Our findings

Our main findings are as follows:

1. In 2018, the Government decided not to make the legislative changes which would permit the CQC to use a ratings system for assessing the quality of healthcare services in IRCs. The CQC's ratings scheme is at the core of its approach to quality assessment of the majority of community healthcare provision, including community GP practices. The application of the scheme to IRC healthcare could have facilitated a direct comparison with community healthcare and the opportunity to engage the mechanisms which the CQC uses in the community to leverage improvement to the standard it considers to be acceptable in community provision. There was no mention of having taken the community equivalence principle into account when that decision was made.

2. The CQC's statutory role is currently limited to assessing the quality of healthcare in IRCs against the 'fundamental' standards which are applied to determine the suitability of a healthcare provider for registration. The inspectorate assesses the performance of community healthcare providers using its ratings standards of Inadequate, Requires Improvement, Good and Outstanding and uses mechanisms, including its enforcement powers, to move providers to the minimum ratings standard of 'Good' which, it acknowledges, goes beyond the fundamental standards.

3. The CQC explains that a joint inspection framework has been developed in which the HMIP's inspection criteria (its Expectations) have been mapped to the CQC's 'key lines of enquiry' (KLOE). But it is far from clear that the resulting KLOE scheme for secure settings incorporates a minimum 'Good' quality standard; the CQC itself says that it is used to determine whether the *fundamental* standards are met. Furthermore, there is a significant level of discrepancy between the indicators used as part of the Expectations scheme and the characteristics of what the CQC considers to be a service of a 'Good' standard. At best, the approach taken has created a concerning transparency and accountability deficit because it makes it more difficult to make direct community comparisons. At worst, it has resulted in a lower quality standard being applied.

4. Data which would allow for direct comparative analysis is not systematically available or is not embedded for use within the IRC inspection scheme. In particular, the Quality Outcomes Framework (QOF) data, which is used by the CQC to assess the quality of community GP practices, is not systematically available for IRC healthcare providers who, it appears, may not receive the same financial incentives as community healthcare providers to produce it.

5. One source of evidence of quality that could be used for comparison with community GP practices is the patient's view of their experience of the service. Although a robust survey of those subject to detention is undertaken as part of the inspection process and includes a question about experience of healthcare which is comparable to a question asked of patients of community GP practices nationally, the only comparison undertaken using the IRC survey data is with previous assessments of that IRC and with other IRCs. This risks institutionalising poor practice.

6. Patient reports on the quality of their experience are not in themselves treated as an indicator of quality in IRCs, in contrast with their use in the CQC community healthcare scheme.

7. In the HMIP scheme, the evidence provided by those detained is treated as one source of evidence in a triangulation methodology which will usually require evidence from three different sources to support a finding. No such methodology is mentioned in the CQC material on the inspection of community GP practices. Given that three of the five sources of evidence which are considered in the HMIP scheme are institutional sources, this triangulation methodology has the characteristics of an underlying systemic unfairness. There were a number of instances in the 2016 and 2019 reports on Brook House where the findings were not consistent with the evidence of those detained but the reasons for reaching the contrary conclusion were not entirely clear. The explanation may lie in the triangulation approach.

8. There are worrying indications of a systemic institutionalised culture of disbelief within the IRC system. Visitors' groups report complaints from their clients of not being believed by healthcare staff. The issue is mentioned in a number of the reports considered as part of our literature review. The Deputy Head of Healthcare at HMIP, in her evidence to an investigation undertaken following the Panorama programme which found evidence of abuse at Brook House, reported that staff have often said that those in detention overstate their complaint in order to secure their release. If there is an institutional bias amongst staff against believing those in detention, this risks tainting one of the sources of evidence (IRC staff) on which the inspectors rely.

Our recommendations

1. There is a pressing need to operationalise the principle of community equivalence in HMIP/CQC inspections in a way that allows for transparent and meaningful comparisons with the quality of community health provision. As with prison healthcare, there is a need for a 'resource describing how equivalence should be defined, measured and compared with health and care in the community'.[6]

2. Currently the quality of healthcare in the community is measured and assessed using the CQC's rating scheme. The scope of the CQC's powers to quality assess beyond the fundamental standards used for the purpose of registration of healthcare providers, should be extended to IRCs so that the CQC can develop and apply the ratings scheme to those facilities. This would facilitate direct comparison with the quality of community health care services and equivalent leverage for improvements. This represents an extension to IRCs of the recommendation of the Health and Social Care Committee to apply CQC ratings to prisons. This is not intended to stand as a recommendation for the continued use of a 'ratings' approach. An assessment of the effectiveness of ratings schemes is beyond the scope of this project. The issue here is the principle of comparability in the assessments of community and IRC healthcare. If a different approach, based on something other than ratings, or modifications to that approach, were to be adopted in the future, IRCs should be included within such reforms to ensure community comparisons could still be made.

3. Measures need to be identified and data identified or developed which allow for direct performance comparisons to be made. In particular, IRC healthcare providers should receive the same incentives to provide Quality and Outcomes Framework (QOF) data as community healthcare providers. This does not, of course, mean that an IRC provider will be assessed as requiring improvement just because there may be significant deviations from community healthcare performance. However, the scheme would render those deviations visible to inspectors so that the explanations for them could be explored and could inform the quality adjudication.

4. Patient experience should be adopted as one of the quality measures as it is in community healthcare inspections.

5. As a reasonable adjustment to the recognised hurdles to participation faced by those subject to detention, the inspection system should develop, with visitors' groups, a scheme which would facilitate their ongoing provision of relevant evidence about healthcare which is reviewed regularly by the CQC to identify whether there is a need for a focused inspection, and is, in any event, reviewed prior to a comprehensive inspection to identify issues to investigate. Decisions with reasons for any action or inaction decided upon should be given to visitors' groups following each review.

6. The triangulation methodology should be removed from the HMIP Inspection Framework and replaced with guidance on weighing evidence. Such guidance should advise on weighing staff evidence in a way that takes into account evidence of institutionalised cultures of disbelief and should stress the need to provide clear reasoning for conclusions, in particular where patient experience and other sources of evidence are at odds.

7. If CQC inspections continue to be undertaken at the same time as an HMIP inspection, a separate CQC report should be used which is structured in the same way as community healthcare inspections to support CQC inspectors in making community equivalent judgements and at the same level of detail in order to maximise effectiveness as a lever for improvement. This is key to facilitating transparency and public trust and confidence that inspection is delivering according to the community equivalence principle and is open to challenge if it fails to do so.

8. The CQC's current reform programme offers an opportunity to address the issues identified in this report, but to be effective in producing a quality assessment scheme for IRCs that delivers on community equivalence, it will need to tackle the task in a sector-specific way. In its most recent consultation it announced an intention to hold 'fewer large-scale formal consultations, but more on-going opportunities to contribute' to reforms to its quality assessment processes.[7] It is vital that those with experience and expertise in the IRC sector are fully engaged at this early stage.

6 Health and Social Care Committee, Prison Health (HC 2017-2019, 963-XII) <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/963/963.pdf> accessed 16 June 2021.

7 Care Quality Commission, 'Consultation on Changes for More Flexible and Responsive Regulation' (January 2021) 10 <https://www.cqc.org.uk/sites/default/files/Consultation_on_changes_for_more_flexible_and_responsive_regulation_consultation_document_1.pdf> accessed 27 October 2021