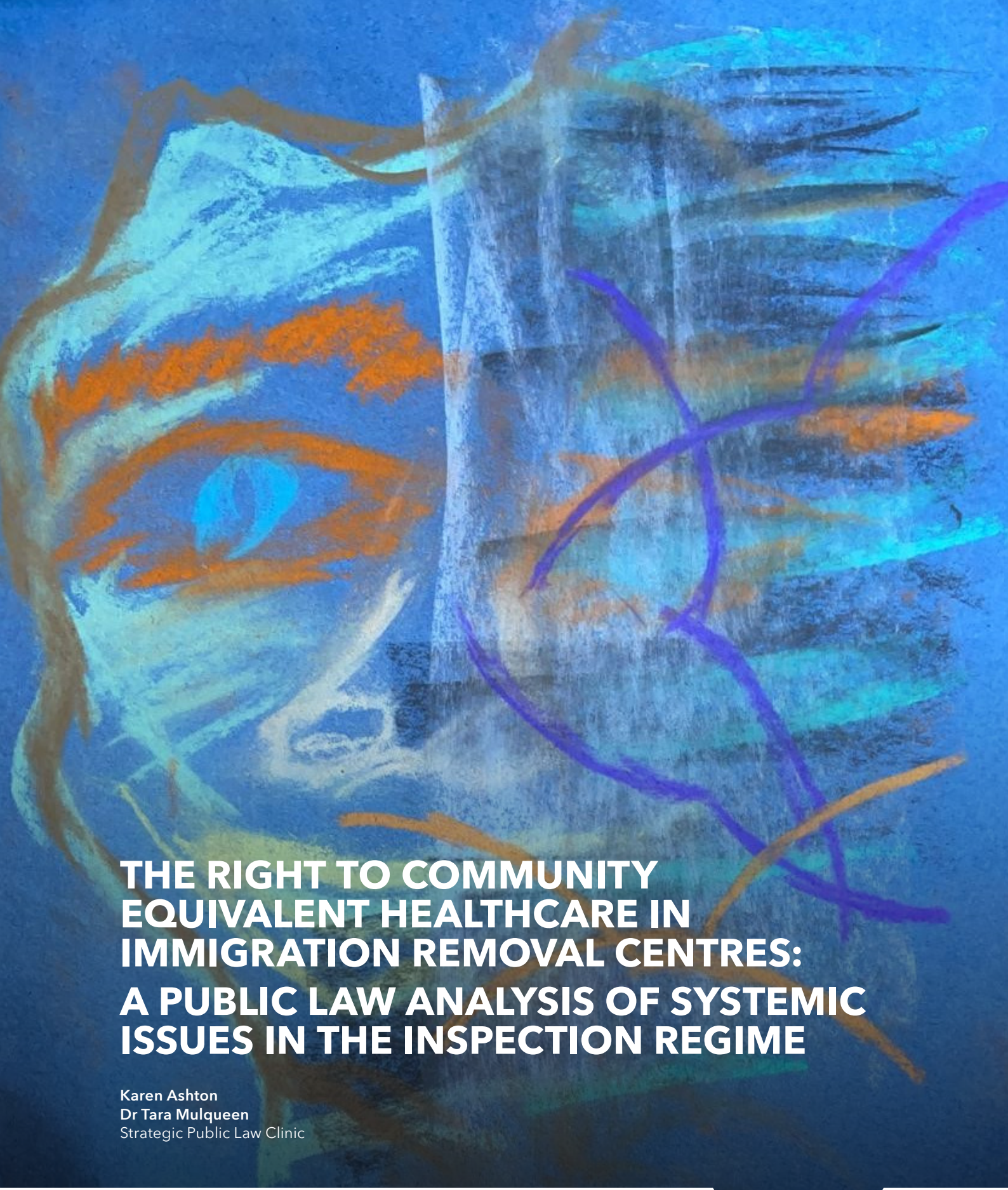

THE RIGHT TO COMMUNITY EQUIVALENT HEALTHCARE IN IMMIGRATION REMOVAL CENTRES: A PUBLIC LAW ANALYSIS OF SYSTEMIC ISSUES IN THE INSPECTION REGIME

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FOREWORD

'The principle of "equivalence" between the quality of NHS services received by those in state detention and those in the community has been a declared aim of the NHS since 2004. But does the reality match the policy? The reported experiences of those in immigration detention, and the near universal views of those assisting or representing them, is that there is nothing like equivalence, with NHS services for those detained being the poor relation of NHS community services. It is sadly commonplace, for example, to read an independent psychiatric report on a person in detention outlining serious mental health problems which were never recognised, diagnosed or treated (or capable of being treated) by healthcare staff at an Immigration Removal Centre.

However, the perceived shortcomings in the quality of healthcare services for those in immigration detention have largely not been backed up by the findings of CQC/HMIP healthcare inspections. This report looks at why there is such a clear disconnect between the reported quality of immigration healthcare services experienced by service users and those who support them and the outcome of inspections.

The clear answer emerging from this impressive report is that the problems are structural. In simple terms, different rules apply to inspections of healthcare services in IRCs and those in the community. The methodology means the dice is loaded to prevent inconsistent, unreliable or poor NHS services being discovered within immigration detention. The detailed analysis in this report goes a long way to explaining why shortcomings and problems with healthcare in immigration detention are unlikely to be uncovered by the existing methodologies.

The report rightly asks whether these differences in approach are justifiable. Why, for example, should the reported experiences of patients be given far less credibility depending on whether the person is in detention or not? Should patient concerns only be given weight if they are supported by documents from the healthcare provider – or is that inviting healthcare providers to mark their own homework?

There are also particular problems within immigration detention which are not replicated in the community and can lead to poor healthcare, which the existing methodologies do not appear to recognise and tackle. Detained people report a pervading culture of suspicion amongst healthcare staff that people in detention exaggerate their symptoms to try to secure release. Is this true and is it being tackled? Are those designing the inspection methodology sufficiently challenging themselves to develop methods to tackle this issue?

There are challenges in this report for CQC and HMIP. However, as this report makes clear, the rules by which HMIP and CQC inspections are conducted are very largely set by the government and these rules can only be changed by the government. The report thus challenges policy makers to justify or change existing policies.

I hope that this serious and focused piece of work will influence the debate on how to improve NHS services for those in immigration detention, especially given that the deficiencies in individual cases can be so clear to those of us working in the field.

David Lock QC,
Landmark Chambers, London

Front cover artwork © Ridy

PREFACE

For 25 years Gatwick Detainees Welfare Group befrienders have been supporting people in detention at Gatwick. Throughout that time, Immigration Removal Centres have been experienced as places of isolation, fear, uncertainty and suffering. GDWG visitors have been privileged to learn about the lives of thousands of detained persons over the years. We have repeatedly heard descriptions of poor quality healthcare in detention. This report responds to the people who have trusted us with their testimony, and we hope that in examining the issues they faced we are honouring our connection with them and all they have shared. Previous GDWG research has touched upon the failings of healthcare in detention namely 'Prison in the Mind' and 'Don't Dump Me in a Foreign Land'. Other immigration detention visitor groups also report that healthcare is inadequate throughout the detention estate. Charities in the sector note that the concerns described by detained persons regarding healthcare do not match the findings in HMIP and CQC joint inspections that frequently rate healthcare as being of an acceptable standard.

The experience detained people report to us is not of a good service. They tell us that receiving the care they need does not happen in a timely manner, including delays in accessing their medication. It is not unusual for our staff team to be told by detained persons that they return again and again to healthcare with the same issue only to be told there is nothing wrong with them. It has been accepted in previous studies that indefinite immigration detention leads to a deterioration in people's mental health. Despite this people with pre-existing mental health conditions continue to be detained and when detained people experience mental health issues there is a lack of support available. Crucially, detained people tell us that they are not believed when they describe their symptoms and health concerns and that this barrier of disbelief is itself detrimental to well-being.

Healthcare is a fundamental right in the UK, and we believe everyone should receive good quality care, regardless of their immigration status. We seek to understand why the mechanisms put in place to ensure detained people are receiving healthcare that is equivalent to that in the community are not working.

Whilst we believe that healthcare in IRCs should serve detained people better, and in a community equivalent manner, we also believe the only way to truly end inadequate healthcare in detention is a future without detention. Immigration detention itself is harmful to the mental health of detained persons as noted by Stephen Shaw (2016) Medical Justice (2019) and the British Medical Association (2018). This research addresses healthcare issues but it is also the view of GDWG that any treatment for health issues in detention takes place in a system that is intrinsically damaging, and improvements can only seek to cause less harm. The harm to health in detention will always exist until detention ends.

Thank you to Karen Ashton from Central England Law Centre and Tara Mulqueen, University of Warwick Law School for your generosity, tenacity and careful work on this report. Thank you to the Warwick Law in the Community students for your dedication to the project. Thank you to Karris Hamilton who led the project for GDWG and without whose outstanding work the report would not have been possible. Thanks to Gatwick Detainees Welfare Group volunteer visitors who were interviewed and responded to surveys during our research and to our colleagues at other IRC Visitor groups who assisted the research. Thanks to Jean Gould for identifying the need for this research and initiating the project. Finally, thank you to everyone with lived experience of detention who described their experiences to GDWG and have trusted us to share them with you.

Anna Pincus
Director, Gatwick Detainees Welfare Group

ACKNOWLEDGEMENTS

We would like to thank Gatwick Detainees Welfare Group for inviting us to work on this pressing issue with them and supporting the project at every stage, the students who contributed to the research and development of this project through the Strategic Public Law Clinic, and our colleagues at Central England Law Centre and Warwick Law School for their valuable support and input. We would also like to thank the Care Quality Commission for speaking with us at a key stage in the project's development.

ABOUT THE AUTHORS

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Dr Tara Mulqueen is an Assistant Professor at the University of Warwick, School of Law and the Director of Warwick Law in the Community (LinC). She specialises in public legal education, and she has worked with a wide range of organistions to develop interventions to improve public understanding of complex legal issues. She currently leads the Strategic Public Law Clinic alongside Karen Ashton.

ABOUT THE STRATEGIC PUBLIC LAW CLINIC

The Strategic Public Law Clinic (SPLC) is a joint initiative between Central England Law Centre (CELC) and Warwick Law in the Community (LinC). It specialises in using the tools of public law to address systemic disadvantage and achieve effective change, and it provides students with opportunities to gain meaningful experience and develop skills in using the law creatively to advance social justice.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The background

There is broad consensus that those detained by the state should receive healthcare that is equivalent to that enjoyed in the wider community. This principle is reflected in a number of international legal instruments and endorsed in a variety of NHS England policy documents, including the agreement which sets out the shared strategic intentions of NHS England, the Home Office and Public Health England in relation to the provision of healthcare in IRCs. This identifies the first of its joint principles in the following terms:

> Detainees should receive high quality healthcare services, to the equivalent standards of community services, appropriate to their needs and reflecting the circumstances of detention.[1]

There has been a persistent and consistent concern about the quality of healthcare in immigration removal centres (IRCs) for many years which has continued beyond the shift in responsibility for the commissioning of health services in IRCs to NHS England in 2013. These concerns appear in many reports and reviews from a wide variety of sources and are reflected in the issues raised with Gatwick Detainees Visitors Group by those subject to detention. However, the overall conclusions by the statutory inspectorates have, on the face of it, painted a rather different picture. Generally, they have found the quality to have improved and to have reached an acceptable standard by the date of the last inspection of each IRC, undertaken at some point in the period 2017-2019. For example, the inspectorate report found healthcare to be 'adequate' in Brook House IRC in 2016[2] and 'reasonably good' in 2019,[3] findings which were accompanied by a limited number of recommendations for improvement, none of which achieved the status of main recommendations in the 2016 report or key recommendations (as they were then termed) in the 2019 report.

NHS England's infrastructure for quality assurance in the health and justice sector (which includes the IRC estate) acknowledges the community equivalence principle and the responsibility of the two statutory inspectorates, the Care Quality Commission (CQC) and Her Majesty's Inspectorate of Prisons (HMIP) 'to ensure detainees are safeguarded against ill treatment and receive the same quality of care as the rest of the population'. [4]

We use a public law analysis to address the question of whether the inspection scheme is consistent with the community equivalence principle. It is not an attempt to assess the quality of inspections undertaken within the scheme that has been adopted, either on a case-by-case basis or as a general pattern. Our concern is whether there are relevant systemic issues within the scheme itself. We have looked carefully at the scheme used by the CQC to quality assess community healthcare provision and made comparisons at a detailed level with the scheme adopted to respond to the overlapping responsibilities of the CQC and HMIP for inspecting healthcare in IRCs. In light of the concerns raised by Gatwick Detainees Welfare Group (GDWG) about the discrepancy between what is reported to them by those in detention and the conclusions of the inspection reports, we have paid particular attention to the way the voice of the patient is heard in the two schemes.

In the main, we have relied on documentation in the public domain, but, in addition, for the purpose of understanding the issues of concern, we have undertaken an analysis of the GDWG's casework records and a survey of their volunteer visitors; considered the views of other visitors' groups as provided in interviews undertaken by GDWG for the purpose of this report; and obtained further information from the CQC using requests made pursuant to the Freedom of Information Act 2000 and in an interview which the organisation generously offered in response to our request for clarification of some of the responses.[5]

1 'The Partnership Agreement between Home Office Immigration Enforcement, NHS England and Public Health England 2018-21' (2018) 16 <https://www.england.nhs.uk/wp-content/uploads/2018/07/home-office-immigration-enforcement-partnership-agreement.pdf> accessed 16 June 2021.

2 HM Chief Inspector of Prisons, 'Report on an unannounced inspection of Brook House Immigration Removal Centre 31 October –11 November 2016' (2017) 15 <https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/brook-house-immigration-removal-centre/> accessed 16 June 2021.

3 HM Chief Inspector of Prisons, 'Report on an unannounced inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons 20 May - 7 June 2019' (2019) 39 <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/09/Brook-House-web-2019.pdf> accessed 16 June 2021.

4 NHS England and NHS Improvement, 'Quality Assurance and Improvement Framework: Health and Justice and Sexual Assault Referral Centres' (2019) 25 <https://www.england.nhs.uk/wp-content/uploads/2019/07/qaif-health-justice.pdf> accessed 16 June 2021.

5 Copies of the Freedom of Information Act requests submitted to the Care Quality Commission and their responses are available on request from the authors.

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

INTRODUCTION

> Nothing is more central to the detainee experience than healthcare.[1]

Gatwick Detainee Welfare Group (GDWG) is a charity that organises volunteers to visit people in detention and offers casework welfare support to those detained in two of the immigration removal centres (IRCs) in England, Brook House and Tinsley House.[2] For some time, it has had serious concerns about the quality of healthcare provided in these two IRCs, located near Gatwick Airport. These concerns have emerged from their day-to-day work with people in detention, in which those detained regularly report problems in accessing healthcare services as well as deficiencies in the quality of care that they receive. Similar concerns, which will be explored in more detail below, are also shared by other visitors' groups operating at IRCs around the country, as well as prominent NGOs, such as Medical Justice and Medact, and the British Medical Association.[3]

In 2020, the Strategic Public Law Clinic, a joint initiative between Warwick Law School and the Central England Law Centre, offered its resources to GDWG to explore the issue from a public law perspective, in an effort to offer fresh insights into the problem and potential solutions. This approach would not seek to assess the existing evidence on the quality of healthcare in IRCs in order to provide any kind of determinative answer to substantive questions about quality, but it would ask whether there is a quality of healthcare that those detained are, in any sense, *entitled* to expect from the state, and, if so, whether there is any systemic unlawfulness in the processes designed to deliver on that entitlement. This report and its recommendations are the outcome of that work.

In order to provide a context for this analysis, in this introductory section, we explore some of the problems with healthcare services that GDWG has encountered through its casework with people in detention, particularly at Brook House IRC, as well as other sources of evidence of the patient experience in Brook House. We consider the risks of characterising the concerns expressed solely as matters of perception. We then introduce the perspective offered by public law that is employed in this report.

The evidence of a persistent problem: the experience of Gatwick Detainees Welfare Group

As part of the work undertaken for this report, we conducted an anonymised review of GDWG's casework records in the four months preceding each of the unannounced inspections by Her Majesty's Inspectorate of Prisons (HMIP) of Brook House in 2016 and 2019, as well as a survey of their volunteer visitors. While these reports reflect the perceptions and experiences of the individuals they support and thus do not necessarily indicate that there is always an underlying problem with the quality of healthcare services, these records nonetheless reveal a persistence in the level and types of healthcare concerns raised by people in detention. For each period, we considered the proportion of cases in which concerns about the quality of healthcare services were raised with GDWG and applied a simple, issue-based coding for the purpose of highlighting the prevalence of particular issues. This analysis is not intended to be exhaustive but rather to provide an indication of the nature and frequency of problems with healthcare reported to GDWG.

In the four months preceding the unannounced inspection of Brook House in 2016, GDWG provided casework support for 106 individuals. Of these 57 described having particular health issues or needs, and 56% (32) of these described specific problems with access to and/or the quality of healthcare services. Similarly, in the four months preceding

1 Stephen Shaw, 'Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons: A Follow-up Report to the Home Office' (Cm 9661, 2018) 43 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728376/Shaw_report_2018_Final_web_accessible.pdf> accessed 16 June 2021.

2 GDWG staff offer initial meetings held twice a week at Brook House in a legal visit rooms. In these meetings they give information on their charity, allow the client to explain any issues they are having and to discuss their case and suggest ways that GDWG may be able to assist. Prior to the Covid-19 pandemic, GDWG's staff and volunteers visited the IRCs regularly. GDWG made 174 visits to people held in Brook House and Tinsley House in 2017, 218 visits in 2018, 170 in 2019 and 141 in 2020. The numbers of detained people seen by volunteers on their visits are not recorded as this is an informal process. The numbers of people seen by casework staff at drop-ins for initial casework meetings is: 375 in 2017; 479 in 2018; 517 in 2019; 321 in 2020. The figures for 2020 include initial casework meetings which took place over the phone and in-person. Since the Covid-19 Pandemic the numbers of visits has decreased due to greatly reduced access and fewer people being detained.

3 See for example; British Medical Association, Locked up, locked out; health and human rights in immigration detention (Medical Ethics Committee, 2018) <https://www.bma.org.uk/media/1862/bma-locked-up-locked-out-immigration-detention-report-2017.pdf> accessed 16 June 2021; Medact, 'First do no harm': Clinical roles in preventing and reducing damage to vulnerable immigration detainees' (2017) < https://www.medact.org/wp-content/uploads/2018/01/Medact-Submission-for-Shaw-FINAL-WEBSITE.pdf> accessed 16 June 2021; Medical Justice, Failure to Protect From the Harm of Immigration Detention (2019) <http://www.medicaljustice.org.uk/wp-content/uploads/2019/09/Failure-to-Protect-final.pdf> accessed 16 June 2021.

the inspection in 2019, GDWG provided casework support for 79 individuals, and 52 described having particular health issues or needs. 63% of them (33) described specific problems with access to and/or the quality of healthcare services.

The predominant issue reported to GDWG in both periods was insufficient support for mental health, but delays and cancellations, access to medication and not being taken seriously are also recurring issues (see Table 1 and Table 2 below for the distribution of issues reported in each period).

Table 1: GDWG Casework Records 2016

Access to medication	6
Delays and cancellation of appointments	7
Inappropriate use of restraints	1
Insufficient support for mental health	12
Not being taken seriously	5
Overuse of paracetamol or ibuprofen	1
Rude or inappropriate behaviour	2
Rule 35	3

Table 2: GDWG Casework Records 2019

Access to dental care	1
Access to medication	8
Delays and cancellation of appointments	5
Inappropriate use of isolation	1
Inappropriate use of restraints	1
Insufficient support for mental health	16
Not being taken seriously	7
Overuse of paracetamol or ibuprofen	3
Rude or inappropriate behaviour	3
Rule 35	1
Unable to be cared for in detention	1

The persistence of these problems is further supported by the survey responses of 24 of GDWG's volunteer visitors, some of whom had 15-20 years of experience visiting people in detention (see Annexes for survey questions). More than half of the respondents estimated 50% or more of the people in detention they had visited had raised concerns about healthcare. All but one respondent placed this estimate as at least 20%, and some estimated as high as 90%. While these are only rough figures, based on the experience of visiting people in detention, they suggest that problems with healthcare feature regularly in the conversations between people in detention and visitors. Only two respondents suggested that this had improved in the time they had been volunteering as a visitor, with all other respondents reporting that this dynamic had either stayed the same or worsened over time. The issues that visitors provided as examples reflect many of the concerns raised through GDWG's casework.

The recurring complaints that have been observed by GDWG at Brook House have also appeared in other sources, including the annual reports of the Independent Monitoring Board (IMB) for Brook House and the healthcare-related findings of the 2018 investigation, commissioned by G4S, into Brook House IRC, following the broadcast of a BBC Panorama documentary evidencing verbal and physical abuse of people in detention there. The IMB reports from 2016 and 2019, for instance, discuss the prevalence of reports from people in detention about the dismissive attitude of staff, as well as formal and informal complaints about medical care, which include issues such as prescribing, delays in attending external appointments, conditions being overlooked and the quality of care.[4]

The G4S-commissioned investigation of Brook House summarises reports that '[m]any detainees in our forums had a poor opinion of healthcare', including comments on the overuse of paracetamol, inadequate mental healthcare, difficulty getting appointments to see healthcare, and poor staff attitudes.[5] However, these issues are summarised as reflecting 'significant levels of distrust of healthcare staff' as opposed to evidence of underlying problems in the quality of healthcare.[6]

4 Independent Monitoring Board for Brook House IRC, Annual Report for Reporting Year 2016 (2017) <https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2017/04/Brook-House-IRC-2016.pdf> accessed 16 June 2021; Independent Monitoring Board for Brook House IRC, Annual Report for Reporting Year 2019 (2020) <https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/06/Annual-Report_Brook_house_2019-for-circulation-RG.pdf> accessed 16 June 2021. As required by the Prison Act 1952 and the Immigration and Asylum Act 1999, Independent Monitoring Boards (IMBs) provide oversight in prisons, immigration removal centres and some short-term holding facilities at airports. They are comprised of ordinary members of the public, appointed by Ministers.

5 Kate Lampard and Ed Marsden, 'Independent Investigation into Concerns about Brook House Immigration Removal Centre' (2018) 176 <https://www.g4s.com/en-gb/-/media/g4s/unitedkingdom/files/brook-house/brook_house__kate_lampard_report_november_2018.ashx?la=en&hash=42B2E56AD3E9946AC659516AB1D6D919> accessed 16 June 2021

6 ibid 183.

Perception, reality and cultures of disbelief

Healthcare, as suggested by Stephen Shaw above, is absolutely central to the experience of people in detention. A survey study undertaken by Mary Bosworth and Blerina Kellezi found a correlation between levels of distress, depression, and isolation and views expressed about the quality of healthcare and, on this basis, identified healthcare as one of the 'five key dimensions to detainee perceptions of life in detention'.[7] Given this, it is not surprising that GDWG often hears concerns about healthcare in the course of their work with people in detention. However, we concluded from our exploration of the issue that the complaints they hear about healthcare are not 'mere' matters of perception, incidental to the fact of detention or the heightened healthcare needs of a population in detention. For example:

- in his 2016 Review into the Welfare in Detention of Vulnerable Persons, commissioned on behalf of the Home Secretary, Stephen Shaw identified extensive issues in relation to healthcare and his progress review 2018 found continuing issues of significant concern;[8]
- the Home Affairs Select Committee concluded in their 2019 report that, although those in detention in IRCs 'should be able to access high-quality healthcare, equivalent to that in the community...[f]rom the evidence we have heard, this is not always the case';[9]
- there is some evidence that the relative view ('perception') of healthcare of those in detention also has a degree of correlation with the overall (again relative) view of the statutory inspectorates. Morton Hall has been given the most positive inspection assessments of all the IRCs since 2015, being assessed as 'good' in the two inspections in 2017 and 2019. It is also the only IRC, in that time, that has achieved a majority (58.3%) positive approval rating from those in detention in the official inspection survey. The lowest ratings are those for Colnbrook in 2016 (16%) and Yarl's Wood in 2015 (20.7%), which were two inspections in which the Care Quality Commission identified concerns amounting to breaches of the basic regulatory standards (see Section 6).

There is a risk that a focus on, and use of terminology such as, 'perception' can feed into a view that the complaints of those in detention are not to be trusted as reflecting any kind of objective reality. This can, over time, become embedded as a culture of disbelief which, as an institutionalised view, can mask the need for, and hamper efforts to secure, meaningful improvements. There is clear evidence that this risk has already materialised. The is a pressing need for agreed measures of quality that can provide the basis for transparent and reasoned quality judgments.

Moreover, as part of this report, we will argue that the low level of patient satisfaction with healthcare services across the detention estate, is in itself a problem and community-equivalent healthcare standards would require that it should be regarded as such.

Using a public law approach

The first question is whether there is a quality of state-provided healthcare that those detained are *entitled* to expect. The agreement which sets out the shared strategic intentions of the relevant statutory authorities in England (NHS England,the Home Office and Public Health England) in relation to the provision of healthcare in IRCs identifies the following as the first of its joint principles:

> Detainees should receive high quality healthcare services, to the equivalent standards of community services, appropriate to their needs and reflecting the circumstances of detention.[10]

The quality standard adopted here reflects the 'community equivalence' principle found in a number of international legal instruments (see

7 Mary Bosworth and Blerina Kellezi, 'Quality of Life in Detention: Results from MQLD Questionnaire Data Collected in IRC Yarl's Wood, IRC Tinsley House, and IRC Brook House, August 2010 - June 2011' (Centre for Criminology, University of Oxford 2012) 3 <http://irep.ntu.ac.uk/id/eprint/27059/1/PubSub4441_Kellezi.pdf> accessed 16 June 2021.

8 Stephen Shaw, *Review into the Welfare in Detention of Vulnerable Persons: A Report to the Home Office* (Cm 9186, 2016) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/490782/52532_Shaw_Review_Accessible.pdf> accessed 16 June 2021; Stephen Shaw, 'Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons: A Follow-up Report to the Home Office' (Cm 9661, 2018) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728376/Shaw_report_2018_Final_web_accessible.pdf> accessed 16 June 2021.

9 Home Affairs Committee, *Immigration Detention* (HC 2017-2019, 913 – XIV) 77 <https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/913/913.pdf> accessed 17 June 2021.

10 'The Partnership Agreement between Home Office Immigration Enforcement, NHS England and Public Health England 2018-21' (2018) 16 <https://www.england.nhs.uk/wp-content/uploads/2018/07/home-office-immigration-enforcement-partnership-agreement.pdf> accessed 16 June 2021.

Section 2). The significance is not only that it sets a quality standard and creates a legitimate expectation of community equivalent healthcare, important though that is. This could be fairly meaningless if it were to be honoured merely by assertion in policy documents. The public law principles of legality, fairness and rationality also require that any relevant quality assurance function exercised by a public authority incorporates that principle, and that the systems for doing so are not unlawful, i.e. that they do not embed any errors of law and they are systemically fair and rational.

Quality standards in healthcare can, of course, be imposed, monitored and enforced, directly and indirectly, in a number of ways, for example through commissioning contracts, the regulation of professional conduct, and complaints adjudications. However, the primary focus of any examination of quality assurance in this context must fall on the Care Quality Commission (CQC) as the statutory regulator of health and social care in England. But there is an overlap with the responsibilities of Her Majesty's Inspectorate of Prisons (HMIP) which is of great significance. In 2006, the role of the Chief Inspector of Prisons was extended to IRCs and the broad scope of the HMIP inspection and reporting function includes healthcare. The process solution to the performance of this overlapping responsibility is that the CQC participates in a joint inspection led by HMIP and the findings relating to healthcare are incorporated within HMIP's published report.

While conducting our initial research for this project, we were struck by the findings of the unannounced inspections of Brook House IRC in 2016 and 2019, which seemed to contrast with the experience of GDWG and the people in detention they support. The 2016 report recorded the finding that healthcare in Brook House was 'adequate'.[11] In 2019 the inspection found that it had improved to the level of 'reasonably good'.[12] Unsurprisingly, these assessments were not seen by GDWG as reflective of the experiences reported to them and they believed that their view was generally shared by visitors' groups across the IRC estate. It is this evident discrepancy that led us to investigate, within the context of the community equivalence principle, the processes of the statutory inspectorates in more detail.

The structure of this report

The GDWG experience has been placed, by means of a literature review, in the wider context of reports on healthcare quality in IRCs, some of which have identified the 'community equivalence' principle as the relevant quality standard for healthcare in that setting. We examine that principle, and its incorporation into government policy for healthcare quality across the secure estate. We have then focused on the question of whether the principle has been effectively operationalised within the statutory system for inspecting healthcare in IRCs. A number of issues have emerged which have informed a series of recommendations as set out in our Executive Summary.

11 HM Chief Inspector of Prisons, 'Report on an unannounced inspection of Brook House Immigration Removal Centre 31 October –11 November 2016' (2017) 15 <https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/brook-house-immigration-removal-centre/> accessed 16 June 2021.

12 HM Chief Inspector of Prisons, 'Report on an unannounced inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons 20 May - 7 June 2019' (2019) 39 <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/09/Brook-House-web-2019.pdf> accessed 16 June 2021.

SECTION 1 - THE CONTEXT: EVIDENCE OF A WIDESPREAD PERSISTENT PROBLEM

In this section, we review relevant literature concerning the quality of healthcare services in immigration removal centres (IRCs) in England. While there has been very little academic research directly focused on the quality of healthcare in IRCs in England, it has received considerable attention as part of various reports and reviews, particularly following the shift in responsibility for the commissioning of health services in IRCs to NHS England in 2013.[1]

Since the shift in commissioning, concerns about the quality of healthcare services in immigration removal centres have been well-documented. These concerns appear in reports and reviews specifically commissioned by the Home Office and the reports of Select Committees, All-Party Parliamentary Groups, independent investigations and reviews, and reports from non-governmental organisations. The main focus of successive reports has been on the provision of mental health services and the detention of vulnerable people, but there are also recurring concerns about the quality of healthcare services more generally. We have limited our literature review to only government and parliamentary reports emerging in the immediate context of the change in commissioning and thereafter. This literature demonstrates the centrality of healthcare services to the welfare of people in detention, the persistence of problems, as well as the lack of a consistent approach to evaluating the quality of those services. Moreover, this literature suggests that the concerns raised by people in detention are more than just perception and reflect ongoing, systemic shortcomings in healthcare provision.

We focus on summarising the types of problems identified by the reports and noting particular areas of concern, how these are evidenced, and what reference, if any, is made to the principle of community equivalence in determining shortcomings in healthcare provision in IRCs. These questions help to orient the focus in the remainder of this report on the principle of community equivalence, the inspection regime in IRCs, the quality standard applied in those inspections and the sources of evidence they rely on.

Problems in Healthcare Services in IRCs

Review of Mental Health Issues in Immigration Removal Centres (2014)

In 2013 the Home Office commissioned the Tavistock Institute of Human Relations to conduct 'a review into the way that mental health issues are dealt with in immigration detention'.[2] The report was completed in the period of commissioning transition to NHS England in 2014, though they state that all research preceded the change. The report itself is concerned with the fundamental question of who may or may not be detained for reasons of mental health and how this is administered (acknowledging as part of its premise that '[t]he Home Office accepts that it has not always got decisions right on the detention of those with mental health conditions' and noting the success of recent legal challenges to these decisions), but it also focuses on the quality of mental healthcare services provided within IRCs.[3]

The Home Office commissioned the review in an effort to improve mental health services in immigration detention. In particular, the Terms of Reference state that

> the purpose of the Review is to consider how Home Office policy on dealing with mental health issues in immigration detention, and how that policy is put into practice, can be improved in order to improve the wellbeing of detainees and so that fewer cases end up in legal challenge.[4]

The terms of reference also provide for a specific emphasis on identifying mental health issues, the timeliness of access to treatment, communication processes, and the knowledge of caseworkers (on how mental health should influence their decision-

1 The Health and Social Care Act 2012 gave the Secretary of State power to require NHS England to commission services, including in immigration removal centres. This was widely regarded as a welcome move. See for example Sarah Turnbull, 'Changes to Healthcare Provision in Britain's Detention Estate' (Oxford Law Faculty, 8 October 2014) <https://www.law.ox.ac.uk/research-subject-groups/centre-criminology/centreborder-criminologies/blog/2014/10/changes> accessed 25 January 2021.

2 David Lawlor, Mannie Sher and Milena Stateva, 'Review of Mental Health Issues in Immigration Removal Centres' (Immigration and Border Directorate, Home Office 2015) <https://www.tavinstitute.org/wp-content/uploads/2015/02/Tavistock_Review-of-Mental-Health-Issues-in-Immigration-Removal-Centres_2015.pdf> accessed 21 January 2021. This is usually referred to as the Tavistock Report.

3 ibid 1.6.

4 ibid 2.2.

making).[5] They describe their methodology as 'action research', and as part of this, they interviewed people in detention, managers, custody staff, healthcare staff and medical practitioners, caseworkers and NGOs.[6]

Amongst a range of issues, the review identified shortcomings in training on mental health awareness, deficiencies in the initial healthcare assessment carried out on arrival at IRCs, a lack of multidisciplinary teams, and feelings of exhaustion amongst healthcare staff. They note the lack of talking therapy on offer in IRCs and acknowledge that detention itself increases stress for people in detention and staff.

In terms of identifying causes, the report links these problems in mental health services to 'complexity inherent in the system,' which in turn means that Home Office policies and procedures '...do not always work smoothly in practice'.[7] They further note that '[t]he relationships between policymakers, managers, detention centre custody staff, healthcare staff and caseworkers may sometimes be characterised by a degree of mutual defensiveness'.[8] The authors also do not seem to have a great deal of hope in the potential for change, commenting that: '[b]ecause of the defensive dynamic, the current cultures in the IRCs will likely continue unchanged'.[9]

The question of community equivalence is not directly addressed or assessed in the report, but the authors suggest that 'it is not possible to provide the full range of services to treat mental health conditions that would be available to patients in hospital or in the community'.[10]

The Home Office fully accepted the recommendations of the Tavistock report, apart from three which were accepted in part.[11]

***Joint Inquiry on the Use of Immigration Detention in the United Kingdom* (2015)**[12]

In 2015, the Joint Inquiry on the Use of Immigration Detention in the United Kingdom by the All-Party Parliamentary Group on Refugees & the All-Party Parliamentary Group on Migration was launched, as stated in the report, after a number of 'high profile incidents within Immigration Removal Centres and amid plans to increase the size of the detention estate'.[13] It describes the overall system as 'expensive, ineffective and unjust'.[14] The inquiry issued a call for written evidence, to which it received a substantial response. In relation to healthcare, it received evidence from a range of medical practitioners, some with experience of working in IRCs, and NGOs. They also took oral evidence directly from people in detention, and they heard from people who had previously been in detention.

The report notes that 'a large number of those who gave evidence to the inquiry raised concerns about health provision'.[15] It identifies ongoing issues, including delays in access to medication, a culture of disbelief, inappropriate use of restraints, and shortcomings in the initial screening process. It concludes that '[m]any of the negative experiences of healthcare provision are caused by the numbers of people detained and the length of time individuals are held within IRCs'.[16] It also acknowledges the recent change in the commissioning of health services in IRCs and expresses hope that this will lead to improvements. It specifically recommends the implementation of a screening process and expresses particular concern about people in detention being asked to consent to sharing their medical records with the Home Office.[17]

In addition to overall health services, the inquiry also focused particularly on the experience of those in detention with mental health conditions. The

5 ibid 2.3.
6 ibid 1.1.
7 ibid 3.1.
8 ibid 3.4.
9 ibid 3.9.
10 ibid 1.5.
11 Home Office, 'Home Office Response to: Tavistock Institute's Review of Mental Health Issues in Immigration Removal Centres' (2015) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/402205/tavistock_response.pdf> accessed 21 January 2021.
12 All Party Parliamentary Group on Refugees and the All Party Parliamentary Group on Migration, *The Report of the Inquiry into the Use of Immigration Detention in the United Kingdom* (London 2015) <https://detentioninquiry.files.wordpress.com/2015/03/immigration-detention-inquiry-report.pdf> accessed 16 June 2021.
13 ibid 6.
14 ibid 7.
15 ibid 53.
16 ibid 55.
17 ibid.

report quotes the then Immigration Minister, who notes that 'the experience of detention itself can be inherently stressful [...] and can therefore exacerbate mental health problems'.[18] Nonetheless, and rejecting this as an explanation or justification for conditions in IRCs, the report states that 'the inquiry was frequently told that the provision of mental healthcare services is very poor', and references the Tavistock report in support of this.[19]

Echoing the findings of the Tavistock report, the inquiry reached a series of strong conclusions about mental health care in IRCs, including that '…it is not possible to treat mental health conditions in IRCs and we believe that the Home Office policy that individuals suffering from serious mental conditions can be managed in detention puts the health of detainees at serious risk'.[20] They recommend returning to a pre-August 2010 policy of only detaining those with mental health conditions in exceptional circumstances.[21] They further note that staff in IRCs, including healthcare staff, lacked adequate training in recognising and responding to mental health conditions, and recommend a mandatory training programme developed by those with expertise in working with people in detention.[22]

Review into the Welfare in Detention of Vulnerable Persons (2016)[23]

In January 2016, Stephen Shaw's Review into the Welfare in Detention of Vulnerable Persons, commissioned on behalf of the Home Secretary, revealed extensive issues in relation to healthcare. He mentions the recent shift in healthcare commissioning to NHS England and notes that '[it] should put IRC healthcare delivery on a more level footing with provision in the wider community, as well as providing a degree of stability that was previously impossible'.[24]

The terms of reference for the Shaw Review were broad and largely framed in terms of welfare and vulnerability. Welfare was interpreted to include 'all aspects of a detainee's treatment',[25] while 'vulnerability is intrinsic to the very fact of detention, and an individual's degree of vulnerability is not constant but changes as circumstances change'.[26] Healthcare, Shaw notes, is 'at the heart of this review'[27] and healthcare is 'a critical part of the detention regime. The health, safety and wellbeing of all detainees depend on the professional, efficient and timely delivery of healthcare services'.[28]

Shaw collected evidence for the review through visits to each of the IRCs, conversations with staff and people in detention, as well as representatives of the Independent Monitoring Board, and forums with groups of people in detention. He also solicited written evidence, met with stakeholders and made in-depth observations of healthcare at Harmondsworth IRC.

The report goes on to detail a fairly extensive range of problems and deficiencies in the provision of healthcare services in immigration removal centres. One of the overarching concerns noted, for example, is a lack of data available about the health needs of those in detention, which is linked to the lack of a standard screening assessment tool across IRCs. As Shaw writes, 'the data currently provided is not sufficiently robust and... better information is required if informed decisions are to be made'.[29] He evaluated evidence from Detention Action suggesting that the screenings were often short, conducted at inappropriate or less than optimal times (e.g. after long journeys), asked 'very little' about mental health, and did not always use interpreters.[30] This was corroborated with reference to the All Party Parliamentary Group in 2015 and the Tavistock Report. However, Shaw notes that his team did observe good practice and no specific recommendation was made concerning the initial screening process.[31]

The use of interpreters formed another focus. Shaw observed non-medical induction interviews, and

18 ibid 56.
19 ibid.
20 ibid.
21 ibid.
22 ibid.
23 Stephen Shaw, Review into the Welfare in Detention of Vulnerable Persons: A Report to the Home Office (Cm 9186, 2016) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/490782/52532_Shaw_Review_Accessible.pdf> accessed 16 June 2021.
24 ibid 159.
25 ibid 8.
26 ibid.
27 ibid 9.
28 ibid 158.
29 ibid 159.
30 ibid 161.
31 ibid 161–163.

> [a]t no time was an official interpretation service actually used. Other detainees were seen interpreting at the request of those conducting an induction, and detainee custody officers were witnessed using their own language skills to converse with detainees.[32]

He concludes that '[t]he observations that my team and I made ourselves, and the evidence of others, have convinced me that professional interpreters (whether in person or by telephone) are not used widely enough'.[33] He recommends a review of the use of fellow detained people for interpretation and 'that the Home Office remind service providers of the need to use professional interpreting facilities whenever language barriers are identified on reception'.[34] He also found that there was significant variation across the detention estate in the healthcare services available to people in detention and hours of access.[35]

The report also relays an extensive range of criticisms of healthcare received as part of written evidence submitted to the review, noting that healthcare was a central concern in the submissions. However, many of these criticisms remain unsubstantiated in the context of the report. For example, the report references a series of 'serious allegations' from Asylum Welcome, including denial of medication for HIV and chronic conditions, non-adherence to clinical plans, overuse of paracetamol, difficulty in getting hospital appointments and delays due to a lack of available escorts, lack of access to dental treatment and inadequate support for mental health issues.[36] However, Shaw states that he did not investigate the allegations and 'in the interests of balance' contrasts these claims with the inspection report from Campsfield House IRC, which indicated that overall healthcare services were good.[37] There was no further comment on this from Shaw or any related recommendations.

A similar approach was taken to concerns raised by Freedom from Torture and Medical Justice. Freedom from Torture reported an uneven approach to the mental health of survivors of torture, a lack of specialist expertise and inadequate health screening, and non-responsiveness when they had attempted to liaise regarding the health of detained clients.[38] They also noted issues with discontinuity of medication. Medical Justice reported that '...the range and quality of care in IRCs is not equivalent to that offered to the community or in accordance with NICE guidelines'.[39] They also reported 'a lack of access to specialist healthcare',[40] cancelled or missed external appointments, denial of treatment for serious conditions, and insufficient treatment and diagnosis of communicable diseases. The report offers no further comment on these issues, though they do echo some of Shaw's earlier findings.

The report also details a submission from the Royal College of Midwives concerning what was broadly referred to as a 'culture of disbelief' in which 'detainees' symptoms or health complaints were viewed with suspicion'.[41] On this issue, Shaw confirms that he 'encountered such a culture on the part of at least one IRC doctor to whom I spoke'.[42] In the report, this is followed by an extract from the independent legal assessment provided by Mr Jeremy Johnson QC at the request of Shaw for the purposes of the report, assessing cases in which there has been a breach of Article 3, suggesting that the criticisms of healthcare in immigration detention indicate a systemic problem:

> There is criticism of the healthcare provided to detainees. Of course, individual poor clinical practice may not have any underlying systemic cause. But the nature of the findings made in these cases do not really concern individual poor clinical practice. There is little or no criticism of individual clinicians. The findings are more concerned with a lack of assessment and treatment – see in particular HA and D and MD. These findings have been made in respect of several different removal centres and over prolonged periods of time. In several cases, detainees who were in urgent need of assessment and treatment were not seeing a specialist for months on end. The nature and pattern of findings are such that they are more likely to be a reflection of a systemic problem (i.e.

32 ibid 162.
33 ibid 163.
34 ibid.
35 ibid 160.
36 ibid 165
37 ibid.
38 ibid 166.
39 ibid 167.
40 ibid.
41 ibid.
42 ibid.

> insufficient medical – particularly psychiatric – provision) rather than individual failings.[43]

However, the report offers no further commentary on the systemic nature of the issues identified. In relation to the views of people in detention, Shaw notes that healthcare was

> a feature of most of my discussions with detainees; indeed, many expressed a deep frustration. There were accusations of rude and dismissive behaviour by staff, and poor quality treatment (receiving the wrong medication, not being able to access medication, misdiagnosis, lack of appointments) was consistently reported.[44]

Following a brief analysis of healthcare complaints, Shaw notes that '[i]t is clear that the dissatisfaction detainees express verbally about healthcare does not translate into written complaints'.[45]

Shaw also spoke to healthcare staff in IRCs who 'reported being overworked, with high caseloads to manage'.[46] Staff mentioned feeling 'a conflict between the provision of appropriate treatment and the imperative of ensuring that a detainee was fit for travel and therefore for removal from the UK'.[47] The report goes on detail further issues with aspects of healthcare such as continuity of care, informed consent, a blurring of lines of accountability and responsibility between healthcare staff and Home Office staff, understaffing, and an over-reliance on temporary staff.[48]

On mental health, Shaw writes that '[n]o issue caused me more concern during the course of this review than mental health. That concern embraces both the detection and treatment of mental illness, and the impact that detention itself may have on mental wellbeing'.[49] He also acknowledges that mental health issues can trigger other health problems. Shaw primarily focused on the impact of detention on mental health, but there were a few specific concerns about the provision of mental health care and related recommendations. These were made with the acknowledgement that 'some of those who submitted evidence would argue that the very conditions of detention are such that no therapeutic environment can be created in which proper treatment can be delivered'.[50]

The report notes specifically that 'the starting point [for mental health services] is very far from satisfactory,' and cites the submissions of Mind and the Royal College of Psychiatrists, which argue that 'there is no equivalence between the services provided in IRCs and those available in the community'.[51] He found variation in the provision of mental health services and notes a lack of reliable data from the Home Office about the demand for mental health services. On this point, the report recommends that a clinical assessment be undertaken for the whole of the immigration detention estate.

The review found significant variation in the availability of talking therapies and also recommended that these be made available across the estate. The report also notes differences in 'the ability of IRCs to arrange speedy transfers of the most ill patients to appropriate psychiatric provision in the community'.[52] Access to specialists was inconsistent and 'may not reflect clinical need'.[53] The report identifies a need to review available training for IRC staff and Home Office caseworkers on mental health. He recommends the creation of a joint action plan between the Home Office, NHS England and the Department of Health to improve mental health services in IRCs.

The Government's response to the Shaw Review's findings in relation to healthcare focused on the recommendations related to mental health.

> The Government will carry out a more detailed mental health needs assessment in Immigration Removal Centres, using the expertise of the

43 ibid 168. Mr Jeremy Johnson QC was 'asked to assist Mr Shaw by providing an independent legal assessment of cases where the Courts have found a breach of Article 3 of the European Convention on Human Rights in respect of the treatment of immigration detainees since May 2010' (ibid 269). More specifically, he was 'asked to provide a summary of the relevant judgments in which such a breach has been found, to offer an opinion on the degree to which the Court's findings are case specific, or whether they show some of kind of specific failing either in policy or the actual conditions of detention' (ibid).
44 ibid 165.
45 ibid 168.
46 ibid 165
47 ibid 165
48 ibid 169 – 173.
49 ibid 175.
50 ibid 178.
51 ibid.
52 ibid 182.
53 ibid.

Centre for Mental Health. This will report in March 2016, and NHS commissioners will use that assessment to consider and revisit current provision to ensure healthcare needs are being met appropriately. In the light of the review, the Government will also publish a joint Department of Health, NHS and Home Office mental health action plan in April 2016.[54]

***Immigration Removal Centres in England: A Mental Health Needs Analysis* (2017)**[55]

In response to the Shaw Review, NHS England commissioned the Centre for Mental Health to conduct a 'rapid mental health needs analysis of IRCs in England'. The report confirms the findings of the Shaw Review and adds more detail to these.

As part of the research for the report, the authors interviewed key stakeholders and staff. They also developed a survey for health care managers in IRCs and collected relevant data from IRCs. They conducted a needs assessment by asking staff at IRCs to conduct the Health of the Nation Outcome Scale for a sample of people in detention at each facility. They also conducted interviews with 32 people in detention from different IRCs, with some interviewed in groups and visited each IRC 2-3 times.

The review identifies a number of challenges, including the lack of a screening process to identify vulnerability before the decision to detain was made.[56] They note issues with communication, and particularly that '[o]n arrival, there is no guarantee of information flow regarding an individual's vulnerability from the detention source... to the IRC'.[57] Screening for learning disability, autistic spectrum disorder and acquired brain injury they note are perceived as 'weak' and 'very limited'.[58] They also describe problems with the screening process when people in detention have had a stressful experience of being detained. They find that access to primary care varied and caution that

> [w]hen compared to access in the community, IRCs might appear to compare well, but detainees do not have access to alternatives (e.g. advice from a local pharmacist) and... their very detention can pose significant challenges to their mental and physical health.[59]

They also note delays in Rule 35 assessments, and, drawing on interviews with staff, they find delays of up to five weeks in hospital transfers, meaning that people in detention who suffer from mental health issues are inappropriately placed in segregation.

They observed 'an inadequate number of private rooms with the necessary facilities for clinics and therapy to take place' and a lack of translation facilities and health background information in the rooms.[60] They report that people in detention often perceive that they are not listened to or taken seriously and that they are treated as if they are lying. Interviews with staff also confirmed the pervasiveness of this culture of disbelief and 'othering'. They also note a lack of access to supervision for mental health staff and variable access to training, as well as issues with short-staffing, explaining that 'across the centres, the mental health teams were very small and described as 'isolated'.[61]

The report made a range of recommendations, including improving information sharing to identify those who are vulnerable, requiring a standardised approach to screening for mental health, and mental wellbeing reviews for those in detention at regular intervals.[62] They recommend a review of compliance with NICE guidelines and increased availability of psychological interventions. They also recommended appropriate staffing levels to manage the need for mental health services, staff training and development (particularly in the Stepped Care Model), clinical supervision, and general mental health awareness training for all IRC staff. In relation to continuity of care, they recommend that planning for this should be

54 HM Government, 'Government Response to the Review on Welfare in Detention of Vulnerable Persons' (2016) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/492227/gov_paper__2_.pdf> accessed 5 April 2021.
55 Graham Durcan, Jessica Stubbs and Jed Boardman, 'Immigration Removal Centres in England: A Mental Health Needs Analysis' (Centre for Mental Health, 2017) <https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/immigration_removal.pdf> accessed 17 June 2021.
56 ibid 27.
57 ibid.
58 ibid.
59 ibid 28.
60 ibid 30.
61 ibid 32.
62 ibid 3.

managed centrally (within the NHS), with maximum notice for IRC healthcare staff when release is planned.

A lack of progress

In spite of the detailed action plan that followed the Shaw Review, subsequent reports suggest that progress has been relatively limited and that many of the same concerns persist.

Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons (2018)[63]

In 2018, Stephen Shaw published an assessment of the government's progress in relation to the findings and recommendations of his 2016 review. Shaw writes that:

> I have been told of significant progress across a number of areas identified in my first review, but obtaining data to verify this has proved challenging. In every IRC I visited, the demands on healthcare remained significant, and I also found considerable patient dissatisfaction. I was pleased, however, to note in a recent survey commissioned by NHSE that most detainees feel they are treated with respect.[64]

While Shaw notes that reports from the Chief Inspector of Prisons and the Care Quality Commission identified that there had been improvements in healthcare services at Yarl's Wood IRC and the two immigration removal centres that service Heathrow,[65] the report also includes comments from Medact and Medical Justice attesting that there had not been any improvement since the first report. According to Medact,

> There were high hopes that the transfer of the commissioning of healthcare in IRCs to the NHS would result in rapid and significant improvements in its practice. These remain largely unrealised as yet. We suggest that when the transfer occurred, NHS bodies were unaware of the extent of the task they were taking on and unprepared for complex practical and ethical issues (including dual loyalties) which are unusual in every day NHS practice, and it is not clear that the responsible entities (NHS England and its local bodies, but also the CQC, GMC and NMC) have yet taken the necessary steps to identify (through conducting or mandating audit) and to direct (by contractual or other means) effective action to reduce risk and harm to vulnerable detainees.[66]

According to Medical Justice:

> The care provided fails to meet equivalence with that provided in the community, mental health services continue to be inadequate or inappropriate. There has been little change in the healthcare provision following the Shaw Review that we are aware of, and we continue to see serious failings in healthcare provisions, around the quality of care, around the attitude of staff and in particular in relation to mental health services.[67]

When Shaw visited Brook House as part of the research for the follow-up report, he made a range of concerning observations. There were issues with cleanliness and storage in clinical rooms. Mental health staff reported seeing patients whom they believed were not fit for detention and could not be transferred to outside hospitals. Rule 35 assessments continued to be an issue, with healthcare staff suggesting that 'it was outside their competence to interpret what constituted torture'.[68] He notes concerns about patient privacy and the lack of a dental suite. There were also concerns amongst staff about healthcare management, including the computer system (SystmOne) and patient consent. Healthcare staff also reported that 'sharing best practice across IRCs with different healthcare providers is challenging, as it is seen as business sensitive'.[69] A 'high proportion' of written healthcare complaints from those in detention

63 Stephen Shaw, 'Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons: A Follow-up Report to the Home Office' (Cm 9661, 2018) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728376/Shaw_report_2018_Final_web_accessible.pdf> accessed 16 June 2021.

64 ibid 43.
65 ibid.
66 ibid 46.
67 ibid 43. Medical Justice's full submission is available here: http://www.medicaljustice.org.uk/wp-content/uploads/2018/07/MJ-submission-to-Shaw-II-30.11.2017-final-edited.pdf.
68 ibid 49.
69 ibid 50.

concerned medication. Shaw also notes that '[t]he lack of a trauma therapist and community-equivalent counselling services is challenging for staff and detainees alike'.[70] Concerns relating to privacy and conduct were also raised by staff about the phone interpreter service.

More generally, across the areas of concern identified in the original report, Shaw found a lack of evidence of improvements and the continuation of unacceptable conditions, even where specific interventions had been promised. For example, in relation to 'Environment and Resources', Shaw finds that 'a number of clinical rooms were not compliant with Care Quality Commission (CQC) expectations or infection control guidelines,' and he 'observed some examples of desensitisation' amongst staff members who seemed not to notice inadequate conditions that were 'clearly not equivalent to clinical areas in the community'.[71] He further remarks that '[m]y team member seconded from the NHS was so concerned in one establishment that he reminded the head of healthcare of the infection control and CQC guidance relating to safe care and treatment'.[72]

In relation to 'Pharmacy and medicines management', Shaw found that in spite of an agreement from NHS England to deliver an IRC medicines optimisation programme during 2016/17,

> mechanisms to support the safe administration of medications were not in evidence during my visits, nor did staff make reference to them. I was not satisfied that the healthcare facilities I observed offered appropriate dispensing arrangements.[73]

However, in relation to 'Primary care', Shaw finds that 'this degree of access to a GP access [sic] is equivalent to, and in some areas superior to, that in the community'.[74] Yet it is unclear how this equivalence was established, and Shaw further qualified this, stating that

> …this is not to compare like with like. Detainees do not have access to over-the-counter medication, as they would in the community […]. Detainees do have access to Accident and Emergency if they require emergency hospital triage but are not able to access drop-in services while in detention. Manifestly, detainees are also denied the normal support mechanisms of family and friends.[75]

The report makes a series of recommendations related to healthcare provision, including the establishment of a 'best practice forum', a review of the quality of interpreter services, and an action plan to address issues with facilities.[76]

Immigration Detention – Report of Home Affairs Select Committee 2019[77]

The Home Affairs Select Committee's inquiry into immigration detention was prompted by the abuses documented at Brook House IRC. They spoke to G4S, Gatwick Detainees Welfare Group and Stephen Shaw and received written evidence from many NGOs and other bodies. They frame their report on healthcare in immigration detention in relation to community equivalence, stating that

> '[d]etainees are entitled to the same range and quality of services as the general public receives in the community'.78 They note comments from Medical Justice that there continue to be problems with the quality of healthcare in IRCs. They also note issues such as staffing shortages, emphasised particularly by the British Medical Association, a culture of disbelief, and delays in receiving care.

In their conclusions, they stress that '[t]he Home Office must meet its obligations to those individuals it detains in immigration removal centres (IRCs). This means that people should be able to access high-quality healthcare, equivalent to that in the community. From the evidence we have heard, this is

70 ibid 49–50.
71 ibid 60.
72 ibid.
73 ibid 61.
74 ibid 62.
75 ibid.
76 ibid 123–126.
77 Home Affairs Committee, Immigration Detention (HC 2017-2019, 913 – XIV) <https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/913/913.pdf> accessed 17 June 2021.
78 ibid 76.

not always the case'.[79] They also state, in support of the recommendations of the British Medical Association, that the Home Office 'should consider the appointment of a clinically qualified individual to advise on the development of health policy specific to IRCs,' and

> the Home Office should ensure that there is a clinically qualified point of contact within the Home Office for IRC healthcare staff who may require advice relating to Rule 35 reports. Problems with recruitment and staff retention across the whole IRC workforce (including healthcare) must be urgently addressed to prevent staff shortages negatively affecting the health and wellbeing of detained individuals.[80]

Summary

The various reports reviewed here demonstrate that the quality of healthcare services has been a persistent concern within the broader conversation on immigration removal centres in England. While the reports suggest that there have been some improvements over time, it is difficult to ascertain from the literature what specific improvements have been made. A number of concerning issues appear repeatedly. In particular, we note the comments of the Home Affairs Select Committee in 2019 that community equivalence is not always achieved.

Community equivalence is a key concern of our report. As we detail in Section 2, the principle of community equivalence has been recognised as the standard to which healthcare provided to those detained by the state must be held. However, it has only been addressed sporadically in the various reports reviewed here. Where there have been substantive assertions of community equivalence, this has usually been done without any indication of the basis on which it has been ascertained. It has also been suggested in some instances and in relation to particular aspects of healthcare that it would be impossible to achieve, which is particularly concerning given that this is the relevant standard to which healthcare services in secure settings are supposed to be held.

Moreover, we note that the reports reviewed here have not generally made reference to the inspection process and its role in ensuring the quality of healthcare in IRCs, and more specifically, in ensuring that community equivalence is achieved. In the Shaw Review, it is notable, as indicated above, that some of the criticisms of healthcare services submitted by NGOs were set alongside the findings of an HMIP inspection report that the service was satisfactory, but without consideration being given to whether the inspection process is clearly delivering quality assessment in accordance with the equivalence principle.

79 ibid 77.
80 ibid 77-78.

SECTION 2: COMMUNITY EQUIVALENCE

Several of the reports considered in the literature review in Section 1 reference the 'community equivalence' principle, the idea that those detained by the state should receive healthcare that is equivalent to that enjoyed in the wider community. Although it is necessary to operationalise the principle for the purpose of practical application, nevertheless it sets the basic quality standard required of healthcare in secure settings.

It is a principle that is reflected in a number of international legal instruments; for example, Rule 24 of the United Nations Standard Minimum Rules for the Treatment of Prisoners 70/175 (the Nelson Mandela Rules) adopted 17 December 2015 states that:

> The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.[1]

Domestically, Mr Justice Collins found the law to be 'clear' on the point in the case of R (on the application of Nathan Brooks) v (1) Secretary of State for Justice (2) Isle of Wight Primary Care Trust:

> …it is accepted, and the law is clear, that prisoners have to be treated in a way which respects their right to proper treatment and it is again accepted by both the Ministry of Justice, who are responsible for the prisons, and the healthcare trusts or whoever (I suppose the Department of Health generally) that prisoners are entitled, insofar as it is possible, to the same attention as would be provided for any person under the terms of the National Health Service.[2]

The issue has been not whether the principle is sound, but how equivalence should be measured and whether the state delivers on its obligation in practice; two closely related questions. Monitoring effective delivery is dependent on knowing how to define and measure the desired outcome.

Defining and measuring community equivalence

In 2018 the Royal College of General Practitioners (RCGP) published what has become a much-cited position statement in which they noted that, despite the agreement on the principle, 'there is no resource setting out how equivalent care should be defined, measured or compared within the secure setting to that in the wider community'.[3] It proposed the following to fill the definitional (but not the measurement) gap:

> Equivalence is the principle by which the statutory, strategic and ethical objectives are met by the health and justice organisations (with responsibility for commissioning and delivering services within a secure setting) with the aim of ensuring that people detained in secure environments are afforded provision of or access to appropriate services or treatment (based on assessed need and in line with current national or evidence-based guidelines) and that this is considered to be at least consistent in range and quality (availability, accessibility and acceptability) with that available to the wider community in order to achieve equitable health outcomes.[4]

The publication recognises that equivalence does not mean that what is provided must be exactly the same; healthcare needs may differ in a secure setting and the fact of the service being delivered within a secure environment can have an impact on what is required and how it is delivered. However, this does not mean that the principle of equivalence is empty of meaningful content. For example, the impact of detention on mental health may be such that preventative provision (of equivalent quality) must be provided more promptly to achieve an equivalent outcome.

The issue of equivalence was subsequently considered by the House of Commons Health

1 UNGA Res 70/175 (17 December 2015)
2 [2010] 1 Prison LR 266 [5].
3 Royal College of General Practitioners – Secure Environments Group, 'Equivalence of Care in Secure Environments in the UK: Position Statement (July 2018) 4 <http://allcatsrgrey.org.uk/wp/download/prisons/RGCP-secure-group-report-july-2018.pdf?platform=hootsuite> accessed 17 June 2021.
4 ibid 5.

and Social Care Committee in an inquiry into prison health (published in October 2018).[5] Its criticism of the lip service paid to equivalence was uncompromising:

> Equivalence is endorsed internationally and has (in theory) been a core part of the Government's approach to the health of prisoners since the Joint Prison Service and National Health Service Executive Working Group in 1999 endorsed the following principle: 'To give prisoners access to the same quality and range of health care services as the general public receives from the National Health Service'. Despite this endorsement and continued support, what equivalence means in practice has remained vague. For example, there is no resource describing how equivalence should be defined, measured and compared with health and care in the community. The National Audit Office criticised the then partnership between the National Offender Management Service, NHS England and Public Health England for not having defined measurable outcomes of equivalence and for not measuring progress, saying: 'it is not clear how partners can assess whether healthcare in prisons is equivalent to healthcare in the community'.[6]

The Committee recommended that:

> [t]he National Prison Healthcare Board [NPHB]7 work with stakeholders over the next 12 months to agree a definition of "equivalent care" and indicators to measure the extent to which people detained in prison receive at least equivalent standards of care, and achieve equivalent health outcomes, as the population as a whole - in other words, to measure the health inequalities of people detained in prison.[8]

In response to the Committee's recommendations, the NPHB adopted a definition which was largely a replication of the RCGP's version and, 'committed to consider the extent to which available indicators could help evidence the achievement of equivalence of care'.[9] The stage reached in this work is unknown. However, the NPHB limited its work to the prison setting so that it fell within the scope of its remit i.e. it does not extend to the whole of the secure estate.[10]

Community equivalence and government policy on healthcare in IRCs

There is no doubt that the principle of community equivalence is also treated as a fundamental principle in the key governmental policy and operational documents in the IRC context. For example:

- The overarching agreement which sets out the shared strategic intentions of NHS England, the Home Office and Public Health England in relation to the provision of healthcare in IRCs identifies, sets out as the first of its joint principles, that:

> '[d]etainees should receive high quality healthcare services, to the equivalent standards of community services, appropriate to their needs and reflecting the circumstances of detention'.[11]

- NHS England's current service specification for the provision of primary care in IRCs requires that the provider '[p]rovide and develop a community equivalent GP/ ANP [Advance Nurse Practitioner] service to patients that meets the needs of the population in the IRC'.[12]

5 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.
6 ibid 15.
7 'National Partnership Agreement between: The National Offender Management Service, NHS England and Public Health England for the Co-Commissioning and Delivery of Healthcare Services in Prisons in England' (2018) 5 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/460445/national_partnership_agreement_commissioning-delivery-healthcare-prisons_2015.pdf>. The NPHB has responsibility for the oversight and delivery of the objectives in the agreement.
8 *Prison Health* (n5) 16.
9 'National Prison Healthcare Board, 'Principle of Equivalence of Care for Prison Healthcare in England' 4 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/837882/NPHB_Equivalence_of_Care_principle.pdf> accessed 20 January 2021.
10 ibid.
11 'The Partnership Agreement between Home Office Immigration Enforcement, NHS England and Public Health' (2018) 16 <https://www.england.nhs.uk/wp-content/uploads/2018/07/home-office-immigration-enforcement-partnership-agreement.pdf> accessed 20 April 2021.
12 NHS England and NHS Improvement, 'Service Specification: Primary Care Service – Medical and Nursing for Immigration Removal Centres in England (2020) 27 <https://www.england.nhs.uk/wp-content/uploads/2020/03/primary-care-service-spec-medical-nursing-irc-2020.pdf> accessed 17 June 2021.

- NHS England's publication explaining the infrastructure for quality assurance in the health and justice sector sets out the underlying aim which is to ensure 'those in secure settings are given access to the same quality and range of health care services the wider public receives from the NHS'.[13]

Community equivalence and quality assessment

This last publication makes clear that equivalence is not simply a case of ensuring that the same *types* of healthcare are available to meet the presenting needs of an IRC's population, but that the *quality* of that healthcare is equivalent. It relies on what it calls the 'single definition of quality'[14] derived from NHS England's statutory quality improvement duty:[15]

> The following three dimensions must be present to provide a high-quality service:
> **Patient Safety** – quality care is care which is delivered to prevent all avoidable harm and risks to the individual's safety.
> **Clinical Effectiveness** – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes.
> **Patient Experience** – quality care is care which looks to give the individual as positive an experience of and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect.[16]

Reassuringly, it notes that the Care Quality Commission (CQC), the regulator of health and social care in England, takes the same view of quality:

> The Care Quality Commission's (CQC) single shared view of quality supports this definition. The CQC's assessment of quality has been developed around five questions asked about every service.
>
> - Is it safe?
> - Is it effective?
> - Is it caring?
> - Is it responsive?

The fifth question asked by the CQC (Is it well-led?), recognises the link between leadership and quality improvement.[17]

It later acknowledges the role of the inspection regime in ensuring healthcare is delivered to that community equivalent quality standard.

> The CQC works with HMIP [Her Majesty's Inspector of Prisons] with a shared aim […]. Working jointly, they share a responsibility to ensure detainees are safeguarded against ill treatment and receive the same quality of care as the rest of the population.[18]

This report is an examination of the extent to which the inspection scheme that has been developed is able to deliver on this responsibility.

13 NHS England and NHS Improvement, 'Quality Assurance and Improvement Framework: Health and Justice and Sexual Assault Referral Centres' (2019) 4 <https://www.england.nhs.uk/wp-content/uploads/2019/07/qaif-health-justice.pdf> accessed 16 June 2021.
14 ibid 7.
15 See National Health Service Act 2006 s 13E.
16 'Quality Assurance and Improvement Framework: Health and Justice and Sexual Assault Referral Centres' (n 13) 7–8. Here they quote directly from National Quality Board, 'Quality in the New Health System: Maintaining and Improving Quality from April 2013' (2013) 13 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213304/Final-NQB-report-v4-160113.pdf> accessed 17 June 2021.
17 ibid 8.
18 ibid 25.

SECTION 3: THE INSPECTION REGIME

This section provides an overview of the current inspection regime for immigration removal centres (IRCs) and the particular way in which healthcare services are inspected in light of the overlapping responsibilities of Her Majesty's Inspectorate of Prisons (HMIP) and the Care Quality Commission (CQC).

HMIP and the CQC: their overlapping responsibilities

Section 1 of the Health and Social Care Act 2008 established the CQC as the current regulator of health and social care in England. Providers of 'regulated' health and social care 'activities' are required to register with the CQC; it is a criminal offence to fail to do so.[1] The definition of 'regulated activity' and the exemptions are set out in the legislation.[2] Most healthcare services provided in IRCs are such that providers must register with the CQC.[3] For example, the scope of the CQC's responsibilities covers both general practice services in the community and in IRCs. In this report the terms 'community healthcare services' and 'community general practice' will be used to refer, respectively, to healthcare services generally and GP practices in particular in the community (i.e. outside of secure settings).

In 2006, the role of the Chief Inspector of Prisons[4] was extended to IRCs.[5] The broad scope of the HMIP inspection and reporting function covers all conditions and treatment of those detained and includes healthcare. It is this that creates an overlapping of responsibilities with the more focused, specialised remit of the CQC.[6]
The Memorandum of Understanding ('MOU') between HMIP and the CQC sets out the relationship between them for the purpose of meeting their respective responsibilities.[7] The two organisations agree that CQC is to treat HMIP as the expert body in relation to the justice system, and HMIP will treat the CQC as the expert body in relation to the health and social care system. But, nonetheless, for there to be clarity about the statutory powers under which action is being taken, the MOU identifies the lead body as being HMIP in ensuring that the service 'meets expectations *including the expectations of them for health and social care*' and the CQC as leading to ensure that 'providers comply with *registration and regulated activities regulations*'.[8] This distinction is rooted in the underlying statutory responsibilities of each body which, together with its implications for community equivalence, will be elaborated in the next section.

As to the process by which these responsibilities will be discharged, Protocol 2 to the MOU ('Key principles for inspection and assessment of healthcare providers') requires that '[a]ll of CQC's regulatory activities in places of detention will be coordinated with HMIP'.[9] Accordingly, save for 'focused inspections', the CQC undertakes its inspections as part of the broader (usually unannounced) inspections scheduled and led by HMIP and the findings of the CQC are included in the joint inspection report.[10] Focused inspections may be undertaken and led by the CQC in response to specific issues of concern but will involve HMIP inspectors where necessary.

Despite the embedding of the CQC process within that of the overarching and broader process of HMIP, the foreword to the CQC handbook for healthcare providers in secure settings is clear about the CQC role in such settings, in particular in relation to the application of the principle of community equivalence:

1 Health and Social Care Act 2012 s 10.
2 See in particular ibid 8; The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
3 Care Quality Commission, 'How CQC Regulates Health and Social Care in Prisons and Young Offender Institutions, and Health Care in Immigration Removal Centres: Provider Handbook' (July 2015) 10 <https://www.cqc.org.uk/sites/default/files/20150729_provider_handbook_secure_settings_0.pdf> accessed 17 June 2021.
4 The role of the Chief Inspector of Prisons was established by Prison Act 1952 s 5A (as amended by Criminal Justice Act 2003 s 57).
5 Immigration, Asylum and Nationality Act 2006 s 46.
6 It is worth noting here that HMIP can delegate any of its functions to a number of authorities, including the CQC, although that has not been the solution of choice to date to avoid the potential duplication and confusion. Prison Act 1952 para 1 Schedule A1.
7 Care Quality Commission and HM Inspectorate of Prisons, 'Memorandum of Understanding' <https://www.cqc.org.uk/sites/default/files/20161221_mou-cqc-hmip-2016.pdf> accessed 20 April 2021.
8 ibid 3. Emphasis added.
9 ibid Protocol 2.
10 ibid.

> People who use services in secure settings are generally more vulnerable because they rely on authorities for their safety, care and well-being, and they are unable to choose their place of care. It is our responsibility, working with Her Majesty's Inspectorate of Prisons (HMIP), to ensure that detainees are safeguarded against ill treatment and receive the same quality of care as the rest of the population.[11]

Accordingly, the CQC commits itself to an approach which '…is based on the same principles and key questions which underpin our inspections of both health and social care providers in the wider community'.[12] This is explored in more detail below.

HMIP Inspection Process

HMIP Inspection criteria

The Chief Inspector is required[13] by the legislation to produce 'a document setting out the manner in which he proposes to carry out his functions of inspecting and reporting (an "inspection framework")'.[14] The inspection framework in operation prior to the introduction of the temporary Covid-specific arrangements was published in March 2019 ['the HMIP Framework'].[15] The inspection criteria are known as 'Expectations'. As the HMIP Framework explains:

> …the starting point of all inspections is the outcome for detainees. The Inspectorate's Expectations are based on and referenced against international human rights standards, with the aim of promoting treatment and conditions in detention which at least meet recognised human rights standards.[16]

There are specific Expectations for immigration detention.[17] They vary with the type of IRC (for example, there are specific and separate criteria for centres for adult men and for adult women), and they are structured by reference to HMIP's four aspects of a 'healthy establishment': 'Safety', 'Respect', 'Activities' and 'Preparation for removal and release'.[18] These are known as Healthy Prison Areas (HPAs). The Expectations for health services are to be found in the 'Respect' section under the following headings:

- Strategy, clinical governance and partnerships
- Primary care and inpatient services
- Mental health
- Substance misuse treatment
- Medicines optimisation and pharmacy services
- Oral health.[19]

They are subject to the general statement of principle that:

> Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health …Human rights standards require that detainees be provided with the same standard of health care as available in the community and that places of detention should safeguard and improve the health of those in their care […].[20]

Each Expectation is associated with a list of 'indicators' of whether that Expectation is being met. For example, in 'Primary care and inpatient services', it is expected that '[d]etainees' immediate health, substance misuse and social care needs are recognised on reception and responded to promptly and effectively'.[21] This may be evidenced by a range of practices (indicators), including but not limited to:

- A competent health professional screens all new arrivals promptly to identify their immediate needs and vulnerabilities and assess their mental capacity. Appropriate onward referrals are made.

11 Care Quality Commission, 'Provider Handbook' (n3) 5. Emphasis added.
12 ibid 8.
13 There is a duty to consult with specified authorities including the CQC. Prison Act 1952 para 2(2) Schedule A1.
14 ibid 2(1)(b) Schedule A1.
15 HMI Prisons, 'Inspection Framework' (March 2019) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/03/INSPECTION-FRAMEWORK-2019.pdf> accessed 20 April 2021.
16 ibid 2.26 p.10.
17 The pre-Covid version is published as HMI Prisons, 'HMIP Expectations for Immigration Detention, Criteria for Assessing the Conditions for and Treatment of Immigration Detainees Version 4' (2018) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/03/Immigration-Expectations-FINAL.pdf> accessed 20 April 2021.
18 ibid 6.
19 ibid 2.
20 ibid 47.
21 ibid 50.

- All relevant risk, vulnerability and care planning information is shared between centre and health staff, and the Home Office where appropriate, on the first night and throughout detention to ensure detainees' safety.
- With consent the patient's medical records are obtained and any relevant care agencies are contacted promptly to ensure continuity of care.[22]

Based on the evidence gathered, an overall assessment is made for each of the four healthy establishment tests using a score allocated on the basis of the following criteria.[23]

4	**Outcomes for prisoners are good** There is no evidence that outcomes for detainees are being adversely affected in any significant areas.
3	**Outcomes for prisoners are reasonably good** There is evidence of adverse outcomes for detainees in only a small number of areas. For the majority there are no significant concerns.
2	**Outcomes for prisoners are not sufficiently good** There is evidence that outcomes for detainees are being adversely affected in many areas or particularly those areas of greatest importance to the well-being of detainees. Problems/concerns, if left unattended, are likely to become areas of serious concern.
1	**Outcomes for prisoners are poor** There is evidence that the outcomes for detainees are seriously affected by current practice. There is a failure to ensure even adequate treatment and/or conditions for detainees. Immediate remedial action is required.

The Inspection Report

HMIP publishes a guide for writing inspection reports, the pre-Covid version being dated March 2018.[24] This deals with editorial processes, timescale and house style, and it structures the report by reference to the four healthy establishment tests. It includes guidelines on word counts. 2050 words are allocated to the Health, wellbeing and social care section. It is said that the word counts 'are for guidance only', that '[s]ome sections will require more or fewer words',[25] and that they 'will be kept under review'.[26]

The report writing guide also carries criteria for identifying a 'recommendation' and the number of recommendations likely to be associated with a particular 'score'. A recommendation is:

- something fundamental to the healthy establishment tests (and including anything that is important enough to be included in the report summary), or
- something that will require significant changes in culture or procedures, or new or redirected resources, and will therefore not be achievable immediately by the senior management team, or
- something of sufficient importance for us to seek evidence of implementation on a return visit.[27]

Having met these criteria, recommendations are divided, for the purpose of the report into 'main recommendations' and other recommendations. The former are 'key areas of change required for the establishment to improve its performance towards a healthy establishment…'.[28] and are included in the report summary. The other recommendations are listed at the end of the section in which they arise. The guidelines in Appendix II suggest that up to 5 recommendations per healthy prison area (HPA) might be associated with a 'good' rating, 10 per 'HPA' for a 'reasonably good' rating, up to 15 per HPA for a 'not sufficiently good' rating and up to 20 per HPA for a 'poor' rating.[29]

The IRC is expected to produce an action plan within 2 months of the publication of the inspection report to set out whether the recommendations are agreed and action, if any, to be taken.[30] An

22 ibid. Emphasis in original.
23 HMI Prisons, 'Inspection Framework' (n 15) para 3.32.
24 HMI Prisons, 'Guide for Writing Inspection Reports' (March 2018) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/03/4.-GUIDE-FOR-WRITING-INSPECTION-REPORTS-March-2018-1.pdf> accessed 17 June 2021.
25 ibid 20.
26 ibid para 1.3.
27 ibid para 3.13.
28 ibid para 3.10.
29 ibid 20.
30 HMI Prisons, 'Inspection Framework' (n 15) para 3.35.

Independent Review of Progress (IRP) may be undertaken to assess progress in implementing recommendations.[31]

The CQC inspection process

Whilst the joint inspection report is structured according to the HMIP's framework, the CQC must nonetheless fulfil its own statutory responsibilities as part of the inspection process. The MOU acknowledges that HMIP and the CQC are separate bodies with distinct remits, and that '[d]uring the joint inspections, each organisation will work to its own remit and cover its respective key lines of enquiry and expectations, but they will work closely together and the work will be coordinated'.[32]

Registered healthcare providers in both community and secure settings must comply with the statutory 'fundamental standards'[33] 'below which the provision of regulated activities and the care people receive must never fall'.[34] If they do, the provider can be subject to enforcement action by the CQC, including, ultimately, de-registration. HMIP does not have regulatory enforcement powers of this kind. The fundamental standards are set out in Health and Social Care Act (Regulated Activities) Regulations 2014 (as amended) and apply to all service types in all settings. They cover the following issues:

- Person-centred care
- Dignity and respect
- Need for consent
- Safe care and treatment
- Safeguarding service users form abuse and improper treatment
- Meeting nutritional and hydration needs
- Premises and equipment
- Receiving and acting on complaints
- Good governance
- Staffing
- Fit and proper person employed
- Duty of candour
- Requirement as to display performance assessments (where relevant).[35]

The last does not apply to secure settings because of the exclusion of these settings from the CQC's performance assessment duty (which is explored in more detail below).

Statutory guidance on compliance with the regulations must be issued by the CQC.[36] The current version is *Guidance for providers on meeting the regulations March 2015* ('the Guidance for Providers').[37] This explains that, during inspections, the CQC will 'ask five key questions about the service, are they:

- Safe?
- Effective?
- Caring?
- Responsive to people's needs?
- Well-led?'[38]

The CQC has the authority to inspect the undertaking of regulated activities and is given a number of powers (including entry of premises and disclosure of documents) to allow it to do so.[39] The Guidance for Providers explains that '[t]o help our inspection teams direct the focus of their inspections, they use a standard set of 'key lines of enquiry' (KLOEs) and prompts'.[40] The regulator has also developed what it calls 'characteristics' which describe what a particular standard of service looks like.

In addition to this guidance, the CQC has also published guidance specific to secure settings ('The Secure Settings Provider Handbook').[41] This confirms that the same approach to inspections is used in that the five key questions remain the same:

> We always ask if services are:
> - Safe? People are protected from abuse and avoidable harm.
> - Effective? People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.
> - Caring? Staff involve and treat people with compassion, kindness, dignity and respect.

31 ibid para 3.44.
32 Care Quality Commission and HM Inspectorate of Prisons (n 7) Protocol 2.
33 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 8.
34 Care Quality Commission, 'Guidance for Providers on Meeting the Regulations' (March 2015) 5 <https://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf> accessed 20 April 2021.
35 See Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulations 9-20A.
36 Health and Social Care Act 2008 s 23.
37 Care Quality Commission, 'Guidance for Providers' (n 34).
38 ibid 9.
39 See Health and Social Care Act 2008 2008 ss 60–65.
40 Care Quality Commission, 'Guidance for Providers' (n34) 9.
41 Care Quality Commission, 'Provider Handbook' (n3).

- Responsive? Services are organised so that they meet people's needs.
- Well-led? The leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.[42]

The joint inspection framework and quality standards

Although the five key questions remain the same, the CQC has developed, together with HMIP, what it calls a 'joint inspection framework' underpinned by a 'mapping' of HMIP Expectations to those five key questions.[43] This has produced a modified set of KLOEs, prompts and characteristics which are set out in the Secure Settings Provider Handbook. It is said that '[h]aving a joint framework and a standard set of KLOEs ensures consistency of what we look at and a focus on the things that matter most, including peoples' experience of care. This is vital for reaching a credible, comparable judgement'.[44]

The CQC cautions that 'the prompts and characteristics are not exhaustive and should be read in conjunction with CQC's published provider guidance on fundamental standards'.[45] It is noteworthy that the CQC's explanation of the joint inspection framework used for IRCs directs the reader to guidance on the *fundamental* standards for additional material. The standards applied to community healthcare services through its rating scheme go *beyond* the fundamental standards. This important issue is explored in more detail below.

The Secure Settings Provider Handbook goes on to say that, in the course of an inspection:

> [i]nspection teams will take into account the information gathered in the preparation phase and the evidence they gather during the inspection to determine which aspects of the KLOEs they should focus on. Our assessment will lead to a judgement about whether the care that is provided is safe, effective, caring, responsive and well-led, based on whether the regulations are being met.[46]

The standards included in the *regulations* are, of course, the fundamental standards, again of significance in light of the standards applied to community healthcare using the ratings scheme.

IRCs and CQC quality ratings

The second major difference in the CQC's approach when quality assessing 'health and justice' services is the exclusion of ratings. In its Secure Settings Provider Handbook, it says:

> Although we have introduced ratings as an important element of our new approach to inspection and regulation of other sectors, we do not intend to rate secure settings but we may be granted the power to do so in the future. Many of the providers who deliver care in secure settings also provide registered activities in the wider community and are inspected and rated by the CQC. However, we do not rate them separately on the services they provide in secure settings.[47]

This absence of CQC quality ratings for healthcare in secure settings derives from an underlying statutory difference in the regime. In addition to its registration functions, and its associated power to inspect to ensure a registered provider is meeting the fundamental standards, the CQC is additionally required by section 46 Health and Social Care Act 2008 to quality assess the performance of registered providers and to produce a report of that assessment *unless the service is exempted by regulations*. There is an exemption from the section 46 duty that applies to health and justice (including IRC) healthcare services.[48]

The s46 duty permits the CQC to devise its own quality assessment scheme. It has used this power to devise a ratings scheme for non-exempt services (such as community GPs) and uses it to impose standards which go 'beyond' the minimum fundamental standards required for registration purposes.[49] It is this scheme that is not available in IRCs. The significance of this for community equivalence will be explored further in the next section.

42 ibid 12.
43 ibid 11.
44 ibid.
45 ibid 34.
46 ibid 11. Emphasis added.
47 ibid 16.
48 Care Quality Commission (Reviews and Performance Assessments) Regulations 2018 Regulation 2.
49 Care Quality Commission, 'Guidance for Providers' (n 34) 9.

CQC reforms

The CQC is currently undertaking reforms to its processes. Between January and March 2021, it consulted on a new strategy, which was subsequently adopted.[50] The consultation responses are reported to have been generally supportive but with some criticism of a lack of detail of what would change in practice.[51] There has been one additional consultation on 'Changes for more flexible and responsive regulation' which has produced to three reforms which have already been implemented.[52]

The first, introduced in July, adopts a new approach to assessing quality which is less reliant on on-site inspections. In response to concerns raised by consultees about the risks of reducing such inspections the CQC said:

"We'll continue to carry out site visits. We know that poor cultures can exist in all types of services, but we'll focus particularly on the types of care setting or provider where there's a greater risk of a poor culture going undetected. This may mean we make more frequent site visits to those settings. We'll use our powers to visit services when we need to respond to risk, when we need specific information that can only be gathered through a site visit, when we need to observe care, and to ensure that our view of quality is reliable."[53]

IRCs appear to fall into the category of those facilities which would be subject to the CQC's greater 'focus', but the current embedding of CQC's inspection within the HMIP process would seem to reduce the CQC's ability to be flexible.

The remaining two changes are concerned with how the ratings scheme works. The first of these implemented (again in July) a new approach to re-rating services which is not based on fixed inspection schedules; thus, it is said, creating a scheme which is more responsive to changes. As noted above, IRCs are not currently rated. The final change adopted from October, has adjusted the ratings scheme for GP practices and NHS Trusts. The former has some relevance to this report and will be considered in Section 4.

The intended implications of the reform programme for IRCs remains unclear. Although the second consultation was said to apply to all services, whether they are subject to the CQC's rating scheme or not, there is no express mention in either document of either secure settings in general or of IRCs in particular.

Problems in the joint inspection framework

In spite of the attempt to clearly define roles, the explicit commitment to achieving community equivalence through the joint inspection framework and the efforts made to integrate the approaches of the two bodies, there are several identifiable process issues that emerge that may compromise the ability to adequately measure and deliver equivalence. These are:

- as already noted above, the standard by which healthcare providers in IRCs are assessed by the CQC as compared to those in the community;
- the mechanisms for achieving improvements;
- the current limitations in the use of benchmarking data for the assessment of healthcare providers in IRCs;
- the relative weight given to the 'voice of the patient' in the inspection of healthcare providers in secure settings as compared to the community, a difference which may be exacerbated by an institutionalised culture of disbelief in IRCs; and
- limitations of the HMIP reporting structure in regard to healthcare.

These issues will be discussed in turn over the next several sections of the report.

50 Care Quality Commission, 'A New Strategy for the Changing World of Health and Social Care' (January 2021) <https://www.cqc.org.uk/sites/default/files/Our_strategy_from_2021.pdf> accessed 27 October 2021.

51 Doug Jefferson, Annie Milburn, Igor Augustynowicz and Jemima Martin, 'Independent Analysis of Responses: Consultation on the Care Quality Commissions New Strategy' (May 2021) 4-5 <https://www.cqc.org.uk/files/independentanalysisofresponsesconsultationonthecarequalitycommissionsnewstrategydocx> accessed 27 October 2021.

52 Care Quality Commission, 'Consultation on Changes for More Flexible and Responsive Regulation' (January 2021) <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.

53 Care Quality Commission, 'Responding to Our Consultation: Changes for More Flexible and Responsive Regulation' (July 2021) <https://www.cqc.org.uk/about-us/our-strategy-plans/responding-our-consultation-changes-more-flexible-responsive-regulation> accessed 27 October 2021.

SECTION 4: RATINGS AND COMMUNITY-EQUIVALENT QUALITY

As indicated in the foregoing section, there is a key difference between how the Care Quality Commission (CQC) assesses and reports on the performance of healthcare providers in the community and those in immigration removal centres (IRCs). Whilst providers in IRCs are regulated for registration purposes by the CQC, there is a relevant exemption from section 46 of the Health and Social Care Act 2008 which otherwise requires the CQC to assess and report on the performance of healthcare providers. Where that exemption applies, the CQC is only required to ensure that the fundamental standards for registration have been met.[1]

In this section, we explore whether this difference, and the associated absence of a ratings system for IRCs, potentially creates a substantive difference in how they are quality-assessed and the implications for community equivalence.

For those healthcare providers who fall within the scope of the section 46 duty, they will be assessed on the basis of indicators which the CQC is permitted to devise itself. The CQC decides how it will go about the process, and it is permitted to use different indicators and assessment methods for different cases, but it must publish both the indicators and the statement of practice.[2] For example, it has set out its scheme for assessing GPs in its publication *How CQC monitors, inspects and regulates NHS GP practices* (April 2019).[3] This explains that it has adopted a ratings scheme which is used not only to rate the provider overall as 'Outstanding', 'Good', 'Requires Improvement' or 'Inadequate', but also to rate detailed aspects of the GP's service, such as provision to those whose circumstances make them vulnerable, and people with poor mental health.[4] In a separate publication, it sets out what are termed the 'characteristics' of a service which would fall into each of those ratings.[5] The operation of the scheme is explored in more detail below.

Importantly, there is no requirement that limits the section 46 performance quality standards to those set by the fundamental standards used to determine whether a provider qualifies for registration. Indeed, if it did, it would make this duty somewhat superfluous, given that the CQC has the power to inspect to ensure registration requirements (which include the fundamental standards) are met.[6] As explained below, by means of a ratings scheme, the CQC has established a system which imposes and seeks to move community healthcare providers towards a minimum standard of 'Good' which goes beyond the registration minimum set out in the fundamental standards. Because the section 46 duty is not applied to IRCs, this ratings scheme is not used to quality assess healthcare services provided in secure settings.

As explained in the previous section, the CQC has published a *joint* inspection framework for healthcare services in secure settings, which it says has been devised by 'mapping' the HMIP's Expectations to the CQC's five key questions (asking how safe, effective, caring, responsive and well-led the provider is) and is to be used by both bodies.[7] In relation to community equivalence, the question is whether the joint inspection framework effectively utilises the 'Good' standard that CQC applies in community settings as a minimum standard in secure settings.

As discussed in more detail below, a number of issues arise which are of significance for the achievement of community equivalence:

1. The resulting joint inspection KLOE scheme is different from that used in other settings such as community GP services, and it is difficult to make direct comparisons between the two which itself has significant implications for achieving community equivalence. Although many of the characteristics of a 'Good' service found in the CQC's ratings scheme appear to have been incorporated, the joint scheme does not clearly

1 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ss 15 and 20.
2 ibid s 46 (3)-(6).
3 Care Quality Commission, 'How CQC Monitors, Inspects and Regulates NHS GP Practices' (April 2019) <https://www.cqc.org.uk/sites/default/files/20191104%20How%20CQC%20regulates%20primary%20medical%20services%20GP%20PRACTICES_MASTER.pdf> accessed 23 April 2021.
4 ibid 22.
5 Care Quality Commission, 'Key Lines of Enquiry, Prompts and Ratings Characteristics for Healthcare Services' (2018) <https://www.cqc.org.uk/sites/default/files/20180628%20Healthcare%20services%20KLOEs%20prompts%20and%20characteristics%20FINAL.pdf> accessed 23 April 2021.
6 Health and Social Care Act 2008 s 62.
7 See Care Quality Commission, 'How CQC Regulates Health and Social Care in Prisons and Young Offender Institutions, and Health Care in Immigration Removal Centres: Provider Handbook' (July 2015) Appendix A <https://www.cqc.org.uk/sites/default/files/20150729_provider_handbook_secure_settings_0.pdf> accessed 17 June 2021.

and consistently deliver the same quality standard to secure settings as that used in the community.

2. In any event, in spite of the mapping exercise, there is no evidence that it is this mapped KLOE scheme that is used in IRC inspections; it appears to be HMIP's Expectations scheme. So, the question arises as to whether the Expectations scheme, in effect, incorporates the CQC's 'Good' standard. We found that the indicators used to test Expectations in the HMIP scheme only match fully or partially less than 50% of the 'Good' characteristics the CQC uses to assess the quality of healthcare providers in the community.

3. There are also significant differences between the application of ratings in a community setting, which allow it to identify matters that require improvement at a granular level to reach the standard of 'Good', and how the performance of healthcare services is adjudicated upon within the context of the much broader scope of the HMIP inspection and its criteria for making recommendations for improvement.

These differences, and the lack of a ratings system in secure settings, are not easily explained by contextual differences between community healthcare services and IRCs. The policy objectives of a ratings system were explained in the Government's response to the 2017 consultation on expanding the CQC's scheme.[8] It not only assists the public to exercise informed choice (which is, of course, irrelevant to IRC detainees), but it also: '[…] provides a means through which the public, service commissioners and other stakeholders can challenge providers to improve'.[9]

In this section, we first provide some background to the exclusion of secure settings from the CQC's ratings scheme. We then turn to an analysis of the quality standard applied by the CQC through its ratings system in the inspection of healthcare providers in community settings and consider this in comparison with the joint inspection KLOE scheme developed through the mapping exercise. This is followed by an analysis of HMIP's Expectations and the extent to which their indicators incorporate the characteristics used by the CQC to assess quality in community settings. Finally, we turn to the question of how ratings are applied by the CQC in community settings and compare this with the approach taken in the joint inspection framework.

Quality ratings, secure settings and community equivalence

The exclusion of healthcare providers in secure settings from the CQC's ratings system has received some limited consideration through a Government consultation undertaken in 2017 and an enquiry by the Health and Social Care Select Committee in 2018.[10]

The CQC began publishing ratings in October 2014. However, 'to avoid overloading the CQC',[11] this was limited by the 2014 regulations, which implemented the section 46 duty, to NHS Trusts, NHS Foundation Trusts, GP practices, adult social care providers and independent hospitals (the prescribed providers).[12] In 2017 the Government explained that:

> …[t]his was to enable the CQC to focus its reviews and assessment on those providers where choice was more relevant to people and where risk was perceived to be higher. This approach enabled CQC to develop and test its methodologies for those sectors to ensure its approach was robust before scaling up.[13]

A consultation in 2016 resulted in the first extension,[14] and the 2017 consultation proposed a more radical expansion to all providers of regulated activities save for specified exceptions which included health and justice

8 Department of Health, 'New Proposal to Expand the Scope of Performance Assessments of Providers Regulated by the Care Quality Commission' (September 2017) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643771/New_Consultation_Scope_of_Performance_Assessments.pdf> accessed 23 April 2021.

9 ibid 4.

10 Department of Health, 'New Proposal' (n8); 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.

11 Department of Health, 'New Regulations to Expand the Scope of Performance Assessments of Providers Regulated by the Care Quality Commission: Response to the Consultation' (December 2017) 6 para 11.1 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/670448/NEW_Master_Copy_Consultation_Response.pdf> accessed 23 April 2021.

12 'Care Quality Commission (Reviews and Performance Assessments) Regulations 2018' (Queen's Printer of Acts of Parliament) 6 para 11.4 <https://www.legislation.gov.uk/uksi/2018/54/contents/made> accessed 20 April 2021.

13 Department of Health, 'New Regulations' (n11) 6 Para 11. 6.

14 Department of Health, 'Scope of Performance Assessments of Providers Regulated by the Care Quality Commission' (August 2016) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/547103/Scope_of_CQC_ratings_Con_Doc_A.pdf> accessed 23 April 2021; Care Quality Commission (Reviews and Performance Assessments) Regulations 2018 s 46 duty 'to include providers undertaking certain regulated activities relating to cosmetic surgery services, transport services, dialysis services, refractive eye surgery services, substance misuse services and termination of pregnancy services'.

services.[15] The criteria used to identify those exceptions were set out in the consultation paper. These were:

- '…the number of registered providers is so small that ratings would not contribute to public or consumer choice';
- '…the activities or the providers who carry them out are already regulated by other agencies besides the CQC, and […] their rating by the CQC [would] run the risk of confusing the public'; and
- '…sectors which […] receive infrequent inspection because they are of relatively low risk. Such a frequency of inspection would not be adequate for rating; however, it would not be a good use of resources for the CQC to increase the rate of inspection for these providers'.[16]

Those falling into an excepted category in relation to section 46 would continue to be inspected, but only to ensure that they met the baseline fundamental standards as required for the purpose of registration. Two reasons were given for the exclusion of health and justice services from the rating system, drawing on the first two criteria:

- '[…] patient choice is extremely limited and as such a rating would be of limited benefit'; and
- 'the service is jointly inspected with HMIP, and a rating by the CQC would be potentially confusing'.[17]

In relation to the first reason, as the consultation acknowledged, patient choice is not the only policy objective of the ratings system. It is also used to improve quality standards which have been an issue in IRCs for some time, as explained in Section 1. Insofar as the second reason is concerned, the implications of exclusion for assessment of community equivalence, which, as an international human rights standard, arguably outweighs the risk of confusion to the public (and which, in any event, could be addressed in other ways), was not mentioned.

While consultees were asked whether they agreed with the approach of extending the assessment duty to all providers save for specified exceptions and whether they agreed with the criteria (a majority approved both), they were not specifically asked whether they agreed with the *application* of the criteria.[18] That is, they were not asked expressly to consider whether the exceptions selected, such as health and justice services, were the appropriate ones.

Although the online response form is no longer available, it appears from the Government's response to the consultation that there was space for consultees to make other comments.[19] It is not known whether there were any responses objecting to the exclusion of health and justice services. Nonetheless, the implications of this exception for community equivalence are significant. Of the 12 exempted services, 10 were types of *activity*, such as minor cosmetic surgery, blood and transplant services and independent pathology laboratories, and, as such, any negative consequences of the exemption from quality ratings would be experienced by *all* those in need of that type of healthcare. But two were types of *setting* – health and justice services (including secure settings such as prisons, young offender institutions and IRCs) and children's homes, which provide any kind of regulated activity.[20]

Where, as in these two instances, an activity in a particular residential setting is intended to replicate and substitute for the same kind of health service provided in the community, the question arises as to the equivalence of the standard of healthcare provided within that setting and that provided in the community. Given this, on the face of it, and in the absence of any further explanation, it is somewhat surprising that the risk of confusion was not resolved in favour of the use of the CQC rating scheme, which would have allowed for a more direct community comparison. This factor does not appear to have been considered by the consultation, even though the principle of community equivalence is vital when setting the standard to be applied to health services in secure settings. (See Section 3.)[21]

15 Department of Health, 'New Proposal' (n 8).
16 Department of Health, 'New Regulations' (n 11) 9._
17 ibid 10.
18 Department of Health, 'New Proposal' (n 8) 17.
19 Department of Health, 'New Regulations' (n11) 18.
20 In the case of children's homes, the reason given for the exemption was the potential for confusion given that the children's home had to be *registered* with both Ofsted and the CQC. This significantly different reasons given for exempting Health and Justice services. In the latter case IRCs are not registered with HMIP although they are inspected by that body. They are only registered with the CQC and subject to its enforcement powers
21 Department of Health, 'New Proposal' (n 8).

Following the consultation, the 2014 regulations (as amended) were replaced by the Care Quality Commission (Reviews and Performance Assessments) Regulations 2018 which came into effect on 1 April 2018. These implemented the health and justice proposal by excluding the following from the rating system:

> Any regulated activity carried on in—
> (a) a prison;
> (b) a police station;
> (c) a place for the detention of young offenders;
> (d) an immigration removal centre; or
> (e) a sexual assault referral centre
> except where it is carried on by a registered service provider, which is an NHS Trust, an NHS Foundation Trust or a provider of primary medical services.

The last qualifying element appears to be for the purpose of implementing the government's decision to 'continue to rate sexual assault referral services provided in an independent hospital or by an NHS trust or NHS foundation trust or primary medical service'.[22]

In October 2018, the Health and Social Care Select Committee reported on its enquiry into health in prisons.[23] It expressed concern about the lack of clarity in what equivalence means in practice:

> For example, there is no resource describing how equivalence should be defined, measured and compared with health and care in the community. The National Audit Office criticised the then partnership between the National Offender Management Service, NHS England and Public Health England for not having defined measurable outcomes of equivalence and for not measuring progress, saying: "it is not clear how partners can assess whether healthcare in prisons is equivalent to healthcare in the community".[24]

It concluded:

> A whole prison approach and equivalency in standards and health outcomes for prisoners, as in the population as a whole, should be reinforced by a rigorous, respected inspection regime that supports the Government, prisons and providers of prison health and social care to improve. Such a regime needs to provide a robust picture of the state of health and care in prisons and drive up standards up ensuring best practice is shared, and, most importantly, lessons are learnt.[25]

In that context, it recommended:

> Where a health and social care provider delivers services in prisons, the Care Quality Commission's rating system should convey, as it does for other health and care services, the quality of care delivered to prisoners against each of CQC's five key questions, namely whether the service is safe, effective, caring, responsive and well-led.[26]

The Government responded in the following terms:

> Although these are not included in the narrative set out in the joint HMIP/CQC inspection reports, CQC does look at the services against their five criteria (safe, effective, caring, responsive and well-led).[27]

This response was inadequate in a fundamental respect. The recommendation was that the CQC applies its *rating system,* not merely 'looks at' prison healthcare using the key questions. The CQC does not do so because of the health and justice exemption from the section 46 performance assessment duty. But the Select Committee's recommendation that the CQC's rating system should be used in prison inspections as in

22 Department of Health, 'New Regulations' (n 11) 11 para 33. Despite this 'exception from the exemption' the CQC's June 2019 for regulated providers of sexual assault referral centres says, says '[u]nlike most types of service that CQC regulates, we do not currently have the legal powers to give a quality rating to providers of sexual assault referral services, although this may change in the future'. Care Quality Commission, 'How CQC Monitors, Inspects and Regulates Providers of Sexual Assault Referral Centres' (2019) 2 <https://www.cqc.org.uk/sites/default/files/20190628_how_cqc_regulates_primary_medical_services_sexual_assault_referral_centres.pdf> accessed 5 May 2021.

23 Health and Social Care Committee, *Prison Health* (n 10).

24 ibid 15 para 31.

25 ibid 40. Emphasis added.

26 ibid 42.

27 HM Government, 'Government Response to the Health and Social Care Committee's Inquiry into Prison Health' (CP4, January 2019) 42 Para 13.6 <https://www.gov.uk/government/publications/prison-health-inquiry-government-response> accessed 23 April 2021.

inspections of community services was not addressed in the Government's response. This is surprising given it had so recently consulted on the issue of exempting healthcare in secure settings from the CQC's section 46 duty and did so without addressing the implications for achieving community equivalence. Although the Select Committee's inquiry was into healthcare in the prison system, the issues raised are clearly relevant to other secure settings, including IRCs.

The joint inspection framework and community equivalent quality

Given the decision to include secure settings in the exemptions from the section 46 duty, and, therefore, exclude such settings from any CQC rating scheme, and, in particular, from the CQC's scheme used for community healthcare services, the question arises as to whether the mapping process between HMIP's Expectations and the CQC's KLOE delivers on the objective of community equivalence in terms of quality of service.

This section compares the quality standard applied by the CQC in community settings with that applied in secure settings through the joint inspection framework and considers the implications for establishing community equivalence.

The CQC's *Guidance for providers on meeting the regulations* not only covers compliance with registration requirements; it also explains how it rates the service performance of those who are not exempted from the section 46 duty.[28] Of great significance here is the fact that it uses its section 46 powers to impose standards which 'go beyond' the statutory minimum of the fundamental standards.[29] As explained in the previous section, when inspecting, the CQC asks 5 'key questions'.[30] Is the service:

- Safe? 'By safe, we mean people are protected from abuse and avoidable harm'.[31]
- Effective? 'By effective, we mean people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence'.[32]
- Caring? 'By caring, we mean the service involves and treats people with compassion, kindness, dignity and respect'.[33]
- Responsive? 'By responsive, we mean that services meet people's needs'.[34]
- Well-led? 'By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation and promotes an open and fair culture'.[35]

To help inspectors focus their inspection on the relevant issues, they use key lines of enquiry (KLOEs) and prompt questions for each line of enquiry. The guidance goes on to explain that the CQC awards 'a rating for each of the five key questions and, where relevant, produce[s] an overall rating for the service'.[36] The ratings are 'an important part of our inspection process and use a four-point scale: outstanding, good, requires improvement or inadequate'.[37] To assist in determining the appropriate rating, inspectors use published 'characteristics'. These are statements which describe what a service falling within each of those four ratings looks like. It is this scheme that is used to set the quality standard used in section 46 performance assessments, and it is a standard which goes beyond the fundamental standards set by the registration requirements.

> Our use of ratings and the focus on looking for 'good' are an important part of our model for assessing the overall quality of the care people received. The characteristics of good and outstanding care that we look for in our inspections, as set out in our handbooks, go beyond the fundamental standards as set out in the regulations.[38]

For example, in relation to the effectiveness of the health care services provided (a crucial quality question), there are six KLOEs.

- 'E1 Are people's needs assessed and care

28 Care Quality Commission, 'Guidance for Providers on Meeting the Regulations' (March 2015) <https://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf> accessed 20 April 2021.
29 ibid 9.
30 ibid.
31 Care Quality Commission, 'Key Lines of Enquiry' (n 5) 3.
32 ibid 8.
33 ibid 13.
34 ibid 16.
35 ibid 20.
36 Care Quality Commission, 'Guidance for Providers' (n 28) 9.
37 ibid.
38 ibid. Emphasis added.

and treatment delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes?

- E2 How are people's care and treatment outcomes monitored, and how do they compare with other similar services?
- E3 How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, treatment and support?
- E4 How well do staff, teams and service work together within and across organisations to deliver effective care and treatment?
- E5 How are people supported to live healthier lives and, where the service is responsible, how does it improve the health of its population?
- E6 Is consent to care and treatment always sought in line with legislation and guidance?'[39]

Each of these KLOE has a series of prompt questions. E1 has six prompt questions, E2 has four and so on. For each KLOE, the document also sets out a series of characteristics for each rating level. If the service falls below the standard of 'Good', it will be assessed as either 'Requires improvement' or 'Inadequate'. For example, in relation to the first KLOE exploring effectiveness, the characteristics for each of the ratings include the following in table 1[40]

So, where a healthcare service, during a section 46 assessment, is found to 'not always' adopt best practice in care and treatment, it would be expected to improve so that it always did so. In short, the minimum standard the CQC is looking for when undertaking its s46 quality assessment duty is 'Good', and the scheme operates to move services to that standard.

As noted in Section 3, the CQC's Secure Settings Handbook explains that, for the purpose of creating a joint inspection framework, HMIP's Expectations are 'mapped' to the CQC's five key questions 'to create a standard set of key lines of enquiry' for use in secure settings.[41] The resulting KLOEs for secure settings are set out in the appendix.[42] As no CQC rating is awarded when inspecting secure settings, there is only one set of characteristics for each KLOE. This contrasts with the standard approach for community settings where four sets of characteristics are devised which describe, for each KLOE, what a service at each of the four ratings levels (Outstanding, Good, Requires Improvement and Inadequate) looks like.[43]

Table 1

E1: Are people's needs assessed and care and treatment delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
New evidence-based techniques and technologies are used to support the delivery of high-quality care.	People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies.	*Care and treatment does not always reflect current evidence-based guidance, standards, best practice and technologies. Implementation of evidence-based guidance is variable.*	People's care and treatment does not reflect current evidence-based guidance, standards, practice or technology.

39 ibid 10–11.
40 ibid 38–39. Emphasis added.
41 Care Quality Commission, 'Provider Handbook' (n 7) 11.
42 ibid.
43 Care Quality Commission, 'Key Lines of Enquiry' (n 5) 26–46.

The CQC's Secure Settings Handbook clearly states that the quality standard described by the set of characteristics devised for secure settings is the regulatory minimum:

> Judgments are made following a review of the evidence under each KLOE. Each KLOE is accompanied by a number of questions that inspection teams will consider as part of the assessment. We call these "prompts." The KLOEs and prompts are supported by "characteristics" that describe what we would expect to see to demonstrate that the fundamental standards are being met.[44]

This contrasts with the 'Good' rating standard used in community settings which, as noted above, explicitly goes 'beyond the fundamental standards as set out in the regulation'.[45] On the face of it, this is inconsistent with the commitment to ensuring that people in detention receive the same quality of care as the rest of the population.

However, the actual characteristics used in the secure settings joint scheme paint a somewhat different picture. A detailed comparison of the characteristics used in the KLOE scheme described in the Secure Settings Handbook with those used to identify a service of a 'Good' standard in the community KLOE scheme is difficult to undertake because of the omission or reframing of some of the KLOEs, prompts, and the related characteristics. The overall picture is certainly confusing. Some of the characteristics used in the mapped secure settings KLOE scheme appear more consistent with (and sometimes identical to) characteristics used in the ratings scheme to indicate a 'Good' quality service. This is despite the CQC stating in its Secure Settings Handbook that it uses the joint inspection characteristics to 'describe what we would expect to see to demonstrate that the *fundamental standards* are being met'.[46]

This lack of clarity is itself of concern given the importance of the community equivalence principle. But in addition, a closer analysis reveals that, in some instances, apparent similarities (between the characteristics used to assess in a secure setting and those used to describe a 'Good' community provider) in fact conceal important differences. For example, one of the KLOEs used in a community setting reads as follows:

> [a]re people's needs assessed and care and treatment delivered in line with current legislation standards and evidence-based guidance to achieve effective outcomes?[47]

The secure settings KLOE scheme uses an almost identically worded key line of enquiry

> E1 Are detainees' needs assessed and care and treatment delivered in line with legislation, standards and evidence-based practice?[48]

Although the questions asked are similar, the important issue for quality assessment is what is considered to be an acceptable answer to the question. The characteristic of a 'Good' service in the CQC ratings scheme is that:

> [p]eople's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies.[49]

By way of contrast, the following characteristic in the ratings scheme indicates a service which requires improvement:

> [c]are and treatment does not always reflect current evidence-based guidance, standards, best practice and technologies. Implementation of evidence-based guidance is variable.[50]

This sets a clear standard that the failure to ensure *every* patient's 'care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies' would indicate a service falling

44 Care Quality Commission, 'Provider Handbook' (n 7). Emphasis added.
45 Care Quality Commission, 'Guidance for Providers' (n 28) 9.
46 Care Quality Commission, 'Provider Handbook' (n 7) 15.
47 Care Quality Commission, 'Key Lines of Enquiry' (n 5) 45.
48 Care Quality Commission, 'Provider Handbook' (n 7) 40.
49 Care Quality Commission, 'Key Lines of Enquiry' (n 5) 32.
50 ibid. Emphasis added.

below the desired quality.[51] Despite a similar KLOE being used in the secure settings joint inspection framework, the associated characteristics used do not set that clear standard. The closest is that '[d]etainees are cared for by a health service that accurately assesses and meets their health needs in the secure setting'. But this does not spell out the standard of service expected in meeting those assessed needs nor the expectation that the standard will be found to have been applied to all people in detention.

In summary, the CQC appears to understand the characteristics of the joint inspection KLOEs as reflecting the basic fundamental standards and states that it uses the scheme to make its judgment about compliance with the registration requirements when inspecting secure settings. If it is right, then that scheme will not deliver on community equivalence in quality. Community healthcare services are assessed against the CQC's ratings standard, and the minimum requirement in that scheme is 'Good', a standard which goes beyond the fundamental standards. Having said this, some of the actual characteristics used in the joint inspection KLOE scheme do appear to be closer to those used to describe a 'Good' service, but not consistently so, and apparent similarities do not always stand up to close scrutiny.

Mapping HMIP Expectations and delivering community equivalence

As demonstrated above, the KLOE scheme established for secure settings does not provide a clear means of establishing community equivalence. However, it is not entirely clear that this is the scheme that is actually used, in any direct sense, in the inspections of IRCs. The publication of an inspection framework setting out how HMIP's inspection function is to be carried out is a statutory requirement, but the current publication makes no express reference to this joint inspection KLOE scheme.[52] Neither is there any reference to it in the HMIP publication which sets out the Expectations that are used. The HMIP-led joint report is structured by reference to those published Expectations.

In the context of the section explaining the joint framework, the CQC's Secure Settings Handbook says that 'HMIP and CQC inspectors will record evidence using a shared template that addresses CQC's five key questions'.[53] We requested a copy of any template used for the purpose of collating evidence in IRC inspections in the 'freedom of information' request made to the CQC. However, during the interview with the CQC, which was offered for the purpose of clarifying the organisation's responses, it was confirmed that, in fact, no such template is used and, to the extent that evidence is collected in relation to the KLOEs, this would only be found in an individual inspector's notes.

Furthermore, the Memorandum of Understanding setting out how the HMIP and CQC will work together refers to HMIP's use of the standards set by its own inspection criteria (its 'Expectations') and to those set by regulations for use by the CQC (the fundamental standards).

> Where we work together, there will always be a lead body so that we and regulated bodies can be clear about which statutory powers we are acting under. Where healthcare or social care are provided as part of an offender service, then HMIP will have the lead in ensuring that the offender service meets expectations, including the expectations of them for health and social care. CQC will have the lead in ensuring that healthcare and social providers comply with registration and regulated activity regulations.[54]

Although Protocol 2 to the MOU makes reference to the mapping exercise, there is no mention of the mapped KLOE scheme despite its description by the CQC as a *joint* inspection framework. Indeed, the emphasis is on each organisation working to its own scheme:

> During the joint inspections, each organisation will work to its own remit and cover its respective key lines of enquiry and expectations, but they will work closely together, and the work will be coordinated. This approach will be underpinned by a mapping of key lines of enquiry and expectations and by ongoing working relationships between the designated leads in CQC and HMIP.[55]

51 ibid.
52 Prison Act (as amended) 1952 para 2 Schedule A1.
53 Care Quality Commission, 'Provider Handbook' (n 7) 11.
54 Care Quality Commission and HM Inspectorate of Prisons, 'Memorandum of Understanding' (2016) 3 <https://www.cqc.org.uk/sites/default/files/20161221_mou-cqc-hmip-2016.pdf> accessed 20 April 2021. Emphasis added.
55 ibid Protocol 2.

The MOU only makes reference to a 'joint inspection report' rather than the joint framework itself, in spite of the fact that the framework predates the MOU.

If the joint inspection KLOE scheme described in the CQC's Secure Settings Handbook (which does not clearly deliver on community equivalence in any event) is not used in the HMIP-led inspections, the question arises as to whether equivalence in quality standards is delivered by the Expectations scheme. Does *that* scheme apply the standard for healthcare used by CQC when inspecting community facilities? There is an overarching community equivalence statement in the HMIP's 'Expectations for Immigration detention': '[t]he standard of health service provided is equivalent to that which people would expect to receive elsewhere in the community'.[56] However, unless this is translated into a transparent framework against which healthcare can be assessed for equivalent quality, the achievement of equivalence is simply a matter of assertion.

HMIP's standards are operationalised through its 'Expectations'. The HMIP's Expectations are said to have been mapped across to the CQC's KLOEs.[57] However, analysis suggests that the *indicators* used in the HMIP's framework (to assess whether the service meets the Expectations) and the characteristics of a 'Good' service (the minimum standard used by the CQC when assessing community services) have significant differences and strikingly little overlap.

For example, continuing with the same example as above, a characteristic of 'Good' community service in relation to the key test of effectiveness includes:

> People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice and technologies. This is monitored to ensure consistency of practice.[58]

The closest Expectation indicator to this characteristic appears to be the following:

> Effective governance systems and partnership working between the centre, commissioners and providers ensures health and social care provision meets the required regulatory standards.[59]

While bearing some broad similarities in content, it is not at all clear that this HMIP Expectation requires an equivalent evidence-based, best practice approach to individual patient care that is required by the CQC in community settings. The reference to 'regulatory standards' would appear to be a reference to the legislative standards used by the CQC as the regulator of health and social care in England. But, as explained above, those are the fundamental standards set out in the relevant regulations, not the ratings standards which are applied to community healthcare providers. An evidence-based, best practice approach to individual patient care is *not* to be found in the fundamental standards.

A search was undertaken for the purpose of this report to find the nearest equivalent indicator in the HMIP scheme to each characteristic of a 'Good' service in the CQC ratings scheme used for community healthcare services. If an indicator was found which largely covered the same ground as the characteristic, the characteristic was coded as having a 'matching equivalent' (ME); if there was an indicator which provided partial coverage but omitted some element of significance, the characteristic was coded as having a 'partial equivalent' (PE); if no indicator was found which could be said to address the same issue as the characteristic, the latter was coded as having 'no equivalent' (NE). In some cases, the characteristic appeared to be irrelevant to the IRC context and, for this reason, was disregarded for the purpose of this analysis. Only five were disregarded for this reason out of a total of 88.

56 HMI Prisons, 'HMIP Expectations for Immigration Detention, Criteria for Assessing the Conditions for and Treatment of Immigration Detainees Version 4' (2018) 47 <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/03/Immigration-Expectations-FINAL.pdf> accessed 20 April 2021.
57 Care Quality Commission, 'Provider Handbook' (n 7) 11.
58 Care Quality Commission, 'Key Lines of Enquiry' (n 5) 32.
59 HMI Prisons, 'HMIP Expectations for Immigration Detention' (n 56) 47.

This analysis provided the following results:

Keyline of enquiry area (Number of characteristics)	Percentage of characteristics with an ME (Number)	Percentage of characteristics with a PE (Number)	Percentage characteristics with an NE (Number)
Safe (31)	45% (14)	19% (6)	36% (11)
Effective (15 relevant – 3 disregarded)	53% (8)	20% (3)	27% (4)
Caring (10)	50% (5)	10% (1)	40% (4)
Responsive (12)	42% (5)	33% (4)	25% (5)
Well led (20 relevant – 2 disregarded)	15% (3)	20% (4)	65% (13)
All (88)	40% (35)	20% (18)	40% (35)

In summary, only 40% of the characteristics used to determine whether a community service has achieved a 'Good' standard were adjudged to have a matching equivalent in the indicators used by the HMIP scheme. 40% were adjudged to not have even a partially matching equivalent. The matching was particularly poor in the section dealing with leadership and governance; only 15% falling in the 'matching equivalent' category. For example, the characteristics of a good GP service in the community include the following:

> There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well-defined objectives that are achievable and relevant. The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners. The strategy is aligned to local plans in the wider health, and social care economy and services are planned to meet the needs of the relevant population.
>
> Progress against delivery of the strategy and local plans is monitored and reviewed, and there is evidence of this.
>
> Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood, and an action plan is in place. Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.[60]

No indicators could be found in the HMIP scheme, which require a vision statement and associated strategy. An IRC is expected to produce an action plan in response to the recommendations following an inspection, and these are used to monitor progress, but this is a very different tool.[61]

An indication of the HMIP's own view of the nature of the standard which it applies in practice is of interest. The Deputy Head of Healthcare was interviewed by the investigators commissioned by G4S to investigate the concerns raised by the Panorama documentary in 2017. Her explanation (as quoted in the report) of the reasons for assessing healthcare services as 'reasonably good' was:

> [t]here were no breaches of the regulations from the CQC perspective, so I think our judgement was that overall it was reasonably good. We were quite clear that fewer detainees were satisfied with the quality of it than they had been previously, and there was a lack of a health needs assessment. There were some issues around the health complaint system and primary care services, the feeling was that it was quite accessible, and the care planning was good, the waiting lists were short. Therefore, I think our general sense of it was that it was reasonably good.[62]

60 Care Quality Commission, 'Key Lines of Enquiry' (n 5) 47–48. Emphasis added.

61 HMI Prisons, 'Inspection Framework' (March 2019) para 3.35 <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/03/INSPECTION-FRAMEWORK-2019.pdf> accessed 20 April 2021.

62 Kate Lampard and Ed Marsden, 'Independent Investigation into Concerns about Brook House Immigration Removal Centre' (2018) 170 <https://www.g4s.com/en-gb/-/media/g4s/unitedkingdom/files/brook-house/brook_house__kate_lampard_report_november_2018.ashx?la=en&hash=42B2E56AD3E9946AC659516AB1D6D919> accessed 16 June 2021.

The reliance on the CQC's finding that there were no breaches of regulations suggests an equivalence between the 'reasonably good' standard applied by HMIP and the 'fundamental standards' set by those regulations. This would not, of course, amount to community equivalence when community healthcare services are subject to a quality threshold that goes beyond the bare minimum fundamental standards.

In short, it is far from clear that the Expectations scheme used by HMIP delivers a standard at least equivalent to a 'Good' quality service which is the minimum required of community healthcare services in the CQC scheme. In fact, the evidence suggests otherwise. At best, it does not facilitate the necessary comparative analysis, and, at worst, it risks assessing against a lower quality standard.

The application of ratings and overall assessment of quality

There is a further issue related to how ratings are applied by the CQC in community settings, compared with how the HMIP reaches a quality assessment which is of significance for the community equivalence issue.

How the CQC applies ratings

From October 2021 the CQC changed the way that it rates GP practices. Prior to that change, the system worked on the basis of ratings at four levels:[63]

- Level 1: This was a rating for the service provided to each of a number of population groups using the 'Effective' and 'Responsive' key questions. Of interest for our purposes is that the population groups considered included people whose circumstances make them vulnerable and people with poor mental health conditions. The quality of the practice's service for each group was assessed against both inspection findings and against national comparators.
- Level 2: An aggregated rating for each population group was given, drawing on the Effective and Responsive ratings.
- Level 3: An aggregated rating was given for each key question. For the key questions Effective and Responsive, this is aggregated from the ratings at Level 1. For the Safe, Caring and Well-led questions the rating was based on the overall evidence for the practice as a whole in relation to each of those key question.
- Level 4: This was an overall aggregated rating for the practice on the ratings at level 3.

This was a rather complex scheme, and it was simplified in October 2021. Now a rating is given for each key question and these are aggregated to give an overall rating.[64] Consultees expressed concern about the loss of focus and information about vulnerable groups. In its response the CQC gave the assurance that:

> 'Although we will not provide a rating for each population group for the effective and responsive key questions, we will use the information about them to inform our ratings of these key questions overall. In line with our current approach, we will still publish information about the evidence we have used to make our judgments and decisions about ratings.'[65]

The scheme clearly still has the potential to foster a structured analysis of the quality of different aspects of the practice and what needs to be done to improve.

How HMIP assesses overall quality

The HMIP scheme works in the following way. The scheme requires inspectors to apply the 'healthy establishment' test to each of the healthy prison areas (HPAs): 'Safety', 'Respect', 'Purposeful activity', and 'Preparation for removal and release'.[66] Health services are just one element amongst a number of diverse aspects of the service overall in the healthy prison area (HPA) of Respect. The others which fall under the Respect umbrella are:

- staff-detainee relationships;
- daily life (which includes living conditions, complaint and redress processes, and meals); and
- equality, diversity and faith.[67]

Each element of each HPA is assessed against a series of 'Expectations'.

63 Care Quality Commission, 'How CQC Monitors, Inspects and Regulates NHS GP Practices' (n 3) 21.
64 Care Quality Commission, 'Consultation on Changes for More Flexible and Responsive Regulation' (January 2021) 6 <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
65 Care Quality Commission, 'Responding to Our Consultation: Changes for More Flexible and Responsive Regulation' (July 2021) <https://www.cqc.org.uk/about-us/our-strategy-plans/responding-our-consultation-changes-more-flexible-responsive-regulation> accessed 27 October 2021.
66 HMI Prisons, 'Inspection Framework' (n 61).
67 ibid 10. HMI Prisons, 'Guide for Writing Inspection Reports' (March 2018) 12 <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/03/4.-GUIDE-FOR-WRITING-INSPECTION-REPORTS-March-2018-1.pdf> accessed 17 June 2021.

As noted in the previous section, the possible judgments of quality in each HPA, based on a numeric scale, are: poor (1), not sufficiently good (2), reasonably good (3) and good (4).[68]

The conclusion may well be that, in the area of Respect, the establishment achieves a 'Good' or 'Reasonably good' judgement using the HMIP healthy establishment schematic (see Section 3), even though there may be concerns about healthcare. In short, the assessment of healthcare is one element of a much broader set of issues which, taken together, attract an overall judgement. This can result in insufficient attention and priority being given to healthcare in general, or particular aspects of that service. This was also a concern for the Select Committee in the context of joint prison inspections, reported to them by the CQC.

> Currently CQC's judgements inform the score HMIP awards to prisons under its 'respect' test. CQC told us significant breaches of fundamental standards may not receive sufficient attention as other aspects of a prison that come under HMIP's respect test are "disproportionately positive" and outweigh CQC's judgements.[69]

An example of how healthcare can become lost in the 'Respect' undergrowth in the context of an IRC inspection is to be found in the 2016 Brook House inspection. The overall assessment of the area of Respect found:

> [p]oor ventilation and the general prison-like environment remained significant shortcomings. Cleanliness varied and some deep cleaning was required. Staff detainee relationships were a particular strength. Equality and diversity structures were robust and outcomes were reasonably good for most detainees. Faith provision was excellent. Complaints were well-managed. The standard of food was reasonable, and the cultural kitchen was used more often. Health care provision was adequate. There were shortcomings in some areas, including pharmacy. Outcomes for detainees were reasonably good against this healthy establishment test.[70]

The finding that the health care service was 'adequate' does not engender confidence that it was found to be equivalent to the standard of care expected in a community healthcare setting (i.e. the CQC's rating of 'Good'). Although the body of the 2016 report sets out the expected outcome of community equivalence, there is no clear statement of whether this was found to be the case or not.[71]

So, not only does the joint inspection process as currently configured not produce ratings of detailed aspects of the health service (unlike assessment of performance in of community healthcare), thus limiting its efficacy in driving effective and relevant improvements to a 'Good' standard, but the healthcare service overall does not attract its own assessment.

Securing quality improvements – an equivalent regime?

As noted at the outset of this section, one of the policy objectives of a ratings system is to 'challenge providers to improve'.[72]

The availability of the 'Requires improvement' rating in the assessment of community healthcare services allows clear signalling that improvements are expected. Furthermore, the application of the healthy establishment rating system at the HPA level, as explored above, risks a loss of significant detail that might otherwise inform improvements of importance to detainees.

But there is another aspect of the HMIP scheme - the threshold test for making recommendations - which may also impact on learning opportunities. If a community provider falls below the standard of 'Good' it will be rated by the CQC as either 'Requires Improvement' or 'Inadequate' and recommendations are made on that basis. An HMIP report only makes recommendations where the recommended improvement meets - what appears to be - a rather restrictive definition:

- 'Something fundamental to the healthy establishment tests (and including anything that is important enough to be included in the report summary);
- Something that will require significant changes in culture or procedures or new or redirected resources and will therefore not be achievable

68 HMI Prisons, 'Inspection Framework' (n 61) 17–18.
69 Health and Social Care Committee, *Prison Health* (n 10) 41.
70 HM Chief Inspector of Prisons, 'Report on an unannounced inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons 20 May - 7 June 2019' (2019) 15 <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/09/Brook-House-web-2019.pdf> accessed 16 June 2021. Emphasis added.
71 ibid 3.
72 Department of Health, 'New Proposal' (n 8) 4.

immediately by the senior management team; or

- Something of sufficient importance for us to seek evidence of implementation on a return visit'.[73]

In its Secure Settings Handbook, the CQC notes that it 'may recommend areas for improvement even when a regulation has not been breached'.[74] Its 'test' for making recommendations is not whether the service has fallen below the fundamental standards. However, its recommendations are made in the context of the HMIP scheme and the latter's report writing guidelines and would therefore appear to be constrained by the HMIP definition. It is not clear whether there has been any equivalence mapping between the CQC and HMIP approaches to making recommendations.

Furthermore, the CQC has a number of enforcement powers to improve standards. The HMIP does not. The CQC's powers can be used in secure settings if a registered provider is in breach of a regulation, such as a failure to meet the fundamental standards (or other breaches of legal requirements). These range from a 'Requirement Notice' where there is a breach of regulations, but the 'impact on people is not immediately significant' and where 'the provider should be able to improve its standards within a reasonable timeframe', to cancellation of registration and prosecution.[75] These are the regulatory 'sticks' that can motivate improvement.

While the CQC has issued requirement notices to IRCs, the full benefit of the CQC's enforcement powers is not felt because an important aspect of them is linked to the ratings scheme, which is not available in secure settings. The provider handbook for community GP practices explains that if a service is rated as 'Requires Improvement' (for example, in the area of safety) on more than one consecutive occasion, irrespective of whether the deficiency amounts in itself amounts to a breach of regulations, 'it shows that they cannot demonstrate the necessary leadership or governance processes to assure and improve quality'.[76] The CQC will therefore consider whether *this* is a breach of Regulation 17, which imposes a minimum fundamental standard in relation to governance. The handbook goes on to say that if the practice is rated as 'Requiring improvement' for a third time, this will trigger a potential use of formal enforcement powers. This offers the CQC a set of enforcement tools that can be used to move a provider from the basic fundamental standard to the standard of 'Good' even though the regulations only require the fundamental standard to be met. It is unclear how repeated deficiencies in IRCs, which are not in themselves regulatory breaches, would or could be similarly addressed, in particular when the relevant remedial actions may not even achieve the status of 'recommendation' on the HMIP's criteria.

Summary

It is far from clear that the mapping exercise between HMIP Expectations and CQC KLOEs has produced a quality standard to be used in inspections of healthcare in IRCs that is equivalent to that applied to community healthcare services. In fact, the evidence in the publications produced by both authorities to explain the schemes suggests to the contrary despite the unequivocal statements of commitment to community equivalence.

The Select Committee's conclusions in relation to prison healthcare could be applied equally to IRCs: '*...there is no resource describing how equivalence should be defined, measured and compared with health and care in the community*'.[77] The decision to exclude IRC healthcare from the CQC's powers to use a ratings scheme failed to take account of the need to develop mechanisms to operationalise the equivalence commitment.

Those mechanisms must apply a clearly comparable quality standard and comparable drivers to reach that standard. It is puzzling why the CQC, which assesses community healthcare services and is the acknowledged expert partner, should be limited to applying the basic fundamental standards rather than applying community equivalent ratings standards.

73 HMI Prisons, 'Guide for Writing Inspection Reports' (n 66) 33.
74 See Care Quality Commission, 'Provider Handbook' (n 7) 31. The HMIP-led joint report is structured by reference to HMIP's published Expectations.
75 Care Quality Commission, 'Enforcement Policy' (February 2015) 18 <https://www.cqc.org.uk/sites/default/files/20150209_enforcement_policy_v1-1.pdf> accessed 23 April 2021.
76 Care Quality Commission, 'Provider Handbook' (n 7) 31.
77 Health and Social Care Committee, *Prison Health* (HC 2017-2019, 963-XII) 15 <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/963/963.pdf> accessed 16 June 2021. Emphasis added.

SECTION 5: EVIDENCE GATHERING FOR INSPECTIONS – USING COMPARATIVE DATA TO ASSESS EQUIVALENCE

Introduction

The question of how to operationalise the measurement of community equivalence inevitably raises the issue of comparative data. Although the use of data which enables comparison to be made with other providers of services can risk institutionalising inadequate quality if there is evidence of generalised poor practice, in the absence of such evidence, it has a potentially important role to play in ensuring consistent quality and identifying unacceptable quality.

This section explores the use of comparative data in the inspection of healthcare provision in IRCs, first by identifying the key evidence used in the inspection of community GP practices and then considering the relevance to and availability of this material in IRC inspections.

Evidence used in the inspection of community GP practices

The CQC monitors community GP practices using what is known as CQC Insight:

> CQC Insight brings together the information that we hold about your practice in one place. We analyse this information and compare it against local and national data and identify potential changes in the quality of care.
>
> We update our analysis throughout the year, so our inspectors have the most recently available information about services. This information helps us to plan when and what we inspect. We will include some of the information in your inspection report as evidence to support our judgements about the quality of care.[1]

The current (pre-Covid) version of the model is to be found in the CQC publication, *NHS GP practices indicators and methodology (December 2019)*.[2] The model utilises nationally available data in the assessment of one GP practice's data against all other practices in England. The data used is drawn from a number of sources:

- Quality and Outcomes Framework (QOF) (NHS Digital);
- GP patient survey (GPPS) (NHS England);
- NHS Business Services Authority; and
- Public Health England.[3]

The data is used to assess the GP practice against a series of 33 selected indicators currently covering four of the CQC's five key questions – Caring, Effective, Responsive and Safe.[4] A score is given based on the statistical measurement of the practice's performance in relation to the average in England. The model identifies not only practices which vary significantly from the national average and therefore warrant further enquiry[5] but also those tending towards a deviation. The material guides the inspection and is included in the evidence tables that are appended to the CQC's inspection reports.[6]

For illustrative purposes, some of the quality indicators for which national comparative data is used and the source of the national data used are set out in the following table.[7] Each of them is potentially relevant in a secure setting.

1 Care Quality Commission 'How CQC monitors, inspects and regulates NHS GP practices' (April 2019) 2 <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices> accessed 01 June 2021.
2 Care Quality Commission, 'NHS GP Practices: Indicators and Methodology' (2019) <https://www.cqc.org.uk/sites/default/files/20191217_gpinsight_indicators_and_methodology_guidance.pdf> accessed 25 April 2021.
3 There appears to be only limited usage of PHE data and this is not considered further.
4 Care Quality Commission, 'NHS GP Practices' (n 2) 3.
5 'We assess relative performance for the majority of indicators using a z-score, which gives us a statistical measurement of a practice's performance in relation to the England average and measures this in standard deviations. We highlight practices which significantly vary…We consider that z-scores which are +2 or more or – 2 or less are at significant levels, warranting further enquiry'. ibid.
6 ibid.
7 Full details can be found in ibid.

Key question	Indicator	Data source
Caring	Healthcare professional listening to patients	GPPS
	Health professional treating patients with care and concern	GPPS
	Being involved in decisions about care and treatment	GPPS
	Confidence and trust in the healthcare professional	GPPS
	Positive experience of GP practice	GPPS
Effective	High blood pressure management	QOF, NHS Digital
	Diabetes – managing blood glucose level	QOF, NHS Digital
	Mental health – comprehensive care planning	QOF, NHS Digital
Responsive	Patient satisfaction with GP practice appointment times	GPPS
	Overall experience of making an appointment	GPPS
	Needs met at last GP appointment	GPPS
Safe	Antibiotic prescribing	NHS Business Services Authority
	Oral NSAIDs	NHS Business Services Authority

Using comparative data when inspecting healthcare in IRCs

The Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) is a voluntary scheme which rewards community GP practices financially for the provision of quality care. QOF points are achieved based on the proportions of patients on defined disease registers who receive defined interventions. Participation by practices is voluntary but high, with more than 95% participating in 2018-2019.[8]

The potential for QOF to be used in secure settings and to act as a measure of community equivalence appears to have been recognised, at some point, by NHS England. *The Health and Justice Indicators of Performance (HJIPS) User Guide 2017-18 (draft)* explains that: '[p]roviders are able to access their QOF achievement outcomes via a report embedded in SystmOne'.[9] It continues: '[t]his reporting enables assurance that there is parity of provision between residents of the secure estate and the wider community'.[10] (An electronic copy of this draft document was accessed in October 2020. A final version could not be located.)

The CQC advised during our interview (which was offered for the purpose of clarifying the organisation's responses to our 'freedom of information' requests) that they will access an IRC healthcare provider's QOF data if they are using the system, but, unlike community practices, providers do not do so as a matter of course. It is understood that they do not receive the financial incentives available to community GP practices.[11] The CQC explained that if the QOF is used, they may take this as an indication of quality, but they do not report against the QOF benchmarks as they do

8 NHS Digital, 'Quality and Outcomes Framework, Achievement, Prevalence and Exceptions Data 2018-19 [PAS] – Frequently Asked Questions' (2019) <https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2018-19-pas/frequently-asked-questions> accessed 25 April 2021."plainCitation":"'Frequently Asked Questions' (NHS Digital

9 Information Management Team – Health & Justice, 'Health and Justice Indicators of Performance (HJIPs) Adult Secure Estate User Guide 2017-18 (Draft)' (2017) 26 <https://supplierlive.proactisp2p.com/PublicDocument/Get?d=l5dgapako5621843v2kb35xot3> accessed 25 April 2021.SystmOne is an IT system used in primary care to record patient clinical information.

10 ibid.

11 Nat Wright and others, 'Long-Term Condition Management for Prisoners: Exploring Prevalence and Compliance with QOF Monitoring' (Research Square 2020) <https://www.researchsquare.com/article/rs-45365/v1%20This%20is%20a%20preliminary%20report%20that%20has%20not%20undergone%20peer%20review.> accessed 25 April 2021. This is a preliminary report that has not undergone peer review. The website says that as such it 'should not be considered conclusive, used to inform clinical practice, or referenced by the media as validated information'.

systematically for community GP practices. [12]

The IRC primary medical service 2020 contract specification requires the healthcare provider to provide care that is consistent with national standards such as QOF.[13] Given this, it appears that QOF data could be required of providers in IRCs or encouraged with a financial incentives scheme as with community GP practices. It could then be made available to the CQC as standard information, which could be used systematically in the same kind of scoring system as that used for community practices, thereby facilitating a more direct community comparison. Indicators could be selected or developed which reflect differences in the issues arising in IRCs, but, nonetheless, on the face of it, the use of such data would contribute to the assessment of community equivalence.

The GP Patient Survey (GPPS)

The GPPS is an England-wide annual survey undertaken by NHS England which asks patients about their experience of their GP practice. As the NHS England website explains:

> [r]eplies to the survey will help GP practices understand where they can improve. This survey is an opportunity for patients to have their say about how well their practice is doing at providing these services to patients.[14]

The survey is not used for primary medical services delivered in IRCs, but a survey of those in detention is used, which covers a wide range of issues not limited to healthcare. This includes one question which is, arguably, sufficiently similar to allow for a degree of comparative analysis using patient assessment of community healthcare. The question asks for the views of those in detention about their overall assessment of the quality of the healthcare service. However, the only comparative use of the resulting data is to benchmark the results of the current inspection against the previous results for that particular IRC and other IRCs. This is, of course, of limited value in a context where there are concerns about the quality of healthcare services across the sector. As indicated above, in these circumstances, there is a risk of institutionalising poor practice. These issues are considered in more detail in Section 6, which explores the role of the 'patient's voice' in assessing the quality of community GP practices and IRC healthcare.

NHS Business Services Authority and prescribing data

The NHS Business Services Authority provides, amongst other things, prescribing data for English GP practices, including:

- all prescribed and dispensed medicines (by chemical substance and presentation level);
- dressings and appliances (at section level and presentation level);
- the total number of items that were prescribed and then dispensed;
- the total Net Ingredient Cost (NIC) and the total Actual Cost of these items.[15]

In its assessment of community GP practices, the CQC looks at relative prescribing between practices of a number of key medications such as antibiotics and non-steroidal anti-inflammatory painkillers such as ibuprofen.

Although it is unclear whether the NHS Business Service Authority holds prescribing data for IRC services, the CQC confirmed during an interview that it does have access to the IRC provider's own prescribing data, and the provider is asked how they audit their own prescribing practices, but the national database is not accessed for community healthcare comparisons.[16]

12 In a relatively recent report on an inspection of Colnbrook IRC, the use of QOF was commented on in the following terms: 'the use of the NHS England Quality Outcome Framework helped to support the identification and monitoring of long-term conditions. This was overseen by the primary care lead. GPs managed and reviewed detainees with long-term conditions and nurse triage clinics provided supplementary support'. HM Chief Inspector of Prisons, 'Report on an Unannounced Inspection of Colnbrook Immigration Removal Centre' (2019) para 2.52 <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/04/Colnbrook-web-2018.pdf> accessed 25 April 2021.

13 NHS England and NHS Improvement, 'Service Specification: Primary Care Service – Medical and Nursing for Immigration Removal Centres in England (2020) 27 <https://www.england.nhs.uk/wp-content/uploads/2020/03/primary-care-service-spec-medical-nursing-irc-2020.pdf> accessed 17 June 2021.

14 GP Patient Survey, 'Frequently Asked Questions' (2021) <https://gp-patient.co.uk/faq> accessed 25 April 2021.

15 NHS Business Services Authority, 'Detailed Prescribing Information' <https://www.nhsbsa.nhs.uk/prescription-data/prescribing-data/detailed-prescribing-information> accessed 25 April 2021.

16 Interview with Jan Fooks-Bale, Health & Justice Inspection Manager, Care Quality Commission and Dayni Johnson, Health & Justice Inspector, Care Quality Commission (Teams, 8 September 2020).

Summary

Although comparative data is a significant tool in the assessment of the quality of community GP practices, it plays little part in the assessment of healthcare in IRCs. However, the replication of the approach used in community GP practices which simply compares the performance of a community GP with other community GP practices, would not be appropriate. The IRC healthcare is a sector where there are concerns about quality across the estate, and there is a risk of institutionalising poor practice if IRCs are simply compared with other IRCs. Nonetheless, this is the only comparative exercise that is undertaken (and, even then, in a limited way).

No specific changes to the types of data collected are identified in the CQC's new strategy. The emphasis appears to be on greater efficiency of process, making use of better analytical tools and improved sharing of information.

The Health and Social Care Select Committee's criticism that 'there is no resource [in the prison healthcare sector] describing how equivalence should be defined, measured and compared with health and care in the community' needs to be addressed in the context of IRC provision.[17] There appears to be scope in the available measures for relevant comparisons to be made. Some reforms might be required (such as in the incentives to produce data in forms such as QOF which allow for comparative use), but if community equivalence is going to be assessed in a meaningful fashion, those reforms may need to be made.

17 Health and Social Care Committee, *Prison Health* (HC 2017-2019, 963-XII) 15 <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/963/963.pdf> accessed 16 June 2021.

SECTION 6: THE PATIENT'S VOICE – THE DETAINEE SURVEY AND INTERVIEWS

The CQC's Provider Handbook for Secure Settings is absolutely clear about the importance of the patient's voice in the inspection process for secure settings:

> A key principle of our approach to inspecting is to seek out and listen to the experience of detainees and those close to them, including the views of the people who are in vulnerable circumstances or who are less likely to be heard.[1]

HMIP makes a similar commitment. Its 'Values' include that '[t]he experience of the detainee is at the heart of our inspections'.[2]

How is the patient's voice heard in the inspection of community healthcare, and does the inspection system for secure settings deliver equivalence in this context? An illustrative comparative analysis reveals significant issues for community equivalence, the underlying causes of which appear to lie, in large part, in the details of the inspection schemes used.

The Secretary of State for Health established a National Outcomes Framework to drive quality improvement throughout the NHS.[3] One of the outcomes sought in that scheme is to improve patient experience of GP services. That goal is, to a significant extent, reflected in the CQC's KLOE scheme, which treats what patients have to say about their experience as a characteristic of quality. However, although the HMIP's scheme of Expectations makes it clear that inspectors are looking for a 'caring and compassionate' service, the patient's account of their experience is not, in itself, an indicator of that expectation being met, but merely one source of evidence which is subjected to the triangulation principle (i.e. the requirement that there are three sources of mutually corroborating evidence). Three of the identified five potential evidence sources in the HMIP inspection framework are, to greater and lesser extents, within the institutional control of the IRC. That is of particular concern where, as here, there is some evidence of an institutional culture of disbelief which could infect evidence and the inspection process.

The patient's voice in CQC inspections of community GP practices

The GP Patient Survey (GPPS)[4] is an England-wide annual survey undertaken by NHS England which asks patients about their experience of their GP practice. The responses to a number of the questions are used by the CQC when looking at various aspects of their key lines of enquiry (KLOEs). (See Section 3.) In particular, one of those key lines of enquiry asks, '[h]ow does the service ensure that people are treated with kindness, respect and compassion and that they are given emotional support when needed?'[5] The first characteristic of a 'Good' quality service in this respect includes the following elements:

- 'Feedback from people who use the service, those who are close to them and stakeholders is positive about the way staff treat people'.
- 'People are treated with dignity, respect and kindness during all interactions with staff and relationships with staff are positive'.
- 'People feel supported and say staff care about them'.[6]

It is important to note here that what patients say in relation to community health services is in itself a characteristic of a quality service. The evidence used by CQC inspectors includes the following GPPS data identifying the percentage of respondents who:

- stated the last time they had a GP appointment, the healthcare professional was good or very good at listening to them;
- stated the last time they had a GP appointment the healthcare professional was good or very good at treating them with care and concern;

1 Care Quality Commission, 'How CQC Regulates Health and Social Care in Prisons and Young Offender Institutions, and Health Care in Immigration Removal Centres: Provider Handbook' (July 2015) 22 <https://www.cqc.org.uk/sites/default/files/20150729_provider_handbook_secure_settings_0.pdf> accessed 17 June 2021.

2 HMI Prisons, 'Inspection Framework' (March 2019) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/03/INSPECTION-FRAMEWORK-2019.pdf> accessed 20 April 2021.

3 NHS Digital, 'About the NHS Outcomes Framework (NHS OF)' <https://digital.nhs.uk/data-and-information/publications/ci-hub/nhs-outcomes-framework> accessed 17 June 2021.

4 GP Patient Survey, 'Frequently Asked Questions' (2021) <https://gp-patient.co.uk/faq> accessed 25 April 2021.

5 Care Quality Commission, 'Key Lines of Enquiry, Prompts and Ratings Characteristics for Healthcare Services' (2018) 13 <https://www.cqc.org.uk/sites/default/files/20180628%20Healthcare%20services%20KLOEs%20prompts%20and%20characteristics%20FINAL.pdf> accessed 23 April 2021.

6 ibid 38–39.

- stated during their last GP appointment, they had confidence and trust in the healthcare professional they saw or spoke to;
- responded positively to the overall experience of their GP practice ('the overall experience question').[7]

A focused analysis is to be undertaken here in relation to the last of these: the percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice. This will facilitate a comparison with the use of a similar question in the survey of people in detention undertaken in connection with the HMIP/CQC joint inspection.

The data from the GPPS is analysed by NHS Digital to provide indicators of performance against the national outcome goals set by the Secretary of State (the NHS Outcomes Framework).[8] The aim of that framework is of direct relevance to the issues of concern here: it is to 'drive transparency, quality improvement and outcome measurement through the NHS'.[9] One of the outcome goals which supports the achievement of that aim is to '[i]mprove patients' experiences of GP services'.[10] NHS Digital's indicator specification explains that the 'overall experience' question asked in the survey is: '[o]verall how would you describe your experience of your GP practice?'[11] The possible answers are:

- Very good
- Fairly good
- Neither good nor poor
- Fairly poor
- Very poor.[12]

A calculation is undertaken to identify the weighted percentage of people reporting an overall good experience of their GP (i.e. good or fairly good). The weighting adjusts the data to account for potential differences between the demographic profile of all eligible patients in the practice and the patients who actually complete the questionnaire.

In order to explore how this material has been used in community GP inspections, ten GP practices were selected which had been given an overall assessment rating of 'Good', ten which had been rated as 'Requiring Improvement', and ten which had been rated as 'Inadequate' in 2019 or 2020 (see Annexes).

The dates of the inspections fell between February 2019 and February 2020. We noted the following:

1. Of the practices that had an overall assessment of 'Good', only one practice (A) had a negative variation compared with the national average for the overall experience question. There was clear evidence that CQC inspectors explored this issue with the practice and reported that it was a practice that had been taken over since the GP survey had been carried out and had since carried out its own survey, which had produced 'overwhelmingly' positive results. It was assessed as being 'Good' in the Care domain as well as overall.

2. Two of the ten practices assessed as Requiring Improvement did not have data for the relevant question. In one case, the practice had been taken over by a new GP provider only six months previously, and the GP survey data was not used because it related to the previous provider. The second was a review undertaken because information indicated that there might have been a significant change to the quality of care provided since the previous inspection, and the inspection focused on the key questions relating to being effective, responsive and well-led. This may explain why data from the national survey relevant to the issue of whether the practice was caring was not included. Of the remaining eight, which did have the relevant data, 4 (B, C, D and E) had negative results.

   B and C were rated as Requiring Improvement in the Care domain. D and E were rated as Good. The following factors were noted which would have been relevant to this judgment:

   - B and C's scores were lower (60.4% and 51.8% respectively, the latter falling into the 'significant' negative variation category); D and E had figures of 69.7% and 73%, respectively (both falling into the 'tending towards negative' category).
   - B had negative results in two of the three other patient experience questions in this domain, and C had negative results in all three. D and E had no other negative results for the other three questions; indeed, D had a positive result for treating its patients with care and concern.

7 A sample inspection report and evidence table can be accessed here: <https://www.cqc.org.uk/sites/default/files/evidence/evidence-AAAJ2241.pdf> accessed 28 June 2021.
8 NHS Digital, 'About the NHS Outcomes Framework (NHS OF)' (n 3).
9 ibid.
10 NHS Digital Clinical Indicators Team, 'NHS Outcomes Framework: Domain 4 – Ensuring that People Have a Positive Experience of Care, Indicator Specifications' (Version 2.8, May 2019) 5 <https://files.digital.nhs.uk/0D/2271B2/NHSOF_Domain_4_S.pdf> accessed 17 June 2021.
11 ibid 7. Emphasis in original.
12 ibid.

- The inspection reports recorded that each of the practices was aware of the results and already taken specific steps to address the issue

The inspection report explained its decision to rate B and C as Requiring Improvement in the Care domain, and in each case, the performance on the GPPS was cited. Indeed, for C (where there had been significant variation from the average), it was the sole reason, which is of particular interest in light of HMIP's approach to triangulation of evidence which is considered below.

3. Three (F, G and H) of the ten practices rated overall as Inadequate had negative results on the overall experience question; 62.5%, 63.7%, and 69.4%, respectively.

   F and G were not assessed as Inadequate in relation to the Care domain but as Requiring Improvement. H was assessed as Inadequate in relation to Care. Again, it was clear from the reports that the inspectors had explored the issue and had made a judgement based on reasons which were recorded in the report.

   - F had undertaken its own survey a couple of months after the GPPS data had been released to find out what the problems were and had produced an action plan to address these, although the CQC was critical of that plan in the final report. F also had negative results for all four of the patient experience questions, including one at a significant level. The CQC issued a Requirement Notice on the basis of a breach of Regulation 17 (good governance), and one of the four factors which were identified as justifying that step was that there were '[n]o effective systems or processes to see and act on feedback from patients as demonstrated through consistently low survey results'.[13]
   - G had no other statistically negative results, but there was no evidence that it had reviewed the result of the GPPS data or planned to make changes to improve the overall experience. Again, a Requirement Notice was issued on the basis of a breach of Regulation 17.
   - H was assessed as Inadequate in relation to the care domain as well as inadequate overall. It had negative results for all four of the patient experiences questions, including one at a significant level. It had a history of inspections going back a number of years where it had been assessed as requiring improvements, including, specifically, in relation to the Care domain, and the GPPS showed deteriorations in the results for the patient experience questions since the previous inspection.

In summary, poor patient feedback was treated as a substantive quality issue. The GP practice was expected to be aware of the survey results and to have acted appropriately to address the relevant issues. Persistent failures to do so were treated seriously as raising regulatory concerns.

The patient's voice in inspections of immigration removal centres

The survey

Although NHS England's GPPS is not used in IRCs, a survey of those in detention is undertaken during the first week of the HMIP inspection process. It is described in the HMIP Inspection framework as 'crucial', a 'key source of evidence' and 'robust and representative', which would suggest that the results would play an important part in the assessment.[14]

The survey includes some questions which are specifically related to healthcare. These have changed over time. The survey used for the 2016 Brook House inspection includes the following four questions in Section 9 on 'Healthcare':[15]

- Is healthcare information available in your own language?
- Is a qualified interpreter available if you need one during healthcare assessments?
- Are you currently taking medication?
- What do you think of the overall quality of healthcare?

The 2019 report has seven questions in Section 11 on 'Health and Support'.[16]

13 This is consistent with its stated policy to not apply the ratings scheme mechanically but to exercise professional judgement which will take into account the degree of confidence in the service addressing the concerns. See Care Quality Commission, 'How CQC Monitors, Inspects and Regulates NHS GP Practices' (April 2019) 23 <https://www.cqc.org.uk/sites/default/files/20191104%20How%20CQC%20regulates%20primary%20medical%20services%20GP%20PRACTICES_MASTER.pdf> accessed 23 April 2021.

14 HMI Prisons, 'Inspection Framework' (n 2) 14.

15 HM Chief Inspector of Prisons, 'Report on an unannounced inspection of Brook House Immigration Removal Centre 31 October –11 November 2016 (2017) 87,78 <https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/brook-house-immigration-removal-centre/> accessed 16 June 2021.

16 HM Chief Inspector of Prisons, 'Report on an Unannounced Inspection of Colnbrook Immigration Removal Centre' (2019) 86 <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/04/Colnbrook-web-2018.pdf> accessed 25 April 2021.

- Is a professional interpreter available if you need one during healthcare assessments?
- What is the quality of health care services here?
- Do you have mental health problems?
- Have you been helped with your mental health problems while in this centre?
- Have you ever felt depressed while in this centre?
- Have you ever felt suicidal while in this centre?
- If you have felt depressed or suicidal here, did you receive any help from staff?

Although not identical, the general question (asking detained people their opinion about the quality of health care (the 'overall quality' question)) is similar to the 'overall experience' question used in the GPPS. The available response choices to the 'overall quality' question in the 2016 survey were:

- Have not been to healthcare
- Very good
- Good
- Neither
- Bad
- Very bad.

In the 2019 survey, they were:

- Very good
- Quite good
- Quite bad
- Very bad
- Have not been to healthcare.

The percentage of responses (excluding those who had never attended healthcare)[17] which rated healthcare in each IRC inspection since 2015 as 'good' and 'very good' (where the older version was used) and ' 'quite good' and 'very good' (where the more recent version was used) was calculated, with the following results as shown in table 2.

Table 2

IRC	Survey results (first inspection in period from 2015)	Survey results (second inspection in period from 2015)
Harmondsworth	2015: 26.5%	2017: 26.8%
Yarl's Wood	2015: 20.7%	2017: 38.5%
Brook House	2016: 29.4%	2019: 44.8%
Colnbrook	2016: 16%	2019: 28.9%
Morton Hall	2017: 42.2%	2019: 58.3%
Tinsley House	2018: 44.4%	None

The striking thing about these figures is how low they are compared to those found in the GPPS survey for community GP practices. In the GP practice reports considered above, a 73% result in the percentage of people reporting an overall good experience (i.e. good or fairly good) was considered to be a noteworthy variation from the average ('tending towards negative'), and a score of 51.8% fell into the poorest performing category of 'significant variation'. For IRCs, the *highest* result was 58.3%, and the rest were below 51%. The average percentage score is only 34.22%. Only one IRC (Morton Hall in 2019) had a majority (i.e. over 50%) positive response.

The lowest ratings are those for Colnbrook in 2016 (16%) and Yarl's Wood in 2015 (20.7%), which were two inspections in response to which the CQC issued Requirement Notices based on numerous identified concerns amounting to breaches of regulations. But for those where no regulatory breaches were found and no Requirement Notices issued, only one (Harmondsworth 2017) was found to have included a recommendation addressing the issue of poor patient feedback results: '[h]ealth services should engage with detainees to understand their perceptions of health care and respond actively to legitimate concerns'.[18]

The inspection response to poor feedback from those detained is considered in more detail for the 2016 and 2019 Brook House inspections.

17 Those who had never attended healthcare were excluded for the purpose of this comparison because it was assumed this would be relatively rare in community GP practices and would depress the scores perhaps artificially for this purpose.

18 HM Chief Inspector of Prisons, 'Report on an Unannounced Inspection of Heathrow Immigration Removal Centre Harmondsworth Site 2–20 October 2017' (2018) 39. <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/03/Harmondsworth-Web-2017.pdf> accessed 17 June 2021.

Brook House 2016

In 2016, the HMIP inspection report said:

> In our survey, 29% of detainees said that the overall quality of healthcare was good against a comparator of 42% and 40% at the last inspection. Many detainees we spoke to were negative about their experiences of health care, but we could find no evidence to support these perceptions apart from health notices displayed in English. The health interactions that we observed were polite and professional.[19]

This contrasts with the response to negative feedback from patients of community GP practices sampled in the analysis above. There, a negative patient view was a substantive issue to be addressed, not to be considered solely as one source of evidence. Furthermore, the practice was clearly expected to have investigated the cause of the dissatisfaction and have in place what the CQC adjudged to be an effective action plan to address poor patient feedback. Where the CQC was unhappy with the response and/or saw a pattern of negative assessment, particularly a deterioration, then it made it clear that improvements were required, which were considered in subsequent inspections.

In the Brook House 2016 inspection report, the only evidence specifically identified and relied on in reaching an implied conclusion that there was no issue of concern was the inspectors' observations during the inspection that healthcare staff were 'polite and professional'.[20] There is no obvious explanation in the report itself of why the weight to be given to these observations was such that the inspectorate could conclude that the negative feedback should not be treated as an issue of concern. The weight to be given to observations must, of course, be lower by reason of the fact that they are observations of 'on notice' behaviour. No recommendations were made which were expressly and specifically addressed to the issue of the negative views of those in detention.[21]

Although the response to the survey does not provide any detailed information on the reasons for detained people's negative assessment, the report's reliance on observations of healthcare staff interactions suggests that one of concerns of those detained was the way that they were treated by healthcare staff in those interactions. Given this, it is surprising that there was no cross-referencing to the responses to the survey questions on 'Staff' or 'Safety'. (Safety is, of course, one of the CQC's KLOEs.)

In response to survey questions about 'Staff', 23% of detained persons said that they did not feel they were treated with respect. 37% responded to the survey saying they felt unsafe. 21% reported victimisation by other detainees and 18% by staff.[22] In the section on safety, the report records that there were investigations into 21 reports of bullying. It is unclear whether any of these were investigations into allegations against staff, and there is no further mention of the latter. The only detailed commentary and the sole recommendation appears to relate solely to allegations made against other people in detention. Furthermore, there is no mention in the report that, in response to the survey, more than 50% said they did not report the victimisation that they experienced. The survey does not explore whether a proportion of these related to allegations of victimisation by staff.

There is one other factor that is mentioned in the report which may have contributed to a negative experience, but which, again, goes unaddressed. Only 20% responded in the affirmative to the survey question about the availability of a professional interpreter during healthcare assessments.[23] The report makes no mention of this evidence but said: '[w]e observed professional interpreting in use, but it was not always recorded'.[24] Again, there is a reliance on 'on notice' observations, and, again, no recommendations were made to address this issue.

Brook House 2019

By 2019 the inspection process had been changed to include not only a survey of those detained, but also a semi-structured interview process. The report explains that every detained person was offered a confidential interview, and 65 out of 239 participated.[25] Two people who had been released from detention were also interviewed. The inspection report summarised the feedback from

19 'Report on an Unannounced Inspection of Brook House Immigration Removal Centre [2016]' (n 15) para 2.33, p 36.
20 ibid.
21 ibid 52.
22 ibid 20.
23 ibid 78. 49% said they did not know whether an interpret was available or they did not need one – the categories were not separated.
24 ibid 2.34.
25 HM Chief Inspector of Prisons, 'Report on an unannounced inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons 20 May - 7 June 2019' (2019) 73 <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/09/Brook-House-web-2019.pdf> accessed 16 June 2021.

interviews in an appendix as follows:

> 46% of interviewed detainees said their physical and mental health needs were not met [61 out of 67 answered the question]. A large minority of interviewed detainees reported concerns about health care. These centred mainly around the attitude of health care staff, saying they were "dismissive," "rude", or "disbelieving." There were some reports of poor care.[26]

The survey findings were based on a larger sample of 158 completed questionnaires (a response rate of 65% from a random sample). This found that only a minority (44.8%) of those who had used healthcare assessed it as being quite good or very good.

However, the view of healthcare from the perspective of those detained was summarised in the report itself as follows:

> Overall health care provision was a reasonably good and responsive service. Most detainees we spoke to were positive about healthcare, although, in our interviews, a significant minority complained about their treatment, particularly about dismissive behaviour of a few healthcare staff. We found evidence of concerns about the attitude of a few healthcare staff. However, the majority of work that we observed was good.[27]

There was no mention at all of the survey results, which were based on a larger sample and which are considered by HMIP to provide statistically significant results and a robust and representative detained people's view. The overall summary in the Respect section did note that 'many' detained people had complained about the attitude of healthcare staff and that 'managers had been working on improving communications with detainees', but there is no evidence of a detailed exploration of the issue, and no recommendations were made to address it.[28] For our purposes it is of relevance to note the following:

1. The inspectors found evidence of concerns about the attitude of some healthcare staff. On its face, this appears to be more consistent with a service 'Requiring Improvement' in the 'Care' domain, rather than one that could be described as 'Good'. The following is the CQC's relevant characteristic indicating a community healthcare service which requires improvement:

> Some people who use the service, those who are close to them and stakeholders have concerns about the way staff treat people. People are sometimes not treated with kindness or respect when receiving care and treatment or during interactions with staff.[29]

   The CQC's characteristic of a good service in this respect is: '[p]eople are treated with dignity, respect and kindness during *all* interactions with staff…'.[30]

   Where the CQC found in the inspection of the community GP practice B that some staff did not treat patients with kindness and compassion and patient feedback was poor, the practice was assessed as Requiring Improvement in the Care domain. (See above.)

2. In response to the evidence of poor attitudes from some staff, the report relies on observations of 'work', the majority of which was said to be 'good'.[31] It is assumed that this refers to the observation of interactions with staff. As in 2016, there is no obvious reason (and no reason is given) why the weight to be given to observations made when staff knew they were being observed outweighed the reports of treatment made by detained people, and there is no cross-reference to the corroborative evidence from staff in the section on staff-detainee relationships, which says:

> In our staff survey and interviews, there were comments about a lack of respect, often related to the attitude of some health care staff. In the survey, 35% of staff thought that healthcare staff treated detainees well and 48% reasonably

26 ibid 74.
27 ibid para 2.45 p 39.4,25]]}},"locator":"para 2.45 p.39"}],"schema":"https://github.com/citation-style-language/schema/raw/master/csl-citation.json"}
28 ibid 16.
29 Care Quality Commission, 'Key Lines of Enquiry' (n 5) 38–39. Emphasis added.
30 ibid. Emphasis added.
31 HM Chief Inspector of Prisons, 'Report on an unannounced inspection of Brook House Immigration Removal Centre [2019]' (n 24) para 2.45 p 39.

> well, but there were many comments about rude, dismissive or suspicious behaviour by healthcare staff.[32]

3. Again, there is no cross-referencing to the issue of safety. The percentage of respondents to the survey who said they felt unsafe had increased from 37% at the last inspection to 66%. The section of the report dealing with personal safety set out the following analysis:

> In our survey, two-thirds of detainees said they felt unsafe. However, very few detainees in our confidential interviews told us they felt physically unsafe in the centre, and none said that they had been assaulted by staff or other detainees. The detainees who said they did not feel safe cited concerns such as indefinite detention, anxiety about possible removal, the behaviour of other detainees or concerns about healthcare.[33]

However, this was based on a very small sample. Only 5 of the detained people who provided an interview (out of 67) said they had been treated inappropriately by staff.[34] There is no mention here of the fact that 20% of the 158 who responded to the survey failed to confirm that they had not experienced victimisation or bullying by staff[35], and those who had such experiences reported victimisation/bullying in the following variety of forms, which included physical assault: [36]

- Verbal abuse: 15
- Threats or intimidation: 11
- Sexual comments: 2
- Sexual assault: 2
- Physical assault: 4
- Theft: 2
- Other: 10

Nor was there any mention of the fact that 25% said they would not report staff bullying, and 15% said they felt unsafe at healthcare (a question that was not asked in 2016).

In relation to the issue of the availability of a professional interpreter, 28% of those responding to the relevant survey question (141) said that no professional interpreter was made available. The inspection report made no mention of these survey figures but said:

> Professional telephone interpreting was used regularly for health care consultations, but we found a few cases where another detainee was allowed to interpret which undermined the quality of the assessment and compromised confidentiality.[37]

It is not clear from this whether this was based solely on observation, whether 'regularly' corresponded to need, or whether the patient was offered a professional interpreter and expressed a preference for the other detained person to interpret. No recommendations were made to address what was found to be the case. It is worth noting the CQC's characteristic of a 'Good' community healthcare service: '[r]easonable adjustments are made, and action is taken to remove barriers when people find it hard to use or access services'.[38] The corresponding characteristic of a service requiring improvement is: '[r]easonable adjustments are not always made'.[39]

The patient's voice as reflected in the HMIP and the CQC schemes

Although the CQC and HMIP make statements of principle about the importance of the voice of those in detention in their main publications on their respective inspection frameworks, the way that this is reflected in the detail of their evaluation schemes differs in ways which may explain some of the important differences identified above between the approaches taken in the inspection of community healthcare services and of the services provided in IRCs.

As noted above, the first indicator of a 'Good' quality service in the 'Care' domain in the KLOE scheme used for community healthcare services includes the following elements.

- Feedback from people who use the service,

32 ibid 33. Emphasis added.
33 ibid 27.
34 ibid 73.
35 The question was worded in such a way that it is not known whether 20% were saying that they had had that experience.
36 ibid 85.
37 ibid 17.
38 Care Quality Commission, 'Key Lines of Enquiry' (n 5) 43.
39 ibid.

those who are close to them and stakeholders is positive about the way staff treat people;
- People are treated with dignity, respect and kindness during all interactions with staff and relationships with staff are positive;
- People feel supported and say staff care about them.[40]

These are repeated in the KLOE developed for the joint inspection framework for secure settings. However, it is unclear in what sense this KLOE scheme used in the inspection of IRCs. (See Section 4.) The relevant Expectation in the HMIP scheme is Expectation 55:

> [p]atients receive safe, accessible, caring and compassionate treatment, which is sensitive to their diverse needs, from competent staff in an environment which promotes dignity and maintains privacy.[41]

None of the indicators related to this Expectation are framed in terms of what those in detention say about their experience of the service. For example, the first indicator says: '[p]atients are treated with respect, compassion and cultural sensitivity while they receive care and treatment'.[42]

Whilst the distinction may seem to be a fine one, it is potentially one of considerable significance, particularly when it is placed in the context of the approach taken to evidence in the HMIP scheme. This is set out in the Inspection Framework, which explains there are five key 'sources' of evidence for the inspection.[43] The first is 'observation', which makes specific reference to the assessment of the quality of 'staff-detainee relationships'. The next source is 'detainees', and the importance of 'hearing the detainee voice' is stressed. This is followed by 'staff'. This is said to offer the opportunity to 'ask staff what they think really happens'. The next source is 'relevant third parties' and a few examples are given, which include voluntary groups and visitors who can be 'a good source of information'. The final source is 'documentation', which includes the records of people in detention.

The Framework goes on to explain that a 'triangulation' approach is to be taken.

> Inspectors will, wherever possible, base all inspection finding/judgements on the triangulation of multiple evidence sources. Triangulation, in this case, merely describes the corroboration of an evidence source by at least two other evidence sources (although sometimes an incident/perception will be important enough to stand alone).[44]

The problem with the triangulation approach is that it appears to require three different kinds of evidence sources to support a finding within a scheme where three of the five potential evidence sources are, to some degree, within the control of the IRC as an institution. Although the policy allows an exception to triangulation to be made, this is only triggered when there is something which is determined to be of sufficient importance (the meaning of which is not altogether clear). The standard approach requires triangulation. This has the hallmarks of an embedded systemic unfairness which may explain some of the issues identified in the approach to the voice of those in detention in HMIP reports. Nothing similar could be found in the CQC's account of the way it treats evidence when inspecting community healthcare services, and nothing found in any of the material considered which suggests that the inspection of healthcare in IRCs is exempted from the triangulation principle.

This apparent unfairness may be exacerbated by, and may exacerbate, another factor. There is some evidence of an institutionalised culture of disbelief in play. The Deputy Head of Healthcare at HMIP was interviewed as part of the investigation commissioned by G4S in response to the 2017 BBC Panorama programme showing staff at Brook House making derogatory remarks about people in detention and incidents of verbal and physical abuse.[45] In response to the investigation's finding that people in detention had a 'poor opinion' of healthcare, she said:

40 ibid 38.
41 HMI Prisons, 'HMIP Expectations for Immigration Detention, Criteria for Assessing the Conditions for and Treatment of Immigration Detainees Version 4' (2018) 48. <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/03/Immigration-Expectations-FINAL.pdf> accessed 20 April 2021.
42 ibid.
43 HMI Prisons, 'Inspection Framework' (n 2) 15–16.
44 ibid 16.
45 Kate Lampard and Ed Marsden, 'Independent Investigation into Concerns about Brook House Immigration Removal Centre' (2018) <https://www.g4s.com/en-gb/-/media/g4s/unitedkingdom/files/brook-house/brook_house__kate_lampard_report_november_2018.ashx?la=en&hash=42B2E56AD3E9946AC659516AB1D6D919> accessed 16 June 2021.

> [i]n most cases, what we have tended to find is, actually, it is not bad provision, and most of the time it is ending up as reasonably good in actual terms, but it is very different when you are living with this. Sometimes, what staff will say to me is that their perception is that some detainees will have an investment in being perceived to be particularly unwell or being more unwell than their clinical judgement is because if the judgement is that they are too unwell to be detained, therefore, they won't be detained and so healthcare are basically keeping them in. That is a big factor.[46]

If there is an institutionalised culture of disbelief, reliance on the views of staff who are working within that culture as evidence that detained people's views should be given limited weight involves a very worrying circularity and could influence the inspections themselves.

There is evidence that suggests that this theory (of an unchangeable inherent negativity on the part of people in detention which is of limited evidential value) should be treated with extreme caution. On the face of it, it is inconsistent with the variations in patient ratings of healthcare between IRCs and over time. The two centres with the lowest ratings were the very ones in respect of which the CQC took enforcement action because of breaches (in numerous ways) of the bare minimum fundamental standards imposed by regulations.[47] These demonstrated the greatest percentage improvements in patient approval across time in the reports considered in the above analysis.

Summary

The above analysis of the way that the patient voice is embedded within and used in the scheme for inspecting community healthcare services in comparison with the HMIP inspection framework suggests a further 'community equivalence' flaw in the process for inspecting IRCs.

One of the aims of the NHS Quality Outcomes Framework is to improve patient experience of GP services; it does not simply treat that experience as a source of evidence. This is reflected in the KLOE scheme used to inspect community GP services. However, it does not map through to the HMIP's Expectation indicators which appear to be the primary basis for quality assessment over and above the quality requirements of the fundamental standards embedded in the CQC's regulatory regime (see Section 4).

Furthermore, the use of triangulation methodology in the analysis of evidence appears to create what can be termed a systemic unfairness, which makes it more difficult for evidence from those in detention to be reflected in the findings made in the final report. This may be contributing to and/or exacerbated by an institutionalised 'culture of disbelief'.

There is an increased emphasis on listening to the patient's voice in the CQC's new strategy. It acknowledges that improvements need to be made, including making it easier for users of services and their advocates to provide feedback, improving the CQC's skills for reaching out to those whose voices are not often heard, and recording and analysing feedback in ways that help identify changes in the quality of care. Whilst this is to be welcomed, there is no mention of the specific hurdles to achieving those objectives which are embedded in the current scheme for assessing quality in IRCs. Unless these are addressed in the implementation of the new strategy, the risk is that community equivalence gap will be exacerbated by the reforms.

46 ibid 177.

47 A Requirement Notice was also issued to Yarl's Wood in 2017 but this was because of only one specific and serious issue – the employment of an unregistered doctor.

SECTION 7: THE ROLE OF VISITORS' GROUPS

The Care Quality Commission (CQC) describes people's experiences of care as being 'vital' to their work.[1] Their provider handbook for secure settings recognises that users of healthcare services in secure settings 'may find it difficult to voice concerns about their care'.[2] For that reason, it is said, '[i]t is particularly important in our work with this sector to maintain good relationships with local organisations and community groups that represent detainees and routinely gather their views'.[3] The CQC's strategies to securing that information are said to include '[e]ncouraging voluntary organisations that support detainees and their families to share information with the CQC on a regular basis'.[4] HMIP's Inspection Framework also identifies voluntary groups and visitors as 'good sources of information'.[5]

IRC visitors' groups are clearly one of the core organisations for this purpose for both the CQC and HMIP. The main purpose of a visitors' group is to visit and befriend those held in each immigration removal centre, and each has volunteer visitors who make regular visits to people in detention. A number also have casework staff who provide advocacy support to those detained. There are seven such groups in England who are supported through training, information and other resources by a national umbrella charity, the Association of Visitors to Immigration Detainees (AVID).[6]

1. **Gatwick Detainees Welfare Group (GDWG)**
GDWG was formed in 1995 when the government began to detain people at a small holding centre near Gatwick Airport. The following year, Tinsley House Detention Centre was built. They have seven members of staff and approximately seventy volunteers who befriend and support people in both Brook House and Tinsley House IRCs.
2. **SOAS Detainee Support (SDS)**
The SDS Group was founded as a society at SOAS in 2006. Membership now includes students from other London universities and non-students. SDS visits people who are being held in Harmondsworth and Colnbrook (Heathrow), Brook House and Tinsley House (Gatwick), and Yarl's Wood IRCs. They also visit people who are held in London prisons under immigration powers. There are two part-time members of staff.
3. **Detention Action**
Detention Action is a registered charity founded in 1993 and originally known as the London Detainee Support Group. Detention Action provides support for people who are detained at Colnbrook, Harmondsworth and Morton Hall IRCs and for people detained under immigration powers in prisons.
4. **Jesuit Refugee Service (JRS)**
JRS is an international Catholic organisation that works in over 50 countries around the world with a mission to accompany, serve and advocate for the rights of refugees and other forcibly displaced persons. JRS UK supports those detained for the administration of immigration procedures at Colnbrook and Harmondsworth IRC's. Their team of volunteers provides one-to-one visits, and a small team of staff offer pastoral care.
5. **Morton Hall Visitors Group (MHDVG)**
MHDVG was set up in Nottingham in 2011, shortly after the opening of Morton Hall IRC. Volunteers visit and provide support on a weekly basis to people detained at the centre. The group has one staff member.
6. **Sudanese Visitors Group**
The Sudanese Visitors Group is a project of Waging Peace, a charity that campaigns against human rights abuses in Sudan and supports Sudanese people in the UK. Waging Peace has three members of staff. The visitors' group was established in 2012. Their volunteers support and visit Sudanese people held in immigration detention and prisons across the UK.
7. **Yarl's Wood Befrienders (YWB)**
YWB was set up in 2000 by the then Bishop of Bedford, John Richardson, when work started on Yarl's Wood Immigration Detention Centre, now known as Yarl's Wood Immigration Removal Centre. The befrienders started visiting detained people as soon as Yarl's Wood IDC opened in 2001. YWB has six staff members and around sixty volunteers.

GDWG invited these visitors' groups to participate in an interview-based survey to explore what has been

1 Care Quality Commission, 'How CQC Regulates Health and Social Care in Prisons and Young Offender Institutions, and Health Care in Immigration Removal Centres: Provider Handbook' (July 2015) 20 <https://www.cqc.org.uk/sites/default/files/20150729_provider_handbook_secure_settings_0.pdf> accessed 17 June 2021.
2 ibid.
3 ibid.
4 ibid 18.
5 HMI Prisons, 'Inspection Framework' (March 2019) 16 <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/03/INSPECTION-FRAMEWORK-2019.pdf> accessed 20 April 2021.
6 See 'Welcome to AVID | AVID' <http://www.aviddetention.org.uk/welcome-avid> accessed 5 May 2021.

reported to them by people subject to detention with whom they have contact and their experience of the inspection process. Five responded, including the CEO of GDWG, who was asked the same questions. One staff member from each of four of the groups was interviewed, and two from the fifth. The survey revealed a consistent picture of reported poor quality healthcare across the estate, very little awareness in visitors' groups of the role of the CQC in the inspection of IRCs and shared concerns about the inspection process.

The visitors' groups - what do they say?

The standard of healthcare as reported by people in detention to visitor groups

The response of all interviewees was that people in detention report that healthcare is consistently poor, save for the service in Morton Hall. Healthcare was described by one group as consistently the second most common issue raised after access to a solicitor and their casework team frequently contacted healthcare teams about various issues.[7] A second group which visited two IRCs described it as 'not a great picture',[8] and a third group noted that they hear 'a lot of complaints'.[9]

Interestingly, the groups which visit Morton Hall had some positive comments to make. One group that said there have been fewer healthcare complaints and concerns in the last couple of years than historically and commented on work done generally on improving standards there. [10] However, they cautioned that this may not be reflective of wider experience in the IRC as they had only spoken to a small number of people in detention. Their sense that there may have been improvement reflects the detainee survey undertaken in as part of the 2019 inspection, which produced the highest overall quality rating from detained people of all the results from surveys for all IRCs since 2015 (though it should be noted that this is still only with 58.3% describing the quality of healthcare services as 'very good' or 'quite good'). (See Section 6.)

The groups illustrated their responses with a number of specific healthcare issues, including:

- failures to respond appropriately to serious physical health conditions such as hernias, back problems and kidney stones;
- inappropriate medication issues and failures to ensure the continuity of medication;
- difficulties with, including delays in, making appointments;
- detained people being disbelieved.

Information requests from CQC/HMIP

Only one interviewee (a policy officer) was aware that the CQC Provider Handbook says voluntary and community groups are encouraged to share information about healthcare on an ongoing basis.[11] One respondent said they had had very little communication with CQC specifically and suggested that the CQC could actively encourage input from visitors' groups, including making it clear how to submit information.[12]

Four of the five groups reported having been contacted for information by HMIP for the purpose of an upcoming inspection.[13] Two commented that they were not expressly asked anything specific in relation to healthcare,[14] although one said they were informed that the CQC would be involved in the inspection.[15] A third group forwarded a copy of a recent email invitation (late 2019) from an inspector which made no mention of healthcare.[16] The fourth group did not mention the kinds of issues raised by HMIP.[17]

The fifth group interviewee said that they only realised that providing information to the HMIP was possible as a result of attending a conference and had sent emails occasionally since, but they remained unclear about what issues should be raised and how and when to do so.[18] They had reported concerns about the use of isolation for someone with mental health problems which they were told would be logged for the next inspection However, they had not been working for the visitors' group at the time of the previous inspection and so were unable to comment on the inspection process.

7 Karris Hamilton, Interview with [1], (Telephone, 8 July 2020).
8 Karris Hamilton, Interview with [2], (Telephone, 21 July 2020).
9 Karris Hamilton, Interview with [3], (Telephone, 29 July 2020 and 27 January 2021).
10 Karris Hamilton, Interview with [4] (Telephone, 24 August 2020).
11 Hamilton (n 8).
12 Hamilton (n 7).
13 Hamilton (n 7) (n 8) (n 9); Tara Mulqueen, Interview with [5] (Telephone, 9 September 2020).
14 Hamilton (n 7); Mulqueen (n 13).
15 Mulqueen (n 13).
16 Hamilton (n 7).
17 Hamilton (n 10).
18 Hamilton (n 9).

None of the groups had a working relationship with the CQC; two described it as being 'non-existent'.[19] None of the organisations felt that the CQC or HMIP worked to maintain a relationship for the purpose of exchanging information about healthcare, although one did comment that perhaps they could perhaps do more about keeping in touch.[20] One commented that they did feel able to raise issues with the 'inspectorate' but it was clear that this was a reference to HMIP given that they had earlier explained that they did not have a working relationship with CQC and would not know how to contact them.[21]

The inspection process

The four groups able to provide information about the inspection process were contacted by HMIP by email.[22] One said they had been given a week to respond and a second 8 or 9 days.[23] Two said they received an email just before or on the first day of the inspection.[24] One was offered the opportunity to provide written information,[25] one offered a call with an inspector,[26] and two had a face-to-face meeting.[27] One was informed by the umbrella organisation AVID that they could ask for a meeting – the email they had received did not mention this. AVID contacted HMIP who agreed to meet them.[28]

Two spoke of a positive experience of the process in relation to an inspection of Morton Hall and one, which also visits other centres,[29] contrasted this with their experience of investigations in other centres of which they had experience.[30] A second group, which also visited the same additional centres, found the process to be 'better than nothing' but inadequate and lacking in depth.[31]

One group commented that they were only allocated 30 minutes for a meeting and this limited time was further diminished by a delayed start.[32]

One group mentioned taking material including case study examples, eight of which concerned healthcare and included the following cases:[33]

1. Two detained people had raised issues about the healthcare treatment they received for ongoing problems following alleged assaults by staff;
2. One detained person had complained that he was provided only with paracetamol in response to kidney pain and blood in his urine.
3. One detained person's operation had been cancelled because of his release from prison before being transferred to the IRC. On complaining to the IRC doctor about the pain he was experiencing he reported being advised to ring for help at night and pretend to be in severe pain in order to access hospital.
4. Another detained person complained of rude and dismissive behaviour by healthcare staff when he acted as an interpreter for another person in detention.

The group reported that the feedback they received was that the issues they were raising about healthcare were well-known to the inspectorate (i.e. they were not saying anything new or surprising). The HMIP did indicate that they would be prepared to follow up on some of the cases. The case studies had been anonymised because the group did not have consent from the detained persons. The group tried to obtain consent afterwards, but they found that a number of those whose case studies had been presented had been released and could not be contacted. They were able to pass on two case studies but did not receive any subsequent feedback.

Even in relation to Morton Hall, criticisms were made by one group of the process.[34] The group commented that had they had a more ongoing relationship with HMIP or the CQC they could have provided that information as and when it arose. They recalled that there was not much discussion about healthcare in the meeting that they had.

19 Hamilton (n 9) (n 10).
20 Hamilton (n 13)
21 Hamilton (n 7).
22 Hamilton (n 7) (n 8) (n 9); Mulqueen (n 13).
23 Hamilton (n 7); (n 8).
24 Hamilton (n 10); Mulqueen (n 13)
25 Hamilton (n 8)
26 Hamilton (n 7).
27 Hamilton (n 10); Mulqueen (n 13).
28 Mulqueen (n 13).
29 Hamilton (n 7) (n 10).
30 Hamilton (n 7).
31 Hamilton (n 8).
32 Mulqueen (n 13).
33 ibid.
34 Hamilton (n 10).

Follow up

We asked two questions about follow up: (1) whether the CQC or HMIP had ever followed up on issues they had raised with them about healthcare; and (2) whether the groups were aware of any instances where issues they had reported regarding healthcare had appeared in subsequent inspection reports.

In relation to the first, four said not. One interviewee reported an inconsistent approach. In the past, in connection with their work with another visitors' group, they were told by HMIP that others had raised similar issues, but they had never had any feedback otherwise.[35] It was unclear whether the feedback they had received had been about healthcare issues.

Of the four able to answer the second question,[36] one was unsure and the other three said not, at least in relation to healthcare.[37] One group identified a number of specific issues they had raised in their meeting with HMIP which were not mentioned in the subsequent inspection report.[38] These included:

- Cancelled medical appointments.
- Over-prescription of paracetamol
- Difficulties accessing doctors overnight.
- Food that is not appropriate for certain medical conditions.

None had had any experience of information they had provided leading to a focused inspection. (A focused inspection is one led by the CQC either to follow up on a previous inspection or to respond to a particular issue or concern.)

Consistency of inspection reports with visitors' groups' experience

The only positive response was from one of the two organisations able to comment on Morton Hall.[39] This is of interest given the improving feedback from those in detention at Morton Hall received by this group, and the fact that healthcare at Morton Hall has been given the most positive inspection assessments of all the IRCs since 2015, being assessed as 'good' in the two inspections in 2017 and 2019.[40] Three of the groups raised concerns about the disparity between the feedback about healthcare from those in detention and the conclusions in the inspection report .[41] The answer from one group did not seem to address the question.[42]

Two of the groups raised specific concerns about the transparency of the inspection process. One group commented unfavourably on the generality of the level of the inspection report.[43] Another said: 'I am not saying that detainees' views of healthcare's failings should be taken as gospel but it's not clear what standards IRCs are being compared to ....'.[44]

We considered the overall conclusions reached in recent inspections of each IRC and undertook a more detailed analysis of the Brook House Inspections in 2016 and 2019 to put these reflections into context.

The inspections have found that the overall quality of healthcare at each of the IRCs inspected twice since 2015 (save for Morton Hall) has improved. Colnbrook moved from being 'inadequate' in 2016 to 'reasonably good' in 2019.[45] Harmondsworth was found to be improving in 2015 and 'reasonable overall' in 2017.[46] Yarl's Wood healthcare was 'not sufficiently

35 Hamilton (n 7).
36 Hamilton (n 7) (n 8) (n 10); Mulqueen (n 13).
37 Hamilton (n 7); (n 8) (n 10); Mulqueen (n 13).
38 Mulqueen (n 13).
39 Hamilton (n 7).
40 HM Chief Inspector of Prisons, 'Report on an Unannounced Inspection of Morton Hall Immigration Removal Centre, 21-25 November 2016 (2017) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/03/Morton-Hall-IRC-2016.pdf> accessed 23 June 2021; HM Chief Inspector of Prisons, 'Report on an Unannounced Inspection of Morton Hall Immigration Removal Centre, 28 October – 15 November 2019' (2020) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/03/Morton-Hall-IRC-web-2019.pdf> accessed 23 June 2021.
41 Hamilton (n 7) (n 8); Mulqueen (n 13).
42 Hamilton (n 10).
43 Hamilton (n 9).
44 Hamilton (n 7).
45 HM Chief Inspector of Prisons, 'Report on an Unannounced Inspection of Colnbrook Immigration Removal Centre, 29 February – 11 March 2016' (2016) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2016/07/Colnbrook-Web-2016.pdf> accessed 23 June 2021. HM Chief Inspector of Prisons, 'Report on an Unannounced Inspection of Colnbrook Immigration Removal Centre 19 November - 7 December 2018' (2019) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/04/Colnbrook-web-2018.pdf> accessed 23 June 2021.
46 HM Chief Inspector of Prisons, 'Report on an Unannounced Inspection of Heathrow Immigration Removal Centre, Harmondsworth Site, 7-18 September 2015 (2016) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2016/02/Harmondsworth-web-2015.pdf> accessed 23 June 2021; HM Chief Inspector of Prisons, 'Report on an Unannounced Inspection of Heathrow Immigration Removal Centre Harmondsworth Site 2-20 October 2017' (2018) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/03/Harmondsworth-Web-2017.pdf> accessed 17 June 2021.

good' in 2015 but only requiring improvement in some aspects in 2017.[47] Brook House, as indicated in the Introduction, was found to have 'adequate' healthcare in 2016 and had improved to 'reasonably good' in 2019.[48] Tinsley House, which has only been inspected once in this period, in 2018, was found to have 'reasonable healthcare'.[49] In short, the message appears to be that healthcare had reached an acceptable standard in all IRCs (save perhaps for Yarl's Wood) by the time of their most recent inspections.

The two inspections of Brook House did find some problems with healthcare services, but these do not readily map onto the issues raised by people in detention. For example, in the 2016 inspection report there are several significant issues noted related to governance, including understaffing. It may be possible to infer that some of the issues raised by people in detention are symptomatic of 'chronic staff recruitment problems', but the report itself does not offer any such link or note in any detail the consequences of problems with staff recruitment.[50] Moreover, in relation to 'delivery of care', which would relate to many of the concerns raised by people in detention, there were no issues identified by the report. In relation to the delivery of mental health care, the report only notes very limited issues to do with having up to date training and hospital transfers under the Mental Health Act. GDWG's casework records, in contrast, suggest that access to appropriate mental health care is a common problem for people in detention. (See Introduction.) While the issues in accessing medication reported to GDWG in 2016 may be explained by the systemic issues identified by the inspection in the pharmacy, these specific issues or their impact on people in detention do not appear to have been addressed as part of the inspection. A comparison of the report of the 2019 inspection with GDWG's casework records shows a similar pattern. Some of the problems noted in governance arrangements could account for some of the concerns raised with GDWG, for example issues with staff recruitment and supervision. However, as above, there is no indication in the report of the consequences of these issues in terms of the service that people in detention receive. In 2019, there were no issues identified in relation to the mental health service provision, while the number of people in detention reporting such issues to GDWG persisted as the most common problem.

Listening to people in detention

The groups were asked whether "Overall do you feel that you/detainees are listened to by CQC and/or HMIP when concerns are raised about healthcare?"

One of the groups responded to the question as being one about detained people being listened to and said that although they may be being talked to, they are not 'listened to'.[51]

The other groups treated the question as one about whether they were being listened to. For one group the question was not relevant as they had not raised issues about healthcare in their contact with HMIP.[52] One group reported being listened to by HMIP in relation to what they said about Morton Hall and one other IRC (with which they had been involved, apparently during previous employment). One reported that information they had provided to HMIP appeared to be welcomed.[53] The fifth reported that they did not feel listened to in the inspection process although they had not raised issues directly with HMIP.[54]

The CQC's relationship with Visitors' Groups

It is clear from the interviews with the visitors' groups that they are not approached by the CQC for the provision of relevant information and that, although there is contact with HMIP for the purpose of an inspection that is underway, there is no real focus on healthcare.

47 HM Chief Inspector of Prisons, 'Report on an Unannounced Inspection of Yarl's Wood Immigration Removal Centre, 13 April 2015 – 1 May 2015 (2015) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2015/08/Yarls-Wood-web-20151.pdf> accessed 23 June 2021; HM Chief Inspector of Prisons, 'Report on an Unannounced Inspection of Yarl's Wood Immigration Removal Centre, 5-7, 12-16 June 2017' (2017) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/11/Yarls-Wood-Web-2017.pdf> accessed 23 June 2021.

48 HM Chief Inspector of Prisons, 'Report on an Unannounced Inspection of Brook House Immigration Removal Centre 31 October –11 November 2016' (2017) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/03/Brook-House-Web-2016.pdf> accessed 16 June 2021; HM Chief Inspector of Prisons, 'Report on an Unannounced Inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons 20 May - 7 June 2019' (2019) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/09/Brook-House-web-2019.pdf> accessed 16 June 2021.

49 HM Chief Inspector of Prisons, 'Report on an Unannounced Inspection of Tinsley House Immigration Removal Centre, 3-5, 9-11 & 16-19 April 2018 (2018) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/08/Tinsley-House-Web-2018.pdf> accessed 23 June 2021.

50 HM Chief Inspector of Prisons, 'Report on an Unannounced Inspection of Brook House Immigration Removal Centre 31 October –11 November 2016' (n 48) 35.

51 Hamilton (n 8).

52 Hamilton (n 10).

53 Hamilton (n 9).

54 Mulqueen (n 13).

One of the questions that we submitted to the CQC as part of our request under the Freedom of Information Act was:

> What is the process used by the CQC:
> 3.1. for obtaining information from local voluntary and community groups about healthcare in IRCs for the purpose of a specific inspection.[55]

In response the CQC confirmed that, despite what is said in the Secure Settings Provider Handbook:

> Information is not routinely gathered from voluntary or community groups prior to inspection, unless we hold intelligence that triggers a specific request to such a group.[56]

In our follow up meeting, this response was confirmed to include visitors' groups. Mention was made in that meeting of the CQC's expectation that relevant information provided to HMIP inspectors would be passed on, but, as noted above, the contact made by HMIP with visitors' groups does not include a focus on healthcare. However, in our meeting the CQC showed considerable interest in exploring the possibility of developing working relationships with visitors' groups in the future. Although the CQC would not be able to investigate individual cases, they would be interested in evidence of patterns of issues which arise regularly. It is difficult for them to identify patterns through a 'snapshot' inspection when those detained may be in that facility for a limited period of time.

As matters currently stand, the groups do not have a clear sense of what information it would be useful to collect and in what form. In reply to our 'freedom of information' question about how the CQC encourages local voluntary and community groups that support detained people to share concerns about healthcare on an ongoing manner, the CQC said that '[p]ublished information on our website encourages members of the public and others to share information about services with CQC. The health and justice team also work with some voluntary and community groups on an ad hoc basis'.[57] However, we were unable to find any detailed guidance on the website aimed at organisations such as visitors' groups about how to go about this.

Summary

The evidence is that the inspection process is currently missing information which could be of considerable significance. Visitors' groups could potentially provide more detailed accounts of detained people's experiences over a period of time which may well give a better sense of patterns of issues than an inspection snapshot based on the inspection survey and interviews with those who are detained. Interestingly, one such pattern may be the positive impact of improvement measures as noted by one visitors' group. Furthermore, the evidence would be provided by those with whom people in detention have built a relationship of trust. However, such organisations have not been provided with the active encouragement to provide healthcare-related material or the training to do so.

Having said this, as noted in Section 6, the CQC's new strategy acknowledges that improvements need to be made. There is a commitment to raise public awareness of the CQC and to improve feedback pathways.

'We'll make it easier for people, their families and advocates to give feedback in the most convenient and suitable ways for them whenever they want. We'll also enable those who act as trusted intermediaries to share feedback with us. Working with local communities, we'll make the most of existing sources of feedback so people don't have to repeat themselves.'[58]

The interviews carried out with Visitors' Groups for this report suggest that these improvements are much-needed in this sector.

Visitors' groups not only have a role to play in providing information that might be relevant to a specific inspection; they could also make a valuable contribution to reform to the inspection system. Unfortunately, it appears that they were not contacted to invite their response to the recent consultations (see section 3 at p 30).[59]

55 Karen Ashton, 'Request to the Care Quality Commission under the Freedom of Information Act 2000' (4 August 2020).
56 Care Quality Commission, 'Response Issued under the Freedom of Information Act 2000' (CQC IAT 2021 0094, 22 July 2020) 4.
57 Ibid.
58 Care Quality Commission, 'A New Strategy for the Changing World of Health and Social Care' (January 2021) 6 <https://www.cqc.org.uk/sites/default/files/Our_strategy_from_2021.pdf> accessed 27 October 2021.
59 Gatwick Detainees Visitors' Group was not aware of the consultations at the time they were undertaken and in November 2021 they contacted each of the other 6 visitors' groups. Each confirmed that they had not been aware of the consultations.

SECTION 8: THE INSPECTION REPORT

A single joint inspection report is written for immigration removal centres (IRCs). The structure and content is closely controlled by detailed, directive guidelines published by Her Majesty's Inspectorate of Prisons (HMIP): the '*Guide for writing inspection reports March 2018*' [the Report Writing Guide].[1] The very first paragraph makes it clear that it applies to all reports produced by HMIP and to all inspectors, both HMIP and to, what the Report Writing Guide calls, 'specialist inspectors', such as the Care Quality Commission.

This section explores issues that arise that have implications for community equivalence:

1. There is stark contrast in length between the healthcare section in HMIP reports and the CQC reports of inspections of community GP practices.
2. The CQC produces an 'inspection evidence table' for its inspections of community GP practices which is structured by reference to its key lines of enquiry (KLOE) and which is drawn on for the purpose of reaching rating conclusions. There is nothing equivalent in the reporting of healthcare inspections in IRCs.
3. In the IRC inspection report, aspects of what are KLOE for CQC community healthcare inspections are dealt with in sections separate to that which addresses healthcare.

These issues have implications for the transparency (and therefore the fairness) of decision-making and for the capacity of the process (as one which must handle a large quantity of a range of material) to ensure that all relevant material is taken into account in relation to each aspect of healthcare under inspection.

Healthcare: the length of the report

The HMIP guidelines allocate 2050 words to the healthcare section of the report.[2] The 'Healthcare' section is four pages in length in the 2016 Brook House inspection report and six pages in the 2019 report.[3] This material draws on the evidence set out in annexes, such as the survey of those in detention, but the additional material here that deals with healthcare is quite short. By way of contrast, the CQC report on a GP practice consists of a summary report supported by a report on the evidence gathered. Whilst the former is usually 3 or 4 pages in length (if the service is rated as 'Good'), it is only a summary of overall findings, which are based on the evidence set out in the separate report, which is much longer. The average length of the evidence report for the 10 practices rated as 'Good' and selected for the purpose of the analysis reported chapter 7 is 38 pages (rounding down).

Whilst the length of a report may not indicate a deficiency in the thoroughness of the underlying investigation, it does risk adverse impact on accountability. The striking nature of the difference here, particularly when put in the context of the difference in structure (see below), suggests a loss of detail which does impact on clarity and transparency of decision-making. Transparency is vital to accountability and can lead to unfairness if insufficient reasons are given for the conclusions reached. One visitors' group in their interview[4] commented that it was not always possible to understand why the inspectorate had reached its conclusion, and another[5] commented unfavourably on the generality of the inspection report.

Restrictions on length can also mean that only the most serious issues are included; those with less significant impact may not 'make the cut' thereby reducing the effectiveness of the inspection in securing improvements.

Reporting of evidence

As mentioned, the CQC's reports on community GP practices are in two parts. The first part is the inspection report itself which details the overall ratings awards with a summary of the reasons for

1 HMI Prisons, 'Guide for Writing Inspection Reports' (March 2018) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/03/4.-GUIDE-FOR-WRITING-INSPECTION-REPORTS-March-2018-1.pdf> accessed 17 June 2021.

2 ibid 20.

3 HM Chief Inspector of Prisons, 'Report on an unannounced inspection of Brook House Immigration Removal Centre 31 October –11 November 2016' (2017) <https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/brook-house-immigration-removal-centre/> accessed 16 June 2021; HM Chief Inspector of Prisons, 'Report on an unannounced inspection of Brook House Immigration Removal Centre by HM Chief Inspector of Prisons 20 May - 7 June 2019' (2019) <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/09/Brook-House-web-2019.pdf> accessed 16 June 2021.

4 Karris Hamilton, Interview with [1] (Telephone, DATE)

5 Karris Hamilton, Interview with [3] (Telephone, DATE)

these awards and any action required. The second part is the 'Evidence Table',[6] which sets out the evidence relied on when arriving at the ratings decisions. It has a standard format, structured by reference to each key line of enquiry. The standard format includes space for setting out any additional evidence over and above the standard CQC Insight data (see Section 5), and this includes that provided by the GP practice, such as their responses to adverse material. The provider handbook comments that '[s]eparate evidence tables help make the reports shorter and more accessible'.[7]

The IRC joint inspection report is drafted in accordance with HMIP's Report Writing Guide which contains considerable directive detail about content, style and structure but no guidance on setting out the evidence in support of findings.[8] The CQC's Secure Settings Handbook[9] says of its contribution to the joint inspection report:

> We will provide an appendix to the report to include a short summary of our findings focused on each of the key questions that CQC asks of services. This will clearly set out our assessment of whether services are safe, effective, caring, responsive and well-led. We will present any evidence about breaches of regulations and the actions that we require from providers.[10]

This does not sound as though it was intended to replicate exactly the same structure used for GP practice reports. But, in any event, no such appendices are to be found for any of the IRC reports since 2015. In response to the written 'freedom of information' question asked about this appendix, the CQC explained that the restriction on word count had made it impossible to produce it:

> Due to the style and limited word content of joint reports, we are unable to publish a summary against the five key questions. However, we report by exception and publish a summary of any regulatory breaches and require the relevant registered provider to respond to the regulatory notices in line with our published enforcement policy.[11]

Structuring by healthy establishment area – the risk of evidence silos

The subject of 'Healthcare' is located in the joint inspection report as one aspect of the healthy establishment area of Respect, which also contains under its umbrella, but in a separate subsection, 'Staff-detainee relationships'. Other issues, such as safeguarding, are covered elsewhere. Both are relevant to the CQC's KLOE.[12]

The HMIP Guide for Inspectors recognises the risk of evidence silos and encourages the sharing of evidence between inspectors, saying that '[o]ther inspectors may have further key evidence which is relevant to the area of inspection'.[13] It suggests that: '[t]he indicators section in the Expectations will highlight where this is essential to create a fuller evidence source'. But no express guidance of this kind could be identified in the Expectations publication. There are 78 Expectations for IRCs for adult men, each of which has a number of indicators. The total is over 750. Given this quantity of material, reliance on these indicators to identify when evidence from other areas may be relevant appears to be a rather weak safeguard. No other process safeguard addressing the 'silo' risk could be identified.

Evidence silos could account for some missing cross-referencing in the 2016, and 2019 Brook House reports. A systematic analysis has not been undertaken, but a number of issues of failures to refer to evidence in other sections, for example, in connection with safety and staff-detainee

6 Care Quality Commission, 'How CQC Monitors, Inspects and Regulates NHS GP Practices' (2019) 18 <https://www.cqc.org.uk/sites/default/files/20191104%20How%20CQC%20regulates%20primary%20medical%20services%20GP%20PRACTICES_MASTER.pdf> accessed 23 April 2021.
7 ibid.
8 HMI Prisons, 'Guide for Writing Inspection Reports' (n 1).
9 Care Quality Commission, 'How CQC Regulates Health and Social Care in Prisons and Young Offender Institution, and Health Care in Immigration Removal Centres Provider Handbook' (July 2015) <https://www.cqc.org.uk/sites/default/files/20150729_provider_handbook_secure_settings_0.pdf> accessed 20 April 2021.
10 ibid 29.
11 Care Quality Commission, 'Response Issued under the Freedom of Information Act 2000' (CQC IAT 2021 0094, 22 July 2020) 7.
12 Care Quality Commission, 'Key Lines of Enquiry, Prompts and Ratings Characteristics for Healthcare Services' (2018) <https://www.cqc.org.uk/sites/default/files/20180628%20Healthcare%20services%20KLOEs%20prompts%20and%20characteristics%20FINAL.pdf> accessed 23 April 2021.
13 HMI Prisons, 'Guide for Inspectors' (2018) 21 para 2.85 <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/01/2.-GUIDE-FOR-INSPECTORS-January-2018.pdf> accessed 6 May 2021.

relationships, were noted when considering how reports had incorporated 'the patient's voice' (see Section 6).

Summary

The inspection of healthcare in a secure setting receives significantly less attention in the written report than it does in the stand-alone report of community healthcare inspections. Whilst this is not surprising given the breadth of the areas to be covered by the HMIP inspection, it risks a loss of transparency and accountability, which is of concern.

That concern is exacerbated by the differences in structure between the two types of reports. The community GP reports provide a detailed account of evidence structured by reference to the key lines of enquiry. Although the CQC intended to have what appears to have been some kind of additional summary annexed to the HMIP report, limits placed on the word count available for the healthcare section prevented this from being implemented. Not only does this risk a reduction in accountability, thus impacting on fairness, but it removes an important decision-making support tool. The requirement to articulate the evidential basis is an important mechanism which promotes quality decision-making.

The structure of the HMIP report risks the creation of evidence silos such that relevant evidence may not always be identified which might inform lines of investigation or support findings drawn on for the purpose of reaching conclusions about the quality of the healthcare service. No robust embedded process was identified that would ensure relevant information in other sections is identified.

In its new strategy the CQC says that it will move away from producing lengthy reports after inspections, but the restrictions on length and other issues arising from the current joint approach to reporting on IRCs are not addressed. The issue is less about length per se than about the impact of these issues on community equivalence in the transparency and accountability of decision-making.

CONCLUSION

We embarked on this piece of work looking at the question of whether there is a standard of healthcare which those in IRC detention are entitled to expect, in a legal sense as opposed to the fulfilment of a moral imperative or best practice aspiration. The community equivalence principle was not hard to find. The more complex issue has been whether the statutory inspection scheme, which monitors and assesses quality, operates systemically in way that delivers against that standard. We concluded that it does not. This is not a matter of poor-quality inspections, but of systemic issues that require reform.

The first (and perhaps most fundamental) issue is that the IRC inspection scheme is unable to make use of the ratings scheme utilised in the assessment of the quality of community healthcare providers. This makes it difficult to make the comparisons that an 'equivalence' principle requires. The document explaining the decision to exclude IRCs from the ratings approach when the relevant legislative reforms were under consideration (and which brought most other forms of healthcare within its scope) made no reference to the community equivalence principle.[1]

It is very far from clear that the joint inspection scheme that the CQC operates with HMIP replicates the standard that the CQC uses in the community to perform its quality assessment function (from which IRCs are excluded), as opposed to its registration function. It not only lacks the transparency required by a principle that demands equivalence, but our comparative analysis of the schemes found significant gaps. We also found that the scheme for IRC inspection does not provide for a systematic collection of data that would allow for comparisons to be made.

The patient view is not given community-equivalent status in the IRC scheme. Not only is it not treated in and of itself as a characteristic of quality, but it falls to be considered in a 'triangulation' methodology that creates a presumption that it will be outweighed by staff views, staff records and 'on notice' observation of staff performance if these mutually corroborate. There is no recognition in the scheme of the risk of evidence contamination by the culture of disbelief which has been noted in many reports and which is itself frequently a subject of patient complaint in IRCs.

We have made a number of specific recommendations for reform in the Executive Summary which we do not repeat here, save for that which provides the overarching theme. 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'.[2] Until that resource exists and is embedded in the inspection scheme, public trust and confidence in the reality of community equivalence is unlikely to be established and, against the test of systemic lawfulness, inspections risk being found wanting.

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. It is vital that those with experience and expertise in the IRC sector are fully engaged at this early stage.

1 Department of Health, 'New Regulations to Expand the Scope of Performance Assessments of Providers Regulated by the Care Quality Commission: Response to the Consultation' (December 2017) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/670448/NEW_Master_Copy_Consultation_Response.pdf> accessed 23 April 2021.

2 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. 15

ANNEXES

1. Interview schedule used with Gatwick Detainees Welfare group visitors

1. How long have you been involved in visiting immigration detainees?

2. How many people in detention in total would you estimate you have visited?

3. What's your estimate of the proportion (as a percentage) of the total number of detainees you have visited who have raised concerns about the healthcare service in detention? E.g. issues such as delayed appointments, issues with prescriptions, delays in getting medication, rude healthcare staff, etc.

4. Has that changed during the time you have been visiting? [Has it got better /worse/ remained the same?]

5. What are the most common issues with healthcare that people you support currently raise? Please note the top three in the last 12 months.

2. Interview schedule for Visitor Groups

1. What do detainees tell you about the standard of healthcare in your IRC?

2. The CQC Provider Handbook says voluntary and community groups are encouraged to share information about healthcare on an ongoing basis in relation to 'concerns, complaints and whistleblowing'. Are you aware of this?
   a. Have you been invited or encouraged to share regular information concerning these matters (by either HMIP or CQC)? If so, how did CQC/HMIP go about this?
   b. What (if any) is the process for sharing this kind of regular feedback?
   c. Do you share information about healthcare with CQC or HMIP outside of the inspection process?
   d. If yes, how regularly?
   e. If yes, in what form is the information you share provided to CQC or HMIP?

3. Have you ever been contacted in advance of or during the course of an inspection to provide information about healthcare by either HMIP or CQC? If yes, please describe your experience and answer the following.
   a. How much notice were you given in advance of having to share healthcare information?
   b. In what form were you contacted?
   c. What kind of opportunity were you given to provide information?
   d. Did you feel this opportunity was meaningful?
   e. Would you be willing/able to share with us the information about healthcare shared with CQC/HMIP in the 12 months before the last inspection?

4. Have you ever reached out to either CQC or HMIP regarding the healthcare services in the IRC? If so, how were you received? Please provide detail e.g. waiting time for a response (if one given), or other information relevant to your experience.

5. if you have had contact with CQC or HMIP (whether initiated by them or you), has either ever followed up on issues you raised with them about healthcare?
   a. If so, how did you discover the result of your contact? For example, was feedback provided?

6. Are you aware of any instance(s) where issues you have reported [regarding healthcare] have appeared in subsequent inspection reports?
   a. Are you aware of any instance(s) where something you have reported [regarding healthcare] has led to a focused inspection?

7. Do recent inspection reports adequately reflect your organisation's experience and your knowledge of detainees' experiences, of the standard of healthcare in the IRC? Please provide detail to accompany your answer.

8. Overall do you feel that you/detainees are listened to by CQC and/or HMIP when concerns are raised about healthcare?

9. How would you describe your relationship with HMIP and CQC?
   a. Do you feel as though CQC/HMIP work to maintain a relationship with your organisation in order to regularly exchange information about health care? Please explain your answer, including if yes how this is done.

3. CQC reports used in analysis of community GP practice reports

Reported rating: Good	Reported rating: Requires Improvement	Reported rating: Inadequate
Alexandra Surgery 25/03/2019	Lilyville @ Parsons Green 19/12/2019	Dudley Wood Surgery 13/03/2020
Groby Surgery 24/12/2019	The Willow Tree Surgery 27/01/2020	Bridgemary Medical Centre 01/04/20
Dr R Ali Surgery 23/07/2019	Emersons Green Medical Centre 21/05/2020	Custom House Surgery 19/11/2019
Collingwood Family Practice 02/03/2020	Dr A S Pannu & Partners 01/04/2020	Dr Ravindrasena Muthiah 23/04/2020
Holly Tree Surgery 15/01/2020	Dr Yousef Rashid 26/11/2019	Eastern Avenue Medical Centre 20/04/2020
Ashover Medical Centre 10/10/2019	Sudbury and Alperton Medical Centre 01/04/2020	Swanpool Medical Centre 12/03/2020
Dr PV Gudi and Partner 08/04/2019	Newcastle Medical Centre 30/01/2020	Mevagissey Surgery 14/04/2020
Dr Saramma Samuel 10/06/2019	Clayhill Medical Practice 31/10/2019	Rishton and Great Harwood Surgery 02/01/2020
Dr Parmod Luthra 01/04/2020	Ashington House Surgery 22/01/2020	The Practice Bowling Green Street 18/09/2019
GP at hand 21/05/2019	Ashton Medical Group 02/12/2019	Nuffield House Doctors Surgery 24/12/2019

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--, 'Report on an Unannounced Inspection of Colnbrook Immigration Removal Centre, 29 February – 11 March 2016' (2016).

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