Equality and human rights duties impact analysis (decision making and policies)

CQC Strategy and 2013-2014 Business Plan

1. Intended outcomes (include outline of objectives or aims)	Deliver a CQC strategy for 2013-2016 that will: • Develop and deliver CQC's purpose. • Respond positively and publicly to key external issues (Francis report and others). • Clarify roles and responsibilities of CQC in the wider care system. • Set robust strategic framework and direction for next three years. • Clarify what the public and the services we regulate can expect from CQC. • Engage stakeholders and staff in the future direction of CQC. Deliver a CQC Business plan for 2013-14 that will: • Enable the effective delivery of eight key priorities for year one of the Strategy (strategic development); and CQC's operational priorities. These eight priorities are: o Improve assessment and judgement of all the services we regulate by appointing a Chief Inspector of Hospitals, a Chief Inspector of Social Care and Support, and a Chief Inspector of Primary and Integrated Care. o Improve the safety and quality of care in NHS acute hospitals and mental health trusts by changing the way we inspect them. o Identify, predict and respond more quickly to services that are failing or are likely to fail by using data, intelligence and evidence in a more sophisticated and transparent way. o Improve our understanding of how well different care services work together. o Work better with other regulators and partners to improve the quality and safety of care. o Publish better information for the public, including organisation ratings, to improve transparency. o Introduce a more rigorous test for organisations applying to provide care services, which includes ensuring that

	named directors and managers commit to meeting the standards and tests their ability to do so. ○ Begin to develop and evolve CQC as a high performing organisation that is well run and well led, has an open culture that supports its staff, and is focused on its customers. The Business Plan's key priorities are drawn directly for the CQC Strategy. This EIA is of both the Strategy and the Business Plan.

2. Who will be affected? (People who use services, CQC staff, the wider community)	• CQC staff. • People who use health and social care services and their families/carers. • Health and social care staff. • Wide range of stakeholders.

3.	
• Does the work affect people who use services, employees or the wider community? (This is not only refers to the number of those affected but also by the significance of the impact on them)	Yes
• Is it a major piece of work, significantly affecting how functions are delivered?	Yes
• Will it have a significant effect on how other organisations deliver their functions in terms of equality or human rights?	No
• Does it relate to functions that previous engagement has identified as being important to particular protected groups or human rights?	Yes
• Does or could it affect different protected groups differently?	Yes
• Does it relate to an area with known inequalities or breaches of human rights?	Yes
• Does it relate to an area where equality objectives have been set by CQC?	Yes

4. Do the answers above indicate that this work is relevant to equality or human rights? If yes skip this box and continue below. If no, document the reasons below and forward this EHRDIA to Involvement & EDHR team for sign-off
Yes

5. **Engagement and involvement**

- Have you involved people who use services, staff and other stakeholders?
- What are the key findings of your engagement relating to equality and human rights?

Include known representation across the characteristics protected in the Equality Act: age, disability, gender, gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion and belief, and sexual orientation.

Target group	Summary of involvement
People who use services	The development of the Strategy has engaged various representative groups to ensure that the new strategy takes into account their views and requirements. There has also been engagement that specifically targets people with experience of the protected characteristics under the Equality Act 2010 – for example through the CQC SpeakOut network and a specific workshop with the eQuality Voices group. We also conducted an open public consultation and such groups provided input to the strategy through this channel. We have published a separate consultation document setting out the scope of the consultation, the numbers of people responding and the various ways in which people were consulted. The delivery of the Strategy through the Business Plan will involve ongoing engagement through our Strategy Programme in testing our new approach to regulation.
Staff	In developing our strategy we have engaged with CQC staff through a series of workshops, which have taken place around the country. Both the project delivery team and the steering committee for the review have contained a cross-section of staff representation. We also conducted an open public consultation and staff provided input to the strategy through this channel.
Other stakeholders	We have engaged with key stakeholders through a series of workshops, online forum and targeted meetings. We also conducted an open public consultation and stakeholders provided input to the strategy through this channel.

6. Evidence List the main sources of data, research and other sources of evidence reviewed to determine impact on each protected characteristic or human rights. If there are gaps in evidence, state what you will do to close them in the Log of Equality & Human Rights Actions	
Age: (include younger as well as older people, safeguarding, consent and child welfare)	We know that older people are more likely to use health and social care services than the rest of the population.[1] From our own work (such as dignity and nutrition inspections) and the work of others (such as the Equality and Human Rights Commission Inquiry "Close to home: An inquiry into older people and human rights in home care") we also know that older people can experience poor outcomes from using health and social care services, in relation to age equality and human rights. The current regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting people's needs on the grounds of age and protect human rights such as dignity, privacy, respect, independence and participation. Therefore any changes to the way that we regulate health and social care services is likely to have a high impact on equality and human rights for older people. Promoting the rights of people with dementia has a particular impact on rights for older people using health and social care services. For example, The Alzheimer's Society estimates that 80% of people in care homes have dementia or severe memory difficulties.[2] The needs of younger people with dementia also need to be considered, so indeed, promoting the rights of people with dementia could equally be considered as disability issue. There has been an increased national policy focus on people with dementia, following the publication of the Prime Minister's challenge on dementia in March 2012.[3] Although our inspection and regulation can look at how each service responds to the needs of people with dementia, there is more that could be done to look at the experience of older people with dementia, and other complex conditions, if we take a thematic approach. This can build on our work to date which looked at data about admissions of people with dementia to hospitals, which concluded that people with dementia living in a care home are more likely than those without dementia to go to hospital with avoidable conditions such as urinary infections. Once in hospital, they are more likely to stay longer, be re-admitted or die than those without dementia.[4] This topic is therefore being considered under our Business Plan priority 4 of improving our understanding of how well different care services work together.

[1] Equality Matters – equality information for CQC in 2012 (2013) Care Quality Commission.

[2] http://www.alzheimers.org.uk/statistics.

[3] Prime Minister's challenge on dementia (2012), Department of Health.

[4] *Care Update 2*, March 2013, Care Quality Commission.

	The development of CQC's Strategy (and Business Plan) has taken account of this characteristic through engagement with representative bodies during the design and consultation phases. There is some evidence about age equality in the main equality and human rights issues raised in the consultation. Older people reported having difficulty using and accessing the website and navigating CQC complaints system. As below - Our business plan priority around publishing better information for the **public (priority 6)** is likely to have a positive impact on Older People.
Carers: (impact of part-time working, shift-patterns, general caring responsibilities)	Carer status is not a protected characteristic under the Equality Act 2010. However, carers do receive some protection under the Act in relation to 'discrimination by association' with a disabled person or an older person. We recognise that our work in regulating health and social care services has the potential to have a huge impact on equality for the five million carers in England.[5] Checking that the needs of carers are met is sometimes outside the remit of CQC, for example the focus of the Health and Social Care Act regulations is on the quality and safety of services for people who use services, except in specific circumstances, such as issues of information and consent when a carer is expressly acting on behalf of someone using the service. However, we recognise that if a provider better meets the needs of the person using their service, for example by providing them with appropriate care and cooperating with other providers, this can have a major positive impact on carers. Carers also use health services in their own right, for example GP services. Checking that health care providers meet the individual needs of carers using their service is within the remit of CQC. Carers can also help us in our work by giving us valuable information about the service that the person they care for is receiving. This is particularly important when people using the service may find it more difficult to express their views to us between inspection visits – for example, for people with cognitive and communication impairments such as dementia and some people with a learning disability. Our work under Business Plan priority 5 to establish local partnerships – including with the HealthWatch network – will assist us in responding appropriately to the views of carers through our regulatory work. The development of CQC's Strategy (and Business Plan) has taken account of this characteristic through engagement with representative bodies during the design and consultation phases. Our business Plan priority around publishing better information for the public (priority 6) is likely to have a positive impact on carers – as often the carers are seeking information about health and social care services.

[5] Figures from Carers Trust: http://www.carers.org/key-facts-about-carers

	There is some evidence about addressing the needs of carers in the main equality and human rights issues raised in the consultation phase.
Disability: (include attitudinal, physical and social barriers)	We know that disabled people use health services more than non-disabled people – and that most social care services are provided to people that would be covered by disability equality legislation (including older disabled people, people with a learning disability and people using mental health services).[6] There are some gaps in data around disabled people's use of universal health services as disability is not monitored in some main health data sets such as hospital episode statistics. In our current work on equality data, led by our Intelligence Directorate, we are aiming to make the best use of available data. However, we know from many reports based on people's experiences, such as Sir Jonathan Michael's Inquiry (Healthcare for all: report of the independent inquiry into access to healthcare for people with learning disabilities) that some groups of disabled people also experience inequalities or discrimination in health care. There are particular concerns about the rights of people with a learning disability when using specialist inpatient health services. Following the highlighting of serious abuse and appalling standards of care at Winterbourne View, a private hospital for people with a learning disability, we carried out a programme of 150 inspections of independent hospitals, NHS hospitals and care homes that provided care for people with a learning disability. Our national findings from this inspection programme show that there remains a significant shortfall between policy and practice. We found that nearly half the locations we inspected were not meeting the national standards of care that people should expect. Our findings demonstrate that services for people with a learning disability still need to improve. To respond to this, we are prioritising services for people with a learning disability in our new more rigorous test for organisations applying to provide care services (Business Plan priority 7). This will ensure that named directors and managers commit to meeting required standards and will then test their ability to do so. We know that disabled people using social care services may also be in circumstances, where their human rights are more likely to be breached. Where people are deemed to lack mental capacity, they may be particularly vulnerable to having their rights breached when using

[6] Equality Matters – equality information for CQC in 2012 (2013) Care Quality Commission

	either health or social care services, as key decisions are taken outside of their control. This is also the case for people detained under the Mental Health Act. Our business plan includes a number of actions to protect the rights of these groups of disabled people, including developing thematic approaches to regulating mental capacity, in partnership with councils with social services responsibilities and increasing our use of 'Experts by Experience' in our work to monitor the use of the Mental Health Act. The current regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of disabled people, that providers make reasonable adjustments and that they protect human rights such as dignity, privacy, respect, independence and participation. Therefore any changes to the way that we regulate health and social care services is likely to have a high impact on equality and human rights for disabled people. The development of CQC's Strategy (and Business Plan) has taken account of this characteristic through engagement with representative bodies during the design and consultation phases. There is some evidence about equality for a range of disabled people in the main equality and human rights issues raised in the consultation.
Gender: (men and women)	We know that the pattern of use of health services is different for men and women. We also know that there are more women using regulated social care services than men, due to gender differences in age profiles of the population.[7] The regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of people on the basis of gender The development of CQC's Strategy (and Business Plan) has taken account of this characteristic through engagement with representative bodies during the design and consultation phases.
Gender Reassignment: (transgender and transsexual people, issues such as privacy of data and harassment):	A report from the Equality and Human Rights Commission shows that transgender people experience some specific difficulties in relation to their healthcare. Transgender people need to engage with healthcare services during the transition process and, in addition may also use other health and social care services on the same basis as the rest of the population. There is little data in main health data sets about the experiences of transgender people using health services. In our current work on

[7] Equality Matters – equality information for CQC in 2012 (2013) Care Quality Commission

	equality data, led by our Intelligence Directorate, we are carrying out some specific work to look at the information we hold about gender identity clinics. The regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of people on the basis of gender (including gender reassignment). Any changes to the way that we regulate health and social care services may have an impact on equality and human rights for transgender people. The development of CQC's Strategy (and Business Plan) has taken account of this characteristic through engagement with representative bodies during the design and consultation phases.
Pregnancy and maternity: (impact of working arrangements, part-time working, infant caring responsibilities and breastfeeding)	We have a specific role in ensuring that the health services used by pregnant women meet government standards. Therefore any changes to the way that we regulate health and social care services may have an impact on equality and human rights for pregnant women. The development of CQC's Strategy (and Business Plan) has taken account of this characteristic through engagement with representative bodies during consultation.
Race: (include differences between ethnic groups, nationalities, gypsies and travellers, language barriers)	We know that the pattern of use of health services is different for people in different ethnic groups.[8] We also know that some minority ethnic groups consistently report lower satisfaction with health and social care services. From our mental health act monitoring work we also know that in some minority ethnic groups, people are more likely to experience negative outcomes, such as higher detention and seclusion rates. The regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of people on the basis of race. Any changes to the way that we regulate health and social care services may have an impact on equality and human rights for people from different ethnic groups. The development of CQC's Strategy (and Business Plan) has taken account of this characteristic through engagement with representative bodies during the design and consultation phases. There is some evidence about race equality in the main equality and human rights issues raised consultation – such as the need for CQC to provide better information for people from Black and minority ethnic groups not only in terms of non-English speakers but also in relation to the awareness of some communities of the role of CQC. If

[8] Equality Matters – equality information for CQC in 2012 (2013) Care Quality Commission

	communities are less aware of CQC this affects both their ability use public information provided by CQC and to engage with CQC including giving their views on services that they use. This relates to business plan priorities 3 and 6. In the consultation, people raised issues of the over-representation of some minority ethnic groups in mental health services and the importance of gathering the views of these people in our work this is linked to our Business Plan priority 3 about improving evidence from the public and people who use services)
Religion or belief: (include different religions, beliefs and no belief)	The regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of people on the basis of religion. Other beliefs are also covered in regulations about meeting individual needs. Any changes to the way that we regulate health and social care services may have an impact on equality and human rights for people of different religions and beliefs. The development of CQC's Strategy (and business plan) has taken account of this characteristic through engagement with representative bodies the consultation.
Sexual orientation: (include impact on heterosexual people as well as lesbian, gay and bisexual people)	There are some gaps in data around the experience of lesbian, gay and bisexual people when using health and social care services as sexual orientation is not monitored in some main health data sets such as hospital episode statistics. In our current work on equality data, led by our Intelligence Directorate, we are aiming to make the best use of available data. We know that there have been a number of studies and reports showing that lesbian, gay and bisexual people can experience discrimination and poorer outcomes when using health and social care services.[9] The regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of people on the basis of sexual orientation. Any changes to the way that we regulate health and social care services may have an impact on equality and human rights for lesbian, gay and bisexual people. The development of CQC's Strategy (and Business Plan) has taken account of this characteristic thruogh engagement with representative bodies during the design and consultation phases. There is some evidence about equality on the grounds of sexual orientation in the main equality and human rights issues raised in the consultation.

[9] Equality Matters – equality information for CQC in 2012 (2013) Care Quality Commission

Human Rights (refer to Guidance for examples)	The development of CQC's Strategy (and Business Plan) has taken account of the broad human rights principles: fairness, respect, equality, dignity and autonomy and more specific human rights, such as Human Rights Act Articles including fulfilling our duties under the Human Rights Act to protect people from rights abuses under article eight, (guaranteeing respect for dignity and personal autonomy) article three (prohibition of inhuman and degrading treatment) and article two (the right to life). Some of the 'drivers' for the strategic review, such as the Francis report are closely linked to human rights. The Government's initial response to the Francis report[10] focuses on *'key actions to ensure that patients are 'the first and foremost consideration of the system and everyone who works in it' and to restore the NHS to its core humanitarian values.'* The statement of common purpose in the response reaffirms the key human rights concepts of respect and dignity as a key value for the NHS. Human rights are embedded in the current standards which we use to regulate health and social care providers. In the past year, we have undertaken an evaluation of how we regulate for the equality and human rights aspects of the current standards. We will use the learning from this work and from other work around human rights approaches in health and social care to inform the development of our eight business plan priorities, including the changes to inspection under priority 2 and the development of data, intelligence and evidence under priority 3. There is a evidence about the protection of human rights in the main equality and human rights issues raised in the consultation phase (see below)
Main equality and human rights issues raised in the pre-consultation and consultation phases	**Where should CQC should focus its attention?** There was wide agreement that CQC should focus its attention on situations where people are more likely to have their rights breached – leading to the fundamental standards not being met for these people. Sometimes, this was expressed in terms of 'risk' and 'vulnerability' but several participants felt that this approach 'put the thinking in the wrong box' and that the focus should be on rights and dignity. Consultation feedback highlighted the importance for CQC to address the needs of older people, minority ethnic groups, disabled people, and those with diminished capacity (including families and carers), transgender people as well as lesbian and gay people. These groups face barriers in expressing their voice and asserting their rights.

[10] Patients first and foremost: the initial government response to the report of the mid-Staffordshire NHS foundation trust public inquiry (2013) Department of Health

	Consultation feedback advises CQC to continue working with representative and advocacy bodies and listen to collective voices for these groups to fully explore ways to promote and protect their rights. There are a number of factors that affect whether a situation may lead to CQC needing to focus on ensuring people's rights are protected, including: ***Type of service:*** some people felt that people receiving a service in their own home were most at risk of having their rights breached (as care is provided unsupervised) whilst others felt that residential care was a higher risk, because care is institutionalised. Where people are detained under the Mental Health Act and therefore have no choice about using the service, this can also presents a risk to rights. ***Ability of people using the service to self-advocate:*** this was often linked to an equality characteristic, such as disability (for example some people with a learning disability, communication impairments or dementia) or age. Speak Out groups also mentioned other characteristics – such as whether people were newly arrived in the UK. Whilst some of these personal characteristics are related to service type (e.g. care homes specifically for people with dementia), other people could be at risk of having their rights breached in services which may seem 'lower risk' – e.g. non-English speakers using a dentist service. Whether people have family and friends will affect whether there is anyone else to advocate on their behalf – but this will vary within a service and may not be known to CQC or the provider. ***Risk of discrimination/ having rights breached:*** Some groups of people are more at risk of having their rights breached, even if they are able to self-advocate; Speak Out groups gave examples of where people had received poorer health services because of their ethnicity or religion and belief. CQC has heard examples of discrimination in health and social care services from lesbian, gay and bisexual and transgender people. Some people may be able to self-advocate but the breach of rights still means that the provider is not meeting essential standards. Where a need to protect rights is clearly linked to a service type, this may be easier for CQC to deal with than where the need is variable between people using the same service. However, even in services where a 'risk to rights' is high, there will be different levels of 'risk to rights' for example, in a care home for people with a learning disability, people who lack capacity to make decisions or have no friends or relatives may be more likely to have their rights breached.

[11] Government Equality Strategy – Building a Fairer Britain – pg7

	Mencap, Mind and The Centre for Mental Health would like CQC to strengthen the ways it supports disabled people and those with diminished capacity, and by developing staff capacity (improved training, specialist policy leads) which is a focus of priority 7 and priority 8. **What should CQC focus its attention on?** Again, many participants re-stated the need for CQC to focus its attention on the rights of people using the service, for example around dignity and respect. A focus purely on 'risk' was seen by some to be counter-productive as it may make services risk-averse, which could have an impact on choice and autonomy for people using the service, as well as an impact on innovation more generally. Some groups raised particular equality issues about rights, such as access to interpreters and access to information, as well as CQC checking on relationships between people using the service and staff to ensure that people received an equal service. Some areas raised, particularly by SpeakOut groups, were not clearly in the remit of the regulations – for example whether people could access a service in the first place due to immigration restrictions. Some people faced systematic exclusion from services. There was some debate about whether CQC had a role in prompting debate about these issues in the wider policy arena, even if they are not within the remit of the Health and Social Care Act. There were some comments that issues such as dignity are harder to make judgements about than issues that lend themselves to more quantitative analysis. There was a general consensus that the themed inspection approach had enabled CQC to get to grips with some of these qualitative rights-based issues – particularly the dignity and nutrition inspections. If these programmes of themed inspections are announced well in advance, this can drive up standards across services, whether or not they are inspected. Providers analyse their current performance in that area then make improvements in case they are included in the inspection programme. **How should CQC involve a diverse range of people who use services?** There was a general agreement about the value of involving people who use services in the CQC's work. At the most basic level of involvement, CQC relies on information from people who use services, their families and friends, to alert CQC to services where people's rights may be breached and to make regulatory judgements on

	inspections. There were a wide range of suggestions for how to reach diverse range of people who use services. There is a need to ensure that CQC does not only rely on web-based communication, especially for older people and Gypsy and Traveller communities (due to low levels of literacy).[11] CQC does not have a complaints function. However, many people thought that CQC had a role in signposting people to enable them to self-advocate to resolve individual issues. If a signposting role is developed, CQC will need to consider information issues about equality – such as accessibility of suggested processes or organisations and their expertise in equality and human rights issues. Outreach to groups of people who face exclusion from giving their views or discrimination was highly valued by Speak Out groups. Face-to-face outreach to build awareness of CQC's role and engage with people on the key health and social care issues for their communities was seen to be invaluable. Some people saw that HealthWatch had great potential, but some groups (e.g. Black and Minority ethnic women) were concerned that HealthWatch may not engage with them or represent their perspectives, for example, The National LGB&T Partnership suggested that CQC work more closely with them to know the views and needs of lesbian, gay and transgender people, managing complaints and signposting via them as they already have the trust and confidence of these groups. **CQC's information for the public and people who use services** There was general agreement that it is important to provide some inspection reports in accessible formats (for example, EasyRead). However, there is a more general issue about whether the website provides people who use services and their family and friends with easily understandable information. Many of the comments about the website focused on whether inspection reports are clear and tell people the key information about the service. Also, many people who use health and social care regularly do not use digital and social media. This is an equality issue, in terms of accessibility of inspection reports and information to a wide range of people. There was also an acknowledgement that some people will never be in a position to use inspection reports for decision-making about choice of services – this relates back to the prioritisation of services where people may be at a higher risk of breaches to their rights.

7. Analysis Considering the evidence and engagement activity, set out below the actual or likely effect of the policy, project or work under each of the general duties of the Equality Act. CQC must have due regard to the general duties in the exercise of all of its functions	
Effect on eliminating discrimination, harassment and victimisation (includes unlawful discrimination because of marriage or civil partnership status, as well as other protected characteristics)	Given the evidence in section 6 above, CQC recognises that people most at risk of discrimination use health and social care services in increased and different ways. As such, our strategy development has taken account of four key areas: • That CQC puts the safety, welfare and rights of people who use health and social care services first in everything it does, particularly those who are the most vulnerable to their rights being breached or to discrimination. We will focus our activity where the risk to quality and safety is greatest. • That CQC will involve a diverse range of people in order that they have a greater influence in our business, for example in developing our strategy, our day-to-day business delivery, the way we regulate, and our work plans. To do this, we will build effective two-way communication with the public and groups representing a diverse range of people who use services and input this intelligence into risk profiling, inspection activity and assessment of compliance. • That CQC will monitor and protect people's rights, including people's rights to equality where this is within our regulatory remit. • That CQC will use the information we find to inform policy and sector debate. Where appropriate, this will include equality and human rights issues Our Business Plan includes the following deliverables, which aim to have a specific impact on advancing equalities issues: 2.4 Work with councils with social services responsibilities, particularly through the Health and Wellbeing Boards, and develop thematic approaches to Mental Capacity. 2.6 Develop a new model for monitoring the use of the Mental Health Act by registered providers and in other organisations, which increases our use of Experts by Experience. 4.1 Commence two programmes of themed inspection, at least one 'thematic probe' and at least one thematic data analysis – subject to agreement one of the themed inspection areas will be dementia care.

	7.1 Roll out new registration process (including statement of purpose and contract between CQC and providers), for learning disability service providers. 7.2 Benchmark learning disability service providers against statement of purpose. 8.8 Embed equality and human rights into eight priorities, including change programmes, directorate plans, inspection and regulation and the culture of CQC as an organisation (including following through learning from our evaluation of equality and human rights in inspection).
Effect on advancing equality of opportunity (includes removing or minimising disadvantages, taking steps to meet the needs, and encouraging participation in public life of people from protected groups)	Our strategy has identified that CQC should help the public understand the quality of care of different providers, so that they can make informed judgements (of health services) and choices (of social care services). (It should be noted that this direction implies a notable limitation in CQC's role – whilst it will provide information for the public to consider, alongside other sources, it will not become a "one-stop-shop" that assists individual members of the public to make choices.) With this in mind, CQC has set out a strategic direction to further enhance our information offer over the next five years. This will include investing additional resource and effort to improve inspection reports to further meet needs of multiple audiences, providers and the public, with a focus on understandable and accessible language and usability. In addition, the further commitment in the draft strategy to continuing themed inspection programmes has the potential to assist in advancing opportunity in areas relating to EDHR by these programmes focussing on areas that impact on rights based issues.
Effect on promoting good relations between protected groups	No impact.
Effect on compliance with Human Rights Act 1998	The development of the strategy to date has been explicit in its commitment that an important part of our role is to discharge our responsibilities under the Human Rights Act. This will continue under the new strategy – CQC is a statutory body and it will do everything that it is legally required to do.

8. Log of Equality and Human Rights actions

Give an outline of the key actions based on any information gaps, challenges and opportunities identified during engagement and evidence analysis.
Include any action required to address specific equality or human rights issues where the work may need adjusting to remove barriers or better advance equality as well as actions to mitigate any potential negative effects of the policy on particular groups .
Include how the actual impact on equality and human rights will be reviewed after implementation of the policy or project. Add more rows if required. Refer to Guidance for more information.

Action (If using a project plan this should be a new deliverable or new task within an existing deliverable)	**Start date**	**End date**	**Action owner**	**Outcome** (relate back to analysis section – which equality or human rights issues will be addressed through this action)	**Success measure**	**Actual completion date**
Analyse completed directorate business plans for equality content including incorporation of CQC's nine equality objectives	May 2013	May 2013	Robin Wilson, Senior Planning & Performance Manager	Equality issues embedded	Directorate business plans incorporate CQC's nine equality objectives, delivery is achieved	
Analyse CQC Strategy project plans for equality & human rights content including incorporation of the actions arising from the evaluation of equality & human rights in inspection	May 2013	May 2013	Lucy Wilkinson, Equality, Diversity & Human Rights Manager	Equality & human rights issues embedded	Strategy project plans incorporate key equality and human rights issues, delivery is achieved	

Ensure the equality & human rights elements in the Strategy and corporate and directorate business plans have appropriate monitoring/ governance/ evaluation	April 2013	April 2014	Jill Morrell, Strategy Manager and Robin Wilson, Senior Planning & Performance Manager	Equality & human rights issues embedded	Regular reporting at Corporate and Directorate level on progress against the actions	