Draft report on the CQC Consultation on Healthcare in Secure Settings

June 2015 v1.7

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1. Introduction

About Quality Health

Quality Health is an independent healthcare consultancy, commissioned by the Care Quality Commission to support this consultation process. The consultation documents and the various processes for collecting feedback were designed and organised by the Care Quality Commission. Quality Health has reviewed, analysed and reported on the data collected from all aspects of the process. The conclusions reached in this report are therefore the conclusions of Quality Health based solely on the responses provided to the consultation; they do not necessarily represent our own views or the views of the Care Quality Commission.

2. Summary

An overwhelming majority of respondents agreed with the proposal of a joint HMIP/CQC framework, with CQC's approaches to concerns, complaints and whistleblowers, to gathering experiences of care, to working with National and International Organisations and to gathering information on site. However over half of respondents did not agree a single rating for health and social care in secure settings. Around half of respondents agreed with the proposal to not rate in 2015/15 and with the joint HMIP/CQC inspections. .

Respondents gave very varied and detailed suggestions on the framework of KLOE, prompts and characteristics set out in appendix A, on gathering detainees' experiences of care and on how to improve the suggested approach. Respondent analysis and comments below:

3. Respondents

38 respondents replied to the consultation questions via the webform.

- 13 healthcare professionals.
- 2 CQC staff members.
- 5 providers of services.
- 3 recipients of healthcare.
- 3 members of the public.
- 3 stakeholders.
- 1 commissioner of services.
- 5 social care professionals
- 3 Voluntary and community sector representative.

22 respondents - 21 stakeholders and a CQC specialist advisor - submitted written responses to some or all of the consultation questions.

101 respondents participated via a public online community 'Health and Justice Consultation' which addressed 6 of the consultation questions.

In addition contributions came from the following:

1. Multiple (unspecified) contributors to the Clinks report on person-centred health care for offenders in the community. Evidence to support CQC inspections.
2. 14 participants in the Clinks & CQC workshop: Engaging with service users and their families in the criminal justice sector.
3. An unknown number of participants in the CQC IRC Stakeholder Event.
4. 13 participants in the Criminal Justice Consultation discussion– CQC/HWE and IHW

Where possible, contributions are included against the relevant consultations questions.

Where none or very little of the contribution can be included against the relevant consultation questions, the full documents are included as appendices.

3 late submissions are also included as appendices at the end of the report.

4. Responses to consultation questions

1. Do you agree with the proposal for a joint HMIP/CQC inspection framework?

47 respondents replied to this question:

- All respondents except 1 healthcare professional agreed with the proposal for a joint HMIP/ CQC framework.

In addition, 98% of the public online community agreed with the proposal.

2 stakeholders had some additional comments to make:

- This proposal of a joint approach has a holistic approach towards health and social care inspections within secure settings. This is a positive approach if carried out to its fullness and all parties involved are working together to collaborate expertise, knowledge and information.
  - Need to ensure reports from inspections are complete and published in a timely manner and accessible manner.
  - For this framework to be successful both HMIP and CQC inspectors should have time allocated for joint working and discussion.
  - It is also important to ensure both parties are in agreement as to their focuses and as much as processes are put in place to avoid duplication processes are also included to ensure all aspects are covered.
  - We suggest that recommendations from these inspections are monitored for implementation purposes and to support the sharing of good practise.
- Simultaneous not sequential. It is a very good idea to have joint inspections but only if they are simultaneous; otherwise the managers will have arranged for health facilities to 'look their best' before CQC arrive however much they are requested not to.
  - Specialist training for inspectors. Inspections need to be carried out by people who know what they are looking at. We are especially concerned about: Interpretation and translations and lack of mechanism for inspectors to pick which detainees to talk to in privacy.
  - Discrepancies between the Act and the NHSE contract for primary care: No automatic assessment by a medical doctor, no automatic review by that doctor and no process for release of people found inappropriate by that doctor.
  - Joint reporting: The reports must come out together. Without a full and simultaneous report, it is hard for local bodies to comment on content and veracity, and potentially easier for institutions to prevaricate.

he Criminal Justice Consultation discussion– CQC/HWE and IHW commented on this question:

- Joint inspections with HMIP are key for CQC as services tend to put up barriers to issues being addressed on the grounds that they were a security issue. CQC would have more power in the setting with HMIP.

2. Do you have any comments on the assessment framework of KLOE, prompts and characteristics set out in Appendix A?

30 respondents replied to this question.

7 healthcare professionals:

- KLOEs are a good way of ensuring consistency and a standard.
- A single CQC assessment tool should be used regardless of setting.
- I think the areas of care chosen to be assessed by KLOE are relevant, and will give an accurate assessment of the care being provided. In order to inspect health care provision within a secure setting, I believe it is vital that all inspectors have a real understanding of the challenges that provision of any service within a secure setting brings to both staff and detainees.
- There lacks clarity on the purpose of the process of fitting for court in terms of the physical ability to attend and the mental capacity of the patient being able to understand the purpose of attending court. This area needs to clear on what the assessment is for. There is no SOP for fitting patients for court. PSO (Prison Service Order) 3050 Continuity of Healthcare for Prisoners (Appendix 7) Chapter 6 “Significant Life Events Affecting Prisoners” Health broadly covers situations that may impact significantly on the health of a prisoner such as a court appearance and any potential suicide or self-harm issues. The PSO 1025 Communicating Information About Risks on Escort or Transfer - The Person Escort Record (PER), DETAILED GUIDANCE NOTES ON COMPLETING THE PER DOCUEMENT, page 21 raises communication and language difficulties but only in relation to a foreign prisoner or someone with literacy difficulties or hearing impairments. There is little guidance on capacity in general within offender health and this is a concern for patients who are elderly and confused or have dementia and also patients with mental health concerns. I think there needs to be clarity on this area for staff working within offender health. The Mental Capacity Act compliance will be assessed but I feel that staff are unclear about how they carry this out and there appears to be little in place in some prisons.

- I still think it may be difficult to compare prisons due to the different categories, even if everyone is asking the same questions. However the framework looks very comprehensive.
- It seems comprehensive and appropriate.
- Well-structured and coterminous with other types of inspections

10 stakeholders:

- Have you considered providing a clear definition on the key points that a premises has to reach to be designated "safe"? KLOEs do not appear to indicate this.
- There are many differences between IRCs and the other places of detention covered by this consultation. We suggest it may not be readily possible to find a common format for regulating them all, and a separate document or at least a dedicated annex may be needed for IRCs. Whilst there are clear advantages in using common standards across the secure estate, so enabling comparisons and confirmation that 'NHS equivalence' is being delivered, the special features of immigration detention will also have to be recognised. It is preferable for differences to be recognised in the standards themselves. At least, the listing of characteristics of good practice could be rewritten to reflect more the peculiarities and realities of IRC-practice.
- Any robust assessment of care in secure settings should be focused on prevention.
  - Given the make-up of the prison population prevention will be a key to improve people's future wellbeing.
  - Recommendation 1: mental (and physical) health promotion and prevention must be included as a prompt in KLOE E.
  - To ensure that consent regarding treatment has been obtained, the availability and access to an Independent Mental Capacity Advocate (IMCA) must be evaluated.
  - Recommendation 2: A question regarding whether health care teams understand the eligibility criteria and the existence of mechanisms to access an Independent Mental Capacity Advocate should be included as a prompt in KLOE E6.
- Overall the assessment framework looks comprehensive, though inevitably it is very broad in approach. We have some specific comments that we would like to be considered within the context of this framework in relation to HIV:
  - Under "S3. Reliable systems, processes and practices in place to keep people safe and safeguarded from abuse", specifically "11. Are people's individual care records written and managed in a way that keeps people safe?". We would highlight that such processes and practices must include patient confidentiality. HIV remains a highly stigmatised condition and in these settings it is vital that healthcare staff do not disclose a patient's status to other patients or general staff.

- Under “S3.6 Are there reliable systems in place to prevent and protect people from healthcare associated infections and communicable diseases?”, it will be important for inspectors to ensure that healthcare are providing people with condoms on requests (they are required to do so but we are aware that this is not always happening) and disinfecting tablets (to minimise the risk of BBV infection when sharing injecting equipment, again there is a requirement for these to be provided in prisons but we have been contacted by prisoners who have been refused these). In addition, all prisons are now supposed to be offering opt-out BBV testing for prisoners – knowing your status is the best way to prevent passing the virus on and so it will be important for inspectors to ask prison healthcare if they are offering opt-out BBV testing to all prisoners.
- Under “S3.10 Do arrangements for managing medicines keep people safe?” NAT is often contacted by people in prison who have not been given regular access to their HIV treatment. Proper adherence to HIV medication is vital to its success and stopping a prisoner having access to medication at the right time of day can have serious health consequences. However, prisoners have written to us to say that the pharmacy cannot give them their medication at the right time of day (for example some treatment needs to be taken with food) because they are only open at certain times. Inspectors should ask about what arrangements are in place for prisoners who need to access pharmacy at specific times of day.
- Under “E1 Are detainees’ needs assessed and care and treatment delivered in line with legislation, standards and evidence-based guidance?” we would particularly draw attention to the BHIVA guidelines (NICE accredited) around HIV. Recent evidence from the initial roll out of BBV opt-out testing suggested that prisoners with a positive HIV result were being seen by a specialist after four weeks – this is two weeks later than the rest of the population where people are referred within two weeks (in line with the BHIVA guidelines). The BHIVA standards of care also highlight the importance of psychological support for people living with HIV, and this aspect of care should not be overlooked for those held in detention. (This is also relevant to the points raised under E1.2 where there is specific reference to secondary care and mental health interventions.) We also welcome the focus on timely access to care in R3.
- Under E1.2 the pharmacy service is specifically referred to and we would reiterate the importance of having a service in operation that ensures people living with HIV can access their treatment at the right time of day given the importance of adherence.
- We welcome the recognition of the importance of continuity of care under E1.2 and R1.3 and it is important that when people living with HIV first enter a detention setting or are moved from one place of detention to another, they have unbroken access to specialist care services. Treatment interruptions can have serious health consequences for people living with

HIV including the development of serious illness and drug resistance, and must be avoided. This is particularly important for pregnant detainees due to the need to prevent mother-to-child transmission. NAT recommends ending the detention of all pregnant women, for this reason.

- We welcome "E2.3 How do outcomes for detainees compare to outcomes in the community?" and would highlight that Public Health England have detailed data on outcomes for people living with HIV in the community which could be used for comparison (for example the percentage of people referred to care within two weeks, viral load suppression and percentage of people retained in care). See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/401662/2014_PHE_HIV_annual_report_draft_Final_07-01-2015.pdf.
- Under "E3. Do healthcare staff have the skills, knowledge and experience to deliver effective care and treatment?" we would highlight the fact that people living with HIV often face stigma and discrimination in a healthcare setting (one study found that a third of people had experienced HIV related discrimination, half of these within a healthcare setting). With the roll out of opt-out BBV testing in prisons, and the higher prevalence of HIV in detention settings, we would underline the need for all staff to have a basic understanding of HIV and the reality of living with the condition given the huge advances in treatment.
- We welcome the focus under E4.3 and E5.2 on planning for people's transfer, removal or release. This is particularly important for people living with HIV given the importance of adherence to treatment. It is vital that before they are moved, arrangements are in place to transfer their care. We welcome the focus on assistance to access social care services in the community. When considering removal and release, CQC should be aware that the majority of people living with HIV who go into detention remain in the country after leaving that detention setting. This means they have ongoing clinical care needs in the community, but these are often not planned for by IRC healthcare staff.
- We welcome the focus under C1 (and in R2) on dignity, respect and compassion. As highlighted above people living with HIV often experience stigma and discrimination. In addition, black African communities and men who have sex with men are disproportionately affected by HIV and so may face multiple discrimination related to their race and/or sexuality and HIV status. For this reason the focus on dignity and confidentiality is particularly important. Many people do not realise that HIV is a disability from the point of diagnosis under the Equality Act 2010 so therefore people living with HIV have protection from discrimination. We would also stress when considering R4" How are people's concerns and complaints listened and responded to", that it is very difficult for some people to complain and so the CQC should consider how places of detention attempt

to take this into account. We have had prisoners write to us to raise their concerns because they feel they cannot do this effectively themselves.

- Under C3 "Do detainees receive the support they need to cope emotionally with their care, treatment or condition?" we would highlight the roll out of opt-out testing for BBVs in prisons and suggest that inspectors ask what support prisoners are given if they receive a positive test result. We would also underline the link between HIV and mental health (people living with HIV are twice as likely to experience depression) and suggest that institutions are asked about what support they offer to people living with HIV in their care. There also needs to be particular attention to the emotional support needs of people in IRCs, and in particular the impact of poor mental health on ability to manage HIV treatment demands.
- Under R1 we welcome the recognition of the importance of a comprehensive health promotion strategy and would highlight the need to ensure that this includes the provision of condoms, disinfecting tablets and BBV testing (HJIPs – Health and Justice Indicators of Performance - measure prisons performance in these areas). We note that the focus under R1.3 is on ensuring that young people have access to confidential advice and education about safer sexual practices and contraception, and whilst we support this, we would stress the need for this service in all places of detention as part of providing an equivalent quality of sexual health care as could be accessed in the community. The recent Commission on Sex in Prison found that consensual and coercive sex is occurring in both men's and women's prisons and that the prison population is a high-risk one in terms of sexually transmitted infections and risk-taking behaviours.

- E4/3 and E5 need to include continuity of healthcare when detainees transferred, not just on release - we are aware of situations where agreed/planned treatment has not happened due to transfer to another prison, and then detainee told planned/agreed treatment not necessary. C2 and C3/1 not sure how staff will be able to support people close to detainees with coping emotionally or involving them in care as detainees may be placed long way from families. C3/3 May be conflict between managing own health and care and security concerns around prescription drug misuse. It is not that clear how the balancing of genuine security concerns v appropriate treatment of detainees will happen through this framework. R1 and R3 - 'prompt' access is an ongoing concern and timescales laid out may not be achievable. R4 - include information about advocacy and how to access it. Important to remember often very low levels of literacy among detainees and so information needs to be clear. W1 and W3 Ability of any provider to deliver leadership and culture will depend on leadership and culture of prison etc. This is one reason why a joint rating is preferable as it would better enable such issues to be taken into account.

- SAFE: Standards at S3 should make clear that the use of force is limited to physical intervention required to prevent harm to the individual or others in addition to the requirements that it be used as a last resort and for no longer than necessary. The framework standards should encompass specifically the use of physical restraints in a wider range of circumstances. For example, immigration detainees have been escorted to secondary health care settings in restraints where security is not a concern, stigmatising them and failing to respect their dignity.
- EFFECTIVE: Standards should be included to monitor whether healthcare staff have been proactive in identifying torture, trafficking or health concerns relevant to the question of whether someone is unsuitable for detention and reporting these, with the informed consent of the detainees, promptly and accurately to casework staff. The quality and outcome of those reports should be monitored.
- A further standard should be developed assessing whether active consideration has been given, and recommendations made, as to whether treatment would more appropriately be provided in a community setting and whether concerns have been raised with detention centre staff as appropriate. This section should also specify that, where treatment is continued in detention, this is provided to at least an equivalent standard as that provided in the community in all areas of healthcare.
- Specific standards should be included addressing the need for recruitment, training, and ongoing professional development of staff and their demonstration skills pertaining to, and knowledge and experience of, the common health problems of immigration detainees, including the health needs of refugees and asylum seekers, survivors of torture and ill-treatment, and those with mental health problems.
- Standards related to care planning, continuity of care and management of care records are particularly important given the frequency of moves of immigration detainees within the detention estate and the need to make arrangements for medical care on release or on removal. These concerns must be monitored and addressed. It would be useful for the framework to include examination of action taken by health care professionals to raise concerns with detention centre staff about inappropriate or frequent moves affecting an individual's continuity of care. ILPA members also have experience of seriously ill detainees being released from detention without accommodation being put in place, without appropriate care plans or referrals to community mental health services or without medication or prompt access to medication being organised, giving rise to serious risks to the person. Particular attention should be given to this issue in the application of the standards in this area, including through following the care pathways of individuals on release from detention.
- CARING: Immigration detainees report being treated with disbelief or with a lack of compassion by health care staff in detention so these standards

are very relevant. A specific standard should be included in this section assessing the use of interpreting services for health care appointments.

- RESPONSIVE: Standards in this section must take account of the need actively to consider release and treatment in the community for those detained under administrative powers in immigration detention, contrasting with those confined to detention having been sentenced to imprisonment. In August 2010, Home Office policy changed. Prior to that date the policy was that those with physical and mental illnesses and/or disability would be "suitable" for detention only in the most exceptional circumstances. After that date the policy was changed to refer to those with such conditions "which cannot be satisfactorily managed within detention." Therefore management of these conditions must be kept under close review. Immigration detainees who are physically or mentally ill should not be managed in the detained setting at all.
- WELL-LED: The framework should also take account of the need for health professionals working to be aware of, to manage appropriately, and to be supported to manage, tensions which may arise from their dual obligations within the detained setting, so that medical professionals may advocate appropriately, in line with their primary duty to the patient, where threats are posed to an individual's health within detention. The Istanbul Protocol provides a useful reference point for principles regarding dual obligations on medical personnel and the management of these.

- The guidance is comprehensive in the range of enquiry, but the detail is OK only in as far as it goes. If we are to see consistent and robust inspections I would prefer to see another column of quality indicators. For example:
  - S2.3 A check for this would be to review PPO recommendations following a DIC, the action plans and seek evidence that the actions have been taken. The establishment should have all this documented, so the Inspector should seek documented assurance, not undertaking an investigation.
  - S4.5 When was the last infection control audit and did the establishment pass. Assurance is a copy of the audit documentation.
  - E2.1 How would an inspector be assured that patient outcome data 'is used to improve care'?
  - E3.3 Your guidance is 'Healthcare staff have access to an on-going and regularly updated programme of professional development'. I would prefer to see something along the lines of: 'In the last year at least half of healthcare staff have undertaken CPD training from a regularly updated programme of professional development'. Also 'training records show that 80% of staff mandatory training is up to date'.
  - C1.7 'Do staff respect confidentiality at all times?' Staff could demonstrate behaviours that show 'People's privacy and confidentiality is respected at all times.' Yet the provider or the prison could have installed computers with screens clearly visible to all, in blatant breach of the DPA.

- The KLOEs are not all relevant to short-term holding centres which are part of the IRC estate. For example E1, the only call on a dentist for a short-term holding centre would be in an emergency. I would not expect there to be a negotiated provision in place, access would have to be via acute settings.
- Positive to see Intercollegiate Healthcare Standards (CYPSS) to address the specific needs of children held in YOIs

- We see their role largely in informing the KLOEs by escalating issues highlighted by prisoners through our Wellbeing reps and trends identified through the wider project.
- These questions are the same as those for services in the community. Whilst we agree with the framework, we would welcome specific lines of enquiry for secure settings, as we believe they are distinct environments with distinct challenges. We would also like to see further lines of enquiry that relate to compliance with the Equality Act. We also note that it appears to be heavily weighted towards health rather than social care. There are five key lines of enquiry. We would ask that additional prompts be included in the following areas:

  Safe:
  - How do health and social care staff contribute to the safety of the establishment?
  - How is information sharing understood and acted on?
  - How are safeguarding processes coordinated with the prison?
  - Are health screening reviews of segregation adequate?
  - What arrangements are there for staff to raise safeguarding issues including those concerning the actions of prison staff (bullying, control and restraint, overuse of segregation)?
  - What contact, if any, do prison or health care staff have with the local safeguarding board?

  Effective
  - Are resources used effectively, for example are the same or similar assessments of prisoners carried out by multiple staff?
  - What preventative measures and health care promotion work is being carried out?
  - Are information sharing processes to access prisoners' previous health and social care records effective?
  - Do health and social care staff have adequate knowledge of local agencies to refer people to on release?
  - How long are assessments for mental health hospitals and mental health transfers taking and what are the relationships between health care and commissioners like?

Caring

- Are the specifics of prison environment and the potential trauma of isolation and separation from community and family understood by the health and social care teams?
- What emotional support is available, can prisoners access counselling and therapy?
- What involvement do families and community have with health and social care teams?

Responsive

- Is the needs analysis of the prison population accurate, realistic, thorough and regular?
- Is access to hospital appointments outside limited and if so is this appropriate
- Do all prisoners have access to items to prevent STIs (the consultation mentions young people only)?
- Are people able to make complaints in different formats?
- Complaints about social care are not mentioned in the consultation.

Well led

- How is the joint accountability between prison, health and social care providers evidenced?
- Can examples of innovation and good practice be included?
- The Care Act sets out a duty to cooperate between local authorities and prisons, how will this be monitored?

- It seems most (KLOEs) are weighted towards heath and less so for social care.
    - We suggest an additional KLOE focused on how prison staff and health/social care staff are working together to support prisoners in a timely manner before their needs escalate into crisis.
    - KLOE E3. If an additional clause to assess if staff have access to resources to sign post to appropriate support services and contacts to gain further information if needs be.
    - The collection of sign posting information for Deaf prisoners should be a proactive decision by prison staff and services rather than reactive.
    - We question how health and social care services are promoted and advertised within the prison and if such information is made accessible to Deaf Prisoners.
    - We suggest a wider “characteristic‟ relating to staff demonstrating appropriate cultural competence.
    - KLOE R4. Importance of ensuring accessible complaints processes for Deaf prisoners. Also no mention of ensuring that prisoners‟ families‟ concerns and complaints are listened to and we would suggest that this should also be included.
- Danger with too many prompts and questions that the real situation will remain unrevealed. This is especially true in IRCs, with a transient and fearful

population, in a situation of demonstrable powerlessness, many of whom have a poor grasp of English.

- It should be an essential part of the training that inspectors oflisten to recent ex-detainees about their experiences before using the framework on a visit. Asking about instances of detainees with pre-existing conditions (identified by the detainee) whose medication did not accompany them – and how this was dealt with; asking about hospital visits and if there was ever a time when the lack of guards had resulted in missed or foreshortened appointments outside; asking detainees in private and in confidence if they had asked to see the doctor how long they had waited – these and many other questions would be asked by properly trained and experienced inspectors.

4 social care professionals

- Just have some questions around some homeless services/hostels/day services etc. Still unaddressed issues around the % of people who have a learning disability who are in the penal system who don't have all their needs met. Wondering how some pathway services may 'fit'?
- I feel that it is a comprehensive document.
- It has become hard to identify the social care elements of the KLOE prompts and the health elements outweigh.
- S3.4 Characteristics to include Training in Safeguarding AdultsE6. 1-7 Characteristics - across all elements there is a need to ensure that staff have received Mental Capacity Act Training.

3 voluntary and community services representatives

- It is very important to note that inspectors understand the differences between detention under immigration powers and imprisonment under the criminal justice system, and the impact of this difference upon the mental health of people in IRCs (e.g. as a consequence of the indefinite nature of their detention, and the likelihood of traumatic experience prior to detention).
  - There are important factors relating to immigration detainees of which CQC needs to be aware in its approach to the inspection and regulation of IRCs. These factors should be reflected in the assessment framework. The healthcare provided for people with mental health problems in immigration detention is woefully inadequate. This is reflected by the fact that in the last four years, there have been six cases in which judges have found that conditions suffered by mentally ill immigration detainees amounted to inhuman or degrading treatment contrary to Article 3 of the European Convention on Human Rights. Immigration detainees are very vulnerable. They tend to be particularly isolated from the outside world, with research showing that approximately 80 per cent of asylum seekers do not receive any personal contact from family and friends, and over half do not have

family or friends in their host country. The experience of detention itself exacerbates mental health problems. Moreover, these negative effects are compounded by the long-term or indefinite nature of immigration detention in the United Kingdom. One study has shown that a higher proportion of those who had been detained in excess of six months met the diagnostic criteria for PTSD, depression and moderate to severe mental health related disability that those that had been detained for shorter periods. The Royal College of Psychiatrists has produced a position statement which sets out its view that people with mental health disorders should only be subjected to immigration detention in very exceptional circumstances (http://bit.ly/1F5QLAp). In our view, a person's mental health will not be ""satisfactorily managed"" (ref. Chapter 55.10 of the Home Office's Enforcement Instructions and Guideline) in detention the experience of detention causes or exacerbates mental health problems the person is susceptible to acute or crisis episodes of mental illness which a detention centre does not have the facilities or staff to deal with appropriately the person's mental health could be improved if treated in the community, or the person's mental health could be improved by a particular treatment, such as counselling, but that treatment is not available in detention, or it is not available without delay. In our view, there needs to be adequate healthcare provision in immigration removal centres which mirrors that which is available in the community and is capable of meeting individuals' needs and promoting recovery. Mental health care in the community involves a range of treatments that are not limited to, and may not include, medication. The same range and quality of treatments should be available to immigration detainees, including the provision of talking therapies such as counselling, cognitive behavioural therapy, access to therapeutic groups and activities, drop-in sessions, specialist services and alternative therapies, all delivered by competent practitioners and consistent with NICE guidance. In accordance with the Mental Health Act 1983 Code of Practice and the NICE Clinical Guidance, detainees should be provided with comprehensive information about the available treatment options in a language and format that they understand. Detainees' access to treatments should be timely, in accordance with the time scales adhered to in community mental health care. A person-centred approach can only be facilitated in immigration removal centres if independent interpreters are available during mental health assessments and consultations and if all information relating to mental health care is provided in a language and format that detainees can access and understand. In the past, major concern has been expressed about the lack of consistent use of professional interpreters in immigration removal centres. If mental health care in detention is to be adequate, these concerns must be addressed. We consider that there should be a set of standards that apply to the provision of mental health care in immigration detention. These standards should be independently monitored with

enforceable recommendations and penalties for non-implementation. In our view the provision of mental health care in immigration detention should be governed by a similar set of guiding principles as those contained in the Mental Health Act Code of Practice. It is also our view that people with mental health problems in immigration detention should have access to a trained mental health advocate to assist them in understanding their rights and advocating for appropriate, effective and timely treatment. Specific comments on assessment framework S3/4.This should include consideration of whether staff know how to respond to a suicide risk. The is a prevalent culture of disbelief in these settings when people disclose mental health problems (e.g. recent inquest verdict on the death of Rubel Ahmed http://bit.ly/1F1xpLV). This is particularly problematic given the high prevalence of mental health problems in IRCs. Mental health awareness training should therefore be compulsory for all staff. S3/7. Inspectors should make sure there are no potential ligature points in the IRCS4/4. As S3/4 above.E1/2. Inspectors need to be aware of the impact of detention on a person's mental health problems. In our view, a person's mental health will not be satisfactorily managed in and IRC if the experience of detention causes or exacerbates mental health problems.E3/1. In-depth training should be provided to both healthcare staff and Home Office staff in IRCs. Such training should incorporate: the findings of the courts in cases which have found breaches of Articles 3 of the European Declaration on Human Rights, mental health awareness and mental health first aid training, training on the provision of culturally appropriate mental health care, training on the Mental Health Act 1983 and the Mental Capacity Act 2005, and training on the use of de-escalation techniques.C2/1.

  - It is important that detainees are provided with comprehensive information about the available treatment options in a language and format they understand. There have been major concerns previously about the lack of consistent use of professional interpreters in IRCs."

- Important to consider the issue of effective communication, the use of translators for those whose first language is not English. learning from external safety events should include consideration of how this is embedded into training programmes. in some instances the importance of treatment being available in an appropriate language such as psychological treatments within IRCs
- We welcome the opportunity to comment on Her Majesty's Inspectorate of Prisons (HMIP) and Care Quality Commission's (CQC) joint inspection approach for health and social care in prisons and Young Offenders' Institutions (YOI), and health care in Immigration Removal Centres. As the largest U.K. charity working for people with hearing loss, we help people confronting deafness tinnitus and hearing loss to live the life they choose. We enable them to take control on their lives and remove barriers in their way by undertaking research, campaigning and providing services. We would like to

offer our expertise and support in the development of a joint HMIP/CQC inspection framework. Throughout this response we use the term ˜people with hearing loss" to refer to people with all levels of hearing loss, including people who are profoundly deaf. We are happy for the details of this response to made public.

- E1.1 Are detainees' needs assessed and care treatment delivered in line with legislations, standards and evidence based guidance? Detainees have access to good quality health, and neither physical mental nor physical health should be adversely affected by living in a secure setting. Detainees are cared for by a health service that accurately address and meets their needs while in secure settings and which promotes continuity of health and social care on release. Detainees' immediate health and social needs are recognised on reception and responded to promptly and effectively.
- HMIP/CQC joint inspection framework should consider the needs of detainees with hearing loss. Hearing loss is major public health issue that affects thousands of detainees. Combining available prevalence data (Davis 1995) and the Ministry of Justice's Quarterly Offender Management Statistics (MOJ 2015) for October to December 2014, we estimate at least 6,183 (7%) detainees have hearing loss, out of a prison population of 85,664. The number of detainees with hearing loss is set to grow due to the ageing population. The prevalence of hearing loss increases with age. Over 71.1% of over 70 year olds have some form of hearing loss, and of these, over 40% have moderate or severe hearing loss (Action on Hearing Loss 2011a). Without treatment, detainees with hearing loss may find it difficult to communicate with others and are at greater risk of developing other health problems. Being unable to hear properly can lead to a loss of confidence in social situations, reduced social activities and feelings of social isolation (Gopinath 2012; Monzani et. al 2008; Arlinger 2003). People with hearing loss are more likely to develop paranoia, anxiety and depression (Cooper 1976). There is also strong evidence of link between hearing loss and dementia.
- Research has shown that people with mild hearing loss are almost twice as likely to develop dementia compared to people with normal hearing. The risk increases three fold for people with moderate hearing loss and fivefold for people with severe hearing loss (Lin 2011).There is evidence to suggest that the health and social care needs of detainees are not being met.
- The House of Commons Justice Select Committee's 2013 report on the provision of health and social care for older people in prison (House of Commons 2013) stated that screening programmes upon arrival in prison were inadequate and failing to assess health needs. GPs weren't contacted to obtain medical records and prisons were often reluctant to refer detainees for diagnosis and treatment. Furthermore, the Select Committee report also identified wide variations in social care provision. Social care needs assessments were sporadic and ineffective due to confusion over

responsibilities between Prisons and Local Authorities. In some cases, social care was provided informally by prison staff and even by prisoners themselves. These problems are even worse for people with hearing loss due to low rates of diagnosis and the unacknowledged relationship between hearing loss and other long terms conditions. There are six million people in the U.K. who could benefit from hearing aids, but only two million have them. This means that the needs of at least four million people with hearing loss are going unmet (Action on Hearing Loss 2011b).

- Evidence suggests that there is a ten year delay in people seeking help for their hearing loss. When people do finally contact their GP, referral rates for hearing assessments are low. Research has shown that GPs fail to refer up to 45% of people reporting hearing loss for a hearing test or hearing aids. If a patient receives hearing aids at an early stage of their hearing loss, they are more likely to derive benefit from them (Davis et. al 2007), yet for many, this isn't happening. Also, hearing loss and other conditions dementia, stroke and diabetes are often managed separately and this can lead to an overall deterioration in overall health and wellbeing. For example, there is a risk that hearing loss is misdiagnosed as dementia or that dementia is underdiagnosed due to hearing loss (Boxter et.al 2010).
- In our 2012 report "Joining Up" we estimated that better management of hearing loss in people with dementia could result in savings of up to 28 million per year by reducing the number of high cost care interventions (Action on Hearing Loss 2013). To ensure needs of people with hearing loss are met, characteristics should be added for Key Line of Enquiry (E1) to explicitly state that prisons, YOIs and IRCs should offer a hearing check for all detainees upon arrival and throughout their sentence, and that hearing aids should be provided and maintained those who need them. People with hearing loss should also have access to hearing aid aftercare and rehabilitation services, such as lip reading classes.
- The characteristics should also consider whether local authorities are fulfilling their statutory duties under the Care Act 2014, which for the first time, requires local authorities to carry out robust assessments, provide information in accessible formats and meet the social care needs of adult detainees with hearing loss. Detainees individual health care needs are addressed through a range of care services. We suggest broadening the scope of this characteristic to include other sources of support available for detainees with hearing loss. Under the Equality Act 2010, health and social care providers are required to make reasonable adjustments if detainees are substantially disadvantaged by their hearing loss.
- There is evidence to suggest the provision of communication support and equipment in prisons is poor and needs to be improved. People in the deaf community use British Sign Language (BSL) as their preferred language and have different degrees of ability in English. This can create significant barriers when they have to communicate with others who are not BSL

users. A report by the Howard League for Penal Reform (2012) found that profoundly deaf detainees were often unable to access basic prison services. Upon arrival, some profoundly deaf detainees couldn't understand what was being said during their induction process because no BSL interpreter was provided.

- Other expressed concerns for their safety in the event of a fire due to the lack of visual fire alarms. The absence of textphone and minicom equipment meant profoundly deaf detainees were reliant on letters to contact friends and family (sometimes restricted to one letter per week). Isolating detainees with hearing loss from their surroundings and from their friends and family can have a damaging psychological impact; increasing feelings of loneliness and depression. The above characteristic should be reworded to include a range of care services AND other forms of support, beyond their immediate health needs. A holistic wording would take account of the impact of the prison environment itself on the health and wellbeing detainees with hearing loss.
- E3. Do staff have the skills, knowledge and experience to deliver effective care and treatment? Staff are qualified and have the skills they need to carry out their roles effectively and in line with best practice. The HMIP/CQC joint inspection framework should consider whether care staff are well trained to meet the needs of detainees of hearing loss. In our report on hearing loss in care home ˜A World of Silence" (Echalier 2012) we found that NVQ qualifications in social care focused exclusively on communication needs and neglected the viewpoints of people with hearing loss. Such shortcomings in training prevent care staff from delivering effective care. The care staff who were interviewed for ˜A World of Silence" lacked knowledge and awareness of hearing loss. Care staff were reluctant to advise people that they might be experiencing hearing loss through fear of antagonising them. They also admitted hearing loss was sometimes overlooked compared to other long term conditions such sight loss and chronic pain. Many lacked suitable training to carry out basic hearing aid maintenance and were unable to operate hearing loop systems, TV listeners and amplified telephones.
- For health and social care delivered in secure settings, characteristics should be added to Key Line of Enquiry 3 which considers whether care staff are aware of the communication benefits of hearing aids and the positive impact they have. It should also consider whether care staff are able to carry out basic hearing aid maintenance and are aware of other assistive technologies and the benefits they bring to people with hearing loss.
- C2. Are detainees and those close to them involved as partners in their care? Detainees understand and are fully involved in health assessments. Staff spend time talking to detainees, or close to them. They are communicated with and receive information in a way they can understand.

Detainees understand their care, treatment and condition. Staff enable detainees to access additional support to help them understand and be involved in their care and treatment. We welcome these characteristics because failure to provide communication support can result in worse outcomes when detainees receive information about their treatment in the wrong format or if they cannot communicate properly with health and social care professionals.

- We expect the HMIP/CQC joint inspection framework will consider compliance with NHS England's soon to be published Accessible Information Standard (NHS England 2015) as part of the inspection process. The standard requires health and social care providers to ensure users of health and social care understand the information they are given are able and able to participate fully in decisions about their care. In the context of health and social care delivered in prisons and YOIs, and health care in IRCs; the communication needs of detainees should be identified and recorded as part of their initial health assessment or retrieved from elsewhere e.g. their GP. This information should be shared with health and social care providers and reasonable adjustments should be made. For example for profoundly deaf detainees who use BSL, a suitably qualified BSL interpreter should be offered and more time should be allocated in the appointment/care visit to accommodate the time taken to translate information.

<u>2 providers of services:</u>

- The assessment framework is wholly appropriate in prison settings although inspectors may need to recognise that prison operators may vary in their ability to uphold and manage concerns around health & safety, infection control etc.
- KLOE's appear appropriate, patient focused and easily understandable.

<u>1 member of the public:</u>

- It appears so detailed that it is doubtful that the complete framework will be adhered to/completed in each setting.

<u>1 CQC staff member:</u>

- These are proving to work well and in a comprehensive way .It will prove important that the HMIP and CQC do not cross boundaries on points.

<u>1 commissioner of services:</u>

- Yes, it doesn't seem to have any child focused questions. many questions are generic but I would strongly urge you to review this with ch8ildrens commissioners, providers and YPs.

1 recipient of services

- Excellent

Do you consider that this will help to ensure a robust assessment of care in secure settings?

41 respondents replied to this question:

36 replied yes.

3 replied no – a healthcare professional, a stakeholder and a social care professional, with the stakeholder providing more detailed feedback as follows:

- I am concerned that including a single statement in the KLOE about medicines management is misleading and will not provide robust assurance. Medicines optimisation (which is what the prison and healthcare teams should be trying to achieve) is delivered across all five questions, using many of the criteria in the framework and not just within safety. In order to rectify this, we suggest that the inspectors consider medicines optimisation by taking the framework in its entirety and adding a column to these for the characteristics that demonstrate medicines optimisation.

2 stakeholders didn't answer yes or no but replied:

- Difficult to predict at this stage until you have intelligence and feedback from your initial assessments but optimistic that it will.
- It is a detailed framework asking many important questions. However, the most pertinent to health in IRCs are not directly asked: in the period inspected, did all detainees have their health history available to the health-provider? Was it acted upon? (medication, hospital visits, ongoing care for existing conditions)

3. We do not intend to rate health and justice services in 2015/16. Do you agree with this approach?

44 respondents replied to this question:

23 respondents agree with this approach:

- 7 healthcare professionals.
- 3 recipients of health or social care.
- 3 providers of services.
- 3 social care professionals.

- 4 stakeholders.
- 1 CQC staff member.
- 1 member of the public.
- 1 voluntary and community sector representative.

1 Stakeholder, who agreed, added provisos:

- We would agree with this approach as long as it does not compromise CQC's willingness and ability to take action where serious shortcomings are found in either health or social care delivery. We also are not convinced that a rating system would have significant value in this area of activity given that prisoners will not have the option to select either their health or social care provider in most cases

20 respondents disagree with this approach:

- 8 stakeholders
- 5 healthcare professionals.
- 2 members of the public.
- 1 provider of services.
- 1 commissioner of services.
- 1 CQC staff member.
- 1 social care professional.
- 1 voluntary and community sector representative.

5 of these, all stakeholders, added their reasons:

- There is an imperative about rating health and justice services in 2015/16 both to inform commissioners and service providers about the quality of services and to provide an accurate baseline against which future health service improvements or disimprovements can be judged. Further, there may be a perceived inequity in the approach to these settings compared to others and a perception of a two speed approach to quality improvement. Finally, given some of the challenges around delivering care in settings challenged by resources, including availability of clinical staff, there is a value in rating services now to drive forward the quality improvement required to meet need.
- We can understand that it may be difficult to rate services in 2015/16. However, we do feel that services should in the future be given a rating. This is because if people were to access a service inspected by the CQC in the community then they would be able to see its rating. If we are to ensure that people in detention have a service equivalent to those in the community, it should also be rated. A poor rating will also help to ensure that steps are taken quickly to improve the service.
- Medical Justice feels that a rating can be a good way for people to get a quick overview of the quality of services provided. However, any rating given must be location specific and not subsumed by the overall national rating of the

provider so that a failing location can be given a gloss of respectability by the generally acceptable performance of a provider across all their locations. We also believe it is important that it is clearly explained what exactly the rating is measuring and what the different ratings mean.

- Ratings support and encourage services and teams to achieve and take ownership for activities and responsibilities. It would be understandable if provisional ratings were given as a guide initially to services while the initial implementation of the new system is introduced however no rating is likelynot to be supportive.
- Since rating exists elsewhere in CQC it is necessary to have them here. Otherwise providers will not change their practice – they will consider they are being 'let off' improvement – and that will be the message to the general public.

1 respondent, a stakeholder, neither agreed nor disagreed but added a more detailed response:

- We acknowledge that by not rating services in 2015/16 will allow the inspection process to be tested and amended in response to challenges faced in the unique environment. Ratings given to other services within the community allow people to make a quick yet informed decision about what service, for example a hospital or GP, to access. This is not as applicable in the prison environment, as detainees do not have the choice of what services they access, therefore a more in depth and holistic report to the service provider, commissioner and other relevant parties would be more appropriate.

57% of public online community respondents agreed with the proposal to not rate health and justice services in 2015/16. 43% did not.

4. Should we consider a single rating for health and social care within a secure setting?

42 respondents replied to this question:

17 respondents said yes:

- 7 healthcare professionals.
- 2 social care professionals.
- 2 stakeholders.
- 2 voluntary on community sector representative.
- 1 CQC staff member.
- 1 recipient of health or social care.

- 1 provider of services.
- 1 member of the public.

23 respondents said no:

- 6 stakeholders.
- 5 healthcare professionals.
- 3 social care providers.
- 2 member of the public.
- 2 providers of services.
- 2 recipients of health or social care.
- 1 CQC staff member.
- 1 voluntary and community sector representative.

2 stakeholders neither agreed nor disagreed but commented:

- The approach in prisons and other justice settings should be consistent with the approach in the wider community. Health and social care services are however at different stages of development in the prison estate- healthcare has been an NHS responsibility since 2006 whereas Local Government assumed responsibility for social care in prisons only since April. So perhaps an interim period of dual ratings for health and social care individually will allow identification of where action is required and by whom more effectively than a composite single rating for both health and social care.
- It was suggested that an alternative approach may be to provide both individual ratings for each provider as well as an overall score for the establishment.

1 stakeholder made the following comment:

- While a single rating could encourage joint ownership of health and social care provision across providers and the prison service, this could bring confusion within services as to who is ultimately responsible and accountable for such a rating.
    - A single rating could also cause confusion for prisoners when making complaints as it may confuse the fact that there are a range of health and social care providers within any one establishment. We would suggest an alternative approach may be to provide both individual ratings for each provider as well as an overall score.

<u>Should this be a joint rating with HMIP or a CQC rating?</u>

42 respondents replied to this question:

23 respondents said this should be a CQC rating:

- 7 healthcare professionals.
- 6 stakeholders.
- 3 social care professionals.

- 2 recipients of services.
- 2 providers of services.
- 2 voluntary and community sector representatives.
- 1 member of the public.

18 respondents said this should be a joint rating with HMIP:

- 5 healthcare professionals.
- 3 stakeholders.
- 2 CQC staff members
- 2 social care providers.
- 2 members of the public.
- 1 provider of services.
- 1 commissioner of services.
- 1 recipient of services.
- 1 voluntary and community sector representative.

1 respondent, a stakeholder, neither agreed nor disagreed but commented:

- We support collaborative working between HMIP and CQC and this will benefit healthcare providers on site. However, rating functions together could be challenging when funding and accountability are different for prison and healthcare.

5. Do you agree with our approach to concerns, complaints and whistle-blowers?

45 respondents replied to this question:

All respondents except 1 healthcare professional and 1 stakeholder agree with CQC's approach to concerns, complaints and whistle-blowers.

In addition 95% of public online community respondents agreed with the approach to concerns, complaints and whistleblowers. 5% did not.

5 stakeholders added a more detailed response:

- However this needs to take into account that good quality healthcare (e.g. that reviews and provides good pain management and reduces inappropriate pain medicines) may lead to a rise in complaints that are not upheld by the provider and commissioner.
  - The complaints standards are fine as far as they go. They cover the addressing of individual complaints, the service could learn and change if complaints were collated and evaluated for trends.
  - There is only one reference to whistle blowers in the Appendix. Whistle blowing is just one way that staff can raise issues. Staff should raise concerns via a range of channels including: DATIX, Governance Meetings,

Supervision etc. Whistle blowing should really be the last resort, where the provider has failed, for those who are no longer confident in the organisation's ability to listen and respond.

- We would like further details on how CQC expect this to work in practice. We note the extreme difficulty for people in prison of contacting outside bodies confidentially. We are not convinced that confidentiality for prisoners or staff can be completely guaranteed, even with strong procedures in place to enable this. The fear of repercussions for complaining in prisons is a significant deterrent. Whilst the ideal situation is that those impacted by concerns feel safe enough to take them forward directly, we would encourage the use of outside organisations and families who can contact CQC without fear of reprisal. We would also suggest that the CQC may have a duty to provide information and advice for people who are whistle blowing and putting themselves at risk. It would also be helpful to have information about what action CQC may take if serious and immediate safeguarding concerns are discovered during the course of an inspection.
- As a voluntary organisation working with immigration detainees, MJ would be pleased to be approached to provide intelligence in relation to (a) immigration detention in general and (b) individual IRCs. However it must be understood we would need the permission of the detainee concerned to provide case-specific details, and the short time available when an inspection is announced may mean this is not feasible. Detainees are fearful of reprisals and immigration detention is a setting where the official complaints system is recognised as not working. It should not be assumed all is well if detainees do not speak out. A publicly-available insight into how bad things can get can be found in legal case reports, most particularly those concerning article 3 breaches, of which there have now been 6 in mentally-ill immigration detainees, but inevitably these reports appear sometime after the events in question. MJ would welcome discussions with CQC/HMIP and others as how best to share verifiable evidence of current poor practice in the light of the constraints of confidentiality.
  - As well as receiving the official collective view of the IMB, opportunity should be given for individual IMB members to provide non-attributable information in confidence, whatever the formal IMB remit.
  - Since Healthwatch has a remit which extends to IRCs, they should be asked to contribute. The level of engagement by the LHW should be mentioned in the CQC/HMIP report.
  - The Home Office should also be required to share its audit and monitoring information, most especially any matters impinging on health or healthcare including any internal investigations from its standards unit.
- However the inspection framework for under-18 secure establishments must reflect existing statutory requirements and processes to protect children – particularly in relation to safeguarding concerns. Importantly, this include ensuring appropriate referral routes to external agencies such as the Local Safeguarding Children's Board (LSCB) and the Local Authority Designated Officer (LADO) are in place.
- This doesn't go far enough to safeguard or elicit, from staff, detainees, or voluntary groups who are 'stakeholders'.

Participants in the Criminal Justice Consultation discussion– CQC/HWE and lHW gave the following response:

- Staff whistle blowers must be provided more protection of anonymity. They must feel safe to talk to the CQC

6. Do you agree with our proposals for gathering detainees' experience of care?

47 respondents replied to this question:

All respondents agreed with CQC's proposals for gathering detainees' experience of care except for:

- 3 stakeholders
- 2 healthcare professionals
- 1 member of the public

In addition 92% of public online community respondents agreed with the proposal for gathering detainees' experiences of care. 8% did not.

3 stakeholders added a more detailed response:

- Our experience is that few local Healthwatch's are engaged with detainee populations to the degree that they could access or offer informed patient feedback.
  - Individual feedback may be skewed towards those with specific experiences or where they over or under report due to how their mood is at that time.
  - Prisoner forums are each different and unique, they can be an excellent source of feedback.
  - Prisoners who are Listeners or who staff Prisoner Information Desks (PIDS) or Health Trainers or Recovery Champions/Peer Mentors in drug treatment programmes are all useful informants.
  - Special attention is required with adults and children with neuro disability
  - Need to address the issue that there can be increases in patient complaints robust meds management is initiated and this needs to be acknowledged.
  - The CYP Advocacy Service in YOIs (under 18).
- We feel some of the mechanisms outlined for gathering and analysing information may be problematic for Deaf BSL prisoners who may be withdrawn, isolated and lack confidence or energy to feedback. It is vital to ensure that information about CQC is available in accessible formats.
- This doesn't go far enough to safeguard or elicit , from staff, detainees, or voluntary groups who are 'stakeholders'

Are there any other ways we could gather this information?

25 respondents replied to this question:

5 healthcare professionals:

- I would be concerned that information from detainees is taken in context as many of the patients we deal with don't often agree with decisions made about their care.
- I am unsure that the proposal would capture the views of those with language or literacy difficulties. face to face interviews with detainees if they wished to take part would obviously be preferable, but I acknowledge they are time consuming and resource intensive. Care would need to be given to those detainees who cannot access forums etc. e.g. those in segregation units, who are possibly the least likely to access available services in a timely and appropriate fashion. If questionnaires are used, they should be offered a short time before the inspection, or indeed during it, as, from experience, the outcome can reflect issues reported by detainees, which have already been addressed or the detainees have moved, if done far in advance of the inspection, meaning that the evidence is historical and cannot be verified at the time of the inspection.
- Many detainees will speak to visitors and are happy to tell you about their care. I like attending the various areas and talking directly to detainees about their health care.
- There must be someone who goes in prior to the inspection who the prisoners can talk to in confidence. In my experience in prison there is a huge problem with literacy & so filling in forms would not be appropriate.
- It needs to be a good representation of the population and It needs to be a good representation of the population and would benefit from including the patient experience information gathered by the provider needs robust triangulation with actual level of service provision and mitigating with things out of our control , secondary care, restriction in movements by prison.

9 stakeholders:

- Surprised by no specific mention of Independent Monitoring Boards in the document. They are a key part of the landscape that needs to be engaged in this work. They offer a resource for gathering information about complaints and detainees' experiences of care.
- There needs to be more detailed information and more creative solutions applied to how to gather the views of immigration detainees. This is often a more difficult group to engage than others held in prisons and YOI.
- Providing information freely to the Inspection Team is a major challenge for most detainees because:
  - Detainees have no way of knowing if they can trust the Inspectorate.
  - They don't know if the Inspectorate is simply an information source for the Home Office, and whether any confidential information they provide will be used by the Home Office to cause them harm.
  - If detainees are deported shortly after the inspection they and other in detention are likely to assume that deportation was a result of the information they provided to inspectors.

  - Most detainees come from countries which have leaky boundaries between departments of state in terms of information sharing. Detainees have no way of knowing whether the same is true in the UK, i.e. that agencies with deportation functions will be provided with confidential information by the inspectorate and that collusion will result in unjust deportations.
- The proposal mentions listening to comments and feedback sent to CQC from individual detainees and their families – Medical Justice welcomes this initiative but feels that more detail needs to be provided on how detainees will be encouraged to contact the CQC directly and what format this communication will take. We also feel that even further steps need to be taken to enable feedback directly from detainees, whether currently detained or from ex-detainees. One suggestion would be to set up a dedicated hotline for detainees to raise concerns about healthcare, thus allowing detainees to call either from the privacy of their own rooms or at a later point after they have been released. And to circulate this information and contact number, in a variety of languages, through NGOs, within IRCs and display dedicated posters in healthcare.
  - There needs to be a more sustained effort to get information from those who are without English as a first language, or who are otherwise inaccessible or reticent. Confidential phone interviews should be possible in IRCs in many languages, even if more problematic in some other places in the secure estate.
- The meaningful and effective involvement of people using health and social care services will only happen if frontline staff is better informed on how they can support people with learning disabilities.
  - Recommendation: Ensure that inspectors are informed in how they can support people with mental disabilities whilst gathering their experience of care.
  - Engage directly with people with learning disabilities using the right means to ensure their meaningful involvement.
  - Recommendation: Organise direct consultations with detainees to gather their views on the quality of the care they are receiving. Make sure that people with learning disabilities are represented.
  - Recommendation: Ensure that the views of people learning disabilities are taken into account.
  - Recommendation: Ensure that all materials are accessible for people with learning disabilities.
- Consideration should be given to how detained persons may be able to telephone from prison settings and the Commission should ensure that provision for raising concerns and providing feedback by telephone is via a dedicated and free telephone service (including free from mobile 'phones in immigration removal centres), which affords the opportunity to telephone in private. Interpreting and translation services should be ensured for all mechanisms developed for obtaining information from detained persons, whether face-to-face, by telephone or in writing. Freephone telephone lines should be supported by interpretation services. Material must be available in a variety of languages and it must be acceptable to submit material in the language of the person's choice.

- We would suggest that you consider a more proactive approach in terms of encouraging the voice of the "seldom heard" and therefore most vulnerable detainees. The HMIP report on learning disabled prisoners quotes individuals describing a lack of confidence in understanding leaflets, posters etc. and along with this a lack of confidence in asking questions or raising issues. We wonder whether the approach described is sufficiently proactive to engage with these individuals who, in turn, are probably among the most vulnerable within the prison system.
- Prisoners/ detainees should have opportunity for direct input into inspections and the prison voice should be heard directly. Further, receiving input via written submissions to CQC from prisoners or their families may exclude comments from vulnerable people who may have poor literacy skills in English.
    - We advocate use of focus groups, interviews and use of written forms provided to prisoners to enable feedback (use simple tick box format with opportunity for free text if required).
    - Can also collect information from PPO and other resources collecting information from prisoners and their families in relation to any failure in healthcare.
    - Health Needs Assessments contain stakeholder engagement sections – usually focus groups/interviews with prison/health staff and detainees about healthcare. These could be a useful source of information to inspectors if they were accessed.
- This has never been done adequately; the nearest have been 'secret' filming by TV journalists undercover. Suggest:
    - Healthwatch user groups allowed to meet outside the confines of IRCs.
    - 'Secondhand' information from regular visitors.
    - Talking to trade unions.
    - Conferring with ex-detainees.
    - Enabling detainees to contribute their views through a trusted third party, and include allowing them to contribute anonymously.

<u>3 voluntary and community sector representatives.</u>

- In gathering the experience of detainees (and in reference to Qs 8 & 9) inspectors should consider the cultural differences within the population of the IRC. These differences might make some people reluctant to speak openly in focus groups. The presence of staff whilst this engagement is taking place may also impact upon peoples' willingness to talk to inspectors openly. Inspectors should also ensure that they are gathering evidence from both long term and short term detainees, and should be wary of talking only to those detainees who are most willing to talk.
- It may be useful to consider of site focus groups for organisations such as befrienders to feel confident to raise issues.
- To ensure they are representative, surveys and focus groups must be accessible for detainees with hearing loss. British Sign Language (BSL) translation should be provided for written surveys and online forms. Also, communication support and adaptions should be available during focus group sessions e.g. BSL interpreters and working hearing loop systems for hearing aid users.

2 providers of services:

- Yes but of course every healthcare provider, education contractors, probation and prison operators are all trying to access prisoners to provide feedback on their services.
- Friends and Family test.

2 members of the public:

- The Board of Visitors now generally known as The Independent Monitoring Board - each prison/YOI has one - has a huge amount of knowledge of the individual prison or YOI and should be formally included in these reviews/inspections - they are independent and visit these places on a very regular basis.
- There is a high level of illiteracy within prisoners, I think mor thought needs to be given in how you make sure those with poor literacy can have input, possible suggestions are increasing awareness prior to the visit ie meet with prisoner groups and making sure on the day of inspection there are sufficient staff to at least visit areas where large numbers of prisoners can be found ie education, work areas, kitchen.

1 CQC staff member:

- It is important that a wide range of experience is sought which should include the clinical and operational staff. The help of well-being reps, connections , listeners , through the gate services and patient champions will all help to provide a picture.

1 social care provider.

- Use of electronic equipment for gaining views.

1 commissioner of services:

- Some of the anecdotal feedback I have received is that focus groups may not fully represent the views of all .. especially those perceived as difficult.

1 recipient of health or social care.

- The CQC Inspectors and MHA Reviewers already know the value of Experts by experience in their role of gathering information for the inspection process. In the existing numbers of ebye's there will be some who have had experience of detention in various secure settings and the health services on offer. It is a fact that detainees feel better able to speak with people who have had a similar experience to themselves meaning more in depth and accurate information.

1 specialist adviser:

- I would really want to personally interview Advocacy Service Managers etc. pre inspection in order to hear about the possible underbelly of the secure setting - or at least know that someone equally qualified was asking the salient questions. I do hope that the review puts more than the current approx. 1% of the inspection budget towards this work and I hope you will look at this in terms of your Team budget allocation?

The Criminal Justice Consultation discussion– CQC/HWE and lHW also commented:

- Independent Monitoring Board would be a good source of intelligence and a valuable resource (Note: CQC has been working closely with the IMB)
- Support the idea of local HW adopting the approach taken in Peterborough to set up prisoner engagement programmes.
- HW should be able to identify the views and experiences of people who have left detention centres and live in a local area and now use local health and care services. Their experiences of local care services is also very important

Clinks and CQC workshop on engaging with service users and their families in the criminal justice sector also addressed this question.

Prison forums

- Using existing systems for service user engagement e.g.
  - Prison councils.
  - Older prisoners forums.
  - Norwich Prison health council.
- Look for user-led, self-managed forums.
- Ask prisons to provide the minutes from these council/forum meetings.

Peer-led activity and support

- Peer reps - able to speak about issues individuals might be reluctant to voice themselves e.g:
  - Healthwatch Peterborough health reps model.
  - Well-being reps (gym).
- Listeners services.
  - Gather intelligence from Samaritans.
- Through-the-gate mentoring services e.g.
  - St Giles' peer volunteer mentors.
  - Transforming Rehabilitation programmes.
- Prison reps could also be encouraged to run 'feedback days', organise suggestion boxes; hold surgeries in prison.

BUT beware:

  - Whose voices is CQC hearing? Prison forums are often made up of the most engaged service users.
  - How prisoner groups are chosen may not be inclusive.
  - Forums need to be well-prepared & facilitated
- Reps should be asked to consult with others – not just responding with own views

Families

- Families often know of health needs individuals may not want to report. They can often see whether people are being cared for – including basic physical health needs
- Use visitor centres in each institution – they already have relationship with families and an organisation is commissioned to lead these.
- Work with NOMS to connect with family programmes
- Family forums set up by voluntary sector
- Prison family days
- Troubled families programme providers

- Families are traditionally poorly engaged in institutions anyway. There is an issue about encouraging service providers to engage more with families in the first place
- Need to reach families representing protected characteristics and from diverse communities

Working with people from diverse communities and with protected characteristics

- Work with wide spread of organisations to ensure all groups represented
- Those who can reach the hard to reach
- BAME specialist agencies
- Specialist women's reps

Voluntary sector (prisons & community)

- Develop prior relationships with the voluntary and community organisations working in a prison – they can give an overview of the issues and trends about prisoners care
- Voluntary and community agencies in prison can access prisoner views, and are trusted
- Service user groups run by VCS
- Include groups working in community – people may feel freer to speak post-release
- Local community groups e.g. mosque support services
- People disperse, so need organisations with wide reach
- Voluntary organisations need to know more about CQC and what is does and is looking for.

Other partners & stakeholders

- Prison healthcare feedback – make sure collected by different person to who provided treatment
- Join other prison events e.g. diversity fairs
- Probation – exit surveys
- Private providers (TR)
- Resettlement prisons – links to work in community
- Independent monitoring board
- Anonymised surveys using IMB route for responses?
- Liaison & diversion schemes
- PHE substance misuse groups e.g. London user involvement council
- NHS England
- Healthwatch for info in community

Suggestions for inspection process

- Include evidence that providers include service users in design of services as a criteria for inspections
- Ask for complaints and feedback information from the provider (but be clear with offenders who can/cant deal with their complaints)
- Handle safeguarding and confidentiality issues – be clear about what will be shared and with whom
- Inspectors may need particular skills to do this engagement – or have advisors to support them. Training for inspectors will be key – and the voluntary sector could help with this
- Health promotion and awareness raising important as well as the provision of direct health care services

- Importance of feeding back results of inspections – showing service users that participating has made a difference
- Use call back system e.g. when people leaving prison. This could be built into the discharge arrangements
- Promoting work of CQC to increase responses
  - Posters in community settings e.g. probation offices, visitor centres to advertise general email address?
  - Promote widely to the voluntary and community sector e.g. Clinks newsletters
  - Greater cross-section of involvement, not just specific organisations working in offender settings but also for example people working with homeless groups, drug users, sex workers – some of whom will have experience of the criminal justice sector. Other examples were Fulfilling Lives groups, User Voice programme board who could advise CQC
  - Promoting the inspection findings across the institutions should be part of the feedback process, and providers expected/required to do this. There should be accessible and summary forms of inspection reports.

<u>The CQC IRC Stakeholder event also addressed this issue.</u>

- Attendees will send us contact details for befriender/advocacy/visitor groups for each IRC
- Look at minutes from detainee representative group meetings
- Recently released ex-detainees will be more comfortable disclosing info
- Develop relationships with 3rd party agencies to support ongoing monitoring, advocacy & to identify detainees who want to speak to us on inspections
- EBEs can tell us about the differences between IRCs as are likely to have been transferred between several.
- Poor observation of confidentiality between IRC healthcare and home office.
- Poor clinical information systems.
- Stakeholders feel HMIP are able to get a fairly representative sample for feedback using their current methodology
- G4S are developing a version of the 'friends and family test' to be used in IRCs
- Stakeholders feel it would be beneficial for inspectors to have training in how to use interpreters appropriately
- Detainees have mobile phones- might be more comfortable disclosing info over the phone.

<u>The public online community also addressed this issue:</u>

- Is there anyway concerns etc. could be reported anonymously?
- Occasional questionnaires to families of detainees who have needed medical help.
- By ensuring that communication is open and easy for everyone to access without reprisal, encourage people to give feedback in a constructive way so that they see it as a positive thing.

- Ask the service users and ask staff not the "organisations" as a whole.
- People could be encouraged to comment informally on their experiences perhaps anonymously through e.g. drop boxes.
- Through the Home Office who have responsibility for Prisons Detention Centres etc and through organisation s such as Prison Officers Association and NACRO.
- Consult refugee support groups, who will have contact with people who have been granted refugee status but were previously detainees.
- Could you also engage with organisations such as Langley House Trust and similar, who work towards re-integration of offenders back into the community. They build trust, and therefore the offenders may be open with them on matters they feel less able to share in the environment of a secure unit.
- It must be extremely hard to get balanced information whilst someone is detained. Perhaps interviewing people after they have left prison for example would be beneficial.
- I'm not sure how but a system to ensure detainees who are afraid to speak up are able to voice their concerns.
- It isn't clear whether there would be engagement with individual detainees; the section in question talks about comments and feedback sent to CQC, and making use of evidence from prisoner councils/forums. Both of these might well be paper-sifting exercises; perhaps followed up with individual contact.
- Consideration could be given to giving the opportunity during HMIP/CQC inspections for detainees to speak confidentially to inspectors. If this is already part of the planned approach, i think it should be made more explicit.
- I would suggest anonymous questionnaires be given to prison staff - and perhaps detainees as well - to ask for feedback. I feel strongly that detainees/prison staff may be afraid to voice their concerns through official channels. It must be made clear to detainees/prison staff that the information they provide is 100% confidential and cannot be traced back to them.
- As long as they feel safe and confident in talking to whomever is gathering the information, then I don't feel that there is another way to collect this information. Build trust with the detainees so they feel able to share their experience.
- A ratings scheme would need to take account of the restrictions to delivering healthcare in a secure environment, but I think a rating should still be provided so improvements can be tracked.
- Detainees experience - could you get comments from prison (or other custodial staff) about their view of the detainees' experience.
- The information could be compared with historic info to formulate any already existing patterns of poor care in individual institutions.
- On-site audits of staff and service users could be a useful way of gathering information
- Many prisoners groups/forums are selected by the prison service - need to be robust in finding the views across a range of prisoners, particularly those who are vulnerable though mental health issues, LD or poor English or literacy.
- Ex-prisoners may be at a better position to disclose as they will not have fear of reprisals.
- Anonymous comment books at point of care provision, as the current plans don't seem to allow any way to give anonymous feedback, at least as I read it.

- From what I have read it seems to cover quite a range of approaches, I think it is important all voices are heard and not just those at the prisoner forums as some people will not come forward without encouragement even if they experience problems.
- Spot checks or random interviews with inmates.
- Prisoners are in prison for the public safety, so why any form of spending more tax payers money on their complaints in relation to their human rights etc. is wasted.
- Talk to the professionals carrying out the tasks and care and not just the higher up personnel but the nurses and support staff.
- Through social media. Easier and more accessible.
- Using role play situations through the education teams in prisons. Actors to take part in situations based on real life, in front of a live audience of detainees. Discussion then takes place and prisoners hopefully gain in confidence to express their opinions on the situations.
- Encourage service users to keep a daily diary in which they record and analyse their experience into what aspects of their care worked well for them, and which bits didn't.
- To secure a clear route for individual complaints.
- May not the application of a rating system itself yield avenues by which the existence of issues which impact negatively on detainees will become apparent?
- A joint approach is asking for trouble: I think it is better for one organisation to take responsibility. Although detainees may not have choice in where they live, I think it would be helpful to rate institutions. You do not say that you will speak privately to individual detainees or members of staff, who may have concerns but do not feel safe in passing them to others within the place where they are living or working.
- The onus appears to be on young inexperienced, vulnerable and quite possibly frightened individuals to raise an issue around their care with as they see it the very people caring for them. This may very well lead to inaccurate reporting as the individuals may fear consequences from any compliant they make. If a global survey is completed with all of those within an establishment on a regular basis based on both multiple choice and free text in answer to questions there would be two major benefits. One more likely to get individuals reporting both good and bad practices with reduced fear of consequence and two a bank of information will be collected over a period of time and locations which allow for better data analysis leading to more trend spotting in either service or location as well as individual incidents. Nothing is without fault and this approach may lead to spurious results but competent statisticians can identify these in analysis.
- Constructive dialogue with "Hands-on" Staff members in the prison service without the fear of retribution.
- Discussion with detainees, this has to be viewed seriously, but in the light that some of the prisoners maybe making false accusation for personal revenge or grievance. You could consider using bodies already in place rather than wasting time and energy charging up a new group! Analyse what you already have in place and utilise it better.
- Contact detainees after they are released - un-announced visits.

- Asking detainees prior to release for their thoughts as this may be a different opinion to the one they have either soon after being detained or during.

7. Do you agree with our approaches to working with national and local organisations?

47 respondents replied to this question:

All respondents, with the exception of 1 member of the public and 1 stakeholder agree with CQC's approaches to working with national and local organisations.

3 stakeholders added more detailed responses:

- In addition to the ones listed, as background rather than for individual inspections, CQC could have a programme of engagement with specialist national organisations E.g. The Children's Commissioner, Prison Reform Trust, Barnados, National children's Bureau, Revolving Doors Agency, Howard League, Nacro, Centre for Mental health - etc. Many of these have excellent insight into specific issues that impact on detainee health.
- We would suggest the following considerations:
  - Further thought needs to be given to "local councillors" under the heading of "Patient and public representatives" and discussions with colleagues in the Local Government Association (LGA) may assist here. Local councillors may have a contribution to make but serving prisoners have not, to date, been considered as part of their constituency. Is it therefore a councillor in their role of serving a constituency containing a prison that inspectors would wish to engage with or a councillor in a specific role such as the lead member for adult social care?
  - Under "National, professional and staff bodies" we would recommend adding ADASS and the National College of Social Work.
- With unannounced visits it may be that a mechanism needs to be found to have members of regular voluntary visitors present and their views sought at the time. The IMB are in our view too closely associated with the Home Office to give the only independent view on an unannounced visit. We think it important to be 'flexible' about which organisations to talk to locally – some campaigning groups have much evidence to offer as may local faith groups, and civil society organs such as trades unions.

<u>Is there anything else that we should be doing?</u>

15 respondents replied to this question.

<u>4 healthcare professionals:</u>

- Important to acknowledge the Howard League and the Faculty for Forensic and Legal Medicine.

- Ensuring that information about the change in the inspection process, its intended purpose and the scope of the inspections is available to all parties, including staff, detainees, advocates, families and any other interested parties. Feeling that individuals are a valuable part of the process would encourage them to take part, but not offer false hope, for instance in addressing individual health concerns. It must be born in mind that many detainees have a poor record of using services and formal support effectively, and yet it is those very people that we seek to protect, and care for.
- This looks very good as long as all these organisations have the time & inclination to co-operate.
- More engagement with commissioners.

1 member of the public:

- The Board of Visitors now generally known as The Independent Monitoring Board - each prison/YOI has one - has a huge amount of knowledge of the individual prison or YOI and should be formally included in these reviews/inspections - they are independent and visit these places on a very regular basis.

5 stakeholders:

- Surprised by no specific mention of Independent Monitoring Boards in the document. They are a key part of the landscape that needs to be engaged in this work. They offer a resource for gathering information about complaints and detainees' experiences of care.
- Consultation with worker representatives in the form of trades union bodies.
- The views of legal practitioners with experience of representing persons in immigration detention and of representative bodies such as ILPA must be considered.
  - It is important to be able to receive intelligence from voluntary organisations such as case studies and information that have been anonymised to maintain the confidentiality of thee person concerned.
  - It would be useful for the Commission to engage with bodies which deal with complaints about health care professionals, such as the General Medical Council.
  - You should obtain and review internal audit and monitoring information from the Home Office.
- Please include working with the GPhC about registered pharmacy premises for detained settings. Whether on or off-site, the registered pharmacy providing the service to the site needs to be fit for purpose as a place where medicines are dispensed for detained people. Currently I believe that only on-site premises are inspected. The CQC could gather information about external pharmacy service providers via the GPhC.
  - Ensuring work with interpreters particularly in IRC's and Easy Read systems for those with LDD.
  - You could call themed meetings focussing on secure settings e.g. mental health or substance misuse, or long-term conditions, palliative care etc. The purpose would be a one off collation of relevant current background information on good practice in responding to the theme in secure settings.
- PHE Health & Justice team are expert advisers on public health to NHS England and NOMS. We also support a range of public health programmes in

prisons and other places of detention as well as collect data, provide surveillance function and produce guidelines on managing health in prisons. PHE Health & Justice should be among national professional and expert groups consulted not just the Alcohol, Drugs and Tobacco team at Regional Level.

- In terms of the engagement with 'health' your inspections might benefit from more contact with health improvement and screening/vaccination functions.
- Local Authority drug & alcohol functions are engaged but there are other functions that might provide valuable information.

1 CQC staff member:

- All stakeholders should be able to consult on the services. It is important that those listening and assessing have experience of working in secure settings as the challenges are unique and the work a speciality.

1 commissioner of services:

- What about secure children's settings such as Secure Training Centres and secure children's homes? STCs are currently inspected but not mentioned in this document, are you going to stop visiting? this is a major gap . These YP are the youngest and arguably the most vulnerable yet seem to be overlooked. Looked after children as well needs to be considered. we know so many people in prison are LAC's . What about Approved premises?

1 voluntary and community sector representative

- As an organisation, we have delivered deaf awareness training and British Sign Language courses to a range of prisons and has also worked with disability and criminal justice charities such to raise awareness of hearing loss in prisons. We would be happy to offer further advice and support to HMIP/CQC on hearing loss issues.

1 social care professional

- Working with HCPC and Ofsted.

1 provider of services

- Including the Independent Monitoring Board (IMB).

8. We have described how we will gather the views of detainees in advance of the inspection. Do you think this is an effective approach to supporting our work?

40 respondents replied to this question:

All respondents, with the exception of 2 healthcare professionals, a stakeholder and a member of the public, think this is an effective approach to supporting CQC's work.

In addition 5 detailed responses were given as follows:

1 specialist adviser

- Regarding questions 6) and 8) of the Consultation however and, looking as I do from a Patient and Public point of view, I have growing concerns with the CQC's approach to this most important of groups and in particular 'Gathering the views of detainees in advance of inspection' . This fear may be allayed by the page 23 comment 'The way in which we do this is currently under review'. However to compare with Trust-Wide Mental Health Team inspections, which must cost close to 6 figures per inspection and which of course is announced and thus can be manipulated, the CQC sub contracts with a third sector organisation about £1000 per Trust wide inspection to gain this GOLDEN pre-intelligence. The fact that whilst everything else, KLOEs etc. for the new wave of inspections has ink dried, this least complex area is still being 'reviewed'. It looks like a lack of a lack of priority and afterthought within the CQC- in complete contrast with the clinically/systemic orientated 3 other areas of local and national organisations identified in fig 4. This could be seen as an institutional bias due to the make-up of the staff of CQC coming from the Clinical professions.

4 stakeholders

- It is vital that the views of persons detained under Immigration Act powers be gathered. The effectiveness will depend upon the Commission's ability to obtain information from them and language support is an important part of this. Persons in detention who are unwilling to make a formal complaint may be prepared to provide intelligence: information that is anonymous or whose source is anonymous. Such intelligence can help to inform decisions on when and where to carry out an inspection and what to look for.
- You note very few inspections are announced and HMIP is moving ever further away from announced inspections. Therefore any aspiration to gather views in advance appears flawed, assuming this can be achieved without compromising the fact that the visit is going to be unannounced.
  - Use of HNA's for establishment will convey service user responses to service delivery and experiences.
- We would advise and promote materials and communication methods to be as accessible as possible for Deaf BSL users.
  - The suggested phone line system is unlikely to be supportive to a Deaf prisoner.
  - Engagement with Deaf prisoners during any inspection will require the use of Registered British Sign Language interpreters (RSLI) and possibly the additional use of a Deaf relay interpreter. The booking of RSLI"s at short notice is often quite difficult due to the limited number and many

professionals being pre-booked- we would advise inspectors have a direct access number to a number of registered interpreting agencies.

- The special nature of IRCs means that displaying posters, having messages passed on from HMIP, in our view may not elicit what is really happening because of the real fears expressed by detainees about 'speaking out'. Real because in our experience they lead to detainees being moved, or removed.

9. We have described how we will gather information and evidence while on site at the secure setting. Do you think this is an effective approach to supporting our work?

39 respondents replied to this question:

With the exception of 1 healthcare professional and 2 stakeholders, all respondents think this is an effective approach to supporting CQC's work.

In addition 4 detailed responses were given as follows:

<u>1 specialist adviser</u>

- We may be being overly charitable declaring in writing in advance 'Thanks for support and contributions' - we haven't visited them yet to know!

<u>3 stakeholders</u>

- It is important to ensure that the inspection evaluates services that are actually provided rather than just assess the quality of aspirations as set out in policies. In addition to the steps outlined above for obtaining information from persons in detention, the Care Quality Commission and Her Majesty's Inspectorate of Prisons should also speak with voluntary organisations, visitor groups and legal representatives working with persons detained Under Immigration Act powers in the secure setting under inspection.
  - The Care Quality Commission should give particular consideration as to the manner in which it informs persons in detention of the Commission's right of access as regulators to detainees' medical records as these may contain sensitive information, including about torture and abuse and those in immigration detention may have fears about the use and disclosure of their information.
  - Undercover filming by television reporters uncovered ill-treatment and abuse in immigration detention in Yarls' Wood. Legal judgments have done so and there are very many cases that do not come to court, including a very significant number of damages cases which settle.

- What was filmed tallied with accounts persons who had been detained there had been giving over a considerable period, and that accounts of persons held at different times, and who did not know each other, also tallied. Reports of formal inspections failed to give an impression of what was happening, despite being critical.
- It is very difficult to gather information. It is necessary to be prepared to receive and consider intelligence. Persons in detention need not only to be listened to, but their accounts believed. We consider that interviews with persons formerly detained are a way of checking information and, with the consent of a detainee or former detainee, legal representatives can assist.
- The gap between policy and practice in immigration detention is striking and careful and sustained observation of practice, whether observation of conduct, reading records or studying figures to understand how they relate to practice, will often open up further avenues for inquiry. Time needs to be allowed for this. We strongly support carrying out unannounced inspections wherever this is permitted, and following up all inspections with visits to see whether recommendations have been implemented.

- This has to remain flexible depending on the type and focus of the visit and noting the various comments above
  Queries/observation that does not fit with your questions:
  Section E6.6 'Do staff understand the difference between lawful and unlawful restraint practices?' Would it help to be clear that HMP is responsible for managing the vast majority of restrain situation that staff will witness? There are very few situations where any member of healthcare staff should be in anyway involved in restraint, other than a responsibility to check on a detainee's welfare after they have been restrained or wider healthcare expectations with MMPR. This issue also applies to 6.7
  In regards to your chart for oversight bodies and commissioners – for YOIs (under 18) it does not include YJB or The Children's Commissioner.
- The consultation document does not give detail of the information that will be provided to prisoners on commencement of the inspection and how that will be communicated. This information may be presented via direct methods such as the Prison radio service however this would not be supportive to Deaf prisoners.
- Not effective enough.

5. Appendix 1 – Clinks report on good person-centred care of offenders in the community.

supporting voluntary organisations that work with offenders and their families

Good person-centred health care for offenders in the community

Evidence to support Care Quality Commission inspections

May 2014

About Clinks

Clinks is the membership body that supports, represents and campaigns for voluntary sector organisations working with offenders and their families. Clinks aims to ensure the Sector and all those with whom they work, are informed and engaged in order to transform the lives of offenders.

www.clinks.org

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Introduction

This paper sets out what good person-centred care looks like for offenders in the community. Clinks recognises there are specific issues experienced by people in prison with accessing health care, as well as areas of good practice, but due to the limited time available for this paper we have focused on the experiences of offenders in the community.

We highlight barriers or challenges experienced by offenders accessing health care as outlined in research reports and from evidence from our members, before suggesting ways that these could be addressed. This is done using the five questions highlighted by the Care Quality Commission as a framework. However, all these 5 attributes of good care – well-led, effective, responsive, safe and caring - can only be demonstrated and become relevant if offenders are able to access health care services. As such, we have added another question to the framework- 'is it accessible?'

It is important to note that the 'offender population' is not a homogenous group, as women, people from Black and Minority Ethnic (BAME) communities and disabled people for example experience unique challenges in terms of accessing healthcare, that therefore requires a unique response.

The paper then gives four stories of individual offenders' experiences when accessing health care in the community, covering the key themes and potential solutions identified in the main report. Please note, these are fictionalised stories developed through discussions with Clinks member organisations providing frontline services to offenders, and are each based on case studies of one or more real individuals. All names have been changed.

Offender health

It is beyond the scope of this paper to consider in detail the needs of those in the 'offender population' but it is well documented that they have higher health needs than the general population. Key statistics relating to the health needs of this heterogeneous group include:

- According to the Community Cohort study carried out by the Ministry of Justice (2013), 51% of adults supervised in the community had a long term medical condition or disability; 46% of women and 40% of all those aged 40+ had a mental health condition.
- 39% of adult offenders under supervision in one probation area had a current mental illness; 49% had a history of mental health problems (Brooker et al, 2011 as cited by Revolving Doors Agency 2014).

The Department of Health (2012:7) also highlights that "children and young people in contact with the Youth Justice System (YJS) have more - and more severe - unmet health and wellbeing needs than other children of their age". The large majority of these young people in contact with the YJS are in the community rather than in custody.

A high proportion of offenders also experience multiple or complex needs, which means that:

- they experience several problems at the same time, such as mental ill health, homelessness, drug and alcohol misuse and family breakdown;
- have ineffective contact with services, including health services; and
- are living chaotic lives (Making Every Adult Matter, 2014).

For example, one of our member organisations reports that women coming to their service have needs in an average of 4 or 5 of the 9 offending pathways set out by NOMS, which include mental and physical health, and drugs and alcohol (ISIS Women's Centre, interviewed January 2014). This is supported by the Department of Health (2012:7) which states that adults, children and young people in secure settings "have typically led chaotic lives prior to incarceration, characterised by little formal contact with NHS services."

As such, providing high-quality, person-centred health care to offenders presents some specific challenges; but can have a significant impact on both health and broader social outcomes when these challenges are creatively addressed.

FRAMEWORK QUESTIONS	CHALLENGE TO ENGAGING WITH HEALTHCARE	POTENTIAL SOLUTIONS
Is it well led?	**Fragmented service response** A literature review by Revolving Doors Agency (2011) outlines that when service users are accessing health care from multiple agencies or services, care was typically poorly co-ordinated and services failed to communicate with one another. This often meant that service users were repeatedly and separately assessed, which caused some stress but also meant that the severity or 'depth' of the interconnected nature of their needs was not identified. This is supported by Homeless Link (2012: 2) which found that homeless people cannot access the treatment they need because services are set up to deal with "one need at a time" and are therefore ill equipped to meet their complex health problems. It is important to note that many homeless people have experience of the criminal justice system. **Poor continuity of care** This can especially be true for offenders at transition points, which can include being referred from children's to adult services and on release from prison into the community.	**Joined up provision of services** As many service users will need to access more than one service at a time, it is essential that these services are joined up and/or work in partnership with each other. This ensures that service users don't fall through the gaps and are able to access all the services they need. Indeed, the Centre for Mental Health (2013: 6) highlight that "it is essential that statutory and community agencies work in partnership and forge a network across which knowledge can be shared." One way of co-ordinating services is through the 'MEAM Approach', which is a non-prescriptive framework for co-ordinating services for people with multiple and complex needs (MEAM, 2014). Much of the literature highlights that voluntary sector organisations often 'fill in the gaps' and are adept at acting as a link between different services, from different sectors, on behalf of their service users.
Is it accessible?	**Low engagement with health services** Offenders often have poor experiences accessing formal services, and can be reluctant to engage with health services until their needs are particularly severe. 40% of prisoners declare no contact with primary care prior to detention, for example (Public Health England Offender Health website). This is despite experiencing a higher prevalence of many health needs compared to the general population, including problematic drinking, smoking, and Blood Borne Viruses and Sexually Transmitted Infections	**Location of services** Enabling service users to have access to services at locations where they already need or want to be present (such as at a Women's Centre or in a housing project) can help to ensure they engage. This is particularly beneficial where attendance at the location is voluntary, so that accessing health care services does not become negatively associated with compliance requirements, as may be the case if co-located with probation services for example. Care in these locations can be provided either as an outreach service from a

	(Department of Health, 2012: 7). This results in an over-use of emergency services. This can be exacerbated by a reluctance on the part of health care services to accept patients who they see as problematic, either because of presenting with challenging behaviour, or as coming with an additional set of needs the health professionals do not feel able to meet (Revolving Doors Agency, 2001: 10-14). Probation services and bail hostels report needing to enter into specific contracts with GP services to accept their clients as patients, in breach of the NHS constitution. **Problems navigating systems** Many offenders are likely to be experiencing multiple needs and will therefore need to access a plethora of health and care services. This can be daunting for many service users, as it will require them to navigate complex systems and rules, as well as being required to access many different services, at different times and at different locations; and is especially challenging for offenders experiencing multiple needs or who live 'chaotic lifestyles' (Department of Health, 2012:7). In addition, offenders often have limited information regarding these services or the information they do have is not in a format that is accessible. For example, English may not be their first language or they could have poor literacy levels, which makes engagement challenging. In addition, 20-30% of all offenders have learning disabilities or difficulties that interfere with their ability to cope with navigating complex systems (Prison Reform Trust, 2014b: 5).	statutory health provider, or by commissioning a voluntary organisation to provide this care. Please see stories 2 and 4 for examples of how each of these can be achieved. **Supporting service users to navigate complex health systems** As accessing multiple or even singular services can be challenging for service users, and those with learning difficulties or poor literacy, it is important they are supported when navigating complex health systems. This could be achieved by providing a service user with a key worker, who will support and assist them with accessing the services they need. In some instances, such support can be provided by volunteers, who with sufficient training and support are well placed to attend appointments with service users and advocate on their behalf.

Is it effective?	**Failure to involve service users in care planning** Health services can fail to take into account service users' views in terms of planning for their future care and how the service more widely addresses their needs. This can lead to poor communication between professionals and service users, with service users receiving different care from that which they expect or want, which can mean they are less likely to engage.	**Taking service users' views into account** Service user engagement in health care would involve professionals and service users working in partnership to plan for future care arrangements. Working in this way ensures the service user is informed about their care, meaning they are more likely to receive the care they want and need and therefore making them more likely to engage. Service user involvement can take many forms and is increasingly adopted by health organisations. It is defined by the World Health Organisation (2002) as "as process by which people are able to become actively and genuinely involved in defining the issues of concern to them; in making decisions about factors that affect their lives; in formulating and implementing policies; in planning, developing and delivering services, and in taking action to achieve change." Ensuring health services adopt this approach would enable service users to give their views about how the service is successful and where improvements can be made. In light of this evidence, health services can alter what they are delivering to enable the service to meet the needs of the people using it. It is important that health services make particular effort to engage with marginalised service users, likely to include offenders or ex-offenders, to ensure their voices are also heard. Working in this way again means that service users are more likely to engage with the service. **Early diagnosis** For health care to be effective, it is also important that service users' needs, whether around physical or mental health or problematic drug use for example, are identified at the earliest possible stage. One advantage of this is that needs can be met before they escalate. Please see Story 2 for more information.

Is it responsive to people's needs?	**A 'one size fits all' approach** As outlined in the introduction, the 'offender population' is a heterogeneous group, with women and people from BAME communities for example having unique needs. Health services need to be aware and responsive to these needs to ensure these groups experience successful health outcomes yet at times, health services have been found to be inflexible and take a 'one size fits all' approach to the way they are delivered and designed. The Centre for Mental Health (2013:3) highlight this issue in relation to mental health services for BAME communities "in a bid to address institutional racism some services inadvertently exacerbated the problem by positioning themselves as 'colour blind' or a 'one size fits all' service. This has now been recognised as culturally insensitive and ineffective but there is still some way to go."	**Supporting diversity** It is essential that the unique needs of offenders are met by health services. This requires a flexible and tailored approach to offenders with protected characteristics[1], coupled with an understanding that different inputs or services are required by different groups to achieve the same outcomes. **Women** Women are a minority group in the offender population but have very distinct health needs to men. For example, women have a higher rate of self-harm and eating disorders than men, their rates of depression and anxiety are twice that of men and are more likely to have a mental health disorder and associated with post-traumatic stress disorder (Department of Health, 2003). Many women in the criminal justice system are also victims of domestic violence or sexual abuse (Prison Reform Trust, 2014a). It is therefore essential that services are gender specific and can address the unique needs of women. **BAME communities** It is well documented that people from BAME communities are overrepresented in both mental health care and at all stages of the Criminal Justice System (CJS) and experience unique health needs. However, the Centre for Mental Health (2013) outline that people from BAME communities are under-represented within services such as drug court initiatives and Improving Access to Psychological Therapies (IAPT) programmes that may prove beneficial. In a recent report by the Centre for Mental Health (2013) outlines key considerations related to BAME communities and health care:

[1] Protected characteristics are defined by the Equalities Act, 2010 as including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

		• Perceived racism, language barriers and doubts about the cultural competency of services can lead to BAME communities having negative perceptions of mental health services (Cooper et al. 2012). • Within some African-Caribbean communities a very real fear exists that "involvement with mental health services could eventually lead to their death" (Keating & Robertson, 2004). • These factors can result in a delay in seeking help, meaning some BAME communities only access services when they are at crisis point and are reluctant to engage (Keating et al. 2003). It is therefore centrally important that individuals from BAME communities can access culturally specific support from health services. This can be done through partnership working, as highlighted by the Centre for Mental Health (2013:7) "where practitioners lack a particular cultural expertise they need to be able to effectively partner relevant culturally-specific agencies."
Is it safe?	**Delays in receiving help** The literature demonstrates that at times, health services can fail to respond quickly when service users need or request help. One reason for this is long waiting lists. This was found to be the case at times of crisis, out of hours or at transition points (such as from prison into the community). Also, services can fail to respond quickly at times when service users have high motivation, which is particularly relevant to drug users. This issue can be especially problematic for offenders as "service users emphasised that they need support immediately if they were not to return to old habits" (Revolving Doors Agency, 2011: 8)	**Flexibility and creativity of services** As highlighted earlier, service users are likely to have complex needs and many will live 'chaotic lifestyles.' This increases the likelihood of experiencing crisis, meaning health services need to work flexibly in order to address these issues as and when they arise. Working in this way can also help to reduce the delays service users can experience when accessing health care. It is also important that health services are open to creative ways of working, to ensure the client's needs are addressed. This can also help to ensure service users are engaged with health service.

	Inflexible services Offenders with multiple needs will often have to access more than one service at a time. This not only involves negotiating a complex landscape, but also means that service users are required to make and attend multiple appointments, that can clash. If this happens, mandatory appointments with the Jobcentre for example prevent attendance at a drug treatment service (Revolving Doors Agency, 2011). **High threshold for services** As highlighted earlier, offenders with multiple needs experience different needs at the same time, which can feed into and exacerbate one another. If taken in isolation, each need is experienced as a low-level issue which means that offenders often fail to meet high thresholds of services and consequently receive no support (Durcan ,2014).	
Is it caring?	**Poor professional-client relationships** Many offenders in the community, especially those with complex or multiple needs, often have ineffective contact with services. One reason for this, as argued by Revolving Doors Agency (2011) is that these individuals experience "unhelpful, insensitive and other negative staff attitudes." An example of this is service users reporting a perception that general practitioners took their mental and physical health problems less seriously if they disclosed drug use. Negative staff attitudes can lead to a poor relationship between clients and professionals, which in turn can mean that service users have poor experiences of services and disengage from them.	**Non-judgemental attitude of staff** This could be addressed by service user involvement, as it can allow service users to understand why decisions are made and facilitate more constructing relationships with staff. Also, staff may also develop a deeper understanding of the needs and behaviour of their clients, which can again help to break down the barriers between them. Working with and supporting offenders, especially those with multiple needs, can be challenging. As such, there needs to be adequate training and support for staff working with this group of clients.

Service user stories

Story 1: Subject 1

Subject 1 is a white man in his early 40s living in north-west England. He was diagnosed as HIV positive while in prison, and a local community organisation who were in contact with him referred him to a local charity that works with people living with HIV and their families. Subject 1 also has substance misuse and emotional support needs.

A key worker from the HIV charity visited Subject 1 several times before his release from prison, offering him information and support to understand what living with HIV meant for him. Subject 1's key worker asked him for consent to share information about his HIV diagnosis with other agencies and relevant staff in the prison, which he was happy to give. Subject 1 did not have any accommodation to return to when he was released; so as the charity has strong links with partner agencies in the local area, they arranged an assessment for him from a local housing provider who offered him a place in supported accommodation. This meant Subject 1 would be able to continue to address his health issues after his release, rather than having to worry about the basics of where he was going to sleep and how he was going to eat.

As a result of the charity's ongoing relationship with many health sector agencies, they were able to make referrals for Subject 1 to the local specialist HIV community nurse team, who saw him on the day of his release; and support him to register with a GP. The prison would not have made these referrals without the charity's involvement. The community nurse was able to arrange an appointment for Subject 1 with a consultant at the HIV treatment centre in hospital within a week of his release to renew his prescription. This was especially important as when living with HIV, you would normally see your doctor every 3 to 4 months and be given medication to last between appointments, but Subject 1 was only given 1 week's medication on release. This level of joint working meant there was no break in Subject 1's life-sustaining antiretroviral treatment and so this, along with his other ongoing health conditions, was managed effectively.

For the first few months after his release, Subject 1's support worker from the charity attended medical appointments with him, improving his attendance as well as giving him a greater feeling of consistency and enabling him to properly engage with his healthcare. They also stayed in open communication with the other services supporting Subject 1, including his local cultural organisation, HIV community nurses, drugs services, occupational therapy, probation service and welfare rights support, to ensure all important information was shared. Holding multi-disciplinary meetings with Subject 1 allowed him to be involved in decisions about his care and support.

After 6 months in supported living, Subject 1 had gained sufficient confidence to search for accommodation himself through the local area social housing scheme, and accept an independent tenancy. It is now almost two years since his release, and his confidence to advocate for himself has increased significantly, to the extent that he has now attended drug worker appointments, probation and his GP on his own for several months. The service user-led approach and partnership working employed by the charity gave Subject 1 the space to address his health issues first, then wider family and emotional issues, so that he is now able to manage most of his issues himself.

Story 2: Subject 2

Subject 2 is a white British man in his mid-30s, who has been diagnosed with paranoid schizophrenia. Subject 2 is considered to be a 'forensic offender', meaning he has an identified, severe & enduring mental health condition, and his offending behaviour is directly linked to this. He has spent several periods of time in prison, most recently for assault; and is currently living in a supported housing project run by a charity in London.

The housing charity operate a long-standing partnership with the hospital providing mental health care in the area, under which the hospital provides clinical care and the charity provides support to help people maintain their recovery. A nurse from the mental health team at the hospital visits the project to meet with Subject 2; initially weekly, and now monthly as his level of support needs have reduced. This builds trust with him, and means the staff at the housing project can support his attendance at these meetings. In addition, Subject 2 meets monthly with staff from both organisations for a joint case meeting, to agree strategies for managing his condition, giving him a high level of input into decisions about his care.

On his arrival at the housing project, the joint team met with Subject 2 to agree a crisis management plan to be put into action if his health deteriorated whilst living there. This included signs he suggested they should look out for which would show his condition was worsening, and what action each party would take in that event, such as who they could notify. Establishing this right at the beginning, and involving Subject 2 in the agreement, meant that when he did experience a crisis after a couple of months at the project he was prepared to co-operate with the agreed plan.

Close information-sharing between the agencies, based on mutual respect, has also helped to ensure Subject 2 receives timely and appropriate support for his needs. If Subject 2 misses an appointment for medication at the hospital, they notify his housing project within a day, allowing his support worker to discuss this with him and encourage him to re-arrange the appointment. Similarly, a traffic-light system also allows both agencies to inform one another quickly if they see any change in his condition.

A local GP also visits the housing project regularly to see clients, including Subject 2. Subject 2 had previously been barred by a GP surgery for loud and aggressive behaviour in the reception area at a time when his mental health was poor; and consequently was reluctant to register with a GP. Holding surgeries at the project has helped him to overcome this, and has meant he has been able to access support for other health conditions and general health education, rather than only addressing his mental health.

As a result of this support, Subject 2 has not offended or needed to return to hospital in the year since his release. He is sufficiently confident in managing his condition that he is now beginning to plan for moving on from the supported accommodation and returning to independent living, rather than being "trapped in the mental health system his whole life".

Story 3: Subject 3

Subject 3 is a young man in his early 20s, from a Black African background.

Subject 3 has a history of misusing alcohol, cannabis and cocaine. He has been arrested, held in custody and appeared before court on numerous occasions, most of which are connected to his drug and alcohol consumption. After his most recent arrest, probation staff suspected Subject 3 may have some form of mental health problem, and asked that he be seen by the NHS-funded liaison and diversion service at the local magistrates' court.

The assessment identified that Subject 3 had low-level mental health needs and a possible learning disability, as well his substance misuse. However, he did not meet the criteria to be referred to the community mental health team, as his condition was not severe enough to meet the thresholds set for this. Despite this, an essential part of the liaison and diversion team's role is to maintain a detailed knowledge of the service landscape in the local area, developing good links with both voluntary and statutory organisations. This meant they recommended that he attend a local African community organisation offering a mentoring and support service instead.

Subject 3 was initially reluctant to engage with the service, having had poor experiences attempting to access support in the past. However, the organisation were well known in his community and their centre was located close to where he lived, so he agreed to attend an appointment there the following day.

On meeting with a key worker at the community organisation, Subject 3 felt he could identify with his cultural background and that they understood where he was coming from. This strong sense of connection made him more willing to listen to what the key worker said and to engage with the support being offered. In turn, his key worker took time to listen to him, and gave him the opportunity to express what it was he felt he needed.

The community organisation could not offer in-house support to help Subject 3 address his drug and alcohol use. Instead, after meeting with his key worker several times he agreed they could refer him to another agency in the city who could provide this. Subject 3's key worker contacted the agency on his behalf to make the referral, and then went with Subject 3 to his initial appointment. Having someone with him with whom he had already built a strong relationship meant Subject 3 was fully engaged with the service from the start, whereas previously he had often felt suspicious of professionals working with him and so had dropped out of attending services.

The community organisation worked alongside the drug recovery agency for around 6 months, attending appointments with Subject 3 and supporting him in between to maintain his recovery. By the end of this time, Subject 3 had developed a better relationship with staff at the drug recovery agency, and so continued to follow through with them and has now completed the programme.

Subject 3 was also assigned a mentor by the community organisation who is continuing to work with him, supporting him in developing independent living skills and also in building up a support network to help manage his mental health.

Providing a culturally appropriate service was essential for Subject 3 in enabling him to overcome his reluctance to engage with support, and take his first steps towards a successful recovery.

Story 4: Subject 4

Subject 4 is a 30-year old white British woman, living in a large town in the north of England. Six months ago, Subject 4 was arrested for on-street drinking, her first offence, and was taken to a nearby custody suite. Whilst there she was met and assessed by a mental health triage nurse who works for a local voluntary sector women's centre. The triage team are able to make referrals to a range of different services, for both low-level and more serious support needs.

Subject 4 scored severely on the Mental Health Minimum Data Set tool; but the assessment also included time and questions to allow her to discuss her situation and the reasons behind her mental health issues and offending behaviour. During this, she disclosed that she had significant debt problems; and that she had recently suffered a significant bereavement, driving her further into debt through the funeral costs, as well as adding to her emotional distress.

In the months before this point, Subject 4 had been diagnosed as suffering from depression, and at one point was admitted to A&E having attempted suicide. At the time this was treated solely as a clinical health issue, for which she was prescribed medication; and at the point of her arrest, she had been on the waiting list for counselling services (referred by her GP) for 12 months. None of these services had recognised her financial situation as being a key driver behind her depression.

The custody suite nurse referred Subject 4 for both debt advice and counselling support at her local women's centre, and they were able to offer her appointments for both services within a few days. When she arrived at the centre for the first time, Subject 4 was welcomed by a volunteer who gave her a cup of tea and chatted to her while she waited for her appointment, helping her to feel relaxed and at ease about the meeting. Volunteers also texted her between meetings to find out how she was or to remind her of appointments, and she was able to drop in to the centre whenever she chose, so she was never left too long without support.

The debt advice service helped her to look through her bills, plan a budget, and liaised with her creditors to arrange reasonable repayments. Dealing with these underlying financial issues helped to reduce Subject 4's feelings of panic, and gave her the space to begin to address her mental health issues. Using a stepped-care model, the mental health service were able to provide her with one-to-one counselling followed by group support, all in the same place. Offering all these services under one roof at the women's centre meant Subject 4 only needed to engage once, rather than having to cope with accessing multiple services in different places. And being in a woman-only environment gave her confidence to discuss her past experience of suffering domestic violence with the group, which she would not have done in a mixed environment.

Subject 4 was anxious about the medication she had been prescribed by her GP, but felt embarrassed to raise her concerns with him directly. As the women's centre has good relationships with the GP surgeries in the area, a member of staff was able to call her GP on her behalf, and then talk about the answers in more detail with Subject 4, until she felt happy to continue taking the medication. This also helped her to manage her condition more successfully.

Providing the mental health triage service at the point of arrest meant the Subject 4 was offered the support she needed immediately, rather than being drawn further into the criminal justice system; and the holistic approach taken by the women's centre allowed her to address all her areas of need and not just the most obvious one. Subject 4 is now feeling more confident about her future, and is considering volunteering at the women's centre as a first step to a return to employment.

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6. Appendix 2: Clinks and CQC workshop – Engaging with service users and their families in the criminal justice sector.

Engaging with service users and their families in the criminal justice sector

Clinks & CQC workshop, 13th November 2014

FINAL

Participants

Clinks

Detention Action

Inspirit

Peterborough Healthwatch

POPS

RECOOP

Revolving Doors Agency

St Giles Trust

Thames Valley Partnership

User Voice

Young Advisors

Mubarek Trust

CQC

1. Working with CQC

Clinks welcomed participants and explained the purpose of the meeting. CQC had commissioned Clinks to bring together voluntary sector organisations working in the criminal justice sector, to help advise CQC on how to engage with service users, families and the voluntary sector itself – in the new approach to inspecting health and care services in criminal justice settings.

The proposed new approach to inspecting health and care services across the different parts of the criminal justice system was outlined. CQC has launched a 'signposting' document setting out these proposals for comment and discussion.

Participants asked a number of questions about how CQC currently inspects criminal justice settings in relation to health and social care. For example:

- Do you require providers to involve users in their work. People want CQC to look at how providers involve users?
- What involvement of families would you expect providers to undertake – and how does CQC involve families on inspections?
- What methods to engage with service users, families and voluntary groups does CQC use now in this sector? Participants wanted to know more about how CQC works at the moment.

2. Routes to engaging service users & their families

Participants were invited to brainstorm potential routes by which CQC could engage with service users and their families to understand their experiences of healthcare in criminal justice and detention settings. A number of themes emerged from the suggestions made:

Prison forums

- Using existing systems for service user engagement e.g.
    - Prison councils
    - Older prisoners forums
    - Norwich Prison health council
- Look for user-led, self-managed forums
- Ask prisons to provide the minutes from these council/forum meetings

Peer-led activity and support

- Peer reps - able to speak about issues individuals might be reluctant to voice themselves e.g.
    - Healthwatch Peterborough health reps model
    - Well-being reps (gym)
- Listeners services
    - Gather intelligence from Samaritans
- Through-the-gate mentoring services e.g.
    - St Giles' peer volunteer mentors
    - Transforming Rehabilitation programmes

Prison reps could also be encouraged to run 'feedback days', organise suggestion boxes; hold surgeries in prison.

BUT beware:

- Whose voices is CQC hearing? Prison forums are often made up of the most engaged service users.
- How prisoner groups are chosen may not be inclusive
- Forums need to be well-prepared & facilitated
- Reps should be asked to consult with others – not just responding with own views

Families

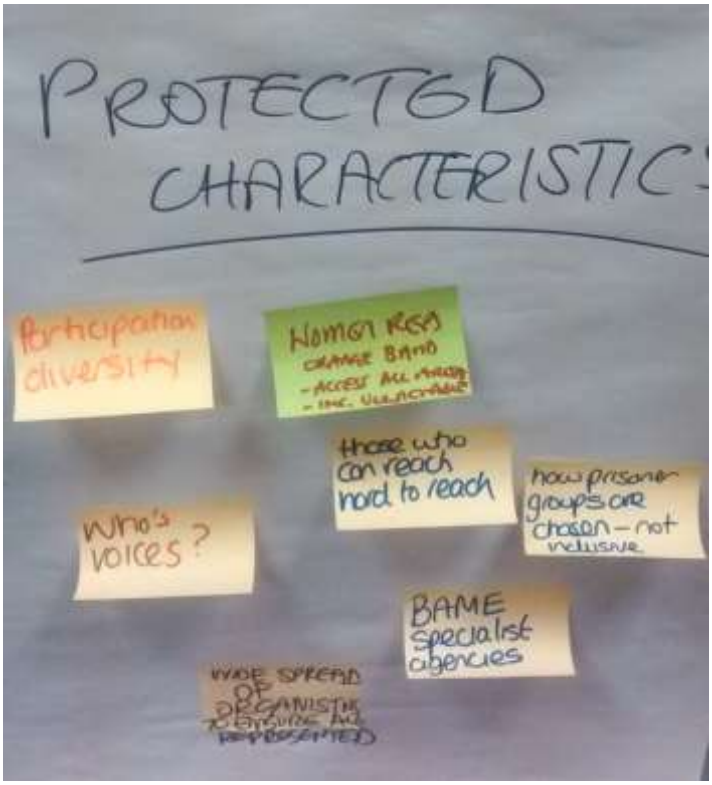
- Families often know of health needs individuals may not want to report. They can often see whether people are being cared for – including basic physical health needs
- Use visitor centres in each institution – they already have relationship with families and an organisation is commissioned to lead these.
- Work with NOMS to connect with family programmes
- Family forums set up by voluntary sector
- Prison family days
- Troubled families programme providers

Issues for engaging with families

- Families are traditionally poorly engaged in institutions anyway. There is an issue about encouraging service providers to engage more with families in the first place
- Need to reach families representing protected characteristics and from diverse communities

Working with people from diverse communities and with protected characteristics

- Work with wide spread of organisations to ensure all groups represented
- Those who can reach the hard to reach
- BAME specialist agencies
- Specialist women's reps



Voluntary sector (prisons & community)

- Develop prior relationships with the voluntary and community organisations working in a prison – they can give an overview of the issues and trends about prisoners care
- Voluntary and community agencies in prison can access prisoner views, and are trusted
- Service user groups run by VCS
- Include groups working in community – people may feel freer to speak post-release
- Local community groups e.g. mosque support services
- People disperse, so need organisations with wide reach

Issues

- Voluntary organisations need to know more about CQC and what is does and is looking for.


Voluntary sector
~~Prisons~~ & Community
Voluntary Community
SERVICE USER GROUPS
BAME specialist
ROLE OF PRIVATE SECTOR?
PRIVATE PROVIDERS


OTHER PARTNERS/ STAKEHOLDERS
Probation 12m so persuasion Exit surveys
Probation pull a group together
LIASON & DIVERSION SCHEMES
NHSE
Join other events eg Diversity fair

Other partners & stakeholders

- Prison healthcare feedback – make sure collected by different person to who provided treatment
- Join other prison events e.g. diversity fairs
- Probation – exit surveys
- Private providers (TR)
- Resettlement prisons – links to work in community
- Independent monitoring board
    - Anonymised surveys using IMB route for responses?
- Liaison & diversion schemes
- PHE substance misuse groups e.g. London user involvement council
- NHS England
- Healthwatch for info in community

3. Specific engagement in relation to Young offender institutions

- Most routes similar to adult prisons (there may be some difference of approach needed in secure colleges)
- Peer to peer projects are particularly important – working with youth advisors for example
- Peer-to-peer research organisations are an useful route
- There will be different agencies involved within the settings and in the community to engage with
- Young Advisors in community criminal justice settings
- Beware:
    - Peer reps may be more important due to mistrust of all adults
    - BUT bullying within YOIs may affect results
    - Transitions between child and adult criminal justice settings are a key area to ask people about.
    - Young people need to build trust with someone to share their experiences; they need to know what will happen to their information and they need accessible information about CQC and the standards
    - Inspection reports need to be accessible to them to know what has happened as a result

4. The different issues for Immigration removal centres

- Immigration removal centres are very different settings to prisons.
- There are fewer voluntary and community sector organisations working in IRCs – very limited support especially post-discharge. Examples of organisations working in IRCs are:
    - Medical Justice
    - Women for refugee women
    - Befriending groups
- People have a huge mistrust of Border Agency & Home Office
- There are significant challenges in people discussing their experiences of care – because of fear of the impact on their immigration status
- The range of health needs are very different and therefore care services needed are different. There are larger numbers of people needing support for post-traumatic stress disorder and following experience of torture
- People from IRCs serving a sentence may be detained in prisons beyond the end of their sentence rather than return to an IRC
- People may be dispersed across the country and harder to follow up after leaving an IRC
- People in IRCs have a greater access to phones – this allows conversations to be kept confidential. It will be an important way in which people may want to discuss their experiences.

- CQC needs a separate conversation with those working specifically in IRCs to understand the options for engaging people in these settings.

5. Other suggestions for CQC

During the discussion, a number of suggestions were made as to how CQC could ensure the best engagement in their inspections, as well as a number of issues to be aware of.

Issues raised

- How to elicit an authentic response?
- Reluctance to make negative comments
- Fear of exposure in revealing issues
- Particular under-reporting of mental health issues:
    - Older prisoners – dementia
    - Young offenders – personality disorders
    - Women – fear of losing care of children if mental health issues known, fear of punishment for self-harming
- ..and of other issues with health implications e.g. sex-workers
- Low awareness of health needs & low expectations of health care among service users - leading to lack of awareness if provision is inadequate

Suggestions for inspection process

- Include evidence that providers include service users in design of services as a criteria for inspections
- Ask for complaints and feedback information from the provider (but be clear with offenders who can/cant deal with their complaints)
- Handle safeguarding and confidentiality issues – be clear about what will be shared and with whom

- Inspectors may need particular skills to do this engagement – or have advisors to support them. Training for inspectors will be key – and the voluntary sector could help with this
- Health promotion and awareness raising important as well as the provision of direct health care services
- Importance of feeding back results of inspections – showing service users that participating has made a difference
- Use call back system e.g. when people leaving prison. This could be built into the discharge arrangements
- Promoting work of CQC to increase responses
    - Posters in community settings e.g. probation offices, visitor centres to advertise general email address?
    - Promote widely to the voluntary and community sector e.g. Clinks newsletters
    - Greater cross-section of involvement, not just specific organisations working in offender settings but also for example people working with homeless groups, drug users, sex workers – some of whom will have experience of the criminal justice sector. Other examples were Fulfilling Lives groups, User Voice programme board who could advise CQC
    - Promoting the inspection findings across the institutions should be part of the feedback process, and providers expected/required to do this. There should be accessible and summary forms of inspection reports

Clinks, Lucy Hamer 20th November 2014

7. Appendix 3: CQC IRC Stakeholder Event

CQC IRC Stakeholder Event
Feedback and Comments

12th Jan 2015

How do we best engage with service users?

- Attendees will send us contact details for befriender/advocacy/visitor groups for each IRC.
- Look at minutes from detainee representative group meetings.
- Recently released ex-detainees will be more comfortable disclosing info.
- Develop relationships with 3rd party agencies to support ongoing monitoring, advocacy & to identify detainees who want to speak to us on inspections.
- EBEs can tell us about the differences between IRCs as are likely to have been transferred between several.
- Stakeholders feel HMIP are able to get a fairly representative sample for feedback using their current methodology.
- G4S are developing a version of the 'friends and family test' to be used in IRCs.
- Stakeholders feel it would be beneficial for inspectors to have training in how to use interpreters appropriately.
- Detainees have mobile phones- might be more comfortable disclosing info over the phone.

What are some of the challenges in this sector?

- High staff turn over
- Training programmes can't keep up with staff turn-over.
- Stakeholders feel CQC team need training in the differences between IRCs and prisons.
- 2 different populations: migrant population and 'hardened' prison population under the same roof- conflicts arise, concerns re vulnerability.
- Conflicting messages/priorities/obligations between DSOs, detention rules, service specs.
- Variability between IRC environments- old prison architecture vs newer hostel style accommodation. Has impact on behaviour and experience.

- Think carefully about conduct: carrying a clip board, being seen going round with a guard, perception of being in a suit vs more casual clothing, what the interview room is usually used for.
- Poor observation of confidentiality between IRC healthcare and home office.
- Poor clinical information systems.

Thematic inspection discussion: potential themes.

- Use of Rule 35 (from a clinical perspective).
- Communicable diseases (?joint with Public Health England).
- Break down mental health in to subsets e.g. SMIs, PTSD, self-harm.
- Appropriate observation of confidentiality.

What does good look like in IRCs?

- Continuity of care on transfer between IRCs/release to community/removal/zero notice removals (inc TB and HIV meds).
- Getting the basics right: is there clinical audit process, are BPs being acted on.
- Seeing the same practitioners consistently.
- Appropriate use of medical holds.
- No inappropriate use of handcuffs.
- Proactive healthcare staff e.g. reminding detainees of appointments.
- Attitude to DNAs- thinking about why and who is responsible.
- Staff able to access training on trauma and torture & demonstrate good awareness (e.g. is it part of induction?).
- Clinical professional development programmes available.
- Healthcare staff engage well with detention staff.

What one thing would you like to see from the CQC?

- Look at outcomes as well as systems.
- Publish more detail- can be in the report itself or in annexes available on website.
- Focus more on safeguarding- stakeholders feel HMIP unable to explore this in much detail.
- Keen for us to set up an IRC advisory group.
- Keen for us to use EbEs.
- Keen to give feedback on handbook draft.

8. Appendix 4: Criminal Justice Consultation discussion– CQC/HWE and IHW

Criminal Justice Consultation discussion– CQC/HWE and lHW

Attendees were asked the following questions:

1. What does your local Healthwatch think about our proposals for new style inspections of health and care services in detained settings?
2. How is your Healthwatch currently focusing on health and care services in detained settings?
3. How CQC can best hear from offenders and their families?
4. How CQC can best work with Healthwatch on these types of inspections?

Responses were as follows:

- Our experience has mainly been in relation to St Andrews where there are a large number of adolescents with criminal justice experience. The HW has conducted enter and view visits at St Andrews, and produced a questionnaire for users in secure settings, which is tailored to the level of security (with Together for Mental Wellbeing).
- Support the idea of local HW adopting the approach taken in Peterborough to set up prisoner engagement programmes.
- Concerns about care for people, including Ugandan refugees in Yarl's Wood IRC. Care is inhumane,, there had been too many suicides, and SERCO staff has been accused of sexual harassment. CQC should not wait to develop their methodology before following up concerns in this service.
- Bedford Borough Council overview and scrutiny committee were also looking into the care provided for people at Yarls Wood.
- Communication with detainees in IRCs is critical both in the provision of care and in any inspection process. It is noted that at Yarl's Wood, official interpreters were not being used and the service was relying on staff which is not
- Further work should be undertaken to consider whether Medical Justice and HW could work more closely with CQC to identify the quality of care in IRCs
- Positive about CQC's proposed approach to inspecting health and justice services. There is a role for HW to work more closely with CQC and to consider the idea of joint activity. Support unannounced CQC inspections.

- English is not going to be the first language for people detained in IRCs there must be provision for interpreters.
- Staff whistle blowers must be provided more protection of anonymity. They must feel safe to talk to the CQC
- Detainees only get £10 phone credit. They are unlikely to call the CQC when they could be calling their families. They also have no privacy to make a call. CQC needs to think of other mechanisms for them to make contact if they want to share their experiences.
- Positive about the information provided.
- Each lHW would need to decide if this would be a priority area for them
- If there is to be any joint activity with CQC and HW there needs to be considerable thought and discussion surrounding training. There are issues for volunteers conducting enter and view activity in these types of services.
- There is secure unit for young people with mental health needs at Bedford Hospital run by a new provider. This service is of concern to the local HW – and poses similar challenges for HW in understanding people's experiences of care
- HWE were not encouraging HW to enter and view detained settings. HWE felt it would be a concern if volunteers were expected to visit these complex settings. HW do not carry out inspections and there are no proposals for any joint visiting arrangements with CQC and HW in detained settings.
- Concerned about the terminology of enter and view and inspection. Inspections are very different
- The role of HW is to provide intelligence to CQC for inspection. Over the last 16 months Peterborough HW has been developing methods and have gathered evidence that they would be happy to send over to the CQC
- Peterborough HW has also been working with NICE who have put out a call for evidence on the physical health of prisoners.
- They have also worked with Bowel Cancer UK and held a focus group with 50 prisoners in a bowel cancer unit where they were able to get some valuable intelligence. An important issue arising from this was that detainees were not aware of the advocacy services available to them and none had heard of PoWHer who provide local NHS complaints advocacy services and other general advocacy provision for detainees.
- Welcome the engagement CQC has undertaken with CLINKS to inform the CQC consultation.
- Care linked to detention centres causes concerns. Firstly the care for detained patients in a local hospital setting – such as the use of handcuffs for a patient when in a consultation with a clinician
- It is very difficult for people in detention to make a complaint about their care. In his experience people in detention are not aware of the advocacy services available to support them and many people are not aware how to make a complaint – or would feel able to do so.

- There is potential for HW, CQC, HMIP and Medical Justice to work more closely together and for HW to work together across local areas covered by detention centres, prisons etc.
- HW should be able to identify the views and experiences of people who have left detention centres and live in a local area and now use local health and care services. Their experiences of local care services is also very important
- Any enter and view activity in these settings would need to be developed carefully to get it right
- Pathways – if detainees have medical requirements these can often get lost when the detainee is transferred or they are told they don't need the health or care service at their new site
- Need to ensure that detainees who have experience of torture are able to receive appropriate physical examinations and this is regulated effectively.
- Independent Monitoring Board would be a good source of intelligence and a valuable resource (Note:*CQC has been working closely with the IMB*)
- Joint inspections with HMIP are key for CQC as services tend to put up barriers to issues being addressed on the grounds that they were a security issue. CQC would have more power in the setting with HMIP
- Importance of speaking to advocacy services about the evidence they hold and whether they are able to support people in detained settings. She felt advocacy services often had experience of speaking to families and relatives.
- How would CQC assess personality disorder units e.g., White Moor as there are so few? (Note: CQC health and justice team are working with the CQC mental health policy team to consider how best to regulate services for people in these types of settings).

9. Appendix 5: Immigration Law Practitioners' Association Submission

ILPA IMMIGRATION LAW PRACTITIONERS' ASSOCIATION

Care Quality Commission consultation on approach to regulating health and social care in prisons and young offender institutions and health care in immigration removal centres

Response by the Immigration Law Practitioners' Association (ILPA)

Introduction

The Immigration Law Practitioners' Association (ILPA) is a registered charity and a professional membership association the majority of whose members are barristers, solicitors and advocates practising in all aspects of immigration, asylum and nationality law. Academics, non-governmental organisations and individuals with an interest in the law are also members. Established over 25 years ago, ILPA exists to promote and improve advice and representation in immigration, asylum and nationality law through an extensive programme of training and disseminating information and by providing evidence-based research and opinion. ILPA is represented on numerous government committees, including Home Office, and other consultative and advisory groups.

ILPA's expertise is in work with persons under immigration control and we have answered the questions accordingly.

1. Do you agree with the proposal for a joint Her Majesty's Inspectorate of Prisons / Care Quality Commission inspection framework?

ILPA agrees with this proposal.

We support the stated aim of the joint inspection framework: to facilitate the monitoring, regulation and inspection of health care providers within secure settings by the Care Quality Commission alongside work with Her Majesty's Inspectorate of Prisons to identify wider health issues within secure settings. The adoption of an holistic approach to monitoring health in secure settings is of importance as regards to the care of immigration detainees given the evidence that immigration detention is likely to be detrimental to the mental and physical health of detainees[2]; the role of detention centre staff other than health

[2] Burnett, A. Peel, M. (2001). 'The health of survivors of torture and organised violence.' BMJ, 322, pp.606-609; Steel Z et al. (2006) 'Impact of immigration detention and temporary protection on the mental health of refugees' British Journal of Psychiatry 188: 58-64. 2006; Pourgourides C, et el. (1996) 'A second exile: the mental health implications of detention of asylum seekers in the United Kingdom'. In: Birmingham: North Birmingham Mental Health Trust, 1996; Robjant K, et al, Mental health implications of detaining asylum

professionals in identifying and responding appropriately to health problems experienced by detainees; and the significance of health considerations to the ongoing duty of the Secretary of State to review the decision to detain.[3]

Short-term holding facilities[4] and pre-departure accommodation[5] should be specifically referenced within the consultation document. NHS England is responsible for commissioning health services in short-term holding facilities and pre-departure accommodation in addition to immigration removal centres and these secure settings are also subject to inspection by Her Majesty's Inspectorate of Prisons. It would therefore be appropriate for short-term holding facilities and pre-departure accommodation to be included within the scope of the joint inspection framework in the same way as immigration removal centres and prisons. This is particularly important given that there is no equivalent of the Detention Centre Rules 2001[6] for short term holding facilities, despite these having been consulted on since 2006.[7] Ministers promised during debates on the Bill that became the Immigration and Nationality Act 2014 that draft rules would be published before the summer recess of 2014,[8] but this did not happen and draft rules have yet to be published.

The joint inspection framework should encompass social care in immigration removal centres. The consultation document states that the inspection will not cover social care in these settings on the basis that the Care Act 2014 does not cover immigration removal centres. We assume that this is on the basis, that the responsibilities of local authorities subject to the regulations of the Care Quality Commission would not be engaged. We disagree. We do not consider that this accurately reflects the position in law.

Under s.76 Care Act 2014, prisons and approved premises are excluded from certain provisions of the Care Act 2014 including the duties on local authorities with regard to safeguarding adults under ss.42-47 of the Care Act 2014. However, s.76 of the Care Act 2014 does not similarly exclude immigration removal centres from these provisions and the local authority retains duties under Part 1 Care Act 2014 to those, including asylum seekers, who are not excluded from receiving services by virtue of Schedule 3 of the Nationality, Immigration and Asylum Act 2002. The Department of Health has confirmed in its guide for local authorities that the introduction of the Care Act 2014 has not changed the legal position for asylum seekers or foreign nationals in immigration removal centres[9]. It would be important therefore that the Care Quality Commission ensures and exercises oversight over the exercise by local authorities of their duties and responsibilities towards detainees. The importance and complexity of social care provision within immigration removal centres

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seekers: systematic review. Traumatic Stress Service, Clinical Treatment Centre, Maudsley Hospital, Denmark Hill, London SE5 8AZ, UK.

[3] Home Office Enforcement Instructions and guidance, Chapter 55, at 55.3.1.

[4] Immigration and Asylum Act 1999 s. 147.

[5] Immigration and Asylum Act 1999 s. 6(2)(b).

[6] SI 2001/248, as amended.

[7] See ILPA's 13 February 2006 response to this consultation at http://www.ilpa.org.uk/pages/non-parliamentary-briefings-submissions-and-responses.html (accessed 23 May 2014).

[8] Hansard HL Report 3 March 2014, col 1140; 1 April 2014, col 856.

[9] http://www.local.gov.uk/care-support-reform/-/journal_content/56/10180/6522988/ARTICLE

make it a particularly appropriate focus for a joint approach to monitoring and inspection between the Care Quality Commission and Her Majesty's Inspectorate of Prisons, drawing on the specialist expertise of the former in relation to social care practice.

ILPA also urges that health care provision in immigration removal centres is inspected with greater frequency than once every four years (compared with annually for young offender institutions and every two to three years for prisons) which the consultation document indicates may be achieved through conducting more frequent and focused, intelligence-led inspections. The UK has been found to have breached detainees' rights under Article 3 of the European Convention on Human Rights, the prohibition on torture, inhuman and degrading treatment and punishment in no less than six cases involving mentally ill individuals held in immigration detention in the last four years.[10] Other cases are pending or have settled. The judgments record how some of these individuals' mental illnesses were managed within the prison estate, but how rapidly their condition deteriorated when they were transferred to immigration detention.[11] Individuals whose condition was managed within the prison estate deteriorated rapidly in immigration detention.

Failings reaching the high threshold of Article 3 have been identified in the provision of health care as well as in wider systems relating to maintaining the decision to detain. . For example, the High Court in *S v Secretary of State for the Home Department*[12] catalogued a series of failings which led to its finding that those responsible for the assessment, treatment and illness management of S at Harmondsworth Healthcare Centre and Colnbrook Healthcare centre, as well as those responsible for his detention, had breached his rights under articles 3 and 8 of the European Convention on Human Rights.

Detention under Immigration Act powers is without limit of time and there is no automatic judicial oversight of either the decision to detain or to maintain detention, making it particularly important that systems to safeguard persons in detention function effectively. The need for monitoring, inspection and oversight of health care provision is therefore

[10] (All accessed 23 May 2015). *R (S) v* Secretary of State for the Home Department [2011] EWHC 2120 (Admin) (5 August 2011), http://www.bailii.org/ew/cases/EWHC/Admin/2011/2120.html; *R (BA) v* Secretary of State for the Home Department [2011] EWHC 2748 (Admin) (26 October 2011) (http://www.bailii.org/ew/cases/EWHC/Admin/2011/2748.html;*R (HA) v* Secretary of State for the Home Department [2012] EWHC 979 (Admin) (17 April 2012), http://www.bailii.org/ew/cases/EWHC/Admin/2012/979.html; *R (D) v* Secretary of State for the Home Department [2012] EWHC 2501 (Admin) (20 August 2012), http://www.bailii.org/ew/cases/EWHC/Admin/2012/2501.html; *R (S) v* Secretary of State for the Home Department [2014] EWHC 50 (28 January 2014), http://www.bailii.org/ew/cases/EWHC/Admin/2014/50.html; *R (MD) v* Secretary of State for the Home Department [2014] EWHC 2249 (Admin) (8 July 2014), http://www.bailii.org/ew/cases/EWHC/Admin/2014/2249.html

[11] See e.g. *R (BA) v* Secretary of State for the Home Department [2011] EWHC 2748 (Admin) (26 October 2011), *op.cit.*

[12] *R (S) v* Secretary of State for the Home Department [2014] EWHC 50 (28 January 2014), http://www.bailii.org/ew/cases/EWHC/Admin/2014/50.html;

acute and urgent within immigration removal centre, requiring a sustained and in-depth inspection regime.

2. Do you have any comments on the assessment framework of key lines of enquiry, prompts and characteristics set out in Appendix A?

Yes.

General comments

ILPA welcomes the setting of standards for healthcare in detention by the Care Quality Commission in consultation with Her Majesty's Inspectorate of Prisons as it is important that robust and objective standards are set based on clinical considerations. The need for independent assessment of health and social care in settings where immigration detainees are held is particularly pressing in light of the history of identification in judgments of poor standards of health care provision in immigration removal centres.

The inspection framework needs to take account of the particular status of immigration detainees who are subject to administrative detention rather than following a sentence by a court. This distinction gives rise to different considerations in law. For example, immigration detention should only be used sparingly, with a presumption in favour of temporary admission or release[13]. This means that, in contrast with those subject to a prison sentence following conviction, release should be considered actively. It is Home Office policy that those suffering serious medical conditions or serious mental illness which cannot be satisfactorily managed within detention, torture survivors or trafficked persons may only be considered "suitable" for detention in 'only very exceptional circumstances'[14].

These considerations have particular implications for the management of those with mental health or other medical conditions. For example, it is the position of the Royal College of Psychiatrists that immigration detention militates against successful treatment of mental illness. The focus of current NHS mental health services is to not only treat the symptoms of mental disorder but also to support community rehabilitation. The Royal College of Psychiatrists identifies that the recovery model that is not possible to put into action in a detention centre[15]. It is important that the standards fully reflect the need for health care

[13] UK Visas and Immigration, Chapter 55: Detention and Temporary Release, Enforcement Instructions and Guidance, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/400022/Chapter55_external_v19.pdf at 55.1.1 (accessed 23 May 2015).
[14] UK Visas and Immigration, Chapter 55: Detention and Temporary Release, Enforcement Instructions and Guidance, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/400022/Chapter55_external_v19.pdf at 55.10 (accessed 23 May 2015).
[15] The Royal College of Psychiatrists, Position Statement on detention of people with mental health disorders in Immigration Removal Centres, October 2013, updated January 2014 at: http://www.rcpsych.ac.uk/pdf/Satisfactory%20Treatment%20in%20Detention%20document%20March%202014%20edit.pdf (accessed 23 May 2015).

professionals to be considering and making recommendations for appropriate alternative provision of care to the individual in a community-based setting.

The duties on the Home Office actively to reconsider the decision to detain immigration detainees place further responsibilities on health care staff to identify relevant health concerns and indicators of torture or trafficking and to communicate these appropriately to detention centre staff responsible for the decision to maintain detention so that those unsuitable for detention are released. Standards reflecting the duties on health care professionals in relation to bringing concerns to attention in this way under Rule 35 of the Detention Centre Rules 2001[16] should be incorporated into the inspection framework.

As indicated above, ILPA supports the aim of the joint inspection approach to monitor health care provision whilst examining wider factors in detention that impact on health and well-being. This has particular importance in relation to the implementation of Rule 35 of the Detention Centre Rules 2001 which requires a whole systems approach of health care providers identifying health concerns and detention centre staff making decisions on continued detention to ensure the effective operation of the rule. Consideration therefore needs to be given as to how the Care Quality Commission will identify relevant issues to Her Majesty's Inspectorate of Prisons as part of the joint inspection framework.

Are services safe? Key lines of enquiry, prompts and characteristics

A further standard should be included at S3 monitoring the use of segregation, which should not be used to manage mentally ill and other detainees. Mental illness is often treated as 'behavioural' and dealt with through disciplinary measures such as the use of force and segregation. The use of these measures on the mentally ill will have disproportionate effects. In the case of *MD*[17], in which a breach of Article 3 European Convention on Human Rights was found in relation to the lack of measures or ineffective application of measures to ensure that MD's mental health was properly diagnosed, treated and managed, MD suffered from major depression with psychotic features and generalised anxiety disorder and was held at Yarls' Wood. The response to her distress, self-harm and aggressive outbursts was to remove her from association and isolate her, actions that an independent doctor identified as liable to make her condition worse. The independent physician also identified that physical force was used in response to her distress, frequently increasing her anxiety and experienced by her as traumatic. The High Court held:

> *I also accept that removal from association and isolation and restraint in its various forms whilst carried out without any intention to inflict suffering on the Claimant increased her suffering and was degrading because it was such as to arouse in the Claimant feelings of fear,*

[16] Detention Centre Rules 2001, SI 2001/238 at:
http://www.legislation.gov.uk/uksi/2001/238/pdfs/uksi_20010238_en.pdf
[17] *R (MD) v* Secretary of State for the Home Department [2014] EWHC 2249 (Admin) (8 July 2014), http://www.bailii.org/ew/cases/EWHC/Admin/2014/2249.html

anguish and inferiority likely to humiliate and debase the Claimant in showing a serious lack of respect for her human dignity.[18]

In our experience, the use of force and segregation for mentally ill detainees is far from isolated. For example, both the 2012[19] and 2013[20] reports of the Harmondsworth Independent Monitoring Board pointed to other cases where mentally ill men had been segregated for prolonged periods of time.

Standards at S3 should make clear that the use of force is limited to physical intervention required to prevent harm to the individual or others in addition to the requirements that it be used as a last resort and for no longer than necessary. The framework standards should encompass specifically the use of physical restraints in a wider range of circumstances. For example, immigration detainees have been escorted to secondary health care settings in restraints where security is not a concern, stigmatising them and failing to respect their dignity.

Are services effective? Key lines of enquiry, prompts and characteristics

Standards should be included to monitor whether healthcare staff have been proactive in identifying torture, trafficking or health concerns relevant to the question of whether someone is unsuitable for detention and reporting these, with the informed consent of the detainees, promptly and accurately to casework staff. The quality and outcome of those reports should be monitored.

A further standard should be developed assessing whether active consideration has been given, and recommendations made, as to whether treatment would more appropriately be provided in a community setting and whether concerns have been raised with detention centre staff as appropriate. This section should also specify that, where treatment is continued in detention, this is provided to at least an equivalent standard as that provided in the community in all areas of healthcare.

Specific standards should be included addressing the need for recruitment, training, and ongoing professional development of staff and their demonstration skills pertaining to, and knowledge and experience of, the common health problems of immigration detainees, including the health needs of refugees and asylum seekers, survivors of torture and ill-treatment, and those with mental health problems.

Standards related to care planning, continuity of care and management of care records are particularly important given the frequency of moves of immigration detainees within the detention estate and the need to make arrangements for medical care on release or on removal. These concerns must be monitored and addressed. It would be useful for the

[18] *Ibid*, para 141
[19] http://www.imb.org.uk/wp-content/uploads/2015/01/harmondsworth-2012.pdf
[20] http://www.imb.org.uk/wp-content/uploads/2015/01/harmondsworth-2013.pdf

framework to include examination of action taken by health care professionals to raise concerns with detention centre staff about inappropriate or frequent moves affecting an individual's continuity of care. ILPA members also have experience of seriously ill detainees being released from detention without accommodation being put in place, without appropriate care plans or referrals to community mental health services or without medication or prompt access to medication being organised, giving rise to serious risks to the person. Particular attention should be given to this issue in the application of the standards in this area, including through following the care pathways of individuals on release from detention.

ILPA has raised concerns in relation to the absence of systems for identifying and making provision for those who lack mental capacity to make decisions about their immigration cases, particularly in the context of the detained fast track process operated at Yarls' Wood and Harmondsworth, where the speed of the process places individuals at particular disadvantage in pursuing their case. The claimants in *R (S) v Secretary of State for the Home Department*[21] and *R (BA) v Secretary of State for the Home Department*[22] had not been identified by the immigration authorities as lacking capacity to participate in their immigration cases; no adjustments had been made to the process for determining their immigration applications for ensuring that they had understood the reasons for their detention and how to go about challenging it. It would be useful for the Care Quality Commission to consider and monitor the role of health care providers in detention in identifying and supporting individuals who do not have the capacity to engage with their immigration case.

Are services caring? Key lines of enquiry, prompts and characteristics

Immigration detainees report being treated with disbelief or with a lack of compassion by health care staff in detention so these standards are very relevant. A specific standard should be included in this section assessing the use of interpreting services for health care appointments.

Are services responsive? Key lines of enquiry, prompts and characteristics

As discussed above, standards in this section must take account of the need actively to consider release and treatment in the community for those detained under administrative powers in immigration detention, contrasting with those confined to detention having been sentenced to imprisonment. In August 2010, Home Office policy[23] changed. Prior to that date the policy was that those with physical and mental illnesses and/or disability would be

[21] *R (S) v* Secretary of State for the Home Department [2014] EWHC 50 (28 January 2014), http://www.bailii.org/ew/cases/EWHC/Admin/2014/50.html
[22] *R (BA) v* Secretary of State for the Home Department [2011] EWHC 2748 (Admin) (26 October 2011), http://www.bailii.org/ew/cases/EWHC/Admin/2011/2748.html.
[23] Chapter 55.10 of the Enforcement Instructions and Guidance. Version 9 was replaced with version 10 in August 2010.

"suitable" for detention only in the most exceptional circumstances. After that date the policy was changed to refer to those with such conditions "which cannot be satisfactorily managed within detention." Therefore management of these conditions must be kept under close review. It is ILPA's position that immigration detainees who are physically or mentally ill should not be managed in the detained setting at all.

Are services well led? Key lines of enquiry, prompts and characteristics

The framework should also take account of the need for health professionals working to be aware of, to manage appropriately, and to be supported to manage, tensions which may arise from their dual obligations within the detained setting, so that medical professionals may advocate appropriately, in line with their primary duty to the patient, where threats are posed to an individual's health within detention. The Istanbul Protocol[24] provides a useful reference point for principles regarding dual obligations on medical personnel and the management of these.

3. We do not intend to rate health and justice services in 2015/16. Do you agree with this approach?

ILPA does not have a view on whether a rating be given to locations or providers in 2015/16. Any rating that is given should be specific to the particular detained setting so that the particular issues arising in the particular setting relate directly to the rating provided. It is important, in all cases, that detailed narrative reports of inspections are published to provide a transparent description and analysis of the concerns identified.

4. Should we consider a single rating for health and social care within a secure setting? Should this be a joint rating with Her Majesty's Inspectorate of Prisons or a Care Quality Commission Rating?

Findings from inspections should clearly identify the responsibilities of health care providers and detention centre staff to ensure that responsibilities may be delineated effectively and recommendations implemented by the appropriate body. We consider that separate ratings by the Care Quality Commission and Her Majesty's Inspectorate of Prisons, alongside detailed narrative reports highlighting the concerns identified, would most effectively support this accountability.

[24] United Nations (2004) *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* at: http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf. See particularly paras 66-73. (accessed 23 May 2015).

It is important, however, that the Care Quality Commission and Her Majesty's Inspectorate of Prisons adopt a joint approach to information-gathering and inspection as well as to the formulation of recommendations to address concerns about processes such as those under Rule 35 of the Detention Centre Rules 2001 which require a whole systems approach across health care providers and detention centre staff for their successful operation.

5. Do you agree without our approach to concerns, complaints and whistleblowers?

As discussed below, detainees rarely make complaints or feel entitled to complain about the treatment they receive in detention and therefore it is important for the Commission and Her Majesty's Inspectorate of Prisons additionally to develop the proactive gathering of information about the experience of individuals subject to immigration control held in secure settings.

6. Do you agree with our proposals for gathering detainees' experience of care? Are there any other ways we could gather this information?

Yes, but the Care Quality Commission and Her Majesty's Inspectorate of Prisons should invest in researching, developing and evaluating proactive methods of gathering information about detained persons.'

Persons subject to immigration control are frequently reticent about making complaints for fear that speaking out may affect the determination of their immigration case, their likelihood of removal from the UK or their ongoing treatment in detention. Sometimes they do not see themselves as holders of ,. Detainees may therefore not recognise or assert their rights as a result . This makes a proactive approach to obtaining information important.

Provision should be made to enable those detained to provide information in individual interviews in addition to the suggested focus groups, both for reasons of confidentiality and because of the difficulties of overcoming language barriers in mixed groups.

Consideration should be given to how detained persons may be able to telephone from prison settings and the Commission should ensure that provision for raising concerns and providing feedback by telephone is via a dedicated and free telephone service (including free from mobile 'phones in immigration removal centres), which affords the opportunity to telephone in private.

Interpreting and translation services should be ensured for all mechanisms developed for obtaining information from detained persons, whether face-to-face, by telephone or in writing.

Freephone telephone lines should be supported by interpretation services. Material must be available in a variety of languages and it must be acceptable to submit material in the language of the person's choice.

7. Do you agree with our approach to working with national and local organisations? Is there anything else that we should be doing?

ILPA welcomes the willingness of the Care Quality Commission and Her Majesty's Inspectorate of Prisons to engage with national and local organisations, including voluntary organisations working in secure settings and with families in the community. We consider that the views of legal practitioners with experience of representing persons in immigration detention and of representative bodies such as ILPA must be considered. It is important for the Commission and Her Majesty's Inspectorate of Prisons to be able to receive intelligence from voluntary organisations such as case studies and information that have been anonymised to maintain the confidentiality of thee person concerned.

It would be useful for the Commission to engage with bodies which deal with complaints about health care professionals, such as the General Medical Council. As indicated above, the number of formal complaints is unlikely to be indicative of the level of concerns present in immigration detention settings because persons detained under Immigration Act powers are reticent about making complaints.

The Care Quality Commission and Her Majesty's Inspectorate of Prisons should obtain and review internal audit and monitoring information from the Home Office.

8. We have described how we will gather the views of detainees in advance of the inspection. Do you think this is an effective approach to supporting our work?

See response to question six above. It is vital that the views of persons detained under Immigration Act powers be gathered. The effectiveness will depend upon the Commission's ability to obtain information from them and language support is an important part of this. Persons in detention who are unwilling to make a formal complaint may be prepared to provide intelligence: information that is anonymous or whose source is anonymous. Such intelligence can help to inform decisions on when and where to carry out an inspection and what to look for.

9. We have described how we will gather information and evidence while on site at the secure setting. Do you think this is an effective approach to supporting our work?

It is important to ensure that the inspection evaluates services that are actually provided rather than just assess the quality of aspirations as set out in policies. In addition to the steps outlined above for obtaining information from persons in detention, the Care Quality Commission and Her Majesty's Inspectorate of Prisons should also speak with voluntary organisations, visitor groups and legal representatives working with persons detained Under Immigration Act powers in the secure setting under inspection.

The Care Quality Commission should give particular consideration as to the manner in which it informs persons in detention of the Commission's right of access as regulators to detainees' medical records as these may contain sensitive information, including about torture and abuse and those in immigration detention may have fears about the use and disclosure of their information.

Undercover filming by television reporters uncovered ill-treatment and abuse in immigration detention in Yarls' Wood. Legal judgments have done so and there are very many cases that do not come to court, including a very significant number of damages cases which settle.

What was filmed tallied with accounts persons who had been detained there had been giving over a considerable period, and that accounts of persons held at different times, and who did not know each other, also tallied. Reports of formal inspections failed to give an impression of what was happening, despite being critical.

It is very difficult to gather information. It is necessary to be prepared to receive and consider intelligence. Persons in detention need not only to be listened to, but their accounts believed. We consider that interviews with persons formerly detained are a way of checking information and, with the consent of a detainee or former detainee, legal representatives can assist.

The gap between policy and practice in immigration detention is striking and careful and sustained observation of practice, whether observation of conduct, reading records or studying figures to understand how they relate to practice, will often open up further avenues for inquiry. Time needs to be allowed for this. We strongly support carrying out unannounced inspections wherever this is permitted, and following up all inspections with visits to see whether recommendations have been implemented.

Adrian Berry

Chair

ILPA

26 May 2015

10. Appendix 6: INQUEST submission to CQC consultation

INQUEST submission to CQC consultation:

Health and social care in prisons and young offender institutions, and health care in immigration removal centres

INQUEST's expertise

1. INQUEST is the only independent charitable organisation in England and Wales that provides a specialist, comprehensive advice service on contentious deaths, their investigation and the inquest process to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public. We have a proven track record in delivering an award winning, free, in-depth complex casework service on deaths in state detention (prison custody, police custody or following police contact, immigration removal centres (IRC) and psychiatric detention) or involving state agents. We work on other cases that also engage article 2, the right to life, of the European Convention on Human Rights and/or raise wider issues of state and corporate accountability.

2. Our specialist casework service gives INQUEST a unique perspective on how the whole system operates through our monitoring of the investigative and inquest process. We work with bereaved families from the outset, facilitate their legal representation and work alongside them until the conclusion of the investigation, inquest and other legal proceedings. It enables us to identify systemic and policy issues arising from avoidable deaths and the way they are investigated, and to ensure this is fed through to government, policymakers and parliamentarians. Our evidence to this CQC consultation draws on this expertise.

3. INQUEST participates in the Ministerial Council on Deaths in Custody through representation on the first tier, the Ministerial Board on Deaths in Custody. INQUEST's co-director Deborah Coles is also a founding member of the cross government sponsored Independent Advisory Panel on Deaths in Custody, the second tier of the Ministerial Council.

4. Below is a sample of our most recent publications which covers our work on deaths in custody:
    - Stolen Lives and Missed opportunities: The deaths of young adults and children in prison (March 2015)
    - Deaths in mental health detention: An investigation framework fit for purpose? (February 2015)
    - The deaths of children and young people in custody: the need for an independent review (January 2014)
    - INQUEST submission to the Home Affairs Committee Inquiry into Policing and Mental Health (May 2014)
    - Preventing the deaths of women in prison (June 2013)
    - INQUEST briefing on deaths in police custody for debate on police procedures and mental health (November 2013)
    - Fatally Flawed (October 2012)

- Learning from Death in Custody Inquests: A New Framework for Action and Accountability (September 2012)
- Dying on the Inside - Examining women's deaths in prison (2008)
- Unlocking the Truth - Families' Experience of the Investigation of Deaths in Custody (2007)
- In the Care of the State? – Child deaths in penal custody in England & Wales (2006)

The health and social care needs of individuals in secure settings – overarching points

In this short submission we have highlighted issues where we feel we can best offer our expertise based on our unique overview of the investigation and inquest process. The provision of adequate, timely and appropriate healthcare in secure settings is an essential element of Articles 2, 3 and 8 compliance of the ECHR. This is also supported by the NHS England's commissioning intentions to ensure parity of access to, and provision of, public healthcare across the secure estate and in the community. INQUEST's specialist casework has revealed systemic failings in healthcare provision, such as the treatment, support and the protection of men, women and children held in secure settings.

It is well documented how imprisonment/detention by its very nature increases the risk of suicide and is damaging to well being. As noted by the CQC, a detained individual is dependent on others for their physical and mental healthcare, and because of this they are in a highly vulnerable position. Their vulnerability and circumstances are influenced by the quality of the regimes, adequacy of healthcare resources and the response of staff. Furthermore, due to a growing elderly prisoner/detainee population, along with a large number of those suffering from poor mental health and underlying medical conditions, access to high quality mental and physical healthcare is a vital safeguard.

Based on our extensive work with families whose relative has died in a detained/custodial setting, our casework has revealed multiple concerns about inadequate and inappropriate healthcare and medical treatment:

- Communication breakdown between different prison/IRC/YOI[1] and healthcare staff, across establishments and with statutory bodies outside secure settings
- Inadequate healthcare and failure to properly treat medical conditions, such as epilepsy, diabetes, asthma, and problems with access to medication,
- Lack of staff training in dealing with prisoners/detainees who have complex mental health needs
- Lack of training of healthcare staff about the impact of prison, the right to life and the right of prisoners to be given equal access to healthcare treatment similar to a patient in the community.

[1] IRC: Immigration Removal Centre; YOI: Young Offender Institution

- Poor assessment of vulnerabilities including inappropriate placement and treatment of those with mental health problems, self harm history and drug/alcohol misuse
- Mental health distress and associated problematic behaviour treated as a disciplinary rather than a medical problem
- Concerns regarding delays or failure to transfer mentally ill prisoners to NHS in-patient hospital care
- Inhuman and degrading treatment of dying and seriously ill prisoners such as the application of restraints and poor palliative care
- Failings in emergency response procedures including access to emergency equipment, timeliness of response and adequacy of medical intervention

The upshot of all these factors is that many of the deaths which have occurred in YOIs, prisons and IRCs were preventable. Due to the absence of a learning mechanism whereby previous institutional failures were not systematically analysed, addressed and rectified, there has been a repetition of deaths raising similar issues across establishments.

INQUEST's monitoring work looks at the progress of healthcare management and patient safety through narrative findings and Prevention of Future Deaths (PFD) reports, previously known as Rule 43 reports. Narrative findings are the conclusions drawn from inquest juries and can outline the key issues of concern and any individual or systemic failings. PFD reports are the recommendations put forward by the coroner to the relevant authorities regarding the need for policy and practice change in a secure setting. INQUEST notes that despite a series of critical narrative findings and PFD reports, there is no effective method to monitor or audit an action taken in response to coroners' findings and inquest juries' conclusions. This is an issue that INQUEST has raised with the National Preventative Mechanism.

There are numerous examples where deaths have occurred in the same institution or in similar circumstances where a PFD report has been made previously. For example INQUEST knows of seven people who have taken their lives in YOI Glen Parva since 2011, and this is despite a number of PFD reports which have echoed similar concerns around poor risk assessments and self-harm prevention procedures.

INQUEST encourages the CQC and HMIP to adopt a multi-disciplinary approach to develop an effective follow-up mechanism. This should ensure that findings and recommendations made as part of the post-death investigation and inquest are integrated, and that issues emerging in narrative conclusions and PFD reports, with both local and national learning potential, are identified. This relates to:

- Mode of investigation and its findings and recommendations, including the clinical reviews and any expert reports which are particularly relevant to the provision of healthcare
- Inquest process findings and recommendations.
- Post-death investigation and inquest action plans/responses.

In all of the above, there is the need for review and follow-up over a specific time period. A systematic analysis of PFD reports and inquest findings should be collated and disseminated to promote cross sector learning and to inform the reasons for inspecting certain establishments.

Lastly INQUEST would encourage the CQC to regularly consult with families – during their inspections, as part of their intelligence gathering work, and in providing feedback to families following their inspections. Our organisation works with more than 200 bereaved families per year, and a key frustration is that families felt that prisons/IRCs did not listen to their concerns, and as a result vital information which may have saved the lives of their relatives was not acted upon. Input from bereaved families is particularly valuable as many have accumulated a strong knowledge of the particular failings in health and social care during their relative's time in prison. As such they can provide a holistic view of healthcare and treatment. Moreover, many families would like to see evidence of accountability and would benefit from feeling that their views are valued and can help foster policy and institutional change. CQC should be mindful of this important evidence base and seek to include families wherever possible.

In this response briefing, we have answered the questions which fit within our area of expertise to ensure we can best inform this CQC consultation.

1. Do you agree with the proposal for a joint HMIP/CQC inspection framework?

INQUEST welcomes a joint inspection framework between HMIP and CQC and hopes that both can work collaboratively to identify health and social care issues among prisoners or detainees before they escalate. Too often there has been a lack of communication between healthcare providers and prison staff and this has led to staff underestimating the risks associated with individuals, particularly those linked to poor mental health and self-harm.

CGL was 22 years old when he took his life in HMP Brixton in 2007 – battling with schizophrenia his distinct needs were not detected at the point of his death. Following a string of transfers he was sent to Brixton and placed in the Health Care Centre. A nurse on the healthcare wing described CGL as suffering from low moods, neglecting his personal hygiene, and in fear of being raped on ordinary location (OL).

Despite CGL's unstable mental health his ACCT was closed and he was transferred to OL. Moreover no communication of his mental illness and self-harming history was shared with prison officers, leading one staff member to refer to this as an endemic problem: "[a] blinkered culture" between prison and healthcare staff, with each "keeping to its own side".

Inquests frequently highlight failures in information exchange occurring when individuals are moved between prisons, IRCs and YOIs. Medical documents containing information about a person's health risks may not accompany an individual during their transfer or there may be severe delays in receiving these documents. Likewise, there have been problems in

obtaining pre-custody healthcare records and we hope that CQC looks at the responsibility of healthcare providers, both outside and inside a secure setting.

Another concern is that due to NHS commissioning of healthcare and other services, and the increasing involvement of the private sector across custodial estate, this has resulted in blurred lines of responsibility and an often antagonistic relationship between different statutory bodies. During inquests this has added to the number of legal teams that are present at inquests and has sometimes been characterised by service providers deflecting blame onto one another.

By way of example, the inquest into Brian Dalrymple, a 31-year-old American man who died at Colnbrook IRC a few days after being moved from Harmondsworth, involved seven properly interested parties:

- GEO Group UK Ltd (private company running Harmondsworth)
- Prime care (private company who provide health care in Harmondsworth)
- Servo Group PLC (private company running Colnbrook)
- Serco Occupational Health (private healthcare providers Colnbrook, which operates as a subsidiary to Serco Group Plc)
- Home Office
- Hillingdon Hospitals NHS Foundation Trust (Brian was referred here due to his dangerously high blood pressure)
- Dr Hamit (locum GP who saw Brian at Harmondsworth)

There are also concerns regarding healthcare failings in prisons, YOIs and IRCs, such as the inability to treat existing health conditions in secure settings, and how this compares with the better quality of healthcare which is provided in the community.

Jason Lawson died of sudden unexpected death in epilepsy at HMP Stocken in 2013. During his incarceration, he was regularly non-compliant in taking his antiepileptic and antipsychotic medication. This was frequently noted in his Inmate Medical Record (SystmOne). There were also a number of entries regarding Jason's inability to understand the importance of taking his medication and inability to rationalise the consequences of not taking it. His prescriptions were not reviewed to ensure that they were being taken or renewed in a timely manner, leading to long gaps in him being prescribed his medication. At the inquest, healthcare staff gave evidence that there was no active system to ensure lapsed prescriptions were reviewed.

Other issues concerning the administration of medicine were also noted. For example, while medication prescription should only have been managed by a healthcare professional, and despite concerns expressed by prison staff, prison officers were often allocated to this task as there was no provision for out-of-hours nursing staff at the prison.

2. **Do you have any comments on the assessment framework of KLOE, prompts and characteristics set out in appendix A?**

The five key measures of assessment (safe, effective, caring, responsive, and well-led) offer a good framework for identifying the quality of healthcare in secure settings.

Safety

Too many deaths reveal concerns regarding the failure to protect and keep safe vulnerable prisoners and detainees. INQUEST's research has documented numerous cases where extremely vulnerable individuals at risk of self-harm did not have the right care or treatment and their level of risk was misjudged. Inquest findings frequently comment on failures in basic training in self-harm prevention and management, where staff do not have the requisite skills to make an appropriate judgement on an individual's level of risk.

Moreover, there has been an over-reliance on prisoner's self-reporting of their wellbeing - as opposed to making assessments based on the individual's medical records or known vulnerabilities.

Steven Davison was 21 years old when he took his life at HMYOI Glen Parva in 2013. He had suffered from severe mental health problems and was diagnosed with a Personality Disorder whilst spending time in a psychiatric unit prior to custody. Steven had carried out a number of suicide attempts which included jumping out of windows and overdosing.

Steven entered the prison system with a self-harm and suicide warning form highlighting his risks. However, the initial assessing nurse did not consider Steven to be at risk of self-harm or suicide despite this information. It emerged during the inquest that the nurse had not been trained in the Assessment, Care in Custody and Teamwork (ACCT) procedures (a system used for prisoners at risk of self-harm) at the time and that she had only received the training in August 2014 by which time she had worked at the prison for 2 years.

The PPO investigation into the death also highlighted key issues around vulnerability and failings in recognising risk factors. These included Steven's long history of poor mental health and self-harm and the fact that it was his first time in custody.

At the inquest, the jury recorded that Steven's individual needs, risks and vulnerabilities were not properly assessed, understood or recorded in line with the ACCT process. For example on 25th September 2013, four days before Steven took his life, Steven's girlfriend had ended their relationship and he was also informed that his grandfather had died. Both of these serious occurrences occurred immediately after Steven had used a lighter to self-harm, yet no ACCT case review was carried out. The jury was also critical of the lack of continuity in Steven's care; that information was not passed on to the appropriate individuals, and that the frequency and recording of observations was inadequate.

Detainees/prisoners have a complex set of needs, which include severe mental health problems, histories of substance misuse issues, abuse and self-harm, yet their symptoms are

often managed through increased discipline and segregation and this has often led to further isolation. INQUEST's research has documented a number of cases where healthcare staff have been mistrustful of an individual's reporting of emotional distress.

Alex Kelly was 15 years old when he was found hanging in his cell at HMYOI Cookham Wood in 2012. He was a troubled and vulnerable child who had suffered serious sexual abuse by a member of his maternal family and was placed in care by age five.

On the evening of 24 January 2012, whilst in prison, Alex was clearly in a heightened state of distress, having had an emotional telephone conversation with his foster parents. He had also made a disclosure to a prison officer about his childhood sexual abuse for the first time. The frequency of his observations was increased but he was later found hanging from the locker in his cell by his shoelaces.

In the coroner's PFD report she expressed concern about the prison staff's response to Alex's self-harming behaviour, commenting that "specific acts by Alex were seen as obstructive/challenging behaviour rather than signs of distress or a means of communicating that he needed help". She also expressed concern about Alex's entry into custody without the benefit of a psychiatric assessment, noting that: "I am aware of the deaths of a number of other children in custody who similarly had not had forensic psychiatric assessments". Had he had a psychiatric assessment, Alex may well have been diverted from custody and subsequent fatal actions.

Effective

INQUEST's casework has documented evidence of poor training and knowledge of effective care and treatment. Protocols are often misunderstood or are not adhered to, leading to life threatening practices. For example, there have been several issues around the delay in emergency response procedures and the absence of appropriate healthcare equipment.

Muhammed Shukat died at Harmondsworth IRC in 2011. The inquest jury found that neglect failures on the part of both health care and immigration detention centre staff contributed to the death of Muhammed Shukat at Colnbrook IRC. The nursing staff and custody officers did not respond and did not call emergency services as soon as the alarm was raised by his roommate at 5.30. Muhammed's roommate pressed the emergency button in their cell 10 times to get help for him as he was passing in and out of consciousness and complaining of bad chest pains.

Muhammed was told that he could see the centre's doctor at 8am by which time he had a cardiac arrest. When staff had realised that his heart had stopped there was a delay of around 15 minutes as the defibrillator was missing from the emergency kit and another one was faulty. Finally a third defibrillator in working order was found.

Caring

Many of the families with which INQUEST works have described the uncaring approach and treatment by some prison/IRC and healthcare staff at a time when their relative was extremely vulnerable. They also describe how they have often faced barriers in giving information about their relatives' healthcare needs and have not been consulted or informed about a deterioration of their relative's physical or mental health. Their lack of involvement has often meant that they could not prevent health issues from escalating.

Likewise the healthcare needs of prisoners/detainees are not always given due priority because there is a preoccupation with security concerns i.e. a focus on detaining individuals as opposed to responding to their immediate healthcare needs. This has become increasingly problematic with the rising number of older prisoners; many which have multiple health issues linked to disability, chronic conditions and cognitive impairment. Despite this acute level of vulnerability, there have been cases where elderly prisoners have not been treated with dignity, particularly at times when they are receiving treatment or dying.

Alois Dvorzac was an 84-year-old Canadian man suffering from Alzheimer's who died in hospital after becoming ill at Harmondsworth in 2013. Alois was initially held at Gatwick airport after a doctor declared him unfit to fly and was sent to Harmondsworth. After spending a brief period at the IRC, he was said to have been 'extremely distressed' before being rushed to hospital following a suspected heart attack. He was restrained in handcuffs for five hours before his death and the handcuffs were only removed after his heart had stopped as doctors attempted resuscitation. Commenting on Alois' death, one doctor at Harmondsworth said 'this person was extremely vulnerable, he was frail, he should not have been there in the first place, let alone to be detained for such a long while".

Alois' case is part of broader pattern, where individuals suffering from severe health problems have been restrained. Some other examples include a prisoner, Michael Tyrrell, 65, who was dying from cancer and too weak to move; 22-year-old Kyal Gaffney, diagnosed with leukaemia, who had suffered a brain haemorrhage; and Daniel Roque Hall, 30, suffering Friedreich's ataxia, a wasting disease that has left him barely able to use his arms or legs. All three were chained in hospital and guarded by three prison officers.

Responsive

INQUEST welcomes CQC's commitment to ensure the needs of particular groups are catered to. Characteristics such as age, gender, disability, race etc. can have a profound impact on a person's level of vulnerability.

For example INQUEST's report, *Preventing the deaths of women in prison: the need for an alternative approach*[2], has highlighted the high rates of self-harm and drug misuse among women. Despite this, there has been a systemic neglect of women's physical and mental

[2] INQUEST (2013) *Preventing the Deaths of women in prison: the need for an alternative approach* http://inquest.gn.apc.org/pdf/briefings/Oct2013_updated_INQUEST_Preventing_deaths_of_women_in_prison.pdf

health; inadequate healthcare provision; and inappropriate drug detoxification and management of drug problems.

In 2010 Sarah Higgins died of a drug overdose at HMP Bronzefield. Her death was the first of two deaths in worryingly similar circumstances at the prison within a ten month period.

The key issues concerning Sarah's death included the failure to communicate and act upon risk information contained in a Prisoner Escort Record (PER) and which accompanied Sarah when she was taken from court to HMP Bronzefield the day before her death. The PER contained risk indicators including a real concern that she may have concealed drugs, the fact that she had been on constant watch at the police station and details about medication that had been given.

At the inquest the jury found that procedural failure and inadequate training contributed to the death of Sarah Higgins. When she died a kinder egg containing various drugs was found in her clothing.

Serious concerns were also raised about the failure to provide the prison healthcare staff with medical information which came within the 'current and relevant risk' section of the PER. Healthcare staff gave evidence that they did not routinely receive medical documents arriving with new prisoners and some were unaware that PERs which accompanied prisoners could contain health information.

The inquest found that on the balance of probabilities had this information been passed to prison healthcare the medication prescribed and administered to Sarah would have been different, and that Sarah should have been located within "healthcare" where facilities were available for closer monitoring and observations".

Well-led

There needs to be a co-ordinated response by the investigation and inspection bodies to develop their post-inquest functions. The jurisdiction of the coroner ceases when a finding is made and a response to a report is received, even if it is felt that the response was inadequate. The current level of resourcing means that coroners are not able to continue this monitoring and follow-up role.

The Prison and Probation Ombudsman and HMIP thematic reports do provide examples of good practice, however there is no systematic case by case timeline of actions taken in response to the individual death and how this impacts nationally and its relevance in terms of cross-sector learning.

Because of this lack of accountability, failings across the detained/custodial sectors become endemic and suggest a culture of complacency. INQUEST's report, *Learning from Deaths in Custody Inquests: A New Framework for Action and Accountability*, analysed a sample of

Prevention of Future Death reports sent to prisons between 2007-09 and noted repeated areas of concern[3]:

Issue	Rule 43 reports (42)	Narrative verdicts (36)
Communications	14 (33%)	9 (25%)
Staff record-keeping	21 (50%)	4 (11%)
Staff training	23 (55%)	5 (14%)
Drugs	6 (14%	2 (6%)
Use of restraint	3 (7%	2 (6%)
Inadequate health care	20 (48%)	8 (22%)
Poor mental health care	4 (10%)	8 (22%)

Repeated recommendations pointed to a need to resolve communication failures, address inadequate record keeping and provide staff training on healthcare needs within secure settings.

Brian Dalrymple died at Harmondsworth IRC in 2011. Brian was a 31-year-old American man with significant health problems and suffered from an anxiety disorder and schizophrenia. The jury at the inquest into the death of Brian detailed a catalogue of errors in his care and stated that the medical record keeping at Harmondsworth IRC was 'shambolic'.

In the 6 weeks of his detention there was no psychiatric assessment carried out on Brian, this was despite the Chief Immigration Officer attempting to flag up concerns and Brian's signs of mental distress. Temporary medical staff working with Brian were not made aware of the separate document management systems maintained by detention officers which would have given insight into his behaviour. Three days before his death Brian was transferred to the Serco run Colnbrook IRC. His medical records did not follow him to this detention centre. Brian died before his appointment to the psychiatrist: his blood pressure caused an aortic rupture.

Moreover the CQC and HMIP must pay more attention to post-death communication, where timely information about the relative's death or action taken in response to their death becomes an integral part of family liaison guidelines and protocols.

3. Should we consider a single rating for health and social care within a secure setting? Should this be a joint rating with HMIP or a CQC rating? Joint with HMIP/CQC rating

INQUEST believes that the CQC should provide a separate rating system to HMIP's rating. In INQUEST's experience, there is significant conflict when it comes to accountability following a detainee's death regarding who was responsible for their care.

A member from our associate network, Inquest Lawyers Group, is currently representing the family of a man who died in HMP Durham from drug-induced bronchopneumonia. Care UK

[3] Coles, D. & Shaw, H. (2012) *Learning from Deaths in Custody Inquests: A New Framework for Action and Accountability* London: INQUEST

provided the health care and there are issues around nursing staff repeatedly failing to follow policy and take clinical observations after the prisoner was discovered to be under the influence of drugs. INQUEST is concerned that there may be attempts to deflect blame between the prison and Care UK. While healthcare failures are noted above, there may be disputes regarding initial screenings by prison and the absence of a urine test to detect the intoxication of drugs.

While it is important to adopt a holistic approach and to encourage collaboration between services providers, the identification of failures requires a pinpoint analysis of where the problems exist so as to prevent future deaths from occurring.

4. **Do you agree with our proposals for gathering detainees' experience of care?**
    - Are there any other ways we could gather this information?

We welcome the proposal for gathering detainees' experience of care. This should not be limited to the time of inspection and should be part of long term engagement plan, as it would allow for a better understanding of problems and trends, and would promote a sense that prisoners' input is valued.

5. **Do you agree with our approaches to working with national and local organisations**?
    - Is there anything else that we should be doing?

As mentioned, INQUEST believes that families have a crucial part role to play in providing information to CQC-HMIP inspections. They can provide an overview of their relative's treatment and issues identified from an inquest. There may be practical difficulties in obtaining evidence from families due to problems of accessibility, and so INQUEST could provide a mechanism for feedback or for anchoring the voices of families during an inspection.

INQUEST has a long history of facilitating forums for bereaved families to share their experiences and concerns with key stakeholders. The most recent examples include two family listening day events which we held for the Independent Police Complaints Commission.

6. **We have described how we will gather the views of detainees in advance of the inspection. Do you think this is an effective approach to supporting our work?**
7. **We have described how we will gather information and evidence while on site at the secure setting. Do you think this is an effective approach to supporting our work?**

Question six and seven have been answered together in the following paragraph.

INQUEST welcomes the use of evidence from prisoner councils/forums and focus groups. With regards to the proposed focus groups we recommend careful consideration is given to how participants are chosen. Both self-selection and selection by prison/IRC staff may not provide a representative sample of the prison/IRC population may and lead to bias within

the outcomes. In addition other channels of communication, via articles in Inside Time or broadcasts on National Prison Radio, should be explored for maximum reach.

We also recommend that any documents which are used for feedback should be simple, cater to all literacy levels, those for whom English is a second language and ensure anonymity. Lastly, we suggest that all surveys make special provisions for the monitoring of particularly vulnerable groups (women, young people, and individuals with special educational needs, different nationalities, religious and BAME groups).

Conclusions

INQUEST welcomes the collaborative work of the two inspectorate bodies and hopes that their joint resources and expertise will develop a central oversight role of health and social care in secure settings and help improve patient safety and accountability. One of the most under-used and yet highly valuable sources of information about health and social care in prisons/IRCs is that arising from the investigations and inquests into deaths in secure settings. In order to maximise the preventative potential of post death investigation and for organisations to reflect and learn from them, there needs to be a systematic approach to their collation and analysis. Inspection bodies can play a vital role in reporting publicly on the accumulated learning. To this end the CQC should publish an annual report on prison health and social care in a similar way to that published by HMIP. This could include information on health and social care concerns raised by post death investigations, making recommendations for change and monitoring actions taken at a local and national level. This would act as an important learning awareness model; help to inform organisational changes to policy and practice; and improvements in patient health and safety in secure settings.

Finally, families should be regularly involved, giving them the ability to feed into inspections, whilst also being consulted on proposed actions and the on-going work of the two inspectorate bodies.

INQUEST 2015.

11. Appendix 7: Prisoners' Advice Service Submission.

PRISONERS' ADVICE SERVICE

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21 May 2015

Care Quality Commission Consultation - regulating health and social care in prisons and young offender institutions and healthcare in immigration removal centres

About the Prisoners' Advice Service

The Prisoners' Advice Service (PAS) is the only independent registered charity offering free legal advice and representation to adult prisoners in England and Wales. We do this through our telephone advice line, letters clinic and legal outreach sessions, as well as providing information within the sector. Between 5 part time case workers we answer 4,000 letters, take 14,000 phone calls and advise 500 prisoners at advice clinics per year.

Response

Do you agree with the proposal for a joint HMIP/CQC inspection framework?

PAS welcomes a joint approach to inspections by CQC and HMIP. This may lead to more joint working and a more coherent approach between health/social care providers and other staff in secure settings.

There is usually quite a time lag between HMIP inspections and report publications. With health and social care matters the findings would be better disclosed within a shorter time frame to ensure timely publication. Measures should be put in place to implement suggested improvements and to review (a) whether this has happened and (b) whether the improvements are effective in improving access to adequate healthcare and social care.

It is important to have the same expectations for the provision of adequate healthcare in secure settings as in the community. Prisoners must have access to the same level of healthcare and social care as those in the community. The CQC will need to develop an understanding of the reality of health and social care being delivered within a prison context.

In PAS' experience factors like overcrowding, low staffing and poor communication between healthcare and discipline staff can have significant negative effects on the provision of adequate healthcare.

Do you have any comments on the assessment framework, KLOE, prompts and characteristics set out in Appendix A?

Better linking to the Care Act 2014 would be welcomed and it is essential to make reference to Prison Service Instructions 15/2015, 16/2015 and 17/2015 to ensure compliance with the PSIs and the Care Act. Clear policies for staff on information sharing should assist in keeping detainees safe and in receipt of more effective healthcare and social care.

We intend not to rate health and social care in 2015/2016. Do you agree with this approach?

PAS believes it would offer better protection to prisoners with health and social care needs if the CQC rated health and social care straight away. However, we understand the need for the CQC to analyse the differences between providing these services in the community as compared to a secure setting and to be fully aware of the complexities and difficulties of the latter. We think it advisable to start rating health and social care as soon as possible.

Should we consider a single rating for health and social care within a secure setting?

PAS is of the view that this is potentially unfair as the two different providers of healthcare or social care may vary in the adequacy of their service. An overall rating will give a misleading impression of the level of a service and avoid each provider taking responsibility for their own score. This may also be likely to confuse prisoners who may find it hard to know who to complain to in the event of a problem. We suggest a separate rating system as this would provide greater transparency and accountability.

Do you agree with our approach to concerns, complaints and whistleblowers?

Yes. However it is important that the CQC takes a proactive approach to seeking out complaints from prisoners, carers and family members. It is unclear how the CQC plans to reach those who lack mental capacity. It should be noted that the most vulnerable prisoners will be the hardest to engage with. Prisoners may not complain to the authorities for fear of reprisals. In PAS' experience this is particularly true of older prisoners, women and those with mental or physical health problems.

Do you agree with our proposals for gathering detainees' experience of care? Are there any other ways we could gather this information?

Yes we agree but we believe feedback should be gathered on an ongoing basis not just around the time of an inspection. Consideration should be given as to how the CQC and HMIP can obtain feedback from more reticent prisoners – often older prisoners, those with mental health or learning disabilities or those for whom English is not a first language. Prisoner forums could be approached for feedback and it could be promoted in Inside Time or on prison radio in most establishments.

PAS is regularly made aware of the confusion, fear and anxiety on the part of many family members of prisoners' with health problems who are often not involved in arranging the prisoner's care at all. The CQC could make it clear to the prisoners that their families can also get in touch if they want to. Information could be advertised in prison Visits Halls or websites.

Do you agree with our approaches to working with national and local organisations?

Yes. The role of the CQC needs to be communicated to prisoners, their families and voluntary sector organisations involved with them. The organisations that have a physical presence in prisons could support the CQC in encouraging prisoners' engagement in inspections.

We have described how we will gather the views of detainees in advance of the inspection. Do you think this is an effective approach to supporting our work?

Yes but given that the CQC plans to be in the secure setting for only a week then preparatory work would be helpful.

A survey of prisoners should be produced in an easy read format ahead of the inspection. PAS welcomes the suggested review of the mechanism for engaging with service users. We would suggest the CQC meets with prisoner forum groups, former prisoners, and charitable organisations and potentially set up a confidential phone line from secure settings.

We have described how we will gather information and evidence while on site at the secure setting. Do you think this is an effective approach to supporting our work?

Clear advice needs to be made available as to how prisoners are to be informed that an inspection is taking place and how they can be involved in providing feedback and raising issues with inspectors. There should be a clear plan to involve prisoners from all areas including segregation, the healthcare wing and vulnerable prisoners' wing.

PAS welcomes the idea of joint inspections and in particular the intention to engage with prisoners and other service users and also the voluntary sector.

Laura Orger
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Prisoners' Advice Service