

Equality and human rights in the essential standards of quality and safety:

Equality and human rights in outcomes

Guidance for compliance inspectors and registration assessors

Introduction

This guidance relates to **the equality and human rights aspects of the essential standards of quality and safety**.

It is primarily to support inspectors in monitoring compliance with the essential standards of quality and safety, but is also useful for other CQC staff in the regulation of health and social care providers, for example in registration, enforcement and methodology development.

Inspectors can refer to this guidance to check how best to include the equality and human rights aspects of the essential standards in compliance monitoring work. For example, when you are carrying out a responsive review, you can check the sections of this guidance that relate to the outcomes you are focusing on in the review. This guidance can be used at various stages of the compliance monitoring process (see question 1).

We recognise that inspectors have a varied level of knowledge and experience around different aspects of equality and human rights. Some of the points may already be very familiar to you from your current practice, others will be new. We want the guidance to be useful to all inspectors, so we do not assume any level of previous knowledge. You should use the guidance flexibly to support your work.

You should read this guidance in conjunction with:

- [Equality and human rights in the essential standards of quality and safety: An overview](#). The overview guidance summarises equality and human rights in CQC's approach to regulation – including the relationship to equality and human rights legislation. You should refer to this when you need to in your work, for example, if you have a concern that a provider may be breaching equality or human rights law, rather than or in addition to non-compliance under the Health and Social Care Act.
- [Appendix of charts mapping the essential standards to protected characteristics under the Equality Act 2010 and to the Human Rights Act 1998](#). You can use this Appendix if you wish to see more detail of how equality and human rights is included in the text of the *Guidance about Compliance: Essential Standards of Quality and Safety*. However, it is not necessary to use the appendix in order to use this guidance.
- [Top 10 things you need to know about equality and human rights in CQC's regulatory role in health and social care](#), which is available as a reminder of the overall approach to including equality and human rights in monitoring compliance and registration.

CQC also intends to publish supplementary notes on **how we promote the rights of people whatever their sexual orientation or gender identity**; however all prompts about sexual orientation and gender identity are included in this guidance.

Issues about equality for carers are covered by a supporting note on carers and the essential standards (forthcoming).

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1. When should I use this guidance?

This guidance can be used flexibly to support your day-to-day work, including:

- **Information capture and analysis** – to ensure equality and human rights information is collected and analysed when carrying out reviews of compliance and visits
- **Judgements on risk** – using equality and human rights perspectives to help you evaluate the impact on people using the service and therefore the level of concern. Dignity, experience, human rights and accessibility are all factors listed in the judgement framework.
- **Regulatory judgement** – deciding on the equality and human rights content of regulatory, compliance or enforcement actions.
- **Publishing judgements** – ensuring equality and human rights feature in review of compliance reports.

You need to integrate your judgements about whether a provider is compliant on the equality and human rights elements of the essential standards into the methodology for reviews of compliance or registration. It is therefore not possible to give a definitive view of when regulatory action will be taken when a provider is non-compliant with an equality or human rights element of the essential standards – as this will depend on ‘setting the bar’, the enforcement policy etc.

If you think that additional action may be required outside the Health and Social Care Act 2008, because of a potential breach in equality or human rights law, please see [*Equality and human rights in the essential standards of quality and safety: An overview.*](#)

2. How are the prompts in this guidance different from the prompts in the essential standards?

The prompts for each outcome probe the equality and human rights elements in more detail than the prompts set out in the essential standards of quality and safety.

The equality and human rights prompts are still within the scope of the outcomes and prompts in the essential standards. They do not require providers to do more; they just provide additional help for inspectors to look at the existing equality and human rights elements.

<p>3. How should I use the prompts?</p>	<p>The list is not exhaustive and should not be used as a checklist or a set of direct questions to ask.</p> <p>They are not intended to replace observation of the environment or staff relationships with people using the service.</p> <p>The prompts can be used flexibly and in the way that helps you best at different times in your regulatory activity.</p>
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<p>4. If a provider is not compliant with a standard that has an equality or human rights aspect, does it mean that they are also breaching equality or human rights law?</p>	<p>If there is non-compliance in an element of the guidance that maps to the Human Rights Act or equality law, it does not necessarily mean that the provider is in breach of equality or human rights laws. This is because the threshold may be different between non-compliance in relation to the essential standards and an unlawful act in relation to equality or human rights law.</p> <p>Guidance about what to do if you think a provider may be breaching equality or human rights law is given in the guidance <u>Equality and human rights in the essential standards of quality and safety: An overview</u>.</p>
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Involvement and information

<p>5. What is the overall context for equality and human rights in this section?</p>	<p>In health care, the current policy context focuses on the patient experience as the driver of NHS modernisation.¹ The ‘driver’ of the modernisation of social care is personalisation which, by its nature, promotes involvement by people in deciding their own care and support.</p> <p>There is a long history of involvement policy initiatives in health and social care aimed at involving people who use services, patients or the public in the review and development of services. Examples include community health councils, LINKs and, most recently, the forthcoming establishment of HealthWatch. Public involvement has also been established as a statutory duty of NHS organisations. Local authorities also have a role in the overview and scrutiny of health and social care decision-making.</p> <p>Involvement can also support public authorities in meeting their public sector equality duty under the Equality Act 2010. Consultation (and by extension involvement) can be an important means of enabling public authorities to have the information needed to understand the effects of their decision-making, helping them to meet their general duty under the Equality Act 2010.</p>
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	<p>Regulation 17(2) h of the Health and Social Care Act 2008 (regulated activities) Regulations 2009 says that:</p> <p>"the registered person must... take care to ensure that care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have."</p> <p>This regulation relates to Outcome 1: Respecting and involving people who use services. However, the wording of this regulation suggests that these equality characteristics should be considered in all aspects of care, treatment and support. This is also the approach taken by CQC in the essential standards.</p> <p>Issues of consent are important in relation to the human rights principles of dignity, respect and autonomy. It is important that all possible steps are taken to enable the person using services to give consent themselves – and to recognise that people’s capacity to consent changes both in relation to the decision they are making and in relation to their cognition, if they have a condition that may fluctuate. There are clearly disability equality dimensions to consent, such as the availability of advocacy for people with a learning disability.</p> <p>There are also other equality dimensions to consent. For example lesbians and gay men have sometimes found that ‘next of kin’ policies or assumptions by health or social care staff have excluded ‘families of choice’, such as same-sex partners or networks of friends, from decision-making when a lesbian, gay or bisexual person has lacked capacity to give consent.²</p>
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<p>6. What equality and human rights prompts should I consider for Outcome 1: Respecting and involving people who use services?</p>	<p><i>Enabling people to make choices</i></p> <ul style="list-style-type: none"> • Is there evidence that staff are competent in the equality and human rights aspects of supporting people to understand choices and make decisions? <ul style="list-style-type: none"> ○ For example, do staff ensure that reasonable adjustments are made so that individual people can make choices? ○ Do staff understand why it is important that everyone is given the right to make a choice? ○ Does this include support for people who have communication or cognitive impairments? • What evidence is there that people using the service have been encouraged and supported to be involved in decisions about their care?
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6. continued

Note: you need to check staff competencies around equality and human rights on the basis of outcomes for people using the service – these include evidence gained from survey results, observation, pathway tracking or from talking to people using the service or staff, rather than relying on checking ‘inputs’ such as whether staff have had training on communication skills.

Advocacy

- How does the service ensure that people know about and understand the role of independent advocacy services?
- How does the service enable people to access independent advocacy when people have to make important decisions?
- Does this access go beyond the minimum legal requirements to involve Independent Mental Capacity Advocates (IMCAs) under the Mental Capacity Act or Independent Mental Health Advocates under the Mental Health Act?
- What information does the service have about available advocacy - is this available in a range of formats?
- Is there evidence that people using the service, or people acting on their behalf, have a copy of their care plan or know where to get a copy?
- Are plans for care, support and treatment (for example, care plans, discharge plans and patient-held records) available in accessible formats where required and/or discussed with people face to face?
- Does the service have access to interpreting and translation services (spoken languages and British Sign Language)?
- How does the provider monitor the quality and use of interpreting services?

Other equality and human rights issues

- Does information about the service acknowledge the needs of diverse groups of people, across all the equality characteristics covered in the regulations?
- Can the provider give examples of work that has been done in the past year to ensure that people’s privacy and dignity are respected?
- How does the provider ensure that all people with equality characteristics would feel comfortable using the service?

Note: It may be difficult for inspectors and assessors to identify people with particular equality characteristics when carrying out

<p>6. Continued</p>	<p>observational work or choosing people who use services to talk to when carrying out inspection work. For example it may be difficult to identify lesbian, gay and bisexual people. It is possible to tailor the prompt above to fill in 'gaps' from other evidence, for example, how does the provider ensure that lesbian, gay and bisexual people would feel comfortable using the service?</p> <ul style="list-style-type: none"> • Is there evidence about the satisfaction of people using services: <ul style="list-style-type: none"> ○ with their involvement in the planning of their care, treatment and support? ○ that they have been treated with dignity and respect? ○ that their privacy and confidentiality has been upheld? • Does this satisfaction vary with equality characteristics? (For example, does satisfaction vary between men and women or between people with different ethnic backgrounds?) • What changes have taken place in how services are run as a result of the influence of people who use the services? • If 1M applies*: What evidence is there that people using the service are able to access the community of their choice? (for example, for a Black or minority ethnic person or for a person wanting contact with the lesbian, gay and bisexual community?) • NHS organisations only: does Equality Delivery System³ analysis of performance contribute any information about compliance with this outcome?
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<p>7. What equality and human rights prompts should I consider for Outcome 2: Consent to care and treatment?</p>	<ul style="list-style-type: none"> • Is there a procedure for situations which involve decision-making for people unable to give consent? • Is there evidence that people have had the opportunity to chose their own representative if they are unable to give consent? • Does this procedure require that all possible steps are taken to enable the person to make a decision themselves before using best interest procedures? (For example, information is provided in an accessible format; access to advocacy and meetings between the person and the service is available in a suitable environment.) • Does the application of consent procedures protect people's
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* 1M prompt is that "people who use services are enabled to participate in the activities of the local community so that they can exercise their right to be a citizen as independently as they are able to". 1M applies to the following types of services: Care homes, domiciliary care agencies, extra care housing, community-based services for people with a learning disability or mental health needs or people who misuse substances, hospital services for people with mental health needs and/or a learning disability and/or problems with substance misuse, long-term conditions services, rehabilitation services, shared lives, supported living services.

	<p>right to life in practice? (For example, consent is obtained in line with best practice and current guidelines when Do Not Attempt Resuscitation decisions are made.)</p> <ul style="list-style-type: none"> • Is there evidence of how consent procedures work in practice, including: <ul style="list-style-type: none"> ○ refusal or withdrawing of consent by people using the service? ○ occasions where there was informed consent? ○ occasions where consent decisions were made through best interest procedures? • Do these outcomes vary by equality characteristics? • NHS organisations only: does Equality Delivery System analysis of performance contribute any information about compliance with this outcome?
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<p>8. What equality and human rights prompts should I consider for Outcome 3: Fees?</p>	<p>Outcome 3: Fees* is not one of the 16 essential standards that most directly relate to the quality and safety of care, so it is not checked in a planned review of compliance. However, if a concern is raised about compliance with this standard, this outcome may also be assessed.</p> <p>There are no outcomes or prompts that directly match to this standard; however the prompt below is relevant:</p> <ul style="list-style-type: none"> • Are legal agreements relating to paying for care, treatment or support provided in alternative formats when requested and/or discussed face to face with advocacy support? <p>Also:</p> <ul style="list-style-type: none"> • NHS organisations only: does Equality Delivery System⁴ analysis of performance contribute any information about compliance with this outcome?
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* This outcome is about ensuring that people who use services have enough information about fees that they may have to pay for a service, for example fees paid to an independent health care provider or to a care home.

9. Are there any examples of putting these equality and human rights aspects into practice?

Example 1

Ms Porter lives in a care home for people with dementia. When the inspector first visited the care home, Ms Porter was able to indicate some responses to questions but as time progressed, this became more difficult for her. Ms Porter had never married and had lived with another woman for a number of years. This woman was her only visitor. Ms Porter's care plan stated that she was a vegetarian.

The inspector was concerned about two aspects of her care. Firstly, that since moving onto a pureed diet, Ms Porter was being given pureed food containing meat.

Secondly, she was receiving personal care from male carers which may not be culturally appropriate for her, as she had spent most of her recent life living with a woman. The inspector did not know whether Ms Porter was a lesbian or not. Many lesbians prefer to receive personal care from other women – as a cultural issue rather than an issue about sexual preference. This can also be a preferred option for many heterosexual women.

The inspector raised these issues with the care provider. In response, the care home improved the way that life history informed person-centred care planning. This included recording people's dietary needs and preferred gender of care staff – thus improving the service for everyone, regardless of their sexual orientation.

Example 2

The Health Development Unit in Coventry runs drop-in services and weekly advice sessions targeted at women in Asian communities in the most deprived parts of the city. Women from the community are involved in identifying the barriers they experience in accessing health services and proposing ways to improve services to overcome these, and this is integrated into work to raise health awareness and improve take-up of services through information, advice and support.

To encourage women to become involved, the service made it a priority to identify and overcome the barriers that prevented Asian women from getting involved with, and using, health services. For example, rather than asking women to come into the Health Development Unit offices, those involved in the work now go to where the women they want to reach are.

Regular women's health sessions take place in community centres, GP surgeries, temples and schools, or centres near mosques. The benefits for participants include improved health outcomes, more opportunities to socialise and increased confidence and wellbeing.

"It is mainly older women who go to my group. I like to meet the other women. It is sociable and relaxed, all very good... We had Diwali and Christmas parties, all very happy... I lost my son. If I stay at home on my own I get upset. Coming to the group makes me feel happier." (attendee of drop-in health services in Coventry).

Benefits of the involvement include higher take-up of cervical screen testing and better health outcomes for women who engage with the service.⁵

Personalised care, treatment and support

10. What is the overall context for equality and human rights in this section?

- The concept of personalisation in health care services was recognised by the Darzi review⁶, which referred to the need for greater personalised services in order to deliver safe and effective services. Personalisation is also a key concept in the government vision for adult social care.⁷
- The need for personalised health and social care services underlies the first strategic priority of the Care Quality Commission that ‘care that is centred on people’s needs and protects their rights’.
- Personalisation is not just about social care but is a central feature of the government’s agenda for public sector reform. Personalisation has become a key concept for the future of the NHS and is being taken forward by the government through the development of choice and control in the NHS⁸, for example through the development of personal health budgets.
- Personalisation means thinking about care and support services in an entirely different way. This means starting with the person as an individual with strengths, preferences and aspirations, and putting them at the centre of the process of identifying their needs and making choices about how and when they are supported to live their lives.
- The traditional service-led approach has often meant that people have not received the right help at the right time and have been unable to shape the kind of support they need. People who face additional barriers to equality, for example black and ethnic minority people, often have their needs met less well in a service-led approach, as this tends towards a ‘one size fits all’ service where flexibility because of diversity is limited.
- Personalisation is about giving people much more choice and control over their lives and goes well beyond simply giving personal budgets to people eligible for adult social care funding. For example, it can mean that a care home for people with dementia utilises best practice in communication with people with dementia to enhance personal dignity and respect for each individual living in the care home.⁹
- For providers of services, the increase in individual purchasing power brought about through personalisation means that services will need to demonstrate to people that they are high quality. Not only this, they will need to offer a more tailor-made service in order to compete with new forms of user-controlled services, for example domiciliary care agencies will need to offer increased flexibility of times and tasks to compete with the option of people employing their own personal assistants.

<p>10. continued</p>	<ul style="list-style-type: none"> • Personalisation may also bring increased uncertainty in forward-planning, as services rely more on individual purchasing rather than 'block contracts' from councils or primary care trusts (PCTs). This may provide particular challenges for smaller providers, including for example black and ethnic minority voluntary sector providers. • Yet while personalisation is important to independence and redressing power inequalities, there are certain conditions for exercising power and control. For example, it may be more difficult to exercise choice and control for a person whose needs fluctuate or deteriorate or someone who does not use speech, without more work to remove the communication barriers that the person faces. • Regulation 9(1) b (iv) of the Health and Social Care Act 2008 (regulated activities) regulations 2009 says that: <p>"The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of... the planning and delivery of care and, where appropriate, treatment in such a way as to avoid unlawful discrimination including, where applicable, by providing for the making of reasonable adjustments in service provision to meet the service user's individual needs."</p> • This relates to Outcome 4. It introduces the concept of 'reasonable adjustments' for disabled people from equality law. Further information about 'reasonable adjustments' can be found in <u>Equality and human rights in the essential standards of quality and safety: An overview.</u>
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<p>11. What equality and human rights prompts should I consider for Outcome 4: Care and welfare of people who use services?</p>	<ul style="list-style-type: none"> • Is there evidence that care plans take account of all protected characteristics in equality law: ethnicity, gender, disability, religion or belief, sexual orientation age, gender reassignment and, where relevant, pregnancy and maternity? • Does care planning information for people using services make specific reference to all the protected characteristics by name? (So that people know that they can express their needs in relation to these aspects of diversity.) • Do care planning tools used by staff use open questions that enable people to express their needs in relation to aspects of diversity? • What evidence is there that staff involved in care planning are competent in equality across all the protected characteristics? • Is there evidence that people using the service are involved in planning their needs assessment, for example in decisions about who should attend any assessment meetings? • Is there evidence that people using the service know about their rights in relation to assessments and planning their care, for
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	<p>example how to challenge decisions?</p> <ul style="list-style-type: none"> • Is there evidence that reasonable adjustments are made for disabled people using the service? • Is there any evidence of discrimination in the care, treatment and support options offered to people (for example that older people are not offered the full range of treatment options)? • Is there evidence that staff providing care and support are aware of equality issues in the care plans of people using the service? • Is there evidence of: <ul style="list-style-type: none"> ○ people's satisfaction with the outcomes of their care/treatment plan? ○ treatment/support options offered to people? ○ enabling people to take informed risks? • Do these outcomes vary by equality characteristics? • Is there a clear process for when decisions made by people may need to be over-ridden by providers on the grounds of safety or clinical cost effectiveness? • Does information from notifications indicate any equality or human rights issues in care treatment or support? • NHS organisations only: does the Equality Delivery System¹⁰ analysis of performance contribute any information about compliance with this outcome?
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<p>12. What equality and human rights prompts should I consider for Outcome 5: Meeting nutritional needs?</p>	<ul style="list-style-type: none"> • What evidence is there that people who use the service: <ul style="list-style-type: none"> ○ can get a drink or a snack whenever they need one? ○ have flexibility about when they eat (including for religious or cultural needs)? ○ are enabled to eat as independently as possible? • Is there any evidence of poor nutrition or dehydration that could amount to inhumane or degrading treatment or may threaten someone's right to life? • Are people actively encouraged to drink, if appropriate? • Where someone is refusing to take adequate food or drink and is deemed to lack capacity to make this decision, what ways does the service take action in the person's best interest, while ensuring that their dignity is respected? • Are people who use the service involved in designing the menu? • Are menus available in appropriate formats for people using the service?
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	<ul style="list-style-type: none"> • What evidence is there that people who use the service get a choice of food that meets religious, belief or cultural needs? • What evidence is there that people who use the service get a choice of food that meets ethical beliefs (for example vegetarians or vegans)? • Do menu choices take account of people’s individual needs, for example nutritional and attractive choices for people with small appetites? • In care homes, do people who choose to eat in their room have adequate menu choices? • Are requirements for food preparation on religious belief or cultural grounds met in kitchen/food preparation areas (eg ensuring no contamination of vegetarian food with animal products by utensils)? • Are people using the service given appropriate information about ingredients in menu choices so that they can maintain their dietary choices (for example ensuring there are no ‘hidden ingredients’ that may contravene someone’s beliefs)? • Are all staff serving food/assisting people with eating and drinking aware of people’s dietary requirements on the grounds of religion, belief, culture or ethical choice? • NHS organisations only: does the Equality Delivery System¹¹ analysis of performance contribute any information about compliance with this outcome?
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<p>13. What equality and human rights prompts should I consider for Outcome 6: Cooperating with other providers?</p>	<ul style="list-style-type: none"> • Is there evidence of: <ul style="list-style-type: none"> ○ people’s satisfaction with the coordination of services they have received? ○ whether this varies by equality characteristics? • Is there a process for sharing information with other services? • Does the information shared include people’s access requirements (for example, formats of information or language)? • Is there monitoring of instances where sharing of confidential activity takes place without consent: <ul style="list-style-type: none"> ○ by error? ○ because it is deemed to be in the interest of safety for that person or a third party? • NHS organisations only: does the Equality Delivery System¹² analysis of performance contribute any information about compliance with this outcome?
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14. Are there any examples of putting these equality and human rights aspects into practice?

Example 1

When Mrs Yeung moved to a care home for older people in Somerset, this was the first time that the care home had provided a service for a Chinese person.

At first, Mrs Yeung's family brought some meals into the care home but the care home quickly took action to provide for Mrs Yeung's needs. They expanded the menu to include a Chinese option and also added pictures to the menu of English food, with descriptions of the food written in Chinese beside them so that Mrs Yeung had a choice of meals.

The inspector saw evidence of this and so was able to confirm that the care home was meeting requirements, not only about culture but also about choice of meals.

Example 2

A children's hospice provides excellent resources for disabled children and adults and is committed to providing equal access. When the hospice was setting up and in their first year, staff had not really considered the spiritual or religious aspects of care. This was picked up via an inspection and followed up through ongoing monitoring from the then Healthcare Commission.

They have now got a chaplain with good links to the wider ecumenical community, have access to all major religious texts such as the Torah, the Bible and the Q'ran and have staff awareness training to ensure staff members know the correct storage and usage of these documents.

They also have policies and training on how to handle the impending death of a child according to various religious and cultural protocols. At a time such as the death of a child, religion and culture often become a very important aspect of care and, through regulation and working together, the hospice has developed excellent provision.

Safeguarding and safety

<p>15. What is the overall context for equality and human rights in this section?</p>	<p>Safeguarding people who use services from abuse:</p> <ul style="list-style-type: none">• In protecting adults from abuse, there has often been a focus on ‘vulnerable adults’. It is better to use the term ‘vulnerable situations or circumstances’ because anyone could be vulnerable in particular circumstances – for example if under anaesthetic while in hospital.• The term ‘vulnerable people’ tends to locate the problem with people rather than situations, mostly with those who have some impairment or lack capacity. Classifying people as ‘vulnerable’ risks stereotyping them as passive recipients of care and can work against a more human rights-based approach. It fails to make the point that within unsafe or oppressive regimes, we all very quickly become vulnerable. Some people are of course more likely to experience abuse or neglect than others, so if vulnerability is the term to be used, it should be used with care. A broad definition might be "those even more likely to be in vulnerable circumstances in unsafe, poor quality or abusive environments, for example those who are already physically very weak, who have mental health problems or other disabilities, or who may encounter prejudice on the grounds of race, sexual orientation, religious belief and so on".¹³• The term ‘abuse’ can also be subject to wide interpretation. The starting point for a definition is that abuse is a violation of an individual’s human and civil rights by any other person or persons. A number of factors are involved. In the essential standards, the definitions used for children’s safeguarding are taken from Working Together to Safeguard Children (HM Government 2006) and the definitions in adult safeguarding are taken from No Secrets (Department of Health and the Home Office, 2000)¹⁴.• Both the definitions of abuse include physical abuse, sexual abuse and neglect, though the definitions of these vary slightly. The definition for abuse of children includes emotional abuse, whereas the definition for adults includes psychological abuse. The definition for abuse of adults includes two additional areas – financial or material abuse and discriminatory abuse, which is defined as: ‘including racist, sexist, that based on a person’s disability and other forms of harassment, slurs or similar treatment’.• There is obviously a strong link between challenging discriminatory abuse and ensuring equality for people using services. Though discriminatory abuse is not in the definition of child abuse, acts of discrimination against children could easily fall into another ‘category’ such as emotional abuse, the ‘categories’ are not mutually exclusive.
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15. continued

- Abuse may be perpetrated as the result of deliberate intent, negligence or ignorance. Incidents of abuse may be multiple, either to one person in a continuing relationship or service context or to more than one person at a time. This makes it important to look beyond the single incident or breach in standards to underlying dynamics and patterns of harm. Neglect and poor professional practice also need to be taken into account. This may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems and this is sometimes referred to as institutional abuse¹⁵.
- Safeguarding has to be delivered within a human rights framework, avoiding over-protectiveness, that supports people's rights to private and family life, right to marry and form a family, and right to freedom, at the same time as upholding the right to life and not to be tortured or treated in an inhuman or degrading way¹⁶. Safety and security are core freedoms, without which people cannot exert choice and control over their own lives or participate fully. But risk is also a normal part of everyday life. Promoting greater independence inevitably involves transferring responsibility for identifying and choosing how to address risks to individuals. The challenge here is to establish an effective balance between risk-taking and personal safety.
- Providers not only need to balance individual risk-taking and personal safety, but in many settings such as care homes and hospitals, the impact of non-intervention with one person on other people using the service. For example, if one person on a hospital ward is very active during the night and walks around the ward, this could disturb others and may impact on their safety. So, the impact on others needs to be factored into any assessment of risk.
- People requiring and/or receiving care and support can find themselves in extremely vulnerable situations where their safety and right to live with dignity and respect can easily be compromised. A thematic inspection of safeguarding showed that in care homes, common shortfalls included inadequate staff training, written documentation such as safeguarding policy and procedures and recruitment processes, as well as poor provision of information to people on their rights to be safe and how to report any concerns¹⁷.
- **In addition to taking appropriate regulatory action, you should use the CQC protocol and guidance if you receive information about or witness abuse or possible abuse.**
- Inappropriate use of restraint may impact on someone's human rights – such as their right to liberty, the right to private and family

15. continued

life, and the right to be free from inhumane or degrading treatment. (See question 23 of the [Overview guidance](#) for more information on the human rights implications of restraint.)

- CQC has produced a supporting note about restraint, which gives more details about restraint, including the equality and human rights dimensions.
- The definition of restraint in the essential standards is based on the definition in the Mental Capacity Act 2005 and includes:
 - physical restraint – holding someone, moving a person or blocking their movement
 - mechanical restraint – use of equipment
 - chemical restraint (use of medication)
 - environmental restraint
 - technological surveillance – use of tags, CCTV, door alarms or pressure pads, and
 - psychological restraint – constant commands.
- The essential standards make it clear that restraint should be used as a last resort. This is also clear in the applicable publications about restraint in Appendix B of the essential standards, for example:
 - As a general rule, restrictive physical interventions should only be used when other strategies (which do not employ force) have been tried and found to be unsuccessful or, in an emergency, when the risks of not employing a restrictive intervention are outweighed by the risks of using force¹⁸.
 - Managing aggressive behaviour by using physical restraint should be done only as a last resort and never as a matter of course. It should be used in an emergency when there seems to be a real possibility that harm would occur if no intervention is made.¹⁹

There are links between abuse and the equality characteristics, for example:

- Anecdotal evidence points to the practice among some religious communities of the forced marriage of disabled adults, as a means of securing care and support in lieu of public service support.²⁰
- A report by Women's Aid finds that disabled women are twice as likely to experience domestic violence than non-disabled women, are more likely to experience abuse over a longer period of time and are more likely to sustain more serious injuries as a result of the violence. Often this is at the hands of a partner who is also an informal carer.²¹

15. continued

- It is estimated that 342,000 people aged over 66 had experienced some form of neglect or abuse - including financial abuse - in 2006/7.²²
- Neglect by providers may constitute abuse. While anyone may be vulnerable to neglect while receiving health and social care services, some groups of people, such as older people may be particularly vulnerable. This has been highlighted by situations such as a doctor having to prescribe water to ensure that older people do not become dehydrated on a hospital ward.
- In health, services must have fully accountable and managed safeguarding functions for both children and adults. A preventative safeguarding strategy needs to pick up on indicators or the vital signs of abuse early on. Arguably, the largest cause of inhuman or degrading treatment experienced in wards or care homes is the failure to prevent incontinence and to support people with this condition in a dignified manner.

Safety and suitability of premises and equipment, medicine management and infection control

- This section also considers safety of premises, medicines management, equipment and infection control. All these safety aspects can have an impact on the human rights of people using services, especially around the right to be treated in a dignified way and, in extreme cases, the right to life.
- However, as with safeguarding, safety aspects must sometimes be balanced with people's right to choice, control and self-determination. For example, in a care home the 'safest' medicines management regime may be to insist that everyone living in the home has their medicines dispensed and supervised by staff, yet this could restrict people who are able to take medicines themselves from leaving the care home when they wish to, if they have to wait for the medicines 'round'. Some people could find that being supervised when they take their medicines is undignified and that it reduces their independence if they would prefer to manage their own medication.
- Thus, the essential standards prompt covering the management of medicines include prompts about personalisation of medicines management as well as about safety.
- Suitability of premises and equipment is about much more than safety. When looking at equality, perhaps the most obvious link with premises or equipment is the issue of physical access for disabled people. Premises should be compliant with relevant building regulations and the Equality Act 2010 requires all service providers to remove or alter physical features that prevent disabled people from having equal access.

15. continued

- However, addressing environmental barriers is not as straightforward as it may at first seem. For example, blind and partially sighted people face a range of barriers such as cluttered layouts, poor signage or colour contrast. People with dementia face environmental barriers including appropriate lighting to assist cognitive function – and not all these barriers are covered in the relevant building regulations.
- In addition, there are other equality aspects regarding the suitability of premises, for example whether there is space available for people to practise their religion.
- The physical design and use of premises and equipment can also have an impact on human rights, such as the right to liberty, a private life and the peaceful enjoyment of possessions. This often involves balancing security and safety with freedom; for example in relation to the use of CCTV in hospitals or providing technological alternatives to locking external doors in care homes for people with dementia.²³
- CQC have produced specific guidance on assistive technology, which includes considerations under the Human Rights Act.
- When the essential standards were mapped to equality and human rights, there were more prompts relevant to equality and human rights in the outcome about premises than in any other outcome.

16. What equality and human rights prompts should I consider for Outcome 7: Safeguarding people who use services from abuse?

- Does staff training in safeguarding cover equality and human rights?
- How does the service support people who have a range of communication needs to express concerns about their safety and welfare?
- Is there:
 - a clear safeguarding policy/procedure that is compatible with maximising people’s human rights?
 - evidence that staff are competent in applying this policy?
 - evidence that the policy/procedure is used in practice (including notifications under Regulation 18)?
- Is there:
 - a clear policy and procedure for the use of restraint that ensures the protection of an individual’s rights?
 - appropriate policy coverage of all types of restraint relevant to the service? (For example chemical restraint through medication where the services administers medicines.)
 - evidence that staff are competent in applying this policy?
 - evidence that the policy/procedure is used in practice?
 - records of when restraint has been used?
 - evidence that restraint is used as a last resort?
- Do the outcomes relating to restraint vary by equality characteristics?
- Do people who use the service know who to talk to if they have a concern about the way they are treated by staff or other people?
- Are there records of:
 - the safeguarding concerns raised?
 - the details of concerns where there was found to be abuse?
 - the views of people using services when involved in a safeguarding situation?
 - the actions put in place where there was found to be abuse?
- Is there evidence that the views of people using services involved in a safeguarding situation influence the outcome?
- Does the application of safeguarding procedure or the outcome vary by equality characteristics?
- What evidence is there that Deprivation of Liberty safeguards are being used only when in the person’s best interests and in line with the law (including notifications under Regulation 18)?
- NHS organisations only: Does the Equality Delivery System²⁴ analysis of performance contribute any information about compliance with this outcome?

<p>17. How do equality and human rights relate to Outcome 8: Cleanliness and infection control?</p>	<ul style="list-style-type: none"> • The Care Quality Commission is not required to produce guidance in relation to this outcome – as guidance is issued by the Department of Health: The Health and Social Care Act 2008: The code of practice for health and adult social care on the prevention and control of infections and related guidance. Thus there are no equality and human rights prompts for this outcome. • Infection control is closely linked to the right to life – as people using services or staff can die as a result of avoidable poor infection control. Poor cleanliness is likely to engage the right to private and family life and in extreme circumstances may also constitute inhumane or degrading treatment. • NHS organisations only: does the Equality Delivery System²⁵ analysis of performance contribute any information about compliance with this outcome?
<p>18. What equality and human rights prompts should I consider for Outcome 9: Management of medicines?</p>	<ul style="list-style-type: none"> • Is there evidence that staff are competent in the equality and human rights dimensions of administering medicines, for example reasonable adjustments, cultural and religious beliefs, age etc? • Is there evidence that staff know when individual people using the service may not be able to take certain medicines because the ingredients may be incompatible with their religious, cultural or ethical beliefs? (For example porcine or non-vegetarian ingredients.) • Is there evidence that people who use services: <ul style="list-style-type: none"> ○ get enough information about the medicines they are taking? ○ always have medicines at the times they need them? ○ are asked, where appropriate, if they would like to take their medicines themselves? ○ get enough support if they taking medicines themselves? ○ have support to take medicines in a way which maximises dignity and independence, if they require assistance to take medicines? ○ do these vary by equality characteristics? • Is there: <ul style="list-style-type: none"> ○ a clear safeguarding policy/procedure for covert administration of medicines that is compatible with maximising people's human rights? ○ evidence that staff are competent in applying this policy? ○ evidence that the policy/procedure is used in practice?

	<ul style="list-style-type: none"> • Is there evidence that the service ensures that the person's prescription for medicines, for which the service is responsible, is reviewed and changed where necessary (to prevent over-prescription of medicines which may breach people's human rights)? • NHS organisations only: does the Equality Delivery System²⁶ analysis of performance contribute any information about compliance with this outcome?
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<p>19. What equality and human rights prompts should I consider for Outcome 10: Safety and suitability of premises?</p>	<ul style="list-style-type: none"> • Has an access audit of premises been carried out, to ensure compliance with the Equality Act 2010 using a recognised access standard? <ul style="list-style-type: none"> ○ Have any adjustments been made to premises as a result of the audit? ○ Are there any areas of improvement to access still required? ○ What plans are in place to complete these? • Do risk assessments of premises include accessibility, for example fire evacuation procedures for disabled staff and people who use the service? • Are there any examples of where making adjustments for one group of people may impact on others? <ul style="list-style-type: none"> ○ How have these been resolved? • Is there evidence that people who use the service: <ul style="list-style-type: none"> ○ can get around the premises? ○ have enough privacy? ○ have comfortable room temperatures? ○ have reasonable noise levels in the premises? ○ have adequate lighting levels? • Do these vary by equality characteristics (for example, for disabled people including people with sensory impairments or people with a learning disability)? • Are there sufficient toilets, in terms of distance to walk to the toilet – for all types of toilet (disabled people, men, women)? • NHS organisations only: does the Equality Delivery System analysis of performance contribute any information about compliance with this outcome?
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20. What equality and human rights prompts should I consider for Outcome 11: Safety, availability and suitability of equipment?

- Is there evidence that sufficient equipment is available to ensure that the dignity of people using the service is upheld? (e.g. that people do not have to wait a long time for equipment which assists them to transfer to a toilet)
- Is there evidence that people who use services:
 - are asked about how they prefer equipment to be used?
 - feel comfortable when they use the equipment?
 - feel that their privacy and dignity is respected when they use the equipment?
 - do these vary by equality characteristics (for example, for disabled people including people with sensory impairments or people with a learning disability)?
- NHS organisations only: does the Equality Delivery System²⁷ analysis of performance contribute any information about compliance with this outcome?

Suitability of staffing

<p>21. What is the overall context for equality and human rights in this section?</p>	<ul style="list-style-type: none"> • A lack of diversity occurs when employers do not manage to look beyond the first thing they may notice about a person – that someone is male or female, older or younger, black or white, disabled or non-disabled, and so on – to consider in depth whether that person has the experience and skills required for the job. Instead, they go for what feels like the safe option of ‘someone like me’. This can lead to unintentional or subconscious discrimination. • A successfully diverse workforce is one that contains people at all levels who have a range of different characteristics, and are able to be themselves at work as well as outside it. They will have been recruited or promoted on the basis of their abilities and competence in doing the job, because their employer has focused on this, and not on any irrelevancies such as what they look like. • This is not just about avoiding discrimination, harassment and bullying, although this is important. Discrimination in employment, wherever it exists, makes it difficult for people to do their jobs properly or excludes people from a workplace altogether because of an irrelevant demographic characteristic. • This wastes individual potential and is also damaging to the organisation: it fails to recruit potential staff, existing staff leave and may bring tribunal claims, and people using the service may have their needs met less well, due to higher staff turnover, poorer staff morale or a staffing profile that does not reflect the community that the organisation serves – so the moral imperative and the business case go hand in hand. • Even more importantly, each of us thrives when we are valued as an individual, including our different experiences and viewpoints, which may in turn relate to our demographic characteristics – age, ethnic origin, disability, religious faith or non-religious belief, sex, or sexual orientation.²⁸ • Having a diverse workforce will bring additional experiences and skills to an organisation, but there are dangers in assuming that this will in itself tackle discrimination. For example, some studies have shown that black and ethnic minority staff are expected to make changes to improve race equality in services when they are not in a position to do so – yet that these staff may face a lack of development opportunities, conflict as a result of bringing in a different perspective or torn loyalties between expectations in communities and the agency that employs them.²⁹ • The same may happen in relation to other equality characteristics, for example expecting a staff group for disabled workers, or lesbian, gay or bisexual workers to tackle all
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institutional discrimination or individual prejudices of other staff.

- So, it is important that managers in organisations continue to provide leadership around equality issues both in relation to improving services and in supporting a diverse workforce with the challenges that they face as staff.
- Suitability of staffing is not purely about ‘matching’ the staff profile to people using the service. For example, in a survey of lesbian, gay and bisexual people using social care services, two-thirds of people said that they did not specifically want to be supported by lesbian, gay and bisexual staff – as long as the staff were positive about their sexual orientation.³⁰ All staff members need to be able to work with a diverse range of people using services.
- Often, the solution to this is seen to be formal equality or human rights training. However there are other ways in which staff can increase their knowledge and competencies around equality and human rights, such as discussions in team meetings or supervision, mentoring, reading and, importantly, listening and learning from the experiences of people who use the service.
- The Equality Act 2010 has harmonised and simplified equality law around employment. The Overview guidance gives a brief description of the changes.

Pre-employment health checks

- One of the changes in the Equality Act 2010 is that except in very restricted circumstances or for very restricted purposes, an employer is not allowed to ask any job applicant about their health or any disability until the person has been:
 - offered a job either outright or on conditions, or
 - included in a pool of successful candidates to be offered a job when a position becomes available (for example, if an employer is opening a new workplace or expects to have multiple vacancies for the same role but doesn’t want to recruit separately for each one).
- This includes asking such a question as part of the application process or during an interview. Questions relating to previous sickness absence count as questions that relate to health or disability.
- Employers can ask questions once they have made a job offer or included someone in a group of successful candidates. At that stage they can make sure that someone’s health or disability would not prevent them from doing the job. But they must consider whether there are reasonable adjustments that would enable the person to do the job.

21. continued

- Employers can ask questions about health or disability before a job offer when:
 - They are asking the questions to find out if any applicant needs reasonable adjustments for the recruitment process, such as for an assessment or an interview.
 - They are asking the questions for monitoring purposes to check the diversity of applicants.
 - They want to make sure that an applicant who is a disabled person can benefit from any measures aimed at improving disabled people's employment rates. For example, the guaranteed interview scheme.
 - They are asking the question because having a specific impairment is an occupational requirement for a particular job. (For example, an employer wants to recruit a deafblind project worker who has personal experience of deafblindness.)
 - Where the questions relate to a requirement to vet applicants for the purposes of national security.
 - Where the question relates to a person's ability to carry out a function that is intrinsic (or absolutely fundamental) to that job. Where a health- or disability-related question would mean you would know if a person can carry out that function with reasonable adjustments in place, then you can ask the question. In practice, even if a function is intrinsic to the job, employers should ask a question about a disabled person's ability to do the job with reasonable adjustments in place. There will therefore be very few situations where a question about a person's health or disability needs to be asked.³¹
- CQC takes the following view on how this relates to Regulation 21 (a) (iii) – that the registered person must 'operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying out a regulated activity unless that person is physically and mentally fit for that work'.
 - Providers should comply with the Equality Act 2010 and only use pre-employment health checks where allowed under the Act. This is in line with Prompt 12C – that staff are recruited following a selection procedure that complies with legislation about employment.
 - Prompt 12A states that staff should be 'physically and mentally able to carry out their role, with a plan of support including reasonable adjustment where necessary'. This means that CQC takes account of the fact that providers should look at reasonable adjustments for disabled staff in relation to 'fitness' to carry out the role.
 - The role of CQC is to look at how the provider ensures that

21. continued	<p>staff are recruited in a way which complies with the law and results in staff who are able to carry out their role in relation to regulated activities. The change in the law, in relation to pre-employment health checks does not change the CQC's overall role.</p> <ul style="list-style-type: none"> ○ It is very important that inspectors do not give advice to providers on recruitment decisions as this is not the CQC's role and could open CQC to legal challenge from individuals. ● If you receive an enquiry about this and need help, please contact the Involvement and EDHR team: ● AskRegulatoryDevelopment@cqc.org.uk ● Note the above email address is only for CQC staff. Others with enquiries about CQC work on equality and human rights should use: involvement.edhr@cqc.org.uk
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<p>22. What equality and human rights prompts should I consider for Outcome 12: Requirements relating to workers?</p>	<ul style="list-style-type: none"> ● Is there evidence of the providers' record on recruitment being legally compliant regarding equality law (for example, number of tribunal claims)? ● How do recruitment processes test out the knowledge and experience of staff in relation to equality and human rights? ● How well does the staff profile match the profile of the community in which the service is based? ● Is there evidence that disabled staff have plans of support, including reasonable adjustments, where these are necessary? ● How does the service guarantee that the interpreters they employ, including for British Sign Language, are professionally qualified to the required standard? ● Is there evidence that staff have competencies to support, appropriate to their role: <ul style="list-style-type: none"> ○ The diverse needs of people using the service? ○ The human rights of people using the service? ○ Including skills to communicate with people who use the service (for example blind and partially sighted people, deaf and hard of hearing people, people with communication or cognitive impairments or people who do not speak English)? <p>Note: It is not the role of CQC or the EHRC to set a formal definition of competencies around equality and human rights. Professional regulators or other bodies may have developed a set of competencies for particular job roles in health and social care. However, you need to check staff competencies around equality and</p>
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	<p>human rights on the basis of outcomes for people using the service – these include evidence gained from survey results, observation, pathway tracking or from talking to people using the service or staff.</p> <ul style="list-style-type: none"> • NHS organisations only: does the Equality Delivery System³² analysis of performance contribute any information about compliance with this outcome?
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<p>23. What equality and human rights prompts should I consider for Outcome 13: Staffing?</p>	<ul style="list-style-type: none"> • Could staffing levels or skills mix ever compromise people’s human rights, for example: <ul style="list-style-type: none"> ○ Right to life. ○ Right to be free from degrading treatment (for example, having to wait too long to be assisted to go to the toilet). ○ Right to liberty. ○ Right to see family and friends. ○ Right for people to take part in community activities (for example, in a care home if there are not enough staff to provide assistance for people to leave the care home for leisure activities). • Could staffing levels or skills mix mean that people’s needs in relation to equality cannot be met? for example: <ul style="list-style-type: none"> ○ Communication needs. ○ Maintaining or developing links with their own community. ○ Preferred gender of staff for personal care tasks. • NHS organisations only: does Equality Delivery System analysis of performance contribute any information about compliance with this outcome?
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<p>24. What equality and human rights prompts should I consider for Outcome 14: Supporting workers?</p>	<ul style="list-style-type: none"> • Is there evidence that all staff respect the rights of people who use services? • Does the induction material or training for staff cover: <ul style="list-style-type: none"> ○ expectations around equality and the human rights of people who use the service? ○ all the protected characteristics (race, gender, disability, sexual orientation, religion and belief, age, gender identity and, if relevant, pregnancy and maternity and marriage and civil partnership)? ○ how to report issues of concern about the service – including safeguarding processes?
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24. continued

- Is equality and human rights integrated throughout induction?
- Is there evidence that staff receive information and advice at induction about what to do if they experience discrimination or harassment from other staff, from people using the service or from others (for example visitors)?
- Are arrangements in place to encourage staff to report bullying and to effectively manage these instances?
- Is there evidence that the provider has taken action to minimise harassment of staff including:
 - racial harassment
 - sexual harassment
 - disability-related harassment
 - homophobic harassment
 - harassment on the grounds of religion or belief
 - age-related harassment, and
 - transphobic harassment (harassment of transgender people).
- Does the provider work with people using the service, if appropriate, to ensure that people understand that all workers have a right to be in an environment that respects their dignity and self-worth?
- Is there evidence that staff from outside the UK have appropriate support including³³:
 - orientation to the health and social care sector in England
 - appropriate induction about what to do if they experience bullying and harassment, and
 - specific work with people using the service to prevent discrimination or harassment of staff from outside the UK, if appropriate?
- Is there evidence that staff feel able to report concerns about the service without fear of recrimination?
- Is there evidence that disabled staff have reasonable adjustments or support plans put into place?
- NHS organisations only: does Equality Delivery System analysis of performance contribute any information about compliance with this outcome?

25. Are there any examples of putting these equality and human rights aspects into practice?

Example 1

An inspector has used discussions about monitoring service quality by equality characteristics to open up discussions with care home managers about improving their support for lesbian, gay and bisexual people.

The fact that the inspector raised the issue has prompted services to look at how they will make changes to ensure people who use their service are fully afforded their human rights.

In care homes for people with learning disabilities, this often involves managers increasing the confidence of staff to discuss sexuality and sexual orientation with people using the service. Some staff members are nervous about the implications of empowering people to have a sexuality at all and they have avoided the subject.

Actions that services have taken include:

- Developing training for staff.
- Holding empowerment and education sessions for people who use services to equip them with knowledge about their rights and about sexuality – promoting their human rights, whatever their sexual orientation.
- Changing policies, and
- Building links with local lesbian, gay and bisexual community facilities.

Quality and suitability of management (combined)

<p>26. What is the overall context for equality and human rights in these sections?</p>	<p>Quality</p> <ul style="list-style-type: none"> • There is a variety of views on the meaning of ‘quality’. In <i>High Quality Care for All</i>, Lord Darzi describes quality as the guiding principle and basis for the future development of the NHS. Lord Darzi defined quality as care that is "clinically effective, personal and safe". • Attention to equality and human rights is crucial to high-quality health and social care services. This is particularly the case for example in relation to the links between a) promoting independence and responding to diverse needs, and b) ensuring safety and wellbeing and respecting human rights.³⁴ (See <u>Equality and human rights in the essential standards of quality and safety: An overview</u> for a summary of the human rights approach taken by CQC.) • There has been a shift from measuring processes to measuring outcomes – this approach underlies not only how we would expect providers of health and social care to look at quality, but how we measure quality ourselves, through the registration model including the essential standards and Quality and Risk Profiles. • An important aspect of an outcomes-based approach to managing quality is that it relies on measuring whether health and social care services are benefiting people, so it is necessary to involve the people who use the service in providing feedback about outcomes. • In relation to equality, a fundamental test is to look at whether there are differential outcomes for people with different equality characteristics using health and social care services. However, this has often been hampered in the past by a lack of information – for example in tackling health inequalities for particular communities, such as specific black or ethnic minority communities or protected groups such as lesbian, gay and bisexual people. In order to meet the public sector equality duty, public authorities will need to have sufficient equality information to understand the effect of their decisions, including for example where there are different needs or where participation of certain groups is low. <p>Suitability of management</p> <ul style="list-style-type: none"> • One of the changes in the Equality Act 2010 is that pre-employment health-related checks are now unlawful, except in very restricted circumstances or for very restricted purposes. More information about this change is given in question 22.
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26. continued

- CQC takes the following view on how this relates to regulations 4 (4)b, 5(3)b and 6(2)b – that the registered person must ‘be physically and mentally fit to carry on the regulated activity’.
 - In Essential standards Prompts 22A, 23A and 24A, the essential standards state that registered managers should be ‘physically and mentally able to do the job, with a plan of support including reasonable adjustment where necessary’. This means that CQC takes account of the fact that providers and CQC should look at reasonable adjustments for disabled people in relation to ‘fitness’ to carry out the registered manager’s role.
 - CQC does not check recruitment processes for managers under Regulations 4-6. However, when recruiting new managers, providers should comply with the Equality Act 2010 and only use pre-employment health checks where allowed under the Act. This is in line with Prompt 12C in the essential standards – that staff are recruited following a selection procedure that complies with legislation about employment. As managers are staff, this essential standard will apply to the recruitment of managers.
 - Regulation 5 Schedule 1 – information required in respect of a service provider who proposes to manage the carrying on of a regulated activity: (7) states that the provider must give CQC ‘satisfactory information about any physical or mental health conditions which are relevant to the person’s ability to manage the carrying on of the regulated activity’. Applications to CQC to become a registered manager under this schedule are not part of the employment application process and are therefore not subject to the change in the law on pre-employment health checks. This is a separate process.
 - In any case, applicants need only give information about health conditions which are relevant to their ability to carry out their role – this aligns closely to the one of the exceptions to the prohibition on pre-employment health checks - about asking questions about a person’s ability to carry out a function that is intrinsic (or absolutely fundamental) to that job.
 - The forms for registered manager applications have been changed to ask for information about reasonable adjustments, so that this information is available when making assessments of fitness of registered managers.
 - **It is very important that inspectors do not give advice to providers on recruitment decisions about managers as this is not our role and could open up CQC to legal challenge from individuals.**

	<ul style="list-style-type: none"> • If you receive an enquiry about this and need help, please contact the Involvement and EDHR team: AskRegulatoryDevelopment@cqc.org.uk • Note the above email address is only for CQC staff. Others with enquiries about CQC work on equality and human rights should use: involvement.edhr@cqc.org.uk
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<p>27. What equality and human rights prompts should I consider for Outcome 15: Statement of purpose?</p>	<ul style="list-style-type: none"> • We do not produce any prompts for this outcome. • Statements of purpose should include ‘the range of service users’ needs which (the services) are intended to meet’ • Whilst it is not the role of Care Quality Commission to advise a provider or negotiate on the content of a statement of purpose, we should be mindful of situations where a statement of purpose may breach equality legislation as we may need to refer this to the Equality and Human Rights Commission. • For example, it <i>may</i> be unlawful to restrict the service to people with a particular equality characteristic – such as people following a particular religion, or to exclude disabled people with certain impairments. However, the law in this area is complex. For example, there are exemptions for certain types of organisations in relation to religion and belief and there is the concept of ‘reasonable adjustments’ in relation to disabled people. • If you are unsure whether a statement of purpose may breach equality or human rights law, please seek advice from the CQC Involvement and EDHR team as outlined in Equality and human rights in the essential standards of quality and Safety: An overview.
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<p>28. What equality and human rights prompts should I consider for Outcome 16: Assessing and monitoring the quality of service provision?</p>	<ul style="list-style-type: none"> • Is there evidence that feedback from people who use services (or others acting on their behalf) influences changes to the service? • Do adverse events, incidents and errors vary by equality characteristics? • Are adverse events, incidents and errors monitored to consider any human rights concerns? • Is equality monitoring carried out to enable the provider to see whether people’s experience in using the service varies by equality characteristics (for example when carrying out surveys of people using the service)? • NHS organisations only: does the organisation use the Equality Delivery System to improve performance around equality?³⁵ • NHS organisations only: does the Equality Delivery System³⁶ analysis of performance contribute any information about compliance with this outcome?
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29. What equality and human rights prompts should I consider for Outcome 17: Complaints?

- What evidence is there that people who use the service know how to put in:
 - a comment about the service?
 - a complaint?
- What evidence is there that people who use the service know how to access information about the complaints system?
- Is information about the complaints system available in alternative formats including relevant languages?
- Does the information about the complaints system include:
 - a named contact?
 - information about advice and advocacy available to people who want to complain?
 - information about steps they can take if they are not satisfied with the outcome of the complaint? (For example relevant ombudsman.)
 - an undertaking that making a complaint will not cause the person to be discriminated against or have a negative impact on their care, treatment or support?
- What evidence is there that people who use services have advocacy support, if they wish, when they make a complaint?
- Is there any evidence that making a complaint has caused any person to be discriminated against or has had a negative effect on their care, treatment or support?
- Is there evidence available of the number of complaints resolved to the satisfaction of the complainant as a percentage of the complaints made?
- What evidence is there that upheld complaints concerning equality or human rights influence policy and practice?
- Is there a way that people using a service can give anonymous comments (rather than making a formal complaint)?
- NHS organisations only: does the Equality Delivery System³⁷ analysis of performance contribute any information about compliance with this outcome?

<p>30. What equality and human rights prompts should I consider for Outcomes 18-20: Notification of deaths and other incidents?</p>	<p><i>Outcome 18</i></p> <ul style="list-style-type: none"> • Does the provider complete equality information when sending the CQC a notification of death? • Does this information state cause of the death? <p><i>Outcome 19</i></p> <ul style="list-style-type: none"> • Does the provider complete equality information when sending the CQC a notification of death for someone detained or liable to be detained under the Mental Health Act 1983? • Does this information state cause of the death? <p><i>Outcome 20</i></p> <ul style="list-style-type: none"> • Does the provider complete equality information when sending the CQC a notification of another type of incident? • Does this information state reasons for the incident? <p>Note: questions relating to findings from the analysis of notification information are included in the relevant outcomes. Also note that providers only need to complete the equality information in a notification if they already have equality monitoring information available. CQC does not expect providers to ask equality monitoring questions to people who use services or their family and friends, purely for the purpose of completing a notification form.</p> <p>For further information about the notification process, please see the notifications guidance: http://www.cqc.org.uk/guidanceforprofessionals/adultsocialcare/registration/notifications.cfm</p>
<p>31. What equality and human rights prompts should I consider for Outcome 21: Records?</p>	<ul style="list-style-type: none"> • Is there evidence that shows proper record-keeping, for example do people who use the service report satisfaction with how their records are kept? • Is there evidence to show confidentiality of record-keeping? • Are people’s needs described in their records in a way which shows respect for the person and avoids judgmental or discriminatory language?

<p>32. What equality and human rights prompts should I consider for Outcome 22-24: Requirements of different types of provider?</p>	<ul style="list-style-type: none"> • Is there evidence to show recruitment decisions are based on meeting qualifications, skills and experience required for the activity? • Is there evidence to show that assessments of character and ability to perform specific roles have not discriminated against applicants who would otherwise meet the requirements for the role? • Is there evidence of providing reasonable adjustments to enable disabled managers to meet the requirements of their role? • NHS organisations only: does Equality Delivery System³⁸ analysis of performance contribute any information about compliance with Outcome 22?
<p>33. What equality and human rights prompts should I consider for Outcome 25: Registered person: training?</p>	<ul style="list-style-type: none"> • What evidence is there that the registered manager has had relevant training or activities to ensure they have up-to-date knowledge and skills: <ul style="list-style-type: none"> ○ about the rights of the people using the service? ○ around equality (covering all protected characteristics)? ○ about equality legislation?
<p>34. What equality and human rights prompts should I consider for Outcomes 26-28: Financial position, notification of absence and notification of changes?</p>	<ul style="list-style-type: none"> • There are no direct equality or human rights dimensions to these outcomes.

35. Are there any examples of putting these equality and human rights aspects into practice?

In a review of compliance in an acute hospital trust, the trust declared compliance with Outcome 21 (records) and said it had evidence to demonstrate that all relevant aspects had been met. However, CQC's quality and risk profile suggested that there was a high level of concern with a high risk of non-compliance.

A site visit was carried out. This indicated that there were a number of issues with the quality of record-keeping, including bringing to light some concerns about confidentiality of people's records – which is linked to the right to privacy. The review of compliance report says:

"We observed that the need to maintain confidentiality or disclose information had been taken into account in some areas but not others with evidence that patient confidentiality could have been breached. For example, in outpatient areas A and B, lists of patient names attending the clinics, including other patient information, had been left unattended on top of trolleys in the patient waiting areas. And in the corridor between the outpatient reception area and the clinic area we observed a large cabinet containing patient records which was unlocked, unattended and out of line of sight of hospital personnel. We asked staff to lock the cabinet but on returning to check it was still unlocked. We were concerned because whilst records should be accessible they need to be securely stored and patient confidentiality should always be maintained."

Non-compliance with this outcome was judged to be a moderate concern.

The provider was required to send CQC a report explaining what action it would take to achieve compliance with these essential standards within 14 days.

References

- ¹ Lord Darzi (2008) High Quality Care for All.
- ² For good practice relating to 'next of kin' issues and sexual orientation (though outdated now in terms of the legal position), see Royal College of Nursing (2003) *Lesbian, Gay, Bisexual or Transgender Patients and Clients: Guidance for nursing staff on next of kin issues*.
- ³ For more information about the NHS Equality Delivery System, see *Equality and Human Rights in the Essential Standards of Quality and Safety: An Overview*.
- ⁴ For more information about the NHS Equality Delivery System, see Equality and human rights in the essential standards of quality and safety: An overview.
- ⁵ Equality and Human Rights Commission (2009), Involvement in Practice Guidance.
- ⁶ Lord Darzi (2008) High Quality Care for All.
- ⁷ Department of Health (2010) A Vision for Adult Social Care: Capable communities and active citizens.
- ⁸ Department of Health (2010) Equity and Excellence: Liberating the NHS.
- ⁹ Commission for Social Care Inspection (2008) See Me, Not Just the Dementia.
- ¹⁰ See Equality and human rights in the essential standards of quality and safety: An overview.
- ¹¹ For more information about the NHS Equality Delivery System, see Equality and Human Rights in the Essential Standards of Quality and Safety: An Overview.
- ¹² For more information about the NHS Equality Delivery System, see Equality and Human Rights in the Essential Standards of Quality and Safety: An Overview.
- ¹³ Equality and Human Rights Commission (2009) Consultation response to the Department of Health's consultation on the framework for the registration of health and adult social care providers and associated regulations.
- ¹⁴ Care Quality Commission: Guidance about compliance: Essential standards of quality and safety p34-35.
- ¹⁵ *Ibid.*
- ¹⁶ Equality and Human Rights Commission (2009) Consultation response to Department of Health consultation on safeguarding adults: the review of the no secrets guidance.
- ¹⁷ *Ibid.*
- ¹⁸ Department of Health (2002) Guidance on the use of Restrictive Physical Interventions for staff working with children and adults who display extreme behaviour in association with learning disability and/or autistic spectrum disorder.
- ¹⁹ Department of Health (2008) Code of Practice Mental Health Act 1983.
- ²⁰ For example, see *The Independent* (25 July 2007) 'Disabled youngsters forced into marriage to provide passports'.
- ²¹ The Women's Aid (2008) Federation Report *Making the Links Disabled Women*

and Domestic Violence.

²² Action on Elder Abuse (2007) Briefing Paper: The UK Study of Abuse and Neglect of Older People 2007.

²³ See article on 'safer walking technology' at http://alzheimers.org.uk/site/scripts/documents_info.php?categoryID=200167&documentID=579&pageNumber=1

²⁴ For more information about the NHS Equality Delivery System, see *Equality and human rights in the essential standards of quality and safety: an overview.*

²⁵ *Ibid.*

²⁶ *Ibid.*

²⁷ *Ibid.*

²⁸ CBI, TUC and Equality and Human Rights Commission (2008) Talent not Tokenism: The business benefits of workforce diversity.

²⁹ Harris, V and Dutt, R, (2004) Meeting the Challenge – A good practice guide for the recruitment and retention of Black and minority ethnic workers, Race Equality Unit, London.

³⁰ Commission for Social Care Inspection (2008) Putting People First: Equality and diversity matters 1: Providing appropriate services for lesbian, gay and bisexual and transgender people: CSCI, London.

³¹ More information about pre-employment health checks and the Equality Act 2010 can be found in the publication: Equality Act 2010 Code of Practice: Employment statutory code of practice (Equality and Human Rights Commission) or in the Government Equalities Office publication: Equality Act 2010: what do I need to know? A quick start guide to the ban on health and disability questions during recruitment

<http://www.equalities.gov.uk/pdf/110406%20Pre%20Employment%20Questions.pdf>

³² For more information about the NHS Equality Delivery System, see *Equality and Human Rights in the Essential Standards of Quality and Safety: An Overview.*

³³ See recommendations of the following report for more details: Cangiano, A., Shutes, I., Spencer, S. and Leeson, G. (2009) Migrant care Workers in Ageing Societies, UK research findings, COMPAS ESRC Centre on migration, policy and society, Oxford.

³⁴ Equality and Human Rights Commission (2009) Response to the Care Quality Commission consultation on compliance guidance for providers of adult health and social care services.

³⁵ For more information about the NHS Equality Delivery System, see *Equality and Human Rights in the Essential Standards of Quality and Safety: An Overview.*

³⁶ *Ibid.*

³⁷ *Ibid.*

³⁸ *Ibid.*