Equality and human rights duties impact analysis for provider handbooks for residential adult social care, community-based adult social care and hospices

1. Introduction

This equality and human rights impact analysis covers the following provider handbooks:

- Residential adult social care handbook
- Community-based adult social care handbook
- Hospice services handbook.

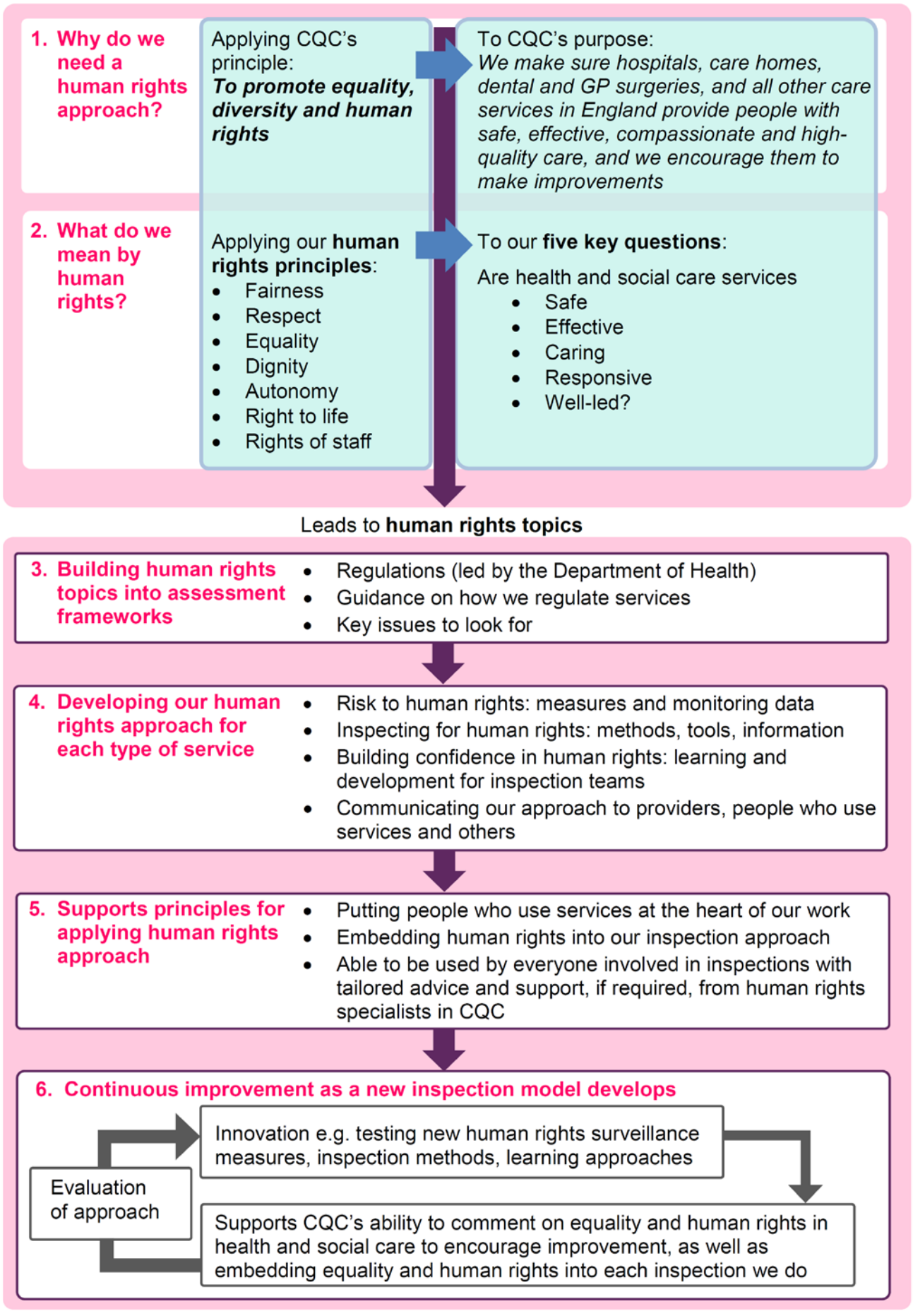
The purpose of this equality and human rights impact analysis is to ensure that, in developing our regulation of adult social care we meet our duties:

- Under the Human Rights Act 1998 to respect, protect and fulfil people's human rights.
- Under the Equality Act 2010 to have due regard, when delivering our functions, to the need to:
    - eliminate discrimination,
    - advance equality of opportunity
    - foster good relations between groups

  in relation to the 'protected characteristics' of age, disability, gender reassignment, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

However, we view this as more than mere legal compliance – we have made one of CQC's principles to promote equality and diversity and human rights. This is a means to an end and not an end in itself. The end is good quality care for all. Respecting diversity, promoting equality and ensuring human rights will mean that everyone using health and social care services receives good quality care.

To put this principle into practice, we have developed a human rights approach to regulation. This approach looks at a set of human rights principles – fairness, respect, equality, dignity, autonomy, right to life and rights for staff – in relation to the five key questions we ask. Our human rights approach is integrated into our new approach to inspection and regulation as this will be the best method to ensure equality and human rights is promoted in our work. We have integrated the human rights principles into our key lines of enquiry, ratings descriptors, intelligent monitoring, inspection methods, learning and development for inspection teams and into our policies around judgement making and enforcement. The diagram overleaf summarises our approach.


1. Why do we need a human rights approach?
Applying CQC's principle:
To promote equality, diversity and human rights
To CQC's purpose:
We make sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and we encourage them to make improvements
2. What do we mean by human rights?
Applying our human rights principles:
Fairness
Respect
Equality
Dignity
Autonomy
Right to life
Rights of staff
To our five key questions:
Are health and social care services
Safe
Effective
Caring
Responsive
Well-led?
Leads to human rights topics
3. Building human rights topics into assessment frameworks
Regulations (led by the Department of Health)
Guidance on how we regulate services
Key issues to look for
4. Developing our human rights approach for each type of service
Risk to human rights: measures and monitoring data
Inspecting for human rights: methods, tools, information
Building confidence in human rights: learning and development for inspection teams
Communicating our approach to providers, people who use services and others
5. Supports principles for applying human rights approach
Putting people who use services at the heart of our work
Embedding human rights into our inspection approach
Able to be used by everyone involved in inspections with tailored advice and support, if required, from human rights specialists in CQC
6. Continuous improvement as a new inspection model develops
Innovation e.g. testing new human rights surveillance measures, inspection methods, learning approaches
Evaluation of approach
Supports CQC's ability to comment on equality and human rights in health and social care to encourage improvement, as well as embedding equality and human rights into each inspection we do

2. Engagement in developing our handbooks for the sector

The responses to the consultation on our strategy for 2013-16 and on our document 'A New Start' have helped us shape our approach to our inspections. In particular, this impact analysis picks up consultation responses from the equality and human rights duties impact analysis for "A new start". A summary of these responses can be found in our Human Rights Approach consultation document.

We have engaged with the public, people who use services and specific equality groups on our new approach: We have:

- Published an adult social care 'signposting' document (*A fresh start for the regulation and inspection of adult social care*) with an email address for responses/comments.
- Carried out social media activity to promote the signposting document.
- Compared our draft Key Lines of Enquiry (KLOEs) and ratings descriptions with the insight gained through consulting with people who use services and the public about proposed fundamentals of care.
- Consulted with the eQuality Voices group on:
    - definitions of human rights principles that have influenced the key human rights topics in our human rights approach.
    - the detail of key human rights topics that have influenced our KLOEs.
- Held meetings of our public steering group to discuss *what good looks like* in adult social care.
- Asked our online communities (Public reference group and action team) about the five key questions to ask on inspections to inform our KLOEs.
- Met with local Healthwatch advisory groups to identify key issues in adult social care.
- Held adult social care co-production workshops, which have included Experts by Experience and people from organisations representing people who use services and carers.
- Held adult social care focus groups with people from these organisations.
- Looked at adult social care accreditation with some Experts by Experience.

3. What we know about equality and human rights in the adult social care sector

What we know about equality for people using adult social care and hospices, in relation to:

Age	We know that older people are more likely to use adult social care than any other age groups: In mid-2012, 16.9% of the population were aged over 65, an increase from 2011 Census figures of 16.3%. Older people make up the majority of people using regulated social care services. Our data at March 2013 showed that there were nearly 400,000 places in care homes designated for older people, over 80% of all places where the age range is known. An ageing population will place pressure on care homes and hospices (Future ambitions for Hospice care). Although more older people receive home care than either residential or nursing care, the human rights of older people in residential and hospital care have received much more attention. The potential risks to human rights when care is provided 'behind closed doors', in people's own homes (a less easily regulated environment) are in some ways greater than in institutional settings. An Equality and Human Rights Commission (EHRC) inquiry uncovered serious, systemic threats to the basic human rights of older people who are getting home care services. Their evidence shows a picture of weaknesses in the home care system, their impact on older people and shows how easily breaches of human rights can occur. Their findings suggest that age discrimination is one of the key factors explaining why older people face risks to their human rights in home care services. They have also uncovered examples of where someone's age determines the funding and provision of home care services (Close to Home: An inquiry into older people and human rights in home care, EHRC, (2011). Regarding hospices: in the UK there are: Children's services: • 43 hospice inpatient units and 338 hospice beds for children. Adult services: • 223 hospice and palliative care inpatient units; • 3,200 hospice and palliative care beds;

	• 291 home care services; • 129 Hospice at Home services; • 275 day care centres; • 346 hospital support services.
Disability	Disabled people make up a significant percentage of the population (ONS Census 2011data: 9.5 million people have a limiting long term illness or impairment). The definition of disability in the Equality Act 2010 includes people with a physical or sensory impairment, people with a learning disability and people experiencing mental distress, as well as people with other long term conditions that have a substantial and long term effect on the ability to carry out daily activities. In March 2013, there were approximately 462,000 places in care homes in England (CQC data). We know that: • A large proportion of people using regulated social care services would also have protection under disability discrimination law – even if many of these people (particularly older people) may not self-identify as disabled people. • Approximately 278,000 care home places have been identified as being for people with dementia (Equality Counts report). • Among people living in care homes, hospital admissions for avoidable conditions were 30% higher for those who had dementia compared with those without dementia (State of Care report 2012-13). • The investigation and report by the Confidential inquiry into premature deaths of people with learning disabilities reported deficiencies by social care, as well as the NHS, in the treatment and care of people with a learning disability. • There is a strong link between age and disability as census data shows the degree of limitation in day-to-day activities increases by age. There are many more disabled people aged 85 and over living in communal establishments compared with those aged 65 to 84. Residents of communal establishments in England (including care homes) by degree of disability and age. Equality Counts • Disabled people under 65 may use social care for long periods – even for the whole of their lives, whether they have a physical or sensory impairment, a learning disability or use mental health services. The way that social care is organised and delivered can be a critical factor in disabled people being able to exercise their human rights over a large proportion of their adult lives. Independence is a fundamental human rights principle which

	underpins other human rights. The Joint Committee on Human Rights report on the rights of disabled people to independent Living (2012) reaffirms the importance of independent living principles for all disabled people, including those in residential care. Disabled people have rights to independent living enshrined in Article 19 of the United Nations Convention on the Rights of People with Disabilities, to which the UK is a signatory. The report makes a number of recommendations about upholding these rights including the role of regulation in this. • Some groups of disabled people may face particular stigma when using social care services, for example people with HIV, who are included in the definition of disabled people under the Equality Act 2010. In 2012 there were approximately 100,000 people living with HIV in the UK. (Public health England) As the population ages, the numbers of people with HIV living in care homes or using the services of hospices will increase. Work by The National Aids Trust suggests that a significant minority of the public still hold stigmatising and discriminatory views about people with the virus, and this can be particularly relevant for people living in care homes and staying in hospices, if work is not done to address staff attitudes.
Gender, including pregnancy and maternity	Women more likely to live in communal establishments (including care homes) with some exceptions in different ethnic groups (Equality Counts report). There are a number of reasons that may contribute to this difference, including the differing age profile of men and women, which increases with age. This difference, and the fact that the social care workforce is predominantly female, can mean that it is harder to meet the gender-specific needs of men in care homes. For example if there are some personal care tasks for which a man would prefer support from another man (Overview of the health and social care workforce, Kings Fund, 2012). The gender and ethnicity of people can create different patterns of disadvantage which have an impact on how social care services deliver care and support. For example: • The difference in the ability to speak English, to understand and to be understood in a care setting differs between males and females in England. • In addition, there are gender differences in the ability of people to read in their first language, which can mean that women are less able to gain information about health and social care through translated written materials (Equality Counts report, page 14). • In 2012, Dementia and Alzheimer's disease were the leading cause of death for women aged over 80; a large proportion of people living in care homes will be affected by these conditions.

Race	Figures about usage of registered social care services by ethnic group are not collected at the moment. We can deduce some information from census data about people living in communal establishments in relation to residential care for older people. We cannot use this data source for younger people living in residential care, as there 'communal establishments data' will also include people in, for example halls of residence or other communal facilities not registered by CQC. We have no data about usage of community based adult social care or hospices by ethnicity. This has an implication for planning culturally appropriate care. White British people make up 84% of the population, (ONS, Mid-year statistics 2012), and although we know that the majority of people in care homes are from white British backgrounds, the population is ageing for people of across all ethnic groups. As a result we may expect to see increasing numbers of people from other ethnic groups using social care services, especially if patterns of family support around looking after older family members changes. We know that: • Black and Asian people aged over 65 are living in communal establishments have a higher proportion who are men, compared to white and other ethnic groups (Equality Counts report: Ethnicity by gender Source: ONS 2011 census table DC2117EWla). • People from Black and minority ethnic (BME) groups have reported lower levels of satisfaction with social care services than the White British population (NHS NIHR S Asian attitudes towards social care). The Marie Curie Foundation report: Palliative and end of life care for Black, Asian and Minority Ethnic groups in the UK made recommendations for how health and social care commissioners and providers should incorporate the needs of people from BME backgrounds in how they plan and deliver services. In early 2014 they published a follow up report: Next steps. The ethnic background of people living in care homes will have implications for care homes and hospices in relation to a range of issues about providing appropriate care such as ensuring race discrimination does not take place, provision of culturally appropriate personal care and activities, communication and staffing. Even though the Commission for Social Care Inspection bulletin about providing appropriate care for Black and minority ethnic people was produced some years ago, the good practice checklist is still relevant (Putting People First- Equality and Diversity matters, CSCI, 2008).

	Language may be a barrier to understanding for staff and for people using services. This will be particularly important if the numbers of people with dementia increase across ethnic groups, as people can lose the ability to communicate in languages that they have acquired later in life as their dementia progresses.
Religion and belief	Census data shows that residents in care homes in England are predominantly from a White background. However, this does not mean that they all observe the same religious beliefs. It is important that assumptions are not made about a person's religion based on appearance, and that people are given the choice and are helped to observe the customs of their religions (Equality Counts). Some non-religious beliefs are also covered by equality law around religion and belief, for example vegetarianism. There are many ways in which religion and beliefs have an impact on social care provision: • Diet. This includes the type of food that can or cannot be eaten. • Some religions observe fasting times, for example, Hindus and Muslims. • Orthodox Jews observance of the Sabbath. • Blood transfusion. For example, many Jehovah's Witnesses have strong objections to the use of blood and blood products. There are implications for people without capacity in relation to individual decision-making and the balance of the views of relatives and those of care staff or health professionals.
Sexual orientation	The UK Government uses figures of between 5-7% to estimate the number of lesbian, gay and bisexual (LGB) people in England. There are no census figures to support this estimate. However, on this basis there are more than 400,000 LGB people aged 65 or over who may potentially need to use social care services – there will also be LGB people aged under 65 who need to use adult social care. It is not known how many LGB people are living in care homes or hospices. However: • Older LGB people are more likely to be single and more likely to live on their own than heterosexual people. • They are also much less likely to have children or regularly see family members. • If people do not have a partner or family to support them as they get older, they are more likely to need to use social care services for help.

	The impact of the fear of discrimination on LGB older people is made clear in a document produced for care providers by Age UK and Opening Doors Camden, Supporting older LGB people – a checklist for social care. A large scale survey has shown that 3three in five LGB people are not confident that social care and support services, such as paid care staff would be able to understand and meet their needs. LGB in later life- Stonewall. There are now a number of publications which outline good practice in providing appropriate care for lesbian, gay and bisexual people. Even though the Commission for Social Care Inspection bulletin about providing appropriate care for lesbian, gay and bisexual and transgender people was produced some years ago, the good practice checklist is still relevant. Putting people first Equality and Diversity Matters- Providing appropriate services for lesbian, gay and bisexual and transgender people (CSCI 2008). In some situations, a person's sexual orientation may be more evident because of reduced inhibition sometimes caused by dementia. Whilst people of all sexual orientations may have reduced inhibition, for LGB people this could lead to an increased risk of prejudice, discrimination and perhaps abuse (Supporting lesbian, gay and bisexual people with dementia, Alzheimer's Society). When LGB people approach the end of their lives, it is important that they experience quality and equality of care. The route to Success in end of life care.
Gender identity	There is no official estimate of the transgender population in England. However, the Gender Identity Research and Education Society (GIRES) estimate the number of transgender people in the UK to be between 300,000 to 500,000. Existing evidence suggests that transgender people experience, and are badly affected by, discrimination. Like all other people, transgender people will experience the need for social care, they are as likely as everyone else to need support as they experience the onset of age-related impairments, and they will need end of life care. There are no figures for the number of transgender people living in care homes or hospices. However, accommodation and care for transgender people should be provided according to their presentation: the way they dress, and the name and pronouns that they currently use. EHRC guidance. The transgender person's experience of social care may change when their needs change, for example in the provision of personal

	care – if the person had not had surgery in line with their gender presentation, this may be a shock to the people providing care if they had not been aware of the situation. This could lead to an adverse reaction from care home staff. When transgender people approach the end of their lives, it is important that they experience quality and equality of care. MacMillan Cancer have produced The route to Success in end of life care.
Carers	The number of carers in the UK is increasing as the population ages and disabled people with serious illnesses live longer and are more likely to live at home. At the time of the 2011 census, figures showed that the total number of people providing unpaid care in England was 5.5 million (10.3% of the population). Of these people, 1.2 million (2.4%) provided more than 50 hours of unpaid care each. Overall experiences of carers, which can have an effect upon their health, include: • Stress, for example, if home care services are unreliable. • No time to eat properly. • Becoming exhausted. • Experiencing physical injury. • Experiencing emotional effects from not being consulted about what is happening to the person for whom they care (Always On Call, Always Concerned – A Survey of the Experiences of Older Carers, The Princess Royal Trust for Carers). Social care services have the potential to have a large positive impact on the lives of people providing unpaid care as they can reduce stress, and provide assistance in caring.
Human rights principle of fairness	People should be treated fairly by social and domiciliary care providers, regardless of their background. It is recognised that resources are limited but, under Fair Access to Care Services (FACS), individuals and carers seeking or referred for social care support are entitled to an assessment of their circumstances, needs and risks. This must ensure they can maintain as much control as possible of their lives, of the care and support that they receive, and of the opportunities to engage in training, employment, civil society and voluntary activities. An individual's financial situation must not pre-empt or influence the assessment of their social care needs. Fair Access to Care Services (FACS): prioritising eligibility for care and support SCIE (2013)

	The service should be asking whether it is able to respond to people's needs in the allocated time, for example whether a 15 minute visit is adequate. Fairness also requires that people who use the service have ways of giving their views about their care, including making complaints about the service. For many people using social care services, people may need access to support, such as advocacy services, in order to give their views or to make a complaint. We will look at access to advocacy when we inspect and regulate services.
Human rights principle of respect: **People who use services are valued as individuals, are listened to and what is important to them is viewed as important by the service**	All people have the right to respect. Rather than treating everybody in a uniform way which ignores difference, care providers should be aiming to treat every individual with the same level of respect. This is particularly important when people are unwell or dependent on the actions or care of others; for example, by carers at home (Being treated with respect, EHRC). Services need to consider how a person's individuality is respected and what is done to accommodate difference. For example, staff may not always know the best way to communicate with and support someone with a learning disability. They need to find the best way to communicate, picking up on non-verbal communication. For example, looking at facial expressions, gestures and body language, and keeping information simple and brief. Treating people with respect involves cultural and other needs: if a person is in a care home, those caring for them should respect their cultural needs such as religious practices or dietary requirements, or any other needs which may be part of their private life.
Human rights principle of dignity: **People who use services are always treated in a humanitarian way with compassion and in a way that values them as a human being and supports their self-**	People have the right to be treated in a way that respects their dignity. Abuse or neglect can have a major impact on a person's dignity. Research shows that people may suffer abuse or neglect in care homes or when receiving home care. Statistics suggest that there is slightly more abuse in people's own homes (39% of all locations) than in care homes (36%) though these figures do not take account of the greater number of people receiving home care services. The source of harm was most commonly reported as a social care worker (32% of all perpetrators) 2012-13 final report of abuse statistics from HSCIC. Situations that may involve a breach of dignity include: • Unchanged sheets. • Neglect leading to bed sores. • Leaving trays of food without helping people to eat if they are

respect, even if their wishes are not known at the time	too frail to feed themselves. • Excessive force used to restrain people. • Calls for help being routinely ignored. • Washing or dressing people without regard to their dignity. The treatment does not need to be deliberate – it is the impact it has on the person that matters. For example, if staff in a care home leave residents in soiled bed sheets for long periods because they are understaffed, this may still amount to inhuman or degrading treatment. Background reports looking at dignity in social care: • Time to Listen in care homes Dignity and Nutrition report (CQC-2012) . • What's next for Social Care? (Age UK). • Delivering Dignity (Age UK). • Delivering dignity: Securing dignity in care for older people in hospitals and care homes. Final report, Commission on Dignity in Care (2012) Local Government Association, the NHS Confederation and Age UK. National bereavement survey (Voices) report on dignity at the end of life found that staff in hospices were more likely to treat people with dignity and respect than those in hospitals.
Human rights principle of autonomy	People have the right to choose where they want to live and be cared for – either at home or in a residential care home. This includes the right to live as independently as possible, to make routine decisions and to be consulted about professional decisions. Care homes and supported living schemes are different from other health and social care services in that they are where people live and spend the vast majority of their time, thus the positive application of human rights principles can have a greater impact on people's lives. Home care services can also make a fundamental difference to people's overall quality of life. There is a particular need for us to ensure that people can exercise autonomy as this is often the key to people being able to exercise a range of human rights in their daily lives. The Joint Committee on Human Rights report on the rights of disabled people to independent Living (2012) reaffirms the importance of independent living principles for all disabled people, including those in residential care (see disability equality section above).

	Our document A Fresh Start for the regulation and inspection of Adult Social care states that our approach to regulating adult social care will emphasise the need for person-centred approaches that enable people to exercise choice and control. There are particular concerns about people with dementia and their right to choice. There are 800,000 people with dementia in the UK, a third of whom live in care homes (Alzheimers Society). As someone develops symptoms in dementia, their ability to communicate their wishes and challenge breaches of their human rights falls. In the Adult Social Care Survey of 2012-13, 32% of people reported they have as much control as they want over their daily life (up 2% from 2011-12) and 44% reported they have adequate control (down 1% from 2011-12). Also 20% reported they have some control but not enough, and 5% reported they have no control; both these figures are the same as 2011-12. (Adult Social Care Survey, England 2012-2013, HSCIC). Research from the UK and other countries suggests that strategies to enhance shared decision making can improve people's knowledge about their condition and treatment options, people's involvement in their care and people's satisfaction with care (Health Foundation report).
Human rights principle: right to life	Social care providers have a duty to take steps to protect the life of people for whom they provide care. This includes not placing do not attempt resuscitation (DNAR) notices on patients' files without the person's consent or knowledge or appropriate use of the Mental Capacity Act, nor should a hospital make decisions about DNAR notices based on purely on age or disability. In more than 10% of inspections of care homes, problems with safeguarding and safety, staffing, or the care and support received by people using services were uncovered. This indicates that these care homes may potentially, by their actions or lack of them, create a risk of harm which, in some severe cases may breach people's rights to life. On analysing the notifications of deaths that care providers send to us, we found a link with higher staff turnover rates (CQC: State of Care report 2012-13). In addition, the right to life includes minimising the risk of suicide. Safeguards should be in place to prevent people from taking their own lives by: • Removing ligature points,

	• Securing windows so that people cannot fall out through them. • Securing medication in locked cabinets
Human rights for staff working in the sector	Staff working in social care have the right to be safe and to be treated with dignity and respect. Violent and aggressive incidents are the third biggest cause of injuries reported from the social care sector. Employers and employees should work together to establish systems to prevent or reduce aggressive behaviour (Health and safety Executive) . Also, under the Equality Act 2010 employees can: • Expect reasonable steps to have been taken by the employer to ensure protection from discrimination by fellow employees, people using the service and others. • Expect employers to deal with bullying and harassment.

4. Development work on equality and human rights to date

In developing our inspection model for adult social care, we have reviewed best practice by other regulators who take a human rights approach (for example, in Northern Ireland). We have looked at the personalisation agenda in social services to help us base our approach on the experience of people who use services.

Taking what we have called a co-production approach, we held workshops with people who use services, stakeholder organisations and our staff. This is helping us develop an inclusive inspection model, which includes relevant lines of enquiry and incorporates human rights principles.

Last year, we developed pre-inspection methods that will enable us to gather information from people who use community-based services, such as home care, and service providers that will help us evaluate risks and guide inspectors. We consulted with equality groups and stakeholders to help us develop these methods, made changes based on their feedback and completed actions from an equality impact assessment.

Our guidance for inspection teams will address the specific issues that affect each adult social care sub sector, of residential, community based and hospice care.

Most of our adult social care inspections will include an Expert by Experience.

We will test our human rights approach in pilot inspections of adult social care services between April and October 2014. This will inform the development of our new adult social care inspection model.

We will identify human rights topics for the sector and share them with the pilot inspection teams. We will provide specialist EDHR support and advice to inspection teams to help them consider human rights topics and take a human rights approach to their inspections.

- We will review tools and methods against relevant human rights topics, drawing on our experience in previous pilot inspections. We know from acute hospital inspections, for example, that, while it was possible to pick up all the human rights topics with our range of methods, whether this happens in practice will depend on two key factors: the awareness and skills of inspection teams around human rights and the evidence that comes into inspection teams, from people who use services, members of the public, staff and others.
- We will work to make sure that a diverse range of people can participate in giving views on adult social care services being inspected, for example, by working with local groups, including equality groups, to gather views and finding a range of ways for people using adult social care services, and people close to them, to give us their views.
- We will support the learning and development of operations and policy staff teams (policy, intelligence, registration and inspection) to ensure they have the knowledge, skills and aptitude to deliver a human rights approach to their regulation work.

5. Conclusion and actions required

- Our approach to inspecting adult social care draws on our overall human rights approach, which aims to have a positive impact on equality and human rights:
    - Mainstreaming human rights by applying human rights principles to our five key questions in developing key lines of enquiry that cover human rights topics.
    - Integrating human rights into our inspection approach through new surveillance, tools and methodologies that address key human rights principles and topics.
    - Enabling inspection team members (who are not human rights specialists) to know, understand and apply the human rights approach, with specialist advice/support if needed.
- General features of the new inspection approach, that will have a positive impact on our ability to protect human rights through include:
    - Our document A fresh start for the regulation and inspection of adult social care states that our approach to regulating adult social care will emphasise the need for person-centred approaches that enable people to exercise choice and control. This is often the key to exercising other human rights.
    - Inspection teams will make greater use of Experts by Experience, enabling human rights topics to be covered in more depth.
    - Increased emphasis on gathering the views of people who use services and those close to them. Human rights issues can often only be identified through people's experiences.
    - The widened scope of regulation looking across a range of performance to make judgements for ratings. This enables us to look at equality and human rights issues outside the scope of the regulations, such as whether services plan to meet the needs of the a range of equality groups and service access issues that affect groups.
    - The new 'well-led' domain, which enables us to look at the culture of organisations we inspect, and check if this culture protects and advances equality and human rights for people using the service and for staff.
    - Using specialists in inspection teams – we may use equality and human rights specialists from within CQC, who could support inspections.
    - Our assessment frameworks and methodology for adult social care services will continue to develop – we need to ensure that these developments will enable inspectors to assess performance against key human rights topics.
- However, there are some issues which will need to be resolved, or they could negatively impact on equality and human rights:
    - Paucity of intelligence measures in adult social care.

- A need to ensure that our intelligent monitoring measures for adult social care services have coverage of key human rights topics, e.g. in information we use to evaluate risk and in data provided to inspection teams.
- For many equality and human rights topics, the only source of evidence is the views and experiences of people using the service or people close to them, but many people using adult social care services face barriers in expressing or giving their views to CQC.
- While many adult social care services are specifically provided for people with certain equality characteristics (e.g. disability and age) it can be more challenging to assess equality issues for other equality groups using adult social care – such as Black and minority ethnic people or lesbian, gay and bisexual people or transgender people.
- We need to ensure appropriate weight is given to the evidence and views of all members of inspection teams – inspectors, Experts by Experience and specialists.
- We need to ensure that all members of teams understand human rights and have the skills and confidence needed in their role to gather evidence about human rights topics or to assess providers' performance on human rights topics in our key lines of enquiry.
- There are some particular privacy issues with potential adult social care methodology ideas – around collecting and using personal information and the potential use of CCTV to gather evidence. These need to be resolved.

Proposed actions

Issue to address	Proposed action	Lead	Timescale (start and end)
Assessment frameworks and KLOEs will develop over time – need to ensure continued attention to human rights topics in frameworks	1. Continue to use the human rights topics list to check assessment frameworks adequately reflect the human rights topics for the service type	Adult social care policy team to provide assessment frameworks and make amendments EDHR team to provide specialist check at appropriate development stages	April - September 2014
Developing tools and methods will continue over time – need to ensure continued attention to assessing human rights topics in	2. Embed human rights topics in generic tools	Adult Social Care Policy team to provide tools for checking and make amendments	April 2014-September 2014 arch 2015

methods and tools	3. Develop specific tools where required to address human rights topics	EDHR team to provide specialist check and advice at appropriate development stages Either policy team or EDHR team depending on project	
Intelligent monitoring measures in adult social care services are under-developed for many human rights topics	4. Work to review and develop monitoring measures for gaps, where data is already available but is under-used	Intelligence with advice from EDHR team	April 2014 - March 2015
Need to ensure that provider equality and human rights information is integrated (where available) into the main pre-inspection information available	5. Work to integrate key EDHR information into pre-inspection resources, such as provider information return	Adult Social Care Policy team (with advice from EDHR team)	April -September 2014
Many human rights topics are dependent on obtaining the experiences of people using services or those supporting them beyond those gathered actually on inspection visits – but this is harder for dispersed services such as adult social care than hospitals	6. Ensure local teams have links, methods and skills to gather information about human rights topics in adult social care e.g. through local engagement work with local Healthwatch and community groups	Engagement (with advice from Policy and EDHR teams)	April 2014 - March 2015
Differences in quality of care for equality groups can often only be uncovered through talking to people using services beyond those gathered actually on inspection visits	7. Develop the proposal for local relationships to include engagement with local equality groups	Engagement (with advice from EDHR team)	April 2014 - March 2015
Inspectors need knowledge, understanding and	8. Develop role specific learning on applying the human rights	Learning and development, with specialist input	April 2014-March 2015

confidence to apply the human rights approach in adult social care services	approach and human rights topics for adult social care inspectorate staff	from the EDHR team	
Developing approaches to different groups of people using adult social care services – eg. people with a learning disability or people with dementia which address the particular equality and human rights issues that are likely to arise for these people	9. We will evaluate this after wave 1 and decide whether this is the right approach to implement or not.	Adult Social Care Policy team	April - September 2014
We need to be able to focus some inspection activity on people in equality groups who might be at a higher risk of poor care when using adult social care services, beyond the 'service user groups' described above – e.g. on the grounds of race, sexual orientation, religion and belief, gender or gender identity.	10. Continue to develop methods to reach experiences of specific equality groups e.g. work on lesbian, gay and bisexual people using adult social care 11. Look at whether thematic approaches are required to reach experiences of some equality groups using generic services	Lead dependent on topic – but overall approach is joint work between EDHR team, Policy Team and Adult social care directorate EDHR team	April 2014-March 2015 After evaluation of EDHR
Need to ensure that inspection teams work together to ensure that the views of experts by experience are equally valued in team discussions /decisions, and given the same weight as the views of professionals.	12. Evaluate after wave 1 and refine for wave 2. Joint training required for inspectors and Experts by Experience	The Academy with input from the policy team	April - October 2014
Need to ensure that the CQC inspector workforce for the adult social care directorate enables diversity on	13. Continue current work on good practice in recruitment equality / positive action in	Recruitment team/EDHR team with support from CQC staff networks	April 2014 - March 2015

adult social care inspections	relation to race and disability 14. Identify existing profile of adult social care inspectorate workforce after the preference exercise 15. Use lawful positive action measures in recruitment, if required to increase the diversity of the workforce	Transformation Team Recruitment team/EDHR team with support from CQC staff networks	
The scheduled inspection window is narrow for people using services and carers to be notified and contribute views to an inspection.	16. Posters and leaflets and other forms of messaging need to be assessed to see what the most effective way of informing people.	Adult Social Care Policy team	April 2014 - October 2014
Specialists are used based on a medical model for their expertise such as pharmacist rather than from a social model/ human rights approach	17. Look at more innovative use of specialists, such as using DOL advisors, safeguarding leads, reps from orgs such as Stonewall, Age UK, etc.	ASC inspection directorate – Involvement team (with advice from EDHR team)	April 2014- March 2015
Safeguarding personal contact details of people using services as part of our pre-inspection process.	18. Portal needs to be developed as Caldicott Approval makes it clear current methodology is temporary measure only.	ISD with direction from ASC policy team and Intelligence	April - September 2014
Questionnaire for service user and carers – contacting them and usage of their personal views	19. Privacy Impact Assessment needs to be completed to ensure we don't breach human rights and data protection	Adult Social Care Policy team with Information Governance	April - September 2014
Use of CCTV in surveillance model and potential impact on privacy	20. We will consult on this in April and May	Adult Social Care Policy team with final decision from Executive Team	April - September 2014
Usability of forms/templates for disabled staff	21. We need to carry out work with ICT, CRM, Disability Network to ensure they are compatible with	ISD and Disability Network	April - September 2014

	Dragon software.		
Need to ensure that our new model addresses the recommendations of the Joint Committee on Human Rights report on the rights of disabled people to independent Living (2012)	22. During the consultation period for the handbook, we will review the proposals for regulating adult social care to ensure that we have taken account of the recommendations of the JCHR	Lead – EDHR team – working with policy team and Chief Inspector of Adult Social Care	April - September 2014

The individual actions will be evaluated as part of our regular Equality and Human Rights Impact assessment evaluation cycle. We also aim to carry out an evaluation of our overall human rights approach before March 2015 – seeing what difference our regulation has made overall to equality and human rights for people using services.