Equality and Human Rights Impact Assessment (EIA)

1. Name of policy/guidance document/project or programme:

Regulatory Transition Programme

2. Directorate:

Cross sector

3. People responsible for the EIA

- Emma Price, Programme manager
- Vickie Priest, Interim Head of Primary Medical Services Policy (policy lead for regulatory transition programme)

4. The main aims and objectives of the programme

As the risks from the pandemic change, we're evolving our approach to regulation in a way that is both sensitive to the changing circumstances of providers, and that also puts people who use services at the centre of what we do.

Our transitional regulatory approach is flexible and builds on what we learned during the height of the pandemic. The key components are:

- a strengthened approach to monitoring, with clear areas of focus based on existing key lines of enquiry (KLOEs), to enable us to continually monitor risk in a service
- use of technology and our local relationships to have better direct contact with people who are using services, their families and staff in services
- inspection activity that is more targeted and focused on where we have concerns, without returning to a routine programme of planned inspections.

NOTE: this is a long document as we are committed to publishing our assessment in full. To see a summary of impacts and actions, use the table in section 8.

5. Engagement and involvement

Engagement on the project as a whole

Internal:

- workshop with sector representatives and project team on transitional methodology
- intranet page created and populated
- FAQs developed
- conversations with colleagues on our approach, through internal channels (for example, Yammer, Bulletin, intranet, Cue, Teams calls, team discussions, blogs

External (partners):

- provider bulletins and Chief Inspector blogs on our approach
- podcasts with providers on our approach
- brief key stakeholders across all audiences (TBC).

External (people who use services):

- build on existing engagement (for example, through webinars, surveys, CitizenLab activity, Local Healthwatch focus groups, one-to-one interviews).

Policy engagement on the content of this EIA:

- Content in this EIA builds on learning from our COVID-19 EIA, which drew on a number of sources, including our summaries of engagement with external people – including representative organisations of people who use services, providers and other stakeholders. It also drew on our COVID-19 issues log.
- Internal: Closed cultures, Mental Capacity Act and Deprivation of Liberty Safeguards, and Mental Health Act Subject matter experts.
- Consider need to engage with National Preventive Mechanism membership (Mental Health policy team to take forward).
- Regulatory Transition Programme sub programme board (on 20 August).

6. Impacts and mitigations

- **Is the policy, project or programme likely to have a differential impact on any of the protected characteristics? If so, is this impact likely to be positive or negative?**
- **Can any potential negative impact be justified? If not, how will you mitigate, reduce or remove any negative impacts?**

6.1 Age

Impacts

There is existing evidence that COVID-19 has had a greater impact in older age groups.

A survival analysis looked at people with a positive test, and those aged 80 or older, when compared with those under 40, were 70 times more likely to die. These are the largest disparities found in this analysis.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf

Older people, and people of all ages with pre-existing medical conditions (such as diabetes, high blood pressure, heart disease, lung disease, or cancer) appear to develop serious illness more often than others.
https://www.who.int/news-room/q-a-detail/q-a-on-on-covid-19-for-older-people

Older people living in care homes are at risk of not being able to access NHS inpatient services as they have a backlog and a long waiting list to deal with. GPs have referred fewer patients for care to help hospitals tackle the pandemic and also because some patients were reluctant to risk getting infected by going into hospital.

Therefore, we need to be mindful of the impacts on increased age and likelihood of long-term conditions as we cross the threshold and resume inspection activity.

The programme is aware that the risk of infection from COVID-19 will continue to create an inequality, as there is a risk that it can hinder on-site monitoring visits by CQC staff.

We need to be specifically mindful that any transitional methodology that adapts our pre-pandemic regular programme of rolling physical site visits is risk and regulatory impact-assessed against our statutory responsibilities with regard to: the Regulated Activity Regulations, the Registration Regulations that give rise to statutory notifications that assist our monitoring, Mental Health Act Monitoring, and Mental Capacity Act including Deprivation of Liberty Safeguards monitoring. These issues are often important in the care of older people.

We also need to be mindful of our Public Sector Equality Duty and our duties as a public sector body to protect the human rights of people who use services within the remit of our functions – ie the span of our regulations.

Mitigations

Inspectors and health professionals at care homes have undertaken mitigation actions, in keeping with scientific and medical advice received from UK Government guidance, to contain the spread of coronavirus.

CQC introduced the Emergency Support Framework (ESF) to reduce face-to-face visits to services that are classed as having people in the vulnerable groups, including older people.

The Programme aims to adhere to the foundation established through the ESF, but to progress engagement with a hybrid approach of virtual contact and visits where the site status is safe to do so.

Older people are more likely to face access barriers in being able to tell us their experience of care using virtual engagement methods. We will need to build in a range of accessible engagement methods that enable us to understand the experiences of older people using health and social care services (**see cross cutting risk 1).**

The Transitional Regulatory Approach policy guidance includes agreed key lines of enquiry (KLOEs) to explore how the provider delivers safe, effective, caring, responsive and well-led treatment and care to people, and identify any risks. A set of KLOEs were agreed to ensure risks for people using services can be identified including those at risk of greater impact of COVID-19. There is a risk that focusing on a smaller number of KLOEs will mean that key equality and human rights KLOEs important to protect older people might be excluded from the focus **(see cross cutting risk number 2).**

Older people are more likely than others to need the protections of the Mental Capacity Act (MCA) including the Deprivation of Liberty safeguards (DoLs). Most people with a DoLS authorisation are over 70 years old and 70% of them are care home residents. Mitigations relating to our duties in relation to the MCA and DoLs are given under the disability section, as the purpose of this legislation is to protect people of all ages with cognitive impairments **(see cross cutting risk 4).**

There are opportunities to build into our assessment methods key issues around access to, and outcomes from, care for older people that we have learned through COVID-19, such as access to healthcare for older people living in care homes.

6.2 People with caring responsibilities

Impacts

In terms of CQC staff with caring responsibilities: when caring for someone who is deemed to be extremely vulnerable, advice has been to take extra precautionary measures by only providing essential care and ensure carers follow the NHS hygiene advice for people at higher risk.

In terms of gathering information from carers for use in our regulatory activities: Some carers have specific responsibilities towards people they may represent, for example Legal Power of Attorney for finances or wellbeing, or Relevant Person's Representative with regard to DoLS. More targeted and or fewer physical site visits may reduce the opportunity for by-chance engagement.

Mitigations

This programme's approach builds upon the ESF guidance, which enables protection of CQC staff caring for clinically vulnerable members of their households.

It is important that we hear experiences of carers and people with caring responsibilities. In the absence of visiting services and meeting these people, much of this work will be done virtually using telephone and video conference methods, for example. A methodology was proposed and approved in the 'Peoples Voice' paper outlining activities, for example working with stakeholders, to ensure we hear the experiences of this cohort. This work is currently under development. (**see cross cutting risk 1).**

We also have a duty to monitor the use of the Mental Health Act (MHA) in services. Our transitional methodology is likely to include a risk-based approach to prioritising which services to engage with based on improved virtual monitoring of the MHA (monitoring of MHA specific notifications such as deaths in detention and MHA complaints as well as safeguarding alerts etc.). We interview families and carers during our MHA monitoring activity and will continue to do so in the transition period. **(see cross cutting risk 4).**

Our transitional methodology for monitoring MCA and DoLS will need to include an understanding of inherent risk in services where a DoLS authorisation is known to be in place - and also serve a preventative agenda where site visits may take place (if it is safe to do so re: COVID-19) even if no specific risk or persons known to have a DoLS authorisation is apparent but other risk factors may be present. Virtual engagement

with the representatives of people using services with a DoLs authorisation (for example, Legal Power of Attorney holders or Relevant Person's representatives) supported by Experts by Experience will be undertaken **(see cross cutting risk 4).**

6.3 Disability

Impacts

Many providers of adult social care also provide specific services to support disabled people.

Many disabled people are totally dependent on the care they receive. CQC abides by and adheres to the following rights of disabled people and access to healthcare: The rights of disabled people, of all ages, as set out in the Human Rights Act (1998), the Mental Capacity Act (2005), the Equality Act (2010) and the United Nations Convention on the Rights of Persons with Disabilities (2006) and the Convention on the Rights of the Child (1989).

Due to the impact of COVID-19, access to specific services has become difficult as resources have been deployed across the UK healthcare system to tackle COVID-19 priorities. This may place disabled people at a disadvantage as normal access to health and social care may be impeded.

The programme has identified that using a virtual regulatory risk assessment method will affect our ability to meet and speak with disabled people who use services. This may affect how we identify inequality when disabled people are denied their rights.

We need to be specifically mindful that any transitional methodology that adapts our pre-pandemic regular programme of rolling physical site visits is risk and regulatory impact-assessed against our statutory responsibilities with regard to: the Regulated Activity Regulations, the Registration Regulations which give rise to statutory notifications which assist our monitoring, Mental Health Act Monitoring, and Mental Capacity Act including Deprivation of Liberty Safeguards monitoring.

Mitigations

Some disabled people will face barriers in being able to tell us their experience of care using virtual engagement methods. We will need to build in a range of accessible engagement methods that enable us to understand the experiences of disabled people using health and social care services (**see cross cutting risk 1).**

The Transitional Regulatory Approach policy guidance includes agreed key lines of enquiry (KLOEs) to explore how the provider delivers safe, effective, caring, responsive and well-led treatment and care to people, and identify any risks. A set of KLOEs were agreed to ensure risks for people using services can be identified including those at risk of greater impact of COVID-19. There is a risk that focusing on a smaller number of KLOEs will mean that key equality and human rights KLOEs important to protect disabled people might be excluded from the focus **(see cross cutting risk 2).**

We also have a duty to monitor the use of the Mental Health Act (MHA) in provider services. Our transitional methodology is likely to include a risk-based approach to

prioritising which services to engage with, based on improved virtual monitoring of the MHA (monitoring of MHA-specific notifications such as deaths in detention and MHA complaints as well as safeguarding alerts etc.). We are testing improved gathering of disability information in our statutory notifications.

We will continue to interview patients virtually and use Experts by Experience to support this process. In our transitional methodology, we intend to carry out physical site visits if we have serious concerns, where we will be able to interview patients in person **(see cross cutting risk 5).**

We also have a duty to monitor the use of the Mental Capacity Act (MCA), including the Deprivation of Liberty Safeguards (DoLS). The MCA is relevant to all people aged 16 and over in any setting, and the DoLS to people aged 18 and over using care homes and hospitals of all types. Some deprivations of liberty are authorised through the Court of Protection, for example, for children and for those not in care homes or hospitals. Our pre-COVID-19 MCA and DoLS monitoring was based primarily on a rolling programme of site visit inspections across locations. This also allowed us to discharge our responsibilities as a National Preventive Mechanism (see section 7 human rights), particularly the preventive part. The intention of this part is not to respond to risk as such, but to proactively monitor all places of detention/deprivation whether or not a specific risk is known/identified. DoLS is effectively an article 5 protection mechanism.

Our transitional methodology for monitoring MCA and DoLS will need to include an understanding of inherent risk in services where a DoLS authorisation is known to be in place. It also needs to serve as a preventative agenda where site visits may take place (if safe to do so re: COVID-19) even if no specific risk is apparent or people are known to have a DoLS authorisation, but other risk factors may be present **(see cross cutting risk number 3).**

We will carry out virtual engagement with people who have a DoLS authorisation, supported by Experts by Experience There will be a need to ensure that notifications of outcomes of DoLS applications sent to CQC are closely monitored **(see cross cutting risk 5).**

There are opportunities to build into our assessment methods key issues around access to and outcomes from care for disabled people that we have learned through COVID-19, such as access to healthcare for disabled people living in care homes.

6.4 Race/ethnicity

Risks

There is evidence that people who are Black, Asian or from Minority Ethnic groups (BAME) have a higher risk of developing COVID-19. The Public Health England review of disparities in the risk and outcomes of COVID-19 shows that there is an association between belonging to some ethnic groups and the likelihood of testing positive and dying with COVID-19.

The review found that the highest age standardised diagnosis rates of COVID-19 per 100,000 population were in people of Black ethnic groups, and the lowest were in people of White ethnic groups. See:

https://www.gov.uk/government/publications/covid-19-understanding-the-impact-on-bame-communities

The programme is aware that COVID-19 infections and deaths have affected BAME communities most severely, and so the risk of infection remains higher in these communities. This will continue to create an inequality, as the nature of COVID-19 can hinder site monitoring visits by CQC staff for those local areas that contain a higher BAME population.

The programme has identified that using a virtual regulatory method may affect our ability to meet and speak with members of BAME communities who use services. This may affect how we identify risk, inequality and hear their experience of care.

We need to be specifically mindful that any transitional methodology that adapts our pre-pandemic regular programme of rolling physical site visits is risk and regulatory impact-assessed against our statutory responsibilities with regard to: the Regulated Activity Regulations, the Registration Regulations that give rise to statutory notifications that assist our monitoring, Mental Health Act Monitoring, and Mental Capacity Act including Deprivation of Liberty Safeguards monitoring.

CQC needs to be mindful of potential disparity of engagement in inspections during the transitional period for certain local areas across England, as a result of COVID-19 inhibiting visits, as BAME communities are of a higher risk of infection.

Mitigations

Public Health England (PHE) advice regarding the health and wellbeing of staff in BAME groups is that managers should risk-assess staff to ensure work activities do not expose them to unacceptable levels of risk. The main objective is to minimise exposure to and risk from COVID-19 for colleagues, and where possible to enable them to continue undertaking a full range of activity. Where a significant risk is identified and colleagues cannot undertake the full normal range of activity, they will be deployed to other meaningful work which presents a manageable risk.

This individual self-risk assessment form for BAME colleagues acts as a first filter, which enables us to understand what kinds of work a colleague can undertake. It ensures work activities undertaken do not expose them to unacceptable levels of risk. The main objective is to minimise exposure to and risk from COVID-19 for colleagues, and where possible to enable them to continue undertaking a full range of activity.

There are opportunities to build into our assessment methods key issues for BAME people that have arisen through COVID-19, including agreed national actions to address this, for example in the NHS Phase 3 letter on restarting services after COVID-19. The policy guidance for the transitional regulatory approach includes agreed key lines of enquiry to explore how the provider delivers safe, effective, caring, responsive and well-led treatment and care to patients and identify any risks. This includes asking the provider how they take account of the particular needs and choices of different people and how risks to people are assessed, and their safety monitored and managed so they are supported to stay safe? The method also includes a key line of enquiry under well-led to ask how the provider is taking action to protect the health, safety and wellbeing of staff, including BAME staff.

It is important we hear the experiences of BAME communities. In the absence of visiting services and meeting people, much of this work will be done virtually using telephone and video conference methods, for example. A methodology was proposed and approved in the 'Peoples Voice' paper outlining activities, for example working with stakeholders, to ensure we hear the experiences of BAME people. This work is under development currently (**see cross cutting risk 1).**

We are aware that BAME groups are disproportionately detained under the MHA. We will continue to interview BAME patients who are detained during our MHA monitoring visits (whether undertaken remotely or on site). We are also reviewing our MHA well-led methodology to include a focus on how provider services are overseeing the use of the MHA, understanding how it impacts on particular equalities groups and what actions are being taken to improve the patient experience. This will include a particular focus on the experience of BAME individuals **(see cross cutting risk 5).**

6.5 Gender/sex

Risks

There is evidence that working-age males diagnosed with COVID-19 were twice as likely to die as females. It is not yet fully clear what drives the differences in outcomes between males and females.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf.

There is also evidence of an increase in domestic violence during the pandemic, which disproportionately affects women. Women are also more likely to work in health and social care, which are high risk occupations for transmission of COVID-19. Women live longer on average than men, and are therefore more likely to use adult social care services for older people, which are environments where there was a high risk of COVID 19 infection during the first wave of COVID-19.

Mitigations

As part of monitoring visits, CQC inspectors are routinely informed of the current risks regarding COVID19, and that the ESF has been in place to safeguard inspectors and care settings from infection. This programme seeks to promote and adopt risk assessment during a transition phase, which will act as a first filter, which enables us to understand what kinds of work a colleague can undertake, and this should be completed with their line manager before looking at the work activity risk assessment.

Our regulatory work to help ensure people in care homes and staff working in health and social care are protected from any second wave of COVID-19 will have a particular impact on women.

6.6 Gender reassignment

Risks

Trans people now face delays or cancellations on essential gender-affirming treatment, which many have been waiting years to access.

https://www.stonewall.org.uk/about-us/news/how-covid-19-affecting-lgbt-communities

The programme is aware that transgender change is particularly complex, and ongoing care and professional support are required.

Mitigations

The Programme recognises and advocates support for any CQC staff that are undergoing of have ongoing gender-affirming treatment, and this is part of CQC values and is fully supportive to mitigate any risk to staff, through supportive dialogue between line manager and HR. It is aware that certain on-going treatments will have ceased or been delayed due to the impact of COVID-19 on the healthcare systems, resulting in redeployment of staff.

The Transitional Regulatory Approach policy guidance includes agreed key lines of enquiry to explore how the provider delivers safe, effective, caring, responsive and well-led treatment and care to patients and identify any risks. This includes the key line of enquiry to explore about a culture of high-quality, sustainable care, which includes asking the provider how they monitor and protect the health, safety and wellbeing of staff, for example, access to emotional support. The policy guidance also includes key lines of enquiry to explore and identify risk around people accessing treatment in a timely way, and how services are being reinstated and handling backlogs of elective activity.

It is important we hear the experiences of trans people who use services. In the absence of visiting services and meeting people, much of this work will be done remotely using telephone and video conference methods. A methodology was proposed and approved in the 'Peoples Voice' paper outlining activities, for example working with stakeholders, to ensure we hear the experiences of trans-people. This work is under development currently (**see cross cutting risk 1).**

We also have a duty to monitor the use of the Mental Health Act (MHA) in provider services. Our transitional methodology is likely to include a risk-based approach to prioritising which services to engage with based on improved remote monitoring of the MHA (monitoring of MHA specific notifications such as deaths in detention and MHA complaints as well as safeguarding alerts etc.). We are testing improved monitoring of trans status in our statutory notifications **(see cross cutting risk 5).**

6.7 Marriage and civil partnership

No known disparity has been identified.

6.8 Pregnancy and maternity

Risks

In keeping with current advice provided on the impact of coronavirus on pregnancy and maternity see: https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/pregnancy-and-coronavirus/.

At the time of writing, there is no evidence that pregnant women are more likely to get seriously ill from coronavirus. However pregnant women have been included in the list

of people at moderate risk (clinically vulnerable) as a precaution. This is because pregnant women can sometimes be more at risk from viruses like flu. It's not clear if this happens with coronavirus. But because it's a new virus, it's safer to include pregnant women in the moderate-risk group. Latest evidence suggests that that it may be possible for pregnant mothers to pass coronavirus to their baby before they are born. But when this has happened, the babies have got better.

There is currently no evidence that coronavirus causes miscarriage or affects how a baby develops in pregnancy.

In terms of the impact of staff therefore, the risk of inequality is minimised

Findings of an MBRRACE review into maternal deaths during COVID-19 found that all the women included in the review who died from COVID-19 were in the third trimester of pregnancy, and the majority were from Black or other minority ethnic groups. The review concluded that:

- Attention to social distancing in the later stages of pregnancy to prevent infection must remain the key intervention to reduce infection. Ensuring that this occurs without a withdrawal of essential antenatal and mental health care.
- Addressing the disparity in outcomes of COVID-19 among people from minority ethnic groups has already been established as a national and international priority and must be so for maternal services.
- Care of vulnerable women such as those subject to domestic violence must remain a priority.

Mitigations

This programme continues to monitor the latest evidence and guidance to assure that it is aligned with any change to COVID-19 safety guidelines. As such, the programme will routinely and frequently proactively monitor the situation and adapt and adopt any changes regarding coronavirus advice covering pregnancy and maternity arrangements.

Therefore in terms of the impact of staff, the risk of inequality is minimised as there is support from CQC for maternity leave and working from home arrangements that are currently in place.

In our regulatory work, we continue our work with the maternity equity strategy to look at positive interventions to reduce deaths of Black and minority ethnic women and babies.

We consider how we include other factors in the risk of death for pregnant women during pandemics in our regulatory approach to maternity services (for example, women with mental health conditions and women experiencing domestic violence).

6.8 Religion and belief

Risks

The Office for National Statistics (ONS) Report "*Coronavirus (COVID-19) related deaths by religious group, England and Wales: 2 March to 15 May 2020*" is the latest Census 2011 based report published at the time of writing this EIA.

(https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronaviruscovid19relateddeathsbyreligiousgroupenglandandwales/2marchto15may2020)

The highest age-standardised mortality rates (ASMRs) of deaths involving COVID-19 were in the Muslim religious group with 198.9 deaths per 100,000 males and 98.2 deaths per 100,000 females. People who identified as Jewish, Hindu or Sikh also showed higher mortality rates than other groups.

When taking account of region, population density, socio-demographic and household characteristics, and ethnic background, those who identified as Jewish at the time of the 2011 Census showed an increased risk of a death involving COVID-19 compared with the Christian population. Jewish males were at twice the risk of Christian males, with the difference in females being 1.2 times greater risk (additional data and analyses are required to understand this excess risk).

As evidenced above regarding the impact of COVID-19 on the UK population, this programme is aware that the risk of COVID-19 infection will continue to create an inequality, as there is a risk that the nature of COVID-19 can hinder on-site monitoring visits by CQC staff.

The programme has identified that using a remote regulatory method will affect our ability to meet and speak with people from a range of religious groups who use services. This may affect how we identify risk, inequality and hear their experience of care.

Mitigations

Inspectors and health professionals are routinely and frequently updated regarding areas of risk of infection, especially on reported population groups and local areas across the country where infection rate is still being reported as high. Where localised lockdowns occur, CQC is informed by care providers and local authorities regarding social distancing and restricted access to the known high-risk areas within the local area. In these circumstances, it has been agreed that this programme will adapt and adopt different forms of inspection engagement remotely and online, where the risk is too high for site visits.

CQC recognises the need to support people of all faiths and denominations, particularly at this time when many places of worship have been closed and are now re-opening, and that links between religious faith and community service are intertwined.

This programme, as part of CQC's Values, fully supports staff to set aside time for religious observation and obligations.

The Transitional Regulatory Approach policy guidance includes agreed key lines of enquiry to explore how the provider delivers safe, effective, caring, responsive and well-led treatment and care to patients and identify any risks. This includes the key line of enquiry to explore how services take account of the particular needs and choices of different people, how people are supported to stay safe, and how a provider ensures there is a culture of high-quality, sustainable care, including how the health, safety and wellbeing of staff is protected.

It is important that we hear the experiences of members of religious groups who use services. In the absence of visiting services and meeting people, much of this work will be done remotely using telephone and video conference methods. A methodology was proposed and approved in the 'Peoples Voice' paper outlining activities, for example working with stakeholders, to ensure we hear the experiences of religious groups. This work is under development currently (**see cross cutting risk 1).**

In our MHA monitoring methodology, we ask providers how they are supporting the cultural and religious needs of patients who are detained. We will continue to interview patients who are detained during our MHA monitoring visits (whether undertaken remotely or on site) to understand their experience and ask providers to take action to improve when necessary **(see cross cutting risk 5).**

6.10 Sexual orientation

Risks

Some Lesbian, gay and bisexual (LGB) communities are disproportionately affected by COVID-19. For example For some older LGB people, accessing basic provisions such as their medication is difficult without their support networks. Source: Stonewall website https://www.stonewall.org.uk/about-us/news/how-covid-19-affecting-lgbt-communities

The programme is aware that the risk of infection from COVID-19 will continue to create an inequality, as there is a risk that it can hinder on-site monitoring visits by CQC staff.

The programme has identified that using a virtual regulatory method will affect our ability to meet and speak with people from a range of LGB communities, including disabled people who use services. This may affect how we identify risk, inequality and hear their experience of care.

Mitigations

The Transitional Regulatory Approach policy guidance includes agreed key lines of enquiry to explore how the provider delivers safe, effective, caring, responsive and well-led treatment and care to patients, and identify any risks. This includes the key line of enquiry to explore how services take account of the particular needs and choices of different people, how people are supported to stay safe, and how a provider ensures there is a culture of high-quality, sustainable care, including how the health, safety and wellbeing of staff is protected. This also includes asking a provider how they take account of the particular needs and choices of different people to mitigate risk when delivering care.

It is important that we hear the experiences of members of LGBT communities who use services. In the absence of visiting services and meeting people, much of this work will be done remotely using telephone and video conference methods. A methodology was proposed and approved in the 'Peoples Voice' paper outlining activities, for example working with stakeholders, to ensure we hear the experiences of LGBT communities. This work is under development currently (**see cross cutting risk 1).**

6.11 cross-cutting risks and general comments

NHS England has published information about the third phase of the response to COVID-19 that includes a wide ranging set of expectations about reducing health inequalities and ensuring equality. Our work in CQC for NHS bodies needs to reflect these expectations.

We have also identified the following **six cross cutting risks:**

1. **Insufficient focus on people's voice in monitoring activity – compared with the voice of providers.** We know that gathering views of people who use services is essential to identify human rights risks – including closed cultures. This has always been a risk but is increased when 'monitor' activity is used to drive inspection frequency, as it cannot be mitigated by increasing engagement with people who use services at inspection. (However, all systems of triggering inspections can have this risk, including previous ratings.)
2. **Slimmed down set of KLOEs used in monitor phase** focused on safety, access and leadership could lead to equality and human rights issues being missed if they do not fall within this remit, or if there are specific issues for specific service types. Note that full set of KLOEs will be available on inspection, though most inspections will be focused rather than comprehensive. Also that where we have evidence of any regulatory breach, we will continue to consider action required, regardless of whether this is contained within the monitor phase KLOEs.
3. **Scoring system for decisions** may result in equality and human rights issues not being taken further if overall risk score is too low. This could mean it is difficult to tackle specific human rights or inequality issues and therefore to meet Public Sector Equality Duty and human rights/MCA/National Preventive Mechanism duties.
4. **Learning from the ESF** is not yet completely available, so we may be repeating risks from that approach. There is some evidence that the ESF did not pick up certain equality and human rights risks. There was no specific EIA for the ESF, though high level issues were in the COVID-19 EIA. However, some of the ongoing evaluation findings do align with risks in this EIA, for example, about ensuring adequate weighting to voices of people who use services in making monitoring decisions.
5. Need to build **learning from restraint, segregation and seclusion review** into assessment tool – also some specific DoLs and MHA issues need resolving, also auto-populating key data eg mortality and NRLS.
6. **Process of TRA development is rapid and iterative –** this can mean that equality and human rights risks are missed or that they are inserted into the tools but then removed (for example in user testing).

All the mitigations for the six cross-cutting risks are given in the action plan in section 8.

7. 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?**
- **How will any potential positive impact on human rights be maximised?**
- **How will any potential negative impact on human rights be mitigated?**

7.1 General comment – our work as a National Preventive Mechanism (NPM)

Risks

Under the COVID-19 lockdown, NPMs around the world agreed that the first principle of their activity – **do no harm** – would mean that physical visits to places of potential detention could be suspended if these would pose a risk of spreading infection that could not be otherwise managed.

At the start of the UK lockdown, CQC was not recognised with key worker status and did not have access to PPE. This is no longer the case, although the efficacy of visiting, as a preventive mechanism, in high-level PPE is a matter of discussion. Moreover, CQC does not at present have access to regular COVID-19 testing of all its visiting staff, irrespective of symptoms, therefore raising a risk of cross-infection from site to site.

As such, this programme engages very directly with our work in upholding detained people's right to freedom from inhumane or degrading treatment, while maintaining the overarching principle of do no harm. It is a question of finding and maintaining the correct balance between these sometimes-competing priorities.

Mitigations

It should be noted that our work as an NPM has been reflected pre-pandemic in a rolling programme of physical site visits to places where people are or may be detained under the Mental Health Act (generally but not only mental health hospitals) or deprived of their liberty under the Mental Capacity Act DoLS (care homes and hospitals of all types). This affords the opportunity to examine the conditions of the place of detention and also to interview people who are deprived or at risk of being deprived of article 5 rights.

7.2 Right to life

Risks

During the first wave of COVID-19 we did identify some actions by some providers thaht may have had an impact on disabled and older people's rights to life, though we do not have a legal judgement on these actions.

Mitigations

This transitional methodology gives an opportunity to include areas of right to life concern in our key lines of enquiry (KLOES).

7.3 Freedom from inhumane or degrading treatment

Risks

This programme does not infringe or impact on the human rights or civil liberties of CQC staff.

See general comments about the impact of this programme on CQC's work as an NPM, above.

Mitigations

See general comments about the impact of this programme on CQC's work as an NPM above, and the mitigation through continuing physical site visits.

7.4 Right to liberty

Risks

NPM visits encompass our work in monitoring the application of the Mental Health Act and Mental Capacity Act DoLS. Both of these are legal mechanisms designed to establish lawful deprivation of the right to liberty.

Mitigations

See general comments about the impact of this programme on CQC's work as an NPM above, and the mitigation through continuing physical site visits. Also, see specific comments regarding Mental Capacity Act and DoLs in section 6.

7.5 Right to respect for family and private life, home and correspondence (includes autonomy issues in care and treatment)

Risks

During the first wave of COVID-19 we did identify some actions by some providers thaht may have had an impact on disabled and older people's Article 8 rights, for example to be consulted on Do Not Attempt Resuscitation decisions, and sometimes disproportionate restraint to achieve social distancing, though we do not have a legal judgement on these actions.

NPM visits are preventative, and therefore concerned with any potential infringement of human rights as a marker for potential inhuman or degrading treatment, or even torture. It is a matter of degree: severity and duration (for example) could make a practice that would otherwise be a justifiable interference with Article 8 rights to bodily autonomy into something that was an unjustified infringement of that right, or even an infringement of the right to freedom from torture or inhuman or degrading treatment.

Mitigations

This transitional methodology gives an opportunity to include areas of Article 8 concern in our KLOEs.

See general comments about the impact of this programme on CQC's work as an NPM above, and the mitigation through continuing physical site visits.

7.6 Other rights, for example, right to life, right not to be discriminated against in connection with other rights

Risks

See comments above about specific risks for older and disabled people (including people with mental health conditions) in relation to other rights.

Mitigations

See above.

8. Action planning – this should be completed whenever a differential equality impact or human rights impact has been identified

	Action	Action owner	Timescales	Date completed
1	For CQC staff: Mitigating potential health inequalities that are known regarding COVID-19 infections, for CQC staff through our people policies including individual risk assessments.	Safina Nadeem	Ongoing	
2	**Cross cutting risk 1: Address potentially insufficient focus on people's voice in monitor** (compared to the voice of providers) (actions 2-10) Where there is a lack of existing evidence of people's experience of care, inspectors **must** gather up-to-date information about this as part of the TMA. • a set of requirements is created for inspection teams about engaging with/discovering views of people who use services in 'monitor', with engagement methods that are accessible for a range of people using different types of services including those with communication barriers.	Ted Baker	Piloting in Sept 20 – Mar 21	
3	• As part of the requirements to improve engagement in 'monitor' carry out piloting of different approaches to increase the feedback from people who use services, including a focus on people in equality groups such as BAME people. Pilots of	Ted Baker/ Jill Morrell	Piloting in Sept 20 – Mar 21	

	Action	Action owner	Timescales	Date completed
	engagement with voluntary and community sector organisations, people using specific services and role of experts by experience.			
4	• Consider whether additional development of NCSC processes and Give feedback on care online is required to capture equality characteristics of people, using work from Notifications Improvement project on equality monitoring as a basis.	Christine Teasdale / Jill Morrell	TBC – may be longer term aim than transitional approach	
5	• Recommend to senior colleagues that a cross-organisational People's Experiences workstream is established to address risks about operational capacity, information processes, flow and analysis relating to gathering and using people's voices in monitor, outlined in recent RGC paper as part of our Transformation.	Hayley Savage /Morag McInnes /Jill Morrell	TBC	
6	• Build in requirements for engaging with staff working in services in monitor (for example, building on QI work in hospitals) as this is a valuable source of human rights information.	Ted Baker	TBC	
7	• Allocate inspectors adequate time for this engagement.	Ted Baker	TBC	
8	• Enable the results from engagement with people who use services and staff to be factored into the risk levels decided by inspectors and work to identify the automated solutions that enable the views of staff and people who use services to form part of statistical or advanced models.	Hayley Savage/ Morag McInnes/ Hamish Young	TBC	
9	• Explore whether the views of people who use services (e.g. through Healthwatch or engagement with people in a	Lucy Wilkinson/ Quality Assurance team	Jan 21- March 21	

	Action	Action owner	Timescales	Date completed
	sample of services) and staff could verify the risk levels that come from the TMA approach.			
10	• Assess the extent to which we have heard and are actively using the voices of different equality groups.	Helen Louwrens	TBC	
11	**Cross cutting risk 2: Slimmed down set of KLOEs used in monitor phase -** Ensure final KLOE set for each sector or service type used in the App adequately covers all relevant equality and human rights issues required in monitor phase, including those related to closed cultures and produce guidance where required on specific equality and human rights issues.	Vickie Priest/ Lucy Wilkinson	By end Sept 20	
12	**Cross-cutting risk 3: Ensure Scoring system for decisions results in** equality and human rights issues being taken further when needed, if overall risk score is too low – (actions 12-14). • Provide clarity in guidance of the decision making required where there are equality and human rights risks within the wider risk framework.	Vickie Priest/ Lucy Wilkinson	By end Sept 20	
13	• Ensure that the TMA assessment includes a review of inherent risk factors and warning signs for all services (as set out in the Closed Cultures guidance) and is prioritised for intelligence and evidence requirements for the tool.	Alison Carpenter/ Lisa Annaly	Nov 20 – March 21	
14	• Develop approach to considering specific equality and human rights risks in low scoring services – integrated into guidance.	Lucy Wilkinson	By end Sept 20	
15	**Cross cutting risk 4:** Ensure Restraint, segregation. seclusion learning and MHA/MCA/ DoLs issues are incorporated into the	Alison Carpenter/ Adrian Dunsterville/	Oct 20 – March 21	

	Action	Action owner	Timescales	Date completed
	Framework and tools and carry out evaluation against these in practice and improve if necessary.	Caroline Prudames Overall action owner: Kim Forrester		
16	**Cross cutting risk 5**: The Evaluation of COVID-19 approach is not complete and is drawing on our EIA of COVID-19. If this evaluation indicates further development of equality and human rights methods/content is required, including picking up on equality and human rights risks, then build this into future iterations of this methodology.	Lucy Wilkinson	By end Dec	
17	**Cross cutting risk 6:** Ensure the rapid process of TRA development does not miss out on equality and human rights risks; make sure they are inserted into the tools and stay there (actions 17-19) • Ensuring permanent leads in Change on the EIA.	Emma Price	By end Sept	
18	• Regular catch-ups between policy lead HOI and EDHR team.	Vickie Priest/ Lucy Wilkinson	By End Sept	
19	• Adding 'markers' on essential equality and human rights content that should be removed in future iterations without consultation.	Lucy Wilkinson	As required	
20	Build into our assessment frameworks and methods key equality issues around access to and outcomes from care that we have learned through COVID-19, such as issues for BAME people, older people and disabled people including right to life issues.	Vickie Priest/ Lucy Wilkinson	By End Sept	
21	Align our engagement and assessment tools with national expectations around equality, health inequalities and human rights such as those in the NHS phase 3 response.	Heidi Smoult/ Lucy Wilkinson	Q2/Q3	

	Action	Action owner	Timescales	Date completed
22	In our regulatory work, continue our work with the maternity equity strategy to look at positive interventions to reduce deaths of Black and minority ethnic women and babies. Consider how we include other factors in the risk of death for pregnant women during pandemics in our regulatory approach to maternity services (eg women with mental health conditions and women experiencing domestic violence).	Nigel Acheson/ Helen Ketcher	Q2/Q3	
23	In MHA monitoring, continue to interview patients virtually and use Experts by Experience to support this process in our transitional methodology and undertake physical site visits if we have serious concerns where we will be able to interview patients in person.	Caroline Prudames/ overall action owner Kim Forrester	Ongoing	
24	In MHA and MCA DoLS monitoring; keep the option of physical on-site monitoring under review in order to balance risks in carrying out our National Preventive Mechanism (NPM) role; Ongoing liaison with NPM administration/membership.	Kim Forrester/ Adrian Dunsterville/ Mat Kinton	Ongoing	
25	Complete review of our MHA well-led methodology to include a focus on how provider' services are overseeing the use of the MHA, understanding how it affects particular equality groups and what actions are being taken to improve the patient experience. This will include a particular focus on the experience of BAME individuals.	Caroline Prudames/ Kim Forrester	Ongoing	
26	Build virtual engagement with the people using services with a DoLs authorisation and their representatives (e.g. Legal Power of Attorney holders or Relevant Person's representatives) supported by Experts by Experience.	Adrian Dunsterville	Ongoing	

	Action	Action owner	Timescales	Date completed
27	Ensure numbers of notifications of outcomes of DoLS applications sent to CQC are monitored at strategic level.	Adrian Dunsterville	Ongoing	
28	Complete work to improve gathering of disability information in our statutory notifications and test expanding our gathering of information to include gender identity.	Helen Louwrens	Q3	
29	CQC Intelligence will, where possible, continue to gather national and local intelligence on equality and human rights issues: for example. • 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 affected during the COVID-19 pandemic. • Deaths from COVID-19 of older people and disabled people living in care homes, including by ethnicity, to help identify the causes. This activity can be used to support and influence national work to identify causes and address issues relating to, for example, disproportionate numbers of BAME people dying of COVID-19.	Helen Louwrens	Ongoing	
30	Assess whether aggregated TMA App data could be used to report nationally on equality and human rights risks.	Lucy Wilkinson	By end Dec 20	
31	Continue to use our independent voice to highlight key equality, human rights and health inequalities issues to providers as we continue to learn from the progress of the pandemic, including through engagement with NHS trust equality leads.	Lucy Wilkinson	Ongoing	

	Action	Action owner	Timescales	Date completed
32	Continue to use our independent voice to highlight key equality, human rights and health inequalities issues to policy-makers as we continue to learn from the progress of the pandemic.	Ian Trenholm	Ongoing	
33	Continue to use our independent voice to highlight key equality, human rights and health inequalities issues to the public and their representatives as we continue to learn from the progress of the pandemic.	Jill Morrell	Ongoing	
34	To deliver a joint programme of evaluation/research visits with Ofsted to evaluate how well Special Educational Needs and Disability services have responded to the challenges of COVID-19.	Nigel Thompson	November 2020 – March 2021	