1. Introduction

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

- Acute hospitals handbook
- Mental health handbook
- Community health handbook

The purpose of this equality and human rights impact analysis is to ensure that, in developing our regulation of hospitals, 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

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
   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:

1) For all services covered by these handbooks (acute hospitals, mental health services, community health services)

We have:

• Published a signposting document with 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 descriptors 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:
  o definitions of human rights principles – which have influenced the key human rights topics in our human rights approach
  o the detail of key human rights topics, which have influenced our KLOEs.

2) Acute hospitals:

In addition we have:

a) Carried out public consultations on the new approach:

• Asked our online communities (public reference group and action team) about the five key questions to ask on inspections to inform our KLOEs.
• Consulted with the SpeakOut network, local HealthWatch organisations, Disability Rights UK, Mencap, Age UK, Council for Voluntary Services and the Race Equality Foundation on our assessment framework and KLOEs.
• Carried out acute inspection report testing (online communities, public steering group and red eye user testing).
• Delivered a series of targeted workshops with patient advocates in eight core services areas and experts from the Royal Colleges.
• Met with Local Healthwatch about the caring and responsive domains.
• Gathered feedback from Experts by Experience and other members of inspection teams involved in Wave 1 inspections to inform our approach to Wave 2 and this draft handbook.
• Continued to develop our approaches for regulating acute services for children and young people – through our ongoing work programme with our Children and Young people’s advisory group – comprised of young people who are experts by experience.

b) Engaged with specific patient/equality related groups:

• Commissioned public research on what good looks like in eight core services.
• Five Speak out network groups undertook 25 interview with people in their local communities on “What good and outstanding look like” in the sector.
• Focus groups for maternity services on “what good looks like”.
• Patient focus groups with Experts by Experience, Equality Voices, patient representative organisations, members of Speak Out network.
• Commentary on draft KLOEs by Speak Out groups and Department of Health Voluntary sector partners.

3) Mental health services:

In addition we have:

a) Public consultation on the new approach:

• Promoted the pre-consultation engagement work through the launch of our annual Mental Health Act report and associated social media work.
• Published a Mental Health special edition of our Local Healthwatch bulletin: promoting the signposting document and how to give feedback on this.
• Asked our online communities (Public reference group and action team) about the five key questions to ask on mental health inspections to inform our key lines of enquiry (KLOEs).
• Asked the Public steering group (incl. people who use services) about reporting requirements and KLOEs for mental health services.
• Carried out a Mental Health model learning event for CQC stakeholders and members of reference groups, including people who use services.

b) Engagement with patient/equality related groups:

• Community outreach listening events for inspections: added a question at the end of focus groups targeted at seldom heard communities of people who use services about the way we inspect/what good looks like.
• Consulted with the Mental Health Expert User Group about care pathways.
• Supported a Mental Health Expert Reference Group sub-group looking at inspection structure and Intelligent Monitoring.
4) Community health services:

In addition we have:

a) Public consultation on the new approach:

- Consulted with the Community Health advisory group.

b) Engagement with patient/equality related groups:

- Carried out community outreach groups as part of community-based services pilot e.g. groups with young people.
3. What we know about equality and human rights in the hospital sector

What we know about equality for people using acute hospital, mental health and community health services, in relation to:

<table>
<thead>
<tr>
<th>Age</th>
<th>We know that older people are more likely to use acute and mental health hospital services than other age groups:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In mid-2012, 16.9% of the population were aged over 65. However, in 2012-13, older people accounted for:</td>
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<tr>
<td></td>
<td>• 36.9% of acute hospital inpatient attendances,</td>
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<td>• 37.4% of inpatient attendances at mental health and learning disability hospitals, and</td>
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<td></td>
<td>• 21.2% of accident &amp;emergency episodes. (CQC Equality Counts report).</td>
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<td></td>
<td>Some of this increased use of services by older people is due to increasing likelihood of health conditions with ageing. However, there is also evidence that older people are more likely to experience an emergency hospital admission for a potentially avoidable condition. State of Care report 2012-13.</td>
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<tr>
<td></td>
<td>We also know that older people can have a poorer experience when using acute hospital services, for example:</td>
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<td></td>
<td>• Malnutrition Age concern’s report “Later life in the United Kingdom”</td>
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<td></td>
<td>• Breaches of dignity and privacy: CQC Dignity and nutrition national report.</td>
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<tr>
<td></td>
<td>In relation to mental health services:</td>
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<tr>
<td></td>
<td>• There is also evidence that older people face discrimination in using mental health services. (Equality in Later Life - Healthcare Commission (2009)).</td>
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<tr>
<td></td>
<td>• In wards for people with learning disabilities, around 40% of inpatients aged over 65 had been inpatients for five years or more, around twice the proportion of all inpatients (Learning disabilities census report 2013).</td>
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<tr>
<td></td>
<td>• Older people with other equality characteristics can face multiple disadvantage. For example, Stonewall highlighted particular equality issues for older lesbian, gay and bisexual people in its report LGB in Later Life (2011). More than two in five LGB people are not confident that mental health services would be able to understand and meet their needs.</td>
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</table>

When looking at age equality, we also need to consider issues for
Children and young people growing up in England today are healthier than they ever have been before, and previously common diseases which resulted in the deaths of children are now rare. Better health outcomes for children and young people (DH- 2012), which could be one reason why young people aged 0-15 accounted for 19% of the population (Census 2011) but only 12% of all inpatient attendances in 2012-13.

However:

- Some more vulnerable children – such as looked after children – suffer much worse outcomes. Nearly half of looked after children have a mental health condition and two thirds have at least one physical health complaint.
- 26% of children’s deaths showed ‘identifiable failure in the child’s direct care’.
- Half of life time mental illness starts by the age of 14.
- About 75% of hospital admissions of children with asthma could have been prevented in primary care.
- Hospital statistics on teenagers show that girls predominate in self-harm cases, boys in assaults (Health and Social care Information Centre).

The Department of Health has pledged 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 (Better health outcomes for children and young people, Department of Health 2012).

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.

People with a learning disability have higher levels of health needs than most of the population, and can have a poorer experience when using acute hospital services:

- “Death by Indifference, 74 deaths and counting” (Mencap 2012) described what had happened since ‘Death by Indifference’ (2007), which raised the issue of deaths of people with learning
disabilities whilst in the care of the NHS.

- The Confidential Inquiry into Premature deaths of People with Learning Disabilities, (CIPOLD) was set up. Their investigation and report revealed deficiencies by the NHS and social care in treatment and care.

People who have dementia also fall within the definition of disabled people under the Equality Act. Despite some improvements, people with dementia continue to have poorer outcomes in hospital compared to those without dementia. State of Care report 2012-13.

Disabled people with other equality characteristics can face multiple disadvantages. For example some ethnic groups have a higher proportion of the population who are disabled. 25% of people in both White Irish, and White gypsy and traveller groups are disabled. Disability and ethnicity Equality Counts- page 23.

In relation to mental health services:

We know that people with a learning disability can be at risk of poor care and potential breaches of human rights when using specialist mental health or learning disability services:

- Winterbourne View - South Gloucestershire’s Safeguarding Adults Board report made recommendations for preventing abuse of people with learning disabilities in the future. (Serious Case Review).
- The implications of Winterbourne View were also published in Transforming care: A National response to Winterbourne View Hospital and the Winterbourne View Review Concordat: Programme of Action, Department of Health (2012).
- 20% of inpatients with learning disabilities are being treated 100km or more away from home. Health and Social Care information Centre statistics Learning disabilities census report 2013.

The NHS constitution states that “The NHS commits to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one.” However, we know that for people using community mental health, this is not always happening. Our 2013 Community Health Survey report states that there is scope for improvement in providing information and involvement in:

- decisions about medication,
- care planning,
- care reviews,
- crisis care and
- support with day to day living.

Some groups of disabled people have particular needs in relation to community health services, for example people with HIV (who are disabled people under the Equality Act 2010 definition). They are at risk of discrimination and poor treatment because stigmatising and
Discriminatory views about the virus persist ([The National Aids Trust](https://www.nat.org.uk/)). In 2012 there were approximately 100,000 people living with HIV in the UK. ([Public health England](https://www.gov.uk)). HIV care provided in community health settings 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. This stigma can also have an impact on people with HIV receiving treatment in acute or mental health hospital settings.

| Gender, including pregnancy and maternity | Women make up 51% of the population in England and accounted for 56% of acute hospital inpatient episodes. There are a number of reasons that may contribute to this difference, including the differing age profile of men and women, and women’s use of inpatient maternity services ([Hospital Episode Statistics 2012-13, Health and Social Care Information Centre](https://www.hesonline.nhs.uk)).

There are a number of gender-related issues for providing acute and community health care including:

- Varying causes of mortality by gender [ONS statistics](https://www.ons.gov.uk).  
- The importance of maternity services for women: In 2012-13 there were 670,000 deliveries in NHS hospitals (increased by 0.3% cent since 2011-12) [Health and Social Care Information Centre Births in hospital](https://www.hesonline.nhs.uk).  
- The impact on healthcare of gender-specific practices such as female genital mutilation outside healthcare setting. Performing any circumcisions outside of healthcare settings has risks such as lack of surgeon training, poor hygiene, and a lack of follow-up care, which could lead to adverse impact upon the person undergoing the procedure [World Health Organisation](https://www.who.int) (2014).
- Community and hospital pregnancy and maternity services also need to address the needs of women who face multiple disadvantage, for example in relation to teenage pregnancy. The number of teenage pregnancies is reducing. In 2011-12 there were 33,621, and in 2012-13 there were 30,873. There were more teenage birth rates in deprived areas: 31.1 per 1,000 teenage girls in the most deprived areas compared with 3.6 per 1,000 teenage girls in the least deprived areas.
- Men make up 49% of the population and in 2012-13 accounted for 48% of the mental health and learning disability trust inpatient episodes. ([HES) Equality Counts](https://www.hesonline.nhs.uk).  
- Women are more likely to have been treated for a mental health condition than men (29% compared with 17%). This may be because women may be more willing to acknowledge their experiences, to talk about them, and to seek support. [Mental Health Foundation (Women and Mental Health)](https://www.mentalhealth.org.uk). |

| Race | We know that the usage of different types of hospital services varies by ethnicity. |
White British people make up 84% of the population, (ONS, Mid-year statistics 2012).

- They represent only 73% of the hospital inpatient episodes in NHS acute trusts (Hospital Episode Statistics), lower than might be expected.
- People from other Asian or Asian British backgrounds, other Black backgrounds, and ‘other ethnic backgrounds’ had higher numbers of acute inpatient episodes than may be expected. Some people from BME (Black and minority ethnic) communities may be using acute hospital inpatient services more often.

There are particular conditions which affect different ethnic groups. It is important that these are recognised and taken into account in providing appropriate hospital and community health services to these communities. Some conditions affecting Black or South Asian people more than white 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.

Accident and emergency attendances also vary by ethnicity:

- White British people had 65% of accident and emergency admissions, lower than might be expected.
- The white Gypsy and traveller group is disproportionately represented with 5% of admissions. This may be due to Gypsies and travellers not being registered with a GP where they are living, and therefore needing to use accident and emergency instead, rather than any increased susceptibility to accident or injury.

Mental health trust admissions also vary:

- White British people had 72.5% of mental health trust hospital attendances- lower than might be expected.
- Gypsies and travellers who are perhaps one of the groups most likely to face hostility and misunderstanding, represented 5% of mental health trust hospital attendances, supporting evidence that they are more likely to experience poor mental health (EHRC report, How fair is Britain chapter 9).
- There are also differences in attendance by age between and within ethnic groups. For example, the Irish and Chinese ethnic
groups appear to have a larger proportion of mental health service attendances made by older people and fewer by children than other groups.

- People from other Asian or Asian British backgrounds, other Black backgrounds, and ‘other ethnic backgrounds’ had higher numbers of mental health trust inpatient episodes than may be expected. Some people from BME (Black and minority ethnic) communities appear to be using mental health services more often.

Since the David Bennett Inquiry report in 2004, the experiences of BME people relating to discrimination in mental health services have had national attention. Despite similar levels of mental health illness as other ethnic groups:

- higher numbers of Black people are being diagnosed as schizophrenic, and
- they are over-represented among people who are sectioned and picked up by the police under mental health law.
- Efforts have been made to improve outcomes for BME people using mental health services, but people from African-Caribbean and African backgrounds still experience greater dissatisfaction with mental health services than white service users. The Schizophrenia Commission’s 2012 report, ‘The Abandoned Illness’.

There are many ways in which religious practices and beliefs have the potential to affect health and to have an impact on whether health services are appropriate for different religious and belief groups.

Although a high proportion of people in England (59%) state that they are Christian (ONS mid 2012 figures), providers of health and social care should not make assumptions about the religion of people based upon ethnicity. For example, although 68% of people of Muslim faith are from the Asian/Asian British ethnic group, 32% are not: 10% are from the Black African/Caribbean British group. This is particularly relevant to delivering care appropriate to people’s individual religious background.

There are many ways in which religious practices and beliefs have the potential to both affect health and the appropriateness of health services:

- Diet choice, and preparation of the food.
- Observance of fasting times.
- Orthodox Jews observance of the Sabbath.
- Ethics around Blood transfusion.
- Views on termination of pregnancy and contraception.
<table>
<thead>
<tr>
<th>Sexual orientation</th>
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<tbody>
<tr>
<td>The Government uses figures of between 5-7% to estimate the number of Lesbian, Gay and Bisexual (LGB) people in England. There are as yet no census figures to support this estimate. However, many LGB people do use hospital services.</td>
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</table>

There are issues with hospital and community healthcare staff understanding next of kin issues for LGB people. The Royal College of Nursing produced a guidance leaflet (2012) about this.

The home background of LGB people may differ from heterosexual people in that 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, so it is possible that there will not be anybody at home to care for the person after discharge.

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- achieving quality for LGBT people (MacMillan-2012).

In relation to mental health services, there is some evidence to suggest that LGB people are more likely than other groups to face hostility and misunderstanding, and are more likely to experience poor mental health (How fair is Britain EHRC; Mental Health issues if you are gay. NHS Choices).

LGB people may also face discrimination and lack of understanding when using mental health services. These can further affect both their mental health and their access to mental health services. Whole-person care: from rhetoric to reality (2013) Royal College of Psychiatrists.

<table>
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<tr>
<th>Gender</th>
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<tr>
<td>There is no official estimate of the transgender population in</td>
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</table>
| Identity | England. However, the Gender Identity Research and Education Society (GIRES) estimate the number of transgender people in the UK to be between 300,000 and 500,000. Existing evidence suggests that transgender people experience, and are affected by, discrimination.

Like all other people, transgender people will need treatment for a full range of health conditions over the course of their lives.

Inpatient hospital accommodation 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](#).

To avoid lack of understanding which may lead to discrimination, and poor treatment of transgender patients, [The Royal Free Hampstead NHS Trust have produced a Transgender Guide for Acute Hospitals](#) which provides information for clinical and other staff to understand the needs of trans people in a hospital setting.

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 also use hospital services, which might be directly as a result of ill health caused by their caring responsibilities.

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.

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](#))
<table>
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<tr>
<th>Overall experience of carers which can have an effect upon their health.</th>
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<tbody>
<tr>
<td>• Carers can experience stress; for example, if the person they care for is discharged from hospital too early, or not admitted soon enough when they need to be.</td>
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<tr>
<td>• Not have time to eat properly,</td>
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<td>• Become exhausted,</td>
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<tr>
<td>• Experience physical injury through lifting for example.</td>
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<tr>
<td>• Experience emotional effects from not being consulted adequately about what is happening to the person for whom they care.</td>
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<table>
<thead>
<tr>
<th>Human rights principle of fairness</th>
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<tr>
<td>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:</td>
</tr>
<tr>
<td>• vulnerable migrants (asylum seekers and refugees)</td>
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<tr>
<td>• Gypsies and Travellers</td>
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<tr>
<td>• homeless people</td>
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<td>• sex workers.</td>
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It is recognised that resources are limited but in order to be fair, any services that are 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.

When people use mental health services, there are particular risks to ‘fairness’ if they have been compulsorily detained. Where people’s right to liberty is limited by detention under the Mental Health Act, procedures must be followed so that people:

• have the opportunity to have their side of the story represented at a tribunal hearing (either by the person or their representative)
  • have the right to legal representation
  • have an opportunity to see and challenge the report and other evidence which led to the decision to detain them.

The performance of all healthcare providers around complaints can also make a major contribution to fairness.
All people have the right to respect. 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. There is the potential for people to disengage from health services if they have not been treated with respect by a clinician or at a hospital by other healthcare staff. 

Duties of a Doctor (General Medical Council). This involves for example:

- being polite to people using services
- listening to them
- keeping them informed of decisions and changes
- meeting their needs, or if this is not possibly, explaining why

Respect involves cultural and other needs: if a person is in a hospital, 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.

NHS Outcomes framework indicators Domain 4 - Ensuring that people have a positive experience of care looks at the importance of providing a positive experience of care for patients, service users and carers.

Under the NHS Constitution, people have the right to be treated in a way that respects their dignity.

The public inquiry into Mid Staffordshire NHS Trust (the Francis report) and recent reports have highlighted undignified care of older people in hospitals and have necessitated a clearer focus on the delivery of compassionate and dignified care.

Situations in acute and mental health hospitals that may involve breaches of dignity include:

- Unchanged sheets
- Neglect leading to bed sores
- Leaving trays of food without helping people to eat if they are 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
- Breaches of privacy when delivering personal care

The treatment does not need to be deliberate – it is the impact it has on the person that matters. For example if hospital staff leave patients in soiled bed sheets for long periods of time because they are understaffed, this may still amount to a breach of dignity.

Privacy is an element of dignity. The NHS constitution states that
people have the right not to have to share sleeping accommodation with people of the opposite sex – including inpatient wards. In 2012-13 in England:

- There were nearly 4,000 cases of healthcare providers breaches of single sex accommodation requirements.

58% occurred in the London region. Overall, there is a pattern of breaches, which peak in December and January and are at the lowest in August. This is possibly linked to winter pressures (NHS England, *Mixed sex accommodation data 2012-13*).

The use of face down physical restraint in crisis care for mental health patients ignores the dignity of the person, and can be dangerous. *MIND*

Though dignity is a human rights for all, some equality groups may be more at risk of dignity breaches. Not all hospitals are providing dignified care for older people;

- *Delivering dignity: Securing dignity in care for older people in hospitals and care homes. Final report*, Local Government Association, the NHS Confederation and Age UK.

### 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 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.
- Mental health services should protect people’s right to liberty. If their right is limited due to detention, procedures must be in place to ensure that this is not unlawful *NHS constitution*.

### Human rights principle – right to life

Healthcare 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.
Right to life also includes all healthcare providers preventing “avoidable” deaths.

For example, 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

This is an outcome measured in the NHS Outcomes framework indicators: **Domain 1 - Preventing people from dying prematurely**

With regard to Mental Health Services, the [NHS constitution](#) states that:

- They should prevent suicide in detention and when someone leaves the service when known to be at risk, whether or not the person is compulsorily detained;
- Prevent abuse or neglect in detention that could lead to death;
- Not refuse life-saving treatment because a person has a mental health condition;
- Not decide against resuscitation (unless the person has requested this), without consulting the person or people supporting them (this would apply to all hospital settings).

<table>
<thead>
<tr>
<th>Human rights for staff working in the sector</th>
<th>Staff working to provide healthcare have the right to be safe and to be treated with dignity and respect (NHS constitution section 49). For example, staff should:</th>
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<tbody>
<tr>
<td></td>
<td>• Expect reasonable steps to have been taken by the employer to ensure protection from discrimination by fellow employees, people using the service and others.</td>
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<td>• Expect employers to deal with bullying and harassment.</td>
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<td>• Expect employers to enable staff to speak freely about concerns – not only upholding the legal rights of ‘whistleblowers’ but by creating a culture which values staff views.</td>
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<td>• deal appropriately with safety risks that staff might face.</td>
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</tbody>
</table>
4. Development work on equality and human rights to date

Acute hospital inspections

- Wave 1 (18 inspections) and Wave 2 (x inspections) of acute hospital trusts took place between September 2013 and March 2014. These inspections informed our acute hospital inspection model.

- Prior to the pilot acute inspection programme, we identified the key human rights topics for the acute sector and shared these with the Wave 1 inspection teams. Early in 2014, we shared the topics with the subsequent ‘Wave 2’ inspection teams.

- We reviewed tools and methods against relevant human rights topics and came to the conclusion that whilst 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 patients, members of the public, staff and others.

- We have tested support to inspection teams to help them consider the human rights topics. This has included providing inspection teams with an overview of our human rights approach, and with specific equality and human rights information such as demographic data and NHS Equality Delivery System assessments by Trusts. This information helped inspection teams to plan their equality and human rights priorities, alongside specialist equality and human rights advice where needed.

- We have worked to make sure that a diverse range of people can participate in giving views on hospitals being inspected – for example by setting minimum access requirements for our public listening events and by commissioning voluntary and community sector groups to run focus groups targeted at gathering the views of specific communities.

- The findings from this testing contributed to our approach to acute hospitals published for April 2014 and to the evaluation of the pilot inspections.

- We recognise that we need to be able to assess differential outcomes for people in equality groups who may be at a higher risk of receiving poor care. Developed a methodology for case tracking the experience of people with learning disability in acute hospitals in inspections from April 2014 onwards.

Pilot mental health inspections

- We reviewed tools and methods against relevant human rights topics.

- We shared key human rights topics with mental health ‘wave 1’ inspection teams.

- Drawing on learning from acute sector inspections, we continued to test support with mental health inspection teams. This has included providing inspection teams with an overview of our human rights approach, with specific equality and human rights information such as demographic data and NHS Equality Delivery System assessments by Trusts. This information helped inspection teams to plan their
equality and human rights priorities, alongside specialist equality and human rights advice where needed.

Pilot community health inspections

- We reviewed tools and methods against relevant human rights topics.
- Drawing on learning from acute sector inspections, we continued to test support with community health inspection teams. This has included providing inspection teams with an overview of our human rights approach, with specific equality and human rights information such as demographic data and NHS Equality Delivery System assessments by trusts. This information helped inspection teams to plan their equality and human rights priorities, alongside specialist equality and human rights advice where needed.

5. Conclusion and actions required

- Our approach to inspecting acute hospitals, mental health and community services 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 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:
  - Larger inspection teams enabling human rights topics to be covered in more depth
  - Increased emphasis on gathering the views of patients and their carers as many human rights issues can 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 are services planned to meet the needs of the whole population and service access issues that affect groups as well as individual patients.
  - 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.
However, there are some issues which still need to be resolved, or they could negatively impact on equality and human rights:

- We need to analyse intelligent monitoring measures for acute trusts, mental health and community services, to check coverage of key human rights topics, eg. in information we use to evaluate risk and in data provided to inspection teams.

- We evaluated the use of human rights tools in Wave 1 acute inspections. Team leaders told us they wanted human rights topics integrated into KLOEs and the inspection handbooks, equality intelligence and demographic information in datapacks, tools included in guidance and training for teams on equality and human rights issues. The coverage of equality and human rights issues in the Wave 1 reports varied.

- The ‘on-site’ element of our new inspection model was very intensive. Experts by experience, inspectors and managers often had to work long, consecutive days away from home. This could have prevented staff from equality groups such as some disabled people and people with caring responsibilities from participating in inspections. We need to look at whether some people could be involved in part of an inspection, e.g. for one day, to carry out a particular task. We also 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 (like clinicians and inspectors) eg. by having a specific agenda item in feedback meetings for experts by experience.

- Our assessment frameworks and methodology will continue to develop – we need especially to ensure that these developments will enable inspectors to assess performance against key human rights topics for mental health services and community health services which are at an earlier stage of development than acute services.

### Proposed actions

<table>
<thead>
<tr>
<th>Issue to address</th>
<th>Proposed action</th>
<th>Lead</th>
<th>Timescale (start and end)</th>
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<tbody>
<tr>
<td>Assessment frameworks and KLOEs will develop over time – need to ensure continued attention to human rights topics in frameworks</td>
<td>1. Continue to use the human rights topics list to check that assessment frameworks adequately reflect the human rights topics for the service type</td>
<td>Policy teams to provide assessment frameworks and make amendments</td>
<td>EDHR team to provide specialist check at appropriate development stages</td>
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| 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 variable | April 2014–March 2015 |
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<tr>
<td>3. Develop specific tools where required to address human rights topics</td>
<td>4. Work to review and develop monitoring measures for gaps, where data is already available but is under-used</td>
<td>Intelligence (with advice from EDHR team)</td>
<td>April 2014–March 2015</td>
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<tr>
<td>Intelligent monitoring measures in acute, mental health and community services are under-developed for many human rights topics</td>
<td>5. Ensure local teams have links, methods and skills to gather information about human rights topics e.g. at listening events and through local engagement work</td>
<td>Engagement (with advice from EDHR team)</td>
<td>April 2014–March 2015</td>
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<td>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</td>
<td>6. Develop the proposal for local relationships to include engagement with local equality groups</td>
<td>Engagement (with advice from EDHR team)</td>
<td>April 2014–March 2015</td>
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<td>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</td>
<td>7. Develop role specific learning on applying the human rights approach and human rights topics for Hospitals inspectorate staff</td>
<td>Learning and development, with specialist input from the EDHR team</td>
<td>April 2014–March 2015</td>
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<td>Inspectors need knowledge, understanding and confidence to apply the human rights approach in acute, mental health and community services</td>
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<td>8.</td>
<td>Continue to develop methods to reach experiences of specific equality groups e.g. case tracking people with a learning disability and in acute hospitals</td>
<td>Lead dependent on topic – but overall approach is Joint work between EDHR team and Policy Teams</td>
<td>April 2014-March 2015</td>
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<tr>
<td>9.</td>
<td>Look at whether thematic approaches are required to reach experiences of some equality groups using generic services</td>
<td>EDHR team</td>
<td>after evaluation of EDHR in inspections</td>
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<td>Need to ensure Trust specific equality and human rights information is integrated (where available) into the main pre-inspection information available</td>
<td>10. Work to integrate key EDHR information into datapacks and other pre-inspection resources</td>
<td>Intelligence – with advice from EDHR team on content</td>
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<td>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</td>
<td>11. Develop cross-sector thinking for a solution to this</td>
<td>Policy teams (with input from engagement and EDHR)</td>
<td>tbc</td>
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<td>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</td>
<td>12. Develop cross-sector thinking for a solution to this</td>
<td>Policy teams (with input from engagement and EDHR)</td>
<td>tbc</td>
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Need to ensure that the CQC inspector workforce for the hospitals directorate enables diversity on hospital inspections

13. Identify existing profile of hospital inspectorate workforce after the preference exercise

14. Use lawful positive action measures in recruitment, if required to increase the diversity of the workforce

1. Transformation Team
2. Recruitment team with support from EDHR team and CQC staff networks

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