Human rights approach for our regulation of health and social care services
The Care Quality Commission is the independent regulator of health and adult social care in England

Our purpose
We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role
We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our principles
- We put people who use services at the centre of our work.
- We are independent, rigorous, fair and consistent.
- We have an open and accessible culture.
- We work in partnership across the health and social care system.
- We are committed to being a high performing organisation and apply the same standards of continuous improvement to ourselves that we expect of others.
- We promote equality, diversity and human rights.
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Background

Our purpose, outlined in our strategy, is to 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 to encourage them to make improvements.

Our strategy also states that one of CQC’s principles is to “promote equality, diversity and human rights”.

Our new approach to regulation and inspection of health and social care services is underpinned by five key questions:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people’s needs?
- Are they well-led?

Purpose of this document

In the equality and human rights impact analysis that accompanied the CQC three-year strategy, we promised to develop an approach to human rights in our regulation of care services.

The aim of this document is to:

- Explain why we need a human rights approach.
- Explain our strategy for delivering on our commitment to promote equality, diversity and human rights in our regulation work.
- Give some detail about what the strategy will mean in practice.

The detail in this document covers the human rights topics that we need to consider to ensure people receive good quality care, and how we propose to look at these topics. It complements the information on human rights that has been integrated into our provider handbooks.

This document does not set out any additional requirements or standards for providers beyond those in the provider handbooks.

We consulted on the draft of this document between April and June 2014. We received 37 online responses and 20 written submissions about our draft Human Rights approach. These responses have been considered in writing this document.
1. Why do we need a human rights approach?

We need a human rights approach because:

- Respecting diversity, promoting equality and ensuring human rights will help to ensure that everyone using health and social care services receives safe and good quality care. This is our core purpose.

- Our human rights approach will help us to apply our principle of promoting equality and human rights to our purpose, using our five key questions to consistently integrate human rights into the way we regulate.

Our human rights approach diagram (figure 1) shows how we aim to integrate equality and human rights at every stage of the development of our new approach to regulation.

Our human rights approach will apply whether we are regulating adult social care services, hospitals, primary medical services or carrying out other regulatory functions – such as joint inspections of children’s services, prison health services or themed work that crosses organisational boundaries. It applies whether we are registering services or inspecting services.

By taking the steps shown in figure 1, we are also following the first two principles of the human rights based approach to health.¹

Firstly, our approach will put human rights principles and standards at the heart of policy and planning.

Secondly, it will empower staff and people who use services with knowledge and skills, and to provide organisational leadership and commitment to achieve human rights-based approaches. We know that people who use services have a wealth of experience, knowledge and skills about human rights that, if shared, will help us to regulate more effectively. We see our engagement with people who use services around our human rights approach as mutually beneficial. Part of our core purpose is to encourage services to improve. We know that we need to encourage positive practice and a ‘learning culture’ in health and social care services around promoting human rights – as well as needing to use our regulatory powers to take swift and appropriate action when people’s human rights are at risk of being breached.

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*

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 CQC’s purpose:
   *We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage them to improve*

3. Building human rights topics into assessment frameworks
   - Regulations (led by the Department of Health)
   - Guidance on how we regulate services
   - Key issues to look for

4. Developing our human rights approach for each type of service
   - Risk to human rights: measures and monitoring data
   - Inspecting for human rights: methods, tools, information
   - Building confidence in human rights: learning and development for inspection teams
   - Communicating our approach to providers, people who use services and others

5. Supports principles for applying human rights approach
   - Putting people who use services at the heart of our work
   - Embedding human rights into our inspection approach
   - Able to be used by everyone involved in inspections with tailored advice and support, if required, from human rights specialists in CQC

6. Continuous improvement as a new inspection model develops
   Innovation e.g. testing new human rights surveillance measures, inspection methods, learning approaches

   Evaluation of approach

   Supports CQC’s ability to comment on equality and human rights in health and social care to encourage improvement, as well as embedding equality and human rights into each inspection we do

Leads to **human rights topics**
2. What do we mean by human rights?

There are a number of different ways to define human rights in the context of health and social care policy.

To develop a human rights approach for our five key questions, we are using commonly agreed ‘human rights principles’. These are sometimes called the FREDA principles – this stands for Fairness, Respect, Equality, Dignity, and Autonomy (choice and control). These principles are considered to underpin all international human rights treaties. They are used, for example, in the Human Rights in Healthcare framework for local action.²

We will not take a ‘tick box’ approach. While some principles may be more important than others in different situations, our approach to human rights will enable us to be more consistent and therefore more robust.

2.1 Policy context

Some of the reasons for developing our new approach to regulation, such as the Francis report, are closely linked to these human rights principles. The Government’s initial response to the Francis report focused 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.”

While humanitarian values are not defined exactly in the Government’s response, the statement of common purpose in the response document reaffirms the human rights principles of respect and dignity as key values for the NHS. The Government’s response also emphasised the importance of the values and behaviours of healthcare staff – such as compassion – and how leadership and external structures (including regulators) are essential to creating a culture of compassion in health care.³

The Berwick review of patient safety includes a number of actions that relate to respect for both patients and staff working in the NHS.⁴ There are a


³ Department of Health, Patients First and Foremost – the initial government response to the report of the mid-Staffordshire NHS Foundation Trust public Inquiry, 2013, Secretary of State’s introduction on page 6

⁴ National advisory group on the safety of patients in England, A promise to learn, a commitment to act – improving patient safety in England, 2013
number of references to patient empowerment – and empowerment is closely linked to the human rights principle of autonomy.

There is increasing interest in how positive human values and behaviours, such as compassion, can support the protection and promotion of human rights. This is even if the concept of human rights is not explicitly referred to. For example, the human rights principles of dignity, respect, equality and autonomy are all discussed in the new strategy for nursing, midwifery and care staff, *Compassion in practice*. The Berwick review also emphasises the importance of compassion in both frontline delivery of care and as leadership behaviour – alongside other points made about the importance of culture change on frontline practice.

The 2013 version of the NHS Constitution also includes greater emphasis on values than the previous version. It improves coverage of “dignity, respect and compassion” and “patient involvement”. Involvement is vital in upholding the key human rights principle of autonomy. The NHS Constitution enshrines all the FREDA principles, as it also includes rights to equality and non-discrimination and rights to fairness, for example around complaint and redress. The links between the NHS Constitution and our human rights principles are given in more detail in Appendix 2.

The Department of Health’s response to Winterbourne View specifically mentions human rights. It lists principles for high quality services for people with a learning disability and behaviour that challenges. One of the eight service principles is “Service focus on dignity and human rights”.

Parliamentary debates in 2014 about the possible extension of Human Rights Act 1998 coverage to people who are ‘self-funding’ and receiving adult social care emphasised the importance of our regulatory work in upholding human rights for people receiving adult social care.

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5 Department of Health and NHS England, *Compassion in Practice – Nursing, midwifery and care staff – our vision and strategy*, 2013

6 Department of Health, NHS Constitution, 2013


8 Department of Health, *Transforming Care – a national response to Winterbourne View hospital*, 2012

9 In the House of Lords: [http://www.publications.parliament.uk/pa/ld201314/ldhansrd/text/140507-0001.htm](http://www.publications.parliament.uk/pa/ld201314/ldhansrd/text/140507-0001.htm) and in the House of Commons: [http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm140512/debtext/140512-0001.htm#14051222000013](http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm140512/debtext/140512-0001.htm#14051222000013)
There are also a number of strategies and initiatives around reducing health inequalities following the Marmot review\textsuperscript{10}. These may include the social determinants of health inequality as well as access to healthcare and equity of treatment. While reducing the wider social factors which contribute to health inequality is largely outside the scope of CQC regulation, we have included, where relevant, the role of providers in considering the needs of their populations within the questions about whether services are well-led.

2.2 Relationship with the Human Rights Act 1998

We have not used the Articles listed in the Human Rights Act 1998 for our approach for two reasons.

- A large number of human rights issues in health and social care fall into Article 8 – the right to respect for private and family life, home and correspondence. This is not a very easily understood article. It is broadly defined in law. Therefore it is difficult for inspectors, providers and people who use services to easily grasp the scope and issues contained in Article 8. We are trying to build an approach that is easily understood by people who are not human rights specialists.

- Some human rights issues are relevant to more than one Article, depending on the degree of the breach. For example neglect, which compromises someone’s dignity, may be a breach of Article 8 or (if the neglect is very severe) Article 3, in relation to the prohibition on inhuman or degrading treatment.

However, we are aware of our legal obligations in relation to protecting, respecting and fulfilling people’s rights under the Human Rights Act 1998. CQC is a public authority, so we must act compatibly with the Act. In Appendix 1, a table explains the relationship of our human rights principles to the articles listed in the Human Rights Act. This is based on the Human Rights in Healthcare framework\textsuperscript{11}, with additional articles added based on our equality and human rights guidance for inspectors.\textsuperscript{12} We will publish a new version of this guidance in 2015, to align it with our new approach to regulation and our human rights approach.

We are not inspecting for compliance with the Human Rights Act. We are inspecting to see how providers perform in relation to our five key questions and to check that they do not fall below the fundamental standards (Health

\textsuperscript{10} The Marmot review, Fair Society, Healthy Lives – a strategic review of health inequalities in England post-2010 2011

\textsuperscript{11} British Institute for Human Rights and Department of Health, Human Rights in Healthcare – a framework for local action, 2007

\textsuperscript{12} Care Quality Commission, Equality and human rights in the essential standards of quality and safety: an overview, 2011
and Social Care Act regulations). However, there is human rights ‘content’ in both our key questions and the new fundamental standards. We will be able to address many breaches of human rights through our own powers. In our guidance to providers on meeting the fundamental standards\textsuperscript{13} we have cross-referenced the regulations to the Human Rights Act where applicable.

If we find breaches of the Human Rights Act that we think the Equality and Human Rights Commission (EHRC) have more suitable regulatory powers to address we can use our Memorandum of Understanding with the EHRC. This enables both CQC and the EHRC to share information and refer cases where the other regulator has more suitable regulatory powers.

The one article listed in the Human Rights Act which is not obvious from the FREDA approach is Article 2 – the right to life. We have therefore added the right to life as an additional principle in our approach.

Our FREDA definitions are based on the human rights of people who use services, rather than the rights of others. We need an unambiguous approach to this: another of CQC’s principles is that we put people who use services at the heart of our work.

However, there is much recent research that shows that staff empowerment around behaviour change, and supporting the rights of staff, is vital to develop a human rights approach to healthcare.\textsuperscript{14} Research also shows that the level of race discrimination experienced by staff in NHS trusts is strongly correlated with patient survey scores, as is the level of bullying, harassment or abuse experienced by all staff\textsuperscript{15}.

Staff rights include, for example, rights to speak up about poor care through whistleblowing arrangements as well as rights to be free from violence, harassment, discrimination and abuse. These are rights enshrined in the NHS Constitution.

A human rights approach should always recognise the rights of everyone in a situation – the point of human rights is that they are universal. Indeed, some

\textsuperscript{13} Care Quality Commission, \textit{Guidance for providers on meeting the fundamental standards and on CQC’s enforcement powers}, 2014

\textsuperscript{14} For example, see the Macmillan Human Rights in healthcare project report: http://www.macmillan.org.uk/Documents/AboutUs/WhatWeDo/HumanRightsFrameworkForCancerCareReport.PDF

decisions about human rights, for those rights that are not absolute, rely on balancing the rights of one party with the rights of another – such as rights under Article 8, the right to respect for private and family life, home and correspondence.

This is why it is vital that we consider the rights that staff have, alongside the rights of people who use services.

We have added an additional principle around staff rights and staff empowerment – but have separated this in our approach from the rights of people who use services.

2.3 Definitions of our human rights principles

The following list is our working definitions of each principle, following the consultation on draft definitions.

- **Fairness** – people who use services and people acting on their behalf have access to clear and fair processes for getting their views heard, for decision-making about care and treatment and to raise and resolve concerns or complaints.

- **Respect** – people who use services are valued as individuals and are listened to, and what is important to them is viewed as important by the service. People acting on behalf of others, such as family and friends are also valued and listened to.

- **Equality** – people who use services do not experience discrimination and have their needs met, including on the grounds of age\(^16\), disability, gender, race, religion and belief, sexual orientation, gender reassignment and pregnancy and maternity status.\(^17\) This includes looking at the needs of people who may experience multiple discrimination or disadvantage on more than one ground.

- **Dignity** – people who use services are always treated in a humanitarian way – with compassion and in a way that values them as a human being.

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\(^{16}\) Though protection against age discrimination in services under the Equality Act 2010 only covers adults, we are also committed to ensuring that children and young people have their age-related needs met when using health and social care services.

\(^{17}\) The grounds listed are the protected characteristics under the Equality Act 2010. However, the wording “including on the grounds of” means that we will also look at other factors where there might be discrimination if this is required – such as the groups covered in the Inclusion Health document published by Department of Health in 2010. This includes people who are homeless, people who live in poverty, people who are long-term unemployed, people in stigmatised occupations (such as working in the sex industry), people who misuse drugs, people with limited family or social networks and people who are geographically isolated. We also recognise that not all people falling within Equality Act 2010 protected characteristics will identify with the definition. For example, not all people using mental health services identify as disabled people, so we may sometimes need further explanations of what terms mean.
and supports their self-respect, even if their wishes are not known at the time.\textsuperscript{18}

- \textbf{Autonomy} – people who use services can exercise the maximum amount of choice and control possible – in care planning, in their individual care and treatment, in service development, in their relationships with others such as family and friends and as citizens beyond the health and social care services that they are using.\textsuperscript{19}

- \textbf{Right to life} – people who use services will have their right to life protected and respected by the health and social care services that they use.\textsuperscript{20}

- \textbf{Staff rights and empowerment} – staff working in health and social care have their human rights protected and respected, including being encouraged to freely speak up about concerns and have these considered, being free from unlawful workplace discrimination, harassment, bullying or violence and being supported and empowered to promote the human rights of people using their service.

\textbf{2.4 Relationship with the Equality Act 2010}

CQC as a public sector body has a duty to have due regard to the need to:

- Eliminate discrimination.
- Advance equality of opportunity.
- Foster good relations between groups of people who share a protected characteristic under the Act and those who do not.

In relation to our regulation of health and social care services, this duty applies to all the protected characteristics listed in the definition of our ‘equality principle’ given above.

We will look at key areas for the ‘equality principle’ in relation to all the protected characteristics and in relation to the whole scope of our regulatory functions. How we propose to integrate equality into our assessments of providers is explained in section 3 and shown in Appendix 3. When developing intelligence, methods and learning and development for staff we

\textsuperscript{18} The difference in these definitions between respect and dignity is that carrying out the respect principle relies on gaining and acting on the views of the person, whereas people should be able to be treated with dignity regardless of whether their views are known – for example someone who arrives at A&E in an unconscious state should still be treated with dignity.

\textsuperscript{19} Autonomy covers the concept of ‘personalisation’ of care

\textsuperscript{20} This means that health and social care services will fulfil their obligation to protect the right to life, to refrain from unlawfully interfering with the right to life, and to carry out an effective investigation if a person dies, for example, while in the care of a public authority.
will be mindful of the need to consider situations where people face multiple
discrimination or disadvantage.

The Health and Social Care Act 2008 regulations (2014) set out the grounds
on which we can take legal action when services do not meet fundamental
standards of quality and safety. The regulations more closely align with
requirements under the Equality Act 2010 than the previous regulations we
used.

In particular:

- Regulation 10 – Dignity and respect – requires service providers to [have]
due regard to any relevant protected characteristics (as defined in section
149(7) of the Equality Act 2010) of the service user.

- Regulation 13 – Safeguarding service users from abuse and improper
treatment – states that care or treatment must not be provided in a way
that includes discrimination against a service user on grounds of any
protected characteristic (as defined in section 4 of the Equality Act 2010)
of the service user.

- Regulation 9 – Person centred care – requires providers [to make]
reasonable adjustments to enable the service user to receive their care or
treatment.

- Regulation 19 – Fit and proper persons employed – requires providers to
employ people who are physically and mentally capable, after reasonable
adjustments are made, of properly performing tasks which are intrinsic to
the work for which they are employed.

So, there are many areas relating to equality where we can take regulatory
action. In our guidance for providers on meeting the fundamental standards
we have cross-referenced the regulations to the Equality Act 2010 and the
EHRC statutory guidance to the Act where applicable.

In addition, by integrating equality into our assessment frameworks, we will
look at equality issues when assessing the rating of services for our five key
questions across the spectrum of performance from inadequate to
outstanding. We will use a range of evidence sources to make these
judgements, for example for NHS providers we can draw on information from
the NHS Equality Delivery System (EDS2). We are not proposing a direct
relationship between EDS2 gradings and CQC ratings for any of the key
questions.

It is not in our remit to regulate the compliance of health and social care
providers with the Equality Act 2010. That is the job of the Equality and
Human Rights Commission (EHRC). Where we come across possible
breaches of the Equality Act 2010 that we do not have regulatory powers to
address – such as whether a provider has met the public sector equality
duties – we have a Memorandum of Understanding with the EHRC that
enables both CQC and the EHRC to share information and to refer cases where the other regulator has more suitable regulatory powers.

2.5 Relationship with UN Conventions on human rights

The UK is a signatory to a number of UN conventions on human rights. We aim to ensure that our approach to regulation is compatible with these conventions and furthers the rights of people in line with these conventions. In particular:

The **UN Convention on the Rights of the Child** – includes:

- The right to a childhood (including protection from harm and the right to leisure, play, culture and education).
- The right to be healthy (including access to medical care).
- The right to be treated fairly (including changing laws and practices that are unfair on children as well as discrimination against children e.g. on grounds of ethnicity, gender, religion or disability).
- The right to be heard (including considering children's views).  

All the four rights listed above are implicitly covered by our key lines of enquiry (Appendix 3). We are also ensuring that when we consider age equality, we consider equality for children and young people under the age of 18. In our new approach to regulation whenever we inspect acute hospitals, community health or mental health services that provide specific services for children and young people, we will always inspect those services. We will also look at how good the arrangements are for young people to move from children’s to adults’ services (transition). In our regulation of GP practices and GP out-of-hours services, we will always look at the services provided to mothers, children and young people.

The **UN Convention on the rights of persons with disabilities** – includes rights to:

- Equality and non-discrimination
- Accessibility
- Life
- Freedom from torture or cruel, inhuman or degrading treatment, exploitation, violence or abuse
- Live independently and being included in the community
- Personal mobility

• Freedom of expression and opinion, and access to information
• Respect for privacy, for home and the family
• Equal health services and rehabilitation.\(^\text{22}\)

Equality for disabled people is included in the Equality Act 2010 and incorporated into the fundamental standards. We have also included key lines of enquiry that look at equality for disabled people (Appendix 3). These key lines of enquiry include checking how health and social care services comply with other UK law which protect the human rights of disabled people – such as the Mental Capacity Act and the Mental Health Act.

We have also agreed that we will have a focus on people who may be at higher risk of poor care in our inspection of universal health services – this includes disabled people such as people with a learning disability. As a public sector body, we have a duty to set one or more specific and measurable equality objectives\(^\text{23}\). Our equality objectives lay out our priorities for focusing some development work where we know that there is inequality in universal services.

For many disabled people, adult social care services play a crucial role in whether they can exercise rights included in this convention. The Joint Committee on Human Rights report on the rights of disabled people to independent living (2012) reaffirms the importance of the right to live independently for all disabled people, including those in residential care. In our document A fresh start for the regulation and inspection of adult social care we emphasise the importance of our regulation being based on promoting people’s independence.\(^\text{24}\)

**United Nations Optional Protocol to the Convention against Torture: (OPCAT)**

Countries that sign up to OPCAT establish a system of regular visits in order to prevent the torture or other cruel, inhuman or degrading treatment or punishment of people deprived of their liberty\(^\text{25}\). The Care Quality Commission is part of the UK National Preventative Mechanism for this protocol, in relation to people who have their liberty restricted in services that we regulate. We will be looking at how our new approach to inspection could improve how we fulfil this role in the future.


\(^{23}\) See the Equality Act 2010 (specific duties) regulations 2011


3. Building human rights into assessment frameworks

We are using our human rights principles to develop a list of human rights topics for each of our five key questions. And we are using this topic list to ensure we have coverage of human rights in our key lines of enquiry (KLOES).

Our KLOES define the scope of what we will look at when we regulate health and social care services, how we will make regulatory judgements about services and how we will rate services. These KLOEs are based on our five key questions, but will vary between different types of services. For example, the KLOEs for hospitals are different to those for residential care homes.

In our inspection work, having a set of KLOEs ensures consistency of what we look at under each of the five questions and that we focus on those areas that matter most in the type of service. This is vital for reaching a credible rating. To enable inspection teams to reach a rating, they will gather and record evidence in order to answer each KLOE.

As we want to integrate human rights into our regulatory approach, it is vital that we weave human rights into the KLOEs. To do this, we have:

- Defined a list of human rights topics by applying each of our human rights principles to each of our five key questions. This list of human rights topics is shown in the second column in Appendix 3.
- Checked whether each human rights topic is included in the KLOEs for each service type (see Appendix 3). We will not use the human rights topic list in a ‘tick box’ fashion – we will apply it differently to different service types. However, having the topic list ensures that we consider human rights in a consistent way and embed human rights appropriately into KLOEs.

Our ability to take legal enforcement action is defined by the fundamental standards of care. These are Health and Social Care Act regulations that are set by the Department of Health. We have worked with the Department of Health, using our human rights topics list, to ensure that key human rights

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26 For more information about key lines of enquiry and ratings, see the relevant sector handbooks on our website (www.cqc.org.uk)

27 Full text of the regulations are included in Care Quality Commission, Guidance for providers on meeting the fundamental standards and on CQC’s enforcement powers, 2014
topics are covered in these regulations (see Appendix 3). We are producing more detailed guidance on these regulations.\textsuperscript{28}

This approach will provide consistency in the human rights topics that we consider, while enabling us to tailor the human rights content so that it is appropriate for each sector.

\textsuperscript{28} Care Quality Commission, \textit{Guidance for providers on meeting the fundamental standards and on CQC’s enforcement powers}
4. Applying our human rights approach to our regulation of each sector

Once we have established the relevant human rights topics in the assessment framework for each sector, we need to ensure that registration and inspection teams have the information, methods and skills to make judgements about these topics. There are three main ways that we can support teams to do this – described below.

4.1 Identifying risk to human rights

- Our new approach to regulation uses Intelligent Monitoring to identify where the risks are for people using services – based on data and evidence and information from people.

- For each type of service, we will develop an Intelligent Monitoring system with nationally comparable data, built on a set of indicators that relate to the five key questions. We will use these to determine where the greatest risks of poor care might be, so we can plan our inspection programmes.

- To embed our human rights approach, we need to check these indicators for coverage of our human rights topics – and then look at whether any gaps could be filled by developing particular indicators using existing data sources. One of the challenges is to identify how we monitor risk to human rights and what level of risk triggers action – such as a responsive inspection.

- Developing monitoring is also more challenging in services where there is less data collected. For example there is less centrally collected data for care homes than for large hospitals, whether this is equality monitoring data or surveys of experience which would enable us to look at for example dignity and respect from the perspectives of people who have used services. However, there are opportunities to develop the monitoring indicators on equality and human rights that we use in all sectors through developing the use of existing data.

- We also take account of providers’ compliance with legislation, including the data we collect through monitoring the Mental Health Act (MHA) and Mental Capacity Act. This includes activities completed through inspection but also the separate monitoring we undertake for the MHA and in meeting our role as a National Preventative Mechanism under the United Nations Optional Protocol to the Convention against Torture (OPCAT).
4.2 Inspecting for human rights

Inspection

Our inspection teams need methods and tools that will help them to make judgements about the human rights topics. How we embed human rights into inspection methods will vary by the type of service. We will not take one approach to human rights. We will adapt our methods depending on what human rights topics we are inspecting and the service type. For example, we may inspect how organisations support positive staff behaviours which impact on human rights or we may inspect actions they have taken to protect human rights or their governance around human rights.

The new inspection methods for acute hospitals were tested in two waves between September 2013 and March 2014. We reviewed the overall methodology for Wave 1 to check that we can cover all human rights topics through the range of methods available. This suggested that while it was possible to pick up all the human rights topics with our range of methods, whether this happens in practice will depend on two key factors: the awareness and skills of inspection teams around human rights (see 4.3) and the evidence that comes into inspection teams, from patients, members of the public, staff and others.

To address this second point, we have worked in Wave 2 and beyond 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 prior to a hospital inspection.

We are also developing an approach to the management of local relationships with voluntary and community groups. This includes engaging with local equality groups, which will benefit our knowledge of equality issues in all local health and social care services.

In our pilot inspections of both acute hospitals and mental health services, we have tested some methods and tools that specifically support human rights topics, such as:

- Using the NHS Equality Delivery System and demographic profiles for areas in inspection planning.
- Developing question lists based on our human rights approach for acute inspection focus groups run by voluntary and community services.

We are continuing to look at developing tools and methods for future hospital inspections – such as targeting our ‘case-tracking’ in acute hospitals to groups of people who might be at higher risk of receiving poor care or having their rights breached, for example people with a learning disability.
In adult social care, there have been three ‘waves’ to test our inspection methodology. We have tested a number of methods and tools that look at equality and human rights. For example, we have included specific questions to providers about equality in ‘provider information returns’ which are completed before inspections. We have also developed questionnaires, in a range of formats, for people using home care services and for their families and friends. These questionnaires cover whether people are treated with dignity and respect and whether the service helps them to be as independent as possible. These tools to gather information before an inspection will enable inspectors to follow up issues of concern or of good practice on the inspection – through talking to staff, people who use services, observation or other methods.

We are basing our regulation of GP services by looking at the service through the lens of six population groups. Five of the groups relate to equality groups:

- Older people
- People with long-term conditions
- Families, children and young people
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

The sixth group is working age adults and those recently retired (up to age 74).

Our aim is to provide a rating for GP services for each population group. This approach will lever improvement in equality in health and enable us to protect the human rights of groups of people who may be vulnerable to poor care but are not protected by equality legislation – such as homeless people.

Through the KLOEs we will also be able look at GP services for equality groups not covered by the six population groups, for example Black and minority ethnic people, lesbian, gay and bisexual people and transgender people, though we will not provide a separate rating for how a GP practice meets the needs of these groups.

We will also look at innovative new methods across sectors that help us better understand how the organisations we inspect protect, respect and fulfil people’s human rights.

The end result of an inspection is a judgement on the ratings for a service and also a judgement on whether the service falls below any of the fundamental standards and, if so, what regulatory action is required. Our enforcement policy states that promoting equality and human rights is one of
the key principles for our enforcement work. We need to carry out work to ensure that inspectors have good guidance and advice on the ‘triggers’ for enforcement action relating to failure to meet fundamental standards concerning human rights. This is necessary to provide a consistent and swift response when people using services are at risk of having their human rights breached.

Registration

Our registration teams also need methods and tools to help them to make judgements about the human rights topics.

It is imperative that the human rights and the KLOEs are considered throughout registration because we need to make sure that new providers understand the human rights of the people they will be providing a service to.

We recognise that most evidence needed for making judgements about human rights in the registration of new applicants will come from their descriptions of their intent to consider human rights in meeting people’s needs. For applications to vary a registration, this information will usually come from the experiences of people using services and information we already hold.

We are continuing to look at developing tools and methods for:

- Applications to register
- Assessment
- Interviewing new managers
- Assessment of directorship
- Variations.

We expect that the way we embed human rights into our methods and tools will develop over time. We will evaluate how our methods and tools are working, as our new inspection approaches develop (see section 6).

4.3 Building confidence in human rights: learning and development for registration and inspection teams

The impact of our human rights approach depends on the awareness, knowledge and skills of registration and inspection teams around human rights and their motivation and desire to focus on human rights in their work.

We know that many team members – CQC inspectors, Experts by Experience (people with experience of using services) and external professional experts – are strongly motivated by the power of regulation to promote dignity, respect, equality, fairness and choice and control for people who use services. Many team members have years of practical experience to apply to assessing for equality and human rights. Some have specific
knowledge or skills in particular areas around equality and human rights. We will tap into this motivation and use these skills to build up confidence in human rights in our inspections.

From September 2014 to March 2016 we are working with the Equality and Human Rights Commission to deliver a major learning and development programme for our staff and associates, such as Experts by Experience. This programme, funded by the Department for Media, Culture and Sport will deliver:

1. **Mandatory introductory level training on equality and human rights principles**, delivered through the CQC Academy (which provides training and development for our staff). This will enable CQC staff and others on inspection teams to reflect on equality and human rights, e.g. through looking at ‘unconscious bias’ and provide an overview of the practical application of equality and human rights when inspecting services.

2. **Bespoke external advice on future CQC Academy curriculum development to embed equality and human rights in existing learning and development programmes for inspection and registration teams**. This will cover equality and human rights topics in the inspection of particular services, skills required to gather evidence and make judgements about these equality and human rights related topics and the relationship of CQC regulation to other equality and human rights law.

3. **Role-specific learning for CQC staff responsible for regulatory policy and methodology design**

4. **Higher level training for equality and human rights team leads** to enable equality and human rights expertise to be developed throughout CQC.

5. **An online equality and human rights learning resource**, as part of the CQC Academy resource library, which will provide regularly updated information and sharing of good practice for CQC staff such as inspectors and others on inspection teams.

The programme is based on six features:

- **Knowing where we need to target learning and making learning role specific**: In a recent ‘skills survey’ of frontline staff, we asked staff about their confidence in applying equality and human rights in their role. Alongside general broader learning about applying human rights, we will use these results to target learning activities for specific groups of staff to help them in their work.
• **Peer learning approaches to human rights:** We will draw on the existing knowledge, skills and experience of CQC staff and others in inspection teams. We have already used this approach to learning through sharing case studies from inspectors on how they promoted human rights on inspection. And we have supported team managers to share how they have facilitated their teams to understand how to apply equality and human rights.

• **Providing individual development opportunities:** CQC’s new Academy supports staff across CQC to build their skills and expertise. We will build learning about human rights into the Academy programme, including advanced learning for staff who lead on equality and human rights in their department or team.

• **Sharing key elements of the human rights approach in a timely way:** An incremental approach to build shared understanding. For example, we have developed human rights presentations, available for all staff piloting new inspections.

• **Setting the human rights approach in a wider context of culture change at CQC:** Research shows that staff are better motivated to think about equality and human rights for others if they feel that they have their own equality and human rights respected. So we need to look at equality and human rights for CQC staff in the same way as we look at the rights of staff in the services we inspect. We need to change CQC’s culture, for example, in our human resources functions and how we behave towards each other. Our internal culture change work is beyond the scope of the human rights approach to regulation and our joint work with the Equality and Human Rights Commission, but will include our new Equality Objectives and new learning for CQC line managers around unconscious bias and ensuring equality in staff management and support.

• **Evaluation of all learning interventions** – built in from the start of the programme so that we can improve the programme as it develops.

### 4.4 Communicating our approach to human rights

A number of people responding to the consultation on our draft human rights approach raised the importance of how we communicate our approach to providers of health and social care services, to people who use services and to the public. While this was not in our draft approach, the consultation responses have prompted us to add communicating our human rights approach as a fourth element of developing the approach for each type of service.

We can see that communicating our approach to human rights to providers will both encourage providers to consider how they can promote human
rights and will provide clarity around our role, as the regulator, in ensuring that people’s human rights are protected, respected and fulfilled.

Communicating our approach to human rights to people who use services, to service providers and the public will help people to understand their rights and responsibilities – and will help us gather relevant information about service performance in relation to human rights.

We will work on a communication plan for our human rights approach from October 2014.

Some work in communicating our approach to equality and human rights and associated work programmes will be part of work we do with other national bodies – for example, with the Equality and Human Rights Commission or the NHS Equality and Diversity Council.
5. Principles for applying our human rights approach

All the elements of our human rights approach described so far support our principles for applying the approach. These principles are:

- **Putting people who use services at the heart of our work** – taking an approach based on the rights of people using them – rather than what services ‘should do’. This helps us to put people who use services at the centre of our regulatory work and leads to our work on intelligence, methods and learning and development having a strong focus on the views of people using services. Beyond this, we also will engage with people who use services in developing our human rights approach – for example through consultation or advice – and in delivering our human rights approach – for example through our Experts by Experience programme. Our leaning and development plans include learning for Experts by Experience.

- **Embedding human rights into our regulatory approach** – as described in section 4, we will do this through defining human rights key topics and ensuring these are in our assessment frameworks, followed by building human rights into monitoring system, methods and tools.

- **Ensuring staff who are not human rights specialists can use the human rights approach** – through using a set of human rights principles rather than the more technical articles of the Human Rights Act 1998 as our basis for the approach, and then supporting inspection teams to apply the human rights approach as described in section 4. In our new regulatory model, we are using a wider range of people on inspections – including more professional experts and Experts by Experience. We need to ensure that our human rights approach works for these members of inspection teams as well as our full-time inspectors.

- **Providing tailored advice and support, if required from human rights specialists within CQC** – there will be times when inspection teams need more support around how to apply the human rights approach, for example:
  - When we are introducing new methods or tools with a specific human rights focus.
  - When we are testing the approach in a new sector.
  - Where staff want advice on how to follow up a specific risk to equality or human rights that has become apparent through information into CQC.
  - Where the concerns about poor care found on inspection relate directly to the Equality Act 2010 or Human Rights Act 1998.
The central Equality and Human Rights team will continue to provide specialist support to inspection teams in these circumstances. For example, in Wave 1 and 2 of the acute and mental health hospital inspections, the team has offered tailored advice to each inspection team at the inspection planning stage. The central team is also able to request specialist advice from the Equality and Human Rights Commission (EHRC), as part of our Memorandum of Understanding with the EHRC.

We also plan to use the results of the CQC staff skills survey, which enables staff to list any specialisms that they have. We aim to draw better on the specific knowledge, skills and expertise in equality and human rights in our inspection workforce.
6. Continuous improvement and national reporting

CQC is going through significant change. We recognise that, even once we are through the initial changes for each sector, we will need to refine and improve the way that we apply our human rights approach in practice.

This will mean we will need, over time, to develop our monitoring of human rights, our methods and tools and how we build the skills and confidence of inspection teams to tackle human rights issues.

We are committed to evaluating our human rights approach at all stages of its development. For example, we have evaluated the impact of the human rights approach in pilot hospital and adult social care inspections, through talking to inspection teams and analysing human rights issues that appear in the published inspection reports.

We will base our evaluation of our human rights approach on the outcomes for people using services – we need to answer the question: How has our approach to human rights in practice contributed to ensuring that people receive care that is safe, effective, compassionate and high-quality? We will also want to know what is working well and what needs improvement.

We will look at three aspects when we are evaluating success of the approach:

- Analysis of inspection reports and outcomes
- Feedback from providers on whether inspection has helped organisational improvement around human rights
- How has our approach to human rights in practice contributed to ensuring that people receive care that is safe, effective, compassionate and high-quality?
- Feedback from people who use services, their family and friends
The central EDHR team will work with the evaluation team to develop a plan for how we evaluate the success of our Human Rights Approach, using these three sources of evidence and following good practice developed by the evaluation team, such as use of ‘logic models’. Where possible we will integrate evaluation of the human rights approach into existing evaluation and quality assurance work in order to maximise efficiency and minimise duplication – for example incorporating questions about human rights into planned surveys of providers or people who use services.

Our evaluation of our success in promoting human rights may identify human rights topics where regulation is more challenging – for these topics we can consider using ‘thematic’ approaches to look in more depth at the topic. Our programme of thematic data reviews and thematic inspections focuses on specific topics. This can lead to both improvement in health and social care services in relation to the particular topic, and in development of our ongoing approach to regulation. If the topic relates to equality we could develop an equality objective to provide a plan for a specific, measurable improvement in how we regulate for equality.

We want our human rights approach not only to improve our regulation of each provider, but to enable us to comment on equality and human rights in the health and social sectors, as a further lever for improvement. This will help us to fulfil our principle of promoting equality and human rights. For example, we want to be able to provide informed analysis of equality and human rights issues in our State of Care report.

We will also be looking at how the opportunities provided by our new approach can improve our responsibilities under existing legislation. This includes our role as a National Preventative Mechanism under the United Nations Optional Protocol to the Convention against Torture (OPCAT), and our duties under the Mental Health Act 1983 and Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards. We see this as being an integral part of our delivery of our human rights approach. It enables us to provide evidence-based and authoritative analysis of equality and human rights matters.

We need to ensure that we apply the other CQC principles to our continuous improvement work, so we will:

- **Put people who use services at the heart of our work** – see section 5.
- **Have an open and accessible culture** – by ensuring that we gather feedback from CQC staff, providers, people who use services and others on how well we regulate for human rights and using this to develop our approach. For example, we have incorporated feedback on the Equality and Human rights Impact Assessment for the New Start consultation into our human rights approach.
• **Be independent, rigorous, fair and consistent** – we will have various opportunities to test new monitoring indicators, methods and tools to support our human rights approach and will not apply them until we are sure that they are robust. For example we can use thematic work to test new methods before incorporating them into our mainstream methodology.

• **Work in partnership across the health and social care system** – we work regularly with colleagues in other organisations so that we can work in partnership to address equality and human rights issues, for example through the Inspectors and Ombudsman’s Equality Forum, the NHS Equality and Diversity Council and the Department of Health Equality Act 2010 Implementation Group. We have a memorandum of understanding with the Equality and Human Rights Commission that enables us to work towards making the best use of our respective regulatory powers in relation to equality and human rights in the health and social care sector. We are also working with partners on specific projects. For example, we have worked with Macmillan Cancer Care on looking at how their ‘values-based approach’ could be used on inspections.
## Appendix 1

### Main relationships of our human rights principles to European Convention on Human Rights Articles (as incorporated into the Human Rights Act 1998) and the Equality Act 2010

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Relevant Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fairness</strong></td>
<td>• Article 6 – right to a fair trial (includes a range of processes for fairness beyond a legal trial)</td>
</tr>
<tr>
<td><strong>Respect</strong></td>
<td>• Article 8 – right to respect for family and private life, home and correspondence</td>
</tr>
<tr>
<td></td>
<td>• Article 9 – right to freedom of thought, conscience and religion</td>
</tr>
<tr>
<td></td>
<td>• Article 1 of Protocol 1 – right to peaceful enjoyment of possessions</td>
</tr>
<tr>
<td><strong>Equality</strong></td>
<td>• Article 14 – right not to be discriminated against in relation to other rights contained in the European Convention</td>
</tr>
<tr>
<td></td>
<td>• Note that we are also using this principle to cover CQC statutory duties under the Equality Act 2010 to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between people</td>
</tr>
<tr>
<td><strong>Dignity</strong></td>
<td>• Article 8 – right to respect for family and private life, home and correspondence</td>
</tr>
<tr>
<td></td>
<td>• Article 3 – right not to be tortured or treated in an inhuman or degrading way</td>
</tr>
<tr>
<td><strong>Autonomy</strong></td>
<td>• Article 8 – right to respect for family and private life, home and correspondence</td>
</tr>
<tr>
<td><strong>Right to life</strong></td>
<td>• Article 5 – the right to liberty</td>
</tr>
<tr>
<td><strong>Human rights for staff/ staff empowerment around human rights</strong></td>
<td>• All articles as they apply to staff or to empowerment of staff to act to protect the human rights of people who use services</td>
</tr>
</tbody>
</table>
## Appendix 2

### Main relationships of our human rights principles to the NHS Constitution

The NHS Constitution 2013 is divided into principles, values, rights and responsibilities. Below we show how the NHS Constitution relates to our human rights principles:

<table>
<thead>
<tr>
<th>Human rights principle</th>
<th>NHS Constitution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairness</td>
<td>Right: to information about risks and benefits of treatment</td>
</tr>
<tr>
<td></td>
<td>Right: access to your information and records, privacy and confidentiality</td>
</tr>
<tr>
<td></td>
<td>Right: to complain and have your complaint investigated and responded to</td>
</tr>
<tr>
<td>Respect</td>
<td>Principle: patients at the heart of everything the NHS does</td>
</tr>
<tr>
<td></td>
<td>Value: respect</td>
</tr>
<tr>
<td></td>
<td>Right: to be involved in own care</td>
</tr>
<tr>
<td>Equality</td>
<td>Principle: the NHS provides a comprehensive service, available to all</td>
</tr>
<tr>
<td></td>
<td>Value: everyone counts</td>
</tr>
<tr>
<td></td>
<td>Right: to access free from discrimination</td>
</tr>
<tr>
<td>Dignity</td>
<td>Values: dignity, compassion</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Principle: patients as partners</td>
</tr>
<tr>
<td></td>
<td>Value: working together for patients</td>
</tr>
<tr>
<td></td>
<td>Right: to accept or refuse treatment</td>
</tr>
<tr>
<td></td>
<td>Right: informed choice e.g. GP practice, doctor, commissioned services, information in appropriate formats</td>
</tr>
<tr>
<td>Right to life</td>
<td>Right: Professional standard of care</td>
</tr>
<tr>
<td>Staff rights/empowerment</td>
<td>Right: to be treated with fairness in the workplace and to be supported to raise concerns</td>
</tr>
<tr>
<td></td>
<td>Right: to be treated equally and to be free from discrimination, harassment, bullying and violence</td>
</tr>
</tbody>
</table>
Appendix 3

Human rights topics for our five key questions and their coverage in fundamental standards and key lines of enquiry, prompts and rating descriptors for a ‘good’ service for all service types covered by draft provider handbooks released in April 2014

Note the following code is used:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅✅</td>
<td>Human rights topic is included explicitly</td>
</tr>
<tr>
<td>✅</td>
<td>Human rights topic is implicitly included (e.g. descriptor or prompt may be broader than specific human rights key topic, but include the key topic)</td>
</tr>
<tr>
<td>X</td>
<td>Human rights topic is not included</td>
</tr>
</tbody>
</table>

There are some human rights topics which could be placed in a number of categories – for example the correct use of the Mental Capacity Act to gain consent where someone lacks mental capacity could be an issue of fairness, of respect, of equality – and could be related to whether the service is effective, caring or responsive.

We have not repeated a topic within each of the five questions. In addition, there has been work on the KLOEs to ensure that there is no unnecessary repetition of topics between the key questions. We have used this work as a guideline for the human rights topics list.

The regulations relate to fundamental standards. Some human rights topics are outside the scope of these standards – for example many of the topics in the ‘well-led’ key question.

Similarly, our aim is not that every human rights topic is included explicitly in lines of enquiry for each service type – i.e. not every topic should be coded green in the tables below. It may be that some topics are not relevant for particular service types – in which case the topic may be red.

Some topics may not be central to upholding the human rights for people using that service type. In this case they may be implicitly included in lines of enquiry but not explicitly.

There are some topics that may appear in different key questions for some service types – these have been coded green with the key question indicated in brackets.

We have based our analysis on key lines of enquiry and descriptors of what a good service looks like. Some topics, in certain service types, may be a better indicator of another rating – for example they may be an indicator of an outstanding service or an inadequate service. Where topics are covered by descriptors of ratings other than ‘good’, this is also indicated in the tables.
Is the service safe?
By safe, we mean that people are protected from abuse and avoidable harm

**Summary of human rights topics for safety:**
- Safeguarding protects human rights through dealing with abuse that impacts on equality and human rights, involving people using the service appropriately, balancing risk and autonomy and applying Deprivation of Liberty safeguards
- Participation and feedback from people who use services in safety issues
- Avoidable harm and restrictive practice that impacts on human rights

<table>
<thead>
<tr>
<th>Human rights principle</th>
<th>Human rights topics</th>
<th>Coverage in Fundamental standards (draft regulations)</th>
<th>Coverage in hospital mental health and community health sector lines of enquiry</th>
<th>Coverage in adult social care lines of enquiry</th>
<th>Coverage in NHS GP and GP out-of-hours services lines of enquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairness</td>
<td>Involvement of people using the service/ their carers in own safeguarding or risk assessments</td>
<td>✔ ✔</td>
<td>✔ ✔</td>
<td>✔ ✔</td>
<td>✔ ✔</td>
</tr>
<tr>
<td></td>
<td>Correct use of Deprivation of Liberty safeguards</td>
<td>✔ ✔</td>
<td>✔ ✔ (in effective)</td>
<td>✔ ✔ (in effective)</td>
<td>✔ ✔ (in effective)</td>
</tr>
<tr>
<td></td>
<td>Encouragement for people using services to raise safety concerns</td>
<td>✔ ✔</td>
<td>✔ ✔</td>
<td>✔ ✔</td>
<td>✔ ✔</td>
</tr>
<tr>
<td>Respect</td>
<td>Assessment of levels of harm include experience of people using services and carers</td>
<td>✔ ✔</td>
<td>✔ ✔</td>
<td>✔ ✔</td>
<td>✔ ✔</td>
</tr>
</tbody>
</table>

29 Note the guidance on the regulations is not arranged by the five key questions – it is arranged by regulations. The indication gives whether there is topic coverage in the guidance overall.
<table>
<thead>
<tr>
<th></th>
<th>Dealing with discriminatory abuse</th>
<th>Dealing with abuse that impacts on dignity (e.g. neglect)</th>
<th>Environmental safety and service safety factors which impact on dignity (e.g. cleanliness)</th>
<th>Empowerment around abuse</th>
<th>Restrictive practices, including restraint, are minimised through use of person-centred approaches</th>
<th>Avoidable death through harm</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equality</strong></td>
<td>![X] (in caring)</td>
<td><img src="https://example.com/True.png" alt="✓" /> (in caring)</td>
<td><img src="https://example.com/True.png" alt="✓" /> (in effective)</td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td><img src="https://example.com/True.png" alt="✓" /> (in effective)</td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
</tr>
<tr>
<td><strong>Dignity</strong></td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td><img src="https://example.com/True.png" alt="✓" /> (in effective)</td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td></td>
</tr>
<tr>
<td><strong>Autonomy</strong></td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
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<td><img src="https://example.com/True.png" alt="✓" /></td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td><img src="https://example.com/True.png" alt="✓" /> (in effective)</td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td></td>
</tr>
<tr>
<td><strong>Right to life</strong></td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td><img src="https://example.com/True.png" alt="✓" /> (in effective)</td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td></td>
</tr>
<tr>
<td><strong>Staff rights/empowerment</strong></td>
<td>None</td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td><img src="https://example.com/True.png" alt="✓" /> (in effective)</td>
<td><img src="https://example.com/True.png" alt="✓" /></td>
<td></td>
</tr>
</tbody>
</table>
**Is the service effective?**
By effective, we mean that people’s care and treatment achieves good outcomes, promotes a good quality of life and is evidence-based where possible.

**Summary of human rights topics for effectiveness:**
- Informed consent including use of Mental Capacity Act and reasonable adjustments – to ensure fairness and respect
- Equality and human rights aspects of care and treatment decisions by professionals
- Factors in effective delivery of care and treatment which contribute to dignity and autonomy

<table>
<thead>
<tr>
<th>Human rights principle</th>
<th>Human rights topics</th>
<th>Coverage in Fundamental standards (draft regulations)</th>
<th>Coverage in hospital mental health and community health sector lines of enquiry</th>
<th>Coverage in adult social care lines of enquiry</th>
<th>Coverage in NHS GP and GP out-of-hours services lines of enquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairness</td>
<td>Consent processes, including Mental Capacity Act</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
</tr>
<tr>
<td></td>
<td>Provision of information and support to help people make decisions about care and treatment</td>
<td>✓✓</td>
<td>✓✓ (in caring)</td>
<td>✓✓</td>
<td>✓✓ (in caring)</td>
</tr>
</tbody>
</table>

^Note the guidance on the regulations is not arranged by the five key questions – it is arranged by regulations. The indication gives whether there is topic coverage in the guidance overall.
<table>
<thead>
<tr>
<th>People’s rights are protected through practice which complies with the Mental Health Act 1983</th>
<th>X</th>
<th>✓ ✓</th>
<th>X</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Respect</strong></td>
<td>Involvement in care and treatment in practice</td>
<td>✓ ✓</td>
<td>✓ ✓</td>
<td>✓ ✓ (in caring)</td>
</tr>
<tr>
<td><strong>Equality</strong></td>
<td>Unlawful discrimination in care and treatment decisions</td>
<td>✓ ✓</td>
<td>✓ ✓</td>
<td>✓ ✓ (in safe)</td>
</tr>
<tr>
<td>Reasonable adjustments to consent processes</td>
<td>✓ ✓</td>
<td>✓ ✓ (in responsive)</td>
<td>✓ ✓ (in responsive)</td>
<td>✓ (in effective)</td>
</tr>
<tr>
<td><strong>Dignity</strong></td>
<td>Environmental and service factors which impact on dignity for all – nutrition and hydration, pain management</td>
<td>✓ (all except pain management are specifically covered, pain management is implicitly covered)</td>
<td>✓ ✓</td>
<td>✓ ✓</td>
</tr>
<tr>
<td><strong>Autonomy</strong></td>
<td>Maximising personal control over delivery of care and treatment (e.g. self-medication)</td>
<td>✓ ✓</td>
<td>✓ ✓ (in caring)</td>
<td>✓ ✓</td>
</tr>
<tr>
<td>Right to life</td>
<td>Care and treatment decisions which may affect right to life – e.g. Do Not Attempt Resuscitation and withdrawal of treatment or nutrition/hydration</td>
<td>✓ Nutrition and hydration to sustain life explicitly covered, other decisions implicit</td>
<td>✓ (in effective)</td>
<td>X</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>---</td>
</tr>
<tr>
<td>Staff rights/empowerment</td>
<td>None</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Is the service caring?
By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of human rights topics for ‘caring’:
- Impact of the actions and behaviours of individual staff / staff teams on fairness, dignity, respect, equality, autonomy and the right to life for people using their service

<table>
<thead>
<tr>
<th>Human rights principle</th>
<th>Human rights topics</th>
<th>Coverage in Fundamental standards (draft regulations) 31</th>
<th>Coverage in hospital mental health and community health sector lines of enquiry</th>
<th>Coverage in adult social care lines of enquiry</th>
<th>Coverage in NHS GP and GP out-of-hours services lines of enquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairness</td>
<td></td>
<td>□□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□</td>
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</tr>
<tr>
<td></td>
<td>Staff ensure access to advocacy</td>
<td>□□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□</td>
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<td>□□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□</td>
</tr>
<tr>
<td></td>
<td>Staff ensure confidentiality of personal information</td>
<td>□□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□</td>
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<tr>
<td></td>
<td>Duty of candour (honesty sharing bad news when things have gone wrong)</td>
<td>□□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□</td>
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<td>□□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□</td>
</tr>
<tr>
<td></td>
<td>Staff gather and use the views of people using the service for service improvement</td>
<td>□□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□</td>
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<td>□□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□ □□</td>
</tr>
</tbody>
</table>

31 Note the guidance on the regulations is not arranged by the five key questions – it is arranged by regulations. The indication gives whether there is topic coverage in the guidance overall.
<p>| <strong>Respect</strong> | Staff involve people using the service and carers as partners in care | ✓✓ | ✓✓ | ✓ | ✓✓ |
| Staff build relationships of trust through openness and honesty in communication with people using the service and their carers | X (other than duty of candour) | ✓✓ | ✓✓ | ✓ | ✓✓ |
| <strong>Equality</strong> | Individual staff avoid discrimination | ✓✓ | ✓✓ | ✓✓ (in safe) | ✓✓ (and in responsive) |
| Staff respond to diverse needs (e.g. for community contact and relationships, communication needs, culture) | ✓✓ | ✓✓ | ✓✓ | ✓✓ |
| Staff involve people using the service who lack capacity/their representatives in their own care | ✓✓ | ✓✓ (in effective) | ✓✓ (in effective) | ✓✓ (in effective) |</p>
<table>
<thead>
<tr>
<th>Dignity</th>
<th>Staff provide consistently compassionate care</th>
<th>✓✓</th>
<th>✓✓</th>
<th>✓✓</th>
<th>✓✓</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff meeting needs relating to pain relief</td>
<td>X</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Staff meeting needs relating to eating, drinking</td>
<td>✓✓</td>
<td>✓✓ (in effective)</td>
<td>✓✓ (in effective)</td>
<td>X (not relevant in GP)</td>
</tr>
<tr>
<td></td>
<td>Staff meeting needs relating to going to the toilet</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓</td>
<td>X (not relevant in GP)</td>
</tr>
<tr>
<td></td>
<td>Staff meeting needs relating to privacy</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
<td>✓✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Autonomy</th>
<th>Staff work with people to maximise their independence</th>
<th>✓✓</th>
<th>✓✓</th>
<th>✓✓</th>
<th>✓✓ (in responsive)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Support for people who use services to maintain friendships and relationships that are important to them</td>
<td>X</td>
<td>✓✓</td>
<td>✓✓ (in responsive)</td>
<td>X (not relevant in GP)</td>
</tr>
<tr>
<td></td>
<td>Staff minimise restrictive practices</td>
<td>✓</td>
<td>✓✓ (in effective)</td>
<td>✓✓ (in safe and effective)</td>
<td>✓✓ (in effective)</td>
</tr>
<tr>
<td></td>
<td>Staff use good practice in restraint</td>
<td>✓✓</td>
<td>✓✓ (in effective)</td>
<td>✓✓ (in safe and effective)</td>
<td>✓✓</td>
</tr>
</tbody>
</table>
### Right to life

Avoidable death through neglect – where this is the due to the actions of individual staff rather than service factors

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>✓ (in safe)</td>
<td>✓ (in safe)</td>
<td>✓ (in safe)</td>
</tr>
</tbody>
</table>

### Staff rights/empowerment

None
**Is the service responsive?**

By responsive, we mean that services are organised so that they meet people’s needs.

**Summary of human rights topics for responsiveness:**

- Planning and organisation of services to deliver appropriate care for people in all equality groups and for others who may receive not receive the same quality care unless their needs are specifically considered
- Ensuring people’s human rights are upheld when their needs change
- Service organisation and arrangements which respond to human rights issues for individuals beyond care delivery – such as responding to complaints and maximising people’s independence and citizenship

<table>
<thead>
<tr>
<th>Human rights principle</th>
<th>Human rights topics</th>
<th>Coverage in Fundamental standards (draft regulations)</th>
<th>Coverage in hospital mental health and community health sector lines of enquiry</th>
<th>Coverage in adult social care lines of enquiry</th>
<th>Coverage in NHS GP and GP out-of-hours services lines of enquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairness</td>
<td>Complaints process and effective action on individual complaints</td>
<td>✔️ ✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>People using the service are involved in decision-making when there are major changes to their care (e.g. discharge from a health service)</td>
<td>✔️</td>
<td>✔️ (in effective and caring)</td>
<td>✔️</td>
<td>✔️ (in effective)</td>
</tr>
</tbody>
</table>

---

32 Note the guidance on the regulations is not arranged by the five key questions – it is arranged by regulations. The indication gives whether there is topic coverage in the guidance overall
### Human rights approach for our regulation of health and social care services

<table>
<thead>
<tr>
<th><strong>Respect</strong></th>
<th>People are listened to and their needs and wishes are at the centre of their care and treatment</th>
<th>✓ ✓</th>
<th>✓ ✓ (in caring)</th>
<th>✓</th>
<th>✓ (also in caring)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equality</strong></td>
<td>Due regard to equality groups when planning services</td>
<td>✗</td>
<td>✓</td>
<td>✓ (in effective)</td>
<td>✓</td>
</tr>
<tr>
<td>Addressing barriers in service access</td>
<td>✓ ✓</td>
<td>✓ ✓</td>
<td>✓ (in well-led)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Assessing patients’ cultural, ethical and spiritual needs.</td>
<td>✓ ✓ (though ethical could be added)</td>
<td>✓ ✓ (in caring)</td>
<td>✓</td>
<td>✓ (in caring)</td>
<td></td>
</tr>
<tr>
<td>Care is appropriate to patients in relation to age, disability, gender, race, religion, sexual orientation, gender reassignment including reasonable adjustments, environmental accessibility, support services (e.g. interpreting, catering, spiritual support)</td>
<td>✓ ✓</td>
<td>✓ ✓</td>
<td>✓ ✓</td>
<td>✓ ✓</td>
<td></td>
</tr>
<tr>
<td>Reasonable adjustments are made for disabled people using the service, in line with legal requirements</td>
<td>✓ ✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>The service has an appropriate focus on finding out and meeting the needs and wishes of people with a learning disability or those lacking capacity</td>
<td>✓ ✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Availability of single sex accommodation/choice of gender for person providing care and treatment where required</td>
<td>✓</td>
<td>✓ (same sex accom)</td>
<td>✓ (choice of gender of person providing care)</td>
<td>✓ (gender of person providing care)</td>
<td></td>
</tr>
<tr>
<td>Dignity</td>
<td>Services work together to respond to changing needs of individuals where this has an impact on dignity</td>
<td>✓ ✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>When people move between services or leave services, these arrangements support dignity</td>
<td>✓ ✓</td>
<td>✓ (in effective)</td>
<td>✓ (in caring)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Autonomy</strong></td>
<td>Service arrangements support independence for individual people</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autonomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service arrangements support independence for individual people</td>
<td>✔️ ✔️</td>
<td>✔️</td>
<td>✔️ (in caring and responsive)</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Services support people who use services to be active citizens in the community</td>
<td>✔️</td>
<td>✔️ (in caring)</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td><strong>Right to life</strong></td>
<td>none</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Staff rights/empowerment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Is the service well-led?**
By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

**Summary of human rights topics for well-led:**
- Embedding equality and human rights into organisational culture and strategy
- Leadership oversight and modelling of equality and human rights
- Participation of people who use services and frontline staff in service and organisational development and change
- Upholding equality and human rights for staff

<table>
<thead>
<tr>
<th>Human rights principle</th>
<th>Human rights topics</th>
<th>Coverage in Fundamental standards (draft regulations)</th>
<th>Coverage in hospital mental health and community health sector lines of enquiry</th>
<th>Coverage in adult social care lines of enquiry</th>
<th>Coverage in NHS GP and GP out-of-hours services lines of enquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairness</td>
<td>Leadership oversight of the involvement of people who use services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Organisation vision and values include key human rights</td>
<td>X</td>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Involvement of people using the service and their carers in shaping vision, values, culture and strategies</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Note the guidance on the regulations is not arranged by the five key questions – it is arranged by regulations. The indication gives whether there is topic coverage in the guidance overall.
<table>
<thead>
<tr>
<th>Human rights approach for our regulation of health and social care services</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Involvement of people using the service and carers in service design and improvement</th>
<th>( \times ) (seeking and acting on feedback in regulations but not wider involvement)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oversight that people’s rights are protected through Mental Health Act responsibilities</td>
<td>( \times ) ( \checkmark ) ( \times ) ( \times )</td>
</tr>
<tr>
<td><strong>Respect</strong></td>
<td></td>
</tr>
<tr>
<td>Leadership modelling of respect</td>
<td>( \times ) ( \checkmark ) ( \checkmark ) ( \checkmark ) ( \checkmark )</td>
</tr>
<tr>
<td>The views of people using the service make a difference to the way that services are delivered</td>
<td>( \checkmark ) ( \checkmark ) ( \checkmark ) ( \checkmark ) ( \checkmark )</td>
</tr>
<tr>
<td><strong>Equality</strong></td>
<td></td>
</tr>
<tr>
<td>Leadership modelling and oversight of equality</td>
<td>( \times ) ( \checkmark ) ( \checkmark ) ( \checkmark ) ( \checkmark ) (in responsive)</td>
</tr>
<tr>
<td>Organisational values and culture development around equality and diversity</td>
<td>( \times ) ( \times ) ( \checkmark ) ( \checkmark ) ( \checkmark ) (in responsive)</td>
</tr>
<tr>
<td><strong>Dignity</strong></td>
<td></td>
</tr>
<tr>
<td>Leadership modelling and oversight of dignity and compassion</td>
<td>( \times ) ( \checkmark ) ( \checkmark ) ( \checkmark ) ( \checkmark )</td>
</tr>
<tr>
<td>Org. values and culture development around dignity and compassion</td>
<td>Organisational values and culture development around dignity and compassion</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td><strong>Autonomy</strong></td>
<td>Leadership oversight of choice and control and restrictive practices</td>
</tr>
<tr>
<td>Service shifts towards control by people who use services</td>
<td>Service shifts towards control by people who use services</td>
</tr>
<tr>
<td><strong>Right to life</strong></td>
<td>Leadership oversight of avoidable deaths and decisions not to provide treatment</td>
</tr>
<tr>
<td><strong>Staff rights/empowerment</strong></td>
<td>Views of frontline staff on safety and effectiveness make a difference</td>
</tr>
<tr>
<td></td>
<td>Views of frontline staff on how caring and responsive a service is make a difference</td>
</tr>
<tr>
<td></td>
<td>Staff have opportunities for reflective practice on key human rights issues such as balancing risk and autonomy, human rights in care and treatment decisions, compassion in care, service responsiveness to individual needs</td>
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<tr>
<td></td>
<td>Work to enable staff to stay connected to their vocation</td>
</tr>
<tr>
<td></td>
<td>Oversight of staff safety including bullying and harassment</td>
</tr>
<tr>
<td></td>
<td>Compassion towards staff including staff well-being initiatives</td>
</tr>
<tr>
<td></td>
<td>Work to ensure equality for staff</td>
</tr>
<tr>
<td></td>
<td>Leadership response to frontline views</td>
</tr>
<tr>
<td></td>
<td>Empowerment of staff to provide flexible, person-centred services which uphold people’s rights</td>
</tr>
</tbody>
</table>
Contact us

Call us on:
03000 616161

Email us at:
enquiries@cqc.org.uk

Look at our website:
www.cqc.org.uk

Write to us at:
CQC National Customer Service Centre
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Please contact us if you would like a summary of this report in another language or format.