Equality and human rights duties impact analysis for the provider handbook on NHS GP practices and GP out-of-hours services

1. Introduction

This equality and human rights impact analysis covers the NHS GP practices and GP out-of-hours services handbook.

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

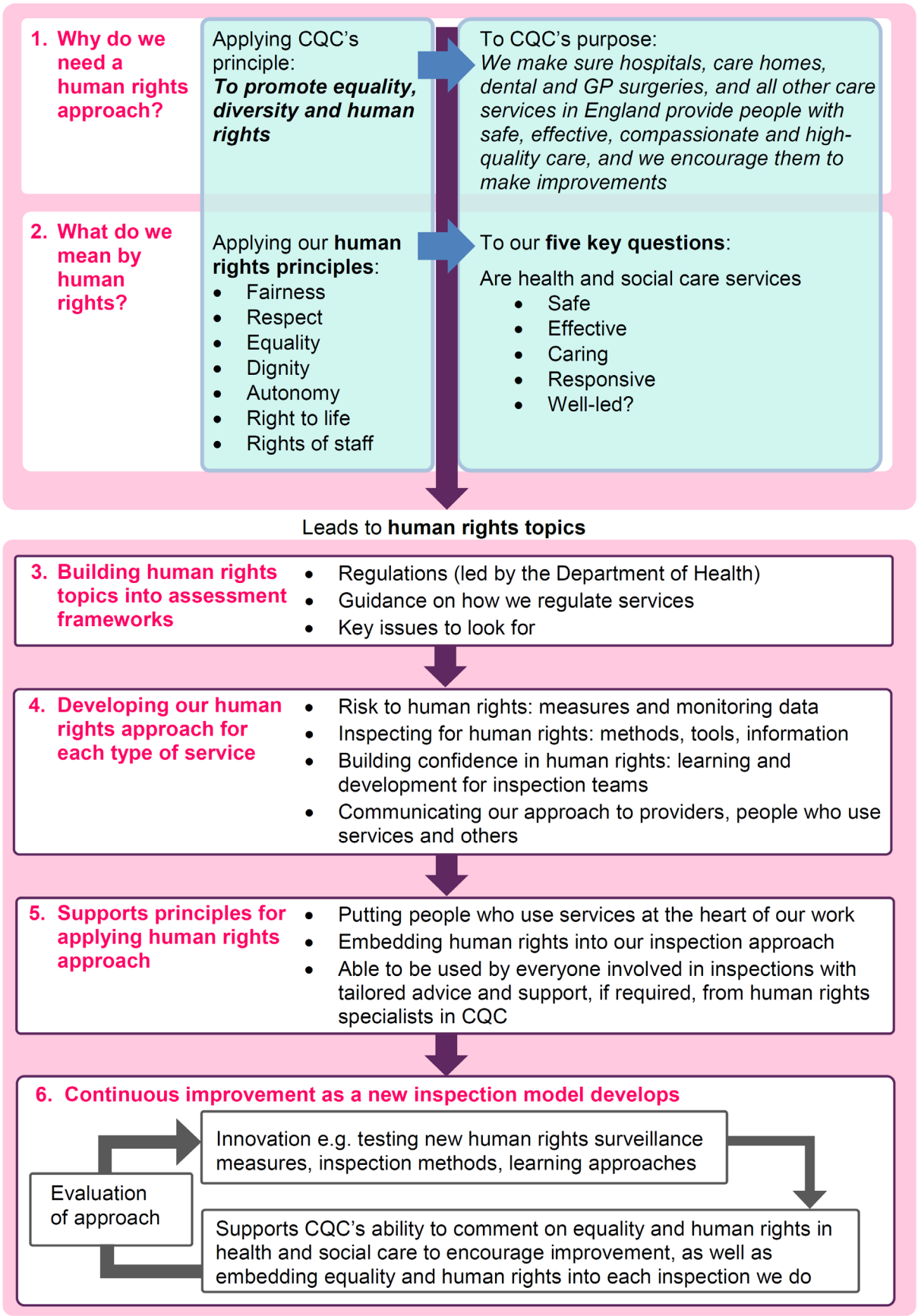
- Under the Human Rights Act 1998 to respect, protect and fulfil people's human rights.
- Under the Equality Act 2010 to have due regard, when delivering our functions, to the need to:
  - eliminate discrimination
  - advance equality of opportunity, and
  - foster good relations between groups

  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.

Figure 1: Our human rights approach to regulation



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 a signposting document about our new approach to inspecting GP practices and GP out-of-hours services 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) to 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, which have influenced the key human rights topics in our human rights approach
    - the detail of human rights topics, which have influenced our KLOEs.
- Asked our online communities (public reference group and action team) about the five key questions to ask on inspections to inform our KLOEs.
- Run an event/workshop on *What does good general practice look like?* With our Experts by Experience and with patient representative organisations.
- Consulted on how on developing our inspection approach to look at long-term conditions, with the National Association of Patient Representative groups and National Voices and our national voluntary strategic partners.
- Consulted with local Healthwatch organisations and with patient participation groups about our proposals.
- Held initial meetings with equality-related groups, including Disability Rights UK.
- Commissioned Research Works Ltd to conduct public research defining 'good' in healthcare. Research Works interviewed 36 people about inspection proposals in primary care services.
- Held focus groups with a range of people who are classified as hard to reach due to their circumstances, carried out on behalf of CQC by an advocacy organisation, relating to all sectors.

In addition we have:

- Carried out a public consultation on the new approach to inspecting GP practices and GP out-of-hours services between April and June 2014. This included:
    - 11 events across the country for people working in NHS GP practices and GP out-of-hours services, members of the public and CQC staff. These were attended by 253 people
    - 76 online responses and 33 written submissions from a range of organisations
    - Two Q&As on Twitter and live Q&As with our online community.
- Worked closely with others to develop our approach, including representatives from charities, national stakeholders such as the General Practitioners Committee of the BMA, the National Association of Primary Care, Royal Colleges, including the Royal College of Nursing and the Royal College of GPs, local Healthwatch and voluntary groups and other government departments.

- We have also been testing our approach since January 2014. Between January and March we inspected 30 GP out-of-hours services. Between April and September we inspected 336 GP practices and 12 GP out-of-hours services in two waves. Throughout these inspections we have been gathering feedback from inspection teams and providers to test our approach.

3. What we know about equality and human in primary medical care

What we know about equality for people using primary medical services, in relation to:

Age	We know that older people are more likely to use GP practices and GP out-of-hours services than other age groups. An ageing population, (a number of those people with multiple long-term conditions) means large numbers of GP consultations are with older people. In the 10 years up to 2009, there was a 95% growth in the consultation numbers for those aged between 85 and 89 years and this number is set to rise. (NHS England). 2012-13, older people accounted for **16.9%** of the population (ONS statistics) and **16.8%** of the number of registrations with GP surgeries.(HSCIC) GP practices undertake some monitoring in relation to Quality Outcome Framework (QOF) indicators relating to age: • QP004 emergency admissions • QP006 3 pathways to avoid emergency admissions • QP009 reducing avoidable A&E attendances. One of the nationally Directed Enhanced Services (DES) that GP practices provide is 'Facilitating timely diagnosis and support for people with dementia', and this includes diagnosis of dementia at an early age. Home consultations are far rarer now than in previous years which means that people have to travel to surgeries. This can have a bigger impact on older people, they may have no transport, they may be more likely to have a mobility, sensory or cognitive impairment that makes travelling in to see a GP more difficult, or they may need other assistance due to their age. Nine per cent of people over the age of 75 find it very difficult to get to their doctor's surgery (AGE UK later life). When looking at age equality, we also need to consider issues for children and younger people using GP services. Young people aged 0-15 accounted for 19% of the population (Census 2011). Children and young people growing up in England today are healthier than they ever have been before, and previously common killer diseases are now rare (Better health outcomes for children and young people DH 2012).

	However: • Some more vulnerable children, such as looked after children, suffer much worse outcomes. • 26% of children's deaths showed 'identifiable failure in the child's direct care'. • Half of lifetime mental illness starts by the age of 14. The Department of Health pledges to put children, young people and their families at the heart of decision-making, with the health outcomes that matter most to them taking priority.
Disability	Disabled people make up a significant percentage of the population (ONS Census 2011 data: 9.5 million people have a limiting long-term illness or impairment) and we know that disabled people are likely to use health services more frequently than non-disabled people, although monitoring data is not as well developed as it is for race, gender and age. 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 2012-2013, 12% of patients in England with a long-standing health condition feel they do not have enough support from local services to help manage their health. (NHS England Improving general practice). People with a learning disability have poorer health than the general population, yet are less likely to access healthcare. These health inequalities have been highlighted in a number of formal inquiries: • Closing the Gap – a report from the Disability Rights Commission (DRC 2006). • Mencap's report Death by indifference (2007). • Mencap Death by indifference: 74 deaths and counting (2012). • Healthcare for All. The findings of the independent inquiry into the health inequalities of people with learning disabilities (Michael 2008). • Six lives: the provision of public services to people with learning disabilities (Parliamentary and Health Services Ombudsman 2009). • Health inequalities & people with learning disabilities in the UK: 2010. The public health learning disabilities observatory. (Emerson 2010). • Premature deaths of people with learning disabilities progress update (September 2014)

	Annual health checks for people with a learning disability, carried out by a GP, are therefore very important. Action on hearing loss report that one in every six patients has a hearing loss. Fifty five per cent of people over 60 have a hearing loss and 90% of patients over 81 experience hearing loss. More than one in every four patients with hearing loss have difficulty getting an appointment at their GP practice because of communication difficulties. Hearing loops, text messages, online appointment booking and other methods of communication are good practice. In addition, blind and partially sighted people may face access difficulties or receive sub-optimal healthcare because staff are unaware of how to meet their needs (British Medical Journal 2012). Important factors include awareness of which patients have a visual impairment, taking time to communicate effectively with these patients about access, facilities, diagnosis, and management plans, communication formats tailored to the person's needs and checking that the person has resources in place to facilitate compliance with treatment plans. There can be barriers for disabled people in accessing GP practice buildings. For example wheelchair users find it difficult to access some premises. Provision of automatic doors, accessible toilets, lower reception counters, wider doors, level access being good practice. People with Cancer, HIV and Multiple Sclerosis are disabled under the Equality Act 2010 definition of disability and are at risk of discrimination and poor treatment. In 2012, there were approximately 100,000 people living with HIV in the UK (Public Health England). HIV care is 'open access' meaning that people can go directly to a clinic of their choice for testing and treatment, rather than needing to be referred by a GP. However, people with HIV may attend GP practices for treatment for health matters other than HIV, and their HIV status can overshadow other conditions. A significant minority of the public still hold stigmatising and discriminatory views about people with the virus (The National Aids Trust). This can be particularly relevant for people receiving healthcare treatment, if learning for healthcare staff does not include looking at attitudes towards people with HIV. GP practices undertake some monitoring in relation to Quality Outcome Framework (QOF) indicators relating to disability: • DEM001 – Register of patients with dementia. • DEP001 – Initial diagnosis- register of new patients with depression. • MH001 – Register of patients with schizophrenia, bipolar and other psychoses.

	• DM001 – Register of people over 17 years with diabetes. • LD001 – Register of adults with learning disabilities. • EP001 – Register of adults with epilepsy. • CAN001 – Register of patients with cancer.
Gender, including pregnancy and maternity	While there are obvious differences in the health needs of men and women, the evidence does not suggest a clear trend of either gender experiencing worse health than the other. Overall, the proportion of people registered with a GP practice is similar – men 49.7% and women 50.3%. However, both genders may find that their health needs are not met: men are less likely to use their GP and women have specific concerns about maternity services (Equality and Human Rights Commission, 2010*, How Fair is Britain?*). In the UK, over 66,000 women and girls living in the UK have experienced female genital mutilation (FGM). FGM tends to occur in areas with larger populations of communities who practice FGM, such as first-generation immigrants, refugees and asylum seekers. It can have immediate effects of pain, shock, bleeding and infections, and long-term effects, including complications in pregnancy and newborn deaths, and the need for later surgery for childbirth. In 2012, dementia and Alzheimer's disease were the leading cause of death for women over 80. Heart disease was the leading cause of death for men aged 50 and over (ONS statistics). GP practices undertake some monitoring in relation to Quality Outcome Framework (QOF)indicators: • CS001 – Cervical screening protocol and management. • MAT001 – Antenatal care and screening. CON001 – Register of women under 54 years prescribed contraceptives.
Race	Health inequalities will have an impact on the use of some health services by Black and minority ethnic (BME) communities. There may be language/communication issues: • People for whom English is not the first language not attending because they could not read the appointment card/reminder. • Lack of language support may mean that people feel they need to bring a family member to interpret. They may not receive the correct medical interpretation or the family member may not accurately pass on information to the GP, for example through embarrassment.

	The GP Patient Survey results for 2012-13 show variation by ethnicity in patients' confidence and trust in their GP: 67% of White British patients trusted their doctor, compared with 42% Chinese patients and 52% Bangladeshi patients. Particular conditions affect different ethnic groups. It is important that these are recognised and taken into account in providing appropriate community health services to these communities. Some conditions affecting Black or South Asian people are: • Sickle cell disease. • Thalassemia. • Higher prevalence of diabetes and high blood pressure, and associated health conditions such as kidney problems. • Higher prevalence of stroke. • Shortage of vitamin D. In 2013 there were 259,680 doctors registered in England. Of these, 63,778 are GPs registered on the GP register. The main ethnic categories of GPs overall was: • 37% White • 11% Indian • 3.9% Pakistani • 3.3% other Asian background • 2.5% African. Some groups of people who experience discrimination and disadvantage are not using NHS GP services as much as expected for the size of their population, for example gypsies and travellers. This may be because of their travelling lifestyle, which makes it more difficult to register with a GP. Race for health have produced a health brief on the benefits of Ethnic monitoring in GP practices.
Religion and belief	There are many ways in which religious practices and beliefs have the potential to impact on the delivery of primary healthcare services and contribute to inequalities in health: • Dietary requirements. This includes whether certain medicines are suitable (for example those containing animal products such as gelatine capsule). • Some religions observe fasting times, for example, Hindus and Muslims. This may cause problems with regard to medication or the control of diabetes. • Orthodox Jews observance of the Sabbath may make it more difficult for them to attend GP appointments on some days.

	• Blood transfusion. For example, many Jehovah's Witnesses have strong objections to the use of blood and blood products, and may refuse them even if they may die as a result. • Views on termination of pregnancy, contraception and circumcision vary between religions. Some GPs do not want to provide consultations on termination of pregnancy, for example, or to examine patients of the opposite sex, because of their religion. This may affect the patient experience. Patients should expect to receive consideration from their GP and other staff working in general practice in respect of their religion and belief. GMC '*Good medical practice*' includes guidance for GPs on personal beliefs and medical practice.
Sexual orientation	The Government uses figures of between 5 and 7% to estimate the number of Lesbian, Gay and Bisexual (LGB) people in England. There are no census figures to support this estimate. However, clearly, a large number of LGB people do use primary health services. There is evidence that some lesbian and gay people are not being treated with dignity and respect by healthcare staff they can trust, and this is having an adverse influence on their experience of NHS GP services. Stonewall commissioned a national survey (Prescription for change 2008), which found that lesbian and bisexual women were: • Less likely to have smear tests and tests for sexually transmitted infections. • More likely to smoke, drink, feel suicidal and self-harm – this is often due to the impact of discrimination or rejection, but could be linked with lifestyle. Due to limited opportunities for building social networks, some lesbians often socialise in bars and pubs. • Often uncomfortable coming out to GPs and GP practice staff because of fear of discrimination; 40% reported that there are assumptions of heterosexuality which can lead to not being given appropriate advice about health. Gay and bisexual men: • Less than half are 'out' to their GP. • Experience higher rates than heterosexual men of HIV and other sexually transmitted infections (STIs), such as syphilis and gonorrhoea (NHS Choices Live well: Gay health). There are particular equality issues for some groups of LGB people, such as older LGB people. One in six LGB people are not confident that their GP and other health services would be able to understand and meet their needs (LGB in Later Life, Stonewall 2011).

	There is evidence suggesting that LGB people are more likely than other groups to face hostility and misunderstanding, and are more likely to experience poor mental health, which may first be brought to the attention of a GP (How fair is Britain, chapter 9, EHRC 2010). LGB people and their families and carers should have access to high-quality end of life care that takes account of their needs and preferences, regardless of their individual circumstances (The route to success in end of life care, MacMillan). Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey (2014)
Gender identity	There is no official estimate of the transgender population in England. However, the Gender Identity Research and Education Society (GIRES) estimates the number of transgender people in the UK to be between 300,000 and 500,000. A 2007 report highlighted the experience of transgender people when they first approached their GP: • Around 21% of transgender people were able to start the process by seeking help from a knowledgeable GP. • 21% of respondents' GPs did not want to help. • In 6% of cases GPs refused to help. • 29% of respondents felt that being transgender adversely affected the way they were treated by healthcare professionals. (Transgendered penalties: transgender and transsexual people's experiences of inequality and discrimination, Press for Change 2007). Like all other people, transgender people will need treatment from their GP and other practice staff for a full range of health conditions over the course of their lives. They may need a minor operation; they may experience mental illness; and they are as likely as everyone else to need support as they experience the onset of age-related impairments. GP practices need better information to meet the needs of transgender patients (The Trans Mental Health Study 2012). Existing evidence suggests that transgender people experience, and are affected by, transphobia. Not having information about transgender patients in the local health database will affect allocation of resources, and training of staff to understand transgender issues may not be a priority.

	Transgender people and their families and carers should have access to high-quality end of life care that takes account of their needs and preferences, regardless of their individual circumstances (The route to success in end of life care: achieving quality for LGBT people, MacMillan).
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. Carers bring health concerns to their GPs. All informal carers are entitled to an assessment of their needs, including young carers, separate from the needs of the person for whom they are caring (Carer's Trust). The experiences of carers varies and it is possible that the assessors need more training in communication with them to find out what they need and what would work for them (Carers' assessments, Skills for Care 2013). 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%) each provided more than 50 hours of unpaid care. Regarding young carers: • Only small numbers of young carers are currently being identified or assessed for support. • Young carers are 1.5 times more likely than their peers to be from Black, Asian or minority ethnic communities, and are twice as likely to not speak English as their first language. • Can experience substantial physical, emotional or social problems, and encounter difficulties in school and elsewhere. • Research also suggests that more girls than boys act as carers (Health and wellbeing of young carers- SCIE). Carers can experience stress, not have time to eat properly, need respite breaks, and can become ill themselves. So GP practices need to ensure that they are sensitive to the health needs of carers. The Royal College of GPs offers training and support to GPs, so that they have a better understanding of the needs of carers and how best to support them. They produced a report: *Supporting carers: an action guide for general practitioners and their teams.*
Human rights principle of fairness	People should be treated fairly by healthcare providers, regardless of their background. This not only includes people with the protected characteristics under the Equality Act 2010, but includes the four vulnerable and excluded groups prioritised by the Inclusion Health Board in their report *Hidden needs* because they experience some of the poorest health outcomes in England:

	• Vulnerable migrants (asylum seekers and refugees). • Gypsies and travellers. • Homeless people. • Sex workers. This means that all people should have equal access to register with a GP practice, and once registered, should have access to appointments. It is recognised that resources are limited, but in order to be fair, any treatment or medication that is offered should relate to the level of assessed needs a person might have. The NHS Constitution says that people have the right to drugs and treatment that have been recommended by NICE for use in the NHS, if their doctor says they are clinically appropriate for them. The NHS Constitution states that 'everyone counts' and includes references to fairness. • The NHS provides a comprehensive service available to all (Principle 1). • Care is provided on the basis of need rather than the ability to pay (Principle 2).
Human rights principle of respect	All people have the right to respect, regardless of their background. There is the potential for people to disengage from health services if they have not been treated with respect by staff working in a GP practice or in a GP out-of-hours service. Rather than treating everybody in a uniform way, which ignores difference, healthcare providers should be aiming to treat every individual with the same level of dignity and respect (Duties of a doctor, General Medical Council (GMC)). This involves, for example: • Being polite to people using services. • Being thoughtful and caring towards them. • Keeping them informed. • Listening to them. • Meeting their needs. • Ensuring their privacy. • Making sure that arrangements are made, wherever possible, to meet patients' language and communication needs.

	The NHS constitution gives patients the right to be treated with dignity and respect. Some examples of respecting individuality and accommodating difference are given below: • Staff may not always know the best way to communicate with and support people with learning disabilities. 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. • A person with a learning disability may have difficulty with crowds, lack of space and long waiting times, and not understanding the social conventions of reception and waiting rooms may cause distress. • Respecting all diverse families, for example same-sex couples with children. Guidance for GP practices has been produced (Improving access, responding to patients, NHS Practice Management network).
Human rights principle of dignity	People have the right to be treated in a way that upholds their dignity. There is the potential for people to disengage from health services if they have not been treated with dignity by a GP, or at a GP practice by other staff. Situations in GP practices and GP out-of-hours services that may involve breaches of dignity include: • Lack of privacy and safety in consultation rooms. • No chaperones/same sex staff present when being examined. • Patients not being given as much time and privacy as is required to take on-board any 'bad news' given by a GP or nurse. Clinical staff should anticipate this need and leave sufficient time between appointments, as necessary. • Reception staff talking in loud voices about the patient and their medical condition in earshot of other people/nowhere for private conversations to take place with reception staff. The treatment does not need to be deliberate, it is the impact it has on the person that matters. Good palliative care can have a big impact on the dignity of people at the end of their life. GP practices undertake some monitoring in relation to Quality Outcome Framework (QOF) indicators: • QOF PC001 – Palliative care – a register of people who need palliative care, regardless of age.

Human rights principle of autonomy	People have the right to choose where they want to be treated for illness and health conditions. This includes the right to live as independently as possible, to make routine decisions and to be consulted about professional decisions about their care and treatment. The NHS constitution reflects this; for example: • People have the right to accept or refuse treatment. • People have the right to choose their GP practice and be accepted by the practice unless there are reasonable grounds to refuse, in which case they must be informed of those reasons. • Patients have the right to choose whether they see a male or female clinician, where available. Arrangements should be in place in case this is not possible, or safe, while respecting choice. • People can choose where to go for treatment or procedures, for example through 'Choose and book'. 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 of right to life	Article 2 of the European Convention on Human Rights protects the right to life. Doctors have a duty to protect the life and further the health of their patients. GPs also have a responsibility to raise and act on concerns for patient safety (GMC guidance). When GPs are considering courses of actions to take regarding providing treatment (or no treatment) for their patients, and in particular, for their patients that live in care homes: • They must consider a person's capacity to make a particular decision, including their ability to communicate their consent. • They must avoid 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 GP make decisions about DNAR notices based on purely on age or disability. GPs and practice staff know their patients and will be able to identify patients who are nearing the end of their life. The organisation Dying Matters has produced guidance (Dying matters) to assist GPs at this time.

Human rights for staff working in the sector	Staff working to provide healthcare (including GP practices) have the right to be safe and to be treated with dignity and respect (NHS constitution section 49). For example, staff should: • 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. • Expect employers to enable staff to speak freely about concerns, not only by upholding the legal rights of whistleblowers, but by creating a culture which values staff views. • Deal appropriately with safety risks that staff might face.

4. Development work on equality and human rights to date

We recognise that we need to assess differential outcomes for people in equality groups (protected under the Equality Act 2010) who may be at a higher risk of receiving poor care.

Our new approach to inspecting NHS GP practices will specifically look at the quality of services through the lens of six key population groups. These are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

Four of these groups are protected under the Equality Act 2010, under age, disability and pregnancy/maternity. In addition, some people whose circumstances may make them vulnerable are covered by protected characteristics under the Equality Act 2010, for example, gypsies and travellers would be covered under the protected characteristics of race.

We do not inspect GP out-of-hours services using these six population groups.

We have developed our methodology so that it helps us to look at everyone's experience of using NHS GP practices and GP out-of-hours services.

We tested our human rights approach in our pilot inspections of NHS GP practices and GP out-of-hours services between January and September 2014. This has informed the development of our final NHS GP practices and GP out-of-hours services' inspection model, which is set out in our handbook.

We have identified human rights topics for the sector and have shared these with inspection teams. We will continue to do this and will provide specialist equality, diversity and human rights (EDHR) support and advice to inspection teams to help them consider human rights topics and take a human rights approach to their inspections.

We reviewed tools and methods against relevant human rights topics and came to the conclusion that, while it is 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 patients, members of the public, staff and others. We are providing further training for our inspection teams on human rights from January 2015.

We have worked to make sure that a diverse range of people can participate in giving views on the NHS GP practices and GP out-of-hours services being inspected, for example by commissioning voluntary and community sector groups to run focus groups targeted at gathering the views of specific communities. We are continuing to explore the best ways to gather the views of all people who use services in advance of our inspections.

We have supported the EDHR 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 work in the regulation of NHS GP practices and GP out-of-hours services. We are providing further training for our inspection teams on equality and human rights from January 2015.

5. Conclusion and actions required

- Our approach to inspecting NHS GP practices and GP out-of-hours services draws on our human rights approach, which aims to have a positive impact on equality and human rights through:
    - Embedding human rights by incorporating human rights principles into our key lines of enquiry under our five key questions.
    - 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.
- Features of the new approach to GP practice and GP out-of-hours service inspections that will have a positive impact on our ability to protect human rights include:
    - The organisation of our GP practice inspections by looking at the service for various population groups. Five of the six groups are more likely to experience breaches of their human rights; these include a number of groups with protection under the Equality Act 2010. We intend to rate each GP practice we inspect at a number of levels. We intend to rate at a practice level, at key question level (how safe, effective, caring, responsive and well-led) and for each population group. So this will include, for example, the services provided for people with mental health conditions. This will be a rating of either outstanding, good, requires improvement or inadequate. We intend that this will highlight where practices provide outstanding and good care for particular population groups. It will also be a lever for improvement for particular groups of people who need to have their rights protected and promoted.
    - More specialist inspection teams enabling human rights topics to be covered in more depth.
    - Inspections of a number of GP practices and the GP out-of-hours service in a CCG area at one time, which will enable us to have an overall view of the quality of general practice in the CCG area, including how equality and human rights issues are addressed. We will be liaising with the CCG and the NHS England Area Team on each area visit, enabling us to feedback on issues of concern as well as areas of good practice.
    - Increased emphasis on gathering the views of patients and people close to them. Human rights issues can often only be identified through people's experiences.
    - The widened scope of inspection 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 the provider is working with the commissioners to make sure services meets the needs of the local population, addressing service access issues that affect groups as well as individual patients.

- Checking to see how well-led GP practices and GP out-of-hours services are, 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.

- There are some issues which will need to be resolved, or they could negatively impact on equality and human rights:
  - We need to continue to develop our Intelligent Monitoring indicators for NHS GP practices and GP out of hours services to check coverage of key human rights topics to better support our inspection teams' evaluation of risk in relation to human rights.
  - We need to continue to ensure that we pay adequate attention to equality groups that are not covered by the six population groups that we will always focus on for each GP practice.

Proposed actions

Issue to address	Proposed action	Lead	Timescale (start and end)
Methodologies 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 methodologies adequately reflect the human rights topics for the service type	Policy teams to provide assessment frameworks and make amendments EDHR team to provide specialist check at appropriate development stages	April 2014–March 2015
Developing tools and methods will continue over time – need to ensure continued attention to assessing human rights topics in methods and tools	2. Embed human rights topics in generic tools	Policy teams to provide tools for checking and make amendments EDHR team to provide specialist check at appropriate development stages	April 2014–March 2015

	3. Develop specific tools where required to address human rights topics	Variable	
Intelligent Monitoring measures in GP practice and GP out-of-hours 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
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	5. Ensure local teams have links, methods and skills to gather information about human rights topics, for example at listening events and through local engagement work	Engagement/ Primary Medical Services and Integrated Care directorate (with advice from EDHR team)	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	6. Develop the proposal for local relationships to include engagement with local equality groups	Engagement / Primary Medical Services and Integrated Care directorate (with advice from EDHR team)	April 2014–March 2015
Inspectors need knowledge, understanding and confidence to apply the human rights approach in primary care services	7. Develop role specific learning on applying the human rights approach and human rights topics for primary care inspectorate staff	Learning and development, with specialist input from the EDHR team	April 2014–March 2015

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 generic health services	8. Continue to develop methods to reach experiences of specific equality groups e.g. case tracking people with specific needs/protected characteristics 9. 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 and Policy teams EDHR team	April 2014–March 2015 After evaluation of the impact of the Human rights approach
Need to ensure GP practice and GP out-of-hours provider specific equality and human rights information is integrated (where available) into the main pre-inspection information available (for NHS primary care services)	10. Work to integrate key EDHR information into data packs and other pre-inspection resources	Intelligence – with advice from EDHR team on content	April 2014–March 2015
Need to consider length of days/ consecutive days that all members of inspection teams are required to be on site to ensure that it does not have an unnecessary equality impact on the make-up of teams	11. Consider this when designing methodology	Policy team/staff scheduling inspections in the Primary Medical Care directorate	April 2014–October 2014

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. Develop cross-sector thinking for a solution to this	Policy teams/ Primary Medical Services and Integrated Care directorate (with input from engagement and EDHR)	April 2014– March 2015
Need to ensure that the CQC inspector workforce for the primary care directorate enables diversity on primary care inspections	13. Continue current work on good practice in recruitment equality / positive action in relation to race and disability. 14. Identify existing profile of primary medical inspectorate workforce after the preference exercise. 15. Use lawful positive action measures in recruitment, if required, to increase the diversity of the workforce.	Recruitment team/ Primary Medical Services and Integrated Care directorate/EDHR team with support from CQC staff networks and Transformation team.	April 2014– March 2015

How will the actions be evaluated?

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 to see what difference our regulation has made overall to equality and human rights for people using services.