Department of Health

Modernising Scientific Careers: The England Action Plan Equality Impact Assessment

DH INFORMATION READER BOX

Policy **HR/Workforce** Management Planning/ Clinical	Estates Commissioning IM&T Finance Social Care/Partnership Working
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Gateway reference	13858
Title	Modernising Scientific Careers: The England Action Plan
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Circulation list	As above
Description	The England Action Plan sets out how implementation will be achieved by working with SHAs and other key stakeholders to enure a phased approach. The pace of change will depend on local SHA priorities in managing transition. A joint DH/NHS England Implementation Board will strategically oversee and coordinate implementation arrangements reflecting the partnership approach.
Cross reference	
Superseded documents	The Future of the Healthcare Science Workforce, Modernising Scientific Careers: The Next Steps A Consultation (Gateway Ref: 10913)
Action required	N/A
Timing	N/A
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Description of Policy

In November 2008, the UK Health Departments published a document for consultation *The Future of the Healthcare Science Workforce. Modernising Scientific Careers: The Next Steps*.[1] It set out proposals to ensure that the healthcare science (HCS) workforce was educated and trained to meet the challenges of modern healthcare.

Following consultation and stakeholder engagement, *Modernising Scientific Careers: The England Action Plan*[2] has been published. It aims to transform education and training and career pathways with appropriate regulation to deliver a world class HCS workforce from healthcare science assistant through to consultant healthcare scientist and across 45 or so specialisms.

It aims to:

- meet future service needs by ensuring scientific and technological advances are incorporated into emerging models of integrated care
- provide an improved approach to workforce planning and development of appropriate skill mix
- bring the education and training of the HCS workforce more into line with that of other healthcare professionals
- create clear career pathways and education and training programmes in a common framework for the whole of the scientific workforce
- ensure the focus in education and training programmes is on training and enhancing the training experience rather than on trainees being required to deliver service
- include greater flexibility in skill and knowledge development in initial training rather than an emphasis on extensive uni-disciplinary experience.

[1] Department of Health (2008) *The Future of the Healthcare Science Workforce. Modernising Scientific Careers: The Next Steps*. London: DH.
[2] Department of Health (2010) *Modernising Scientific Careers: The England Action Plan*. London: DH.

2. Evidence

2.1. Sources of evidence

How is the policy likely to affect the **promotion of equality** and the **elimination of discrimination** in **each** of the groups?

Age

The NHS workforce is growing older.[3] The NHS Workforce Census for September 2008 shows that the qualified healthcare science (HCS) workforce has a flatter age profile than the nursing workforce and allied health professionals (AHPs).

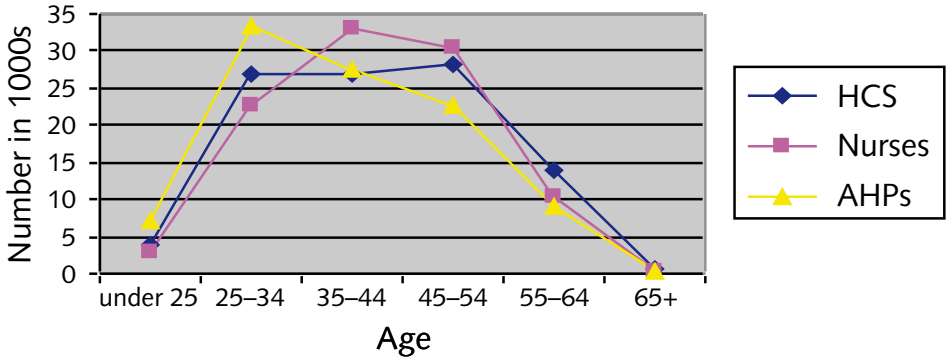

Figure 1 – Age structure of qualified workforce, September 2008

Data from the 2006 survey of NHS staff suggests that between 1% and 2% of healthcare scientists who responded reported that they had experienced discrimination on the grounds of age in the previous 12 months.[4]

The simplified career framework with related training and education programmes of Modernising Scientific Careers (MSC) aim to make healthcare science more transparent and attractive as a career option. This should encourage a diverse age range of applicants, such as returnees to work and new recruits looking for a career in healthcare science.

Clear career pathways and local progression routes have the potential to remove barriers and perceived glass ceilings, encouraging those already in the workforce or joining it to stay and progress in their careers if they demonstrate the right set of skills and knowledge.

The opportunity to demonstrate the equivalence of prior achievement under MSC will ensure that the achievements of older workers are recognised in the new career framework.

Employers and higher education institutions (HEIs) will need to ensure that their policies meet the development needs of all workers.

The development of communications materials by the Department of Health (DH) for use nationally and locally will help raise the profile of healthcare science as a career option for a more diverse range of age groups.

Procurement requirements for new training and education programmes can also ensure the needs of different age groups are catered for where appropriate.

[3] Yar M, Dix D, Bajekal M (2006) *Socio-demographic characteristics of the healthcare workforce in England and Wales – results from the 2001 Census*. London: Office for National Statistics.

[4] Healthcare Commission (2007) *NHS National Staff Survey 2006*. London: Healthcare Commission.

How is the policy likely to affect the **promotion of equality** and the **elimination of discrimination** in **each** of the groups?

Disability

Data on disability can be recorded on the NHS Electronic Staff Record (ESR) but coverage and accuracy are variable across the country. This means that a national picture is unclear. However, analysis of the Labour Force Survey suggests that the percentage of people working in the public sector who have a long-term limiting illness or disability grew from around 11.5% in 1998 to 14.2% in 2006.[5] However, even with this growth in employment, disabled people are underrepresented in the workforce. Data from the General Household Survey suggests that around 19% of the working age population has a disability.[6]

The experience of disabled people in the labour market is also increasingly being documented. Studies have reported the persistence of disadvantage[7] and discrimination.[8]

The 2007 NHS Staff Survey recorded that around 11% (3,120) of AHPs (the nearest comparable group to healthcare science) reported that they had a long-term limiting illness or disability.

The survey also asked respondents whether their employer had made adequate adjustments to enable them to carry out their work. The majority suggested that this had been done or that no adjustment was required. However, around 16% (477) across AHPs suggested that this had not been done, with radiographers the most likely to answer 'no' (22%).[9]

People suggested during consultation on development of MSC that the presence of disabled people in HCS professions might be lower than in the general population because of the 'fitness for practice' requirements or 'good health standards' of some of the professions. These requirements were not limited to physical capability and learning disabilities, but also included mental well-being.

Under MSC, employing bodies, commissioners and HEIs will need to ensure that learning and employment opportunities are suitably accessible to all.

DH can also have some influence in this through its development of communication materials for use nationally and locally to raise the profile of healthcare science as a career option.

Specifications for commissioning new training and education programmes can also bring about change, for example by ensuring there are requirements for the materials and media used to cater for those with disabilities.

[5] Millard B, Machin A (2007) Characteristics of public sector workers. *Economic and Labour Market Review*, 1 (5), pp 46–55.
[6] Dunnell K (2007) *General Household Survey 2007*. London: Office for National Statistics.
[7] Berthoud R, Blekesaune M (2007) *Persistent Employment Disadvantage*. London: Department for Work and Pensions.
[8] Smith A, Twomey B (2002) Labour market experiences of people with disabilities, Labour Market Trends, pp 415–27.
[9] Healthcare Commission (2008) *National NHS Staff Survey 2007*. London: Healthcare Commission.

How is the policy likely to affect the **promotion of equality** and the **elimination of discrimination** in **each** of the groups?

Ethnicity

The Office for National Statistics' latest mid-year estimates for ethnicity (2007) show that the black and minority ethnic (BME) population is 11.8% of the resident population of England. In healthcare science, 19% of the healthcare workforce is recorded as BME in the September 2008 NHS Workforce Census.[10] This varies across grades, however, with cytoscreeners and assistant practitioners being the least racially diverse group. Current students are the most diverse group.

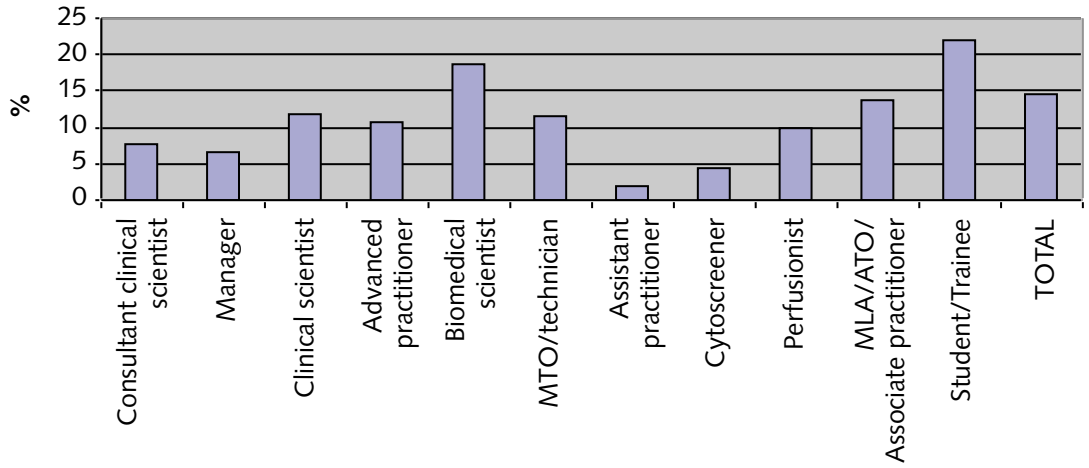

Figure 2 – % headcount from BME background

Several studies have attempted explanations for under-representation of BME people in specific areas and grades across the NHS. In looking at recruitment, they have concluded that it is due to a mixture of pull factors (low profile of some professions,[11] failure to reach out to these communities),[12] push factors (lack of understanding in communities of what some professions do,[13, 14] and a lack of prestige ascribed to some healthcare professions).[15]

In terms of retention, studies have suggested that BME peoples' perceptions are that they are more likely to experience barriers to progress in their careers.[16]

Employing bodies, commissioners and HEIs will need to ensure that learning, employment and career opportunities are open to all and that recruitment policies encourage diversity in the workforce to reflect the population they serve.

DH will play a role in developing materials for communication nationally and locally, including targeted audience groups.

[10] Information Centre (2009) *Annual NHS Workforce Census 2008*. London: Information Centre.
[11] Bogg J, Sartain S, Wain M, Pontin E, Gibbons C (2005) *Allied Health Professionals: Equality and Diversity in the NHS*. Liverpool: University of Liverpool.
[12] Park et al (2003) British Social Attitudes 2003–2004, London.
[13] Bogg J, Sartain S, Wain M, Pontin E, Gibbons C (2005) *Allied Health Professionals: Equality and Diversity in the NHS*. Liverpool: University of Liverpool.
[14] Wright JA, Bithell C, Greenwood N (2006) Perceptions of speech and language therapy amongst UK school and college students: implications for recruitment, *International Journal of Language and Communication Disorders*, 41 (1), pp 83–94.
[15] Wright JA, Bithell C, Greenwood N (2006) Perceptions of speech and language therapy amongst UK school and college students: implications for recruitment, *International Journal of Language and Communication Disorders*, 41 (1), pp 83–94.
[16] Bogg J, Sartain S, Wain M, Pontin E, Gibbons C (2005) *Allied Health Professionals: Equality and Diversity in the NHS*. Liverpool: University of Liverpool.

How is the policy likely to affect the **promotion of equality** and the **elimination of discrimination** in **each** of the groups?

Gender (including transgender)

The September 2008 NHS Workforce Census shows that 67% of the healthcare science headcount is female. They represent only 64% of whole-time equivalent staff, indicating a tendency for more women than men to select part-time contracts.

In the consultant and manager grades, females only represent 31% and 43% respectively. This pattern is closely aligned with the average in other NHS workforce sectors.

The current student/trainee population is slightly more female than the average for the workforce as a whole.

Information on transgender is not currently available nationally, though it is starting to be collected by trusts.

Some studies have identified 'gendered expectations' with regard to the roles for which men and women are 'suited' in healthcare,[17, 18] with women being seen as more suited to frontline roles, for example.

Studies have also suggested that women perceive that there are fewer opportunities for them to progress in clinical settings,[19] or that they are more likely to experience barriers to progress in their careers.[20]

The simplified career structure and multiple entry points of MSC should positively encourage a diverse range of applicants, such as returnees to work and new recruits looking for a career in healthcare science at every level.

Clear career pathways and local progression routes have the potential to remove barriers and perceived glass ceilings, encouraging those already in the workforce or joining it to stay and progress in their careers if they demonstrate the right set of skills and knowledge.

Employers and HEIs will need to ensure that their policies meet the development needs of all workers, including encouraging greater gender diversity in the workforce at all levels.

Development by the DH of communication materials for use nationally and locally should also contribute to improving the gender balance, where this is needed.

[17] Wright JA, Bithell C, Greenwood N (2006) Perceptions of speech and language therapy amongst UK school and college students: implications for recruitment, *International Journal of Language and Communication Disorders*, 41 (1), pp 83–94.

[18] Bogg J, Sartain S, Wain M, Pontin E, Gibbons C (2005) *Allied Health Professionals: Equality and Diversity in the NHS*. Liverpool: University of Liverpool.

[19] Wright JA, Bithell C, Greenwood N (2006) Perceptions of speech and language therapy amongst UK school and college students: implications for recruitment, *International Journal of Language and Communication Disorders*, 41 (1), pp 83–94.

[20] Bogg J, Sartain S, Wain M, Pontin E, Gibbons C (2005) *Allied Health Professionals: Equality and Diversity in the NHS*. Liverpool: University of Liverpool.

How is the policy likely to affect the **promotion of equality** and the **elimination of discrimination** in **each** of the groups?
Religion or belief Data on religion or belief in the HCS workforce is not available nationally, though trusts are now starting to record this data. The 2006 NHS Staff Survey suggests that none of the respondents from healthcare science had experienced discrimination on grounds of religion.[21] People consulted during the development of MSC suggested that some practices in the training of healthcare scientists may not be acceptable to some religious groups. One example quoted was issues around gender and dignity, particularly for some Muslim students working on sensitive subject matters such as sexual health. However, Greenwood and Bithell suggest that religion (and culture) do not necessarily create conflict for students in healthcare professions.[22] They argue that issues to do with the prestige associated with medicine are more significant in career decisions. Employing bodies, commissioners and HEIs will need to ensure that learning, employment and career opportunities are appropriately open to all. As above, DH action on developing communication materials on healthcare science as a career can support local action.
Sexual orientation Data on sexual orientation in the HCS workforce is not available nationally, though trusts are now starting to record this data. Studies have shown that the health sector is as susceptible as any other sector to discrimination on grounds of sexuality.[23,24] McDermott's study of health professionals' experiences suggested that people encountered workplaces where heterosexuality is the expected norm, with accompanying pressure to conform.[25] Other studies have noted that a practitioner's sexuality may help in relating to the experiences of patients.[26] However, this study also noted that knowledge of a practitioner's sexuality could, in some cases, lead to homophobic abuse by both patients and colleagues. As above, employing bodies, commissioners and HEIs will need to ensure that learning, employment and career opportunities are open to all, and that any discriminatory behaviour is tackled. Communication materials developed by the DH may help.
Socio-economic disadvantage Data on socio-economic disadvantage in the HCS workforce is not available nationally, though trusts are now starting to record this data. Employing bodies, commissioners and HEIs will need to ensure that learning, employment and career opportunities are open to all.

[21] Healthcare Commission (2007) *NHS National Staff Survey 2006–07*. London: Healthcare Commission.
[22] Wright JA, Bithell C, Greenwood N (2006) Perceptions of speech and language therapy amongst UK school and college students: implications for recruitment, *International Journal of Language and Communication Disorders*, 41 (1), pp 83–94.
[23] Hunt R, Cowan K (2006) *Harassment and sexual orientation in the health sector.* London: DH.
[24] Hunt R, et al (2007) *Being the Gay One.* Stonewall.
[25] McDermott E (2006) Surviving in dangerous places: Lesbian identity performances in the workplace, social class and psychological health. *Feminism and Pyschology*, 16 (2), pp 193–211.
[26] Riordan (2004).

How will the policy meet the needs of **different communities** and groups?
Age MSC will make healthcare science more transparent as a profession, with a simplified career structure and clear entry and career progression requirements linked to training and education opportunities. This should attract a wider age range of new entrants at every level and provide opportunities to change the age profile in healthcare science over time. The ability to demonstrate the equivalence of prior learning will also ensure that older people will have their skills and knowledge recognised in the new career framework. HEIs will need to ensure equality of access to learning.
Disability Local recruitment and retention policies need to ensure equality of opportunity for people with disabilities. HEIs will need to ensure equality of access to learning.
Ethnicity Local recruitment and retention policies need to ensure equality of opportunity. HEIs will need to ensure equality of access to learning.
Gender (including transgender) Local recruitment and retention policies need to ensure equality of opportunity. HEIs will need to ensure equality of access to learning.
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Sexual orientation Local recruitment and retention policies need to ensure equality of opportunity. HEIs will need to ensure equality of access to learning.
Socio-economic disadvantage Local recruitment and retention policies need to ensure equality of opportunity. HEIs will need to ensure equality of access to learning.

Give details of any **consultation** that has already been done which is relevant to this policy.
Age Evidence has been drawn from a combination of desk research, responses to the consultation document *The Future of the Healthcare Science Workforce. Modernising Scientific Careers: The Next Steps*,[27] and further work during August and September 2009 with stakeholder groups: Greenwich Action on Disability The Ipswich Hospital NHS Trust PRISM – Department of Health LGBT Network Macmillan Cancer Support NHS North West Healthcare Science Network Nottingham University Hospitals BME Staff Group The Metropolitan Police Diversity and Citizen Focus Directorate University Hospitals Bristol
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[27] Department of Health (2008) *The Future of the Healthcare Science Workforce. Modernising Scientific Careers: The Next Steps*. London: DH.
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[29] Department of Health (2008) *The Future of the Healthcare Science Workforce. Modernising Scientific Careers: The Next Steps*. London: DH.
[30] Department of Health (2008) *The Future of the Healthcare Science Workforce. Modernising Scientific Careers: The Next Steps*. London: DH.

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[31] Department of Health (2008) *The Future of the Healthcare Science Workforce. Modernising Scientific Careers: The Next Steps*. London: DH.

[32] Department of Health (2008) *The Future of the Healthcare Science Workforce. Modernising Scientific Careers: The Next Steps*. London: DH.

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Socio-economic disadvantage Evidence has been drawn from a combination of desk research, responses to the consultation document *The Future of the Healthcare Science Workforce. Modernising Scientific Careers: The Next Steps*,[33] and further work during August and September 2009 with stakeholder groups: Greenwich Action on Disability The Ipswich Hospital NHS Trust PRISM – Department of Health LGBT Network Macmillan Cancer Support NHS North West Healthcare Science Network Nottingham University Hospitals BME Staff Group The Metropolitan Police Diversity and Citizen Focus Directorate University Hospitals Bristol

Give examples of existing **good practice** in this area, for example measures to make it easier for people in particular groups to influence policy.
Age The NHS Employers website shows examples of good practice in equality and diversity across all strands, including toolkits for action www.nhsemployers.org A case study of a Public Sector Compact in the West Midlands aimed at promoting the public sector and improving career development is available at www.idea.gov.uk
Disability The NHS Employers website shows examples of good practice in equality and diversity across all strands, including toolkits for action www.nhsemployers.org A case study of a work experience programme for teenagers with learning disabilities in City Hospitals Sunderland NHS Foundation Trust is available at www.dh.gov.uk
Ethnicity The NHS Employers website shows examples of good practice in equality and diversity across all strands, including toolkits for action www.nhsemployers.org A case study of a targeted campaign in Brighton & Hove City Council for bilingual care workers is available at www.dh.gov.uk
Gender (including transgender) The NHS Employers website shows examples of good practice in equality and diversity across all strands, including toolkits for action www.nhsemployers.org A case study on training para-professionals to work in community health service delivery in South Birmingham Primary Care Trust (PCT) is available at www.dh.gov.uk

[33] Department of Health (2008) *The Future of the Healthcare Science Workforce. Modernising Scientific Careers: The Next Steps*. London: DH.

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Religion or belief The NHS Employers website shows examples of good practice in equality and diversity across all strands, including toolkits for action www.nhsemployers.org A case study about the multi-faith chaplaincy team at Guy's and St Thomas' NHS Foundation Trust is available at www.dh.gov.uk
Sexual orientation The NHS Employers website shows examples of good practice in equality and diversity across all strands, including toolkits for action www.nhsemployers.org
Socio-economic disadvantage The NHS Employers website shows examples of good practice in equality and diversity across all strands, including toolkits for action www.nhsemployers.org A case study on ensuring the workforce reflects the community in the London Borough of Tower Hamlets Council and Tower Hamlets PCT is available at www.idea.gov.uk

2.2. Key facts

How is the policy likely to affect the **promotion of equality** and the **elimination of discrimination** in **each** of the areas?
Age A more transparent and simplified career structure. Clearer opportunities for training and development, including defined entry requirements at each career level and defined outcomes from training. The opportunity to demonstrate the equivalence of prior achievement. Improved communications on healthcare science as a career, with target audiences identified. Improved workforce planning data enabling monitoring of the workforce profile.
Disability A more transparent and simplified career structure. Clearer opportunities for training and development, including defined entry requirements at each career level and defined outcomes from training. Improved communications on healthcare science as a career, with target audiences identified. Improved workforce planning data enabling monitoring of the workforce profile.

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2.3. Challenges and opportunities

What measures does the policy include, or what could it include, to address existing patterns of **discrimination**, **harassment** or **inequality**?
Evidence on discrimination, harassment and inequality in the HCS workforce is limited. The workforce comprises 46,000 people in England spread across 45 or so healthcare specialisms. The relatively small numbers employed by individual NHS employers and their consequent low profile within NHS organisations results in a fragmented and limited picture of the HCS workforce as a whole. Raising the profile of this workforce by making the career structure and progression routes much more transparent will increase awareness and help bring to the surface any underlying issues. Improvements in workforce planning data will also help. Strategic health authorities (SHAs) and HEIs will collect and monitor equality data. HEIs get feedback from students to inform their curriculum development and delivery. Students can also give feedback through the National Student Survey on their experiences.
What impact will the policy have on **helping different groups of people** to get on well together to **improve community relations**?
The policy has limited impact on community relations but improved communications on the role of healthcare science and the application of improved diagnostics and better treatments through scientific and technological innovation will enhance the role of healthcare science in service design and encourage a diverse range of new recruits. SHAs have engagement activities to ensure they are meeting the needs of all.
If the policy is likely to have a **negative** impact, what are the reasons?
N/A
What **practical changes** will help reduce any adverse impact on particular groups?
N/A
What will be done to **improve access** to, and **take-up** of, services and **understanding the policy**?
Those already in the workforce or considering entering it need to understand better the positive role they can play in changing patterns of patient care, bringing in innovation through developments in science and technology. DH will take this forward by: • working with stakeholders including: Medical Education England (MEE); NHS Employers, SHA Workforce Directors, education commissioners, HEIs, DH workforce policy leads, Skills for Health, professional bodies, trades unions and current trainees • setting up a communications reference group for developing and testing materials • building structured and targeted audience groups for communications. DH will develop materials for use in communications nationally and locally, identifying the key role in 21st century healthcare of healthcare science and addressing concerns over delivery of change, building on evidence from MSC early adopter sites.

What can you do to **promote equality** and **eliminate discrimination** when you procure goods and services?
Education commissioners will ensure that the promotion of equality and elimination of discrimination are an explicit part of their tender specifications.

2.4. Equality Impact Assessment

Please give a summary of your findings.
A negative impact is unlikely. The policy has the potential to reduce barriers and inequalities that currently exist. However, there is not enough evidence to make this assessment with as much confidence as we would like.

2.5. Action plan

Please give an outline of your action plan based on the challenges and opportunities you have identified.
See chapter 3.

2.6. For the record

Name of person(s) who carried out the Equality Impact Assessment (EqIA):
Ziggi Alexander *Impact Assessment Consultant*, John McDermott *Communications Manager*, Caroline Brock *Delivery Manager*
Date EqIA completed: 15 November 2009
Name of Director/Director General who signed the EqIA: Claire Chapman *Director – General, Workforce*
Date EqIA was signed: 30 November 2009

3. Action Plan

This template is to help you make your action plan.

You might want to change the categories in the first column to reflect the actions needed for each policy.

Category	Actions	Target date	Person responsible and their directorate
Involvement and consultation	Local impact assessments and targeting of specific groups, including engagement activities	Ongoing	Strategic health authorities (SHAs) and higher education institutions (HEIs)
	Development of communication materials for use nationally and locally working with Medical Education England (MEE), NHS Employers, SHA Workforce Directors, education commissioners, HEIs, DH workforce policy leads, Skills for Health, professional bodies, trades unions, and current trainees in Modernising Scientific Careers (MSC) early adopter sites	By Spring 2010	Communication Manager
	Establish National MSC Equality and Diversity Reference Group to help monitor delivery across the six strands of equality and diversity, and ensure that the human rights-based approaches to empowerment, dignity, respect and autonomy are respected in delivery of MSC	Winter 2010	Chief Scientific Officer

Category	Actions	Target date	Person responsible and their directorate
	Professional voice and scrutiny of education and training workforce planning and commissioning through the Healthcare Science Programme Board as a sub-group of MEE. Four working groups to support its work, covering education and training, workforce planning, academic career pathways, and leadership	Established already. Ongoing role	Chief Scientific Officer
Data collection and evidence	Improve workforce data for HCS workforce	Spring 2010 and ongoing	Director of Implementation working with SHAs and the NHS Information Centre
	Gather evidence from early adopter sites	Ongoing	Director of Implementation working with SHAs and early adopter sites
Assessment and analysis	Monitor changes in workforce profile	Ongoing	Director of Implementation working with SHAs and the NHS Information Centre
Procurement	Ensure procurement documents and processes include equality and diversity aspects	Spring 2010 and ongoing	Director of Implementation working with SHAs and education commissioners
	Monitor compliance as part of contract performance management	Winter 2010 and ongoing	SHAs
Monitoring, evaluating and reviewing (including publishing the results)	National MSC Equality and Diversity Reference Group to monitor progress against the 6 strands of Equality & Diversity & Human Rights standards	Spring 2011 and ongoing	Chief Scientific Officer
	Communications strategy using appropriate media	Spring 2010 and ongoing	Communication Manager
	Monitor equality and diversity data against 6 strands	Ongoing	SHAs and HEIs

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