

## Equally outstanding

### Equality and human rights – good practice resource

How can a focus on equality and human rights improve the quality of care in times of financial constraint?



# Foreword

One of CQC’s aims is to encourage improvement in health and social care services. To achieve this we are working with a wide range of partners to understand and develop best practice among providers. This publication is a part of that process. It demonstrates how those services that have the improvement of equality and the recognition of human rights at their core, provide better services for the public.

Most of our inspection reports give the service a rating – the best being outstanding. Here we demonstrate that some of those outstanding services have also developed practices that deliver equality and safeguard human rights for both the public and staff. This demonstrates that it is wrong to see a focus on equality as, in some way, a distraction. Improving the rights of people is a mainstream part of the delivery of health and social care.

Increasingly, CQC recognises that we are limited in what we can achieve on our own. Therefore, while we have been responsible for organising this publication, we have developed and published it with others. Given that we want the document to be used, rather than just read, we felt that the wider the set of partnerships that helped to develop it, the wider the audience might be that would use it.

We also recognised that we needed help to gather wider evidence from other organisations that either had deeper experience of equality and human rights, or represented providers.

This is not a linear document with a beginning, a middle and an end but is a resource that invites different readers to construct their own path through its material. We have published the case studies online so that they can be easily searched and linked to our assessment framework.

We have also decided to publish it as a ‘beta’ version, which will allow us to rework the links and other material after six months when we will have a better idea about how it has actually been used and how we can improve it.

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Takes you to each section

# Introduction

Welcome to this good practice resource. In times of financial constraint, we often see equality and human rights as a challenge. We rarely look at equality and human rights as a solution.

Yet, there is growing evidence that equality and human rights for people using services and staff needs to play a central role in improving the quality of care. And we are finding that some of the best providers are doing this successfully – even in times of constraint.

CQC rates health and social care providers into 4 categories – inadequate, requires improvement, good and outstanding. We call this resource “Equally Outstanding” in recognition that many outstanding providers are using equality and human rights approaches to drive improvement in care. If other providers have an ambition to be outstanding also, they can learn much from these providers – as we have done too, in developing this project.

This is what we want to explore in this resource. We want to help providers put equality and human rights at the heart of their improvement work so that the quality of care gets better for everyone.

This resource has been produced by the Care Quality Commission with our partners:



## Who is this resource for?

- Managers of health and social care services
- Quality improvement and organisational development staff
- Senior managers and Board members
- Frontline staff with an interest in how to use equality and human rights to improve their service
- Regulators, commissioners and policy makers
- Organisations and groups of people using health and social care services – in their work with providers to improve care. If you are using a health or social care service and want to raise a concern about equality and human rights, please visit our online information about reporting concerns or contact us by phone, email or post

**This resource is also available online at**  
[www.cqc.org.uk/EquallyOutstanding](http://www.cqc.org.uk/EquallyOutstanding)

# Summary

**1. Often people see equality and human rights as a problem – not a solution. Especially in times of financial constraint.**

Yet, there are [ethical](#), [business](#), [economic](#) and [legal](#) arguments for providers to pay attention to equality and human rights. Human rights principles of fairness, respect, equality, dignity and autonomy are at the heart of good care provision.

There is a strong link between the quality of care and equality for staff that requires work on basic fairness and building an inclusive culture that recognises and celebrates diversity. There is also a link between the quality of care and whether people who use services say their human rights are upheld.

Research shows that money spent on reducing health inequalities is the most efficient way of improving health outcomes for a local population. Equality and human rights is likely to become more important over time because of demographic and system changes, as well as financial constraint.

 [Go to '1. Why focus on equality and human rights?'](#)

**2. Many providers could learn from the best providers in using equality and human rights to improve the quality of care.**

This work involves promoting human rights and ensuring equity in access, experience and outcomes. Importantly, it means empowering people who use services, their families and friends – and staff working in services.

Outstanding care providers build on strong person-centred care and inclusive leadership. Attention to equality and human rights at a service level is also needed to tackle specific quality improvement issues.

None of the common 'success factors' in the best providers took a large amount of resources. Their success was based on changing behaviours and thinking about issues. In particular:

- Leadership committed to equality and human rights
- Putting equality and human rights principles into action
- Developing a culture of staff equality
- Applying equality and human rights thinking to improvement issues
- Putting people who use services at the centre
- Using external help and demonstrating courage and curiosity.

 [Go to '2. Case studies'](#)

### 3. Providers may still face challenges in times of constraint

There might be a need to reduce costs, reduce service demand or increase income – such as through fees or charges.

However, there are ways to minimise the impact of these changes on people who use services or staff, if careful attention is paid to mitigating any negative impacts on equality and human rights.

▶ [Go to '3. Overcoming challenges'](#)

### 4. Providers cannot do this work alone.

- **Commissioners** can help by building equality and human rights into contracts and monitoring. They also need to mitigate any potential negative impacts of the way they commission services. They can also consider commissioning to meet the needs of specific groups.
- **Regulators** need to build equality and human rights into their regulatory frameworks. They need to ensure there are no "unintended consequences" of regulation, e.g. risk aversion. They should reward people acting in an innovative way around equality and human rights. A focus on outcomes for people will help this.
- **Policy makers** need to support providers through ensuring they embed equality and human rights into national policy and system wide co-ordination.

▶ [Go to '4. Empowering people and communities  
Whole system approach'](#)

### 5. Empowering people and communities is essential to advance equality and human rights.

To do this, health and social care leaders need to look beyond provider boundaries. They need to ensure the community involvement of individuals – especially those facing the greatest disadvantage. This will enhance people's wellbeing by enabling them to take control of their health and their lives.

Leaders need to develop broader, more holistic services that meet the needs of diverse communities. So, a range of people using services and their representative organisations must be involved in developing health and social care services at a local level.

Local system leadership is important too. Sustainability and transformation partnerships (STPs) have an important role to play in reducing health inequalities. There is some emerging good practice about how to look at equality in STP work.

▶ [Go to '4. Empowering people and communities  
Empowering services'](#)

[For a definition of what we mean by equality and human rights, go to page 45](#)

# 1. Why focus on equality and human rights?

Often people see equality and human rights as a problem – not a solution. Especially in times of financial constraint. Yet, there is an:

- [ethical case](#)
- [business case](#)
- [economic case](#)
- [legal case](#)

for providers to pay attention to equality and human rights.

## Questions for reflection

- Which reasons for a focus on equality and human rights are most important or compelling in the organisation or service that I work in – the ethical case, business case, economic case or legal case?
- What evidence is there to back up these reasons?
  - e.g. feedback from people using the service or staff, identified quality improvement issues or staff equality data
- Will different reasons appeal to different people I work with?
  - e.g. senior managers, managers, clinical staff, care staff, other staff groups, people using the service, their families and friends, service commissioners

## Ethical case

### Outcomes people want

Paying attention to equality and human rights improves care for people using services – because it gives people the outcomes that they want. Find out more from the [resources section](#).

### A policy priority

The importance of equality and human rights has long been recognised in national health and social care policy. From the [founding principles of the NHS](#), through to the [NHS Constitution](#). And more recently in the [NHS National Quality Board shared commitment to quality](#) and the [Adult Social Care Quality Matters initiative](#). [NICE guidance on improving the experience of care and support](#) includes the importance of looking at equality of access, of recording and addressing people's needs relating to equality and diversity through care and support plans, as well as people's rights to make their own decisions about their care and support.

### Complexity – and simplicity

Sometimes this work can feel daunting. There are many different equality groups that a provider could consider. "Human rights" cover a wide range of topics. Then there are the legal considerations which can seem complex. Yet, the outstanding providers featured in the [case studies](#) have tackled this by putting better outcomes for people at the heart of their service development work through conscious attention to equality and human rights.

"Both ethical and instrumental cases for person-centred care have been made. The first makes a values-based argument, presenting person-centred care as respecting autonomy and being a good in its own right – the 'right thing to do' (nothing about me, without me). The second justifies person-centred care as a means to achieve better outcomes." [Health Foundation: Person-centred care: from ideas to action](#)

### Person-centred care, equality and human rights

**Person-centred care is a human rights approach to care.** This is because it is based on respect and autonomy. Skills for Care, Skills for Health and Health Education England have produced a [Person-Centred Approaches Core Skills Education and Training Framework](#). This framework helps develop the workforce to enable them to put person-centred approaches into practice and to create sustained behavioural change. Work by [National Voices in 2017](#) shows that person-centred care is variable between different areas, types of services and for different groups of people – and suggests that progress on person-centred care may be at risk in some services.

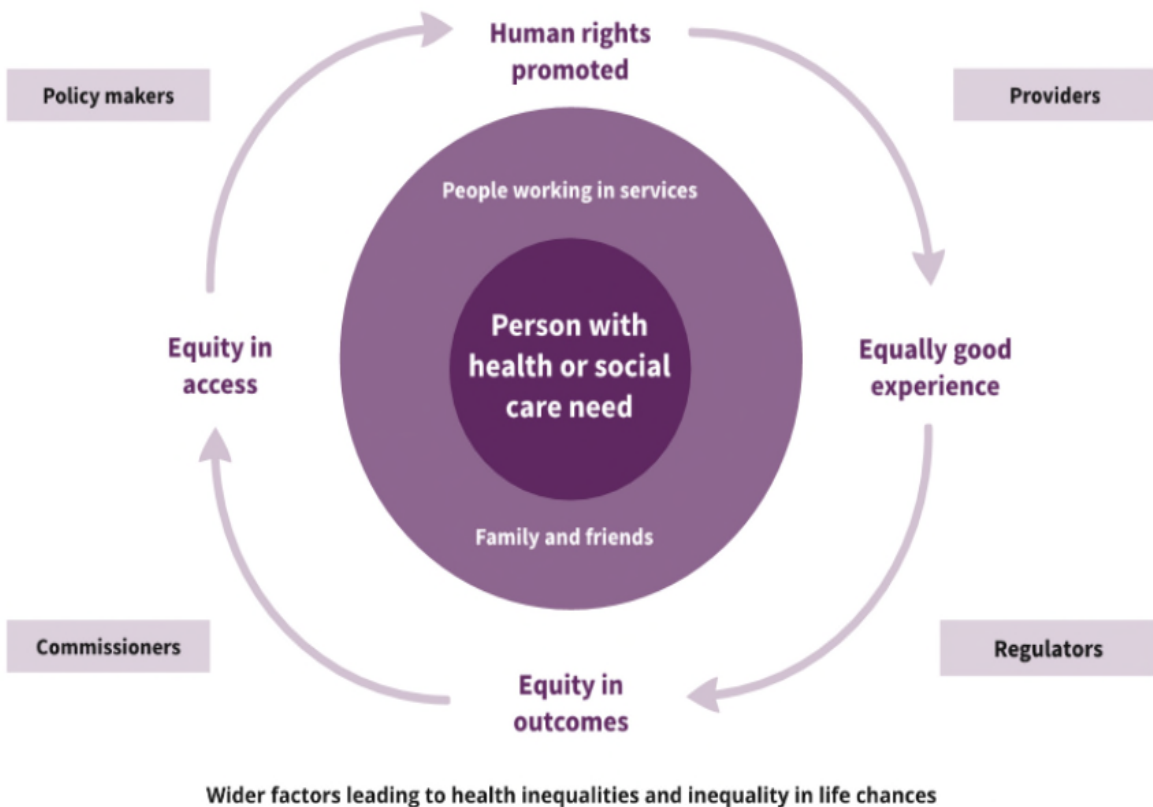
### Person-centred care approaches will also help achieve equality.

This is because individual needs will be met. This includes needs based on people's equality characteristics such as disability, culture, language, gender, religion, sexual orientation. This might include tackling barriers to equality faced by individuals. Removing these barriers might also improve care for others.

**A focus on promoting human rights and providing equally good access, experiences of care and outcomes will create good quality care for all.** However, equity does not mean treating everyone the same – it means treating everyone according to their needs. Our focus is on the role of providers but this is a dynamic system – see the person-centred

model below. Person-centred care is one of the requirements in CQC regulations – in [regulation 9](#). It is also in the assessment frameworks for [health services](#) and for [adult social care services](#).

### Person-centred model



There are “five groups who influence the quality of care” – providers, staff, people who use services and the public, [commissioners and funders](#) and [regulators](#). [Policy makers](#) indirectly influence these five groups in relation to the quality of care and also influence other aspects of the “model” such as wider health inequalities and life chances.

The person needing services is not passive in the middle. The more that the person’s influence can be strengthened, the greater the likelihood of equality and human rights for the individual. This will lead to good quality care and improved outcomes. The person also has “assets” that they can utilise. Their own strengths and skills and for most people, a network of family or friends. These need to be factored into the care provided.

Health and social care staff have a large influence over whether equality and human rights are secured for people using care services. Providers that promote equality and human rights for staff are more likely to ensure good quality care for people using their service.

All this is in a wider context of other factors leading to health inequalities: including poverty, poor housing or legal factors such as immigration status. Wider factors also lead to inequalities in life chances, important for social care outcomes. For example, discrimination leads to disabled people having a lack of opportunity to exercise citizenship and poor employment prospects.



## Removing barriers at a service level

Some inequality needs addressing at a service level – not on the individual basis possible through person-centred care.

**Staff may need support to understand – and act on – the needs of particular groups.**

**Example:** Lesbian, gay, bisexual, transgender and intersex (LGBT&I) people can face discrimination, prejudice, misunderstanding or ignorance when using adult social care services. This means they can be afraid to "come out" when needing adult social care. This can affect their wellbeing and whether person-centred care is possible for them. The Age UK resource "[Safe to be me](#)" gives many examples of issues for LGBT&I people and how these may be addressed by health and social care professionals.

A project by Anchor and University of Middlesex worked with community advisors to develop more LGBT&I inclusive environments in 6 care homes in London. They found that a range of work was required to enable care home staff to deliver person-centred care for LGBT&I people. This included development of staff training, cultural safety, risk management and community engagement. The project developed [a service assessment and development tool](#) for use by the community advisors.

Read [an inspection report for one of the participating care homes here](#).

**Some groups may need specific service developments to achieve the same outcomes as others.**

**Example:** Lower wellbeing is linked to poorer health and life expectancy. There is a difference in reported wellbeing for Black and Minority Ethnic (BME) people in the UK compared to white people. This is true even if factors such as differences in employment, housing and household income are taken into account. This could lead to poorer physical and mental health outcomes for BME people, including lower life expectancy.

[Research Recommendations](#) relevant to providers include:

- Improved engagement with communities: using "[appreciative inquiry](#)" to determine the actions needed for particular communities.
- Systematic analysis and reporting of data on the extent of ethnic differences in the quality of care. A [range of data](#) showing where there are ethnic differences in health access, experience and outcomes is now available through work for the Government's [Race Disparity Audit](#). This would be useful for local services to consider.
- More action to address wellbeing per se, rather than using wellbeing just as a measure of success.

We discuss this further in "[empowering people and communities](#)".

## Removing barriers to people's human rights also sometimes needs action at a service level.

**Example:** The British Institute of Human Rights project [“Connecting human rights to the frontline”](#) provides useful examples of how providers have worked at a service level to improve the quality of care through tackling specific human rights issues in health and social care services.

Staff involved in the project said:

- “It has revolutionised decision making. People are thinking differently and making decisions differently. It needs to be rights based not just risk based.”
- “Human rights helps you demonstrate what otherwise seems indemonstrable. Otherwise how do you monitor a compassionate approach.”
- “It’s very enabling and there have been many lightbulb moments – it’s turned decision making on its head.”

CQC regulations focus on care provided to individual people. So, removing barriers for groups of people is implicit rather than explicit in regulations. However, the need to look at equality and human rights at a service level is included in the assessment frameworks for [health services](#) and for [adult social care services](#). Supporting staff to understand the needs of particular groups is also included. So, these issues contribute to CQC ratings.

## Some groups face barriers to receiving good health and social care support through inequality in wider services and systems

**Example:** [The Lammy review of the treatment of Black, Asian and minority ethnic \(BAME\) individuals in the criminal justice system](#) found that BAME people are less likely to be identified with learning difficulties or mental health conditions upon reception into custody. So they do not receive appropriate support in prison. This is partly due to inequalities earlier in the lives of BAME individuals – for example in the education system or in mental health services.

Services are working in increasingly integrated local systems, with a wider range of partners. Health and social care providers and individual staff can play a positive role in reducing inequalities in other services that have an impact on people's health and wellbeing.

## Health and social care professionals have a role in protecting and promoting people's human rights beyond their service

**Example:** The British Medical Association has published [“Locked up, locked out: health and human rights in immigration detention”](#) which explores the role of doctors in protecting and promoting the human rights of detained people.

Social care organisations can play a role in supporting people to gain and exercise their human rights and citizens' rights in society, for example the [Love Your Vote](#) Campaign.

## Business case

### Link between equality and inclusion for staff and good care

Improving the quality of care makes good “business sense” – it enhances the reputation of the service. And there is a “business case” for tackling workforce equality issues to improve the quality of care.

[Research looking at the NHS staff survey and inpatient survey for different NHS trusts](#) found a number of correlations between equality for staff and the quality of care. For example, where Black and Minority Ethnic staff experienced discrimination, there tended to be lower levels of patient satisfaction.

[Research by the King’s Fund](#) has found widespread workforce inequality in the NHS across a range of equality characteristics.

The link between the quality of care and levels of staff discrimination and bullying and harassment is supported by [CQC analysis](#) of NHS trusts’ ratings. This shows that staff in acute or combined trust with higher ratings are less likely to say they have experienced discrimination, bullying or harassment.

The NHS Improvement [Culture and Leadership Programme](#) helps NHS trusts improve through developing a culture of compassionate and inclusive leadership. The tools include a range of evidence, linking inclusive NHS workplace cultures and better financial and quality performance.

[Developing People – Improving Care one year on](#) gives examples of the impact of inclusive workplace cultures on good care.

Though there has been less work on this topic in primary care and adult social care, our case studies show that the basic principle holds true – where organisations value and support staff equally, this will help lead to better care. There are some good examples of this in the [Skills for Care Good and Outstanding care guide](#).

The development of inclusive organisational cultures and attention to workforce equality features strongly in the “well-led” key questions in the assessment frameworks for [health services](#) and for [adult social care services](#).

### Increasing staff equality will save money for providers

**Turnover:** [Equality-related causes of high staff turnover](#) include harassment, bullying and abuse at work, lack of flexible working options and lack of effective management action to deal with violence and harassment from members of the public. When a staff member leaves the NHS, the average immediate cost to a trust is £4,500. Long term costs in hiring and training new staff, are much greater. In social care, the average cost is estimated at £4,000.

**Absenteeism:** [Equality-related causes of absenteeism](#) include work-related stress due to harassment and bullying. Inclusive cultures, free from discrimination also lead to higher employee engagement which is linked to lower absenteeism. NHS staff are absent from work, on average, 10.7 days each year. This loses the service a total of 10.3 million days and costs £1.75 billion. This equates to the loss of 45,000 full time staff.

**Unnecessary disciplinary and fitness to practice actions:** [Research shows](#) that BME nurses and midwives (working in health and social care settings) are more likely to be referred by their employer to the Nursing and Midwifery Council fitness-to-practice process and more likely to have to progress to the later stages of the process. However, they were less likely to be barred from practice as an outcome. This not only has a personal cost for the BME nurses and midwives involved, it has a financial cost to the health and social care system.

**Values-based recruitment leads to cost savings:** [Skills for Care](#) have found a return of £1.23 for every £1 spent on values based recruitment by adult social care providers. This is due to lower turnover and training costs for staff recruited this way. These values almost universally include Equality and Human Rights.

### Having a diverse workforce adds value

**Talent management:** Removing barriers to equality widens the pool of talent available to providers. [Values based recruitment](#) can increase the diversity of applicants appointed, for example to recruit more men to work in frontline care roles. Social care employers also say that applicants recruited this way are more likely to deliver high quality care.

**Staff profile reflecting the people using the service:** This helps gain the confidence of people using the service as well as enabling “matching” staff and people using the service to provide more person-centred care. [Though organisations need to handle "matching" carefully](#) and this should

always be the choice of the person receiving care. For example, some refugees fleeing persecution and lesbian, gay and bisexual people from minority ethnic groups may fear that “ethnic matching” might lead to confidentiality issues.

**Organisation’s leadership reflecting the local population:** This helps gain the confidence of people using the service and of staff and can encourage under-represented groups to use the service. A diverse leadership can also provide the organisation with insight about equality and inclusion issues.

**Diverse teams perform better.** There is some academic debate over whether diversity is a cause of higher performing teams. But there is some research which shows that [“diversity trumps ability”](#) in tasks which require teamwork. This suggests we often need the best team for the job – not always the best person for the job, if this leads to a lack of diversity. Work by [McKinsey](#) shows that in the commercial sector there is a strong correlation between greater gender and ethnic diversity at the top of UK and US companies and better financial performance.

### A link between the quality of care and performance on equality and human rights?

There is also a “business case” for improving equality and human rights for people using the service, if this leads to improved quality and therefore enhanced reputation.

CQC ratings are based on detailed inspections of thousands of services. Over time, the links between providers that we rate as outstanding and their work on equality and human rights are becoming more evident.

**Quality ratings:** We looked at key **human rights-related questions in the NHS inpatient survey**. Patients in outstanding acute NHS trusts are significantly more likely to say that they are treated with dignity and respect in hospital and that they have the emotional support that they need. Their overall satisfaction with their hospital stay was also higher.

When we looked at **responses to these questions by different equality groups**, outstanding trusts were more likely to have no difference in satisfaction between patients of different age groups. Lesbian and gay patients were less likely to give positive responses to all 3 questions compared to heterosexual patients- except in outstanding trusts where they were more likely to give positive responses than heterosexual patients. However, due to small numbers of lesbian and gay respondents in outstanding trusts, these results were not statistically significant.

University of Lancaster looked at comments made about the quality of care for people with a learning disability in acute hospital inspection reports. They found that the proportion of comments that were positive increased in line with the trust rating.

Looking at 14,000 adult social care “provider information returns”, services rated good or outstanding were slightly more likely have undertaken some specific work on equality in the past 12 months. But there was a lot of

variation when looking at whether services had done work on specific equality characteristics and comparing this to ratings.

The links between outstanding care and equality work were particularly strong for hospices. Seventy-five per cent of hospices rated as outstanding had carried out some work on equality for disabled people, but only 55% of other hospices had done so. Eighty-eight per cent of hospices rated as outstanding had carried out some work around equality for people of different religions and beliefs compared to 65% of lower-rated hospices.

### Working on equality and human rights for people using services is good for staff

**Skills building:** Staff can gain good skills and experience through finding creative solutions to meet the needs of different people using their service. The same is true for working on quality improvement projects that improve equality or human rights for people using the service.

**Morale:** Some organisations take a corporate social responsibility approach to promoting equality and human rights beyond the service they deliver. This type of work often really engages staff – because staff in health and social care are keen to make a difference through their work.

**Staff retention:** A number of the case study organisations said that improved staff morale was a large business benefit for equality and human rights work because it improves staff retention. This is particularly true in sectors where there may be problems with staff retention – such as care staff in social care and GPs.

**Example: Equality-focused change campaigns**

Dimensions UK have carried out national campaign work on disability hate crime. They have developed the campaign [#ImWithSam](#). This has benefits for people using the service, for staff and for the wider community– working together as citizens on a positive change campaign improves everyone’s wellbeing.

**Working on equality and human rights can lead to greater efficiencies – and win contracts**

Work on equality or human rights can create organisational efficiency and save providers money. But there is little research to measure this. Here are just a few examples:

- Sending out appointment letters in the right format or language could reduce the number of missed appointments in a GP practice or hospital.
- Investing in environmental adaptations in social care settings could increase autonomy for disabled people and reduce the amount of staff help that people need.
- LGB&T people are more likely to present late for medical support due to lack of trust in the health system. This is particularly true for trans people. Creating an explicitly welcoming service can result in earlier diagnosis and treatment, saving money at a local and systemic level.

- Changing care pathways for particular equality groups using a GP practice can [may improve care outcomes – and create greater efficiencies](#).
- Not-for-profit and private providers find that effective work on equality and diversity is often a requirement to win public sector tenders due to the [public sector equality duty](#).

**Example: Rights-respecting adult social care that saves money**

Choice Support is national social care charity providing support to people with a learning disability. In this [short video](#) they show how person-centred care through Individual Service Funds:

- gives people more control and advances their citizenship
- increase the quality of care
- lead to good outcomes in terms of health and well-being
- and saves money.

## Economic case

### A focus on equality and human rights can save money for the health and social care “system”

This is through preventing ill health, or deterioration in people’s health, **by tackling health inequalities or barriers to accessing health and social care services.**

[Research in the US](#) has shown that people in some minority ethnic groups are more likely to have multiple and chronic health needs which are costly to manage, have inappropriate and often costly health tests ordered and have longer and more frequent hospital stays. This led to an estimated excess cost to the health sector of \$60 billion a year in 2009. The 2017 Government [Race Disparity Audit](#) and the accompanying [Ethnicity Facts and figures](#) suggest that race inequality in access to health and health outcomes might also have an economic impact in the UK.

Economic research in the UK has generally focused on inequality based on “levels of deprivation” in different areas where people live. [In 2010, health inequalities were estimated to cost the NHS £5.5 billion per year.](#) This is based on the cost of treating ill health associated with these geographical health inequalities. It covers extra costs in acute care, prescribing and mental health but not primary care. There is evidence that restricting access to primary care costs more money than it saves, for example [European research](#) shows that reducing access to primary care for “irregular migrants” may have a public health impact and may cost more money than it saves. One example of a costed impact of equality provision is work by the charity [Sign Health](#). They asked health economists to calculate the cost to the NHS

of failures to provide British Sign Language interpreters for Deaf people. The estimate was that lack of BSL interpreters was causing missed diagnoses and poor health which cost the NHS £30 million a year. The British Medical Association report [“Health at a price”](#) also gives many examples of the inter-relationships between inequality, poverty and costs to the NHS – as well as innovative ways that doctors can help mitigate these problems.

For local government, there has also been work on [the “efficiency case”](#) for improving the health of particular groups of people. This includes looking at the social factors that impact on health (sometimes called “social determinants”). This work aims to **prevent ill health that has a financial impact on both health and social care services.**

**People may be experiencing more than one form of disadvantage.** It is important to consider this. For example:

- Disabled people are more likely to be on low incomes than non-disabled people.
- BME people experiencing mental ill health have different outcomes from white people – such as higher levels of compulsory detention.
- Lesbian, gay and bisexual older people may be more reluctant to approach health and social care services than others, due to fear of discrimination. This can affect the well-being and therefore health status of these older people.

Public Health England produce a useful tool covering the wider determinants of health across England. This enables you to look at potential factors leading health inequalities in your local area and to compare with other areas. They have also recently published [a health equity report focusing on ethnicity](#). This report found a mixed picture, including:

- children in Black ethnic groups generally had poorer health outcomes than average for England
- health outcomes are generally poor for people of Bangladeshi or Pakistani origin.

### **A focus on equality and human rights can save money for the wider economy**

Poor health leads to lower productivity – for example through greater staff sickness. It also leads to higher welfare benefits costs. This might be for people experiencing ill health – or their informal carers. So, health inequalities have a wider impact on the economy beyond the costs to the health and social care system.

[Research in the US](#) has shown that ethnic disparities in health led to \$22 billion in lost productivity in 2009.

[In the UK](#), the economic cost of geographical health inequalities was estimated at £33 billion in lost productivity in 2010. This inequality also led to an additional £20 billion cost to government – in lost taxes and increased welfare benefit payments.

### **A focus on workforce equality and developing employment in the sector can save money for the wider economy**

The health and social care sector is also a major employer. So, through action on workforce equality, the sector can help to reduce the economic impact of employment inequalities.

The [McGregor-Smith review](#) has estimated a £24 billion potential benefit to the UK economy from full representation of BME individuals across the labour market – through improved participation and progression. Reducing employment inequality in the health and social care sector, as a major employment sector, would contribute to this.

The Equality and Human Rights Commission has argued that the social care sector, rather than being a “drain” on the economy [could contribute to economic prosperity](#), if equality and human rights are taken into account. From an economic perspective, this includes:

- optimising the social and economic participation of people requiring support and their families
- agreeing a fair and sustainable approach to funding social care and for the role of informal care
- developing a committed and competent social care workforce
- addressing the changes needed for everyone to thrive in our ageing society.



## Legal case

### Considering equality and human rights is often a legal requirement – as well as a way to provide better care

The legal case is often the first “argument” used when people want organisations to consider equality and human rights. This argument is usually based on reputation and financial risks of non-compliance.

It is not always the most persuasive argument, particularly for wider culture change and outstanding care rather than basic compliance. But some of the “processes” associated with legal compliance, such as thorough equality impact analysis, can be helpful.

This is why we include a basic outline of legal requirements opposite.

### Summary of legal requirements relating to equality and human rights:

- All providers of public services need to comply with the Equality Act 2010 sections that relate to [service provision and to employment](#).
- Public sector providers will also need to comply with the [Public Sector Equality Duty](#).
- Public sector organisations – and those carrying out “public functions” will also need to respect, protect and fulfil [the Human Rights Act 1998](#).
- However, the benefits for all providers in complying with human rights law is shown in [this video](#): and there is also [guidance for all businesses on human rights](#).
- The Human Rights Act is a “foundation law” and many other pieces of legislation are designed to ensure that human rights are upheld, such as:
  - The Health and Social Care Act [regulations used by the Care Quality Commission](#)
  - The Mental Health Act [1983](#) and its [Code of Practice](#) and the Mental Health Act [2007](#)
  - [The Mental Capacity Act 2005](#) and its [Code of Practice](#).

## 2. Case studies

**There is a large gap between the best providers in using equality and human rights to improve the quality of care and others. Many providers could learn from the very best providers.**

Closing this gap has the potential to lever substantial improvements in the quality of care for a large number of people. Those least well-served in health and social care will benefit most.

Outstanding care providers build on strong person-centred care and inclusive leadership. They develop approaches to equality and human rights for staff and people using the service. This work results in outstanding quality – even in times of financial constraint.

Attention to equality and human rights at a service-level is also needed to tackle specific quality improvement issues. This is necessary to remove organisational barriers and to empower frontline staff and people who use services.

Though these services vary greatly, there are a number of common features – particularly about organisational culture – that other services could learn from.

Looking at the common “success factors” in the best providers none of these took a large amount of resources.

We update case studies for Equally Outstanding on our website. You can find more examples of good practice on the CQC website [here](#). There are also more examples in the [Extra Resources pages](#).

### Questions for reflection

- Which of the case studies inspired me – and why?
- Which of the case studies seemed most relevant to my organisation?
- Can I identify any common success factors in using equality and human rights approaches in these case studies?
- Looking at the “common factors” we identified across all the case studies – which ones are particular strengths in my organisation...
- And which ones need more development?
- What learning from the case studies could I transfer into my organisation?
- Who could help me with this?
- What resources could help me do this?



Shadon House



Dimensions Kent



Castlebar Care Centre



East London NHS Trust



The Christie NHS Trust



The Docs GP practice



Herstmonceaux integrative care centre

## Success factors

The case studies in this section are quite different – ranging from private sector care homes to large NHS trusts. Yet there are some common factors that most, if not all, share.

These factors have helped to make the services successful in using equality and human rights approaches. But more than that, these factors have been crucial in developing outstanding care. None of these factors take large resources – they take shifts in thinking and in behaviours.

These nine factors are closely linked to six elements for cultures of inclusion in the King's Fund report [Making the Difference](#). In the [resources section](#), we also link them to **CQC key lines of enquiry** and the **NHSI Culture and Leadership Programme**.

- 1. Committed leadership:** The key role of leaders who are enthusiastic and committed to equality and human rights. We need to move away from “heroes and heroines” to making this the business of all leaders.
- 2. Equality and human rights principles into action:** These principles run through as a thread from organisational values, through leadership behaviours and actions to frontline staff and their work.
- 3. Culture of staff equality:** They developed a culture of equality and human rights for their staff as a basis for quality improvement. This is likely to include both broad work to develop an open and inclusive culture and, particularly in larger organisations, work to tackle specific workforce inequalities.
- 4. Apply equality and human rights thinking to improvement issues:** They started with the quality improvement issue, created some

space to innovate and then applied “equality and human rights thinking” to the issue – rather than thinking “we must do something about equality and/ or human rights”.

- 5. Staff as improvement partners:** All staff were involved as partners in the thinking about, planning and delivery of the equality and human rights interventions to improve the quality of care. This was done within a “no blame” culture of learning and is aligned to collective leadership approaches.
- 6. People who use services at the centre:** The rule was “how do we serve this person?” They listened carefully to people who used the service and viewed them as people with a life beyond their immediate need for a service – including their future aspirations.
- 7. Use external help:** They linked to the outside – reaching out to others for help and being prepared to have a mirror shone on their work.
- 8. Courage:** They were courageous and bold in their approaches – including positive risk-taking, being honest about issues and tackling difficult problems.
- 9. Continuous learning and curiosity:** They were curious and humble – they started somewhere, learned from mistakes and were always looking for the next thing that they could improve – whether for a small service like Shadon House that was how to best meet the needs of the next person admitted, or for larger services what project to focus on next or service to develop.

## Case study 1: Shadon House Dementia Resource Centre

[Shadon House](#) is a care home for people with dementia providing respite care and assessment place for up to 23 people at a time. The service employs 30 staff. Shadon House was rated “outstanding” in June 2016 – read the inspection report [here](#).

**Shadon House bases its work on the Human Rights “FREDA principles”:** These principles are fairness, respect, equality, dignity and autonomy. Procedures and training for staff make FREDA ‘live’ every day through all the work.

**Listening to people’s needs – and their aspirations:** Staff assess people’s capacity on admission. They then tell the staff team about the person’s needs. So all staff know about the person’s life and how to support them to achieve next goal.

**Staff respect, support and development:** The whole management team works with all staff. Managers will not ask staff to do something they are not prepared to do themselves. This shows respect for staff at every level; good relationships with staff result in a good service to people staying in Shadon House.

All staff are engaged – there are three handover sessions a day which include all staff. Staff are well supported with supervision, discussion at staff meetings and development sessions. These sessions include human rights topics such as Deprivation of Liberty (DoLs), confidentiality and duty of candour. All staff attend the sessions including staff such as the cleaners.

Staff at Shadon House are passionate about what they do. There is good continuity of staff for people using the service (e.g. on respite visits) because staff ‘don’t leave’.

**Reaching out:** Shadon House makes links with the local hospital, charities and others. This helps to find ways to provide support and care for individuals. For example, one person was showing a lot of distress. Staff discovered that this was partly because they loved hens and were no longer able to care for them. Shadon House now has free range hens and this reduced the person’s distressed behaviour. The hens also provide interest and happiness to other people using the service and staff.

Shadon House has also found external facilitators for arts and craft and drama from charities at no cost to the service. This enables people to live fulfilling lives: e.g. people using the service created their own book.

“When service users come into Shadon for assessment the greatest thing they learn is what they are capable of – they are revived and ready to live at home again with new found confidence. Our emphasis is on wellbeing and building on positives.” (Joanne Matthewson – Registered Manager)

## Case study 2: Dimensions Kent

[Dimensions](#) is one of the largest not-for-profit providers of support to people with learning disabilities and those who experience autism in the UK. Their Kent domiciliary care service was awarded an outstanding rating by CQC in December 2016 – read the inspection report [here](#).

**Vision and values into strategy:** Equality and human rights are at the centre of their [vision, mission and values](#). The vision is “An inclusive society where people have equal chances to live the life they want”.

In 2010, Dimensions created a specialist equality and diversity role. Their first task was to develop [an equality and diversity strategy](#) to “bring to life” equality work for both staff and people using services. The strategy outlines the “business case” for equality and diversity, the work that Dimensions has taken and how progress will be monitored. This covers processes such as Equality Impact Assessments and governance. It also covers equality in key programmes of work – such as **learning and development, support planning and personalised technology**. These support the organisation's approach to person-centred care.

**Equality for staff:** The strategy commits Dimensions to participation in the Skills for Care Moving Up Programme to increase the number of BME employees in management positions. Dimensions are also developing their staff development programme to include tailored resources for people from minority backgrounds. The strategy also contains a commitment to increase the number of disabled staff and to offer appropriate support to disabled staff. This is enabled by making reasonable adjustments, flexible working and seeking advice and support from Access to Work.

**Communicating and campaigning for change:** Equality topics are featured in monthly staff bulletins, quarterly equality and diversity newsletters and in regular communications to families. Equality and

diversity issues are built into surveys and complaints monitoring. Survey results are analysed demographically. There are two “Diversity matters” groups – one for staff and one for people Dimensions support – and a senior champion.

Dimensions also has strong national work on equality and human rights-based campaigns. They run campaigns around disability-related harassment – [#ImWithSam](#) and – removing barriers to people with a learning disability voting in elections – [Love Your Vote](#). This Corporate Social Responsibility work is positive for the people they support, staff and the wider community. Engaging together as citizens to make positive changes improves people's wellbeing.

**Local benefits:** The benefit of this national work was evident on the Dimensions Kent inspection. There was strong person-centred care that took account of diversity. There was good staff awareness of human rights principles, such as dignity and autonomy. Staff were able to talk about the national communications that they receive around equality and the campaigns work – and how these are used in the local service. Staff praised the culture of the service. They spoke about the opportunities they had for personal development. They felt able to contribute to quality improvement, using the Dimensions values as their guide.

“The biggest challenge is enabling people to understand that equality and diversity is the thread that runs through everything and not a stand-alone issue. Clear, consistent and regular communication for both staff and the people we support has facilitated this, alongside our vision and the rationale of our equality and diversity business case.” (Lisa Govier, Equality, Diversity and Inclusion Manager)

## Case study 3: Castlebar Care Centre

[Castlebar care centre](#) is a private sector nursing home for 59 people in Lewisham, London. It is owned by Excelcare, a family owned company which has grown slowly but now owns 33 care homes. Castlebar was rated outstanding in January 2017. Read the report [here](#)

**Culture and values to promote individual rights:** The culture and values of the organisation are important in promoting people's rights at Castlebar. This includes:

- celebrating and recognising diversity. In the care home, there are people living there originally from 12 countries, with staff from 27 countries.
- getting to know people well and discovering their history
- challenging accepted views to move from "risk aversion" to enabling people to live more fulfilled lives
- enabling people to do as much as possible for themselves,
- offering people choices that recognise their mental capacity and always looking for ways to provide the least restrictive care possible
- seeing change as the norm and being open about death and dying.

**Investing in service development:** In times of financial constraint, there may be a tendency to see quality and cost as in opposition. But, Excelcare have found that – by careful investment, sharing resources and devolving budgets – quality and cost can go hand-in-hand. They have invested in buildings, equipment, and staff recruitment, development and retention.

They have also invested in IT systems which incorporate care planning, human resources, audits and daily "dashboards".

Castlebar offers people new challenges and exciting opportunities with the view that "you are never too old to try something new". These activities include:

- [Sweet readers](#) – an intergenerational, arts based programme (pioneered in the USA) between Castlebar and a local school, recognised on the school curriculum
- [Namaste](#) – a multisensory programme for people with advanced dementia which includes individualised activities and promotes dignity at the end of life
- ballet classes
- an in-house physiotherapist
- a wide range of social activities both in the home and trips out to places of interest
- supporting significant days – such as a walk for International Day of Older People and a Caribbean Summer Party
- support for individuals to follow specific interests.

"Investment and culture change took patience and trust over time – but has led to big improvements in care and many areas of outstanding practice." (Terry O'Connor, Registered Manager)

# Case study 4: East London NHS Foundation Trust

[ELFT](#) is a large, complex Mental Health and Community NHS Trust which serves East London, Luton and Bedfordshire and Richmond. In September 2016 ELFT was rated “outstanding” – read the report [here](#).

**Enthusiastic leadership:** A few years ago the trust Board changed the way it viewed performance. There was shift from performance matrixes to looking at the culture of the organisation and creating an environment which supports staff to provide the best care.

Enthusiastic leaders are open to having conversations about how the Trust works. They have brought together quality improvement (QI) approaches and commitments to equality and human rights.

**Bold with culture change and quality improvement to improve rights:** [QI methods were introduced](#), so that improvement became everyday business for all staff. The principle is that the people who know the problem are pivotal to creating the solution. Staff went to the board with a QI idea for a [project to reduce violence on acute mental health inpatient wards](#). This is generally regarded as ‘impossible to do’, but the Board supported the idea because this issue had a big impact on staff and service users’ experience and their rights. The project resulted in a massive reduction in violence in inpatient units.

**A frontline focus on equality and human rights for staff and patients:** Engaging frontline staff in equality and human rights related QI work is promoted through a clear [equality, diversity and human rights strategy](#). A programme of specific projects are underpinned by an overall

ambition: ‘Our vision is for ELFT to be an exemplar of best practice in advancing equality, diversity and human rights in England by 2018.’

The trust has embraced values-based recruitment. Trust values include respect and ensuring care is inclusive. In the recruitment process, candidates are asked questions to make sure potential staff share the trust’s values. The trust has started to address race inequality in the workforce by looking at ethnicity variation in promotion and disciplinary cases. A programme of work is underway to tackle this.

The trust recognised the need to do something in parallel about equality and human rights for patients. So, they started a project looking at human rights in psychiatric intensive inpatients services. They engaged an external human rights expert to find out the experience of service users anonymously. So, staff heard directly from service users about their experience of ward restrictions from a human rights perspective. They had to ask difficult questions and have outsiders shine a light on their service. This project is now developing training on human rights in Psychiatric Intensive Care wards. The trust is also using data to look at experiences of people in different equality groups and restrictive interventions.

“Our biggest success is having people talking about equality and human rights in their day to day work while reviewing what they do. Naming the elephant in the room. Allow everyone to contribute to solutions. But we are not complacent – we need to continue to improve.” (Lorraine Sunduza, Director of Nursing, London Mental Health)

## Case study 5: The Christie NHS Foundation Trust

[The Christie](#) was the first specialist cancer hospital in the country to be rated 'outstanding' following [inspection in May 2016](#). Three years ago, it was a different story. In 2013 there were some significant governance challenges. In 2014, Monitor reviewed the trust. Following this, the Board changed significantly, there was an external audit of leadership, and the Christie started a programme of culture change.

**Principles and values drive culture change:** The culture change work was based on the Christie Commitment of "we care, we discover, we teach". There are associated equality and human right behaviours including: "we treat everyone with compassion, dignity and respect" and "we promote a fair culture". The Christie developed a network of "Champions" to take forward culture change at a local level. They also made a number of pledges to staff which were developed through trust-wide work programmes, e.g. becoming a "Disability Confident Employer".

**Using national equality programmes well:** The Christie has made good use of national NHS equality programmes:

- Using [EDS2 to agree specific improvements](#). For example, work with the leadership team has enabled the trust to move from "developing" to "achieving" for an EDS2 outcome about the board and senior leaders promoting equality.
- Work on bullying and harassment – including promoting the trust's approach and developing a network of staff advisors – has resulted in significant improvement in aspects of [workforce race equality](#). In 2014, 28% of BME staff said that they had experienced bullying or harassment – in 2015 this decreased to 11%. But the trust recognise that they still need to reduce other "gaps" between BME and white staff. They have used the metrics in the Workforce Race Equality Scheme (WRES) to make this a priority for their equality work in 2016-2017.

### Targeted work to address specific equality issues:

- Improved physical accessibility and easy read information on cancer treatments.
- Engaging the LGBT community in Manchester, through work with the LGBT Cancer Alliance and having a presence at Manchester Pride. Working with a Macmillan LGBT project worker, the trust has improved the understanding of LGBT issues amongst staff through learning sessions and an interactive display to support Trans Day of Visibility.
- Upgrading the chapel, prayer room and multi-faith room – which are now well-used by patients, visitors and staff with much positive feedback.

### Feedback:

- The Christie see patient and staff feedback as essential to improving quality – including equality:
- All surveys include equality monitoring. Disclosure rates have improved – for example 97% of staff disclose their ethnicity and 80% their sexual orientation.
- Professional interpreters are available to assist people using services to complete feedback questionnaires, if their first language is not English
- Responding positively to complaints has led to some improvements. For example, a complaint by a Deaf patient led to improvements in interpreting provision.

### Monitoring data shows how this wide range of work reaps benefits, for example:

- 95% of staff believe that the trust provides equal opportunities for career progression
- The trust scored 9.7 out of 10 on the 2015 national patient survey for patients saying they were treated with dignity and respect.



# Case study 6: The Docs GP practice, Manchester

[The Docs](#) is a GP practice in Manchester city centre with 7,500 patients and 17 staff. The Docs was awarded [an “Outstanding” rating in August 2016](#).

The Docs has an unusual "mix" of patients: a high number of gay men, a small older Chinese population, students and international visitors. The practice has the highest number of patients with HIV in the UK. Unlike some other city centre practices, it has not been commissioned as a specialist GP practice to meet specific needs.

**Focus on specific equality groups served:** The practice has worked for years on sexual health and HIV care without stigma. The practice has developed services particularly for people who might be anxious of facing discrimination.

Many of the older Chinese people have moved away from the city centre, but still travel into the practice because of its welcoming nature. For example, the reception staff have learned some basic Cantonese. They have good links to interpreting services.

**Go beyond clinical hierarchy:** There is a team effort beyond clinical hierarchy – from the cleaners to the GPs. They make opportunities for everyone to contribute. Staff enjoy working on new projects to improve care for particular groups of patients. These have included:

- specialist sexual health nurse and community outreach clinics for people who are HIV+
- yoga on prescription
- links with voluntary sector mental health organisations

- work on domestic violence in same sex relationships
- currently looking at working on HPV vaccinations for men and emerging new sexual health risks like “chemsex”.

**Look after staff to look after patients:** The practice staff look after themselves so they can look after patients well. This includes clinical support for each other and external clinical supervision – run as counselling sessions.

There is strong communication between staff. This includes a daily coffee time debrief for clinicians and a monthly practice meeting for all staff. There is a space for partners/leaders to ‘disagree’ – supported by a negotiated agreement.

The practice encourages all staff to act at level of competence and get it right first time, so patients only need to say something once. They also foster a learning environment with no blame – when things go wrong they view this as a learning opportunity.

All this means that the Docs “go the extra mile” for patients. The Docs have found their outstanding rating is good for attracting new staff. It is also good for recognising and motivating existing staff.

“Despite funding uncertainties, we are committed to developing sexual health work because it matches the needs of our patients and the service, in the form we offer it, is not available elsewhere. By growing, recruiting more expertise and treating more patients, we become harder to ignore.”  
(Dr Matt Joslin, GP partner and trainer)

# Case study 7: Herstmonceux Integrative Health Centre

[Herstmonceux Integrative Health Centre](#) is a GP practice serving 4,200 patients in rural East Sussex. The purpose-built centre, opened in 2014, provides a sustainable, calm and relaxing environment for patients. It has a “non-clinical feel”: maximising natural light, with curved corridors and minimal environmental impact. The practice was [rated outstanding in January 2017](#).

**Mission:** Integrative medicine is based on treating the whole person rather than just the illness and the symptoms. The centre has a five-year plan to deliver integrative medicine supported by the NHS. The practice’s mission statement includes: “We are committed to sustainable living, sustainable working, providing safe and effective quality health care in an environment of equality and respect”.

**Autonomy and empowerment:** The ethos is empowering patients to achieve their health goals. This aligns well with the human rights principle of autonomy:

- “Health curiosity talks” encourage people to engage with their own wellbeing.
- Patients with long term conditions work with their GP to develop a “Health Vision”, and a council-funded “Health Coach” coach helps the person put this into practice.
- Alongside NHS clinics, there are complementary medicine practitioners available, who offer free “taster sessions”. Patients can also access a range of classes on a private basis including tai chi, yoga, medicinal Pilates and meditation. The practice aims to evidence the benefits of these therapies and classes to increase access to people on low incomes through NHS funding.

**Meeting everyone’s needs:** The practice runs free social prescribing and community based schemes. These include a patient library, singing workshops and healthy walks. Some focus on specific groups:

- A monthly coffee morning for older people to respond to social isolation.
- A “Vitality Villages” scheme promotes recreational activities. The scheme holds events for older people, families and children and those who are isolated. The centre is currently developing work with young men – the biggest users of the local food bank and vulnerable to poor mental and physical wellbeing.
- All staff at the centre are trained as “dementia friends”. The centre is working with others in the parish to promote dementia-friendly practices.
- The centre is actively promoting the new Accessible Information Standard.

Patient feedback is good about being treated with dignity and respect and being involved in their care.

**Strong patient and staff engagement:** There is a very active patient participation group which has an impact on service development. The group suggested some popular projects such as the coffee mornings and a local resource list to help people find beneficial activities, such as art classes. Practice “Health walks” are now organised by two patients. The practice seeks out evidence-based research – particularly about tackling social issues that have an impact on patients’ health. They have set up a “practice book club” for staff to read recently published work that could benefit patients.

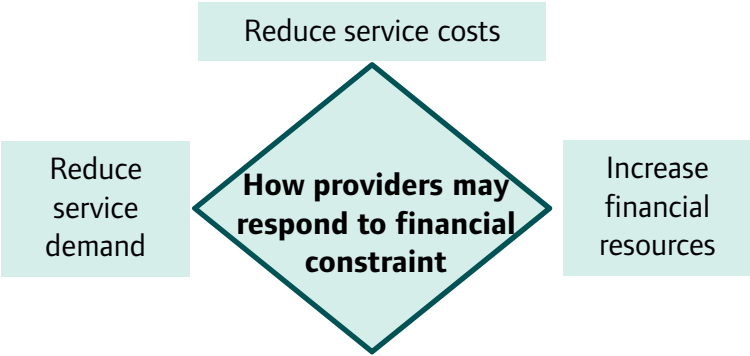
“Do you want to be doing what you are doing today in 5 years’ time? If not get involved in creating the right health movement for your patient population- exciting, innovative, community health care that is as empowering for your patients as it is for you.” (Dr John Simmons, Lead GP)

# 3. Overcoming challenges

In other sections of this resource, we have rightly focused on how equality and human rights can be a solution to improve care. And how these solutions often cost little – because they are based on changing people’s thinking and behaviour so they approach quality improvement in new ways. But we cannot ignore potential impacts on equality and human rights in times of financial constraint.

In this section, we do not aim to cover every single risk or solution. We just highlight some potential equality and human rights risks to trigger your thinking. We also point to some potential solutions.

In times of financial constraint, providers have some choices about how to balance budgets – see the diagram below.



**Questions for reflection**

- Which challenges to equality and human rights do I currently face in my work, service or organisation? How could I assess challenges if I am uncertain of them?
- What might be the solutions to these challenges? How could I find solutions?
- How will I assess which are the best solutions?
- Who will be able to assist me with the analysis of challenges and solutions?
- Who will be able to assist me with implementing solutions?
- What resources will we need?

# 1. Reduce service costs

Change	Equality and human rights impacts	Ways of reducing these impacts
<p><b>Reducing staffing numbers</b></p>	<ul style="list-style-type: none"> <li>Reduced dignity as there is a relationship between staffing levels and meeting people needs in timely way.</li> <li>Harder to provide personalised care – with an impact on individual choice, autonomy and meeting people’s diverse needs.</li> <li>Differential impact on staff equality groups – for example BME staff may be concentrated in job roles where there are greater redundancies or be less likely to have long lengths of service if this is used in redundancy decisions.</li> </ul>	<p>Equality Impact Analysis to see where staff reductions may have an adverse impact on particular groups – either staff or people using services. Use this to plan lawful positive action to mitigate any impact. See <a href="#">EHRC guidance on making fair financial decisions</a>.</p> <p>Use staffing tools to ensure that people’s dignity and other rights can be upheld if staff numbers are reduced. NHS Improvement are co-ordinating work on safe and sustainable staffing tools for a variety of settings including adult <a href="#">acute inpatient care</a> and <a href="#">learning disability services</a>.</p> <p>Improving workforce equality is covered <a href="#">later in this section</a>.</p>
<p><b>Changing service delivery to save money</b></p> <p>e.g. moving towards generic “high volume” services rather than more “bespoke” services. Or not commissioning outreach services or other support services. Also “unintended consequences” of takeovers and mergers.</p>	<ul style="list-style-type: none"> <li>Poorer access – lower uptake of services from particular groups.</li> <li>Less innovation in equality and human rights practice – poorer outcomes.</li> <li>Takeovers and mergers may mean that smaller user-led organisations or those for particular equality groups are unable to maintain an equality focus as part of a larger organisation. Momentum can also be lost on staff equality issues such as flexible working.</li> </ul>	<p>Equality Impact Analysis to see where service changes may have an adverse impact See <a href="#">EHRC guidance</a> above.</p> <p>For NHS trusts, good use of the Equality Delivery System (<a href="#">EDS2</a>) can help uncover where more consideration for particular equality groups might be needed for future service changes.</p> <p>Monitoring service use can be vital to assessing impact of changes on access and use of services. Monitoring sex, ethnicity, age and disability is well established – monitoring sexual orientation is recent in many services. The LGBT Foundation has produced <a href="#">a guide</a> to help – following the introduction of a sexual orientation monitoring standard in the NHS, Commissioners need to take account of the Public Services (Social value) Act 2012 – to consider how to improve the economic, environmental and</p>

Change	Equality and human rights impacts	Ways of reducing these impacts
<b>Changing service delivery to save money</b> (contd)		<p>social wellbeing of local communities when procuring service contracts. <a href="#">The Voluntary Organisations Disability Group Social Value toolkit</a> can help health and social care providers work with commissioners in delivering “social value” – including equality for people who use services and staff – when services are being recommissioned.</p> <p>British Institute of Human Rights <a href="#">health and human rights hub</a> brings together resources which will help consider human rights when changing services. This covers social care as well as health services.</p> <p>As part of the General Practice Forward View, NHS England have published a guide for GP practices and commissioners – <a href="#">Improving access for all: reducing inequalities in access to GP services</a>.</p>
<b>Reducing capital expenditure to save money</b>	<ul style="list-style-type: none"> <li>• Care environments less likely to meet people’s needs – equality, dignity, autonomy.</li> <li>• This might have a particular impact on disabled or older people.</li> </ul>	<p>Providers must meet the Equality Act 2010 “reasonable adjustments” requirements. This includes making their premises more accessible to disabled people. This is an “anticipatory duty”. So providers should consider this, even if no-one currently using the service needs the adjustment. See the <a href="#">EHRC Statutory Code of practice</a> on providing goods and services, chapter 7.</p> <p>Some ways to improve accessibility of care environments are low cost. For example, keeping corridors clear or improving signage. Improving accessibility can be cheaper if considered as part of regular maintenance rather than a separate activity. For example, better colour contrast can be specified on all routine redecoration.</p> <p>Person-centred approaches to accessibility are important. So, discussing planned improvements with individual people, their relatives and staff cost little and can make a big difference. This will make a building <a href="#">more accessible to individual people with dementia as well as blind and partially sighted people</a>.</p>

## 2. Reduce service demand

Change	Equality and human rights impacts	Ways of reducing these impacts
<b>Changing clinical criteria for treatment</b>	<p>Sometimes this can have hidden impacts on equality groups , for example:</p> <ul style="list-style-type: none"> <li>• People with a learning disability are more likely to be obese than others. A policy decision to recommend that all obese people lose weight before they are recommended for certain types of surgery could have a larger impact on people with a learning disability.</li> <li>• A recommendation that smokers quit smoking before treatment could have a larger impact on people with enduring mental ill health, who are more likely to be smokers.</li> <li>• Both these decisions are also likely to have a higher impact on people living in poverty.</li> </ul>	<p>Developing person-centred approaches to clinical decision-making – <a href="#">“shared decision-making” between clinicians and patients</a>.</p> <p>Equality Impact Analysis to see where clinical policy may have an adverse impact on particular groups. Use this to review decisions. See <a href="#">EHRC guidance on making fair financial decisions</a>.</p> <p>For NHS trusts, good use of the Equality Delivery System (<a href="#">EDS2</a>) can help uncover where more consideration for particular equality groups might be needed for future service changes.</p>
<b>Not increasing services in line with increased demand</b>	<ul style="list-style-type: none"> <li>• Some social care services are under financial pressure and are “handing back” local authority contracts. Others are choosing only to expand their services for people who are self-funding. This is likely to have impacts on particular groups of older or disabled people who are more likely to need publicly funded social care.</li> <li>• Waiting lists in some health services are growing due to financial pressures. This is likely to have particular impacts on some groups – for example older people who use health services more than others.</li> </ul>	<p>These are some of the major national policy questions facing health and social care at the moment – and are beyond the scope of this resource.</p> <p>Solving these issues is beyond the control of a single provider and involves system transformation. Ensuring equality is considered within this system transformation is discussed in the section on <a href="#">“the whole system approach”</a>.</p>

### 3. Increase financial resources

Change	Equality and human rights impacts	Ways of reducing these impacts
<p><b>Charging for healthcare services</b></p> <p>This could be universal charges – such as prescription charges – or local charges such as hospital car parking fees. Or this could be increase in charges targeted at particular groups of people – for example <a href="#">NHS charges for non-urgent care for overseas visitors</a></p>	<ul style="list-style-type: none"> <li>• Universal charges can have impacts on different groups, even with exemptions policies in place. For example, there is international <a href="#">academic evidence</a> that charging for prescriptions has a particular impact on older people as well as poorer people– and that it does not improve either efficiency or health equity.</li> <li>• If healthcare charges are targeted some people may be uncertain whether they will be charged for care. This can prevent them from seeking healthcare at an early stage in an illness, even if they are entitled to free care. Also, as we reported in State of Care 2015, staff working for healthcare providers may be uncertain about people’s entitlements.</li> </ul>	<p>Carry out Equality Impact Analysis to see where proposed charging policies may have an adverse impact on particular groups. Use this to plan lawful positive action to mitigate any impact. See <a href="#">EHRC guidance on making fair financial decisions</a>.</p> <p>Publicise people’s entitlements to free care or to exemptions from charges. Ensure that staff understand these entitlements. For example, NHS England has <a href="#">produced leaflets about registering with a GP for Refugees and asylums seekers and members of the gypsy, Roma and travelling communities</a>. These are useful for both patients and primary care staff.</p>
<p><b>Increasing fees in the social care sector</b></p>	<ul style="list-style-type: none"> <li>• More social care services are only available to self-funding people. This will have a different impact on groups of people including on the grounds of ethnicity, gender and disability as well as socio-economic status.</li> </ul>	<p>This is linked to major national policy questions around social care funding – beyond the scope of this resource and often beyond the control of a single provider. System transformation is needed. Ensuring equality is considered within this system transformation is discussed in the section on <a href="#">“the whole system approach”</a>.</p>

## 4. Improving staff equality

This is a big topic and one attracting much interest in terms of “what works”.

There are particular challenges in times of financial constraint. For example, it might be harder to recruit externally if there are planned redundancies and this might have an impact on increasing diversity within an organisation. But there are also opportunities – for example to improve progression for BME staff within the organisation.

We can only give a very brief outline here to stimulate people’s thinking.

**There are 4 key steps to improving workforce equality:**

### 1. Understand where you are now

For large organisations, this will include making best use of your data. For NHS trusts and independent healthcare organisations with NHS contracts, the [Workforce Race Equality Standards Indicators](#) are invaluable. But trusts can also extend this to look at other equality issues. And the Workforce Disability Equality Standard will come into effect in 2018/19 too.

Adult social care providers can use the [Skills for Care National Minimum Data Set](#) for the social care workforce to look at diversity data across different social care job roles and regions.

For all organisations, you will need to listen to the views of your staff in different equality groups. This will help you to understand the data, for example whether inequality is a particular issue in specific services. In some circumstances, it might be necessary to get help from outside

organisations to do this, particularly if staff have concerns about speaking up on equality issues.

### 2. Understand the root causes for any workforce inequality

This is a necessary step before looking at solutions to inequality but it is often missed out. Again, talking to staff is important in establishing causes. Sometimes, more analytical “root cause analysis” is needed. [2016 NHS Workforce Race Equality Standard data analysis report](#) gives some examples. See the Chapter “What works – characteristics of effective interventions”.

### 3. Apply effective interventions

There can be a willingness to tackle workforce inequality – but the interventions are often ineffective. Effort is put in, but the outcomes change little. To give two examples:

Research shows that a focus on equality training alone is not very effective. Unconscious bias learning has become very popular. Unconscious bias can explain some of the reasons why inequality happens. But learning about bias is not enough. Even willing people need support to change their behaviours rather than relying solely on individuals changing their minds. Institutional barriers to equality also need to be addressed.

A focus on changing policies and procedures may seem like the way forward in reducing institutional barriers. However, policies and procedures are not enough. Organisations need to be more proactive and preventative in their approach to tackling inequality.



There is developing work to show how tackling inequality can be “designed into” various activities at an organisational level rather than an individual level such as recruitment or disciplinary procedures. For example see this short video about [gender equality by design](#). Quality Improvement (QI) methods can also be helpful to address workforce inequality. Sheffield Teaching Hospital Trust has used [QI approaches to tackling differences in the likelihood of BME staff](#) and white staff being successful in promotion.

The 2016 NHS Workforce Race Equality Standard data analysis report identifies 5 building blocks for effective interventions, these are:

- Accountability – at the centre of the other 4
- Leadership
- Metrics
- Voice of BME staff
- A convincing narrative and business case

Creating a broader positive culture change for all staff also has an impact on staff equality. The King’s Fund report [Making the Difference](#) suggests six key points for developing a culture of inclusion:

- A clear vision and values which managers consistently demonstrate
- Clarity of objectives and performance feedback for all staff
- Positive relationships – support, respect, care and compassion
- Quality improvement, learning and innovation which values diversity in the workforce, constructive debate and hearing all voices
- Team based working and a culture of co-operation

- Collective and collaborative leadership – recognising how all staff play leadership roles at various points.

These six points also chime well with the [common features we found in outstanding providers who are using equality and human rights approaches to improve care](#).

The NHS Improvement [Culture and leadership programme](#) uses these six points to help NHS trusts improve through developing a culture of compassionate and inclusive leadership. The tools include culture assessment tool, guidance, resources and case studies.

#### 4. Review your progress...and keep going

Workforce inequality can be complex to tackle. It is important not to be disheartened if change takes time.

Using a “Plan, do, check, adjust” cycle could help. This is a simple continuous improvement approach.

You can use annual data, such as workforce surveys to see the impact of your interventions. You also need to keep talking to staff about how they think the change is working.

You might also need to study each of the interventions in more detail to see what is working. And what is not making as much impact as you had hoped. This is particularly important if you bringing in more than one intervention at a time.

NHS trusts can also use the Equality Delivery System ([EDS2](#)) to review and plan their progress on workforce equality.

## 4. Empowering people and communities

### Whole system approach

Providers cannot do this work alone. They need support from commissioners, regulators and policy makers to put equality and human rights at the heart of quality improvement.

Empowering people and communities is essential to advance equality and human rights. To do this, health and social care leaders need to look beyond provider boundaries. And people using services and their representative organisations need to be involved too.

Local system leadership is also important. Sustainability and transformation partnerships (STPs) have an important role to play in reducing health inequalities. There is some emerging good practice about how STPs can consider equality in their work.

#### Providers working together to improve people's rights

How providers can use equality and human rights approaches to improve care – and to support people's rights – has been covered in section 2 and 3. However, providers can also work together.

Effective change can be brought about by providers supporting each other to change practice and improve people's rights – for example, the [VODG STOMP campaign](#), which aims to stop the over-medication of people with a learning disability, autism or both.

#### Role of commissioners

Commissioners can help providers by:

- **Putting equality and human rights requirements into contracts:** This will help commissioners to fulfil their duties under the Equality Act 2010 and the Human Rights Act 1998.
- **Contract monitoring:** Some equality considerations are in national health contracts already – such as the [NHS Workforce Race Equality Standard](#) and – for NHS trusts – use of [Equality Delivery System 2](#). Commissioners have an important role in making sure these national schemes are implemented well. The [Accessible Information Standard](#) is also a legal requirement for publicly funded health and adult social care services, so is likely to fall within contractual requirements for providers to follow legal obligations.
- **Recognising equality and human rights implications of commissioning decisions:** by listening to people using services and to providers to mitigate any negative impacts of commissioning decisions. For example, the EHRC has provided training resources about [commissioning for human rights in home care for older people](#).

- **Commissioning services to meet needs of specific groups:**  
Sometimes equity can be best achieved through commissioning services for particular groups. There are some good examples of this in the CQC review: [“A different ending – reducing inequalities in end of life care”](#). A key finding of the report was “where commissioners and services are taking an equality-led approach that responds to people’s individual needs, people receive better care.” The review [“My diabetes, my care”](#) also provides examples of good commissioning to meet the specific needs of Black and minority ethnic communities and people with a learning disability.

**Role of regulators**

Regulators can help providers by:

- **Ensuring regulatory frameworks support providers’ work on equality and human rights as a core to the quality of care**  
For example, CQC uses a [Human Rights Approach to regulation](#) to ensure that equality and human rights are “embedded into” assessment frameworks. These were reviewed in 2017, including working with NHS Improvement to strengthen the focus on equality in the “well-led” question for all health and social care services.
- **Equipping regulatory staff consider and act on equality and human rights**  
At CQC, this includes:
  - building equality and human rights into our “intelligence” i.e. the evidence that we have available about services for inspectors to use

- learning and development for inspection teams – for example our learning and development programme with British Institute for Human Rights. We are continuing to develop our equality and human rights capability. Over 250 staff have signed up to our equality and human rights network. They are supported by over 40 leads, as well as the small specialist Equality and Human Rights team of 3 staff.
- equipping inspectors with methods, tools and information that cover equality and human rights – a range of support from guidance to specialists on hand to answer technical queries.

- **Ensuring there are no “unintended consequences” of regulation that might negatively impact on human rights**

A regulatory focus on “minimising safety risks” might help with some rights – for example the right to life. However, it might make providers unduly risk-averse and reduce the autonomy of people using the service, potentially affecting other rights such as right to a private life. To counter this, regulators should use definitions of “risk of harm” which include risks to people’s rights. This enables a rights-based approach to risks.

CQC has incorporated infringements of people’s rights into “risk of harm” in our policy on what enforcement action we will take – our [Enforcement Decision Tree](#).

We recognise that sometimes providers may think that we are more interested in “risk minimisation” rather than “rights maximisation”. We hope that other work – such as publicising outstanding providers who work creatively to maximise people’s rights whilst minimising risks – will help address this.

- **Sharing learning from regulation to encourage improvement across the quality spectrum**

This ranges from what needs to be done to protect equality and human rights when the quality of care is poor to the sharing the best practice found through regulatory work. This project is an example of that work

Examples of work on human rights from other regulators in other sectors and professional regulators can be found in the [EHRC case studies](#) from regulators, inspectorates and ombudsmen.

### Role of policy makers

- **Policy makers can help providers to improve the quality of care by ensuring equality and human rights are embedded in policy and national system wide co-ordination:**
  - For example, there is an emphasis on equality, diversity and inclusion in [Developing People – Improving Care](#) – the national framework for action on improvement and leadership development in NHS funded services. This is published by the National Improvement and Leadership Development Board. [Developing People – Improving Care one year on](#) includes examples of both national organisations and health and social care providers improving care through a focus on staff equality and inclusion.
  - Equality also features in the [Shared commitment to quality](#) framework published by the National Quality Board as part of the NHS Five Year Forward View.
  - Equality and human rights feature in [Adult Social Care Quality Matters](#) initiative.
  - In the NHS, the [Equality and Diversity Council](#) plays a key role in bringing national organisations together to work on equality for both patients and NHS staff.

## Empowering services<sup>i</sup>

### Why do some people have poorer experience and outcomes from care?

The persistence of comparatively poorer experience and poorer outcomes for black and minority ethnic communities who use health and care services has been explained by:

- Evidence on the continuing experience of racism. For example: even when regulatory activity has led to action (for example the inquiry into death of David ‘Rocky’ Bennett resulted in the NHS Delivering Race Equality national programme) it does not appear to result in the scale of change needed, or ensure that progress endures.
- The lack of spread of better practice For example: reports of better experiences and outcomes as a result of services provided black and minority ethnic-led voluntary and community organisations are rarely accompanied by the lessons learnt being replicated in mainstream provision. [NICE guidance on improving the experience of care and support](#) for people using adult social care services includes the importance of seeking advice from the voluntary and community sector in order to meet the needs of people in equality groups.
- Uncertainty of what works with whom and in what context.
- At times this has been accompanied by an expectation that because a particular change is seen as valuable for one ‘equality’ group it will

be so for all. An example is ‘Direct Payments’ which clearly made a difference to some disabled people’s lives, but was not widely taken-up by black and minority ethnic disabled people.

There are lessons that if applied will make a difference. Some, but not all of these lessons are in the control of a provider.

#### Robert’s story

Robert was interviewed when he was on his way back up. A few years earlier he had a complete breakdown in his mental health. In his case, this was a result of the childhood trauma of losing a parent to suicide. He ended up on the streets, frequently being arrested, sectioned, medicated and discharged.

Eventually he found actual help when he heard about a place for people who had a mental illness and who were African Caribbean. With a secure roof over his head, and an environment he found supportive, he could start working on his recovery, start working on putting back together a life that had been torn apart with his breakdown.

These were things that the police, NHS, and homelessness services had not done.

i. With thanks to Jabeer Butt and Samir Jeraj of the Race Equality Foundation for writing this section.

## Keys to success: Broader services and more involvement

The Race Equality Foundation looked at examples of good and best practice in black mental health together with MHPF (now MHPA) in 2014. In particular, we found two keys to success:

- The inclusion of **broader services beyond specific and medicalised mental health services**. These services provide a more accessible and culturally appropriate way into discussing and addressing mental health issues. Services that seek to support the broad needs of the individual and the community they are in, and support their right to involvement in both services and the community creates a far more positive and engaged process. It is also a process that strengthens the rights of the individual, and those in their community who may need these services in future.
- The [examples of outstanding practice for GPs](#) on the CQC website give case studies of how GP practices have worked with voluntary and community sector groups to meet the broader needs of individuals and communities (see examples under the “responsive” key question).
- **Service user involvement** was also a common feature, but had important differences between providers. The focus on what individuals can do, and can do now meant service users and former service users were involved in service design and delivery in some organisations. In other organisations, they became advocates within the community and/or were supported into representative roles on local boards and forums.
- East Midlands Academic health sciences network has produced a series of [“top tips guides”](#) on involving and engaging people in different

communities, such as transgender people, people in Roma communities and young carers.

### Dhek Bhal, Bristol

Dhek Bhal, an organisation supporting South Asian people provides:

- a ‘sit-in service to give a break to carers,
- home care service for elderly, support around the home, washing, dressing, cooking, taking medication, cleaning, companionship, read the inspection report here.
- day care service and very vibrant luncheon club, a range of activities, talks on health, diabetes, heart disease.

Importantly, these services are an important gateway to addressing the key issue of mental health where it may otherwise be difficult.

### Kadimah

Kadimah is an organisation which works primarily with non-practicing people of Jewish descent. Although in contact with the local Orthodox community, they describe the relationship as “delicate” due to issues of stigma surrounding mental health.

The promotion of their services to Orthodox communities is therefore rarely explicit, but instead depends upon “people who have benefited from the therapies going out into the community to discuss their experiences and raise awareness in the community and to educate community elders about the issues.”

### Holistic approaches, complexity and challenges

Recent attempts to improve the quality of support available to people living with dementia have also emphasised the need for more holistic support, for example the [Dementia, Equity and Rights report](#). For example, Macintyre have supported with people with learning disabilities who are living with dementia to maintain their independence as well as continue care for their peers.

A holistic approach does not overcome complexity. For instance enabling ‘choice and control’ has been widely accepted as the right approach and is consistent with rights-based approach. We may call it self-directed care or personalisation, but the key elements remain consistent:

“It is important that individuals are supported in making their own decisions and deciding for themselves how support and services should be organised to meet their needs”

[In-Control, Supporting Choice and control](#)

However, this can pose challenges. One young Asian disabled woman argued that she did not want an adapted flat to make her more independent, but did want her parents’ house extended so she could have space of her own in the house.

This holistic human rights based approach has the potential to address the need for support in a personalised manner at the same time as ensuring everyone benefits. However, there are significant issues if there are inequalities of access – then there cannot be equality of experience or outcome.

### System wide support to enable equity of access

Specific good practice in developing equity of access has to be accompanied by system-wide change to ensure that the benefits are available to all.

One example: the benefits of being able to access high quality community language interpreting services when providing care are now well-established. This has to be accompanied by everyone recognising that communicating effectively is a skill that has to be practiced and is a fundamental part of a quality service which promotes equality and reduces health inequalities.

# Transformational change

Transformational change is an essential option in times of financial constraint, which often involves reducing costs through preventing ill-health. This benefits both individuals and health and social care budgets.

There is a focus on tackling health inequalities in NHS Five Year Forward View (5YFV). The ‘Health and wellbeing gap’ is one of three gaps 5YFV aims to close. It is early days yet to see how this plays out in practice in Sustainability and Transformations Plans (STPs) and in the future through [Accountable Care Organisations](#). Some STPs are looking at integrating equality into their plans – not only as a ‘inequalities work stream’ but to check the equality impact of all their work including radical service reconfiguration.

There can also be a shift towards “[population health](#)” models which are designed to improve health outcomes for a particular group of individuals. This could include some equality groups – such as older people, or people with a learning disability. These “system changes” often require new ways of organisations working together and could have a major impact on equality of access and outcomes.

### Example: Devo Manc – Testing an equality approach to service transformation

The NHS Transformation Unit used the “Healthier Together” project as test of an equality approach. This focused on the transformation of general surgery across Greater Manchester.

A community organisation undertook an Equality Impact Assessment (EIA) informed by a series of engagement meetings with equality groups. The EIA also included socio-economic impacts and travel impacts, as well as impacts on equality groups.

- The EIA was independently assured by an Equality Advisory Group (EAG): providers, commissioners, voluntary and community groups, local authorities
- The EIA had equal status to other factors in the option appraisal for the transformation
- The EAG prioritised the most important actions to mitigate any negative impacts on equality
- Disabled people’s rights organisation carried out an access appraisal for different options

Mitigating actions and access requirements became conditions for implementing the service changes (e.g. advertising NHS travel vouchers, good signage, face to face communication skills)

Providers were “benchmarked” to enabled best practice relating to mitigating actions to be identified and shared by the EAG

Area action plans were drawn up to ensure equality was consistently addressed by preferred providers – bringing all up to the highest standard of the best providers

**They are now rolling out this approach to other transformation projects. For more details contact: [transformationunit@nhs.net](mailto:transformationunit@nhs.net)**



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## Extra resources

### The ethical case: People speaking up about equality and human rights

[CQC short film on what matters to people in a range of different equality groups](#)

**Social Care Institute for Excellence** videos:

- working with [lesbian, gay, bisexual and transgender people](#)
- issues important to [Black and minority ethnic people using social care](#)

A few of the many Local Healthwatch reports suggested by **Healthwatch England**:

- Healthwatch Hampshire: reports about [people with a learning disability](#) and [people with dementia](#). And their [powerful film about health care experiences of transgender people](#)
- Healthwatch Hackney: the specific health and wellbeing needs of [vulnerable sex workers](#)
- Healthwatch Newcastle: [the health needs of refugees and asylum seekers](#), [Black and minority ethnic people's involvement in the ambulance service as patients and potential employees](#), and [young people's mental well-being](#)
- Healthwatch Leicester: inequality in health services faced by [deaf people](#)

- Healthwatch Blackburn with Darwen uses a human rights approach to health care. They work with British Institute of Human Rights and other advocacy organisations as part of the “Care and support: a human rights approach to advocacy” project. You can read some of the project success stories [here](#).

**National LGB and T Partnership:** [Out Loud, LGBT Voices in health and social care](#).

**The [Equally Ours](#) website** contains useful resources to help people talk about human rights – including many health and social care issues. It is co-ordinated by the voluntary sector [Equality and Diversity Forum](#).

### Quality improvement and health equity

The Institute for Healthcare Improvement in the US has done much work around improving equity of access, treatment and outcomes. They have many resources that can help a [focus on health equity](#) in quality improvement work which are also relevant to work in the UK.

## Links between nine common factors in case studies and CQC key lines of enquiry

9 common factors	CQC adult social care <a href="#">key lines of enquiry</a>	CQC health key lines of enquiry	Notes
Leadership enthusiastic and committed to Equality and human rights (E&HR)	W1.6, W1.7	<a href="#">W3.8</a>	
E&HR runs as a thread	W1.6, C3.3, C3.5, R1.2, R3.1, S1.3	<a href="#">W3.8</a> , <a href="#">W7.1</a> , <a href="#">W7.2</a> , <a href="#">S1.3</a> , <a href="#">E1.2</a> , <a href="#">R1.1</a> , <a href="#">R2.1</a> , <a href="#">R2.4</a> , <a href="#">R2.5</a> , <a href="#">R2.9</a>	All key E&HR KLOEs here – collectively they amount to a “thread” starting from well-led
Equality culture for staff	W1.2, W1.3	<a href="#">W3.8</a> , <a href="#">W1.4</a>	
Apply E&HR thinking to Quality Improvement issue	W1.6	<a href="#">W2.5</a>	
People who use services at the centre	C1.2, C1.4, R1.2, W3.1, W3.6	<a href="#">E5.3</a> , <a href="#">C1.1</a> , <a href="#">C1.5</a> , <a href="#">C2.5</a> , <a href="#">R2.7</a> , <a href="#">R2.8</a> , <a href="#">W7.1</a> , <a href="#">W7.2</a>	
Staff as improvement partners	W3.1, W1.8	<a href="#">W7.3</a> , <a href="#">W8.4</a>	
Linked to outside	W3.2, W5.1	<a href="#">W7.4</a>	
Courageous and bold	W4.3	<a href="#">W8.1</a> , <a href="#">W8.4</a> , <a href="#">W8.5</a>	Innovation
Curious and humble	W1.4, W3.3, W3.4, W3.6	<a href="#">W7.1</a> , <a href="#">W7.2</a> , <a href="#">W8.3</a> , <a href="#">W8.4</a>	Continuous improvement, responding to concerns

**Links between 9 common factors in case studies and NHS Improvement 5 cultural elements in the [Culture and Leadership Programme](#)**

	Vision & values	Goals & performance	Learning & innovation	Support & compassion	Team work
Leadership enthusiastic and committed to Equality and human rights (E&HR)	✓	✓		✓	
E&HR runs as a thread	✓	✓		✓	
Equality culture for staff	✓			✓	✓
Apply E&HR thinking to Quality Improvement issue			✓	✓	
People who use services at the centre	✓			✓	
Staff as improvement partners		✓	✓		✓
Linked to outside			✓		✓
Courageous and bold	✓		✓		
Curious and humble	✓		✓		

## Further case studies

### All sectors

The CQC publication [Celebrating good care, championing outstanding care](#) covers equality and human rights topics – especially in the caring and responsive sections.

### Adult Social Care

- The CQC report, [A Different Ending](#) looks at the importance of addressing inequality in end of life care. Some hospices are providing outstanding care which takes equality into account and has a focus on human rights – including [Trinity Hospice and Palliative care](#) in Blackpool, [St Luke's Hospice](#) in Sheffield and [East Lancashire Hospice](#)
- [Care By Us](#), a large homecare agency in North London and West Hertfordshire has adopted seven outcomes from the Hertfordshire "Ageing Well strategy". These include human rights principles around independence, dignity and respect, choice and control. The agency have used these principles to provide outstanding care.
- [Waterside](#), an Anchor Trust care home in London, participated in a Middlesex University project to develop more inclusive services for lesbian, gay, bisexual and transgender people. This contributed towards the care home receiving an outstanding rating in the responsive key question.
- **Skills for Care** have published a Good and Outstanding Care Guide along with some [video examples](#). [The guide](#) is arranged by the 5 key questions that CQC uses and covers many equality and human rights topics – with advice and examples from many good and outstanding services.

- The **Driving Up Quality Alliance** is made up of national bodies with a focus on improving the quality of care for people with a learning disability. They are funded by the Department of Health. [The Driving Up Quality Code](#) is "not intended as a quality measurement tool or to replace other codes and frameworks, but is a process that can enable organisations to think more deeply about what they are trying to achieve and how their behaviour impacts on this". Their website contains many good practice examples related to equality and human rights.

### Hospitals

- [Driving Improvement: case studies from 8 NHS trusts](#) focuses on trusts which have moved from Inadequate or Requires Improvement to Good or Outstanding. We asked all trusts about their work on equality and human rights as part of this. The case studies of Leeds Teaching Hospitals NHS Trust, Cambridge University Hospitals NHS FT and University Hospitals Morecambe Bay NHS FT are particularly strong on how they used equality and human rights in their improvement journey.
- Our report [The State of care in NHS Acute Hospitals 2014 – 2016](#) brings together the key learning from our first comprehensive programme of all 136 NHS acute and 17 NHS specialist trusts. This includes learning about equality and human rights for people using services – under the caring and responsive questions – and equality for staff – under "well led".
- Because of the nature of compulsory detention under the Mental Health Act, there is a history of looking at human rights in mental health care. [Mersey Care NHS Foundation Trust](#) has been a leading trust in developing human-rights based projects and approaches to work. Some examples are given in their [October 2015 inspection report](#).

- Some outstanding independent hospitals are developing strong work around equality, for example [Peninsula NHS treatment centre](#) in Plymouth.

### Primary medical care

We have compiled a large number of [examples of outstanding practice for GPs](#), arranged by the 5 key questions that CQC uses. Many examples – especially but not exclusively in the caring and responsive sections - cover good practice around equality and human rights

### Dental care

Our examples of [notable practice](#) for dentists include practices that have taken action to ensure equal access for patients and to improve health outcomes for particular groups – especially those practices listed under “responsive to people’s needs”.

**What do we mean by equality and human rights?**  
In this resource we have used ‘equality’ to mean that people using services have equal access, experience and outcomes when using health and social care. This is different from treating everyone the same. For example, someone with a learning disability may need to be supported in a different way to achieve the same access to services. We also mean that staff working in services have equality of opportunity, for example in career progression; and equal treatment, for example in relation to disciplinary matters.

The Equality Act 2010 recognises “8 protected characteristics” in service provision – age, disability, race, religion and belief, sex, sexual orientation, gender reassignment and pregnancy and maternity status. But there are other factors that have an impact on equal access, experience and outcomes in health and social care too – such as income, social class, homelessness, immigration status and whether people live in an urban or rural area.

‘Human rights’ cover a wide range of topics. The human rights in healthcare framework covers the ‘FREDA principles’ of fairness, respect, equality, dignity and autonomy. Understanding the legal basis of human rights can be very helpful – as people can interpret terms such as ‘respect’ in a wide range of ways. The legal basis of human rights can also help when making difficult decisions where people’s rights may be competing – e.g. the rights of people using a service and the staff in the service. However, an understanding of human rights law is not needed to use this resource.

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## About CQC

**The Care Quality Commission is the independent regulator of health and adult social care in England.** 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 register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

### Our values

**Excellence** – being a high-performing organisation.

**Caring** – treating everyone with dignity and respect.

**Integrity** – doing the right thing.

**Teamwork** – learning from each other to be the best we can.


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Read more and download this report in other formats at **www.cqc.org.uk/ourstrategy**

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

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