Consultation Impact Assessments – Appendix 3

- A new start – Consultation on changes to the way CQC regulates, inspects and monitors care services

- Equality and Human Rights Duties Impact Analysis (decision making and policies)

A new start

Consultation on changes to the way CQC regulates, inspects and monitors care services

Initial regulatory impact assessment

This Initial Regulatory Impact Assessment has been published to support the proposals contained within the consultation document on CQC's new approach to inspection and regulation. Stakeholders should read this document in full before reading this impact assessment.

This document sets out the initial high level cost and benefit impacts on providers, people and CQC as a basis for starting further engagement with stakeholders throughout this consultation process.

Introduction

The Care Quality Commission (CQC) is committed to making sure it carries out its statutory duty in a way that puts people who use services at the centre of their work. Part of this process includes learning from past actions and changing their current approach to the monitoring, inspection and regulation of providers in order to remain fit for purpose.

The Mid Staffordshire NHS Foundation Trust Public Inquiry identified that people and their families were let down at every level by the individuals and organisations that were meant to protect and care for them. The inquiry uncovered examples of appalling care and a lack of compassion, humanity and leadership. Robert Francis' report on the public inquiry made recommendations for the commissioning, supervisory and regulatory bodies, including CQC.

CQC is committed to rolling out a number of key changes to the way it regulates and inspects providers, including addressing key recommendations made in the Francis Report. CQC's initial thinking around how it could implement some of the changes can be found in the main consultation document, which also includes high level proposals for comment from stakeholders.

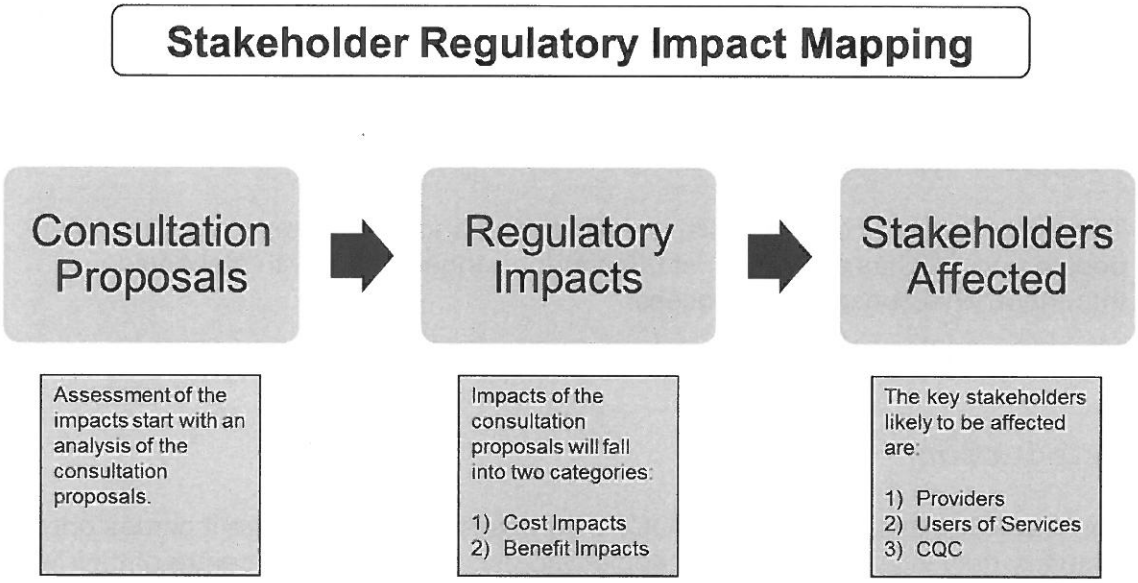
This impact assessment has been designed to accompany the consultation paper and acts as a systematic initial assessment of the impact of the proposals outlined in the consultation paper. Before you read this paper you should read the full

consultation paper, which can be downloaded from:
www.cqc.org.uk/inspectionchanges

Purpose of this Initial Regulatory Impact Assessment

The purpose of this initial impact assessment is to help identify the practical impact of the draft consultation proposals on stakeholders. It aims to engage stakeholders in determining the impact on them, with a plan for this analysis to influence the design of the final proposals. Figure 1 below illustrates the high level process by which we plan to assess these impacts and who these impacts are likely to fall on:

Figure 1: Stakeholder Regulatory Impact Mapping of Consultation Proposals



At every stage of the analysis there are likely to be changes to the impact of the proposals of CQC's new inspection and regulatory regime. A key purpose of this initial impact assessment is to help identify where the potential impacts of CQC's proposals are likely to fall, as well as their anticipated scale and magnitude on stakeholders.

It should be made clear that the illustration of the cost and benefit impacts within this initial impact assessment are 'high level' estimates. CQC plans to roll-out a larger programme of engagement with stakeholders to fully assess these costs and benefits. CQC will provide more details of this in the coming months.

The ultimate aim of this engagement is to influence the design and implementation of the final regulatory model. It also satisfies an aim of the government's Better Regulation Executive (BRE) to trial a new method aimed at improving engagement with the sector so that those affected provide CQC with their own assessments of the likely costs and benefits.

Proposals and Impacts for the new CQC regulatory model

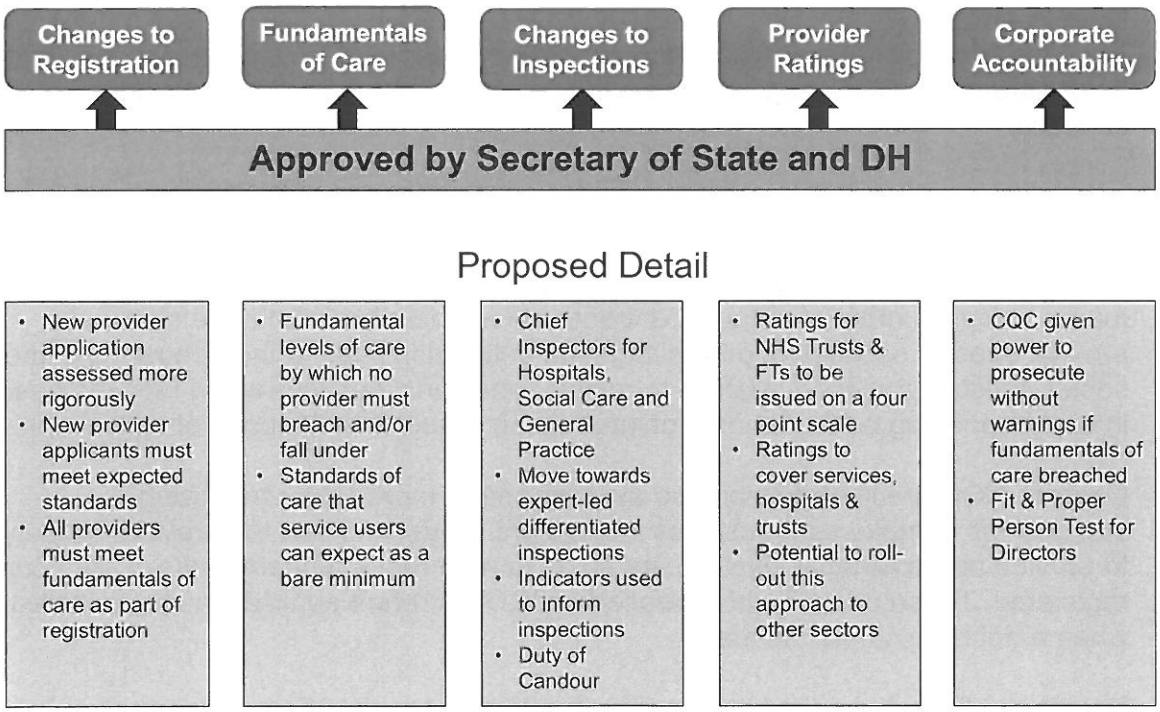
In this section CQC provides a brief summary of the proposals for its new approach to monitoring, inspection and regulation, and a brief description of who these proposals apply to, as well as how stakeholders may be affected by these. Stakeholders should refer to the main consultation document if they require a fuller description and rationale for these proposals.

Stakeholders should note that because CQC has firmly committed to implementing these key changes, this impact assessment focuses on the implementation of these changes so that it maximises the positive outcomes for people, while also minimising any regulatory burden on providers from the way CQC administers these changes. It is the proposed content of these key changes that CQC asks stakeholders to comment on, so that they can shape the formation and roll-out of these key changes in a way that achieves these ends.

Unless otherwise stated, the following proposals will generally affect all providers who fall under CQC's regulatory remit. However there will also be some distinct differences to the way CQC will apply these changes by sector to take into account of differences.

Figure 2 below summarises initial high level proposals around five core policy areas to which CQC is firmly committed:

Figure 2: Summary of agreed changes and proposals for content



Key change: Introducing changes to registration

CQC will introduce a number of registration changes which aim to make sure the registration process is more rigorous.

Rationale
This was agreed by the Department of Health (DH) in *DH Winterbourne Review Condordat: Programme of Action.* It helps to make sure that providers who are unlikely to provide an acceptable level of care are not allowed to hold a CQC registration.

Proposals
CQC proposes that the registration process will be more rigorous for all new providers wishing to be registered, as well as existing providers wishing to register additional services. This will include making better use of information as part of the registration process and drawing in specialist clinical or professional advice where needed to help assess if the service meets accepted good practice.

We propose to assess new providers against a set of expected standards of care as well as ensure that all providers (both current and new) continue to comply with the fundamentals of care and the broader registration requirements.

The Department of Health will develop the new registration requirements and will hold a separate consultation relating to these in the coming months.

Who is affected?
The introduction of these registration changes will affect all new providers wishing to be registered by CQC, as well as existing providers wishing to register additional services.

How are they affected?
Under these proposals we would expect there to be additional costs for new providers applying to be CQC registered. In some cases this more rigorous test may mean a small number of potential entrants will not be allowed into the sector to provide specific services or others might be delayed in making their entrance to the sector. Existing providers wishing to register additional services could face increases in cost depending on the amount of information required at the point of application.

Costs to CQC are likely to increase as it will spend more time scrutinising applications to make sure business models are robust and that the provider is likely to provide an acceptable level of care so as to not breach fundamentals of care once registered. These costs could increase for CQC if it refers applications to specialists when a decision cannot be made.

People are likely to be the key beneficiaries of these registration changes as only new providers who meet the new requirements will be able to provide services – this could correspond to better services and increases in quality of care from such new entrants. People will also be able to gain more clarification on what would be

expected from providers based on core fundamentals of care and expected standards imposed on such providers.

Key change: Introducing fundamentals of care

CQC will introduce fundamentals of care which make explicit the level of care which no provider must breach. These will be universal to all providers registered with CQC who provide health and adult social care services. Fundamentals of care are part of the registration requirements. They are the foundation of good care but not the extent of good care.

Rationale
This was agreed by the Secretary of State and the Department of Health in its response to the Francis Report. Introducing fundamentals of care should facilitate providers understanding of what is and is not expected of them in relation to their provision of care services.

Current proposals
Fundamentals of care set out the basic standards of care that should never be breached; any breach should be seen as unacceptable. CQC will make sure they are driven by the interests of people who use services. Should a provider be found to be breaching any of these fundamentals of care, CQC will have formal powers to take action, including prosecution in the worse cases of poor care delivery. The Department of Health will be consulting on these standards in the coming months.

Who is affected?
The introduction of a set of fundamentals of care will apply to all providers that fall under the remit of CQC.

How are they affected?
All providers will need to comply with these fundamentals of care. It is anticipated that these will not impose additional costs on the majority of providers, as those who already deliver an adequate level of care should currently be meeting these standards. However, there could be additional costs to the worst performing providers in the form of enforcement action, which could range from warning notices instructing providers to improve, to fines and in the worst case revoking the provider's registration with CQC.

There are likely to be minimal costs to CQC as a result of the introduction of fundamentals of care. The likely costs would stem from the development of guidance and approaches to monitoring compliance with these fundamentals of care. However, there could be variable cost elements as a result of taking enforcement action depending on how many providers have breached these fundamentals.

Both people and providers are likely to benefit from the introduction of fundamentals of care. For example, people would have a clearer understanding of what to expect from providers in terms of fundamental safety and quality of care. Similarly providers

should benefit from having greater clarity on what is expected of them, as well as having concrete knowledge as to the level that quality of care must not fall.

Key change: CQC's new model of inspection

CQC's inspection model will change to take into account the differences in the sectors that are regulated by them. CQC will move towards a system of differentiated regulation which will include different ways of inspecting different sectors.

Rationale
CQC has listened to external scrutiny and reviews of its work such as the Kieran Walshe evaluation work and recognised the importance of regulating different sectors in different ways.

Proposals
CQC will appoint three Chief Inspectors to oversee the different sectors that fall under their remit. These will be:

- Chief Inspector of Hospitals
- Chief Inspector of Social Care
- Chief Inspector of General Practice .

The Chief Inspectors will be responsible for forming judgments about the quality of providers, devising and operating a new risk-based, intelligence-driven inspection model, managing the delivery of inspections and acting as the CQC's public face and authoritative voice on the status of care quality within and across providers.

CQC also propose to move away from generalist inspections and towards inspections that are expert-led and by inspectors who specialise in particular service areas. This will be supported by the development of a revised intelligence risk model which will help to identify those organisations at greatest risk of delivering poor quality care. We will make use of data and information and develop key indicators which will help to facilitate the conditions under which CQC will inspect organisations of different risk and their subsequent performance under the proposed inspection regime. These proposals will all contribute to CQC's aim of moving to a system of differentiated regulation, achieved in part by making such changes to the way they inspect different sectors that fall under their regulatory remit.

Who is affected?
CQC's new model of inspection will apply to all providers that fall under its regulatory remit. NHS and independent hospitals services will be impacted by the work of the Chief Inspector of Hospitals. Providers of adult social care will come under the scrutiny of the Chief Inspector of Social Care, as will primary medical services be affected by the Chief Inspector of General Practice.

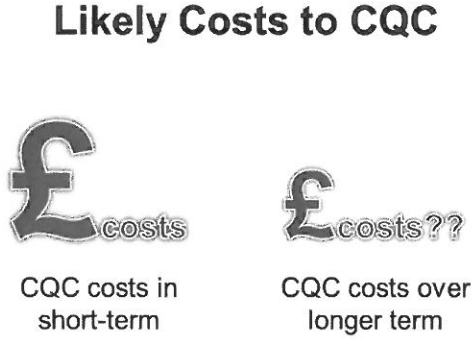
How are they affected?
Costs will heavily depend on how the inspection methodology develops. For example, if the inspection model determines a provider is to have double the number

of inspections in three years than it currently has then costs to providers (and CQC) will also rise. Figure 3 illustrates the costs providers are likely to face depending on judgement by the Chief Inspectors (note that the categories are purely for illustrative purposes are likely to change based on any methodology proposed by the Chief Inspectors):

Figure 3: Differences in costs to providers based on Chief Inspector judgement

CQC will face higher initial costs associated with carrying out these longer more intensive inspections. There could also be costs associated with transitioning towards expert-led inspections in the form of training costs and establishing access to wider expertise. Figure 4 illustrates the costs to CQC which shows that short-term costs are likely to be higher than longer-term costs (this assumes that the level of standards do not change):

Figure 4: Differences in short-term and longer term costs to CQC



People are likely to be the key beneficiaries as these differentiated ways of inspecting different sectors should reduce instances of poor quality care and bad practice as these are more quickly picked up and dealt with.

Key change: Introduction of ratings

CQC will introduce a series of provider ratings which will help inform both patient choice and commissioning decisions.

Rationale
The Care Bill re-introduces legislation from the Health and Social Care Act 2008 which will allow CQC to publish ratings for health and social care providers. This builds on the work carried out by the Nuffield Trust in, *Rating Providers for Quality: a policy worth pursuing? (March 2013)* and sets out advice on a rating system for hospitals, care homes, providers of home care and GP practices.

Proposals
Ratings will be an expression of CQC's regulatory judgments with the purpose of encouraging improvement and supporting people who use services and commissioners to compare services and make choices. To achieve this CQC will publish provider ratings on their website, giving clear and transparent rationale for our judgments.

CQC plans to consult with stakeholders in the coming months on the detailed methodology for creating ratings for all NHS trusts and proposals for CQC's approach to adult social care ratings.

Who is affected?
In time, the introduction of a set of ratings should apply to all providers of health and adult social care. For now, we will begin with rating NHS acute trusts and aim to introduce new style inspections from October 2013. These inspections will allow CQC to begin publishing shadow ratings from December 2013.The programme will extend to all NHS trusts over time and begin rating adult social care later in 2014/15 and primary care in 2015/16. Ratings may also be extended to dental practices and cosmetic businesses in future.

How are they affected?
It is estimated that there would be some additional costs on these providers to comply with an initial inspection in order to establish a preliminary rating on the provider. It is also anticipated that there will be some additional costs on such providers for providing any information to CQC that would aid any decision in producing a rating.

Commissioners and people who use services are likely to be the key beneficiaries of provider ratings as a key objective of this policy would be to support informed choice. For commissioners, ratings would offer the key benefit of better understanding of the quality of service, and the outcomes they are commissioning, when deciding how much of their budget to spend with specific providers. For people who use services, the introduction of a provider rating would better support making informed choices between providers, which should hopefully help to raise the quality bar amongst different providers. There are also some benefits to providers as the introduction of ratings would help facilitate peer-review and benchmarking so they can see how they

are performing in comparison to others and identify areas where they might want to improve.

Key change: Corporate Accountability Proposals

There will be more of a focus to hold providers to account for failing to honour their commitments to provide safe quality care.

Rationale
Subject to the passing of the Care Bill, CQC will be granted a range of new powers from April 2014 which will help facilitate the development of any actions aimed at holding providers to account should they not be providing an acceptable level of care.

Proposals
We plan to specifically hold Board Members to account should the provider not be providing an acceptable level of care. We would also expect all directors to be "fit-and-proper" as well as ensuring that providers are open and honest with people who use the service and their families about things that have gone wrong and why they happened.

The Department of Health will shortly consult on the accountabilities of the Board members in parallel to the consultation published alongside this initial Regulatory Impact Assessment.

Who is affected?
All directors and board members of providers will be affected if they come under CQC's regulatory remit.

How are they affected?
We do not anticipate there to be any additional to costs to providers if they currently provide an acceptable level of care to patients. However, board members and directors who are held responsible for any care quality failings could be impacted financially should they be removed from posts. Such organisations could face greater scrutiny and will likely see their costs increase should CQC decide to take any actions, such as prosecution, associated with the care quality failings.

CQC, users of services as well as their families are likely to be the key beneficiaries of these proposals. For CQC we would likely benefit from a reduction in quality failings stemming from poor direction from board directors. Users of services should benefit as swifter action is taken against senior management for any user subject to poor quality care, and should also act as a deterrent to other providers which could help bring the level of care up to an acceptable standard.

Changes specific to acute hospitals provided by the NHS and independent organisations

In this section we set out the high level cost and benefit impacts of the proposed changes on stakeholders that will only apply to acute hospitals provided by the NHS and independent organisations.

Chief Inspector of Hospitals

The Chief Inspector of Hospitals will undertake a number of duties that are likely to impact on stakeholders. Specifically these are:

- Judging the performance of all hospitals in England, including NHS hospitals and independent sector hospitals.
- Publishing ratings on hospitals.
- Playing a central role in the assurance that the fundamental standards are being met by all trusts. Where trusts are in breach of these standards, the Chief Inspector will determine what action should be taken, including whether a trust is entered into a failure regime.
- Leading a new national NHS inspection team that will undertake in-depth, intensive inspections; the principal focus of these inspections will be on organisations that are of concern to CQC.
- Leading regional teams of dedicated inspectors who will undertake routine inspections on a regular basis of all hospitals/NHS trusts.
- Responsible for overseeing the development of a methodology for inspections, the operational delivery of the inspection programme, and for raising the quality of the inspections that are performed so that they are able to properly identify areas of concern and issues of compliance.
- Working closely with NHS England, Monitor, the NHS Trust Development Authority and the NHS Information Centre for Health and Social Care to determine the sets of data which will be used to contribute to judgements and ratings about hospitals and NHS trusts.

How are acute hospitals likely to be affected by these proposals?

It is not possible to assess what the size and scale of the impacts are likely to be on acute hospitals at this stage, however there are likely to be a number of costs around the following themes including:

- Information provided to the Chief Inspector to facilitate any of the proposals above.

- Any costs should providers be found in breach of any of the fundamentals of care in order to take action to meet these standards and that this effort is maintained in the future.

NHS acute trusts, foundation trusts and independent organisations providing acute services are encouraged to consider their own assessments of the likely impacts of the proposals outlined above. In the coming weeks we will be holding a series of engagements with stakeholders to fully assess the likely impacts of these proposals.

The surveillance model – developing risk indicators for NHS trusts and foundation trusts (FTs)

The surveillance model is being developed with the core purpose of developing a series of risk indicators for NHS trusts and FTs which aims to identify providers most at risk of providing poor quality care or breaching fundamental standards. The proposals likely to have impacts on stakeholders include:

- Developing a model which allows CQC to anticipate and respond more quickly to services where standards are dropping or that are showing signs of failing.
- Developing a series of indicators and intelligence for the model based on three tiers:
  - Tier 1: signalling a decline in quality or immediate concern will prompt a response by CQC.
  - Tier 2: checked if tier 1 indicators signal concern. Used to help understand the issues raised and to focus key lines of enquiry.
  - Tier 3: development set of indicators and analysis which will be used to test and improve sets of indicators that CQC have in tier 1 and 2.
- Trialling the model for NHS acute trusts to identify the indicators for each of the five domains. This will include scoping the key quality and safety issues for the sector and identifying available data to measure these. This approach will subsequently be applied to NHS mental health trusts, community health trusts and ambulance trusts in future.

How are acute hospitals likely to be affected by these proposals?

All acute hospitals will directly be affected by these proposals. The single biggest cost impacts to such providers could be associated with providing and collating information requests which would help inform the development and monitoring of these three tiers of indicators and intelligence contained within the proposed model. There could also be IT and other system and process costs associated with capturing the information which would differ depending on the trust.

There will be benefits to users of services as the surveillance model should be able to detect potential problems associated with the provision of care services, which will allow swifter action to be taken by inspection teams via instruction from the Chief Inspector of Hospitals.

NHS acute trusts, foundation trusts and independent organisations providing acute services are encouraged to consider their own assessments of the likely impacts of the proposals outlined above. In the coming weeks we will be holding a series of engagements with stakeholders to fully assess the likely impacts of these proposals.

The inspection methodology for acute NHS and independent hospitals

The current inspection model will change to take into account the differences within the different sectors that CQC regulates. The proposals likely to have impacts on NHS trusts are:

- A move to target intensive inspections at organisations that are identified as 'higher risk' which would include those with significant or longstanding problems and trusts applying to become foundation trusts.
- A change in the average length of time taken to undertake an inspection – which could be 15 days, with an average of 6-7 days on site – to make a thorough assessment of the quality and safety of care.
- A development of a set of triggers for inspections which would identify which providers would need an intensive inspection, as well as development of any methodology leading to the decision to undertake an announced or unannounced inspection.

How are acute hospitals likely to be affected by these proposals?

We will be carrying out a fuller consultation on proposals for CQC's inspection methodology later in the year. However, it is likely that acute hospitals who fall under CQC's intensive inspection regime will face higher costs relating to increases in staff time spent providing information and supporting the inspection team. Costs could also increase in proportion to the number of inspections taken place, as well as any costs associated with having to take actions based on the recommendations put forward in the inspection report.

NHS acute trusts, foundation trusts and independent organisations providing acute services are encouraged to consider their own assessments of the likely impacts of the proposals outlined above. In the coming weeks we will be holding a series of engagements with stakeholders to fully assess the likely impacts of these proposals.

Acute NHS and FT ratings

We will introduce ratings for all NHS acute trusts and FTs starting with the publication of ratings for these trusts from December 2013 over a two-year period. The proposals likely to have impacts on NHS trusts and FTs are:

- Ratings for NHS trusts are made at domain, service, hospital and trust levels.
- Ratings to be awarded on a four-point scale, ranging from trusts which are classified as "Outstanding" to Inadequate" because they have either breached a fundamental standard and/or many services are not meeting quality standards.
- Frequency of subsequent ratings reviews to be determined by the first initial rating (which sets the benchmark for the provider in question). Higher rated trusts will have less frequent inspections, in the absence of any concerns raised by surveillance.
- All trusts to be under intelligence based surveillance that can trigger inspections at any time which may lead to a change in their rating.

How are NHS trusts and FTs likely to be affected by these proposals?

We will be carrying out a fuller consultation on proposals for the development and roll-out of ratings for NHS trusts and FTs later in the year. However it is highly likely that providers who are given "good" or "outstanding" ratings are likely to face less cost impacts than providers who don't meet the criteria to be awarded these ratings. Costs could also increase in proportion to any review that lowers a provider's ratings, as costs will decrease in relation to a trust improving its rating through better performance.

Acute NHS trusts and foundation trusts and independent organisations providing acute services are encouraged to consider their own assessments of the likely impacts of the proposals outlined above. In the coming weeks we will be holding a series of engagements with stakeholders to fully assess the likely impacts of these proposals.

Introduction of a single failure regime

NHS trusts and FTs who continue to perform badly will be subject to a single failure regime, the details of which will be developed in partnership with Monitor and the NHS Trust Development Authority (NHS TDA). Our initial proposals that are likely to impact on NHS trusts are:

- Provision of a new formal notice which is underpinned by legislation (subject to the passing of the Care Bill) which will require the board of the NHS trust or

foundation trust with its commissioners to improve if CQC thinks significant improvement is required in the quality of care provided.

- Referral of the trust to Monitor or the NHS TDA to take the appropriate action if the trust fails to achieve the necessary improvements – this could mean Monitor or the NHS TDA bringing in expert clinical support to make the improvements.
- If care still fails to improve, the Chief Inspector, through the CQC, will be able to direct Monitor or the NHS TDA to appoint a special administrator, suspending the board of the trust as a result.

How are NHS trusts and FTs likely to be affected by these proposals?

Only NHS trusts who enter the integrated failure regime will face cost implications, which is assumed to be a small minority. These costs will depend heavily on the type of enforcement action, or sanctions, placed on the NHS trust but are likely to stem from making the necessary improvements for alleviating poor performance and/or the production of any turnaround plan should one be requested. CQC will be consulting on their use of enforcement powers separately, the results of which will contribute to the development of the integrated failure regime.

Acute NHS trusts and foundation trusts are encouraged to consider their own assessments of the likely impacts of the proposals outlined above. In the coming weeks we will be holding a series of engagements with stakeholders to fully assess the likely impacts of these proposals.

Next steps

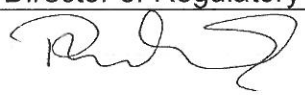
The information on likely cost and benefit impacts contained within this initial regulatory impact assessment are preliminary and likely to change in the coming months as proposals are worked up more fully. CQC plans to hold a series of engagements in the coming months to further quantify the effects of these proposals on stakeholders. More information on this will be provided at a later stage.

Equality and Human Rights Duties Impact Analysis (decision making and policies)

Equality Act 2010
Human Rights Act 1998

1.	
Identifying Name (name of project, policy, work, or decision)	**A new start: Consultation on changes to the way CQC regulates, inspects and monitors care services**
Intended outcomes (include outline of objectives or aims)	Following the fundamental review of our model and approach to regulating health and social care services, we are planning to make major changes to our regulatory model, particularly to make sure that our inspections and ways of assessing providers are more tailored to the different sectors that we regulate. This consultation will set out our high level thinking on: • Applicable to all health and adult social care sectors that come within the scope of regulation: o The fundamentals of care - a clear bar below which care should never fall. o A more rigorous test for those applying to offer new health or social care services. o Better use of information and evidence (which we call surveillance) to decide when, where and what to inspect. o The role of the Chief Inspectors in leading expert teams. o The action we will take in response to poor care. • Changes to our model for regulating NHS trusts and foundation trusts including: o A focus on developing our inspection model for NHS acute hospitals. o Developing our rating of NHS providers. o The introduction of a programme for failing hospitals to make sure that action is taken to protect people and to hold those responsible to account. The responses to the consultation on our strategy for 2013 to 16 have helped us shape many of the proposals in this new consultation, so views from this are referenced within this impact analysis. We want to engage widely through this

	consultation to seek views on our high level proposals, which will shape the detailed plans for developing our inspection and regulation of health and social care services with an initial focus on NHS trusts and foundation trusts.
Who will be affected? (People who use services, CQC staff, the wider community)	The changes will help us to fulfil our purpose which is to make sure that health and social care services provide people with safe, effective, compassionate, high quality care and that we encourage services to improve. The changes will therefore affect both people who use health and social care services and providers of those services. The fundamentals of care and the key principles of the new regulatory model will apply to all regulated providers. The consultation will also include a specific focus on what changes will mean for NHS acute hospitals and NHS providers of specialist mental health services (the NHS sectors identified by the Francis report as the priority areas for developing more effective inspection and regulation).

2.	
For the record	
Who carried out the analysis	Lucy Wilkinson and Nicola Vick
Current Version number	0.07
Date analysis completed:	13th June 2013
Name of responsible Director/Head	Philip King, Director of Regulatory Development
Date analysis was signed off by Director/Head:	 13th June 2013
Involvement & EDHR sign-off name	Nigel Thompson, Head of Involvement and Equality and Human Rights
Date of EDHR sign-off	 13th June 2013

3.	
• Does the work affect people who use services, employees or the wider community? (This is not only refers to the number of those affected but also by the significance of the impact on them)	Yes
• Is it a major piece of work, significantly affecting how functions are delivered?	Yes
• Will it have a significant effect on how other organisations deliver their functions in terms of equality or human rights?	Yes
• Does it relate to functions that previous engagement has identified as being important to particular protected groups or human rights?	Yes
• Does or could it affect different protected groups differently?	Yes
• Does it relate to an area with known inequalities or breaches of human rights?	Yes
• Does it relate to an area where equality objectives have been set by CQC?	Yes

4.
Do the answers above indicate that this work is relevant to equality or human rights? If yes skip this box and continue below. If no, document the reasons below and forward this EHRDIA to Involvement & EDHR team for sign-off
Yes

5.	
Engagement and involvement • Have you involved people who use services, staff and other stakeholders? • What are the key findings of your engagement relating to equality and human rights? Include known representation across the characteristics protected in the Equality Act: age, disability, gender, gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion and belief, and sexual orientation.	
Target Group	**Summary of Involvement**
People who use services	• 240 people who use services took part in our strategy review consultation through specific events targeted at people who use services. Where relevant, their views from the strategy consultation have been incorporated into section 6 of this analysis. • This included some targeted consultation with particular groups that may be less likely to respond to a public consultation through our SpeakOut Network – including community groups for: o Orthodox Jewish community in Manchester o South Asian communities in West Yorkshire and East Midlands o Gypsy and traveller community in East Anglia o Self-advocates with a learning disability in London o Young lesbian, gay and bisexual people in West Yorkshire o Women fleeing domestic violence in the East Midlands o African Caribbean people and families of children with sickle cell anaemia in the West Midlands o Older people in East Anglia. • This analysis also draws on the findings of an evaluation of equality and human rights in the current CQC regulation model. Ten experts by experience participated in this evaluation. • People who use services will be able to respond to this version of the analysis during the formal consultation period – as this analysis will form part of the consultation documents. We will also be undertaking some more targeted consultation with specific groups.

Staff	• 417 CQC staff took part in our strategy review consultation. Where relevant, their views from the strategy consultation have been incorporated into section 6 of this analysis. • Staff equality networks and equality leads in Operations were asked to contribute evidence for section 6 of this analysis and will be specifically alerted to the consultation on this analysis. • This analysis also draws on the findings of an evaluation of equality and human rights in the current CQC regulation model. 80 staff (including 49 inspectors) participated in the evaluation.
Other stakeholders	• Over 1500 organisations and individuals took part in our strategy review through various methods (in addition to the 240 people who use services attending specific events) Where relevant, their views from the strategy consultation have been incorporated into section 6 of this analysis. • Stakeholders will be able to respond to this version of the analysis during the formal consultation period – as this analysis will form part of the consultation documents

6.	
Evidence List the main sources of data, research and other sources of evidence reviewed to determine impact on each protected characteristic or human rights. If there are gaps in evidence, state what you will do to close them in the Log of Equality & Human Rights Actions	
Human Rights (refer to Guidance for examples)	Throughout the consultation on our strategy people who use services, and others, commented that we need to take account of equality, diversity and human rights when developing our new approach. They also said that we need to refer more to how we intend to take this into account[1]. In response to this, we have made it clear that one of CQC's principles is to promote equality, diversity and human rights. We also need to make sure that we communicate how we are doing this to our staff, providers, people who use services, the public and other stakeholders. In the consultation, there was also wide agreement that CQC should focus its attention on situations where people are more likely to have their rights breached – leading to the fundamentals of care not being met for these people. Sometimes, this was expressed in terms of 'risk' and 'vulnerability' but several participants felt that this approach 'put the thinking in the wrong box' and that the focus should be on rights and dignity. Three factors were highlighted by consultation participants where they thought that CQC needed to have a particular focus on the rights of people using the service: • **The type of service:** e.g. where there is little oversight of

[1] Raising standards, putting people first: response to the consultation The next Phase – our strategy for 2013-2016 2013) Care Quality Commission

people delivering the service – either because it is a 'closed' institution or because the service is delivered in people's own homes or where people have no choice but to use the service – if they are detained under the Mental Health Act.

- **The ability of people using the service to self-advocate:** including not only disability but, for example, whether the person can speak English.
- **The risk of discrimination for a group of people using a service:** for example people may be at risk on the grounds of ethnicity, sexual orientation or religion and belief – regardless of the ability of the person to self-advocate and therefore providers may not be meeting required standards for these groups of people.

In the consultation document we have committed to prioritising changes to the way we regulate services where people are most likely to find themselves in vulnerable circumstances – these are the services where people are most likely to have their human rights breached. Our new model will help us to focus on situations where people are most vulnerable to having their rights breached. Firstly, better surveillance including specific indicators for groups of people more likely to be in vulnerable circumstances will help us identify services where people may be at risk of having their rights breached. Secondly, the changes will enable us to make expert judgements through improved inspection methods and thirdly, they will give us new powers to take action where standards are not being met that may lead to a breach of human rights for people using the service.

Some of the 'drivers' for the development of our new model for regulating NHS services, such as the Francis report, are closely linked to human rights. The Government's initial response to the Francis report focuses on *'key actions to ensure that patients are 'the first and foremost consideration of the system and everyone who works in it' and to restore the NHS to its core humanitarian values.'* The statement of common purpose in the response reaffirms the key human rights concepts of respect and dignity as a key value for the NHS.

Human rights, such as the 'FREDA' principles of fairness, respect, equality, dignity and autonomy and rights under the Human Rights Act are embedded in the current standards which we use to regulate health and social care providers.

- The introduction of standards for the fundamentals of care and development of guidance to explain the new expected standards of care (which will replace the current regulations) could help to clarify expectations around human rights. The proposed fundamentals of care which link to equality and human rights are listed in section 7. We will need to pay attention to standards which enable CQC to take action on 'risk to rights' (e.g. rights to independence) as well as standards around 'risk of harm' which can include human rights elements – such as standards around neglect which have an impact on dignity and freedom from inhumane or degrading treatment. Standards relating to 'risk of harm' (i.e. freedom from....) can be easier to regulate than positive rights (i.e. freedom

	to....)
	
	• We will develop and publish a clear approach to human rights in order to clarify the equality and human rights requirements in the new model. This approach will then help inspectors look at their regulatory work using a human rights perspective and help people who use services and providers to know how the standards link to protecting and respecting people's human rights. By doing this we are abiding by the first two principles of human rights based approach to health. Firstly to put human rights principles and standards at the heart of policy and planning and secondly to empower staff and people who use services with knowledge, skills and organisational leadership and commitment to achieve human rights based approaches.[2]
	
	• The 5 new key questions that we will ask about services are
	  • Are they safe?
	  • Are they effective?
	  • Are they caring?
	  • Are they responsive to people's needs?
	  • Are they well-led?
	
	There are important human rights issues contained within all five of these high-level questions. The questions are clearly focussed on putting people who use services at the centre of our regulatory activity – so the new questions should help us to focus on the key human rights issues for people who use services.
	
	• Our human rights approach will assist CQC staff to see the linkages between key human rights principles of fairness, respect, equality, dignity and autonomy, rights under the Human Rights Act and the 5 key questions. This will provide staff with the basis for considering human rights in their work.
	
	• The proposals to differentiate our regulation between different service types should help to clarify expectations on equality and human rights for different services. The move from generalist to specialist inspectors and teams, alongside more in depth inspections where NHS services are at higher risk, could help to make sure that we build capacity for more confident, professional judgement-making on standards relating to equality and human rights for specific types of services.
	
	• The introduction of ratings provides an opportunity to lever improvement in human rights for people who use services above the requirements of the expected standards

[2] For a full list of principles in a Human Rights based approach see Human Rights in Healthcare – a framework for local action (2007) British Institute for Human Rights and Department of Health

Age: (include younger as well as older people, safeguarding, consent and child welfare)	We know that older people are more likely to use health and social care services than the rest of the population.[3] From our own work (such as dignity and nutrition inspections) and the work of others (such as the Equality and Human Rights Commission Inquiry, *Close to home: An inquiry into older people and human rights in home care*) we also know that older people can experience poor outcomes from using health and social care services, in relation to age equality and human rights. The current regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting people's needs on the grounds of age and protect human rights such as dignity, privacy, respect, independence and participation. Any changes to the way that we regulate health and social care services is likely to have a high impact on equality and human rights for older people. In particular, it will be important that the standards we use continue to enable us to take action on age equality and to protect the human rights of older people such as dignity, privacy, respect, independence and participation. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote equality and human rights for older people.
Carers: (impact of part-time working, shift-patterns, general caring responsibilities)	Carer status is not a protected characteristic under the Equality Act 2010. However, carers do receive some protection under the Act in relation to 'discrimination by association' with a disabled person or an older person. We recognise that our work in regulating health and social care services has the potential to have a huge impact on equality for the five million carers in England[4]. Checking that the needs of carers are met is sometimes outside the remit of the current regulations. The focus of these regulations is on the quality and safety of services for people who use services, except in specific circumstances, such as issues of information and consent when a carer is expressly acting on behalf of someone using the service. When reviewing the regulations, we could consider in our discussions with the Department of Health (who are leading the regulation review) whether the new regulations should or could support the needs and rights of carers more. We also recognise that if a provider better meets the needs of the person using their service, for example by providing them with appropriate care and cooperating with other providers, this can have a major positive impact on carers. Carers also use health services in their own right, for example hospital services. Checking that health care providers meet the individual needs of carers using their service is within the remit of CQC. Therefore any changes to the way that we regulate health and social care services could have a high impact on equality and human rights for carers.

[3] Equality Matters – equality information for CQC in 2012 (2013) Care Quality Commission

[4] Figures from Carers Trust: http://www.carers.org/key-facts-about-carers

Disability: (include attitudinal, physical and social barriers)	We know that disabled people use health services more than non-disabled people and that most social care services are provided to people that would be covered by disability equality legislation (including older disabled people, people with a learning disability and people using mental health services).[5] There are some gaps in data around disabled people's use of universal health services as disability is not monitored in some main health data sets such as hospital episode statistics. However, we know from many reports based on people's experiences, such as Sir Jonathan Michael's Inquiry, *Healthcare for all: report of the independent inquiry into access to healthcare for people with learning disabilities*, that some groups of disabled people also experience inequalities or discrimination in health care, including universal health care services such as acute hospitals. There are particular concerns about the rights of people with a learning disability when using specialist inpatient health services. Following the highlighting of serious abuse and appalling standards of care at Winterbourne View, a private hospital for people with a learning disability, we carried out a programme of 150 inspections of independent hospitals, NHS hospitals and care homes that provided care for people with a learning disability. Our national findings from this inspection programme show that there remains a significant shortfall between policy and practice. We found that nearly half the locations we inspected were not meeting the national standards of care that people should expect. Our findings demonstrate that services for people with a learning disability still need to improve. The current regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of disabled people, that providers avoid unlawful discrimination and make reasonable adjustments when planning and delivering care and treatment and that they protect human rights such as dignity, privacy, respect, independence and participation. Any changes to the way that we regulate health and social care services is likely to have a high impact on equality and human rights for disabled people, both for people using specialist health and social care services and for disabled people using universal services, such as acute hospitals. In particular, it will be important that the standards we use continue to enable us to take action on disability equality and to protect the human rights of disabled people such as dignity, privacy, respect, independence and participation. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote equality and human rights for disabled people. We are prioritising services for people with a learning disability for some of our proposals. The more rigorous test for people applying to provide health or social care services will be first used in services for people with a learning disability so that we can use these new tests

[5] Equality Matters – equality information for CQC in 2012 (2013) Care Quality Commission

	quickly where there is unacceptable care in these services – care that can have an impact on whether people with a leaning disability have their human rights upheld.
Gender: (men and women)	We know that the pattern of use of health services is different for men and women. We also know that there are more women using social care services than men, due to gender differences in age profiles of the population[6]. The current regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of people on the basis of gender. We do currently use some data around specific aspects of gender equality, such as the rate of use of mixed-sex wards in hospitals. In order to maintain our ability to promote gender equality, it will be important that the standards we use continue to enable us to take action on gender inequality when necessary. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote gender equality.
Gender Reassignment: (transgender and transsexual people, issues such as privacy of data and harassment):	A report from the Equality and Human Rights Commission shows that transgender people experience some specific difficulties in relation to their health care. Transgender people need to engage with health services during the transition process and, in addition may also use other health and social care services on the same basis as the rest of the population. There is little data in main health data sets about the experiences of transgender people using health services. In our current work on equality data, led by our Intelligence Directorate, we are carrying out some specific work to look at the information we hold about gender identity clinics. The current regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of people on the basis of gender (including gender reassignment). Any changes to the way that we regulate health and social care services may have an impact on equality and human rights for transgender people. In order to maintain our ability to promote equality for transgender people, it will be important that the standards we use continue to enable us to take action on inequality for transgender people when necessary. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote transgender equality.
Pregnancy and maternity: (impact of working arrangements, part-time working, infant caring responsibilities and breastfeeding)	We have a specific role in ensuring that the health services used by pregnant women meet government standards. Therefore any changes to the way that we regulate health and social care services may have an impact on equality and human rights for pregnant women. Some of the proposed changes to the NHS model could have a

[6] Equality Matters – equality information for CQC in 2012 (2013) Care Quality Commission

	positive impact on the human rights of women using ante-natal and maternity services, for example our approach to have more intensive inspection of high risk services should help ensure that women have basic rights, such as rights to dignity, privacy and equality upheld whilst using these services. Again, this positive impact will be dependent on making sure that that the new standards we use enable us to take action on human rights such as dignity, privacy and equality. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote equality and human rights for women using ante-natal and maternity services. We are proposing that in large hospitals, there will be a separate rating for some services – and we give maternity services as an example.
Race: (include differences between ethnic groups, nationalities, gypsies and travellers, language barriers)	We know that the pattern of use of health services is different for people in different ethnic groups. We also know that some minority ethnic groups consistently report lower satisfaction with health and social care services. From our mental health act monitoring work we also know that in some minority ethnic groups, people are more likely to experience negative outcomes, such as higher detention and seclusion rates, which can have an impact on the human rights of Black and minority ethnic people.[7] In the strategy review consultation, people raised issues of the over-representation of some minority ethnic groups in mental health services and the importance of gathering the views of these people when making judgements about whether services are meeting standards. We are proposing to improve the links between our Mental Health Act work and how we regulate mental health services and to give particular attention to the views of people on mental heath wards. We are also currently piloting approaches to equality monitoring in our Mental Health Act work to help us identify services where there may be particular equality issues. The regulations under which we currently register providers and monitor compliance include checking that providers have due regard to meeting the needs of people on the basis of race and that providers avoid unlawful discrimination when planning and delivering care and treatment. Any changes to the way that we regulate health and social care services may have an impact on equality for people from different ethnic groups and has the potential to make a positive impact if learning from our experience of regulation to date can be incorporated into the new model. In particular, it will be important that the standards we use continue to enable us to take action on race equality. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote race equality.

[7] Equality Matters – equality information for CQC in 2012 (2013) Care Quality Commission

Religion or belief: (include different religions, beliefs and no belief)	The regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of people on the basis of 'religious persuasion'. Other beliefs are also covered in other regulations about meeting individual needs. In our discussions with the Department of Health over changes to the regulations, we will raise alignment of terminology around religion and belief with the Equality Act 2010 – to align requirements and therefore make the requirements clearer for both providers and people who use services. Any changes to the way that we regulate health and social care services may have an impact on equality and human rights for people of different religions and beliefs. In order to maintain our ability to promote equality on the grounds of religion and belief, it will be important that the standards we use continue to enable us to take action on any inequality when necessary. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote equality on the grounds of religion and belief for people using health and social care services.
Sexual Orientation: (include impact on heterosexual people as well as lesbian, gay and bisexual people)	There are some gaps in data around the experience of lesbian, gay and bisexual people when using health and social care services as sexual orientation is not monitored in some main health data sets such as hospital episode statistics. In our current work on equality data, led by our Intelligence Directorate, we are aiming to make the best use of available data. We know that there have been a number of studies and reports showing that lesbian, gay and bisexual people can experience discrimination and poorer outcomes when using health and social care services.[8] The regulations under which we register providers and monitor compliance include checking that providers have due regard to meeting the needs of people on the basis of sexual orientation. There can be particular difficulties in identifying lesbian, gay and bisexual people using health and social care services in order to assess the compliance of providers with this regulation. We will consider best approaches to addressing this difficulty as we develop our new regulatory approach. Any changes to the way that we regulate health and social care services may have an impact on equality and human rights for lesbian, gay and bisexual people and has the potential to make a positive impact if learning from our experience of regulation to date can be incorporated into the new model. In particular, it will be important that the standards we use continue to enable us to take action on equality on the basis of sexual orientation. It will also be important that our regulatory model, including our surveillance model and ratings, will enable us to utilise these standards to promote equality for lesbian, gay and bisexual people.

[8] Equality Matters – equality information for CQC in 2012 (2013) Care Quality Commission

7.	
Analysis Considering the evidence and engagement activity, set out below, the actual or likely effect of the policy, project or work under each of the general duties of the Equality Act. CQC must have due regard to the general duties in the exercise of all of its functions	
Effect on eliminating discrimination, harassment and victimisation (includes unlawful discrimination because of marriage or civil partnership status, as well as other protected characteristics)	The new model will assist CQC to have due regard to the elimination of discrimination – provided that the new standards continue to enable CQC to take regulatory action where there is unlawful discrimination or a failure of a provider to have due regard to meeting the needs of people who use services on equality grounds. In the consultation document, one of the proposed fundamentals of care is, 'I will be protected from abuse and discrimination'. There are opportunities in the development of the new model for more in-depth and specialist inspections which could have an impact on eliminating discrimination, provided this is embedded into the new model including the use of appropriate surveillance to identify risks to equality.
Effect on advancing equality of opportunity (includes removing or minimising disadvantages, taking steps to meet the needs, and encouraging participation in public life of people from protected groups)	The new model will assist CQC to have due regard to the advancement of equality of opportunity – provided that the new standards continue to enable CQC to take regulatory action where there is failure by a provider to have due regard to meeting the needs of people who use services on equality grounds. There are opportunities in the development of the new model for more in-depth and specialist inspections which could have an impact on advancing equality of opportunity, provided this is embedded into the new model. The introduction of ratings could also have an impact on improving equality in health and social care services above the level required to meet the essential standards.
Effect on promoting good relations between protected groups	There may be a potential positive impact through ratings – if, for example, ratings include wider issues about how providers carry out community engagement work.
Effect on compliance with Human Rights Act 1998	The new model will assist CQC to have due regard for our responsibilities to respect, protect and fulfil the rights of people using services that are covered by the Human Rights Act 1998 – provided that the new standards continue to enable CQC to take regulatory action on the same range of human rights issues that are covered under the current regulations. The proposed new fundamentals of care include the following standards which would have a direct impact on protecting human rights:

	• I will be protected from harm during my care and treatment.[9] • I will be cared for in a clean environment.[10] • I will be protected from abuse and discrimination.[11] • I will be given pain relief or other prescribed medication when I need it.[12] • I will be helped to use the toilet and to wash when I need it.[13] • I will be given enough food and drink and helped to eat and drink if I need it.[14] There are opportunities in the development of the new model for more in-depth and specialist inspections which could have an impact on protecting and fulfilling human rights, provided this is embedded into the new model, including the use of appropriate surveillance to identify risks to human rights. The prioritisation of changes in services where people are in vulnerable circumstances should also help to protect people at most risk of having their human rights breached.

[9] Relevant to European Convention on Human Rights Article 2 – Right to life and Article 3 – Right to be free from inhumane or degrading treatment (The Human Rights Act 1998 incorporates these European Convention of Human Rights Articles)

[10] Relevant to European Convention on Human Rights Article 2 – Right to life, Article 3 – Right to be free from inhumane or degrading treatment and Article 8 – Right to family life, privacy and correspondence

[11] Relevant to European Convention on Human Rights Article 3 – Right to be free from inhumane or degrading treatment and Article 14 – non-discrimination in relation to other rights

[12] Relevant to European Convention on Human Rights Article 3 – Right to be free from inhumane or degrading treatment and Article 8 – Right to family life, privacy and correspondence

[13] Relevant to European Convention on Human Rights Article 3 – Right to be free from inhumane or degrading treatment and Article 8 – Right to family life, privacy and correspondence

[14] Relevant to European Convention on Human Rights Article 2 – Right to life, Article 3 – Right to be free from inhumane or degrading treatment and Article 8 – Right to family life, privacy and correspondence

8. Log of Equality and Human Rights actions

Give an outline of the key actions based on any information gaps, challenges and opportunities identified during engagement and evidence analysis. Include any action required to address specific equality or human rights issues where the work may need adjusting to remove barriers or better advance equality as well as actions to mitigate any potential negative effects of the policy on particular groups . Include how the actual impact on equality and human rights will be reviewed after implementation of the policy or project. Add more rows if required. Refer to Guidance for more information

Action (If using a project plan this should be a new deliverable or new task within an existing deliverable)	**Start date**	**End date**	**Action Owner**	**Outcome** (relate back to analysis section – which equality or human rights issues will be addressed through this action)	**Success measure**	**Actual Completion Date**
1. Develop our human rights approach (which includes equality) for the 5 domains that we are using in the new model– to help us ensure that we address human rights issues in the fundamentals of care, our approach to regulating the new expected standards of care, ratings and evidence to support these	April 2013	Aug 2013	Lucy Wilkinson	Provides basis for the new model of monitoring, inspection and regulation to eliminate unlawful discrimination, advance equality of opportunity and protect and promote human rights	Human rights approach developed and agreed by CQC	
2. Apply the human rights framework to the fundamentals of care	May 2013	Aug 2013	Lucy Wilkinson/ Karen Wilson	Ensures our development of the fundamentals of care will have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and protect and promote human rights	The fundamentals of care protect human rights and rights to equality	
3. Apply the human rights approach to new NHS inspection methodology; surveillance, tools and guidance for inspectors for both acute and mental health	May 2013	Sept 2013	Lucy Wilkinson/ Sue Macmillan/ Lisa Annaly	Ensures new NHS regulatory model has due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and protect and	Our model to monitor, inspect and regulate NHS trusts and foundation trusts protects and	

NHS trusts and foundation trusts and incorporate learning from our evaluation of equality and human rights in reviews of compliance into this work				promote human rights	promotes human rights and rights to equality	
4. Pilot work to utilise values-based approaches in NHS inspection methodology with a view to incorporating this into new inspection methodology if successful (Joint work with MacMillan Cancer Care)	Q1	Q4	Nigel Thompson/ Lucy Wilkinson/ Matthew Trainer	Develops new NHS regulatory model in relation to the protection and promotion of human rights	We test a methodology which enables inspectors to focus on the values behind human rights in a health setting and how to use these on inspection	
5. Consult on our human rights approach and the way that it applies to expected standards and the NHS inspection methodology for both acute and mental health NHS trusts and foundation trusts in the next public consultation	Q3	Q3	tbc	Engagement to ensure new NHS regulatory model and the new fundamentals of care have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and protect and promote human rights	Views of other stakeholders improve the way that our model to monitor, inspect and regulate NHS trusts and foundation trusts protects and promotes human rights and rights to equality	
6. Apply the human rights approach to developing ratings including how we assess whether services are high quality by using good practice developed by other organisations	Q3	Q3	Lucy Wilkinson/ Emma Steel	Ensures the new method for rating services has due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and protect and promote human rights and assessments of whether services are high quality considers good practice in relation to equality and human rights	Views of other stakeholders improve the way that our method for rating services protects and promotes human rights and rights to equality	
7. Consult on the human rights approach and the way that it has	Q4	Q4	Lucy Wilkinson/	Engagement to ensure the new method for rating services has	Our method for rating services protects and	

been applied to ratings			Emma Steel	due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and protect and promote human rights	promotes human rights and rights to equality	
8. Utilise the human rights approach when we develop learning and development activity for inspectors and others around the new model	Q3?	Q4	Lucy Wilkinson/ Ruth Heron	Ensures that the equality and human rights elements of the new approach can be put into practice by CQC workforce	CQC staff are confident in promoting equality and human rights in their work using the new model	
9. Discuss with the DH some specific suggested revisions to the regulations relating to equality and human rights that are might be required – based on our experience of operating under the current regulations and aligning the wording of the regulations with other legislation (e.g. Equality Act 2010) for clarity for providers and people who use services	Q2	Q3	Lucy Wilkinson/ CQC Lead with DH	In assisting the Department of Health to define the new regulations, we contribute our regulatory experience to date around having due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and protect and promote human rights	The new standards protect and promotes human rights and rights to equality	
10. Give specific consideration, when developing the detail of the new model, to addressing the difficulties with assessing whether providers meet the standards for lesbian, gay and bisexual people using their services (e.g. around discrimination and respect)	Q1	Q4	Lucy Wilkinson	We have had due regard to the need to due regard to the need to eliminate unlawful discrimination and advance equality of opportunity for lesbian, gay and bisexual people	Increasingly, we are able to judge whether health and social care services meet the expected standards for lesbian, gay and bisexual people using their services	
11. Continue to develop our approaches to assessing equality through our Mental Health Act	Q1	Q4	Debbie Mead	We have had due regard to the need to due regard to the need to eliminate unlawful discrimination	The information on equality that we obtain through our	

function and enable this work to inform our work to regulate mental health services				and advance equality of opportunity in the development of our regulation of mental health providers	Mental health Act function contributes to our regulation of mental health providers	