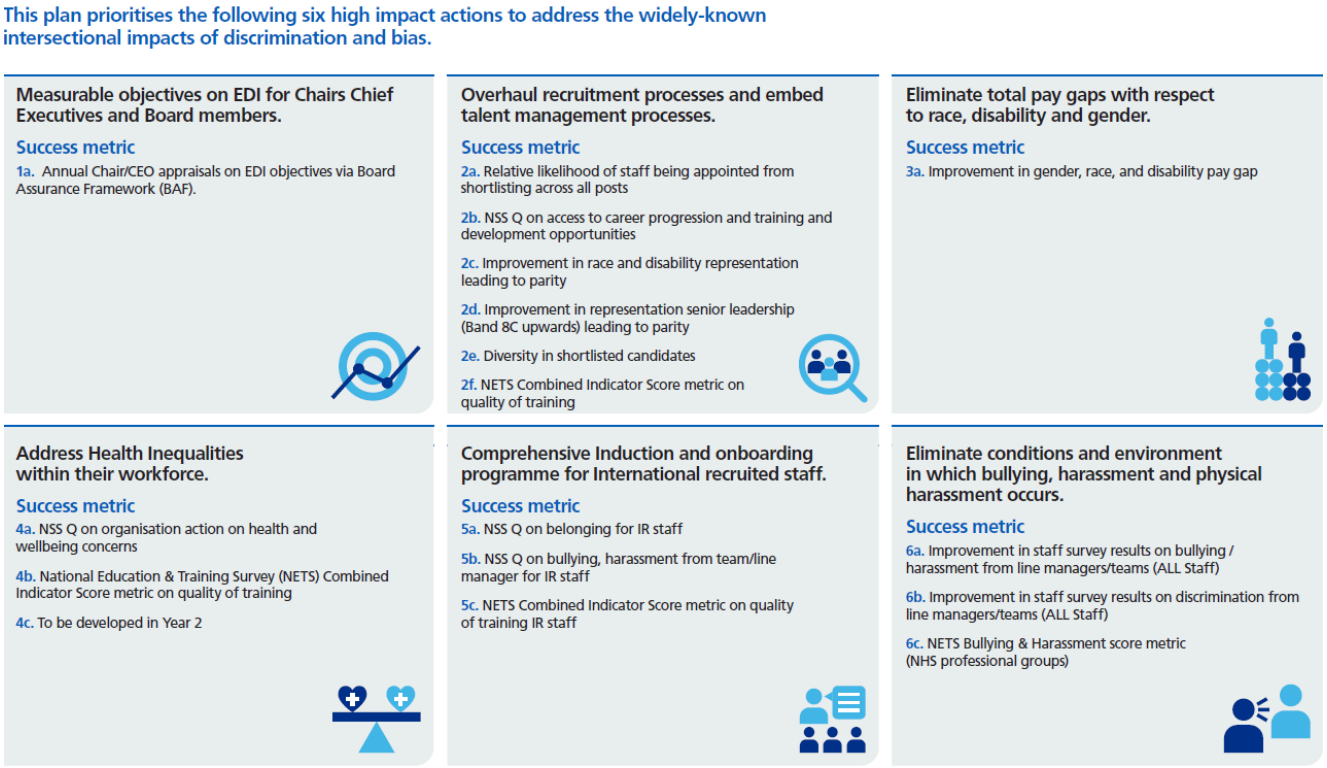
EDI experts interviewed emphasised the importance of an intersectional approach when conceptualising the problems of workforce inequality, as illustrated by the quote below.

> *“Intersectionality is absolutely essential. We're very clear that an intersectional approach is necessary if we want to understand discrimination in the way that people experience it on an everyday basis, rather than in an academic sense. It's only by understanding how people experience discrimination on an everyday basis that we can start developing solutions that will actually make a real difference to people's lives.”* - 13th May 2024, interview with senior member of staff from the Race Equality Foundation

As England’s largest employer, the NHS leads the way in establishing more inclusive workplace environments by addressing the intersectional impacts of discrimination and bias. The 2023 NHS EDI improvement plan sets out exactly how to achieve this. It sets out interventions to address the negative experiences of staff with characteristics protected by the 2010 Equality Act, specifically age, disability, race, religion or belief, sex, pregnancy and maternity, sexual orientation and gender reassignment.

The plan prioritises high-impact actions against each of these characteristics. It is underpinned by the principle that change must be owned by everyone and championed by leaders. It also creates accountability structures, aided by the introduction of measurable objectives to help track progress, and gives responsibility to local trusts and leadership to take the change agenda forward (NHS, 2023a) (see Figure 4.2).

Figure 4.2 Action plan with success metrics from the NHS EDI improvement plan



Source: NHS (2023a)

Key finding 13: acknowledging systemic and institutional inequities

Systemic and institutional racism are important barriers to tackling workforce inequalities because they are deeply ingrained and often operate in subtle hidden ways, making them difficult to recognise and confront.

Institutional racism is defined as 'the collective institutional failure to treat people fairly because of their colour, culture, or ethnic origin. This can be observed in processes, attitudes, and behaviours that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping, disadvantaging racialised and minority groups' (Lea, 2000 as quoted in Hussein, 2022b, pg. 320).

This kind of racism works to normalise historical and societal practices that perpetuate inequality (ibid). Hussein (2022a) found evidence of institutional and structural elements to differing experiences of minority ethnic and white workers, with 'whiteness' and 'white hierarchy' acting as sources of privilege for the latter. This was also described by Hussein et al (2023), who identified how ethnocentric worldviews of white study participants combined with their 'white privilege' allowed them to easily manoeuvre interactions without worrying about the perceptions of race.

Significant systemic change is needed to undo inequalities when they are deeply rooted in pre-existing structures and institutions. As Kline and Warmington (2024) identified, NHS staff found racism within the NHS to be a systemic issue that is often ignored. However, the scope and complexity of the changes required to address systemic racism can sometimes put employers off taking action, despite increasing awareness of what systemic issues look like (ibid). There is also confusion as to what constitutes racism with many believing that this must be overt, rather than the subtle and often ambiguous way it manifests today.

Similarly, Lindsay et al. (2023) highlight the business case for wider inclusion of disabled people. In the face of increasing skills shortages, improving recruitment and retention of individuals with disabilities can help address labour shortages. Skills for Care have made significant strides in attracting a diverse workforce into social care through values-based recruitment. This includes a guide on recruiting disabled people into social care staff.

Although there has been some progress in developing national policies to address inequities in the healthcare sector, these policies often fail to address everyday inequalities and preconceptions around the workplace (Hussein, 2022a). Creating a physically and psychologically safe environment and institutional equity requires a focus on broader inclusion, where all individuals feel valued, supported and empowered.

Key finding 14: collaboration and accountability are key

Cross-sectoral collaboration with other regulatory bodies, along with adopting accountability measures through frameworks and clearly defined targets are key.

Other health regulators interviewed have faced similar challenges to CQC and suggested actions they believe are crucial for addressing workforce inequalities. The most common theme was the **importance of collaboration between regulators and organisations in the sector**. The range of different regulators in the HASC sector, coupled with overlaps and gaps in remit, means that collaboration on the issue of addressing workforce inequalities is essential (Devaney, 2016).

Collaboration between regulators is already commonplace. For example, the Nursing and Midwifery Council (NMC) have been working with CQC and the General Medical Council (GMC) to establish a shared data platform to check the efficacy of pooling data on issues of shared concern like workforce inequality. Nonetheless, there is a consensus among those working within HASC regulation that organisations need to continue sharing information in order to drive improvement, as illustrated by the quote below.

> *"I don't think you can solve some of these issues without ongoing collaboration in different ways*." - 18th June 2024, interview with expert in EDI and regulation in HASC sector

Collaboration in this context could involve sharing data about the performance of particular organisations (for example, EDI performance data) as well as softer, less formal

intelligence sharing (for example, professional judgements on a provider's progress in recent years). It could also involve sharing information about the type of interventions that have been effective in tackling inequalities or using targeted communications that are especially effective with providers.

A second theme was the **importance of integrating workforce equality into frameworks** in a way that holds providers accountable for underperformance. There was praise for CQC's decision to integrate workforce equality into the definition of 'well led' within the assessment framework. There is broad consensus among regulators interviewed that the creation of WRES and WDES has been a significant step forward. These standards require NHS trusts to measure and report on key metrics related to workforce equality.

While CQC is recognised as leading the sector in integrating workforce equality into its assessment framework, some regulators interviewed believe there is more to be done. For example, there is still no mechanism within CQC's assessment framework that holds leaders accountable for failing to address discrimination in their organisation or compels them to take corrective action. One expert believed that EDI issues were often relegated in priority by providers in favour of issues where there are clear penalties for underperformance, as the quote below illustrates.

> *"Who is holding organisations accountable for not doing what they should be doing…at the moment we're working with NHS England colleagues to engage and influence employers, but because it's not mandated they can say 'I'm sorry, we don't have the resource for that, our focus is on this other issue that's actively being measured and I will be penalised by the removal of funding if I don't prioritise it…'. If you get money for meeting your targets, you're going to meet your targets."* - 1st May 2024, interview with expert in EDI and regulation at General Medical Council

Linked to this, some experts outlined the challenges involved in convincing providers to prioritise workforce equality. If providers are to prioritise the issue, then EDI "needs to be seen as business critical as finance reporting." Likewise, another interviewee observed that more immediate, short-term pressures such as reducing waiting times are often prioritised by politicians, which feeds into the priorities of leaders in the sector.

A final theme that emerged from interviews with regulators was the **importance of setting and meeting clearly defined targets** related to workforce equality. In a recent report, the Professional Standards Authority (PSA) praised GMC for setting ambitious targets relating to the disproportionate rates at which doctors from ethnic minority groups were referred to fitness-to-practice panels. The PSA advocated that other regulators should follow their lead.

In addition to this, the setting specific and measurable EDI objectives is the number one 'high impact action' from the NHS EDI Improvement Plan (2023). The introduction of WRES and WDES has fostered a culture of continuous improvement, leading to an

increasing appetite for use of annual targets to drive ongoing progress on workforce equality issues.

Good practices from case studies

Two case studies were developed as part of this research. One was with East London NHS Foundation Trust (henceforth referred to as ELFT) in community/mental health care, and the other was with Buckinghamshire NHS Foundation Trust (henceforth referred to as Bucks) in acute care.

These case studies provide a range of examples of effective interventions employed by organisation to address workforce inequalities. It is important to note that while staff from both organisations acknowledged significant progress had been made in recent years, they also highlighted that there was still considerable work to be done in tackling inequalities within their organisations.

Presence of Staff Networks

- Staff networks for different protected characteristics (such as women's network, LGBTQIA+ network, race and culture equity network) were found to be effective in both case study organisations. These networks served several purposes including representing the interests of particular groups, helping inform the organisation on policies to support these groups and enabling employees to feel part of a community by valuing their differences.

"There's a lot of network building that goes on to make sure that people feel encouraged to be part of the process rather than sidelined." - 20th December 2024, Director at Buckinghamshire NHS Foundation Trust

- Most networks were linked to a board sponsor who advocated for their interests in senior management meetings. This connection to senior leaders was considered one of the most important functions of the networks and ensured that their voices were not marginalised in decision-making processes.
- One potential drawback of staff networks is that, since separate networks exist for different protected characteristics, intersectionality is not always inherently considered. However, both organisations made a conscious effort to incorporate intersectionality into their approach to workforce equality, with many employees being part of more than one network.

At ELFT, staff who served as network leads were given protected time on top of their regular duties to perform their network lead roles. This typically amounted to one day a week dedicated to network activities. Network leads were compensated at the same rate as their normal roles. A collaborative staff network conference is planned later this year to look at intersectionality and how different staff are impacted by intersecting forms of discrimination.

Leadership diversity

Having a senior leadership team comprised of leaders from different protected characteristics was considered important to promote workforce equality. Both case study organisations had senior female staff members from ethnic minority backgrounds in key leadership roles, such as positions on the Board or in Chief Executive and other similar positions.

- A diverse board was viewed as a clear indication that diversity is genuinely valued by leadership. This demonstrates the organisation's commitment to promoting staff from a range of backgrounds and helping to reduce the overrepresentation of white males in senior leadership positions.
- The presence of colleagues from a number of different ethnic groups and nationalities at senior level, demonstrated to junior staff with protected characteristics that there was a clear pathway for progression to senior roles.

Bucks actively encourages staff with protected characteristics to apply for promotions by proactively informing them when new roles become available and directing them to support as needed.

Effective EDI data gathering and sharing

- Effective data gathering relating to workforce equality (beyond what was mandated by WRES and WDES) was found to be a key factor for success in both case study organisations.
- Accurately collecting and monitoring ethnicity data has the dual benefit of enabling organisations to better understand their workforce profile and ensures that staff from minority groups feel their cultural identities are valued and recognised.

At Bucks, an internal campaign successfully changed the ethnic background categories in staff surveys to include Filipino. Previously, Filipino staff (one of the most represented ethnic groups among international nurses) were forced to record their ethnicity as 'Asian/Other'. This omission had happened despite the fact that they are one of the best represented ethnic groups among international nurses. This has now been changed in the data collection processes.

- Sharing EDI data transparently with staff is a statutory requirement. However, it is essential to ensure that staff are not only receiving the information but also engaging with and understanding the communication related to workforce data effectively.

ELFT has been praised for its transparent sharing of EDI data with staff, which has instilled confidence that the trust is not covering up or hiding any issues related to workforce equality. They present the data in a way that allows staff to easily absorb and process its complexity.

Improved grievance or 'speaking up' processes

Both case study organisations have improved their grievance or speaking up process, known as 'Freedom to Speak Up', which has led to an increase in the reporting of incidents. Staff are able to specify the protected characteristic that they are being unfairly treated for, enabling the trust to generate targeted reports. This, in turn, simplifies the process of taking informed action.

"We have a feedback process where people can say specifically what protected characteristic they are being bullied or harassed for. They can be more specific with things, such as racism, bullying and harassment." – 17th October 2024, East London NHS Foundation Trust Staff Member

EDI sessions and workshops

- The delivery of dynamic workshops and training on EDI and workforce equality was another intervention found within both case study organisations to raise awareness on EDI issues and facilitate dialogue.
- Both organisations made a concerted effort to deliver learning beyond the statutory requirements and offering formats tailored to staff needs. For example, webinars on topics such as civility between colleagues from different backgrounds, stammering awareness, and women's issues have been offered.

ELFT has run workshops on xenophobia, islamophobia and antisemitism, while Bucks regularly holds listening events for staff networks on different issues. During the riots in August 2024, the Chief Nurse at Bucks organised webinars to provide a platform for staff who had been affected.

- ELFT also made a conscious effort to deliver EDI sessions to frontline staff on different days and at various times, recognising that EDI sessions were often better attended by corporate staff, while frontline staff were unable to attend due to their shift schedules.

"We spoke to the operation leads so they could ensure they gave the workforce time to attend these sessions, and it could be included as study leave if need be." - East London NHS Foundation Trust Staff Member

Active support to campaigns and diversity initiatives

Both organisations support nationwide NHS initiatives on diversity, which serves to signal to staff that their organisation values them for their differences and helps foster a more inclusive culture. Sponsorship by senior leaders signals their genuine commitment to such initiatives.

Several staff members at Bucks mentioned the 'See Me First' initiative which is a staff-led initiative to promote equality, diversity and inclusivity. The Chief Executive at Bucks is a

sponsor of this initiative and progress is linked to the Chief Executive's personal targets in their performance appraisal.

- An important reason behind running campaigns and listening initiatives is to go beyond the mandatory supervision process, where managers are expected to conduct one-to-one meetings. These active initiatives serve as a vital complement to the appraisal process and suggests a concerted effort to improve overall staff experience beyond just the mandatory wellbeing assessment.

ELFT has been part of the 'Mile in My Shoes' campaign (run by the Empathy Museum) which enables staff to listen to other people's stories and understand what challenges others go through on a daily basis.

Workplace adjustments

- More targeted interventions such as modifying policies to accommodate the needs of particular groups have proven to be effective practices in addressing inequalities.
- The case study organisations reviewed their policies and procedures to ensure staff from certain minority groups and international staff in particular feel valued, for example by modifying the annual leave policy to better accommodate the needs of these employees.

At Bucks, the annual leave policy initially required staff to take annual leave in two-week blocks. This created challenges for international staff from countries like the Philippines, as they felt they did not have sufficient time to spend with their families when they visited their homes or to settle in fully before needing to return to the UK. In response, the organisation modified this policy so that annual leave could be taken in blocks of up to three weeks, to better accommodate the needs of international staff.

5 Recommendations

Overall, our aim was to identify manifestations and drivers of workforce inequalities in the health and adult social care sector, explore current strategies to address them and integrate best practices to shape our recommendations. This chapter presents the recommendations derived from this research.

These recommendations were developed based on evidence gathered through primary research, including case studies, expert interviews and the employee voice survey, alongside secondary analysis of the broader literature to triangulate our findings. We then refined our recommendations in consultation with CQC through two tailored workshops (see Methodology in Appendix A for details).

The recommendations presented here are mapped against CQC's eight regulatory impact mechanisms (The King's Fund, 2018). A further detailing of suggestions for the assessment framework, for inspections and for engaging providers are provided in Appendix E.

Anticipatory impact: before inspectors arrive

Focus: CQC sets quality expectations, and providers understand those expectations and seek compliance in advance of any regulatory interaction.

1. **Establish clearly defined targets for EDI that are linked to measurable progress**. The findings suggest there is a need to create clear EDI metrics that provide transparency around expectations, in the same way that clinical outcomes are assessed. This will elevate the level of prioritisation around workforce equity, building on the progress achieved via WRES and WDES. It may be worth considering the introduction of incentives to meet workforce equity targets to encourage workplace practices that enhance equity (e.g. around recruitment, performance management, disciplinary action, promotions etc). Some stakeholders highlighted the success of the Quality and Outcomes Framework (QOF) in the GP sector, as a conceptual model to build upon in order to achieve positive results.
2. **Encourage the collection and use of EDI data for all providers.** This should include demographic data on complainants and the categorisation of discrimination data (e.g. sexism/racism), which also allows for identification of intersectional discrimination (multiple forms concurrently). Without widespread monitoring of detailed EDI and discrimination data, it is more challenging to review and act on instances of workforce inequalities. It is emphasised that this data is needed on a larger scale beyond NHS Trusts to make meaningful progress, although NHS Trusts could be expected to take a leading role.

3. **Take a proportionate approach to setting expectations around workforce equity, tailored to the size and scale of the provider.** Insights from case studies, sector interviews and CQC colleagues, suggested a flexible approach is required that takes into account the level at which providers are able to engage with workforce equity. This is particularly relevant when considering what best practice might look like, for example, staff networks are effective for creating a sense of belonging in large providers but may not be as relevant for smaller providers; where every manager is likely to play a significant role in setting the tone for workplace equity.

Directive impact: responding to specific requirements

Focus: providers take actions they have been directed or guided to take by CQC (enforcement actions or may involve formal legal repercussions).

These recommendations focus on building the capacity of inspectors, enhancing inspection processes, and the successful engagement of providers on workforce equity.

4. **Inspectors should be fully upskilled on how to assess and identify signs of workforce inequality.** It is essential that skills are built within the CQC workforce to ensure action is taken transparently in response to issues raised. It may require specialised expertise to ensure CQC builds trust with workers through the inspection process. For example, through:

- Creation of a specialised groups of **'super users' who specialise in EDI** and/or inspections, overseen by a 'WRES expert', to enhance the training of inspectors.
- **Developing EDI resources** such as lists of questions and training resources for conducting inspections derived from experiences of staff raising issues with CQC.
- **Using fully observational techniques** and indirect questioning to gain a comprehensive understanding of staff culture with more widespread training available in these methods to handle uncomfortable conversations.
- **Recruiting inspectors who have lived experienced of inequality** to enhance diagnostic capabilities. Promoting diversity within the CQC workforce will acknowledge and help to address its own structural biases, encouraging a more equitable inspection process.

5. **Inspectors need to be aware of relevant provider data in preparation for inspection**. If inspection is to be effective in tackling workforce inequalities, it is important that inspectors monitor data and make a forward assessment of the most prevalent inequalities they may encounter. Inspectors should also have a broader understanding of sector and workforce contexts concerning equity.

6. **Providers should be held accountable for addressing workforce inequalities.** To effectively challenge racism and discrimination in the workplace, it is important to clearly define where responsibility lies for addressing workforce inequalities and that inaction would lead to serious consequences. Enforcement-focused measures may be

necessary to ensure compliance with standards required under the Health and Social Care Act 2008 and its related regulations Where there is discrimination that requires enforcement action, but the Equality and Human Rights Commission have more appropriate enforcement powers (as the regulator of the Equality Act 2010), then CQC should liaise with EHRC. This arrangement is already in place and has been used successfully.

Organisational impact: leading to internal organisational developments

Focus: Regulatory interaction leads to internal organisational developments, reflection and analysis. This leads to changes in areas such as internal team dynamics, leadership, culture, motivation and whistleblowing.

7. **Support clear accountability structures that ensure senior leadership take responsibility for EDI.** Given the strength of findings from the employee voice survey around perceptions of what is most effective in making an impact of workforce equity, visible senior leader sponsorship is critical to drive the introduction and implementation of policies and practices that will deliver progress. It is important to establish processes, accountability structures and systematic actions when issues are flagged internally to ensure that reports of racism and discrimination are effectively and transparently dealt with. Employee voice should play a clear role in the assessment process to understand worker experiences of senior leadership engagement with EDI and design-in accountability to employees at all levels.
8. **Encourage providers to take a proactive approach to workforce equality, with appropriate strategies in place that support individuals at risk**. This would include the collection of EDI data at sufficiently granular level to identify employees with (multiple) protected characteristics, who are at most risk of experiencing racism and discrimination. This concept of proactivity could be embedded within the ‘well-led’ quality statement and reinforced in CQC communications; that highlight promoting workforce equity is a fundamental requirement of being a 'good' leader, employer and provider of health and social care. Providers should also feel confident when raising concerns with CQC, for example workforce EDI should be a standing item on NHS engagement agendas.

Relational impact: regulation as a social process

Focus: Results from the nature of relationships between regulatory staff (i.e., inspectors) and regulated providers. Informal, soft, influencing actions have an impact on providers.

9. **Facilitate an open, honest, collaborative approach with providers to improve workforce equity**. Reflecting on the reluctance of some providers to engage with the research due to concerns about exposing a lack of understanding and sufficient action on workforce equalities, our recommendation is that a more collaborative approach is required to encourage genuine improvements. This may involve incorporating a

degree of flexibility and proportionality when setting bespoke targets to allow for a range of possible actions to be considered. Progress should be framed as an opportunity, with dedicated learning resources available. Accountability for performance levels should then acknowledge actions taken and degree of progress, to balance the directive and relational impact of regulatory mechanisms.

10. **Establish supportive peer networks for inspectors that encourage the sharing of best practice**. To build the skills, confidence and capability to inspect workforce equality effectively, we heard from several sources that building networks of inspectors would accelerate progress by generating feedback responsively in real time. This would then provide a platform for the collation of intelligence and help drive continuous improvements in CQC's approach to workforce equalities issues.

Informational impact: responses to published data on performance

Focus: CQC collates intelligence and puts information about provider performance into the public domain or shares it with others who then use it for decision-making.

11. **Strengthen evidence linking how workforce inequalities interact with care quality and equity for people using health and care services**. Some stakeholders emphasised that linking workforce equalities to outcomes for people who use services would help to increase its relative prioritisation. This may require examining how workforce inequalities manifest across the different sectors regulated by CQC, highlighting any differences between them, and reinforcing the downstream impacts experienced by people using services including clinical outcomes.

12. **Facilitate the identification and sharing of good practices on workforce EDI**. It is crucial for CQC to take a leadership role in identifying and sharing evidence-based interventions that advance workforce equity. By collecting and showcasing good practice examples through collaboration with peer and provider networks, CQC can better support providers in addressing sector-specific inequalities. This approach will ultimately enhance provider capabilities, but it is essential they retain the autonomy to implement strategies that best fit their unique contexts.

Systemic impact: aggregated findings provoke wider change

Focus: Aggregated findings/information from regulation are used to identify systemic or interorganisational issues, and to influence stakeholders and wider systems other than the regulated providers themselves.

13. **Use CQC's national independent voice and promoting cross-sectoral collaboration with other regulatory bodies**. It is important for CQC to act on workforce equalities alongside other regulators who also have a responsibility towards increasing workplace equity and supporting good practice. Shared frameworks, standards and accountability structures will support this aspiration to be better realised. It is essential that any frameworks developed adopt an intersectional

approach to reducing workforce inequalities, to tackle the multiple forms of discrimination experienced concurrently by many individuals. CQC can amplify this message through sector wide roundtables and partnerships with external stakeholders to influence policy.

14. **Emphasise a lived experience-centred approach to inspection, encouraging wider system impact through the adoption of evidence-based practices by others.** CQC has an opportunity to lead a shift in focus toward what our research shows truly matters to workers - clear leadership and meaningful action on workforce equalities by providers. Capturing the perceptions of workplace practices through lived experience is key to understanding organisational culture. However, this approach may require additional strategies to support staff engagement with CQC inspectors, for example, through accessing staff networks or active random sampling. Remote inspections, though helpful to access wider workforce views, are likely to be less effective in gaining insight into the lived experience of individuals.

15. **Encourage alternative initiatives to increase staff knowledge of EDI and reduce bias, beyond standard training sessions.** The survey findings indicate EDI training and cultural awareness days are perceived as relatively less effective in addressing workforce inequality compared to disciplinary procedures and senior leadership engagement. However, the wide prevalence of EDI training in its current form is often perceived as a tick-box exercise. There is need to increase awareness among providers of this finding to encourage a shift in focus to more systemic action on workplace inequalities and addressing incidents as and when they arise. Equally, there is a need to establish accountability among leaders to find alternative strategies beyond EDI training and cultural awareness that will genuinely enhance workforce equity by addressing everyday behaviours of bullying, harassment and discrimination.

6 Conclusion

Equality, diversity and inclusion in the workplace has become increasingly prominent in in public discourse in recent years. Movements like ‘Me Too’ and ‘Black Lives Matter’ have driven significant activity in this area, while the COVID-19 pandemic further highlighted the impact of discrimination and inequality.

However, this greater awareness has not necessarily led to real improvements in equality and inclusion for health and care workers. As this research has shown, workers continue to experience bullying, harassment and discrimination in the workplace, due to their ethnicity, gender, disability, nationality, or other protected characteristics. Evidence also links workforce inequalities in the health and adult social care sector to broader health inequalities and the quality of care received by people using health services in England.

Regulators such as CQC, GMC, NMC, are increasingly focusing on addressing workforce inequalities to improve equity of access, experience and outcomes for people using health and care services. Alongside mandatory legislation by the UK government (such as the Equality Act 2010 or mandatory gender and ethnicity pay gap reporting since 2017), as well as the NHS Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES), there have been improvements in raising awareness of inequalities issues with providers and highlighting examples of good practice.

This research synthesises the available evidence on the manifestation of workforce inequalities in health and social care and the ways regulatory mechanisms can address these issues. It also provides a new dataset for CQC, incorporating the voices of health workers and staff and leaders working across all sectors regulated by CQC. By adopting an intersectional approach as a conceptual foundation and making sectoral comparisons, this research highlights the deeply ingrained nature of systemic and institutional inequalities, as well as the hidden power dynamics that perpetuate these inequitable behaviours, cultures and processes.

The broad study design adopted (which includes a review of existing literature, interviews with regulators and sectoral bodies, an employee voice survey and the identification of good practices from providers leading in EDI) makes this research a unique and valuable contribution to building the evidence base on workforce inequalities in the health and adult social care sector.

Mapping workforce inequalities

The findings from this research indicate that race and ethnicity inequalities are the most common type of inequality experienced and/or observed by staff, followed by discrimination based on gender or sex, physical disability/condition, mental health condition/illness and nationality. There is also evidence of combined discrimination, where

individuals experience discrimination or harassment due to multiple social identities. The most common forms of intersecting inequalities reported include ethnicity and nationality, highlighting the lived experiences and challenges faced by international migrant workers, ethnicity and gender, focusing on the experiences of ethnic minority women, and other prominent intersections such as gender, physical disability and mental health conditions.

The research also notes how inequalities, particularly racism, have shifted, over time, from overt and direct forms of bullying to more implicit and subtle forms of social exclusion, unfair treatment and microaggressions. Survey respondents and interviewees highlighted several challenges, including limited access to career opportunities, challenges in recruitment, slower progression, and negative work experiences or relationships with colleagues. Notably, low pay emerged as a significant factor contributing to discrimination.

Drivers and causes of workforce inequalities

To understand the factors driving and sustaining these workforce inequalities, the research found the source of discriminatory behaviour to most often come from managers or team leaders, followed by peers or colleagues, and then systemic and institutional factors such as organisational culture, systems and wider issues of inequality in the UK. This finding is crucial for developing effective solutions.

A critical insight of the above is the dynamic interaction between interpersonal factors, such as the individual attitudes of managers, leaders and staff and the more institutional and organisational factors, such as policies and ineffective grievance procedures. These elements work together to perpetuate unequal treatment at work. The preference to raise issues informally rather than making a formal complaint suggests that a pervasive fear of speaking up is. This often leads to distress, depression, anxiety, and feelings of isolation. Many respondents also reported having considered leaving their job or the sector entirely. These findings point to the need for systemic approaches that address both mindsets and workplace practices to bring about meaningful change.

A final driving factor that warrants close attention from CQC is the two-way relationship between workforce inequalities and the quality of care provided. Racial inequalities and stereotypical beliefs continue to influence individual views, leading to discriminatory treatment of care workers. This in turn adversely affects the quality of care and interactions these workers have with people using services. The same applies when care workers hold negative beliefs about people using health and care services from ethnic minority groups. Furthermore, a culture where it is difficult for workers to speak up about concerns due to discrimination, makes poor care more likely for everyone and highlights the importance of institutional processes in addition to addressing individual concerns.

Reducing workforce inequalities

There are significant variations between sectors and our research identified some of the sector-specific challenges such as underfunding, the small size of many providers, negative perceptions of social care, or the ongoing long-term effects of the pandemic.

These sectoral insights must be considered in any effort to tackle health and workforce inequalities. An intersectional approach to EDI initiatives is a key success factor, along with the need for better quality EDI and workforce data that underpins targeted action. The research also emphasises the need for a holistic view of inclusion, going beyond individual protected characteristics to address systemic and institutional efforts that can benefit everyone and promote fairness and inclusion for all.

An interesting finding from the survey was that commonly used EDI initiatives, such as staff training and celebration days, were not seen to be as effective in driving meaningful change. Instead, respondents identified greater impact from robust complaints/grievance procedures, data transparency and active senior leadership engagement. These factors are considered more crucial in fostering a genuine culture of support for EDI and tackling the most serious forms of discrimination and inequality through systemic change, rather than relying solely on individual efforts.

Additionally, the research identified examples of good practice from case study organisations, such as the presence of staff networks, promoting diversity within senior leadership teams, gathering and transparently sharing EDI and workforce data, awareness raising sessions, workshops, campaigns and initiatives to raise awareness. These initiatives also provide platforms for staff to engage and share their perspective, while offering reasonable workplace adjustments to support inclusivity.

Recommendations for action

A key strength of this study is its inclusion of perspectives from other regulators and providers, which were then triangulated with employee insights. This approach has highlighted the need for cross-sector collaboration with other regulatory bodies and the need to adopt accountability measures, such as EDI frameworks and targets.

Good quality data is critical for effective action, especially data from an intersectional perspective. While much of the literature and leadership attention focus on gender and race, this can overlook other forms of discrimination, such as nationality, religion, physical or mental disability and health conditions. This study reinforces the importance of adopting an intersectional lens to identify and address combined discrimination and its harmful effects.

Commitment by senior leaders at the provider level is another crucial factor that needs to be emphasised. It also underscores the importance of greater diversity in senior positions such as on boards and executive teams. Similarly, leadership commitment to workforce EDI among regulators is important given the decline in funding for inspections, changes to tribunal requirements, and the need to address the climate of suspicion and mistrust faced by certain communities or immigrants. An example could be to promote greater diversity on fitness-to-practice assessment panels.

CQC is a prominent independent voice in shaping the national debate and broader narratives around EDI. This research emphasises the value of diversity and inclusion efforts to tackle real inequalities in health outcomes. It contributes to strengthening the

evidence base on what works and where change is needed, while also offering practical suggestions, such as toolkits and training for inspectors, to fully support them to engage with staff at the provider level.

Real action is needed. A lack of awareness of rights, a climate of fear and distrust, and the absence of clear guidelines on acceptable standards for providers to follow, can all undermine good intentions. By aligning the recommendations with the CQC's eight regulatory mechanisms, this research outlines steps to strengthen the role of EDI within the assessment framework. It also calls for better equipping of inspectors to identify persistent inequalities and encourages providers to address workforce issues, not out of fear, but by recognising the benefits from investing in EDI.

Future Research

The report has identified areas for further research. For example, there is a need to go beyond race and gender to understand the experiences of disabled people (be it due to physical conditions or mental health). This study was unable to identify the underlying factors contributing to feelings of social exclusion and isolation among disabled people.

Similarly, the data across the sectors regulated by CQC was uneven and incomplete, primarily due to challenges in securing provider engagement and survey participants. Further research could explore specific sectoral contexts in greater depth and provide insights on the similarities and differences between them. This research lays the foundation for future work in making sectoral comparisons.

While there will always be limitations to what can be achieved by CQC in addressing the broader structural inequalities present in society, it can play a pivotal role in driving meaningful improvements.

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Appendix A: Methodology

The research employed an ambitious and mixed methods study design, drawing on the voices and lived experiences of staff through a survey and organisational case studies, alongside reviewing secondary literature and speaking to experts. An intersectional lens, as outlined in the study's conceptual framework, was applied throughout the research to ensure an understanding of how power relations and the interaction of socio-identity markers interact shape and influence workplace inequalities.

The methodology used for each component of the research is described below.

Literature review

Mapping staff experiences of workforce inequalities

The research team conducted a desk-based literature review of existing evidence on inequalities, with a particular focus on discrimination, harassment and bullying within the HASC sector. The following research questions were posed for this review:

- What types of workforce inequalities exist within HASC sector organisations in the UK?
- How are these experienced by people across different intersecting social identity markers?
- What, if anything, is being/can be done to reduce workplace inequalities within HASC sector organisations?

When reviewing the current literature, it was important to consider the contextual and structural factors influencing the HASC sector, including laws and government regulations, privatisation of healthcare, the role of the NHS, funding and budgets, recruitment, retention and staffing shortages.

Following the pandemic and the subsequent cost of living crisis in the UK, which impacted individuals with different socio-identity markers to varying degrees, workforce inequalities have been experienced very differently.

An initial sift and search process was carried out using the search terms listed in Table A.1 below. The resulting studies were evaluated for their relevance to the research topic.

Inclusion criteria - Literature focusing on workforce inequalities in the HASC sector in the UK across the different types of organisations regulated by CQC (hospitals, care

homes, in-home care, GPs, dentists, mental health, ambulance) were included, with a preference for UK-based literature that was published since 2014 (covering the last 10 years). Grey literature, including reports from independent research bodies and charities in the HASC sector, was included alongside academic publications from experts on EDI issues.

Exclusion criteria – Papers published before 2014, papers not relevant to the HASC sector or similar industries, and papers not relevant to the UK context were excluded. Grey literature was quality assessed using the AACODS framework.

Table A.1: Search terms included in the literature review

Primary	Secondary	Tertiary
At work/workplace	Inequalities	In retail
Health and social care	Discrimination	In manufacturing
Workforce…	Marginalisation	In construction
In the UK	Exclusion	In logistics
Reduce	Intersectionality	
Address	Sexism	
Hospitals	Racism	
Care homes/In-home care	Classism	
GPs	Ableism	
Dentists	Systematic discrimination	
Mental health care	Institutional discrimination	
Ambulance	Othering	
Supported living with care home	Inequity	
Nursing home	Disparity	
Social care	Unequal	
Residential care	Exclusion	
	Prejudice	
	Micro-aggressions	
	Homophobia/c	
	Ageism	
	Religious/faith/belief discrimination	
	Transphobia/c	
	Direct/indirect discrimination	
	Diversity	
	DEI	

Source: IES, 2024

A total of 23 pieces of literature were analysed and extracted. Common types of inequalities identified include racism, sexism, ableism, migrant workers' experience, and low pay. The themes of intersectionality, bullying, harassment, exclusion, discrimination and stereotyping were frequent across the literature. There were also a few papers highlighting how migrant workers are especially vulnerable to inequalities in the HASC workplaces, especially through modern slavery.

The literature referred mostly to the NHS but also private HASC settings, along with specific NHS Trusts, hospital settings, residential care and adult social care settings. Majority of extracted papers were set in the UK, with some papers specifically focusing on England. A small number of papers looked at Western countries or similar contexts as the UK, including the US, Ireland, Canada, Australia and New Zealand.

Mapping regulatory theories and mechanisms

The regulatory strand of the literature review focused on the following key research questions:

- What is the existing evidence base on regulatory theories and mechanisms found to be most effective in influencing employers' workplace policies and behaviours in relation to DEI issues?
- How have other regulators approached the issue of workplace inequality- what steps have they taken and what mechanisms have they implemented to combat it?
- What staff experiences of workplace inequalities (discrimination, marginalisation and exclusion) are there in the HASC sector and how might regulation/policy help to mitigate these?

Inclusion criteria – Papers published by an academic with expertise in DEI issues or an organisation that has some responsibility for regulation of workforce issues, UK-based studies as the cultural context is important and may not translate from other countries, those published within the last 15-years, with a preference for newer articles / publications that are most connected into the current DEI agenda and practice, and publications or articles by regulatory bodies focused on the regulatory aspect of DEI where possible, but anticipating the need for a broader search into organisational DEI policies in health and social care

Exclusion criteria – Research conducted over 15-years ago, studies that did not explicitly include an element focusing on regulation of race equality as a central remit of this project, and any international research on regulations for HASC providers.

Using these inclusion/ exclusion criteria, a total of 12 documents were reviewed and extracted.

Expert interviews

Expert interviews were included to build robust data beyond existing datasets and published literature to explore how health and social care providers can tackle workforce inequalities most effectively.

The aim was to speak to a range of regulators who work closely with equality, diversity and inclusion issues (EDI) within health and social care including national bodies responsible for creating the blueprint for best practice and managing bad practice relating to EDI.

The research team spoke to 10 EDI specialists across 6 regulatory and HASC sector expert organisations. All interviews were completed on either Microsoft Teams or Zoom, between 16th October and 12th December 2024. The list of organisations interviewed is provided in Appendix D.

The interviews focused on gaining insight from experts to make sense of the current approaches to regulation relating to workforce inequalities and identifying factors that help or hinder progress in implementing best practice.

All participants were interviewed using the same topic guide but some questions were adapted based on the organisation these experts represented. This was done to clearly distinguish the different approaches regulators are taking and the variable ways best practice appears.

Employee voice survey

The employee voice survey was designed as a key element of the research to gather primary data on the lived experiences of those who work in the HASC sector organisations. It aimed to collect employee perspectives and experiences of workforce inequalities within the sector.

Survey questions gathered data on personal and work characteristics, personal or observed experiences of inequalities, and interventions made to address and/or reduce inequalities. Questions included single, multiple, and open-text response options to collect relevant data.

The survey was designed by IES and launched on 30th September and closed on 22nd November 2024, allowing sufficient time for CQC, IES, IFF Research and other network partners to disseminate the survey link in the widest possible way.

In total, there were 832 responses to the survey, comprising 437 fully submitted responses and 395 partial responses. After data cleaning, which involved removing any blank responses or responses that did not reach question 7, which asked about experiences and/or observations of inequalities, the final sample of 646 responses was analysed. Details of personal and demographic characteristics of the survey respondents are provided in Appendix B.

The mixed-method design provides rich insights and a comprehensive understanding of the wide range of experiences and issues despite the limitations from the survey sample. Descriptive statistics on responses to survey questions are presented as the survey sample was found to be too small for robust analysis of statistical significance and extensive reporting of disaggregated findings into smaller groups. Comprehensive cross-sectoral comparisons were not possible due to small sample sizes across respondents from certain sectors, for example dentistry.

Another limitation is the small proportion that the sample represents of the larger HASC workforce which cautions over the extent to which findings are generalisable for the whole workforce. A final caveat is on the potential for bias in interpretation when a small sample is available for quantitative analysis. It is potentially likely that staff with experiences and interest in the issue of workforce inequalities participated in the survey and may not represent all views and experiences within the sector more widely. Triangulation of survey findings with data gathered from the evidence review and interviews aims to minimise such bias and develop robust analysis.

Explanatory note on use of sex and gender in the survey

The survey questions attempted to separate sex from gender as an axis of inequality in order to acknowledge the differing experiences of discrimination on the basis of binary sex (male and female) from those of people identifying as trans or other non-binary gender identities. However, from the analysis of survey responses it became apparent that some respondents had conflated sex and gender perhaps due to insufficient definitional clarity, and the common usage of gender inequality to refer to discrimination against women who identify as female from birth, some respondents appear to have interpreted both terms in favour of meaning discrimination against women or misogyny

There were 142 respondents who reported experiencing and/or observing inequalities due to gender, 111 who selected sex, and 48 respondents who selected both. A review of open text responses confirmed that some respondents had interpreted both sex and gender inequalities to mean discrimination against women, misogyny, sexual advances toward women, sexism, etc.

Gender inequalities emerged as one of the top four inequalities based on the 142 respondents selecting gender which also includes experiences of 48 respondents who simultaneously selected sex. Figure 2.1 reports the combined frequency for sex and gender (excluding the overlapping 48 responses) to show the prevalence of inequalities due to sex or gender. However, the rest of the report presents findings for gender inequalities while acknowledging that 63 additional respondents reporting sex inequalities may potentially (but not definitely) be raising similar concerns.

This issue points to the challenges in survey design and framing questions to avoid misunderstanding of terms or categories, and reiterates learning from the experience of the Office for National Statistics which found that too many people misunderstood the 2021 census question on trans identities. The concerned question read “Is the gender you identify with the same as your sex registered at birth?” Of those who answered yes, about

2% did not speak English well. But of those who answered no, around 13% did not speak English well. Scotland, on the other hand, used a direct question, “Do you consider yourself to be trans, or have a trans history?” and did not face the same problem.

Organisational case studies

A key aim of the research was to complement the employee voice survey by collecting primary data on the views of employers and staff engaged in EDI and tackling inequalities within provider organisations that the CQC regulates. These case studies were intended to build on findings from the first stage of the study.

The original intention of the research was to develop one case study each for the six sectors that CQC regulates: adult social care, GP practices, dentistry, mental health care, community care, and acute care.

The main objective of these case studies was to explore how wider sectorial workplace inequalities manifest in the 6 sub-sectors of HASC, identifying the available EDI infrastructure and management practices at an organisational level in each case study organisation, and identifying examples of good practices in tackling workplace inequalities, discrimination and race inequality.

Inclusion criteria for case study organisations

A sample frame was developed with 2-3 providers from each sector. Organisations were shortlisted for inclusion in the case study research based on their demonstration of good practice relating to workforce inequality and EDI, using both CQC-collected data and intelligence gained from scoping interviews and other networks.

However, due to challenges with provider engagement and availability, the research team were only able to secure the involvement of only two organisations as case studies. These were the East London NHS Foundation Trust, representing mental health and community care, and Buckinghamshire NHS Foundation Trust, representing acute care. These two organisations had dedicated EDI leads and a clear plan and strategy to make progress on workforce equalities issues.

To bridge the evidence gap for the remaining sectors, the research team undertook interviews with sector experts and/or trade association bodies for GPs, dentistry, and adult social care, as well as undertaking a review of secondary literature in these specific sectors.

Sectoral comparisons and fieldwork

The case studies were used to assess the structural, institutional, and interpersonal contexts of workplace inequality within each sub-sector that CQC regulates and develop examples of successful interventions and good practices in tackling inequalities. The fieldwork and analysis applied an intersectional lens to conduct case study interviews to identify the structural barriers that individuals may be facing.

At the structural level, researchers conducted in-depth interviews with key stakeholders to understand the broad sectoral context, the labour market context, and the policy context that shape the experience of workplace inequalities and the EDI policies, practices and initiatives.

They spoke to stakeholders from umbrella organisations, trade associations, and reference groups for further insight on the wider context of workplace inequalities and EDI policies, practices and initiatives. They sought to understand the organisational context and how and why particular EDI policies and practices and infrastructure have been created at chosen case study organisations. The researchers spoke to a mix of employers (senior staff) and employees (mid-level staff) within the provider organisations.

Case study interviews were used to identify examples of good practice and illustration of good work. They probed for enabling factors, the impact of good practice, lessons to takeaway and how challenges have been overcome.

A total of 14 in-depth interviews were conducted across 16 participants (some were paired interviews) using the same scope but with some questions being adapted based on whether the interviewee was an employee or employer. Interviews were completed on Microsoft teams between 16th October and 12th December 2024.

Stakeholder workshops

Two workshops were held on 6th February 2025 and 25th February 2025 with senior stakeholders (directors, deputy directors, and function heads) and with inspectors, respectively. The aims of these workshops were to:

- Present the research findings and discuss their implications for CQC regulation, assessment and inspections on tackling workplace inequalities.
- Identify desired changes to current assessment mechanisms that CQC can monitor and improve workplace equity, in light of the research findings.
- Produce actionable learnings on what regulatory measures we can adopt to translate these mechanisms into regulatory activities across sectors.

The first workshop was conducted for senior stakeholders at CQC to discuss the findings and steer the draft recommendations. Feedback from this session was incorporated and then presented to inspectors and CQC staff with experience in the field. We checked the overall viability and effectiveness of the proposed recommendations and added their suggestions into the final report.

Appendix B: Survey respondent profile

The tables below present the personal and work demographics of the employee voice survey respondents. A total of 832 persons responded of which 646 were included for analysis after data cleaning.

Personal demographics

Table B.1 Ethnicity of survey respondents

Ethnicity	%
White	61% (259)
Black/African/ Caribbean/Black British	15% (63)
Asian/Asian British	13% (56)
Mixed/Multiple	2% (9)
Other ethnic groups	4% (17)
Prefer not to say	6% (24)

Table B.2 Sex of survey respondents

Sex	%
Female	75% (332)
Male	18% (78)
Prefer not to say	7% (30)

Table B.3 Age of survey respondents

Age	%
18-30	8% (31)
31-40	20% (74)
41-50	32% (117)
51-60	31% (116)
60+	8% (31)

Table B.4 Location of survey respondents

Location	%
North East	4% (22)
North West	16% (104)
Yorkshire and the Humber	18% (111)
East Midlands	7% (43)
West Midlands	12% (79)
East of England	9% (55)
London	13% (84)
South East	14% (90)
South West	8% (48)

Table B.5 Survey respondents with a health condition

Health conditions	%
Yes	36% (153)
No	57% (242)
Prefer not to say	8% (32)

Table B.6 Respondents with caring responsibilities for adults or children

Caring responsibilities	%
Children	39% (166)
Adults	23% (100)

Table B.7 Nationality of respondents

Nationality	%
British	60% (241)
Other nationalities	34% (136)
Prefer not to say	6% (24)

Work demographics

Table B.8 Sector working in

Sector	%
Primary Care settings (e.g. GP practices)	6% (41)
Adult Social Care	20% (130)
Mental Health Care	7% (47)
Acute Care (NHS Trusts)	41% (261)
Dental Practices	4% (25)
Community Care Services	7% (45)
Other	12% (79)
Prefer not to say	2% (14)

Table B.9 Length of time worked in the HASC sector

Length of service	%
Up to 5 years	20% (126)
5-15 years	27% (175)
15 or more years	53% (341)

Table B.10 Survey respondents' role

Role	%
Management	19% (123)
Medical and dental staff	19% (122)
Registered nurses and midwives	18% (114)
Wider team	17% (110)
Health professionals/ scientists and technical staff	9% (59)
Adult social care roles	8% (52)
Other	7% (42)
Operational, nursing or healthcare assistants	2% (13)

Table B.11 Type of employment contract

Employment contract	%
Full-time, permanent contract	71% (457)

Part-time, permanent contract	17% (112)
Fixed-term (full-time or part-time)	4% (27)
Substantive bank-only worker	0% (3)
Locum	1% (9)
Agency staff	0% (1)
Self-employed or freelancer	3% (22)
Other	1% (8)
Prefer not to say	0% (3)

Table B.12 Respondents with managerial responsibilities

Managerial responsibilities	%
None	35% (224)
Lead teams/ projects	36% (229)
Lead department/ division	18% (115)
Lead organisation(s)	7% (44)

Table B.13 Salary of survey respondents

Income	%
Under £24,999	14% (88)
£25,000 to £49,999	45% (287)
£50,000 to £74,999	21% (136)
£75,000+	14% (93
Prefer not to say	6% (40)

Appendix C: Literature on migrant workers and modern slavery

Migrant experience

Recruitment

Non-UK nationals represent 17% of the social care workforce in England in 2020 (Turnpenny & Hussein, 2022). In the nursing profession, historically in the early 2000s, the largest number of migrant nurses were from the Philippines and India. However, the expansion of the European Union (EU) in 2002 to include Eastern European nations, increased the number of EU nurses (Spiliopoulos, Cuban & Broadhurst, 2021).

The recruitment of migrant healthcare workers has been described as 'politically and financially driven' with migrants providing an additional talent pool that providers use to fill labour shortages and skill gaps (ibid). Structural factors also drive this hiring, such as the chronic underfunding of the HASC sector and the UK's 'care deficit', that is care being increasingly outsourced to private and third-sector providers. These factors all contribute to the poor working conditions in the sector.

Recruitment is most often facilitated through personal networks or recruitment agencies (Spiliopoulos, Cuban & Broadhurst, 2021). However, the latter combined with high visa fees pose an additional financial risk for migrants. Additional challenges to recruiting and retaining staff include low pay, insecure employment as well as shift and part-time work (ibid).

In recent news, UK care agencies have been accused of exploiting foreign workers. Individuals have reported paying thousands of pounds to secure jobs in UK care homes or residential care which did not materialise on their arrival, leaving them burdened with significant debts (Stacey & Joshi, 2024).

This trade-off may explain why non-UK nationals are more likely to leave a social care job compared to UK citizens (Turnpenny & Hussein, 2022). Differences in workplace experiences and social integration for this group also plays a significant role. The high turnover of staff in the sector is further linked to a lack of social mobility and other issues for migrant staff.

The immigration system

As of 2017, the UK was the second largest destination for 'mobile care workers' within the EU, accounting for one-fifth of intra-EU mobility. However, this trend may now be shifting following Brexit and the UK's departure from the EU. A Nuffield Foundation report (2022) describes the move as having exacerbated longstanding recruitment challenges within the

healthcare sector, and the increase in recruiting doctors and nurses from outside of the UK appears insufficient in addressing the ongoing shortage.

The NHS long-term workforce plan (2023b) proposed an increase in domestic education and training to address the underlying issues, expanding current funding by £2.4bn in the next six years. However, the plan acknowledges that some professions, despite targeted interventions to build up a domestic workforce, will continue to rely on migrants and temporary staff.

Migrant care workers are often faced with a lack of familial connection or network in the UK. In the context of restrictive immigration policies, this means difficulties in managing family expectations, finances and caring arrangements, all of which add to their vulnerability to exploitation (Turnpenny and Hussein, 2022). These factors coalescing may explain why exploitation is rife in the UK's care sector and is said to bear hallmarks of trafficking and modern slavery (Stacey & Joshi, 2024).

Recent changes in UK immigration rules instituted by the previous Conservative government saw an almost total ban on HASC workers bringing family to the UK. Provisional figures from the Home Office suggest a sharp decline in the number of visa applications. The effect is particularly pronounced in applications for HASC worker visas which dropped by 80% (Whannel, 2024).

The decision to move

The evidence review highlights the concept of 'migrant agency'. This refers to decision-making on the part of migrants to move abroad and take up employment. Turnpenny and Hussein (2022) describe the decision to move to the UK for employment in social care as separate steps in the migration trajectory. The UK is said to often be chosen as a direct destination, in part due to the English language acting as an 'exportable asset.'

The decision to work in social care is said to be a pragmatic one. Despite recognising the disadvantages of the sector – low pay, low status and precarious working conditions with unsociable hours – migrants see it as a stepping stone to other jobs either within the sector or beyond.

Structural issues

Turnpenny and Hussein's review (2022) highlights the specific risks and vulnerabilities of migrant care workers. These risks are often the result of a combination of structural factors such as personalisation and the organisation of care work, which place migrants at greater risk of abuse (often gendered), unfair treatment, precarity, isolation and emotional challenges. These issues are often further compounded by the financialised and marketised nature of care work itself, particularly home care, which blurs the boundaries between private, public, employer and client aspects of work.

Coping mechanisms

Despite patients' racialised preferences when receiving care from international migrant nurses, study participants had learned not to hold these against patients, instead

choosing to view these microaggressions within the broader context of the patient's historical and social background (Estacio and Saidy, 2014).

Migrants focus on their role and contribution to the field of social care, finding that despite difficulties, many migrant care workers value the relational aspects of their work greatly (Turnpenny & Hussein, 2022). They construct work as 'nurturing' and 'holistic,' characterising the client as 'family.'

Acculturation

Spiliopoulos, Cuban and Broadhurst (2021) use Berry's concept of 'acculturation' to examine intercultural adaptation and how newcomers settle, adapt, assimilate or reject new cultures and surroundings. These authors looked at the experiences of highly skilled migrant care workers who had moved to rural England. They found that migrant workers in the study overwhelmingly described a feeling of being othered. This aligns with the concept of acculturative stress rooted in life events relating to acculturation and associated psychosocial difficulties.

Individuals adopt different strategies to acculturation, ranging from assimilation or discontinuation in practising the previous cultural activity, to integration where cultural practices are maintained with mutual accommodation. There is also marginalisation where newcomers reject their own culture and have little interaction with the culture in the new environment. Study participants resist exclusion by 'claiming ground' which involves actively establishing local networks.

Modern slavery

Recent media discourse has brought increased attention to working conditions in the care sector and possible exploitation. This review found one study relating to modern slavery in the care sector. The study interviewed managers at residential care and nursing homes and asked them about recruitment and the risk of forced labour within their organisation.

The care sector is rife with staff shortages and relies on quick recruitment methods via agencies which leads to limited transparency and the exploitation of migrant workers. The use of recruitment agencies means there is limited visibility of the recruitment process. Employers do not carry out pre-recruitment right-to-work checks, resulting in illegal workers coming into the country and being particularly at risk of exploitation (Emberson & Trautrims, 2018). In particular, these authors found a significant risk of forced labour, withholding wages and sexual abuse of workers.

The UK's Modern Slavery Act (2015) requires large organisations to make a statement about eradicating modern slavery from their supply chains. Most care organisations are too small and are therefore not required to do this. The resultant gap in reporting requirements and the overall regulatory weakness of the sector put the human rights of workers at severe risk (Emberson & Trautrims, 2018).