Equality Impact Assessment (EIA)

1	**Name of the Policy/Guidance document or project/programme**	**CQC COVID-19 Regulatory Response version 2**	
2	**Directorate**	**Cross CQC**	
3	**Details of the person responsible for the EIA**	**Name:** **Job Title:**	Lucy Wilkinson Equality, diversity and human rights manager
4	**What are the main aims and objectives of the Policy/Document/ project or programme**	Our response to COVID-19 is arranged through five workstreams: 1. Engagement – internal and external 2. Organisational readiness 3. Organisational resilience 4. Regulatory response 5. Intelligence and data collection **This is a fast-moving situation, where life and death decisions need to be made by the health and social care system. Our Equality and Human Rights impact analysis (EIA) will need to be regularly reviewed as the health and social care system, and our regulation of it, adapts quickly. This is the second version.** **This EIA focuses on changes to our regulation. Whilst it takes into account general measures to ensure CQC staff health and welfare, specific measures for groups of staff with particular protected characteristics are not considered in this EIA but are being considered separately.** Because of the nature of our regulation, there are 3 types of relevant impacts: • Differential impacts of the COVID-19 pandemic on particular groups of people using health and adult social care services, for example where some equality groups have a higher risk if they contract COVID-19 • Impacts on equality and human rights of the way that providers of health and social care respond to the COVID-19 pandemic, both the way that providers provide care to people who contract COVID-19 and the impact on people using other services they provide • Potential impacts of the way that CQC responds to the COVID-19 pandemic – both in relation to regulatory issues	

		arising from COVID-19 and also our ability to carry out our usual functions, for example through CQC staff observing social distancing requirements in their work. **The action plan in section 8 is the summary of the actions which we propose to take.**

5. Engagement and involvement Who have you consulted with as part of this EIA? E.g. Staff Networks, Trades Unions, groups of people who use services, providers
• Key people working on COVID-19 workstreams • CQC COVID-19 Silver Command and Regulatory Oversight Group • Equality and Human Rights staff network - including a virtual meeting attended by around 90 colleagues (17 March 2020) • Online discussion with around 80 external people interested in the first version of the Equality Impact Assessment, mostly Equality, Diversity and Inclusion leads from NHS Trusts (23/04/2020) • Discussion on key issues with NHS Equality and Diversity Council (23/04/20) • Cross CQC engagement activity summaries, including engagement with advocacy and representative organisations (18 -24 March 2020; early April-12 May 2020) • CQC Staff Equality Network Chairs and Vice Chairs (7 May 2020)

6	**a) Impact** **Is the policy, project or programme likely to have a <u>differential</u> impact on any of the protected characteristics? If so, is this impact likely to be positive or negative?** **Consider:** How does the policy, project or programme help us meet our public sector duty of:- • Eliminating Unlawful discrimination • Advancing Equality of Opportunity • Promoting good relations between groups Does the policy exclude individuals with a protected characteristic e.g. females, older people etc? What does existing evidence show? E.g. consultation from different groups, demographic data, questionnaires, equality monitoring data, analysis of complaints For internal policies, projects or programmes, you need only consider impacts on CQC staff. For external facing policies, projects and programmes you should consider others affected by the proposals, such as people using health and social care services and people working for providers.	**b) Mitigation** **Can any potential negative impact be justified? If not, how will you mitigate, reduce or remove any negative impacts?** Think about reasonable adjustments Consider positive action Consider how you would measure and monitor the impact going forward e.g. equality monitoring data, analysis of complaints.
Age	1. Older people in England are more likely to develop serious ill health and are more likely to have complex co-morbidities which place them at greater risk of complications if they	See general comments below

	contract COVID-19 so our ability to respond well to COVID-19 will have a large impact on older people 2. A high number of older people use health and social care services so if COVID-19 has an adverse impact on our ability to regulate the quality of services, older people will be disproportionately affected 3. Providers need to consider mitigating the impact of "social distancing" approaches to COVID-19 on the human rights of older people, whilst still maintaining infection control in order to protect lives. 4. People over 70 are the most likely age group to be subject to a Deprivation of Liberty safeguard authorisation. 5. Older people living at home may experience the impact in relation to isolation, safety and wellbeing if home care agencies cannot deliver care due to staff shortages. Older people may also withdraw from home care because of fears of COVID-19 6. Older people living in care homes are at risk of not being able to access NHS inpatient services because some GPs and other doctors (including in hospitals) are carrying out blanket advance care plans and completing Do not attempt resuscitation forms which state that they should not transfer to acute care if they get COVID-19 (this may also be a risk for young people with long term conditions and other disabled people) 7. Older people in hospital may be at risk of not getting access to intensive care if they need it because of discriminatory decisions based on age alone, unrelated to the ability to respond to treatment 8. Older people with dementia in care homes may be subject to the use of chemical restraint to stop them walking around, as a social distancing measure when this is not the least restrictive approach available 9. Discharge of COVID-19 positive people and COVID negative older people from acute hospital into care homes may put the lives of other older residents at risk, if infection control cannot be managed 10. Potential for excess deaths due to stopping routine care for older people with long term conditions (also a specific risk for some BME and disabled people) 11. A fall in the numbers of children and young people accessing front line health services, including GPs and acute or emergency care, has meant that these services are not seeing children who are at risk or who are already subject of safeguarding arrangements. This will lead to children at risk not being identified and remaining in unsafe situations without intervention. 12. Reduced visibility of children at risk or subject to safeguarding (including by health services) due to lockdown and increased risk of abuse for children not at school 13. Decreased referrals to children's healthcare and Children and Adolescent Mental Health Services may cause surge in referrals after lockdown and also create difficulties in transition planning for young people 14. There may be risks to the wellbeing and care of children if their parents become unwell due COVID-19	
Carers / People with caring responsibilities	1. Changes to the quality or availability of health and social care services during the COVID-19 outbreak are likely to have an impact on informal carers, so our response to the preparedness of services to deal with increased numbers of people will have an impact on carers	See general comments below

Disability	1 Potential for excess deaths due to stopping routine care for disabled people with long term conditions. 2 Disabled people living in care homes and in the community are at risk of not being able to access NHS inpatient services because of some GPs and other doctors (including hospital doctors) carrying out blanket advance directives and DNACPR which state that they should not transfer to acute care if they get COVID-19. This includes disabled people with a learning disability and autism, and others with long term conditions 3 Disabled people in hospital may be at risk of not getting access to critical care if they need it and experience disability discrimination. NICE guidelines have been reviewed and improved but there are a number of other guidelines on access to critical care which may be confusing and hamper good clinical decisions and risk discrimination. 4 The higher numbers of deaths from COVID-19 of people living in deprived areas of England will have a disproportionate impact on disabled people who are more likely to live in these areas 5 There has been an increase in the numbers of death notifications of people detained under the Mental Health Act, who have died of confirmed or suspected COVID-19. 6 Discharge of COVID-19 positive people and COVID –19 negative disabled people from acute hospitals into care homes may put other disabled residents at risk where it is not possible for the care homes to manage the necessary infection control. 7 People with some long-term conditions (which would be classed as a disability under the Equality Act 2010) are more likely to develop serious ill health if they contract COVID-19, so our ability to respond well to COVID-19 will have a large impact on disabled people 8 A high number of disabled people use health and social care services so if COVID-19 has an adverse impact on our ability to regulate quality of services, disabled people will be disproportionately affected 9 Changes to the Care Act through coronavirus legislation, if implemented, may have a disproportionate impact on equality for disabled people, due to limiting entitlement to care and support 10 People with long term conditions may have their access to regular and specialist services and support reduced when resources (staff, facilities, specialist equipment and centres) are used to respond to COVID-19). There may also be impacts on medication supply chains. 11 COVID-19 may have an impact on hospital bed availability which may have an impact on hospital accommodation issues for people with long term conditions (eg. availability of suitable bed space) 12 Some disabled people, such as people with mental health conditions or a learning disability or autistic people are more likely to be in secure environments where o If they contract COVID-19, they will not be able to access mainstream treatment services o If many staff are away from work due to COVID-19, this could have a particular impact on people's human rights if they are reliant on staff for basic needs, for example being cared for in segregation, so the human rights risk might increase at a time when we are less able to monitor this o If CQC's ability to undertake inspection visits is reduced, because they may be more at risk of	See general comments below

	serious harm or human rights breaches unrelated to COVID-19 ○ These two points above are also relevant to our specific obligations relating to Mental Health Act monitoring and National Preventive Mechanism work including monitoring of Deprivation of Liberty safeguards in hospitals and care homes. ○ People with a learning disability and autistic people are more at risk of being admitted and unable to be discharged from inpatient units due to the lack of social care support in the community, likely to get worse during COVID-19 pandemic. 13 Some disabled people, such as people with advanced dementia might face difficulties using health care for people with COVID-19. This group might be more likely to be cared for in other regulated settings (e.g. nursing homes) with less access to specialist equipment or staff 14 Some disabled people receiving domiciliary care may be impacted by staff shortages due to COVID-19 and experience risks to their human rights. 15 Some disabled people with information and communication needs may receive poorer quality information about COVID-19 when staff are working under pressure and where information is being produced quickly. 16 Providers need to consider whether "social distancing" approaches to COVID-19 might have an impact on human rights of disabled people and people with long term conditions, eg. blanket bans on care home or hospital visitors beyond government guidance. Decision making about social distancing and self-isolation might have particular implications for disabled people restricted or deprived of their liberty through the Mental Capacity Act and DoLS (engaging article 5 rights to Liberty under the European Convention of Human Rights) 17 Social distancing policies of providers might have a higher impact for Black and Minority Ethnic disabled people who have experienced discrimination and this may reinforce a sense of stigma 18 Changes to the Care Act through coronavirus legislation, if implemented, may have a disproportionate impact on equality for disabled people, due to limiting entitlement to care and support 19 People with a learning disability may be subject to the use of chemical restraint (PRN medications) to address increased distress due to social distancing measures, when this is not the least restrictive practice 20 Asymptomatic people being admitted to Mental Health Inpatient wards may be a low priority for COVID-19 testing but there are high transmission risks for other patients and staff 21 Lack of clarity over the duty to make reasonable adjustments for disabled people may lead to some health services to fail to provide BSL interpretation services for deaf people when needed 22 Providing GP appointments online may have accessibility issues for disabled people with information and communication needs and people who are digitally excluded may not be able to access an online GP appointment 23 Social distancing may lead to an increase in mental health issues and, for example, an increase in young people going to A&E with mental health concerns and an increase in suicides	

	24 Some of our methods to gather the experience of care from people during this time when we are not carrying out inspections may not be accessible for some disabled people. There is a particular difficulty where we would normally observe care to assess people's experience, where people are non-verbal, for example, people with advanced dementia or some people with a learning disability. 25 People with severe mental health conditions may not receive support that meets their needs as mental health service move to more digital and telephone consultations 26 Insufficient social distancing because of shared bathrooms in mental health inpatient units may put people at increased risk of infection from COVID-19	
Race / Ethnicity	1 Disproportionate numbers of BME people are dying of COVID-19 and also there are also disproportionate numbers of BME people in intensive care with severe effects of COVID-19. Reasons for this are currently unknown. BME people may be more likely to have health conditions associated with a worse outcome from COVID-19 (such as diabetes) or be in occupations where social distancing is harder to maintain. There may also be factors connected with access to healthcare. 2 There have also been a disproportionate number of deaths of BME staff who have been delivering health and social care. Some BME staff have said that, because of discrimination, they are fearful of asking for adequate PPE. 3 The higher numbers of deaths from COVID-19 of people living in deprived areas of England will have a disproportionate impact on BME people who are more likely to live in these areas 4 Potential for excess deaths due to stopping preventative or routine care for long term conditions during the pandemic, some of these conditions are more prevalent in BME communities 5 People who speak English as a second language may have less access to information about COVID-19 and therefore may be at a higher risk 6 'Social distancing' policies of providers might have a greater impact for BME older or disabled people who rely on family for advocacy/ social contact in care settings 7 Social distancing policies of providers might have a higher impact for BME older or disabled people who have experienced discrimination and this may reinforce a sense of stigma 8 People in immigration detention centres are in secure environments where a. If they contract COVID-19, they will not be able to access mainstream treatment services b. If more severe restrictions are applied in order to maintain social distancing, this may have an impact on their mental health c. If CQC's ability to undertake inspection visits is reduced, they may be more at risk of serious harm or human rights breaches 9 People who experience barriers to accessing health services eg. homeless people, asylum seekers, refused asylum seekers and undocumented migrants may need special consideration for information about COVID-19 and access to care. Regulations came into force on 29 January to add coronavirus (COVID-19) to Schedule 1 of the NHS (Charges to Overseas Visitors) Regulations. It is very important, for public health protection, that overseas visitors	See general comments below

	and other migrants are not deterred from seeking treatment for COVID-19[1]. 10 The emergency nature of the pandemic in the NHS, exacerbated by many staff moving roles could have an impact on work to ensure race equality in the NHS (this would also apply to work on other equality issues for the workforce) 11 The prior complete ban on hospital visiting, especially for people at the end of their life, has had different impacts on different faith groups. This may have had an impact on the decisions of families to contact the NHS about health concerns for their loved ones, particularly for older relatives and particularly where their relative did not speak English. 12 Concerns about racism and distrust of health services among BME communities may lead to people avoiding going to hospital, for fear that their needs wouldn't be considered a priority 13 There may be limited access to healthcare during COVID-19 for victims of modern slavery and human trafficking. Modern slavery may increase, due to the economic impacts of COVID-19.	
Gender	1 Women make up the majority of the frontline health and social care workforce, so may be disproportionately likely to contract COVID19 2 Women are more likely to be informal carers for older or disabled people, who are more likely to have serious illness as a result of COVID-19 3 Significant increases in domestic violence during lockdown disproportionately impacts women and will increase their need to access health services, domestic and sexual assault referral centres. This may result in increased safeguarding referrals. 4 Access to reproductive health services and medications such as HRT for women may be limited during the lockdown 5 In some places, there is a particular shortage of PPE which is suitable for women health and social care staff (such as smaller face masks), putting them at a higher risk of contracting COVID-19 6 Men are more likely to experience severe COVID-19 symptoms and are disproportionately represented in deaths from COVID-19	See general comments below
Gender Reassignment	1 'Social distancing' policies of providers might have a higher impact for trans older people who rely on their external contacts for advocacy/ social contact in care settings 2 COVID-19 may have an impact on hospital bed availability which may have an impact on hospital accommodation issues for trans people (eg availability of suitable bed space) 3 Social distancing policies of providers might have a higher impact for trans older people who have experienced discrimination and this may reinforce a sense of stigma 4 Social distancing, pressure on and cancellations of medical services, and logistics affecting the availability of medicines may limit trans people's access to regular appointments, surgery and medicines they need as part of their transition. This includes closure or reduced services offered by Gender Identity Clinics, which already have long waiting lists	See general comments below

[1] https://www.gov.uk/government/collections/nhs-visitor-and-migrant-cost-recovery-programme

	5 Trans people are disproportionately more likely to have poor mental health and social distancing may have disproportionate impacts on them 6 Where trans people need to "socially distance" with families who may be unsupportive of their trans identity, this could have an impact on their mental health and put them at risk of transphobic abuse and violence	
Marriage & Civil Partnership	No differential impact	See general comments below
Pregnancy & Maternity	1 Pregnant women are included in the list of 'high risk' groups. 2 Extreme pressure on health services or staff shortages may have an impact on the continuum of maternity and post- natal services 3 Social distancing for pregnant women might have an impact on their ability to manage their own healthcare, including mental health	See general comments below
Religion & Belief	1 "Social distancing" policies might have different impacts e.g. in terms of end of life care for people in different religious groups, for example, where it is more important in some religions that the person sees either their family or a religious or spiritual leader or official when they are nearing death. 2 Eventual vaccines for COVID-19 might not comply with requirements of some religions 3 The complete ban on hospital visiting, especially for people at the end of their life, has had different impacts on different faith groups. This may have had an impact on the decisions of families to contact the NHS about health concerns for their loved ones, particularly for older relatives and particularly where their relative did not speak English.	See general comments below
Sexual Orientation	1 Social distancing' policies of providers might have a greater impact for LGB older people who rely on their external social networks for advocacy/ social contact in care settings 2 Social distancing policies of providers might have a higher impact for LGB older people who have experienced discrimination and this may reinforce a sense of stigma 3 LGB people are disproportionately more likely to have poor mental health and social distancing may have disproportionate impacts on them 4 Because of social distancing, some LGB people, especially young people, may be confined in family situations where they are at risk of homophobia, homophobic abuse and violence which could have an impact on their mental health 5 Some gay men's organisations are concerned that diversion of anti-retro viral drugs to treat people with COVID-19 or disruption to the supply chain for these drugs might impact on people with HIV 6 Some LGB people may be at risk of discrimination if hospitals do not recognise their relationships, especially when their partner is severely ill	See general comments below

	General Comments across all equality strands Equality impacts for people who use services can be summarised as follows:	Mitigation of negative impact/ maximisation of positive impact
1	Older people and disabled people may have their access to care and treatment for COVID-19 blocked or limited: • if unlawful blanket DNACPR orders are applied to them • or they are unable to access NHS acute inpatient or intensive care admission because of decisions about access based on their age or disability that are irrelevant to their ability to benefit from treatment	Mitigation of potentially negative impact • make sure our methodology enables inspectors to identify if this is happening and take action to stop it; including enforcement action if necessary • raise awareness among providers that this is unlawful • work with other national organisations to amplify this message • where we have concerns that there is a high level of unlawful decision making in an area, use regional escalation protocols to address this
2	The higher numbers of deaths from COVID-19 of people living in deprived areas of England will have a disproportionate impact on disabled people and BME people, who are more likely to live in these areas	Mitigation of negative impact- • Raise awareness through our public work • Make sure our methodology enables our inspectors covering deprived areas to escalate issues of concern where they see them and alert providers • Use Intelligence where possible to create better understanding about this issue and help inform our public work • Carry out survey of BME people to gather their experiences of care, to help us inform our work and work with national partners •
3	Disproportionate numbers of BME people dying of COVID-19 and also disproportionate numbers of BME people in intensive care with severe effects of COVID-19.	Mitigation of potentially negative impact • Support and influence national work to identify causes and address this issue, including through using our intelligence where possible, and meeting regularly with key national partners • Share good practice by providers in addressing the causes • Carry out survey of BME people to gather their experiences of care, to help us inform our work and work with national partners • Use our methodology, raise inspectors' awareness of issues (at a provider level) and use regional escalation where needed
4	Disproportionate number of deaths of BME staff who have been delivering health and social care.	Mitigation of potentially negative impact – as above
5	There has been an increase in the numbers of death notifications of people detained under the Mental Health Act (MHA), who have died of confirmed or suspected COVID-19.	Mitigation of potentially negative impact - • Contact mental health providers to highlight concerns about COVID-19 related deaths of patients' subject to the Mental Health Act (MHA) • Clarify expectations of providers on their management of coronavirus and asking some providers to urgently confirm the action they are taking to manage coronavirus outbreaks • Continue to review data on these deaths to understand what factors might be driving this and if any additional action is required to safeguard people
6	There may be excess deaths and poorer health outcomes for people with long term conditions (especially older and BME people) and disabled people because routine services are stopped, reduced or impacted during the COVID-19	Mitigation of potentially negative impact – • raise awareness through our public work of where services are still operating and available

	pandemic. This may also affect victims of modern slavery or human trafficking	• using our data and intelligence, work with other partners on considering health inequalities in the "restoration phase" of NHS services • Carry out survey of BME people to gather their experiences of care, to help us inform our work and work with national partners
7	Reduced or no access to other services may also disproportionately impact women (eg. reproductive and maternal health, domestic violence services), trans people and children and young people (eg. safeguarding and mental health services)	As above
8	Older people and disabled people living in care homes may die from COVID-19 if people with COVID-19 (diagnosed or not) are discharged to care home which are unable to isolate residents	Mitigation of potentially negative impact – • raise this concern through policy work • inspectors provide support to individual care homes where they have concerns about their ability to manage infection control • escalate any concerns through regional escalation processes • Our work on providing information about deaths in care homes will support national intelligence on this
9	Older people and disabled people are more likely to have a serious illness if they contract COVID-19 so any work we do on emergency preparedness for COVID-19 should have a positive impact	Our work on COVID-19 preparedness will have a greater positive impact on older and disabled people than others in the population, as older and disabled people are more likely to need treatment for COVID-19
10	Older people and disabled people are more likely to rely on health and social care services that we regulate. This means that carers are also reliant on these services.	Mitigation of potentially negative impact– any change to our methods should consider how we can help the health and social care system ensure essential care quality for older people and disabled people. This includes care quality impacts caused by COVID-19 such as staff shortages which might impact on specific types of services used by older or disabled people – such as domiciliary care agencies and supported living services. Our proposals to monitor adult social care services during COVID-19 will therefore have a positive impact.
11	Providers need to consider "social distancing" approaches to COVID-19 which might have an impact on human rights of older people and disabled people, e.g. blanket bans on care home and hospital visitors ahead of government guidance.	Mitigation of potentially negative impact - Produce quick turnaround guidance for inspectors on maintaining human rights whilst following social distancing guidelines – updated as national situation changes
12	Self-isolation policies and the following of government advice might have a higher and more complex impact for people whose article 5 rights relate to the application of the DoLS scheme in hospitals and care homes, and in more general approaches to best interest decision-making and capacity in adhering to the Mental Capacity Act. Local authorities and DoLS teams may experience stretch in required resources or redeployment reducing DoLS management.	Mitigation of potentially negative impact - For self-isolation to manage infection spread, consider and agree the impact of MCA and DoLs on any CQC guidance and liaise with stakeholders as appropriate.
13	In addition, particular groups, such as LGBT and BME disabled and older people, people with mental health conditions and people in secure environments may be disproportionately affected by social isolation. Article 8 (Human Rights Act) is a qualified right and any interference needs to be proportionate: is it lawful, for a legitimate	Mitigation of potentially negative impact - include issues for equality groups in guidance and communications for inspectors and providers– based on providers assessing how to reduce social isolation for each person through care planning.

	reason, is it proportionate, with the least restrictive option put in place and alternatives made available so people can keep in touch with families and friends.	
14	Changes to the Care Act through coronavirus legislation, if implemented, may have a disproportionate impact on equality for disabled people, due to limiting entitlement to care and support	Mitigation of potentially negative impact - CQC will engage with DHSC, Local Authorities and local government stakeholders (eg. LGA, ADASS) to understand and help mitigate changes under The Care Act. We will gather and share information on Care Act Easements with providers, including information on impacts from organisations that represent people who use health and social care services.
15	People receiving care in secure environments – including in mental health hospitals, prisons and immigration detention centres might: • have less access to specialist health services if they contract COVID-19. • be more likely to have their human rights breached if many staff contract COVID-19. • be at greater risk of human rights breaches unrelated to COVID-19 if CQC are not able to carry out inspection visits • more people might be moved into secure environments during the COVID-19 outbreak, for example children and young people on • 52-week placements in residential special schools which are closing. Their human rights might be particularly at risk due to the urgent nature of their move and the disruption to their lives which might cause them distress which results in restrictive practice such as restraint	Mitigation of negative impact on equality and human rights if we cannot carry out inspection visits in secure environments • Consider how we use our MHA, MCA and DoLS duties to support providers to ensure people's human rights are upheld during this period – focus on monitoring information/notifications/relationship management • Consider equality and human rights in our interim methodology, with a focus on secure environments and other services with a high inherent risk of a closed cultures, as defined in our supporting information on closed cultures
16	In some circumstances, it may be preferable to care for people with COVID-19 outside hospital because of their particular equality characteristics, such as people with advanced dementia in nursing homes. There might be issues about equitable access to high quality clinical care for COVID-19 in these circumstances	Could be positive or negative impact – work with NHSE to identify where guidance suggests that people will not be cared for on a "standard COVID-19 care pathway" to build monitoring of this into our intermediate methodology. Address any discrimination in access to acute care, such as blanket decisions for people living in care homes. (see 13 below)
17	A Fast track registration approach is being developed to assist with extra capacity that might be required to respond to COVID-19. There may be a need to consider equality and human rights implications of this process and how these can be mitigated.	This will have a positive impact on older and disabled people, who are more likely to need care services during the COVID-19 outbreak but there could be individual negative impacts if the fast track registration does not identify equality or human rights concerns with services registered this way – assess fast track registration methodology for equality and human rights impacts
18	People who use health and social care services who have information and communication needs because of a disability or sensory impairment, or because English is their second language, may need targeted communications. This includes people who experience barriers to accessing health services eg. homeless people, asylum seekers, refused asylum seekers and undocumented migrants, who may need specific consideration	Mitigation of potentially negative impact - Consider how we can support the health and social care system to give people accessible information about COVID-19 through research into and promotion of work in this area carried out by others

19	As the NHS moves into the "restoration phase" there is a need to address health inequalities that might have arisen as a result of closure of some preventative services and an opportunity to address more longstanding health inequalities, for example by looking at immunisation, screening services and community mental health services.	Mitigation of potentially negative impact • Build consideration of health inequalities into our regulatory approach to services reinstated in the "restoration phase" • Engage with other system partners around the opportunities to address health inequalities in the restoration phase
20	Older people with dementia and people with a learning disability or autistic people living in care homes may be subject to the inappropriate use of chemical restraint to stop them walking around, as a social distancing measure when this is not the least restrictive approach available	Mitigation of potentially negative impact – • make sure our methodology enables inspectors to identify if this is happening and support providers to change it • produce guidance and promote guidance from others regarding use of the Mental Capacity Act
21	People with a learning disability and autistic people are more at risk of being admitted and unable to be discharged from inpatient units due to the lack of social care support in the community, likely to get worse during COVID-19 pandemic	Mitigation of potentially negative impact • make sure our methodology enables inspectors and Mental Health Act reviewers to identify where this is happening. • Escalate any specific concerns about discharge of people being cared for in segregation through the ICETR process • Use our national independent voice to advocate for change if necessary
22	Disabled people with information and communication needs may not be getting the reasonable adjustments they need to access health services eg. BSL interpreters for deaf people in hospitals or at GPs or if needing access to online appointments and access to written information in formats that people need	Mitigation of potentially negative impact • make sure our methodology enables inspectors to identify where this is happening and to support providers to improve or take other action. • Use our national communications to share good practice and ensure that providers are aware of their Equality Act 2010 duties to disabled people and the Accessible Information Standard
23	Concerns and distrust prevent BME people accessing healthcare when they need it, including for COVID-19. BME relatives may also avoid contacting health services when needed for themselves or family, because of concerns, for example that they will not be able to visit their relative at the end of their life, especially if English is not their first language.	Mitigation of potentially negative impact • use our national communications to support BME people to access services for themselves and their relatives • If we find that the practices of individual providers are creating barriers for access to BME people, address this through our regulatory work, escalating as necessary • Carry out survey of BME people to gather their experiences of care, to help us inform our work and work with national partners •
24	Women, as the majority of the health and care workforce, and carers, are disproportionately at risk of contracting COVID-19. This risk may be exacerbated because of poorly fitting PPE eg. masks, which are designed to fit men	Mitigation of potentially negative impact • support and influence national work to address these issues, where we have the opportunity
25	Women, children and LGBT people may be at greater risk of emotional and physical abuse and violence during lockdown	Mitigation of potentially negative impact – • ensure that our safeguarding alerts pick up and channel concerns when we receive them (eg. via NCSC, Give us feedback on care) • Identify and address through the work of the Children and Justice team (doesn't pick up the LGBT abuse issue though)
26	Closures and reductions in access to services of Gender Identity Clinics will affect the care and support for people transitioning their gender	Mitigation of potentially negative impact - • Use our influence with partners in the health and care system to address this
27	Changes to our methodology may impact on our ability to monitor how providers ensure that clinicians make ethical decisions that impact on human rights, including the right to life, when	Mitigation of potentially negative impact • Consider how we monitor how providers ensure that clinicians make ethical decisions that impact on human rights, including the right to life, when resources to

	resources to address COVID-19 healthcare needs become limited	address COVID-19 healthcare needs become limited, as it relates to regulation 12 and 17. • Use provider engagement methods and work with system partners to flag good practice and expectations around equality issues in clinical decision-making
28	Where we change our methodology, moving to a risk-based approach and are not carrying out routine inspections, it will be harder for us to gather the views of people using services and their families and friends. These views are a very important evidence source about whether people's human rights and rights to equality are upheld. Additionally, there may be new equality and human rights issues arising in the way that providers respond to COVID-19, that we will only understand if we can obtain the views of these people. In addition, physical mail services into our Newcastle Customer contact centre may be interrupted, which may affect our response to people who are digitally excluded. (We have listed mitigation under public engagement mitigations)	CQC public engagement mitigations: Under the Health and Social Care Act, we have a statutory duty to listen to the views of people who use services about their experiences and local groups such as Local Healthwatch, We will • increase promotional activity of Give Feedback On your Care, including piloting digital marketing in an area, encourage support by representative communities • urge public stakeholders to promote Give Feedback On your Care via their communication channels and request providers to promote Give Feedback On your Care using their communication channels. • explore new channels for promoting Give Feedback On your Care and encouraging and enabling people to give their feedback • explore ways that Experts by Experience could support interim methodology and ways of speeding up piloting of Services B in the new Expert by Experience contracts – these are services which gather feedback on care from seldom heard communities/vulnerable groups. Organisational mitigations: • Improve our ability to analyse large volumes of feedback from people and to provide this to inspectors to inform their decision making • At a local/regional level, we will consider the feasibility of increasing our engagement by inspectors of representatives of communities, particularly those who are digitally excluded, in line with Engagement directorate guidance, for example increasing telephone contact or online connecting with Local HealthWatch and voluntary sector organisations representing specific groups. This will need to be done in a way which does not risk safety and welfare of CQC staff or the people that they are engaging with • Explore new channels to better capture the views of people who are digitally excluded.

If the policy, project or programme changes the way that we deliver our functions, please complete section 7 - Human Rights duties assessment. You do not need to complete this section if the policy or document is internal-facing, e.g. a People policy – you can skip to section 8 – Action Planning.

7	**a) Human Rights duties compliance** **Is the policy, document, project or programme likely to have human rights implications If so, is this impact likely to be positive or negative?** **Consider:** - The impact **on CQC respecting people's human rights.** Could our actions directly affect people's rights? For example, by compromising their privacy - **If the proposals could affect rights to privacy, a data protection impact assessment should be undertaken –** - **The impact on CQC protecting people's human rights** e.g. regulatory changes which impact on how we protect the human rights of people using services, - **The impact on CQC fulfilling people's human rights,** this relates to helping people exercise their human rights themselves, for example through the provision of information about rights or promotion of advocacy	**b) Mitigation** **Consider:** **How will any potential positive impact on human rights be maximised?** This helps us to meet our duty to fulfil human rights. **How will any potential negative impact on human rights be mitigated?** Note that there are differences in our duties depending on the rights concerned and whether the impact relates to respecting, protecting or fulfilling human rights. For example, the duty to respect the right to freedom from inhuman or degrading treatment is absolute. However, respecting rights to privacy can be restricted if this is lawful, for a legitimate aim and proportionate. Further advice is available from the Equality and Human Rights team
Right to life	Many of the equality issues in the section above relate to Right to life, if they could lead to deaths that were avoidable by public bodies taking a different course of action. This relates to CQC's duty to protect people's human rights through use of our regulatory powers. Some examples • Decisions on DNACPR notices that are unrelated to clinical factors and do not involve the person and their representatives, such as blanket decisions • Other clinical decisions about access to healthcare that are not based on clinical factors that may result in avoidable death, such as blanket decisions not to transfer people from care homes to hospitals. Also, decisions not to provide critical care to individuals where there is not clinical basis for the decision and there is critical care capacity to treat the person • Decisions about use of health and social care facilities which do not enable others to be protected from COVID-19 infection, when an alternative option was available which would not have led to this outcome.	a) Consider how we monitor how providers ensure that clinicians make ethical decisions that impact on human rights, including the right to life, when resources to address COVID-19 healthcare needs become limited, as it relates to regulation 12 and 17. b) Use provider engagement methods and work with system partners to flag good practice and expectations around equality issues in clinical decision-making
Freedom from inhumane or degrading treatment	Could be potential negative impact if human rights is not adequately considered in: • development of methodology during COVID-19	a) Consider equality and human rights in our interim methodology, with a focus on secure environments or places of state detention and other services with a high

	• engagement with people who use services and their families and advocates during COVID 19	inherent risk of a closed culture, as defined in our supporting information on closed cultures b) Consider human rights in decisions to carry out inspection activity because of risk of harm.
Right to liberty	As above. Article 5 rights relevant to the application of MCA DoLS may be more complex to monitor	Consider duties under National Preventive Mechanism membership and liaise/pool response with other members.
Right to respect for family and private life, home and correspondence (includes autonomy issues in care and treatment)	As above, plus attention to how providers consider whether "social distancing" approaches to COVID-19 might have an avoidable impact on human rights, through taking a less restrictive approach as described above Article 8 is a qualified right, which means it can be 'interfered with' by a Public Authority in certain circumstances including public safety, protection of health or morals, or for the protection of rights and freedoms of others. Any interference must be proportionate. Health and social care services may need to restrict access to family and friends in order to protect right to life. However, providers need to consider how they can limit visitors whilst fulfilling Article 8 rights, for example by considering alternative ways that each person can maintain contact with their family and friends if possible.	a) Produce quick turnaround guidance for inspectors on maintaining human rights whilst following social distancing guidelines – updated as national situation changes b) use our national communications to support BME people to access services for themselves and their relatives c) If we find that the practices of individual providers are creating barriers for access to BME people, address this through our regulatory work, escalating as necessary d) Carry out survey of BME people to gather their experiences of care, to help us inform our work and work with national partners e) make sure our methodology enables inspectors to identify where this is happening and to support providers to improve or take other action. f) Use our national communications to share good practice and ensure that providers are aware of their Equality Act 2010 duties to disabled people and the Accessible Information Standard
Other rights, eg right to life, right not to be discriminated against in connection with other rights	As above	

8. Action Planning – this should be completed whenever a differential equality impact or human rights impact has been identified				
Action	Action Owner	Timescales	Progress	Link to COVID-19 workstream
1. Produce quick turnaround guidance on maintaining human rights whilst following social distancing/self-isolation guidelines – updated as national situation changes • Include issues for equality groups in guidance – based on providers assessing how to reduce social isolation for each person through care planning • Include MHA and MCA/DoLS issues	Margaret Flaws/ Adrian Dunsterville	Initially 27 March and ongoing	Internal guidance for CQC staff produced on MCA issues Visiting Guidance FAQ being revised	Regulatory Response
2. Produce other communications that give support to the health and adult social sector to promote equality and human rights within existing COVID-19 limitations, as required, for example in relation to ethical decision making.	Lucy Wilkinson/ Margaret Flaws	Ongoing	Replaced by action 23 below	Engagement Internal and External
3. Assess fast track registration methodology for equality and human rights impacts	Margaret Flaws/ Emily White/Liz Palmer	TBC	Completed	Regulatory Response
4. Determine responsibility and work needed for regulatory activity to check COVID-19 response in secure environments, including mental health environments	Lucy Wilkinson/ Kim Forrester	Initially by 6th April	Completed	Regulatory Response; Engagement Internal and External/ Intelligence and data collection
5. Consider regulatory activity to check COVID-19 response in prison and immigration secure environments – and children's work with Ofsted	Nigel Thompson	Ongoing	Actions underway including: - Tools for inspection- - Risk sharing and escalation protocols for particular services - Risk escalation of national issues	Regulatory Response; Engagement Internal and External/ Intelligence and data collection
6. Establish DHSE position on care and treatment for people that need to pay for NHSE treatment (such as people from overseas) and ensure this is communicated to providers	Lucy Wilkinson/ Margaret Flaws	Ongoing	- COVID-19 treatment exempt, no other changes - Shared information on need to ensure providers are following correct assessment of charging with NHS trusts and at NHS EDC	Engagement Internal and External
7. Develop approach to Mental Health Act monitoring and NPM activity including MCA DoLS and closed cultures	Kim Forrester/Adrian Dunsterville/ Alison Carpenter	Initially by 27th March	Development completed and now in use by Mental Health Act reviewers	Regulatory Response

8. Consider equality and human rights in our intermediate/interim methodology, with a particular focus on: a. secure environments, those where people may be deprived of their liberty, and other services with a high inherent risk of a closed culture, as defined in our supporting information on closed cultures b. how providers ensure that clinicians make ethical decisions that impact on human rights, including the right to life, when resources to address COVID-19 healthcare needs become limited, as it relates to regulation 12 and 17. c. Specific safety issues for people that might be excluded from access to healthcare such as migrants and homeless people	Lucy Wilkinson/ Margaret Flaws/ Alison Carpenter	Initially by 27th March	23rd April completed for first draft of Emergency Support Framework Under review for future versions Easy read version of Emergency Support framework published 14th May	Regulatory Response/ Intelligence and data collection
9. Consider how CQC can monitor care quality to support providers and the care system to respond appropriately to Care Act easements in their care for older people maintain essential care quality and disabled people in our interim methodology. This includes care quality impacts caused by COVID-19 such as staff shortages which might impact on specific types of services used by older or disabled people – such as domiciliary care agencies and supported living services	Dave James	Initially by 27th March	Actions to date: CQC has published a regularly updated list of councils in England which are operating easements under the Coronavirus Act to inform the public. The Care Act and the 'easements' to it CQC in regular contact with local authorities to understand impact of easements and with ADASS, LGA, and advocacy organisations to understand issues and gather their views	Regulatory Response
10. Work to identify where people are not being cared for on a "standard COVID-19 care pathway" to build monitoring of this into our interim methodology, for example where a decision is made not to transfer to acute care (see also action 25) With regard to unlawful blanket DNACPR orders being applied: • make sure our methodology enables inspectors to identify if this is happening and take action to stop it; including enforcement action if necessary	Debbie Ivanova	Initially by 27th March and ongoing	23rd April completed for first draft of Emergency Support Framework Under review for future versions Communications with providers to ensure non-discrimination in treatment decisions including: Chief Inspector letter to Primary Care providers on ensuring individual decisions in advance care planning	Regulatory Response

• raise awareness among providers that this is unlawful • work with other national organisations to amplify this message where we have concerns that there is a high level of unlawful decision making in an area, use regional escalation protocols to address this			Joint statement on advance care planning used in Emergency Support Framework to guide inspectors	
11. Undertake national communications, especially to providers, so they ensure that there is no unlawful discrimination in treatment decisions	Amy Key	Ongoing	Replaced by action 23 below	
12. Promote accessible information and communication on COVID-19 to providers, via engagement channels	Margaret Flaws	Ongoing	In provider newsletter on weekly basis. Easy read version of Emergency Support framework published 14th May	Engagement Internal and External
13. **Increase promotional activity of Give Feedback On your Care**, including piloting digital marketing in an area, encourage support by representative communities	Jill Morrell	Commence Q1	GFOC plan approved by Regulatory Oversight Group. Workstreams have been established.	Engagement Internal and External
14. **Urge public stakeholders to promote Give Feedback On your Care** via their communication channels	Jill Morrell	Commence Q1	GFOC plan approved by Regulatory Oversight Group. Workstreams have been established.	Engagement Internal and External
15. Engage with providers to explore how providers could use their channels (email lists, text lists) to promote Give Feedback On your Care	Provider engagement	Q1	GFOC plan approved by Regulatory Oversight Group. Workstreams have been established.	Regulatory Response/ Provider Engagement
16. Explore ways that **Experts by Experience could support new inspection methodology** and ways of speeding up piloting of Services B in the new Expert by Experience contracts – these are services which gather feedback on care from seldom heard communities/vulnerable groups.	Jill Morrell	Q1	Relevant learning on equality and human rights is being factored in.	Engagement Internal and External
17. CQC ensures that our **NCSC contact centre is able identify, refer on and escalate safeguarding risks, risks of inappropriate restraint and closed cultures, accessibility and access to services**. Intelligence teams improve our ability to analyse large volumes of feedback from people	Ursula Gallagher Helen Louwrens	Ongoing GFOC plan approved by Regulatory Oversight Group. Workstreams have been established.	GFOC plan approved by Regulatory Oversight Group. Workstreams have been established.	Contact centre Intelligence/ data collection
18. At a local/regional level, **CQC will consider how we might, within resources available increase our engagement by inspectors**	Nigel Acheson	Ongoing	GFOC plan approved by Regulatory Oversight Group. Workstreams have been established.	Regulatory response

of representative of communities, particularly those who are digitally excluded, in line with Engagement directorate guidance, for example increasing telephone contact or connecting with voluntary sector organisations representing specific groups whilst maintaining health and welfare of CQC staff and others				
19. CQC will **explore new channels to better capture the views of people who are digitally excluded**. We will redeploy resources to prioritise this, because people affected by COVID-19 are more likely to be older people and disabled people, who are more likely to be digitally excluded	Jill Morrell	Q1	GFOC plan approved by Regulatory Oversight Group. Workstreams have been established.	Engagement Internal and External
20. Consider equality and human rights implications in **CQC strategic work** on our response to COVID-19	Tim Atkins	TBC		All
21. CQC will engage with government at a national policy level to assist with any mitigations to potential changes to **Care Act responsibilities**, such as the Ethical Framework that has been developed to support Local Authorities and Providers make difficult decisions about how to prioritise with a significantly reduced workforce. Where we gather information on the impact on individuals through our regulatory work, we will use this to inform our engagement.	Kate Terroni	Ongoing		Engagement Internal and External
22. **CQC to use our national influence and system partnerships to influence policy** on: • ensuring that all people who need it are able to access care and treatment for COVID-19 and to protect people's right to life and protect them from discrimination • ensuring that all people who need it are able to access care and treatment for long term conditions and other health, care and support needs during the COVID-19 pandemic • emerging equality and human rights issues and risks and action to address them	Ian Trenholm Chief Inspectors: Kate Terroni Ted Baker Rosie Benneyworth Samantha Booth Ian Dodds	Immediately and ongoing	New action Meet regularly with national partners (eg. NHS organisations and Equality and Human Rights Commission) to discuss emerging issues and plan action	

• identifying and addressing the causes of the disproportionate impact of the COVID-19 pandemic on BME people, especially the disproportionate numbers of deaths of BME patients and workforce, and work to prevent this and address discrimination • Addressing the causes of the higher numbers of deaths from COVID-19 of people living in deprived areas of England which disproportionately impact on disabled and BME people				
23. **CQC to engage with providers** so they are aware of and act (including of expectations and good practice) to: • ensure that all people who need it are able to access care and treatment for COVID-19 and to protect people's right to life and protect them from discrimination • ensure that all people who need it are able to access care and treatment for long term conditions and other health, care and support needs during the COVID-19 pandemic • address emerging equality and human rights issues • recognise and address the disproportionate impact of the COVID-19 pandemic on BME people, especially the disproportionate numbers of deaths of BME patients and workforce, work to prevent this and address possible discrimination in their services • recognise and address the increase in numbers of deaths from confirmed or suspected COVID-19 of people detained under the Mental Health Act • mitigate the higher numbers of deaths from COVID-19 of people living in deprived areas of England which disproportionately impact on disabled and BME people, particularly where providers are based in these areas	Amy Key Kevin Cleary (bullet point 5)	Immediate/ and ongoing	Inappropriate use of sedative medicines to enforce social distancing https://www.cqc.org.uk/guidance-providers/adult-social-care/inappropriate-use-sedative-medicines-enforce-social-distancing Chief Inspector letter to Primary Care providers on ensuring individual decisions in advance care planning Joint statement on advance care planning Weekly provider newsletters include links to guidance and accessible information for people using health and social care services Letter to providers of mental health, learning disability and autism services to highlight concerns about coronavirus related deaths	
24. **CQC to engage with people who use services and their**	Jill Morrell	Q1		

representatives, through the actions 13-16, 18-19 above **to discover issues or to pick up intelligence about problems including**: • Using our national communications to support BME people to access services for themselves and their relatives • ensuring that all people who need it are able to access care and treatment for COVID-19 and to protect people's right to life and protect them from discrimination • ensuring that all people who need it are able to access care and treatment for long term conditions and other health, care and support needs during the COVID-19 pandemic • on emerging equality and human rights issues and risks • the disproportionate impact of the COVID-19 pandemic on BME people, especially the disproportionate numbers of deaths of BME patients and workforce, and possible risks and discrimination in services • the higher numbers of deaths from COVID-19 of people living in deprived areas of England will have a disproportionate impact on disabled people (and BME people), who are more • particularly those living in deprived areas where there are higher numbers of deaths from COVID-19 which disproportionately impact on disabled and BME people			Engagement to identify equality and human rights issues through surveys and engagement work with advocacy groups Regular engagement insight information shared internally covers emerging equality and human rights issues Survey of BME people's experience of care in development	
25. CQC to use methodology and raise inspectors' awareness of issues (at a provider level) and use regional escalation: • to ensure that all people who need it are able to access care and treatment for COVID-19 and to protect people's right to life and protect them from discrimination • to ensure that all people who need it are able to access care and treatment for long term conditions and other health, care and support needs during the COVID-19 pandemic	Amanda Hutchinson	31 May	• See action 8 above • Qualitative briefings being prepared for inspectors to use to assess regulatory response to services at medium/high risk where a closed culture is likely • Discussions under way with NHSE on supporting the Action Plan for protecting BME NHS staff through our regulatory work • ICETR meetings held fortnightly with	

• to identify and act on safeguarding risks, risks of inappropriate restraint and closed cultures, accessibility and access to services • on emerging equality and human rights issues and risks • to recognise and address the disproportionate impact of the COVID-19 pandemic on BME people, especially the disproportionate numbers of deaths of BME patients and workforce, and on possible risks and discrimination in the services they regulate • Where we have evidence that the actions of specific providers are creating barriers for BME people in accessing services, enable our inspectors to act on this • Make sure our methodology enables inspectors and Mental Health Act reviewers to identify where those with learning disabilities/autism cannot be discharged from inpatient units in a timely way • Escalate any specific concerns about discharge of people being cared for in segregation through the ICETR process			NHSE where we can address specific concerns about people cared for in long term segregation in mental health hospitals • Awareness raising with CQC contact centre	
26. The CQC Academy will develop learning so that inspection staff have access the learning and development they need to understand, identify and address equality and human rights issues during the COVID 19 pandemic	Darrin Cutting	Q1 and Q2	• New mandatory introductory learning on equality and human rights for all staff launched 4th May • Mandatory learning on closed cultures and human rights during COVID 19 for inspection teams launching week commencing 8th June	
27. CQC Intelligence will, where possible, gather intelligence on equality and human rights issues in this Equality Impact Assessment for example in relation to: • The higher numbers of deaths from COVID-19 of people living in deprived areas of England and the disproportionate impacts on disabled and BME people • Disproportionate number of deaths of BME staff who	Helen Louwrens	30 June	• Information on deaths in care homes being produced on weekly basis in conjunction with ONS • Initial information published on deaths of people with a learning disability and autistic people • Further work underway on producing more	

have been delivering health and social care. • Excess deaths and poorer health outcomes for people with long term conditions (especially older and BME people) and disabled people because routine services are stopped, reduced or impacted during the COVID-19 pandemic. • Disproportionate deaths from COVID-19 of older people and disabled people living in care homes to help identify the causes • the increase in numbers of deaths from confirmed or suspected COVID-19 of people detained under the Mental Health Act • Where people with a learning disability and autistic people are admitted or are unable to be discharged from inpatient units due to the lack of social care support in the community because of COVID-1 This activity can be used to support and influence national work to identify causes and address issues relating to, for example, disproportionate numbers of BME people dying of COVID-19.			information about deaths	
28. Share good practice by providers in equality, including addressing the causes of disproportionate numbers of BME people dying of COVID-19 through engagement with Equality, diversity and inclusion leads in NHS Trusts	Safina Nadeem/ Lucy Wilkinson	30 June	• First online meeting held 23/4/2020 • Next meeting scheduled	
29. Look at how we can promote the consideration of health inequalities in the "restoration phase" of NHS services.	Amanda Hutchinson/ Lucy Wilkinson	End October	• Being scoped	

8. EIA Sign-Off	**If your EIA relates to CQC workforce equality, Your completed EIA should be sent to Safina Nadeem Diversity & Inclusion Manager for approval:-** **Not applicable – separate EIA**
	All EIAs must be sent to Lucy Wilkinson, Equality, Diversity and Human Rights manager for final sign off. **Note: as Lucy Wilkinson led EIA version 1 and due to the wide-ranging impact of COVID-19 on regulatory delivery, it was signed off by Sarah Bickerstaffe, Director of Policy and Strategy and Ian Trenholm, Chief Executive** **Sarah Bickerstaffe: Signed off 24/03/2020** **Ian Trenholm: Signed off 24/03/2020** **This EIA (Version 2): Signed off by CQC Regulatory Oversight Group 14/05/2020**

	CQC Regulatory Oversight Group signed off 14/05/2020