



Our human rights approach for how we regulate health and social care services: February 2019



About the Care Quality Commission

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that 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 that are safe, effective, care, responsive, and well-led, and we publish what we find, including quality ratings.

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

A summary of this document is also available from the CQC website www.cqc.org.uk.

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Background

Many of the major pushes for change in CQC have been related to human rights, such as Mid Staffordshire and Winterbourne View. We identified the need to embed a human rights approach to our regulation in developing our strategy for 2013-2016, *Raising standards, putting people first*. Our human rights approach was first published in 2014, alongside this strategy.

Since then, we have delivered much regulatory work on equality and human rights and developed how we deliver individual elements of the approach, sometimes following evaluation exercises. We now have an approach to human rights which is well-regarded across the sector – and we have gained experience to help us take effective action. For example, the recent “Learning disability improvement standards” produced by NHS Improvement states:

“CQC has embedded a human rights-based approach in its regulatory framework since 2014, this has been a powerful driver for change in trusts.”

However, we have not reflected on the overall human rights approach since it was established in 2014. We know that human rights are still being breached in health and care settings. We know that there are still longstanding inequalities in access, experience and outcomes for people using health and social care services.

There have been significant changes in CQC since the human rights approach was introduced. We are now delivering our second strategy – *Shaping the future*. Our regulatory model has evolved over time and we are developing our organisation and culture through our *Shaping our future* programme. There are new priorities such as a focus on Quality Improvement, digital strategy and being more intelligence-driven.

We need to build and develop the human rights approach, in response to both internal and external changes. To develop this new version of the Human Rights Approach we have considered:

- the successes and challenges of the Human Rights Approach
- how the approach needs to change to respond to changes both in CQC and outside CQC.

Gathering feedback on our approach

Between October and November 2018, we consulted on the successes, areas for improvement and proposed priorities for our human rights approach, through our online provider community and through “co-production groups” involving national organisations, people who use services and providers. We also invited all CQC staff to comment on the human rights approach and held discussions with our staff Equality and Human Rights Network and our Equality and Human Rights Co-ordination group.

In the consultation, there was a good level of agreement around our six priorities for the next four years. The key points raised were:

- CQC needs to continue to make equality and human rights a priority in regulation and needs to maintain the focus on people who use services and unpaid carers in the Human Rights Approach.
- The challenge of finding and using good quality intelligence around equality and human rights.
- The need to improving frontline practice in services, for example – restraint.
- Improving how we get human rights messages across, to achieve the biggest impact, for example publicising enforcement action related to equality or human rights. Sharing guidance and case studies with both inspectors and providers of care would help a common understanding of good and poor practice in equality and human rights.
- We should use more evidence of outstanding work on equality and human rights from providers, for example by speaking to equality leads in NHS Trusts or checking with GPs how they are using demographic data to improve care.
- CQC inspectors, Specialist Advisors and Experts by Experience still have variable knowledge and understanding around equality and human rights – asking the right questions is key. But some respondents have also seen improvement in the way that inspectors are looking at equality and human rights.

We have also considered responses from our 2018 annual provider survey and inspection survey.

In the 2018 provider survey:

- **70% of providers** thought that **CQC inspections advanced equality** for people using their service – 80% of adult social care providers, 65% of hospitals and 58% of GP practices
- **75% of providers** thought that **CQC inspections ensured that people's human rights were upheld** – 88% of adult social care providers, 72% of hospitals and 61% of GP practices
- 88% of providers thought our equality and human rights good practice resource Equally Outstanding was relevant to their service (the highest of any publication during year). 45% of providers who had looked at Equally Outstanding had made a change to their service as a result, the second highest for any publication in the year.

In our 2018 staff survey:

- 76% of staff believe that we promote equality, diversity and human rights in all our work, the same percentage as last year. There is some variation between directorates, with customers and corporate services staff most likely to say this (82%) followed by Primary Medical Services and strategy and intelligence staff (both 76%) then Adult social care staff at 74% and hospitals at 73%. A lower percentage of staff agreeing with this statement may mean that these staff are more reflective about how we promote equality and human rights, not that less equality and human rights work is carried out in those directorates.

Summary of findings: our 2018 review of the approach

The high-level approach to equality and human rights **is still relevant and has worked well as a tool for change**. However, a few minor amendments are needed to reflect changes in CQC and the health and social care system since 2014.

Adding two new principles:

- **The approach must be delivered within a culture of fairness, equality and inclusion for CQC staff.** This will make a stronger link between equality and human rights in our regulatory work and CQC staff equality and inclusion. We know this link is vital.
- **Working with partners to develop a shared view of the place of equality and human rights in the quality of care.** A “shared view of quality” is one of our overall strategic aims. Over the past 4 years, we have increasingly worked with others to develop and communicate a shared view of the place of equality and human rights in good quality care, for example through our partnership work on “Equally Outstanding”¹ and ensuring that equality and human rights are included in adult social care “Quality Matters”² and “Developing people, Improving Care”.³
- Experience with our CQC staff Equality and Human Rights Network suggests empowering staff to act to improve equality and human rights is important – so we have widened the point on “staff learning” to reflect this wider role that staff have to develop and deliver our human rights approach.
- Ensuring the approach covers our new work at the level of local areas, systems and integrated care systems, as well as individual providers and services.
- Better alignment with the current CQC operating model (for example, covering registration and enforcement as specific points, missing in the first version of the approach).

We have made these changes to our diagram outlining the approach (figure 1).

We will continue to develop all aspects of our human rights approach. We have identified six priority areas to develop:

1. **Areas and systems:** Consider how we can embed equality and human rights in new types of work as these develop in CQC, such as local system and area reviews, provider level assessments and thematic work.
2. **Supporting and empowering staff:** Continuing to support colleagues to understand and act on equality and human rights in their job role through learning and development, supportive methodology and the CQC equality and human rights network.
3. **Intelligence:** Strengthening qualitative and quantitative information about equality and human rights in CQC Insight, especially in settings where people are at a higher risk of having their rights breached or where they may be less likely to be able to self-advocate.
4. **Enforcement:** Work to maintain equality and human rights content in regulations and where possible improve regulations and develop how we factor human rights issues into enforcement decisions.
5. **Working with others:** Build on how we work with others to improve equality and human rights across health and social care, for example through aligning priorities and levers for change with other national bodies and engaging better with people who use services.
6. **CQC improvement work:** Look at how we can ensure equality and human rights is consistently considered in new ways of working in CQC, including Quality Improvement, service design and digital development.

We will review our progress in 2021, to support how we develop our new five-year strategy.

1. Why do we need a human rights approach?

We need a human rights approach because:

- Respecting diversity, promoting equality and ensuring human rights helps to ensure that everyone using health and social care services receives safe and good quality care. This is our core purpose.
- Our human rights approach helps us to apply our values, particularly excellence, caring and integrity to our purpose so that we consistently integrate human rights into the way we regulate.
- As a public-sector body, we have duties to respect, protect and fulfil the rights that people have under the Human Rights Act 1998 when carrying out our functions. We also have duties to eliminate discrimination and advance equality of opportunity and foster good relations between different groups, under the Equality Act 2010.

Figure 1 shows how we aim to integrate equality and human rights through our regulation.

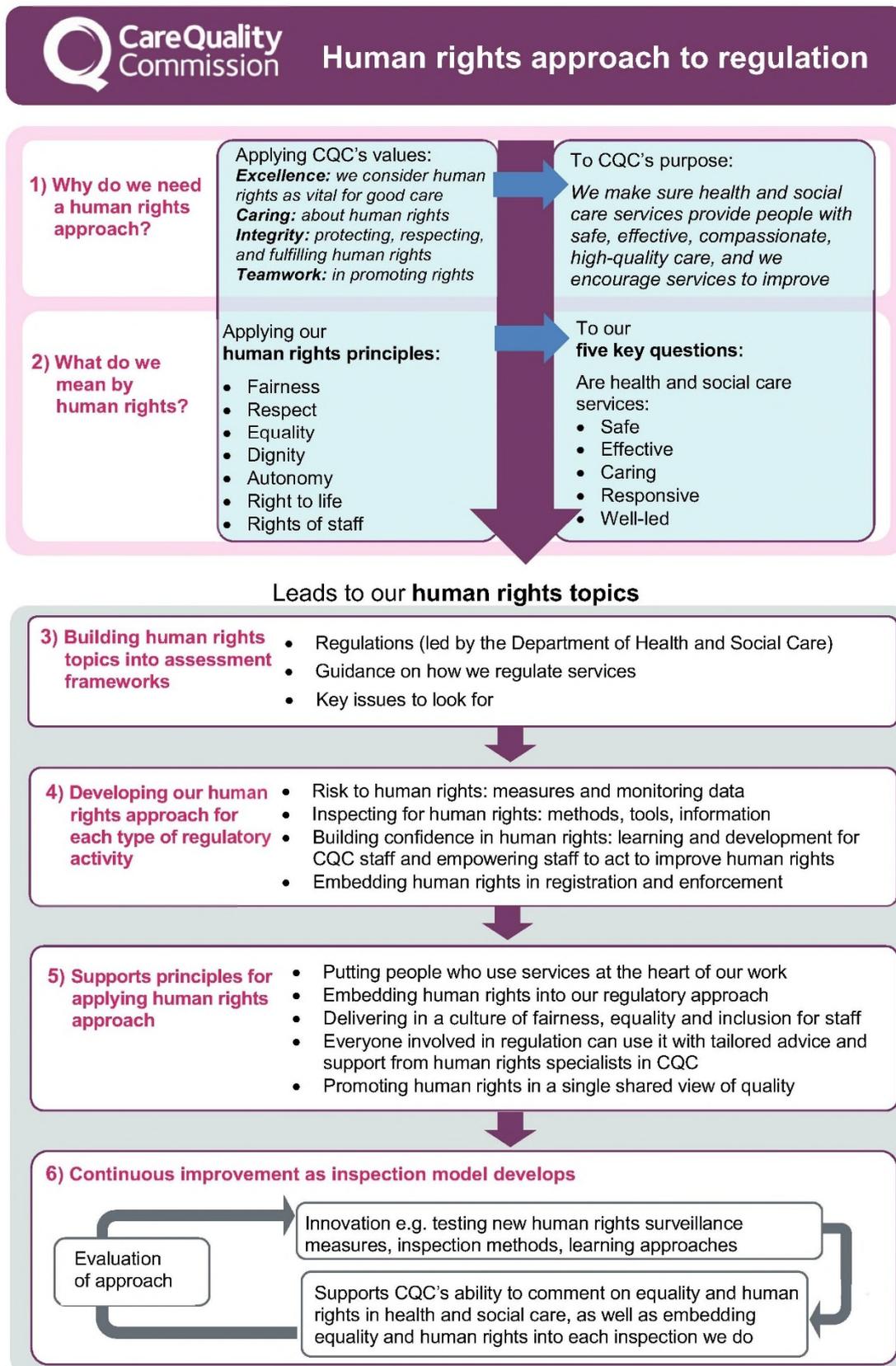
Our human rights approach applies whether we are regulating adult social care services, hospitals, primary medical services or carrying out other regulatory functions – such as joint inspections of children’s services, prison health services or themed work that crosses organisational boundaries.

By taking the steps shown in figure 1, we are also following the first two principles of the human rights based approach to health.⁴

Our approach will put human rights principles and standards at the heart of policy and planning. It will also empower staff and people who use services with knowledge and skills, and provide organisational leadership and commitment to achieve human rights-based approaches.

We see our engagement with people who use services around our human rights approach as mutually beneficial, as they can share their experiences to help us regulate more effectively.

Figure 1: Our human rights approach to regulation



2. What do we mean by human rights?

To develop a human rights approach for our five key questions – whether services are safe, effective, caring, responsive and well-led – we use commonly agreed ‘human rights principles’. These are the “FREDA principles” – Fairness, Respect, Equality, Dignity, and Autonomy (choice and control). These principles are considered to underpin all international human rights treaties.

The one article listed in the Human Rights Act 1998 which is not obvious from the FREDA approach is Article 2 – the right to life. We have therefore added the right to life as an additional principle in our approach.

We have also added an additional principle around staff rights and staff empowerment – but have separated this in our approach from the rights of people who use services. There is much research that shows that staff empowerment around behaviour change, and supporting the rights of staff, is vital to develop a human rights approach to healthcare (see [the Macmillan Human Rights in healthcare project report](#) as an example). Research also shows that the level of race discrimination experienced by staff in NHS trusts is strongly correlated with patient survey scores, as is the level of bullying, harassment or abuse experienced by all staff.⁵

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

A human rights approach should always recognise the rights of everyone in a situation – the point of human rights is that they are universal. Therefore, it is vital that we consider the rights that staff have, alongside the rights of people who use services.

2.1 Definitions of our human rights principles

The following list gives our working definitions of each principle. We consulted on these definitions before publishing our human rights approach in 2014.

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

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

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

Dignity – people who use services are always treated in a humanitarian way – with compassion and in a way that values them as a human being and supports their self-respect, even if their wishes are not known at the time.^c

Autonomy – people who use services can exercise the maximum amount of choice and control possible – in care planning, in their individual care and treatment, in service development, in their relationships with others such as family and friends and as citizens beyond the health and social care services that they are using. Autonomy covers the concept of ‘personalisation’ of care.

Right to life – people who use services will have their right to life protected and respected by the health and social care services that they use. This means that health and social care services will fulfil their obligation to protect the right to life, to refrain from unlawfully interfering with the right to life, and to carry out an effective investigation if a person dies, for example, while in the care of a public authority. This means that health and social care services will fulfil their obligation to protect the right to life, to refrain from unlawfully

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

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

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

interfering with the right to life, and to carry out an effective investigation if a person dies, for example, while in the care of a public authority.

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

2.2 Policy context

Some of the reasons we developed our approach to regulation in 2014, such as the Francis report, were closely linked to these human rights principles. The Government's initial response to the Francis report focused on:

“Key actions to ensure that patients are ‘the first and foremost consideration of the system and everyone who works in it’ and to restore the NHS to its core humanitarian values.”

The statement of common purpose in the response document reaffirms the human rights principles of respect and dignity as key values for the NHS.

The Berwick review of patient safety included actions related to respect for both patients and staff working in the NHS.⁶ There are several references to patient empowerment – and empowerment is closely linked to the human rights principle of autonomy.

The Learning from Deaths programme, the Government response to the Gosport Independent Panel⁷, NHS Speak Up Guardians and CQC Duty of Candour emphasise the importance of listening to patients, families and staff, making the link between the human rights principle of respect and patient safety.

The latest version of the NHS Constitution⁸ also strengthened rights around transparency and candour – essential for ensuring respect – while reinforcing coverage of dignity, respect, autonomy, compassion, and patient involvement. The NHS Constitution enshrines all the FREDAs principles, as it also includes rights to equality and non-discrimination and rights to fairness, for example around complaint and redress (see appendix 2).

The Department of Health's response to Winterbourne View specifically mentions human rights.⁹ It lists principles for high quality services for people with a learning disability and behaviour that challenges. One of the eight service principles is “Service focus on dignity and human rights”.

Parliamentary debates in 2014 about potentially extending the Human Rights Act 1998 coverage to people who are ‘self-funding’ and receiving adult social

care, emphasised the importance of our regulatory work in upholding human rights for people receiving adult social care.¹⁰

CQC's role to improve equality is also recognised nationally, for example in the annual review of the Mental Health Act.¹¹

2.3 Relationship with the Human Rights Act 1998

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

- Many human rights issues in health and social care fall into Article 8 – the right to respect for private and family life, home and correspondence. This is not a very easily understood article. It is broadly defined in law. Therefore, it is difficult for inspectors, providers and people who use services to easily grasp the scope and issues contained in Article 8. We are trying to build an approach that is easily understood by everyone.
- Some human rights issues are relevant to more than one Article, depending on the degree of the breach. For example, neglect, which compromises someone's dignity, may be a breach of Article 8 or (if the neglect is very severe) Article 3, in relation to the prohibition on inhuman or degrading treatment.

However, we are aware of our legal obligations in protecting, respecting and fulfilling people's rights under the Human Rights Act 1998. In appendix 1, a table explains the relationship of our human rights principles to the articles listed in the Human Rights Act. This is based on the Human Rights in Healthcare framework.¹²

We do not inspect a provider's compliance with the Human Rights Act. We inspect to see how providers perform in our five key questions and whether they comply with the fundamental standards (Health and Social Care Act regulations). However, there is human rights 'content' in both our key questions and the fundamental standards. We can address many breaches of human rights through our own powers.

We need to consider the Articles in the Human Rights Act more explicitly when we consider whether to take enforcement action for breaches of the fundamental standards. This is because whether someone's rights have been breached is a factor in our enforcement decision-making.¹³

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

2.4 Relationship with the Equality Act 2010

CQC as a public-sector body has a duty to pay regards to the need, when carrying out our functions, to:

- eliminate discrimination
- advance equality of opportunity
- foster good relations between groups of people who share a protected characteristic under the Act and those who do not.

These duties apply to all the protected characteristics listed in the definition of our 'equality principle' in section 2.1.

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

- Regulation 10 – Dignity and respect – requires service providers to [have] due regard to any relevant protected characteristics (as defined in section 149(7) of the Equality Act 2010) of the service user.
- Regulation 13 – Safeguarding service users from abuse and improper treatment – states that care or treatment must not be provided in a way that includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user.
- Regulation 9 – Person-centred care – requires providers [to make] reasonable adjustments to enable the service user to receive their care or treatment.
- Regulation 19 – Fit and proper persons employed – requires providers to employ people who are physically and mentally capable, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed.

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

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

and to refer cases where the other regulator has more suitable regulatory powers.

2.5 Relationship with UN Conventions on human rights

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

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

- The right to a childhood (including protection from harm and the right to leisure, play, culture and education).
- The right to be healthy (including access to medical care).
- The right to be treated fairly (including changing laws and practices that are unfair on children as well as discrimination against children, for examples on grounds of ethnicity, gender, religion or disability).
- The right to be heard (including considering children's views).¹⁴

Services for children and young people are 'core services' that we regulate in acute hospitals, community health or mental health services. When we regulate GP practices and GP out-of-hours services we look at the services provided to mothers, children and young people.

The UN Convention on the Child Committee's UK report (2016) identified persistent inequality in access to health services and health outcomes for specific groups of children and young people, for example, those from Roma, gypsy, Traveller, and other minority ethnic communities, migrant children and young people, children living with HIV/AIDS, in care and custody, in poverty and deprived areas and lesbian, gay, bisexual, trans and intersex young people. Our ongoing work on improving how we look at equal access to care pathways considers many of these issues.

The **UN Convention on the rights of persons with disabilities** – in addition to rights similar to those covered by the Human Rights Act this convention includes rights to:

- Accessibility
- Live independently and being included in the community
- Personal mobility
- Access to information
- Equal health services and rehabilitation.

Equality for disabled people is included in the Equality Act 2010 and incorporated into the fundamental standards. We have key lines of enquiry that look at equality for disabled people. These key lines of enquiry include

checking how health and social care services comply with other UK law which protect the human rights of disabled people – such as the Mental Capacity Act and the Mental Health Act.

We added the Accessible Information Standard into our key lines of enquiry in 2017.

As a public-sector body, we have a duty to set one or more specific and measurable equality objectives.¹⁵ Our equality objectives target significant areas of inequality and care injustice for disabled people.

For many disabled people, adult social care services play a crucial role in whether they can exercise rights included in this convention. The UN Convention Committee report (2017) recommended that the government create an action plan to address barriers to health care for disabled people, and improve resourcing for disabled people to live independent lives. In “A fresh start for the regulation and inspection of adult social care” we emphasised the importance of our regulation being based on promoting people’s independence.¹⁶

The UN Convention on the Elimination of all forms of discrimination against women (CEDAW)

The last UK report of the UN Convention CEDAW committee (2016) identified access to healthcare for specific groups of women as an area for action. The Equality and Human Commission report to the UN Convention Committee (2018) highlighted the deteriorating mental health of young women and girls, their growing difficulties in accessing services, and the probability of Black African women being detained under the Mental Health Act being more than seven times higher than for White British women.¹⁷

When we regulate GP practices and GP out-of-hours services we look at the services provided to mothers, including women who might be in vulnerable situations. We have also recently carried out work on sexual safety for women using mental health services.

Convention on the Elimination of all forms of racial discrimination (CERD)

The UN Convention Committee (2016) noted the UK’s lack of progress on access and availability of quality healthcare for ethnic minorities and the need to address over-representation of people from Black and Minority Ethnic (BME) groups in mental health institutions and overuse of restraint and seclusion for this group. We have focused on access to primary care for people from BME groups in our equality objectives. We are also starting more specific work on over-representation of people from BME groups as

detained patients under the Mental Health Act, and their experiences during detention.

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

Countries that sign up to OPCAT establish a system of regular visits in order to prevent the torture or other cruel, inhuman or degrading treatment or punishment of people deprived of their liberty. The Care Quality Commission is part of the UK National Preventative Mechanism for this protocol, in relation to people who have their liberty restricted in services that we regulate.

3. Building human rights into assessment frameworks

When we published our Human Rights Approach in 2014, we used our human rights principles to develop a list of topics for each of our five key questions. We then used this topic list to ensure we have coverage of human rights in our key lines of enquiry (KLOES).

Our KLOES define the scope of what we look at when we regulate health and social care services, how we make regulatory judgements about services and how we rate services. These KLOEs are based on our five key questions, but vary between different types of services. It is vital that we weave human rights into the KLOEs. This approach provides consistency in the human rights topics that we consider, while enabling us to tailor the human rights content so that it is appropriate for each type of service. For more information about key lines of enquiry and ratings, see the relevant sector handbooks on our website (www.cqc.org.uk).

Our ability to take legal enforcement action is defined by the fundamental standards of care set by the Department of Health and Social Care. We have worked with the Department of Health and Social Care, using our human rights topics list, to ensure that key human rights topics are covered in these regulations. We have produced more detailed guidance on these regulations, including the links to equality and human rights law.¹⁸

The current situation:

- We used our knowledge of how the human rights topics had worked in practice to strengthen and make the equality and human rights content more consistent in the latest KLOEs.
- Human Rights issues are developing over time. For example, there is now a greater focus on modern slavery, compared with when the human rights approach was first published.
- We need to ensure that any work we carry out to help reduce the regulatory burden on providers does not compromise our ability to act when people's human rights are breached.

There are some gaps in our regulations in practice that we should ask the Department of Health and Social Care to consider during their regulatory review. Firstly, the action CQC can take is unclear where there is discrimination by a provider which means that someone cannot access their service. This is because the regulations about discrimination refer to "service users" which may not include people who have tried to access a service,

but have faced discrimination. Secondly, we need to clarify the action that CQC can take where there is a discriminatory policy in a service but we cannot identify any individual people using the service who have been affected by it yet, for example we have come across an adult social care service where there was a ban on same sex relationships.

We will:

- Review our topic list to update it in 2019/2020 and consider how we can use it in scoping human rights content in more types of work as these develop in CQC, for example thematic reviews, local area reviews and provider level assessments.
- Work with the Department of Health and Social Care to maintain and improve human rights in the regulations.
- Revise the guidance to providers, such as provider handbooks, to reflect national policy, frameworks and standards on equality and human rights.

4. Applying our human rights approach to our regulation

This section looks at how we apply our human rights approach to the CQC operating model of registering, monitoring, inspecting and rating and enforcement.

4.1 Considering human rights in registration

So far, we have not considered registration separately in our human rights approach. However, we have carried out some activity such as checking the registration assessment framework for equality and human rights content.

We may need to develop our approach, for example in:

- applications to register
- assessments
- interviewing new managers
- assessment of directorship
- variations.

We will:

- Ensure that equality and human rights is embedded in registration.

4.2 Monitoring risk to human rights

We have developed the way we monitor risks to quality of care from using 'intelligent monitoring' to the latest system of 'CQC Insight'. This aims to identify where the quality risks are for people using services – based on existing data sets and evidence and information from providers, people using services, their family and friends, people working in services and others. CQC Insight also helps us to identify where providers may be performing above expectations, which is important when we consider ratings and highlight good practice in inspection reports.

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

To embed our human rights approach, we have checked our intelligence systems for how we cover human rights topics. We have looked at whether we can fill any gaps by developing indicators or information using existing data sources. This has been challenging because equality and human rights data is generally poorly developed compared with other areas, such as patient safety or effectiveness of healthcare treatments. And there are few nationally agreed measures for equality and human rights in health and social care.

Developing monitoring is even more challenging in services where there is less data collected. For example, there is less centrally-collected data for care homes than for large hospitals. Some of the settings where there is the least data are the services where people might be at a high risk of having their rights breached. So, a challenge is to identify how we monitor risk to human rights and what level of risk triggers action – such as a responsive inspection.

Over the past 4 years we have:

- Developed our approaches to gathering information from people who use services, the public and staff working in services.
- Used key patient survey human rights indicators such as whether people are treated with dignity and respect.
- Added key equality issues into the information that we collect from providers in all sectors where we use a “provider information collection”.
- Developed our analysis of Workforce Race Equality Standard (WRES) indicators in NHS trust inspections, as part of our intelligence for the “well-led” key question – alongside other indicators from the staff survey about whether staff have experienced discrimination, bullying or harassment.
- Added equality and human rights questions in the evidence grids that inspectors have access to before an inspection.

The current situation:

We are moving to a more risk-based model of regulation based on enhanced use of intelligence, with the help of CQC Insight, as part of our strategy. There are still challenges about national work to improve equality and human rights intelligence. However, we believe that there is work we could do to maximise human rights intelligence from existing data sources, for example using text analysis tools and techniques.

Two priorities emerged from our equality impact analysis of the CQC strategy:

- To develop our approach to gathering the experiences of people who are more at risk of having their rights breached and our ability to identify equality and human rights issues from qualitative information – especially

from what people who use services, the public and staff working in services tell us.

- To continue to identify ways to improve equality and human rights indicators that show changes in quality.

We will:

- Prioritise seeing how we can strengthen both qualitative and quantitative intelligence that indicates risks to equality and human rights in CQC Insight.
- Prioritise developing our approach to how we gather the experiences of people who are more at risk of having their rights breached.
- Also consider how we gather examples of good practice in equality and human rights that might lead us to considering rating providers as outstanding.

4.3 Inspecting for human rights

Inspection

We have strengthened equality and human rights in the key lines of enquiries, prompts and ratings characteristics for health and social care.

Our inspection teams have been provided with a range of methods and tools to help them to make judgements about human rights topics. How we embed human rights into inspection methods varies by the type of service. We have a set of “frequently asked questions” available for inspectors around equality and human rights, some of these apply to all services and some to specific types of services.

Hospitals

To assist inspectors, we developed an “equality and human rights end to end process” for looking at equality and human rights in hospital inspections. We have focused on developing specific topics covered by our equality objectives, including how to assess the quality of care for people with a learning disability using acute services and how to judge whether hospitals are meeting the Accessible Information Standard.

Our inspections of mental health trusts often have a strong focus on human rights because of the need to ensure human rights for people detained under the Mental Health Act. We have also carried out specific work on restraint and on seeing whether the needs of LGBT people are met on inpatient wards.

The development of “well led” inspections for NHS Trusts gave us an opportunity to embed the Workforce Race Equality Standard (WRES) into our

inspections and to widen this out to look at other aspects of leadership around equality for both staff and patients. We have recruited some external “equality and diversity specialist advisors” to help on inspections. We could do more to help our “well led” inspection teams look at equality more consistently, including assessing how well NHS Trusts are using the Equality Delivery System (EDS3) to reduce inequality for their patients, staff and in the local communities they serve.

Adult social care

We have tested several methods and tools that look at equality and human rights. For example, we have included specific questions to providers about equality in ‘provider information returns’ which are completed before inspections. The provider information return also includes information about key human rights issues, for example Deprivation of Liberty applications and authorisations.

These tools to gather information about equality and human rights before an inspection will enable inspectors to follow up issues of concern or of good practice on the inspection - through talking to staff, people who use services, observation or other methods.

We have also developed a set of additional equality and human rights questions for inspectors to ask during inspections, for example, specific questions on LGBT equality and questions relating to sex and relationships for services for people with learning disabilities

Primary medical care

In our regulation of GP services, we look at the service through the lens of six population groups. Five of the groups relate to equality groups:

- older people with complex health needs
- people with long-term conditions (many of whom are disabled people)
- people with mental health conditions
- mothers, children and young people
- people in vulnerable circumstances with poor access to primary care, such as gypsies, travellers and homeless people and people with a learning disability.

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

We provide a rating for GP services for each population group, based on how effective and responsive GP services are to that group. This approach enables us to protect the human rights of groups of people who may be

vulnerable to poor care including those not protected by equality legislation – such as homeless people.

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

The role of enforcement

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

Breach of rights is a factor in deciding the type of enforcement action taken, using our enforcement decision tree.

The current situation:

- We need to ensure that improvements in the way we regulate equality and human rights are maintained while we develop new methodology, for example to produce shorter reports more quickly.
- Improved methodology can help inspectors to feel confident in examining equality and human rights issues. But there is a limit to increasing the volume of methodology available.
- We have done least work on supporting equality and human rights in enforcement methodology and decision-making processes rather than evidence gathering and rating methodology.
- We are now developing our regulation beyond registered “locations”, for example to look at how we regulate at a provider -level and how we regulate integrated care systems in local areas. This could provide new opportunities to look at issues such as equity in access to services and appropriate care pathways for specific equality groups.
- Sometimes inspectors are less confident about the responsibilities under equality and human rights law for types of independent health services, such as independent consulting doctors.

We will:

- Continue to develop our inspection methodology to meet our ambitions around being an excellent regulator for equality and human rights. This includes our work on our equality objectives and by providing specific guidance where needed, for example for independent consulting doctors.
- Develop how we look at human rights consistently in enforcement decision making – this is one of our priority areas for the next 4 years.
- Develop how we look at equality and human rights as new areas of our regulation develop, such as regulating at a provider-level and looking at integrated care systems and local areas.

4.4 Building confidence in human rights: learning, developing and empowering CQC staff to take action

The impact of our human rights approach depends on the awareness, knowledge and skills of registration and inspection teams around human rights.

We know that many team members – CQC inspectors, Experts by Experience and external Specialist Advisors – are strongly motivated by the power of regulation to promote dignity, respect, equality, fairness and choice and control for people who use services. Many team members have years of practical experience in assessing equality and human rights. Some have specific knowledge or skills areas around equality and human rights.

From September 2014 to March 2016 we worked with the Equality and Human Rights Commission and the British Institute of Human Rights to deliver a major learning and development programme for our staff. This programme, funded by the Department for Media, Culture and Sport covered mandatory introductory learning on equality and human rights principles for all staff, role specific learning for inspection, registration and policy teams, and intensive learning for equality and human rights leads.

To create a climate of ongoing learning and culture change on equality and human rights, following this programme, we developed an equality and human rights network for all staff. As of December 2018, over 450 staff are members of the network. This ‘social movement’ is now a well-established and growing focus for staff to share challenges and learning through internal channels, regular meetings, and an annual conference.

We have also developed an “Equality and human rights learning needs analysis” which covers meeting the learning needs for all major staff groups in CQC such as inspectors and managers. This analysis covers learning to support equality and inclusion for CQC staff as well as equality and human rights in delivering our regulatory functions. The analysis helps the CQC

Academy to develop appropriate learning interventions around equality and human rights.

We will:

- Continue to build staff confidence and support staff learning and development on equality and human rights by putting into action learning needs assessments and evaluating our progress.
- Continue to support the CQC Equality and Human Rights Network as a social movement for improvement around equality and human rights in our work.

4.5 Communicating our approach to human rights

Communicating our approach to human rights provides clarity around our role, as the regulator, in ensuring that people's human rights are protected, respected and fulfilled. It helps people to understand their rights and responsibilities – and helps us to gather relevant information about service performance in human rights.

Some work in communicating our approach to equality and human rights and associated work programmes is carried out jointly with other national bodies – for example, with the Equality and Human Rights Commission or the NHS Equality and Diversity Council.

In 2016, we carried out an impact evaluation of our approach to equality and human rights in regulation (see evaluation section for more details). Better communication of our approach to equality and human rights was one of the main actions from the evaluation. Since then, we have worked to highlight equality and human rights to providers through social media, the CQC website, speaking engagements and events. We have worked with other bodies to ensure consistent messages on specific topics, for example the WRES and Accessible Information Standard.

The current situation:

- We have done more work on communicating our approach to providers, rather than people who use services.
- We looked at international human rights treaties to which Britain is a signatory, for example the Convention on the Rights of Persons with Disabilities and the Convention on the Rights of the Child. Through this, we have identified that we have carried out work that contributes to fulfilling United Nations (UN) recommendations to the UK government on human rights treaty monitoring but we do not currently report this to government.

- We have identified UN and other guidelines and standards that may help us drive improvement in services.
- There is a challenge in communicating to providers and others when there is a lack of shared equality and human rights priorities and measures across the system.

We will:

- Work more closely with our public and local engagement teams to better communicate our human rights approach and our work on equality to people who use services and listen to and act on their views.
- Support improvements to our public engagement strategy that encourage better engagement with people who use services.
- Provide support to inspectors to build equality and human rights into their local engagement work.
- Engage more with government to report on how our work on human rights helps to fulfil UN recommendations to the UK government on specific treaty monitoring.
- consider how we can use international guiding principles and standards on human rights and equality in our work.

5. Principles for applying our human rights approach

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

1. Putting people who use services at the heart of our work

When we take an approach based on the rights of people using them – rather than what services ‘should do’ – this helps us to put people who use services at the centre of our work. We have also made the connections between person-centred care and good equality and human rights practice – through our equality objectives and national publications such as State of Care and Equally Outstanding.

However, we could be more consistent in engaging with people who use services to help develop our human rights approach. Our Experts by Experience programme is vital not only in gathering the views of people who use services but in giving people who use services a voice in our regulation.

2. Embedding human rights into our regulatory approach

As we have described in section 4, we have done this through ensuring equality and human rights topics are in our assessment frameworks, followed by building human rights into monitoring, methods, learning and communications.

3. Ensuring that staff who are not human rights specialists can use the human rights approach, providing tailored advice and support, if required from human rights specialists in CQC.

We do this through using a set of human rights principles rather than the more technical articles of the Human Rights Act 1998 as our basis for the approach, and then supporting inspection teams to apply the human rights approach.

The Equality and Human Rights Network has enabled more support for frontline staff. Some regions and local areas have developed their own equality and human rights groups or forums to support their teams.

As interest and commitment grows, staff become more alert to equality and human rights issues. The central Equality and Human Rights has answered over 250 incoming formal queries since 2015. The CQC Legal services team also provide support to these queries where required. The Equality and Human Rights team also provide daily advice, formal and informal support to teams across CQC.

We have also used our Memorandum of Understanding with the Equality and Human Rights Commission to seek specialist legal advice on the Equality Act 2010 and the Human Rights Act 1998 when required. We have recruited some equality specialist advisors to work on hospital inspections to provide expertise around the Workforce Race Equality Standard and other equality issues in NHS Trusts.

Through the 2018 review of our Human Rights Approach, we have identified two new principles that we have been applying, but need to be formally included in our approach:

4. Delivering the human rights approach with a culture of fairness, equality and inclusion for CQC staff

We understand that there is a vital link between promoting equality, diversity and inclusion in CQC and delivering equality and human rights in our regulatory work.

5. Work across the health and social care system to promote equality and human rights with a single shared view of quality

Developing a shared view of quality across health and social care is a priority. We know that there can be no quality of care without equality for people using services and without their human rights being respected. We have worked with others to ensure that equality and human rights are included in national publications which set out expectations around quality – such as adult social care *Quality Matters*¹⁹ and *Developing People, Improving Care*.²⁰

To further our principles for applying our human rights approach, we will:

- Use the opportunity of the recommissioning of the Experts by Experience programme to increase diversity, support them to understand our approach and to hear their views on our work.
- Continue to develop regional support for CQC colleagues and to use the expertise of the central Equality Diversity and Human Rights team and other organisations.
- work to deliver fairness, equality and inclusion for people working at CQC through our equality, diversity and inclusion objective for CQC staff.
- work with others to develop and communicate a shared view of equality and human rights priorities across health and social care. We will work with other bodies to identify gaps and support the development of better agreed measures to monitor performance and measure progress on equality and human rights.

6. Continuous improvement and independent voice

Continuous improvement

CQC is committed to improvement. We need to refine the way that we apply our human rights approach in practice. Increasingly, we are using more formal methods such as Quality Improvement, service design and digital development to improve the way that we deliver our functions.

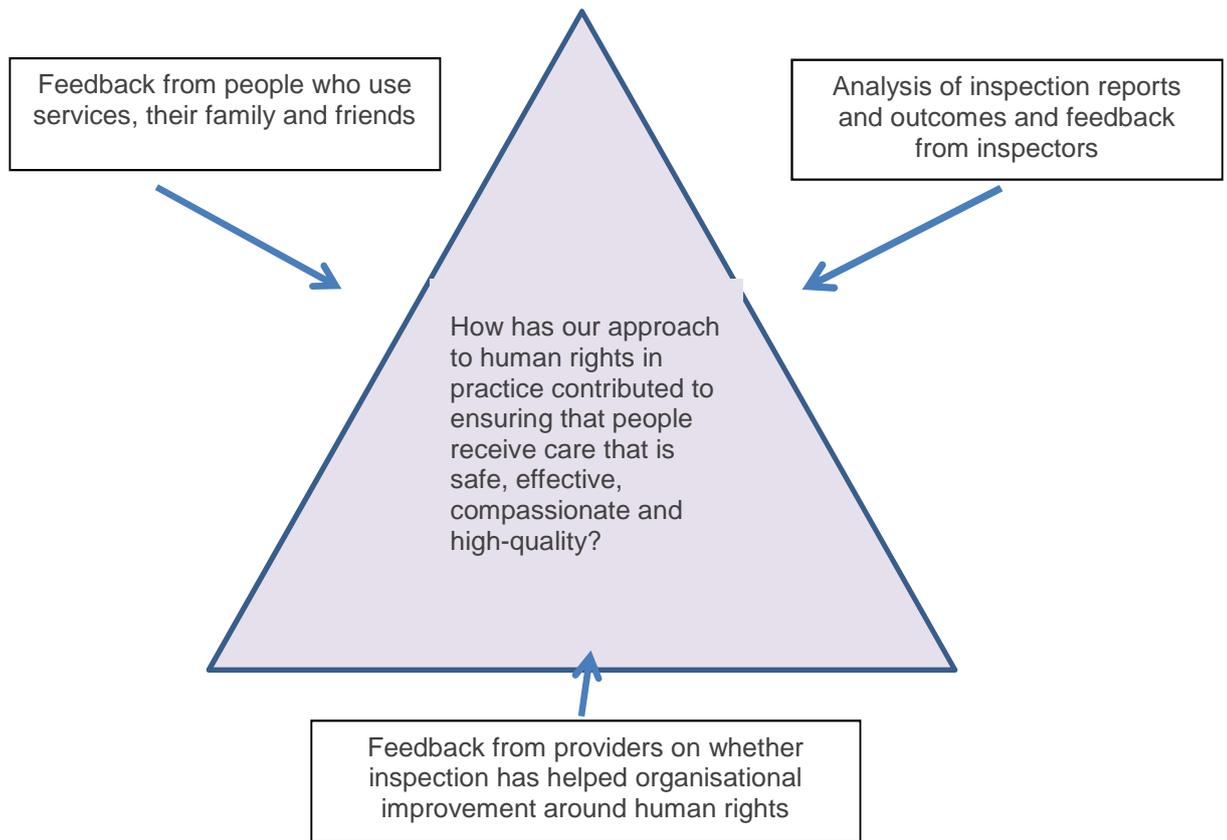
Evaluation

We are committed to evaluating our human rights approach at all stages of its development.

- Early in the development of our current regulatory model, we evaluated the impact of the human rights approach in pilot hospital and adult social care inspections, through talking to inspection teams and analysing human rights issues that appear in published inspection reports.
- In 2016, we carried out an evaluation of the impact of the human rights approach to date. This focused on assessing the impact of the approach rather than whether changes were needed to the approach. The main finding was that the approach was helping to build our work on equality and human rights but we could do better at communicating this outside CQC. Since this, we have had a greater focus on the communications element of the approach.
- We have added questions to provider and inspector surveys to get feedback on how well our inspections promote equality and ensure that human rights are upheld.
- In 2018, we carried out a quality review of equality content in adult social care reports.

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

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



Evaluating the success of how we promote human rights can identify human rights topics where regulation is more challenging – for these topics we can consider using ‘thematic’ approaches to look at the topic in more depth.

For some topics related to equality, we have developed an equality objective to provide a plan for a specific, measurable improvement in how we consider the topic in our regulation. Details of these objectives and our performance against them are found in our published Equality Objective documents²¹ and the CQC Annual Report.²²

Our independent voice

We want our human rights approach to enable us to comment on equality and human rights in the health and social sectors, as a further lever for improvement. We call this our “independent voice”. This helps us to fulfil our principle of promoting equality and human rights.

Using our regulatory evidence, we have provided an evidence-based, informed analysis of equality issues in health and social care in the State of Care report for the last 3 years. Our annual reporting on Deprivation of Liberty Safeguards in State of Care is also important for promoting human rights, as is our annual Mental Health Act report. We also contribute to joint reports on human rights, through our role as a National Preventative

Mechanism under the United Nations Optional Protocol to the Convention against Torture (OPCAT).

In 2017, we published our good practice resource *Equally Outstanding*²³ which shows how a focus on equality and human rights in health and social care can lead to outstanding care – even in times of financial constraint. We updated this resource in 2018 with an e-learning module and extra case studies. Our annual provider survey shows that providers have found this resource highly relevant to their work – with 86% of providers saying it was relevant to their service and 45% of those who had used the resource taking action as a result, the second highest of any publication during the year.

We have also carried out thematic work resulting in national reports with strong equality and human rights content:

- Right here, right now – mental health crisis care review, 2015²⁴
- A different ending – end of life care review, 2016²⁵
- My diabetes, my care – community diabetes care review, 2016²⁶
- Better care in my hands, a review of how people are involved in their own care, 2016²⁷
- Learning, candour and accountability – a review of the way that NHS trusts review and investigate the deaths of patients in England, 2016²⁸
- Are we listening? A review of children and young people’s mental health services, 2017²⁹
- Sexual safety on mental health wards, 2018³⁰

We will:

- Look at how we can ensure that equality and human rights are always considered appropriately when we use new ways to develop our regulatory approaches. For example, service design and quality improvement projects.
- Extend our quality reviews of inspection reports across directorates, share findings and support staff to innovate and learn how to improve content and coverage.
- Continue to use our equality objectives to focus on regulatory equality issues that need improvement.
- Continue to develop our “Independent Voice” work to encourage improvement in equality and human rights in health and social care both through specific equality and human rights publications and by looking at the equality and human rights aspects of wider independent voice topics.
- Continue to gather evidence of the impact of our human rights approach, for example, in provider and inspection surveys and to use this to evaluate and develop the approach.

Appendix 1

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

Fairness	<ul style="list-style-type: none"> Article 6 – right to a fair trial (includes a range of processes for fairness beyond a legal trial)
Respect	<ul style="list-style-type: none"> Article 8 – right to respect for family and private life, home and correspondence Article 9 – right to freedom of thought, conscience and religion Article 1 of Protocol 1 – right to peaceful enjoyment of possessions
Equality	<ul style="list-style-type: none"> Article 14 – right not to be discriminated against in relation to other rights contained in the European Convention Note that we are also using this principle to cover CQC statutory duties under the Equality Act 2010 to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between people
Dignity	<ul style="list-style-type: none"> Article 8 – right to respect for family and private life, home and correspondence Article 3 – right not to be tortured or treated in an inhuman or degrading way
Autonomy	<ul style="list-style-type: none"> Article 8 – right to respect for family and private life, home and correspondence Article 5 – the right to liberty
Right to life	<ul style="list-style-type: none"> Article 2 – the right to life
Human rights for staff/ staff empowerment around human rights	<ul style="list-style-type: none"> All articles as they apply to staff or to empowerment of staff to act to protect the human rights of people who use services

Appendix 2

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

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

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