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

Summary of responses to the consultation on draft equality and human rights guidance
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1. Introduction

About the consultation
The Care Quality Commission (CQC) and Equality and Human Rights Commission (EHRC) have jointly produced guidance about the equality and human rights dimensions of CQC’s essential standards of quality and safety.

This is to provide CQC's inspectors and assessors with coordinated information that clarifies what is required by the CQC’s new registration framework and equality and human rights law. This responds to the Six Lives report (March 2009) by the Parliamentary Health Services Ombudsman, which recommended better collaboration between inspectorates and regulators.

CQC and EHRC held a public consultation on the draft guidance from 18 August to 12 November 2010 as part of stakeholder involvement to ensure that the views of CQC staff, people who use health and adult social care services, carers and providers of services are taken into account.

This report summarises the responses received and sets out what actions both CQC and EHRC decided to take when finalising the guidance and planning future work.

About the guidance
The joint guidance uses the equality and human rights aspects of the six key areas of the essential standards of quality and safety. These are:

1) Involvement and information.
2) Personalised care, treatment and support.
3) Safeguarding and safety.
4) Suitability of staffing.
5) Quality and management, and
6) Suitability of management.

The joint guidance therefore comprises a) overview guidance that summarises equality and human rights in regulation and CQC's approach and b) guidance on each of the key themes in the essential standards of quality and safety, with an explanation to assist CQC inspectors and assessors to understand equality and human rights issues within each outcome of the guidance to use in registration and monitoring compliance once providers are registered.

Note that the draft version of this guidance had a separate document for each of the key themes. Following further consultation with inspection staff and their managers (the key audience for the guidance), we agreed to combine this guidance on key themes into one document, to reduce repetition. This is more a change in structure of the guidance than content. All the comments about the draft ‘key themes’ guidance made during this consultation have been considered in relation to the combined document.
This joint guidance will support inspectors and assessors when they are checking compliance so that they know what to look for and are clear about the role they have to play.

It complements CQC’s Guidance about compliance: essential standards of quality and safety (March 2010) for providers of health and adult social care services.

Structure of the report

This report presents a summary and analysis of the views received during the consultation. CQC and EHRC received a large number and range of views. These have been carefully considered and have informed the final guidance.

Section 2 provides an analysis of the responses to the questions set out in the consultation questionnaire.

Section 3 provides an account of what actions CQC and EHRC decided to take in finalising the guidance, using feedback from respondents to the consultation.

Overview of responses

In total, there were around 70 responses to the consultation document. These came from a variety of backgrounds:

- CQC inspectors and assessors
- other CQC staff
- people who use health and adult social care services
- carers
- health providers
- adult social care providers
- campaigning and representative organisations
- professional bodies, and
- government.

Operations review and stakeholder meetings

The draft guidance was piloted in eight CQC reviews of compliance across the country – covering both health and social care services. Feedback on the use of the guidance and ideas for improvement was gained from inspectors involved in the pilot. This feedback informed both the structure and the detail of the final version of the guidance.

We also specifically requested feedback from people who use services involved in the CQC registration Involvement Group – nine people responded. We supplemented this with meetings with four groups of people who use services to gather views on specific issues to feed these into the guidance development. These were focused around equality groups – the CQC eQuality Voices group and specific
groups to engage with refugees and asylum seekers, and lesbian, gay, bisexual (LGB) and transgender people - to fill gaps in the wider consultation.

Online questionnaire
We devised an online questionnaire to seek views on each area of the guidance. Respondents were asked to grade the usefulness ('very useful', 'useful', 'partially useful', 'not very useful', 'not at all useful') of each question listed below:

- How useful did you find the overview guidance?
- How useful did you find the Involvement and information guidance?
- How useful did you find the personalised care, treatment and support guidance?
- How useful did you find the safeguarding and safety guidance?
- How useful did you find the quality and management and suitability of management guidance?
- How useful did you find the suitability of staffing guidance?
- How useful did you find the top 10 things you need to know?

Of the overview guidance, respondents were asked to rate 'yes' or 'no' to the following questions:

- Were the questions and answers useful?
- Are any of the questions unnecessary?
- Are there any missing questions?
- Are the prompts for each outcome useful?
- Are any of the prompts unnecessary?
- Are there any missing prompts?

Respondents were also asked whether besides this guidance:

- Are there any other actions that the CQC or the EHRC should be taking to help embed equality and human rights legislation into assessor and inspector practice?
2. Analysis of responses

How useful did you find the overview guidance?

Respondents indicated support for this guidance with the following ratings: 33% very useful, 35% useful, 22% partially useful, 2% not very useful and 8% not at all useful.

Some respondents thought that there was too much detailed information about equality and human rights in the overview guidance but others thought that there was not enough, particularly of issues specific to each equality strand, for example the lived experience of LGB people in health and social care services.

Some respondents stated that there was too much theory, which masked the relevant parts that inspectors and assessors would already have in their training.

It was pointed out that there was a lack of clarity about the extent to which independent, voluntary and statutory organisations are bound to different legislation.

Respondents questioned the legal disclaimer which states that “It [the guidance] does not constitute formal policy or advice by either the Care Quality Commission or the Equality and Human Rights Commission nor is it indicative of any action that either of these bodies may consider in response to the issues raised in the guidance” (and this is repeated across the suite of guidance). Respondents said that this undermined the value of the guidance and raised the question about who does take responsibility if these agencies do not, and why these agencies will not, given their statutory responsibilities.

Many respondents highlighted the need for training of CQC inspectors and assessors to accompany the guidance. To make it more real, simulations could be a mechanism to help inspectors and assessors understand what to look for on a visit.

Respondents suggested that inspectors and assessors check for evidence from other sources to a visit; for example reviewing complaints to see if they include concerns in relation to treatment which would constitute failure of the provider to meet the standards required.

One respondent stated that the guidance, because it is in the public domain (which they support), may also set high expectations from inspectors and assessors at a time when the amount of financial resources for CQC is less than those of their predecessors. At the same time, CQC staff are focusing on other work (primarily getting organisations registered).

Respondents said that it was vital that there is a continued commitment to involvement shown by CQC who have a role to play in setting the high standards expected of all health and social care professionals and that the guidance could be strengthened on this point.
One respondent suggested that ‘the social model’ should also be linked to age, religion or belief and gender reassignment as, for each of these, attitudes and behaviours of staff can cause barriers to equality.

One respondent disagreed with the term ‘disabled people’ and suggested that the guidance instead refer to ‘people who have a disability’.

**How useful did you find the involvement and information section?**

Respondents showed support for this area with the following ratings: 24% very useful, 36% useful, 27% partially useful, 4% not very useful and 9% not at all useful.

For those respondents who thought that the whole range of guidance would benefit from more detailed information on each equality strand, the issue of non-recognition of same-sex partners and friends for gay people in accessing health and social care was raised. For example, the exclusion of friends who may make up one’s ‘family of choice’ from care and support decisions because a worker’s understanding of family excludes the network of friends that can form in place of a biological family from which a person has been rejected due to being gay. Flagging this potential issue with assessors and inspectors would be helpful.

One respondent highlighted that reference could usefully be made to contact with foundation trust service user and carer governors for views and experience.

**How useful did you find the personalised care, treatment and support section?**

Respondents showed support for this area with the following ratings: 28% very useful, 41% useful, 18% partially useful, 4% not very useful and 9% not at all useful.

One respondent raised concern that the EHRC and CQC are promoting over-simplified messages about regulated care when setting the context in this guidance and that there is no reason why a regulated domiciliary care provider cannot provide flexible, personalised services.

Again, of respondents who wanted more detail about specific areas, they would like to see an emphasis on high-quality care that responds to the needs of particular groups. For example, *See me not just the dementia*\(^1\) clearly demonstrates that without a specific focus on the needs of people with dementia, you cannot understand the quality of care that this group of people is getting. This is essential to ensure person-centred care, appropriate to the needs of people with dementia, is delivered.

One respondent stated that reference to the ‘one size fits all’ service-led approaches disadvantaging BME service users has an adverse impact on white British service

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users in some parts of the country - particularly but not exclusively within older adult mental health services.

Respondents questioned the meaning of ‘competency in equality’ and therefore that the guidance needed to be clear about examples of this.

Respondents indicated that it would be unreasonable to meet everyone’s diverse preferences given the diversity of service users being catered for in some areas of the country.

How useful did you find the safeguarding and safety section?

Respondents reported support for this area with the following ratings: 36% very useful, 33% useful, 22% partially useful, 0% not very useful and 9% not at all useful.

Respondents highlighted the need for staff training in restraint procedures, not just reliance on knowledge of how to do this.

One respondent questioned the focus on people ‘in vulnerable situations’ instead of ‘vulnerable people’.

One respondent indicated whether there should be specific mention of staff knowing, or systems being in place, to cater for medicines that have porcine or other contents unacceptable to people on religious or dietary grounds.

The availability of outdoor space was highlighted as some parts of the country, such as London, have less access to this.

How useful did you find the suitability of staffing section?

Respondents indicated support for this area with the following ratings: 30% very useful, 36% useful, 23% partially useful, 2% not very useful and 9% not at all useful.

Again reflective of criticism that the guidance did not go into sufficient detail for each of the equality strands, some respondents suggested that the questions and prompts may benefit from some additions relating to the reporting of bullying and harassment and also to highlight whether training specifically mentions LGB issues.

The guidance might also include information around inclusive bullying and harassment policies and how sexual orientation complaints (both staff and resident) are dealt with.

One respondent highlighted that we need to think about the impact of providing personalised services and that giving more power to service users to select their own staff also imparts directly on them the need to be non discriminatory.
How useful did you find the quality of management and suitability of management section?

Respondents indicated support for this area with the following ratings: 28% very useful, 40% useful, 19% partially useful, 4% not very useful and 9% not at all useful.

Reflective of the view that there should be more detail for each of the equality strands, one respondent highlighted that a useful addition would be a question about the anonymity or confidentiality of the complaints process. Gay people may be concerned about ‘outing’ themselves when making a complaint about a poor experience relating to their sexual orientation so this would be a useful point to flag this issue with assessors and inspectors.

Another respondent questioned whether there should be a bullet point relating to transgender to ensure notes have been completed lawfully in relation to confidentiality relating to gender identity where this has arisen.

How useful did you find the Top 10 things you need to know?

Respondents indicated support for this information with the following ratings: 28% very useful, 49% useful, 9% partially useful, 5% not very useful and 9% not at all useful.

While this initiative received support, there was some disagreement with some respondents stating that the top 10 list needed to be briefer and less woolly while other respondents suggested additions. For example, an important evidence source must be the views of people using services and that every person should be enabled to give their views, even when there are barriers to their participation, such as impairments in communication caused by the progression of dementia.

The overview guidance

Were the questions and answers useful?
88% of respondents voted 'yes' and 12% voted 'no'.

There were a couple of suggestions for improvements to the questions. Firstly, of the question ‘Does this satisfaction vary with equality characteristics?’, it is important to develop robust differences between and within groups, and to provide the evidence for services to action. Secondly, of the question ‘Is there evidence that staff involved in care planning are competent in equality across all the protected characteristics?’, it is important to develop training plans and competencies for nurses and health care support workers in all settings.

Are any of the questions unnecessary?
12% of respondents voted 'yes' and 88% voted 'no'.

One respondent highlighted that there was no need for the question ‘If human rights cannot be taken away, why are so many human rights abuses happening in the world?’
Are there any missing questions?
21% of respondents voted 'yes' and 79% voted 'no'.

Respondents offered a few suggestions to cover missing areas:

- The missing area is around Carers (Equal Opportunities Act) 2004 and the specific duty regard the NHS, including GP providers, have in identifying hidden carers and providing support etc. This is an area that has seen limited performance management, a lack of regional leadership and tragic consequences for the cared for.

- We would recommend an additional question is included to emphasise the importance of considering the human rights of people who lack mental capacity. For example, because of their condition some people with dementia will have impaired communication skills. As a result they are often excluded from discussions about their care.

- There needs to be specific emphasis that every step needs to be taken to enable people who lack capacity or who have fluctuating capacity to ensure that their preferences and needs are considered. This should include reference to the Mental Capacity Act and an emphasis upon involving the people who know them best in discussions about their care. Two-thirds of people in care homes have dementia, which will affect their mental capacity. Therefore an understanding of the specific issues relating to mental capacity and human rights is essential and could easily be included as an additional question in the overview guidance.

- The need to emphasise those with sight and hearing impairments and their potential difficulty in accessing documents or communicating with employees.

- The right for mental health patients to have the same choices as general patients.

Are the prompts for each outcome useful?
90% of respondents voted 'yes' and 10% voted 'no'.

Are there any missing prompts?
17% of respondents voted 'yes' and 83% voted 'no'.

If yes, please state which ones?
Respondents had a number of suggestions:

1. In relation to considering the joined-up duty to carers in service provision beyond looking at the Equality Act 2010 for example Carers (Equal Opportunities Act) 2004 and the Department of Health’s work on the National Carers Strategy.

2. Prompts do not appear to provide scope for the proper triangulation of evidence in some key areas:
   - Outcome 1 – around NHS duty to involve patients and public in service design and changes for example the NHS duty under NHS Act 2006 as amended – though applies in large part to NHS trusts only.
   - The higher duty required of public bodies who are NHS providers in relation to assessing impact on people who might be affected – which in some cases requires involvement and not just consultation.
3. Patients on Board – the overlap between staff, service users and patients – is not properly acknowledged when reviewing involvement. This has been key in mental health trusts, who have actively sought to involve patients by encouraging them to become staff and decision-makers.

4. The over-prescription of antipsychotic drugs to treat people with dementia is a serious breach of rights. The Department of Health has recently committed to reducing the use of antipsychotics by two-thirds by November 2011. Given the urgency of this priority, the guidance for inspectors and assessors should include a specific prompt around the use of antipsychotics. This should be included as an additional prompt under either Outcome 4 in the guidance on the ‘Personalised Care, Treatment and Support’ section of the CQC essential standards and/or under Outcome 9 in the guidance on the ‘Safeguarding and Safety’ section of the CQC essential standards.

5. Involvement and information – should include prompts for all protected characteristics in each outcome including consent to treatment. Personalised care – all protected characteristics including 4D, 4G, 4K, 4L; in addition – add gender 4J, add race 4Q, add religion and belief 5D. Safeguarding and safety – Outcome 7 points and prompts should reflect all protected characteristics; prompts re restraint and de-escalation should especially reflect race and age; Outcome 9 – para 2.5 (p.18) – access to advocacy should be included. Suitability of staffing – welcome context which recognises people have differing range of characteristics; all prompts for Outcome 12 should reflect all protected characteristic areas. Quality and management – context – welcome focus on need to be aware of differential outcomes; prompt 16B should reflect all characteristics; Outcome 18 and prompt 18D should reflect all protected characteristics; Outcome 19 and prompts 19D, E and I should reflect all protected characteristics; prompt 22A should reflect all characteristics and should make reference to reasonable adjustments for people with mental health problems; prompts 23 and 24 should reference mental health disability in terms of reasonable adjustments; Outcomes 22-24 – para 2.10 (p.29) should reference managers with mental health disabilities.

6. Concerning the quality of food/drinks and the quality of serving food/water/drinks to those for whom this is a problem.

7. Do you need to put anything in about timelines for dealing with complaints?

8. Don’t forget to allow enough time for you to listen.

9. No mention is made of appropriate language. Use appropriate language in talking to groups or individuals. In some cases, a translator may be required.

10. There is no mention of the involvement of carers. Providing evidence that carers/family have been involved in the formulation of care plans, particularly when the service user may not be able to give his/her views.

11. Are service users aware of/seen their care plans? Have they been involved in decisions relating to their care?

12. What evidence is there that efforts are made for service users with problems with communication to give their views or influence their care?
13. The same checks for the use of restraint under point 3 should apply to the use of drugs/sedation. Staff should know that service users have a right to refuse medication except for in exceptional cases.

14. How does the service support people who have problems with communication enable them to communicate with staff to express their concerns about their safety and welfare?

15. Instead of dressing down, I would say dress appropriately. There’s not anything wrong in wearing a casual suit. I believe that the ID badge necklace is more off putting. It’s a reminder of us and them dynamics in institutions.

16. Sometimes expert by experience skills goes beyond observation of living environment dynamics. Often we are able to recognise certain individual behaviour patterns that might indicate that someone is distressed and reluctant to communicate to staff because of this. And as in one instant during an inspection, a resident who we were told makes a repetitive noise turned out to not be a compulsive defect but their way of manipulating the use of the communal TV.

17. Also on occasions it might well be a health and safety issue, such as missing security locks on some windows and or the gaps under doors, that doesn’t meet regulatory fire protection standards.

18. Might also include sharing lunch with residents where possible and chatting a bit about topical issues. I find that this is one way of putting residents at ease and getting them to open up.

19. Are patients/residents made aware of their rights to having advance directives about their future care?

20. Do advocacy services impede or restrict someone’s advance directive?

21. Evidence that patients were given adequate notice of care plan reviews.

22. Patients have agreed to the number of people attending their care plan review.

23. Patients know their rights to challenge information in their care plan that they believe that they might not have agreed to.

24. If an advance directive is in place, what is the evidence that any safeguard actions have considered this?

25. Evidence that complainants’ rights to anonymity are respected.

26. As a responsible employer I do not believe that employees should be encouraged to spend time with people when they have a smoke due to passive smoking. Another activity should be suggested, for example a walk.

27. There is no evidence gathered that an annual review or questionnaire has taken place including the service user and, if appropriate, the carer or family to allow issues to be raised with a resulting improvement action plan to resolve issues. Is there evidence that the views of people using services and, if appropriate, the carer influence the outcome?

28. It is more important that evidence exists than the training is put into practice, for example evidence of choices being offered and decisions being made.

29. Need to ensure that advocacy is truly independent.
30. It may be difficult for inspectors and assessors to identify LGBT people directly, for example, in observational work - this is the reason for a specific question relating to this equality characteristic. People also have hidden disabilities and it may also be appropriate to ensure you are aware of any difficulty people naturally cover up, for example people with hearing difficulties may not fully understand what you tell them but will make best efforts to answer.

31. Should not evidence exist that the care plan has had an equality analysis?

32. There is plenty of evidence that care planning is done but staff often do not have the time to read the plans, staff that undertake the care plans need to be fully aware of the equality issues, evidence needs to be gathered that staff involved in implementing the care plan are competent in equality across all the protected characteristics.

33. Enabling people to take informed risks is important to allow choice and independence, taking away all unnecessary restrictions of people’s lives. It could be worth noting that as in all aspects of life, not everybody’s choices will be the right ones and they will have to learn from their mistakes. This could easily result in people’s satisfaction with the outcomes being reduced. There is a need to demonstrate that risks can be taken but the process learns from the experience to avoid repeated risks that fail, leading to eventual satisfaction with the outcomes.

34. Do people who use the service know how to access the policy/procedure? Does the service enable people to access independent advocacy?

35. What evidence is there that people who use services are supported to make a complaint? Is there access to independent advocacy, for instance?

36. Staff can be too busy to speak with you, offer an alternative time/way of communicating.

37. Let people see you making notes and taking an interest - feedback if necessary.

38. I would like to see the words family/carer used a little more often.

39. Can we cover if a service user abuses another service user either physically or verbally?

40. Can we include a point which discusses the situation if a member of staff is verbally abused, for example relating to their race/religion etc by a service user or their family/carer?

41. I see care plans mentioned but can we also mention menus/food - dietary rules and considerations?

42. I would add something like ‘has equipment which has been promised materialised’? And perhaps ‘is there any equipment which may help you more’?

43. Is there evidence that staff know who to report a concern?

44. Do staff feel comfortable about reporting a concern?

45. I would include is staff training ongoing and up to date?

46. Does staff training form part of the induction course for new staff at all grades?

47. Your advice is excellent, but will you allow the inspectors time enough to implement it? For example, talking to every one of the 30 residents in a care
home, having gained first their confidence, would take many hours even with the help of an expert. What will you do about those residents who are incapable of speaking for themselves? Talking to their carers would be one possibility. Indeed, inspectors should talk to carers of all service users wherever possible.

48. Inspectors should pay particular attention to people who lack capacity and have no support available from friends and relatives. Has the service called in an advocate when a decision had to be made? Moreover, is the patient treated with dignity on an ongoing basis? Evidence might be obtained from other more capable patients or visitors.

49. The wording suggests that evidence will be available in advance of an inspection. In addition, it should be a priority for inspectors to obtain this evidence from patients and carers when they visit the site.

50. The advice focuses on the need for positive discrimination, but there is also a risk of negative discrimination. For example, older people may not even be informed about an effective but radical treatment on the assumption that they would prefer to die rather than undertake the stress of the treatment. This should be the patient’s decision if possible. Inspectors should be prompted to look out for negative discrimination.

51. Service users and carers should know that if their complaint is not resolved internally to their satisfaction they can take it up with the appropriate ombudsman. There should be a prompt about this.

52. How will you know that all complaints received have been recorded? If not all complaints are recorded the percentage resolved could be inaccurate.

53. Take note of anyone appearing alone or isolated; seek to discover whether there is a sound reason for this.

54. Discover whether service users/patients have experienced shared decision-making with regard to any aspect of their treatment/accommodation options.

55. Discover whether service users/patients of higher than average intellectual ability, feel particularly patronised, not respected, or that they are not listened to, or are ignored.

Besides this guidance, are there any other actions that the Care Quality Commission or the Equality and Human Rights Commission should be taking to help embed equality and human rights legislation into assessor and inspector practice?

For CQC, 40% of respondents voted 'yes' and 60% voted 'no'. For EHRC, 30% of respondents voted 'yes' and 70% voted 'no'.

Specific suggestions for CQC were:

- Discussions with the DH in relation to the National Carers Strategy and implications for healthcare providers.
- Discussions with the National Health Litigation Authority to improve framework for monitoring risk and human rights – with improved tracking outcomes.
• We have noted that we don’t know how these pieces of guidance will be used, that is whether accompanying training will be provided. We would urge the CQC to go further than just written guidance and provide appropriate training to support inspectors and assessors.

• We note that the guidance is not enforceable and is not intended to be used as a checklist – it is for assessors and inspectors who would like clarification of equality and human rights issues when monitoring compliance of health and adult social care services. If this is the case, it may be only those with an awareness of or interest in these issues who use the guidance. Alzheimer’s Society believes that this needs strengthening to ensure that the guidance is read and used. For example, when considering how well assessors and inspectors are performing, could there be specific consideration of whether their work incorporates guidance? Similarly, we would like clarification on how inspectors will be made aware of this guidance and what further training they will have to implement it.

• Promote understanding of mental health needs and requirements.

• Place very strong emphasis on the need to train all employees, regardless of level and category (and to retrain where and when necessary, with regard to all aspects of equality and human rights legislation and how to implement this with regard to those with whom they are constantly in contact.

Specific suggestions for EHRC were:

• Creating a clearer link between information on statutory publication duty around workforce information and the robustness of other equality and diversity monitoring taking place.

• Review of the legal compliance of the framework that the National Health Litigation Authority is using to support its work with NHS trusts, to improve framework for monitoring risk and human rights. This review would encourage trusts to take an integrated approach to examining and evaluating issues that engage equality, human rights and risk.

• Promote need to reduce stigma and discrimination in relation to mental health.

• Continually to publicise through the media in all forms the content of EDHR legislation.

Respondents were also asked if they had any other comments. These are listed below:

1. UK government estimates that approx 6% of the population are lesbian, gay or bisexual. This means that approximately one in 15 people accessing care and support services are lesbian, gay or bisexual. Despite this however, LGB people remain largely invisible in health and care services. Concern that currently neither knowledge nor planning within the sector is sufficiently nuanced to adequately reflect, or provide for, or respond to their specific requirements.
2. Sexual orientation is often overlooked in equality and diversity within the health and care sector (the focus is usually race, disability and gender). However LGB people can and do suffer poorer outcomes – this point should be integral to any training that assessors and inspectors undertake on equality and human rights. LGB people do not always receive culturally appropriate care services and this can be particularly acute when there is a perception of likely discrimination if coming out, there is a lack of knowledge on the part of support staff and when users are either older or have a learning disability.

3. The guidance can be a useful tool to support inspectors and assessors. The guidance is generally inclusive of LGB people’s experiences within health and social care. However, the training inspectors and assessors receive to support them in using the guidance will provide excellent opportunity to ensure lesbian, gay and bisexual people’s experiences are properly covered and included in future inspection and assessment.

4. Individual documents, in other words relating to the six different sections. The prompts at the end of each section could be really useful for providers to work towards, perhaps these documents should be summarised for provider use as are overly long at present. The breakdown in the tables was a bit unnecessary at provider level... although may be useful for inspectors?

5. How is this guidance going to be used to assess providers? There is a lot here... will it be incorporated into AQAAS (annual quality assurance assessments) and visits to schemes or will it be a standalone assessment?

6. We found the ‘facts about discrimination’ in Appendix 1 of the overview guidance particularly concerning and while it is true to say that there are instances of unacceptable care, that need to be highlighted and eradicated, it is important to put these cases into context. The CQC has recently found that the quality of homecare services has improved, with 80 per cent achieving good or excellent quality ratings in April 2010 and we suggest that it would be useful for inspectors and assessors if examples of how regulated care is provided in a way that respects people’s human rights were also described.

7. There is a very good case in the final guidance to provide sector-specific guidance on what the minimum standards and outcomes should be for patient diversity data capture and evaluation.

8. Tackling health inequalities which relate to ethnicity has been hampered by a lack of data. This needs to be corrected by trusts taking responsibility for showing health outcomes by ethnicity for those they treat. This data will also show where communities are failing to access or make use of specific health services.

9. Reference in the guidance for ‘personalised care, treatment and support’ section (and other relevant documents) makes reference to the Mental Health Act (MHA) 1983 Code of Practice. There is no mention of deprivation of Liberty safeguards (DoLS ) or MCA and associated legislation (as these two were not around at the time of this Act!) – MHA, Mental Capacity Act, and DoLS should all be referred to separately.

11. Regulation 11 – (Protecting Service Users from abuse) needs to be added to the list Regulated Activities under section 1.4. Page 3 of Guidance for assessors and inspectors on ‘personalised care, treatment and support’ section of the CQC essential standards.

12. We recommend that the CQC pays further attention to the guidance produced by the Ministry of Justice entitled ‘The Human Rights Framework as a Tool for Regulators and Inspectorates’, which was published in 2009. That document provides clear and explicit guidance on the responsibilities of regulatory and inspectorate bodies as well as providing some practical examples of the link between human rights and equality work. The guidance is useful in providing some case studies in applying a human rights and equalities framework to the day-to-day and strategic operations of regulatory and inspecting bodies. We would also recommend that the Commission considers examples of good practice in the area of providing guidance around human rights issues. We look in this instance to the UN Convention of the Rights of the Child as one such example of good practice.

13. Would urge the CQC to refine its approach to equalities and human rights to move away from the social model of disability.

14. Many parts of the guidance are helpful but could be further refined and the Royal College of Nursing (RCN) would be pleased to work with the CQC and EHRC to do this.

15. Would urge the CQC to include training alongside guidance to complement the guidance.

16. Urge reflection about what is truly feasible for inspectors and assessors given workload for fewer CQC staff.

17. The RCN has said before that the CQC’s approach to equality and human rights appears to be conceived of rights primarily based on a derivation of the social model of disability. The RCN acknowledges the difficulty that organisations face in terms of defining their approaches to these critical issues. However our concern in this instance is that the text fails to sufficiently define and demarcate the approaches and does not contextualise these issues in terms of addressing fundamental inequalities in care. It therefore confuses rather than clarifies what the CQC actually intends.

18. The RCN welcomes this consultation as an important piece of work and has significant implications for patient care. This work has the potential to support practitioners uphold human rights in their practice and ensure that NHS organisations take their responsibilities seriously. The six key sections of the CQC’s essential standards of quality and safety provide rich areas for equality and human rights development and application. Many of the prompts and outcome-mapping questions are key nursing activities and we see great potential of the RCN Principles of Nursing Practice being aligned in the CQC assessment.

19. We would also welcome particularly any comments CQC might make for professional bodies to develop learning and development resources which support staff to demonstrate competency of equality and human rights in support of the essential standards.
20. The summary charts at the end of each specific guidance document are helpful and could be developed further to provide concrete examples of human rights issues in healthcare settings – there might be some merit in publishing this as an ‘aide-memoire’ for service providers and could be used as the basis for training, education and workforce development. However, there are areas which are not as comprehensively mapped across as publications in existence – see for example DH (2007) Human Rights in Healthcare – A Framework for Local Action available from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088970

21. Each of the consultation documents helps to locate the patient/client-centred focus of the inspections and are useful sources generally for considering the broader aspects of equality/diversity and human rights in healthcare.

22. The case studies are helpful in illustrating application, and it would be useful to develop these further to reflect wider areas of healthcare and healthcare dilemmas.

23. We note that there needs to be some caution about using existing data to answer some of the questions about EDHR; that it needs to be done appropriately, ensuring that the data is relevant to the issues under enquiry.

24. We also note that Outcome 5: Meeting nutritional needs should map to equality characteristics and articles in the ECHR. This outcome needs to be strengthened in the mapping of outcomes – the EHRC (2009) Human Rights Inquiry was clear that not being able to eat properly in hospital or a care home is a contravention of Article 2 and 8; and that not having culturally relevant food is contravention of Article 9.

25. Also aware that the Commission is likely to be added to Schedule 19 of the Equality Act 2010 which will place additional responsibilities on the Commission around promoting equality of opportunity, eliminating unlawful discrimination and fostering good relations. As the provisions of the specific public sector equality duties are currently out for consultation we expect that the contents of this proposed guidance will change once the consultation has been completed and the contents of the duty finalised. The RCN welcomes the opportunity to work closely with the Commission in future in reshaping and moulding this guidance as appropriate.

26. We note that the separate pieces of guidance all essentially set out a mapping between the CQC’s essential standards and equality and human rights which make it clear that the two are aligned but the guidance in terms of specific evidence that inspectors and assessors can use is largely absent. The questions are likely to be helpful but there may be a need to provide more guidance on the nature of evidence that can be used to inform making judgments.

27. People with dementia are significant users of health and social care services. Two-thirds of residents in care homes will have dementia and up to one quarter of hospital beds will be occupied by people with dementia over 65 years of age. CQC inspectors and assessors must be aware of particular human rights and equality issues for people with dementia.

28. There is widespread failure to deliver quality care to people with dementia. Poor quality care is a breach of the rights of people with dementia in itself.
29. There are pervasive ingrained and incorrect assumptions about age, such as that meaningful quality of life is not possible in later life. As the prevalence of dementia steadily increases with age, people with dementia are particularly at risk of age discrimination. People with dementia are also at risk of discrimination from negative attitudes towards the condition, leading to dual discrimination and contributing to low quality of life.

30. People with dementia are also at risk when they are not enabled to challenge the discriminatory attitudes that play a part in decisions about their care and support.

31. The over-prescription of anti-psychotic drugs to treat the behavioural symptoms of dementia is a serious breach of rights and of particular concern. The guidance should include specific reference to the need to reduce anti-psychotic use in light of the urgency that the government are placing on this issue. They have committed to reducing use by two-thirds by November 2011.

32. Inspection is a vital part of understanding the care provided to people with dementia, particularly in a care home setting. It must be an integral and frequent part of any review system.

33. There must be specific work to raise awareness of the new guidance when it is published, and training for assessors and inspectors in how to implement it.

34. Note Dementia Action Alliance launched 26 October 2010. The Alliance is a coalition of 45 organisations, including CQC, who are committed to improving quality of life for people with dementia and their carers in England by 2014. On launch the Alliance published a National Dementia Declaration explaining the outcomes we seek to deliver for people with dementia and their carers. In addition each signatory organisation has published an action plan setting out what their role is in delivering better quality of life for people with dementia and their carers and the actions they intend to take in order to help deliver those outcomes. In signing up to the Declaration, CQC identified three key areas for improvement:
   - Ensuring that the care of people with dementia becomes more people-centred, including a greater focus on person-centred care plans.
   - Ensuring that people with dementia receive care that meets the essential standards of safety and quality.
   - Improving the commissioning of services for people with dementia.

35. CQC must be mindful of these priority issues and the commitments it has made as part of the Dementia Declaration. The key areas identified for improvement should be emphasised in the new guidance for inspectors and assessors. As stated in the National Dementia Strategy - England, the role of CQC inspectors is central to improving dementia care. The new joint guidance from EHRC and CQC is a key way to drive forward government priorities, particularly in reducing the use of antipsychotics for people with dementia and improving the quality of care. The role of inspectors and assessors is of particular importance for people with dementia not only because of the number of people with dementia, but also because a number of recent reports have uncovered unacceptable variation in the quality of care provided to people with dementia.
36. Care and support for people with dementia is of highly variable quality. There are a number of reasons for this. They include low priority attached to dementia, mistaken assumptions that meaningful quality of life is not possible and a lack of appropriate workforce training. Poor quality of care and support is in itself a breach of the rights of people with dementia. These include rights to dignity, rights to privacy, the right to a family life and the right to be free from harm. The joint guidance produced by CQC and EHRC will be key to tackling this.

37. Inspection is a vital part of understanding the care provided to people with dementia, particularly in a care home setting where two-thirds of residents will have dementia. The NDSE places an emphasis on understanding the real-life experience of people with dementia, particularly through the use of Short Observation Framework for Inspection (SOFI) tool, and on care home inspections which must include an assessment of the quality of care that people with dementia experience. A regulatory system that is effectively able to review care homes must recognise the specific needs of people with dementia and care homes must have a crucial role in driving up dementia care standards through the assessment and inspection of health and social care services and of how it is working for people with dementia and their carers.

38. Previously have expressed concerns about regulation, specifically the frequency of inspections. Inspection is a vital part of understanding the care provided to people with dementia, particularly in a care home setting, and provides an opportunity to see life for service users in a care setting. It must be an integral and frequent part of any review system.

39. We found Appendix 2 of the overview guidance, which contains human rights case studies, particularly helpful. We would like to see further case studies integrated within the guidance to illustrate the practical application of the guidance and clarify examples of when and how it might be used. It needs to be emphasised that human rights and equality approaches need to be applied at a micro level, as well as on the larger issues – as emphasised in the overview guidance, getting the ‘small stuff’ wrong often leads to more substantial problems in the future. The ‘small stuff’ may not seem a high priority to care providers, but it is very important for the individual and contributes to their quality of life. For example, being able to choose the food you want, or a woman of a particular faith wanting to be washed by a woman.

40. Cultural and spiritual needs are often not understood, and examples would be particularly helpful in providing explanation and increasing understanding in this area. The Appendices of examples in practice that exist for the guidance on Personalised care, treatment and support, Involvement and information and Suitability of Staffing should be added to each of the remaining guidance areas. As two-thirds of care home residents have dementia, a similar proportion of the case studies should be dementia-focused. This will be very useful in illustrating how the guidance is relevant and can be applied to care situations.

41. Although the consultation document is lengthy and detailed, it does not have major implications for the Adult and Community Services (ACS) in-house CQC Registered Services. The guidance is welcomed. After reviewing the document, ACS CQC Registered Services believe that there will be no major impact when CQC use this framework to assess equality and human rights during inspections of our services. The in-house services are already expected to adhere to specific...
values and standards related to equality and human rights, including those specified in the guidance and by the ACS Preferred Provider Scheme. Therefore we are of the view that the in-house services will routinely meet the required outcomes. It will however be useful to have the CQC equality and human rights guidance for reference and to use alongside existing inspection frameworks. Both areas are covered within the Core Contract Terms and Conditions for all Preferred Providers in Lancashire. In addition to this, the Domiciliary Care Preferred Provider Monitoring Framework specifically looks at equal opportunities policies for each provider and ensures that staff adhere to the policy through initial induction and refresher training.

42. The mapping of quality standards to Human Rights principles in Section 2: Involvement & Information are particularly useful prompts for inspectors.

43. Providing prompts will eliminate an individual inspector’s perception when interpreting particularly difficult legislation.

44. Ideally under the Map to Human rights column we suggest the CQC/EHRC specify which Section/Article of the Human Rights Act they are referring to, for example Article 8 as this section of the document as it stands is too vague.

45. Once the guidance for inspectors has been approved we would suggest producing a bite-size synopsis for provider services around equality and human rights and what to expect during inspections.

46. We further suggest when the essential standards are reviewed or revised that the equality and human rights issues are strengthened within the outcomes and prompts.

47. Re Personalised care, Treatment and Support section - prompt points 4A, 4D, 4G, 4K, 4L, 4Q, 5A and 5C are too insular as all points should read ‘all equality characteristics’. Additionally if a particular characteristic is specifically matched to a section or article of the Human Rights Act this should be highlighted as such.

48. Page 9. This prompt point should read ‘all equality characteristics’ and not be left blank as in the pro forma. Pages 17-18, should read all ‘equality characteristics’.

49. Safeguarding & Safety section - the Guidance to Criteria Section is too narrow under the mapping to equality points. Each section should be mapped to all the protected characteristics. For example 3.1 does not just map to Disability & Race as CQC suggest but to all individuals in the protected characteristics groups.

50. CQC are in danger of applying some guidance criteria to homogenous groups rather than thinking through the individual and personalised needs of each person covered by the Equality Act. This is a constant weakness in their consultation documents. Otherwise this section is quite strong and generally well thought out.

51. There is no official body or single official interested in what becomes of vulnerable people who are considered economically useless and therefore suitable for extermination by neglect.

52. The people making a living out of being inspectors have no incentive to bother what happens to the victims, provided there are correctly filled forms.
53. The people making a living out of being human rights lawyers have no incentive to bother with anyone who does not carry a promised fee from legal aid, so racism is worth taking an interest in, so is anything to do with employment tribunals, but no lawyer will take an interest in institutionalised, everyday, routine disablism and ageism (including age apartheid).

54. The purported inspectors’ reports routinely rubber stamp self-assessed box-ticked performance reports. They routinely approve and give good grades to old people’s homes and hospitals where abuse, torture, neglect, starvation, rape, cruelty and every other abuse of human rights is taken for granted and routinely practised. Read any newspaper. Read *Private Eye*. Read Mrs Chubb’s research.

55. This ‘consultation’ is just offensive, being yet another tick-box farce. There is no mistaking the message that if you are old or disabled, that is, in a demographic unlikely to be slaving away to pay taxes contributing to the perks, pay and golden pensions of civil servants or politicians, then your government wants you to be dead, as fast as possible.

56. Re suggestions for inspectors and assessors when gathering evidence: Point 2 why dress down - surely there is another way to address this point - the inspector needs to be well dressed to ensure the importance of his/her role is clearly understood - a smile on the face goes a long way to reassuring people that you are friendly; similarly correct positioning when meeting/greeting/talking to people is also a valid way to deal with this point.

57. The guidance was wordy and time consuming - just added to the burden.

58. Much of the guidance is basic and reads like training which would be useful for compliance induction training.

59. Bullet points (prompts) and table combination works well for background and understanding and checklists.

60. A comment was made about the drawbacks of only including examples relating to ‘the usual suspects’ and making the point that these should only be seen as a way to encourage further thoughts about the need to consider other marginalised people. This needs to be pointed out to inspectors who may have other relevant experience to draw upon.

61. A respondent suggested that the quality assurance asks inspectors the question: ‘Have you considered equality diversity and human rights issues in the judgment for each outcome?’

62. ‘I don’t believe that we need any more additional prompts - perhaps some additional wording in the current standards or nuances might be useful - the observations on a busy ward are very time consuming even if only looking at one/two prompts. I would not want to have a completely separate guidance document. It would be seriously concerning if the people undertaking reviews didn’t already consider areas raised in prompts and already have the basic knowledge of equality legislation. If I was being hard, the terms granny, eggs and suck come to mind. Unless somebody was bordering on incompetent this guidance was not much use as a working tool.’
3. Response to feedback from EHRC and CQC

What we have agreed to change

General points

1. We have reduced repetition within the guidance where possible. For example, reducing overview guidance from 34 questions and answers to 20, and focusing the text on key points.

2. We have removed or reworded any sentence which, on re-reading, could seem to be ‘telling’ inspectors information that is very basic.

3. We have emphasised the need for inspectors to use the guidance flexibly – as some inspectors felt that they knew much of the content, whereas others valued the comprehensive nature of the guidance.

4. We are restructuring the guidance to make it easier for inspectors to work with the equality and human rights prompts – which was the section of the guidance that they found most useful. This means that we are putting the detailed tables that match essential standards prompts to equality and human rights as an appendix.

5. Inspectors will be reminded that the examples included in the guidance are not an exhaustive list and are only a prompt to encourage further thoughts about the need to consider other marginalised people. Many inspectors will have relevant experience to draw upon.

6. We have added more case studies – especially case studies focused around regulation of health services.

7. We cannot add information about equality issues relating to specific medical conditions – because this is an overview document and we are taking a social model of disability approach. However, we have checked that there are the relevant specific prompts relating to cognitive and communication impairments and added some context information about human rights for people with dementia.

8. All CQC staff are about to receive interactive training about equality and human rights. Inspectors and assessors have also all received a briefing about equality and human rights in regulation as part of wider introductory training on the new CQC regulatory model. Additional more in-depth training for inspectors and assessors, based on implementing this guidance, is being planned. From the feedback, it is clear that we will need to make this flexible to meet a range of knowledge and experience of inspectors around EDHR issues.

9. Responses to the question about how equality and human rights should be integrated into the quality assurance process have been passed to the Quality Assurance pilot.

10. Sections involving prompts have been rewritten to incorporate the CQC standard prompts template.
11. Relevant information will be placed in one well-signposted and easily accessible location on the intranet.

12. We have reviewed all suggestions for adding to the mapping tables and amended where necessary.

Overview guidance

13. We have removed the discrimination facts – we cannot have enough in to give good coverage of all characteristics and issues and ensure they remain current. Where they highlight particular outcomes, add them to the relevant context sections.

14. We have expanded the suggestions for evidence-gatherers following more consultation with people using services and added to the sections about what inspectors should do if they think that there may be a breach of equality or human rights law.

15. We have redrafted the overview so that it follows the same sequence for sections on equality law in services, public sector duties and human rights law. This makes the flow of the overview guidance clearer.

16. We will emphasise the need to ensure that inspectors find ways of gathering views from people with communication impairments – for example, through the use of observational tools and communications toolkits.

17. We have clarified how equality and human rights law applies to non-statutory sector providers, for each piece of legislation.

18. We have aligned expectations in relation to how many people inspectors talk to on a site visit with CQC guidelines around ‘sampling’.

19. We have clarified how the social model applies across protected equality characteristics.

Involvement and information section

20. We have emphasised the role of CQC in setting a good example around involving people who use services in CQC’s own work.

21. We have added prompts about whether people, especially those with communication or cognitive impairments, are supported to be involved in their care.

22. We have changed a prompt on staff supporting people to be involved in their care to emphasise staff competence rather than staff training.

23. We have added a prompt about people choosing their own representatives in relation to consent and added some contextual information about the importance of this for lesbian, gay and bisexual people.

24. We have reworded the case study to make the information and outcomes clearer.
Personalised care, treatment and support section

25. Prompts about care plans have been expanded to include all the protected characteristics covered in the Health and Social Care Act regulation 17(2).

26. We have added a prompt about people being involved in decisions about planning their needs assessment (for example, who else should come to planning meetings).

27. We have added a prompt about people knowing their rights to challenge any decisions about their care.

28. We have added a prompt about discrimination in options offered to people.

29. We have added a prompt about reasonable adjustments for disabled people using services.

30. We have added more prompts about food meeting people’s religious or cultural needs – including people’s ethical beliefs, such as vegetarians. These prompts include menu choice, suitability of food preparation methods, staff awareness of people’s requirements and appropriate information about ingredients on menus.

Safeguarding and safety section

31. We have added additional references about use of restraint as a last resort.

32. We have clarified that restraint prompts cover chemical restraint, for example over-prescription of antipsychotics. We have also added a prompt about services ensuring that people have regular medication reviews.

33. We have added a prompt about staff awareness of the ingredients of medicines and whether they are compatible with people’s ethical or religious beliefs (for example in relation to gelatine capsules).

34. We have added a prompt about the distance people have to walk to use toilet facilities.

35. We have added a prompt about whether there is sufficient equipment (for example hoists) to ensure that people’s dignity is upheld.

Suitability of staffing section

36. We will consider doing development work with other organisations, such as professional regulators, around what is viewed as ‘competence’ for staff in relation to EDHR. In the meantime, we have added clarification for inspectors about assessing the outcomes of staff competence, for example through observations of staff interactions with people who use services.

37. We have added a prompt about staff competence in relation to communication, especially with people who have communication or cognitive impairments and blind and partially sighted and deaf and hard of hearing people.
38. We have expanded the prompts on staff bullying, to cover harassment on the grounds of all protected characteristics.

39. We added a prompt about whether staff feel comfortable to report a concern.

40. We have clarified the point about expectations of staff from protected groups, in relation to their ability to change services – to make it clear that this is an issue for LGB and disabled staff as well as black and ethnic minority staff.

Quality of management and suitability of management section

41. We have added a prompt about evidence that feedback from people who use services influences changes to the service.

42. We have added a prompt about whether people using the service know how to access information about the complaints process and whether the complaints process information is available in relevant languages (other formats were already covered).

43. We have added a prompt about whether people are supported to make a complaint.

44. Complaints may not be able to be anonymous as they should result in a change for the individual. However, we have included a prompt about whether the service has a way that people can give anonymous comments.

45. We have added the prompt: does the complaints procedure include information about formal processes that people can use (for example ombudsman) if their complaint is not resolved internally?
## What we have not agreed to change

<table>
<thead>
<tr>
<th>Consultation comments</th>
<th>Reason for not agreeing to change</th>
</tr>
</thead>
<tbody>
<tr>
<td>The guidance includes a legal disclaimer which states that &quot;It [the guidance] does not constitute formal policy or advice by either the Care Quality Commission or the Equality and Human Rights Commission nor is it indicative of any action that either of these bodies may consider in response to the issues raised in the guidance&quot; (and this is repeated across the suite of guidance). Such a statement effectively undermines the value in guidance and begs the question about who does take responsibility if these agencies do not, and why these agencies will not, given their statutory responsibilities.</td>
<td>This is under review.</td>
</tr>
<tr>
<td>The guidance could suggest inspectors and assessors check for evidence from other sources to a visit; for example reviewing complaints to see if they include concerns in relation to treatment which would constitute failure of the provider to meet the standards required.</td>
<td>Do not accept: guidance does not assume that all evidence will be gathered from visits. The evidence for prompts could come from a range of sources in line with CQC compliance methodology. Inspectors will know this.</td>
</tr>
<tr>
<td>3.1 ‘Disabled people’ should read ‘people who have a disability’. Same applies to 3.4, 3.7 and 3.11.</td>
<td>Do not accept: ‘disabled people’ is preferred terminology of CQC and in line with the social model of disability.</td>
</tr>
<tr>
<td>We think reference could usefully be made to contact with foundation trust service user and carer governors for views and experience.</td>
<td>Do not accept: we would need to list all sources of evidence – we do not do this in the guidance.</td>
</tr>
<tr>
<td>Re 5A (People who use services) have food and drink that meet the requirements of their diverse needs. We think ‘needs’ should be clarified. Should it not be that diverse needs are catered for (where it relates to religious or health requirements) and that diverse preference will be taken account of and catered for where possible? It would be unreasonable to meet everyone’s diverse preferences given the diversity of service users being catered for in some areas of the country.</td>
<td>Do not accept: this is wording already agreed in the essential standards.</td>
</tr>
<tr>
<td>Re 2.7 access to outdoor space – is not always achievable in central London locations where we cannot always guarantee access to outdoor secure and safe environments, much as we would like to. This needs to be taken account of.</td>
<td>Do not accept: this is wording already agreed in the essential standards. It only applies to specific service types.</td>
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<tr>
<td>Need to consider here the impact of providing personalised services... giving more power to service users to select their own staff also imparts directly on them the need to be non-discriminatory... how and who is this facilitated by?</td>
<td>Do not accept: outside scope of the guidance as people directly employing workers are not regulated by CQC.</td>
</tr>
<tr>
<td>The right for mental health patients to have the same choices as general patients, for example as a victim of severe prolonged childhood sexual abuse, I am then faced with a total stranger who cannot speak English and is male... it feels like rape all over again.</td>
<td>Choice of staff in all settings is beyond the scope of the essential standards.</td>
</tr>
<tr>
<td>In relation to considering the joined-up duty to carers in service provision beyond looking at the Equality Act 2010 for example, Carers (Equal Opportunities Act) 2004 and the Department of Health’s work on the National Carers Strategy.</td>
<td>Not in scope: the essential standards focus on the person using the service, not their carer (see page 33 essential standards). However, CQC are preparing separate guidance specifically about how regulation can have a positive impact on carers’ rights and carers’ issues.</td>
</tr>
<tr>
<td>Patients on Board – the overlap between staff, service users and patients – is not properly acknowledged when reviewing involvement. This has been key in mental health trusts, which have actively sought to involve patients by encouraging them to become staff and decision-makers.</td>
<td>This would be one source of evidence – but we do not list all the evidence sources in the guidance.</td>
</tr>
<tr>
<td>The over-prescription of antipsychotic drugs to treat people with dementia is a serious breach of rights. The Department of Health has recently committed to reducing the use of antipsychotics by two-thirds by November 2011. Given the urgency of this priority, the guidance for inspectors and assessors should include a specific prompt around the use of antipsychotics. This should be included as an additional prompt under either Outcome 4 in the guidance on the</td>
<td>CQC do not regulate prescription decisions as this is a function of individual prescribers and therefore subject to professional regulation rather than the regulation of providers. However, we have added prompts about the restraint policies and procedures including chemical restraint (sedation) and about services ensuring that medication is regularly reviewed.</td>
</tr>
<tr>
<td>‘Personalised Care, Treatment and Support’ section of the CQC essential standards and/or under Outcome 9 in the guidance on the ‘Safeguarding and Safety’ section of the CQC essential standards.</td>
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<tr>
<td>Concerning the quality of food/drinks and the quality of serving food/water/drinks to those for whom this is a problem.</td>
<td>Quality of food/drink and its presentation are already in the essential standards prompts.</td>
</tr>
<tr>
<td>Do you need to put anything in about timelines for dealing with complaints?</td>
<td>The essential standards do not set a time frame for complaints – because they are outcome focused rather than process focused. However, other prompts may pick up issues with time for complaints handling – for example whether complainants are satisfied with the response to their complaint.</td>
</tr>
<tr>
<td>Don’t forget to allow enough time for you to listen.</td>
<td>We assume that inspectors know this, from their existing skills.</td>
</tr>
<tr>
<td>There is no mention of the involvement of carers. Providing evidence that carers/family have been involved in the formulation of care plans, particularly when the service user may not be able to give his/her views.</td>
<td>The essential standards focus on the person using the service, not their carer. See above. The involvement of carers is only in scope when they are acting on behalf of someone using the service. Additional prompt added in relation to where the person may not be able to give their views – see below.</td>
</tr>
<tr>
<td>Are patients/residents made aware of their rights to having advance directives about their future care?</td>
<td>Advanced directives are not specifically mentioned in the essential standards. This is not in scope.</td>
</tr>
<tr>
<td>Do advocacy services impedes or restricts someone’s advance directive?</td>
<td></td>
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<tr>
<td>If an advance directive is in place, what is the evidence that any safeguard actions has considered this?</td>
<td></td>
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<tr>
<td>Evidence that patients were given adequate notice of care plan reviews.</td>
<td>This prompt is about process rather than outcome and is too detailed.</td>
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<tr>
<td>Re advocacy, is there evidence that choices</td>
<td>It may be difficult for inspectors to get evidence that choice of</td>
</tr>
<tr>
<td>Question</td>
<td>Response</td>
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<td>------------------------------------------------------------------------</td>
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<tr>
<td>Were offered?</td>
<td>Advocacy has been offered as staff would not necessarily be required to record this.</td>
</tr>
<tr>
<td>Re p.6, point 10, it may be difficult for inspectors and assessors to</td>
<td>Covered by suggestions for evidence-gatherers.</td>
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<tr>
<td>identify LGBT people directly, for example in observational work - this</td>
<td></td>
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<tr>
<td>is the reason for a specific question relating to this equality</td>
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<td>characteristic. People also have hidden disabilities and it may also</td>
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<td>be appropriate to ensure you are aware of any difficulty people</td>
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<td>naturally cover up, for example people with hearing difficulties may</td>
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<td>not fully understand what you tell them but will make best efforts to</td>
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<tr>
<td>answer.</td>
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<tr>
<td>Re Outcome 4, should not evidence exist that the care plan has had an</td>
<td>Equality impact assessments are only required for policies and processes in the public sector and will not therefore be carried out for</td>
</tr>
<tr>
<td>EqIA?</td>
<td>individual care plans. It is not the role of CQC inspectors to check that EqIAs are carried out as these are carried out under equality legislation, not the Health and Social Care Act.</td>
</tr>
<tr>
<td>Does the prompt cover that staff are appropriately trained in suitable</td>
<td>Training may be one form of evidence of competence – however the current prompt is more outcome-focused than training alone.</td>
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<td>restraint techniques?</td>
<td></td>
</tr>
<tr>
<td>Staff can be too busy to speak with inspectors, offer an alternative</td>
<td>Outside scope of this guidance.</td>
</tr>
<tr>
<td>time/way of communicating.</td>
<td></td>
</tr>
<tr>
<td>I would like to see the words family/carer used a little more often.</td>
<td>See comments above about scope of essential standards in relation to carers.</td>
</tr>
<tr>
<td>The wording suggests that evidence will be available in advance of an</td>
<td>Inspectors gather evidence from a range of sources. There is no expectation in this guidance that evidence will be gathered using any</td>
</tr>
<tr>
<td>inspection. In addition, it should be a priority for inspectors to</td>
<td>particular method. Existing site visit guidance for inspectors gives a rough guide of 30% of time spent talking to people using the service,</td>
</tr>
<tr>
<td>obtain this evidence from patients and carers when they visit the site.</td>
<td>50% of time observing care in practice and 20% of time talking to</td>
</tr>
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Summary of responses to the consultation on draft equality and human rights guidance
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<th>Outcome 7 Re 3c and d how will you know that the procedures are being used correctly and that records are accurate if the persons being restrained cannot speak for themselves and have no carers to speak for them? Re 6a how will you know that every complaint has been recorded?</th>
<th>These are evidence points rather than prompt points.</th>
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<tr>
<td>Outcome 17 re 4 how will you know that all complaints received have been recorded? If not all complaints are recorded the percentage resolved could be inaccurate.</td>
<td>This is an evidence-gathering issue rather than an issue for the guidance.</td>
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<td>Re point 8 - discover whether service users/patients have experienced shared decision making with regard to any aspect of their treatment/accommodation options.</td>
<td>Out of scope of the essential standards.</td>
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<td>Re point 9 - discover whether service users/patients of higher than average intellectual ability feel particularly patronised, not respected, or that they are not listened to, or are ignored.</td>
<td>This is an issue for all people using the service, regardless of intellectual ability. These points are picked up through observational tools rather than this guidance.</td>
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<td>Point 6 instead phrase ‘are plans for care, support and treatment (for example, care plans, discharge plans and patient-held records) available in accessible formats...’</td>
<td>No change required.</td>
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<td>Discussions with the National Health Litigation Authority to improve framework for monitoring risk and human rights – with improved tracking outcomes.</td>
<td>Noted</td>
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<td>The guidance for ‘personalised care, treatment and support’ section (and other relevant documents) makes reference to the Mental Health Act 1983 Code of Practice. There is no mention of DoLS or MCA and associated legislation (as these two were not around at the time of this Act!) – MHA, MCA and DoLS should all be referred to separately.</td>
<td>Checked – existing wording is legally correct.</td>
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<td>The Mental Health Act 1983 Code of Practice should be written ‘Mental Health Act 1983 Code of Practice/2007 update’ as there is updated legislation for this Act.</td>
<td>See above.</td>
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<td>Regulation 11 (Protecting Service Users from</td>
<td>This regulation falls under</td>
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<td><strong>abuse</strong> needs to be added to the list of Regulated Activities under Section 1.4. Page 3 of guidance for assessors and inspectors on ‘personalised care, treatment and support’ section of the CQC essential standards.</td>
<td>‘Safeguarding and Safety’ not ‘Personalised Care’.</td>
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<td>We note that the separate pieces of guidance all essentially set out a mapping between the CQC’s essential standards and equality and human rights which make it clear that the two are aligned but the guidance in terms of specific evidence that inspectors and assessors can use is largely absent. The questions are likely to be helpful but there may be a need to provide more guidance on the nature of evidence that can be used to inform making judgments.</td>
<td>We agree that additional work is required to assist inspectors in evidence-gathering. This is underway in various projects. The role of this guidance is to ‘baseline’ the equality and human rights dimensions of the essential standards, not to give all potential evidence sources.</td>
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<td>The over-prescription of antipsychotic drugs to treat the behavioural symptoms of dementia is a serious breach of rights and of particular concern. The guidance should include specific reference to the need to reduce antipsychotic use in light of the urgency that the government is placing on this issue. They have committed to reducing use by two-thirds by November 2011.</td>
<td>CQC do not regulate prescription decisions as this is a function of individual prescribers and therefore subject to professional regulation rather than the regulation of providers. However, we have added prompts about the restraint policies and procedures including chemical restraint (sedation) and about services ensuring that medication is regularly reviewed.</td>
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<td>We found Appendix 2 of the overview guidance, which contains human rights case studies, particularly helpful. We would like to see further case studies integrated within the guidance to illustrate the practical application of the guidance and clarify examples of when and how it might be used. It needs to be emphasised that human rights and equality approaches need to be applied at a micro level, as well as on the larger issues – as emphasised in the overview guidance, getting the ‘small stuff’ wrong often leads to more substantial problems in the future. The ‘small stuff’ may not seem a high priority to care providers, but it is very important for the individual and contributes to their quality of life. For example, being able to choose the food you want, or a woman of a particular faith wanting to be washed by a woman.</td>
<td>We have added some more case studies. There is another project being developed to add further equality and human rights case studies, based on the experience of CQC inspectors in using the essential standards. This will build up case studies available over time.</td>
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Cultural and spiritual needs are often not understood, and examples would be particularly helpful in providing explanation and increasing understanding in this area. The Appendices of ‘examples in practice’ that exist for the guidance on Personalised Care, Treatment and Support, Involvement and Information and Suitability of Staffing should be added to each of the remaining guidance areas. As two-thirds of care home residents have dementia, a similar proportion of the case studies should be dementia-focused. This will be very useful in illustrating how the guidance is relevant and can be applied to care situations.

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<th>CQC are in danger of applying some guidance criteria to homogenous groups rather than thinking through the individual and personalised needs of each person covered by the Equality Act. This is a constant weakness in their consultation documents. Otherwise this section is quite strong and generally well thought out.</th>
<th>There is a case study on spiritual needs and a case study on discovering the cultural needs of someone with dementia. Case studies available to inspectors will build up over time (see above). However, we do not think using a percentage base for agreeing case studies, based on impairment or any other protected characteristic, is the way forward – as there can often be learning across issues.</th>
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<td>We do not agree that the guidance encourages looking at people as ‘homogenous groups’ rather than as individuals. The guidance stresses the need to respond to individual needs while, at the same time, removing barriers that may disadvantage a number of people from a protected group: such as improving physical access for disabled people or ensuring lesbian, gay and bisexual people know that the organisation supports equality on the grounds of sexual orientation.</td>
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