

# Why we need this updated approach

Human rights infringements, breaches – and at their very worst, abuses – continue to ignore, undermine and diminish fundamental standards of care for people. There is a growing need to create a major shift in understanding how rights-based care is intrinsically linked with the quality of care.

We have a legal responsibility to assess whether providers meet the regulations in the Health and Social Care Act. Within these, many of the [fundamental standards of care](#) have a strong human rights dimension and provide us with a **strong tool for human rights protections**. Where care fails to protect people and keep people safe in line with the fundamental standards, we will take action to ensure rights are respected. See how the [Human Rights Act links with the Health and Social Care Act, and our new assessment framework](#).

People who use health and care services need to be empowered to understand their rights, and to participate in these discussions. At the same time, commissioners, providers and staff in health and social care services all need to be aware of the link between the regulations and human rights.

When delivering care, practices that respect human rights are fundamental to good outcomes for people. Staff, providers and commissioners can therefore choose to improve quality by delivering rights-based care.

Conversely, rights-rejecting cultures by nature are environments where practices of poor care and poor support for staff are allowed to develop unchecked. Where service providers do not uphold the rights of either the people using their service or their staff – either wilfully or through ignorance – there is a rejection of people’s rights, and the outcome will be poor care.

We can encourage improvement in rights protection by understanding more about where people’s rights are at risk or are infringed, and how to build rights-respecting cultures in care.

## Human rights, power dynamics and discrimination

Discrimination and prejudice can also be factors in undermining people’s human rights. ‘Dehumanisation’ is one way of understanding this process. This happens where there is a denial of a person’s human nature and their humanity, which is only possible when a power dynamic is in operation. For more information on dehumanisation, see [To be or not to be human: Resolving the paradox of dehumanisation](#) and [The Impact of Power on Humanity: Self-Dehumanization in Powerlessness](#).

We know that there are power dynamics when people receive care. When people are seen as ‘other’ and ‘less than’, this seriously affects the quality of treatment they then receive. When people are in situations where their power and autonomy is weakened, the risks of abuse increase, as shown in the findings of investigations at [Winterbourne View](#), and [Whorlton Hall](#). For more information, see [Why Othering should be considered in research on health inequalities](#).

In the independent report following the abuse at Whorlton Hall, Professor Glynis Murphy emphasised that, "People resident in institutions are trained to be compliant and dependent and they are not empowered to defend themselves. The dehumanisation and devaluing attitudes of staff towards residents are major contributors to abusive environments."

People whose voices are less heard, valued and understood are the people who need protecting the most. For example, we know that Black men are much more likely to die in detention on mental health wards. Years on from the death of David Bennett, some practices in mental health services are still illustrating the links between dehumanisation, discrimination and inadequate and sometimes dangerous rights-rejecting care. See the [Independent Inquiry into the death of David Bennett](#) for further information.

As part of reviewing our human rights approach, we spoke with Jacqui Dyer, Mental Health Equalities Advisor for NHS England, who commented:

"Black People detained under the Mental Health Act, or in process of detention, have lost their lives because their human rights weren't taken into consideration or reflected during their detention... Stories of how people are treated inside spread across the community. This means they know what will happen if they get locked up so are terrified to come forward for help. They know they will also be dehumanised, like their friends, family, neighbours and members of the wider community before them."

People who use services, including young people, their families, as well as staff, all told us that where there is a power imbalance, people need their rights protecting more. Their concerns are another illustration of just how much power staff can hold when people's human right to liberty is not upheld and checked.

For example, people's rights have been eroded since the pandemic, with Deprivation of Liberty Safeguards not reviewed for people in a timely way, as we have highlighted in our [State of Care 2022/23 report](#).

This meant that people were more likely to be overly restricted and for longer periods – particularly older people. This could put people's right to liberty at risk.

Since we last reviewed our human rights approach in 2019, we have published several reports that highlight the importance of upholding human rights, particularly for people most likely to be discriminated against and therefore most likely to have a poorer experience of care. Our publications outline the links between understanding the rights of the individual person and poor care. Most notably these include:

- pregnant women from Black and Asian communities: [Safety, equity and engagement in maternity services](#)
- autistic people and people with a learning disability: [Who I am matters, Out of sight – who cares?](#)
- older people, people with a diagnosis of dementia: [Promoting sexual safety and empowerment, Protect, Connect, Respect](#)
- adults and young people using mental health services: [Mental Health Act Review 2022](#).

## Structural, institutional and individual level factors

### Structural factors

Human rights infringements can be driven by factors at a structural level – where commissioning, delivery and oversight of care have led to situations where human rights are routinely at risk. Delays in reviewing Deprivation of Liberty Safeguards is one example of a structural factor that affects human rights.

Inequalities that exist in society affect people from different equality groups who are then more likely to experience human rights infringements. This can be a result of wider determinants (health inequalities), such as social, economic and environmental factors affecting their health and life chances. For example, discrimination and poverty can have an adverse effect on someone's mental health, which means that they are more likely to be in contact with mental health services and they may then experience human rights breaches in those services. Understanding the way structural inequality acts to undermine people's rights is key to promoting and protecting them across society.

## Institutional factors

Failures to protect people's human rights at an institutional level can be traced back to weak and ineffective leadership that leads to the development of toxic cultures. These situations illustrate clearly when people's humanity and rights are not seen or respected and people are treated in inhumane and unlawful ways within a whole culture.

Other aspects of institutional failure include where policies and practices at a provider level can create human rights risks.

People who have used inpatient mental health services told us about examples where staff on wards consistently ignored their right to privacy by insisting that they should have CCTV cameras in their rooms or wear body cameras. We talk about the complexity and importance of protecting people's privacy in our guidance about [Using surveillance in care services](#).

## Individual staff level factors

Human rights abuses and infringements also happen because of the actions of individuals. This is when people's humanity and rights are not seen or respected and they are treated in inhumane and unlawful ways. These instances are perpetrated by individuals who are acting in isolation. Examples can range from an individual member of staff unlawfully restricting a person from leaving a care home, to people being subject to degrading and humiliating treatment while receiving or being denied personal care. Although these can be driven by the same factors involved in institutional abuse, they are more likely to arise out of ignorance and institutional practice rather than malintent. These types of infringements are more common.

When speaking with people in reviewing our approach, we heard examples of staff level factors ranging from:

- not providing suitable sanitary protection for women in inpatient settings
- staff on mental health wards falling asleep during observations of people who are at increased risk of suicide and self-harm
- staff not intervening to support with people's continence needs in acute hospitals.

Individual abuses and infringements can be intrinsically linked to institutional abuse, as a rights-rejecting culture creates an environment for individual acts to take place. In its report [Protecting human rights in care settings](#), the Joint Committee on Human Rights recommended that all registered providers should provide training to their staff that demonstrates the relevance and use of human rights when making decisions about care and treatment.

Providers of services for people with a learning disability told us they felt much more work is needed to support the physical health needs of people using their services, which could be especially complex. They felt there are systemic failures in ensuring that healthcare services catered for people with a learning disability appropriately in terms of environment, information and access to advocacy.

They also commented that their own staff experienced disrespectful behaviours from the healthcare staff teams, which further undermined sharing of information about how best to support and understand the needs of the person being cared for. These failures have been found to put people's rights to life and rights to be free from inhumane and degrading treatment at risk, and are therefore a human rights risk.

Although there is more awareness of systemic human rights issues in the care of autistic people and people with a learning disability, there are other types of services (for example those for older people and people with mental health needs) where we need to look at systemic factors that put human rights at risk.

In the most serious human rights failures and abuses in health and social care, there is often a combination of factors at systemic (structural), institutional and individual levels.

## Rights and closed cultures

Services with rights-rejecting cultures at an institutional level frequently have features of a [closed culture](#) where there is a risk of harm and human rights breaches. Where commissioners, providers and staff fail to understand people's humanity, this translates to care that involves human rights abuses on an institutional scale. Our guidance on [identifying closed cultures](#) shows that they can develop in any service.

Even in services that do not have a closed culture, power dynamics also mean that people's rights can be overlooked in day-to-day work. This could be due to the approach of individual members of staff or institutional factors such as staffing levels or poor policy or practice, for example around weak care planning or blanket policies.

People who had been an inpatient in mental health services told us about their experiences of blanket restrictions about using their phones and overly restrictive approaches to being able to access their personal belongings. This potentially breaches people's rights around home, family and correspondence and their right to enjoy their possessions.

## Epistemic injustice

A key component to effective regulation is to listen well to all people who use services. We have outlined this in how we [use people's experience in our regulation](#). But we also know that because of structural inequality, we need to pay particular attention to the voices of people most likely to have a poorer experience of care and to the staff in services where people are more likely to experience discrimination, prejudice and therefore human rights breaches. To do this effectively, we need to understand the concept of epistemic injustice, first used in our closed cultures work, and incorporate it into our human rights approach.

This concept describes how people and their views can be silenced, ignored or discredited on grounds of prejudice or biased assumptions.

"Epistemic injustice refers to a wrong done to someone as a knower or transmitter of knowledge: due to unjustified prejudice, someone is unfairly judged to not have the knowledge or reasonable beliefs that they actually have."

Epistemic injustice; Power and the ethics of knowing Fricker, 2007



Injustices can happen when services do not listen well and so do not understand the people using their services, or their staff. They can also happen if policies and practices do not encourage, support and act on people's feedback.

Epistemic injustice is a key concept for us as a regulator. It informs when and how we use evidence, as we need to understand how the decisions that we make, both individually and collectively, can undermine the facts of a situation when reviewing and assessing information. There is a clear link between injustice, people's experience of care and regulation, and an inherent need for epistemic justice in the relationship between givers and receivers of care.

The need to consider this will be even greater if people are also at risk of bias or discrimination, for example on the grounds of age, disability, ethnicity, sex, sexual orientation or gender reassignment status.

Epistemic injustice also extends beyond this 'carer and cared for' relationship. For example, when giving testimony to poor care on an inpatient ward, a member of care staff who is a Black internationally recruited staff member, for whom English is a second language, may be less likely to be believed by a regulator than a white consultant giving a contrary view.

The young people we spoke with in reviewing our approach told us that we can do much more to raise awareness of CQC among children and young people so they can have a voice about their care experiences too. They said they were not aware of how to [give feedback on care](#) and highlighted that our reports should be more child/young people friendly.

We know that there is more that we can do as the regulator to listen to both people and staff more effectively. The [Listening learning and responding to concerns](#) report demonstrates the importance of our staff listening well to what both people and staff tell us about their experiences.

People's experiences and those of staff – of both giving and experiencing care – are vital to our work and are key evidence categories in our new assessment framework. Using our [People's experience framework](#) and the experiences of staff in our [staff and leaders evidence](#) category are vital to redressing epistemic injustice.

## Navigating complexity

We also need to be able to understand and talk more clearly about the complexity of rights in health and care, to inform conversations where there are conflicts. Colleagues in CQC need to feel confident to engage in these conversations. A human rights approach supports both discussion and insights using the FREDA principles of Fairness, Respect, Equality, Dignity and Autonomy to help navigate complexity (see section on rights-respecting cultures). In some complex situations, understanding principles will need to be supplemented by advice on applying human rights law.

A person caring for a relative with a diagnosis of dementia told us their relative was cared for in overly restrictive way following a period when they had been acutely ill. Safeguarding measures were taken in response to risks of harm to both themselves and others, which then dominated how the staff interacted with the person from that point on. This led to ongoing restrictive care interventions that severely affected their social needs and their right to family and private life.

## Rights-rejecting cultures: the impact on staff

Rights rejecting cultures in health and care do not just affect how care is delivered for people; they are also in places where staff themselves can be at risk of discrimination, bullying and harassment, poor working conditions and modern slavery.

Modern slavery is an increasing human rights issue, particularly in adult social care settings. We recognise the importance of both dealing effectively with these issues within the scope of our regulation and in partnership with others. This approach is reflected in our [modern slavery policy position statement](#).

Aside from extreme examples of modern slavery, more generally where the workforce is not properly remunerated, trained, supported or recruited, this may pose significant human rights breaches – both for the workers and the people using the services. These cultures are rights-rejecting and, despite good intentions from staff, poor care can be the outcome when delivered by staff who are not properly trained and supported.

“migrant...novice carers may be placed with the most difficult clients that others declined to work with and/or were paid at a lower rate than that which would normally be expected for a particular intensity of support. It was common for live-in carers to find themselves in difficult or even hazardous situations when starting a new placement. Lack of support from agencies were concerns many participants raised”

[The vulnerability of paid migrant live-in care workers in London to modern slavery Nottingham University 2022](#)

In rights-rejecting cultures, we are increasingly aware of workforce discrimination against staff. This can take place either:

- **individually** between staff, or from patients towards staff, for example a person receiving care not wanting to be cared for by a Muslim member of staff
- at **institutional level** for example by a provider who is illegally holding the passports of all overseas staff
- at a **structural level**, for example where a care system employs overseas workers without the training to support their introduction to care roles in the UK.

Rights-respecting cultures: The beating heart of good care

People working in health and social care, including our colleagues in CQC, are working to make a positive difference to people's lives. This motivation is central to a rights-respecting culture, where staff see the humanity – and therefore the dignity – of the person they are caring for. This approach implicitly guards against inequality, discrimination and injustice caused when human rights issues, principles and laws are not respected or understood.

In developing our assessment approaches, we continue to use the 'FREDA principles'. These principles underpin rights-respecting care and help support legal compliance, for example with the Equality Act 2010 and Human Rights Act 1998. They are:

- Fairness
- Respect
- Equality
- Dignity
- Autonomy (choice and control).

These values underpin the essence of rights-respecting care and are incorporated in our new [assessment framework](#). They are generally considered in [Regulation 9: Person-centred care](#) and more specifically in [Regulation 10: Dignity and respect](#).

Our new approach to assessing quality incorporates these human rights principles, which hold humanity at their core. When we apply these principles in health and social care, we view people who receive care as fellow human beings with dreams, aspirations, wants and needs.

Rights-respecting cultures are developed where commissioners, providers, staff and people all feel empowered to create and sustain environments where people, including staff, are acknowledged with the dignity and respect they deserve as human beings in line with the FREDA principles.

In a culture where the rights of staff are respected, care will be of a higher quality as staff are empowered and therefore better able to deliver rights-respecting care in a positive culture. Central to respecting the rights of staff is ensuring equality and inclusion for them and building diverse teams to enable better rights-respecting care.

Some older people told us they experienced excellent services from both GP practices that knew them well and routine screening inpatient services. They felt these services were well-run and staffed by respectful and caring staff.

Providers have told us they understand the importance of human rights to ensuring good care for people and it's a key motivation for them and their staff in their chosen careers. They also told us that when our inspection teams take an emotionally intelligent approach to inspection – particularly with the current challenges facing health and care services – this helped to improve communication and understanding, and therefore more effective regulation. Treating staff and providers with respect and understanding through all our interactions is also key to following a human rights-based approach as a regulator.

Rights-respecting systems can be described as health and care systems that demonstrate their understanding of the centrality of human rights, and the principles underpinning them, in their oversight of commissioning, planning and review of services.

People who use services and their advocates have told us we can do more to ensure we clearly describe the link between understanding human rights principles and good care. We want to do this by describing good examples of rights-respecting cultures that we find, for people who use services, commissioners, providers and their staff to understand and follow.