Care Quality Commission

Our updated human rights approach

Bringing humanity into action

As the regulator, our role is to make sure people have safe, high-quality care. Care that does not respect and promote human rights is neither safe nor high-quality.

We have reviewed and updated our human rights approach as we move forward with our new approach to regulation. A focus on human rights ensures people receive good care and helps us fulfil our duties and purpose by meeting our legal obligations made under the Health and Social Care Act 2008. It helps us prevent failures in care that are usually related to risks to human rights.

Failures in human rights vary – from individual infringements to large-scale institutional and more structural systemic failures. The shocking examples of human rights abuses at Winterbourne View, Mid Staffordshire, Whorlton Hall and Edenfield Centre demonstrate unacceptable failures in care with profound and significant effects on people's lives. These examples show the ongoing potential for human rights abuses within health and care which must be prevented wherever possible. Ensuring that people who use health and care services have their fundamental rights respected and upheld is a priority for us as regulator, for providers and commissioners and of course for staff in the delivery of care.

When we refer to the general scope of human rights in our approach, we are describing human rights-related risks and issues rather than formal legal thresholds for human rights breaches.

When people tell us about what is important in their care, issues of human rights feature strongly – such as dignity, respect and fairness, although people rarely use the formal language of human rights.

In reviewing our approach to human rights in our regulatory work, we used published research and learning in this area. We also engaged with people who use services, their carers, advocacy organisations, providers of health and social care, experts on human rights and senior leaders and inspectors in CQC. Feedback about people's priorities in relation to human rights is valuable in improving our regulatory approach. Common themes included:

- having access to respectful and dignified care where their needs are fully understood and supported, particularly for those most likely to have a poorer experience of care.
- being cared for in ways where restrictive practices are used only as a last resort, for example when there is no other option to keep people safe.
- having conflicting rights balanced and considered appropriately, especially in terms of positive risk taking.
- the rights of staff and how staff are supported.

Care that respects people's rights is good care – we call this **'rights-respecting care'**. Where there is good care there are '**rights-respecting cultures'**, but where there is poor care, the opposite is true, and we can describe these as '**rights-rejecting cultures'**.

It’s important to talk about human rights in the right way, as people’s understanding varies and is often linked to issues such as crime, citizenship and migration rather than health and care. People’s rights are complex, particularly when one right is directly in conflict with another. It is therefore important that we acknowledge and talk about these issues.

We want our updated approach to improve the understanding of human rights. This includes people who use services, commissioners, providers and their staff and colleagues in CQC. We want them to recognise their roles more clearly so that human rights are fundamentally linked to delivering safe and good quality care.

Conversations about human rights issues in health and social care settings should be commonplace. When we are all confident in describing and naming fundamental human rights, we can effectively challenge discrimination, inequality and the inherent power dynamics that work to undermine people’s rights.

As a human rights-focused regulator, we want our new regulatory approach to be a driving force in improving, promoting and protecting the human rights of people who use health and care services.

To do this, we will use the appropriate legal frameworks to address human rights issues that we find. We will use all the Regulatory Impact Mechanisms available to us, from sharing good practice to encourage improvement to enforcement action when necessary. We will promote learning and action on human rights.

This revised approach includes commitments to support this shift by laying out our overall approach to human rights and the opportunities available to us to make positive change.

It is our commitment to bringing humanity into action.

What are human rights?

The Human Rights Act contains 16 rights. These originate from the European Convention of Human Rights and the Human Rights Act 1998 brings them into UK law.

> "Human rights are the basic rights and freedoms that belong to every person in the world, from birth until death. They apply regardless of where you are from, what you believe or how you choose to live your life. They can never be taken away, although they can sometimes be restricted – for example if a person breaks the law, or in the interests of national security.
>
> "These basic rights are based on shared values like dignity, fairness, equality, respect and independence. These values are defined and protected by law. In Britain our human rights are protected by the Human Rights Act 1998."
>
> Equality and Human Rights Commission

Some of us may feel that human rights aren’t relevant to us, as they are often linked to issues such as crime, citizenship and migration, but they are protection for us all. Creating a legal framework for human rights protects our humanity – what makes us unique as human beings, through law. Our human rights need protecting most when we feel the least powerful and are relying on others for our basic needs – including when we are using health and care services. Where care is delivered in line with human rights legislation, it is by nature good quality – this is what we **describe as rights-respecting care**.

As a public authority, CQC is legally required to operate in ways that are compatible with the Human Rights Act 1998. Many of the fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 are related to human rights. As such, the Human Rights Act forms a legal contextual background to the regulations that we use.

Why we reviewed our human rights approach

We need a refreshed regulatory approach to human rights to respond to the challenges of recent years and to support our new regulatory approach.

The impact of COVID-19 on human rights in health and care

We first published our human rights approach to regulation in 2014 and updated the approach in 2019. Since then, the COVID-19 pandemic has changed how health and social care services are delivered.

The pandemic exposed critical human rights issues and highlighted the pre-existing inequalities in our health and care systems. Our State of Care 2021/22 report highlighted these concerns – some of which were also evidenced in the COVID-19 Disparities report. In 2022, the report from the Joint Committee on Human Rights, Protecting Human Rights in Care Settings, raised some concerns about human rights in care settings. These included:

- making Do Not Attempt Resuscitation decisions without consulting people
- restricting people's liberty
- denying people access to their communities and their visitors without individual assessments of the impact on their human rights.

The report described care services struggling to support people in the best way, given the risk they were dealing with, and trying to mitigate at the height of the pandemic. But some examples demonstrated a neglect to fully understand people's rights and freedoms.

CQC colleagues have told us that, in some cases, they thought the COVID-19 pandemic had weakened respect for people's human rights in health and care, and diminished expectations of the quality of care. Our updated human rights approach needs to counteract this, tackle the consequences of the pandemic, and address possible current shortfalls in human rights in health and care in England.

Our strategy and equality objectives

Our strategy from 2021 set ambitions for our new regulatory approach to be more flexible to manage risk and uncertainty, enabling us to respond in a quicker and more proportionate way as the health and care environment continues to evolve. Underpinning this approach is the core ambition of **'tackling inequalities in health and care by pushing for equality of access, experiences and outcomes from health and social care services'**.

There are particularly close links between human rights and inequalities in experience in health and social care.

Under the Health and Care Act 2022, our new responsibility to give a meaningful and independent assessment of care in a local area means we have the potential to influence the quality and safety of care. We can do this by developing rights-respecting cultures across systems – or 'rights-respecting systems'.

Our equality objectives will also contribute to our focus on human rights. For example, our equality objective on **'Amplifying the voices of people most likely to have a poorer experience of care or have difficulty accessing care'** will help us identify and respond to human rights risks.

We need to ensure that the learning from the pandemic is a driver for real change and that our new regulatory approach can make this happen.

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.

How our approach supports rights-respecting care

Our approach to human rights is not new. We first published our human rights approach to regulation in 2014 and updated it in 2019. To embed this in all our work we have:

- built human rights topics into the scope of our previous assessment frameworks and methods
- provided learning for our staff and external guidance, for example on closed cultures and restrictive practice as outlined in our restrictive practices policy statement
- showcased how human rights oriented practices lead to outstanding care in Equally Outstanding
- highlighted human rights issues in national reports, such as Protect, Connect, Respect about the inappropriate use of Do Not Attempt Cardio-Pulmonary Resuscitation and Out of sight – who cares?, which highlighted human rights breaches for people in segregation and seclusion.

But we know we can do more to promote rights-respecting care by using our new regulatory approach. The evaluation report from Alliance Manchester Business School and The King's Fund, Impact of the Care quality Commission on provider performance: room for improvement? describes how regulation can have an impact on the performance of providers. We will use the 8 regulatory impact mechanisms identified in the priority areas where we are committed to improving our human rights approach.

Using our regulatory powers to protect and promote human rights

Our new assessment framework

Our new approach to regulation enables us to focus more on human rights.

We now have our new assessment framework to judge:

- the quality of care in a service

- how well a local authority is delivering its duties under the Care Act
- the performance of an integrated care system

It also applies when registering providers as the first assessment activity. This is vital to ensure people's rights are protected.

The quality statements in the framework are the commitments that providers, commissioners and system leaders should live up to. They link to the regulations and to the FREDA principles, which are central to a rights-respecting culture and rights-respecting care.

Here are the 5 key questions and the quality statements that are linked to human rights:

Safe

- Safe systems, pathways and transitions
- Safeguarding
- Involving people to manage risks
- Safe environments
- Safe and effective staffing
- Medicines optimisation

Effective

- Assessing needs
- Consent to care and treatment

Caring

- Kindness, compassion and dignity

- Treating people as individuals
- Independence, choice and control
- Responding to people's immediate needs
- Workforce wellbeing and enablement

Responsive

- Person-centred care
- Care provision, integration, and continuity
- Providing information
- Listening to and involving people
- Equity in access
- Equity in experience and outcomes

Well-led

- Shared direction and culture
- Capable, compassionate and inclusive leaders
- Partnerships and communities
- Learning, improvement and innovation

We can now gather evidence against 6 evidence categories to bring structure and consistency to our assessments. An important evidence category for our human rights approach is the People’s experience category.

The learning from Listening, learning and responding to concerns report is supporting our work in this area to ensure we improve how we listen well to people’s experiences of care. The staff and leaders evidence category will also support us to listen more effectively to experiences of frontline staff working in health and care and therefore take action sooner to protect the rights of people and staff.

OUR COMMITMENT:
We understand the links between rights-rejecting care, power and epistemic injustice, so we will listen closely to those who are most likely to have a poorer experience of care. We believe people using care services, their unpaid carers, families, friends and advocates are the best sources of evidence about their lived experiences of care and how good it is from their perspective. We champion this in our work using people's experience in our regulation. We will develop a similar approach for staff experience, focusing on staff most likely to experience epistemic injustice when they want to speak up.

This will include complaints. We need to understand these carefully as advocates for people using services told us this information is vital to understanding whether a service is rights-respecting.

On-site inspections

This approach means we can carry out on-site inspections through site visits more frequently where:

- There is a greater risk of a poor or closed culture going undetected – this is where people’s rights are most at risk. Visiting a service, talking to people and observing care is often the only way to assess people’s experience of care.

- We have a statutory obligation to do so, for example as a member of the National Preventative Mechanism, we must visits places of detention regularly to prevent torture and other ill-treatment.

OUR COMMITMENT:
We will develop tools to support our staff when inspecting on site visits to understand whether there is a rights-respecting culture in the service. We can build on our work focusing on inspections of services for autistic people and people with a learning disability.

Safeguarding

Whether or not we are planning enforcement action, we will make a safeguarding referral to the relevant local safeguarding authority if:

- we believe that abuse or neglect is happening, or if there is a risk of serious or significant harm to a person or people
- we are the first organisation to become aware of this information.

Enforcement

Under the Health and Social Care Act 2008, CQC must “have regard to the need to protect and promote the rights of people who use health and social care services” (section 4(1)d). This includes, but is not limited to, people’s human rights.

The Human Rights Act 1998 incorporates the European Convention of Human Rights into UK law. We don't have regulatory powers to take legal action directly under the Human Rights Act 1998, which incorporates the European Convention of Human Rights into UK law. However, human rights are embedded into the regulations we use, which include the fundamental standards. These are the standards below which care must never fall and are set out in Health and Social Care Act 2008 (regulated activities) Regulations 2014. If we assess that health and care providers are not meeting the fundamental standards of care, we will consider using our powers to take enforcement action.

Our human rights approach to regulation means that although we are not required to assess human rights separately, they are embedded into our regulatory methods and processes.

Our process for taking regulatory action is supported by our enforcement decision tree, which sets out how we make decisions about what action to take, if any. When there is a breach of the regulations, we consider whether there was an infringement of a person's rights or welfare, or whether there was a reduction in their quality of life. Where appropriate, we consider whether there was a potential infringement of a person's human rights. These factors affect whether a breach of regulations reaches our enforcement threshold.

If a breach of the fundamental standards does reach our enforcement threshold, we can take enforcement action where it's proportionate to do so – even when only one person's rights are infringed.

Our staff have told us they know upholding human rights is at the core of CQC, but that we need to make clearer the links with regulations that relate to human rights.

Our staff and senior leaders also said we can do more to ensure we use our full regulatory powers together with our understanding of the Human Rights Act.

OUR COMMITMENT:
We will review our approach to enforcement where regulatory breaches involve human rights issues and will ensure we use the right approach to help us take action where we need to. This will improve how we make decisions about the thresholds for action. It will also enable us to test new ways of using our enforcement powers in the best way when people's human rights are at risk.

Joint working with the Equality and Human Rights Commission

Where we think the Equality and Human Rights Commission (EHRC) has more suitable regulatory powers than ourselves to address an issue, we can use our memorandum of understanding. This enables both CQC and the EHRC to share information and refer cases where the other regulator has more suitable powers.

There are many areas relating to human rights where we can take regulatory action. Our guidance for providers on meeting the regulations cross-references the regulations to the Equality Act 2010 and the EHRC statutory guidance to the Act where applicable. In some situations, we may not need to refer a human rights issue to EHRC because we can take action ourselves, but we can work more closely together to use our respective regulatory powers to protect people's human rights.

OUR COMMITMENT:
We will improve our information sharing protocols and risk sharing and escalation with the Equality and Human Rights Commission. This will enable increased joint working using our respective regulatory powers to ensure good quality care and protect people's human rights.

Engagement and our independent voice

We are already starting to build on work here, some of which has resulted from discussions with key partners when revising our human rights approach. This includes people who use services, providers, commissioners, subject matter experts, health and care staff, as well as our senior leaders and colleagues in CQC. We will continue to engage and work with others to achieve the commitments we have made.

This human rights approach serves as a clear organisational statement that states our legal powers to promote and protect the human rights of people who use health and care services.

To improve how we communicate and promote human rights concerns publicly, we are demystifying the language we use. This will help to build a shared understanding of the nature and importance of human rights among people who use health and social care services, providers, staff working in services and others across health and care.

We continue to use our independent voice to speak out about human rights from what we find through our regulation and prioritise work that addresses human rights concerns. This includes promoting stories of people who have had a good experience of care when their human rights have been fulfilled positively and of providers who have developed human rights-respecting cultures.

OUR COMMITMENT:
We will use this human rights approach to engage with everyone about human rights matters and will publish what we find about both good and poor practice to further people's understanding and drive improvement.

Encouraging improvement

CQC is well placed to support and encourage improvement in the quality of care – including improvement on human rights. As a regulator, we can influence both national policy and local health and care systems, for example:

- at a local level through our responsibility to assess the performance of integrated care systems and how local authorities provide adult social care
- at a national level by using our independent voice to publish our findings.

We will use our human rights approach to encourage commissioners, providers, staff and people who use health and social care to join together to ensure rights-respecting care.

Our goal is to develop a shared understanding of human rights concerns across the whole health and care system to support sustainable improvement to benefit everyone.

We have already worked with others to improve human rights and tackle inequalities across health and social care. For example, we are supporting work at a national level to ensure race equality across mental health care, through the Advancing Mental Health Equalities Strategy and Patient and Carers Race Equalities Framework (PCREF). We have also supported development work to improve the Accessible Information Standard for disabled people using health services.

OUR COMMITMENT:
We will continue to work with all partners to identify where people's human rights are not being met and find shared solutions. We will build a resource of evidence of what works and share it widely, supported by our new research capacity.

Capability, confidence and capacity

We provide learning that supports our own staff to understand the opportunities within our new framework to tackle inequality and protect human rights. This explains epistemic injustice and power, and how to understand the relationship between human rights and the quality of care. We will build on this for future learning and development for our staff in this area.

The Joint Committee on Human Rights has recommended that CQC check whether health and social care staff receive training on human rights. We expect providers to give specific training to their staff about human rights and the practical implications for delivering services and making decisions about care and treatment. We will consider evidence of this in our assessments. Training programmes must go beyond simply stating rights or obligations, and effectively demonstrate the relevance and use of human rights. We will explore the possibility of how we can share our learning more widely for those who work in health and social care, to help them understand rights-respecting care more clearly.

OUR COMMITMENT:
We will create a sustainable learning and culture change in CQC so that everyone, at every level of the organisation, has a shared understanding of and commitment to human rights with the knowledge, confidence and courage to take action in their work. We will also encourage those we regulate to provide more learning and development opportunities for staff, linked to their job roles, to support them to protect and promote human rights.

Making an impact and understanding it

We are developing ways to evaluate and understand whether our regulatory and improvement work has an impact on the human rights of people using health and care services, on providers, and on the health and social care system as a whole. We need to know if and where we are making a difference, where we need to improve and what barriers and gaps we need to address.

We have a programme of research projects. Some already aim to understand how we regulate more effectively, especially for people who are more likely to have a poorer experience of care.

OUR COMMITMENT:
We will review our research priorities so that we use opportunities to build human rights into research projects and commission research where it is a priority. In this way, we will develop our own evidence base as the regulator on which to strengthen understanding and support more effective working in this critical field.

We will collaborate with all key partners to deliver on these commitments because it's necessary and fundamental to protect people from harm and improve good care outcomes.

Our overall commitment: bringing humanity into action through rights-respecting care.

Human rights Articles relevant to health and social care

The Human Rights Act 1998 sets out human rights in a series of 'Articles'. Each Article deals with a different right. These are all taken from the European Convention on Human Rights and are commonly known as 'the Convention Rights'.

Human rights cannot be given away or taken away from you by anybody – although some rights (non-absolute) can be restricted in certain circumstances but only if the Government can show that the restriction is:

- lawful
- legitimate (there is a genuine aim or reason for doing it)
- proportionate (it's the least restrictive way to meet that aim).

For example, a person's right to liberty (Article 5, European Convention on Human Rights) can be restricted if they are detained under the Mental Health Act, making this a non-absolute right.

The following table shows which regulations in the Health and Social Care Act 2008 link to the European Convention on Human Rights Articles incorporated within the Human Rights Act. We can use these regulations to take action to uphold aspects of people's human rights.

We also show relevant examples and where this links to specific quality statements in the new assessment framework.

Article/protocol and right:

Article 2: Right to life

Regulation:

- 12 Safe care and treatment

Examples:

Lack of access to food and hydration.
Failure to provide appropriate safe care.
K G Dehydration Case
Who I am matters
LeDeR Report 2021

Key question and quality statement element:

Safe: We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Article/protocol and right:

Article 3: Freedom from torture and inhuman or degrading treatment

Regulations:

- 13 Safeguarding
- 10 Dignity and respect
- 17 Good governance

Examples:

Systemic abuse of people's human rights and failures to safeguard people from harm:
Winterbourne View Response
Mid Staffordshire Public Inquiry

Key question and quality statement element:

Safe: We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Article/protocol and right:

Article 4: Freedom from slavery and forced labour

Regulations:

- 17 Good Governance

- 13 Safeguarding

Examples:

The vulnerability of paid migrant live-in care workers in London to modern slavery

Key question and quality statement element:

Caring: We care about and promote the wellbeing of our staff, and we support and enable them to always deliver person-centred care.

Article/protocol and right:

Article 5: Right to liberty and security

Regulations:

- 11 need for consent
- 13 Safeguarding

Examples:

Restrictive practices where people are deprived of their liberty unlawfully, for example, being in seclusion for extensive periods without proper review.
Unlawful Restriction S N Ruling
Being overly restricted with use of medication or use of physical restraints.
Out of sight – who cares?

Key question and quality statement element:

Safe: We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.
Effective: We plan and deliver people’s care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards**.**
Caring: We promote people’s independence, so they know their rights and have choice and control over their own care, treatment and wellbeing.

Article/protocol and right:

Article 8: Respect for your private and family life, home and correspondence

Regulations:

- 9 Person-centred care
- 10 Dignity and respect

Example:

Restriction of visitors in care homes during the pandemic.
Protecting Human Rights in care settings

Key question and quality statement element:

Caring: We treat people as individuals and make sure their care, support and treatment meets their needs and preferences.

Example:

Prevention of developing relationships and expression of sexuality.
Sexual safety and empowerment guidance

Key question and quality statement element:

Safe: We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.

Regulation:

- 11 Need for consent

Example:

Use of blanket DNACPR decisions that are not made in discussion with the person or their nominated representatives.
Protect, Connect, Respect

Key question and quality statement element:

Effective: We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Article/protocol and right:

Article 9: Freedom of thought, belief and religion

Regulations:

- 9 Person-centred care

- 10 Dignity and respect

Examples:

Inpatient setting or care home obstructing, preventing or going against personal religious practices.
Culturally appropriate care

Key question and quality statement element:

Caring: We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristic.

Article/protocol and right:

Article 12: Right to marry and start a family

Regulations:

- 9 Person-centred care
- 10 Dignity and respect
- 11 Need for consent

Examples:

Supporting people to marry and have a family.
Right to marry case example BIHR

Key question and quality statement element:

Caring: We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Article/protocol and right:

Article 14: Protection from discrimination in respect of these rights and freedoms

Regulations:

- 13 Safeguarding
- 10 Dignity and respect

Examples:

Failing to provide services that meet the needs of people from protected groups so that care outcomes are equal despite equality characteristics.
Protection from discrimination BIHR example
Safety, equity and engagement in maternity services

Key question and quality statement element:

Responsive: We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Article/protocol and right:

Protocol 1, Article 1: Right to peaceful enjoyment of your property

Regulations:

- 9 Person-centred care
- 10 Dignity and respect

Examples:

Blanket bans on use of possessions, for example use of telephones.
Right to enjoy possessions example BIHR

Key question and quality statement element:

Caring: We treat people as individuals and make sure their care, support and treatment meets their needs and preferences.

Article/protocol and right:

Protocol 1, Article 2: Right to education

Regulation:

- 9 Person-centred care

Examples:

Not providing adequate educational support for children and young people in care settings.
Education in inpatient children and young people's mental health services

Key question and quality statement element:

Caring: We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Article/protocol and right:

Protocol 1, Article 3: Right to participate in free elections

Regulation:

9 Person-centred care

Examples:

Not providing opportunities for people to exercise their right to vote.
Care Home election example BIHR

Key question and quality statement element:

Caring: We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Article/protocol and right:

Any or all of these articles or protocols

Regulation:

- 17 Good governance

Examples:

Systemic failures where the leadership has failed to provide the governance for a rights-based culture and therefore where closed cultures can thrive.
Winterbourne View Response
Mid Staffordshire Public Inquiry

Key question and quality statement element:

Well-led: We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.

Relationship with UN Conventions on human rights

The UK is a signatory to several UN conventions on human rights. We aim to ensure that our approach to regulation is compatible with these conventions and furthers the rights of people in line with these conventions.

Our Children's Services team and our Health and Justice team undertake programmes of joint inspections with other bodies. The UN Convention on the Rights of the Child is integrated into these assessments. This includes:

- The right to a childhood (including protection from harm and the right to leisure, play, culture and education).

- The right to be healthy (including access to medical care).
- The right to be treated fairly (including changing laws and practices that are unfair on children as well as discrimination against children, for example on grounds of ethnicity, gender, religion or disability).
- The right to be heard (including considering children's views).

Services for children and young people are also ‘core services’ that we regulate in acute hospitals, community health or mental health services. When we regulate GP practices and GP out-of-hours services, we look at the services provided to mothers, children and young people.

The UN Convention on the Child Committee’s UK report (2016) identified persistent inequality in access to health services and health outcomes for specific groups of children and young people, for example those from Roma, Gypsy, Traveller, and other ethnic minority communities, migrant children and young people, children living with HIV/AIDS, in care and custody, in poverty and deprived areas and lesbian, gay, bisexual, trans and intersex young people.

How we reviewed our new approach

Our updated human rights approach is based on both existing evidence and findings from specific engagement activity to ensure it is current and effective.

As a starting point, we carried out a literature review of published reports and articles during 2022/23. This was to understand the current context and issues as a baseline for this work.

We carried out a 'strengths, weaknesses, opportunities, threats' analysis of our previous [Human rights approach to regulation] and used this to guide our initial thinking on this work.

We spoke with key partners (people who use services, their carers, advocacy organisations, providers of health and social care, experts on human rights and CQC leaders and inspectors). We asked them these questions:

- What are the key human rights issues/priorities in health and care?
- What do you think we should include in our human rights approach?
- How could we as a regulator improve what we do on human rights?

We held 3 sessions with external experts on human rights and human rights approaches in health and care.

We attended 3 CQC convened provider forums with key participants representing primary care, hospitals and adult social care. We also held an additional session with adult social care provider umbrella organisations.

We consulted with equality leads in NHS trusts at one of our regular meetings with them.

We interviewed 22 senior leaders in CQC. We attended 2 CQC team meetings. We have held 3 focus groups, 2 with inspection staff and one with our legal team.

We spoke with people from a range of backgrounds and experiences of care to gain their views. To include:

- people using mental health services: Our expert reference panel
- a focus group for people over the age of 70 commissioned by CQC through an external agency
- Choice advocacy Experts by experience: advocates of people living with a diagnosis of dementia

- Young champions group for CQC: participation group for advocating the voice of young people and children.

What we heard from people who use services, staff, providers and our staff in these interviews and meetings shaped the themes for action in this updated human rights approach.