Stakeholder Engagement 13
The Care Quality Commission (CQC)
Fergus Currie

Background on role of CQC in Custodial Settings

The remit of the CQC includes health as it relates to the CJS. This includes providing an integrated framework for Secure Training Centres, prisons and Young Offender Institutions, Immigration Removal Centres and Police Custody. Inclusion of prisons is relatively recent and CQC role here is still being developed. The CQC currently looks at Registered Services within a prison and will check for compliance with regulations. CQC also contributes to HMIP inspections although a more integrated inspecting and reporting approach is being developed.

CQC liaise with NHS England staff in relation to the establishment that is being inspected and the associated recommendations and any relevant aspects such as the identification of health needs through assessments or the commissioning processes.

CHARACTERISTICS OF 18-24 YEAR OLDS

It was suggested that there needs to be better acknowledgement of the range of health problems and needs of this age group. A comprehensive assessment should be carried out, that includes alcohol and drug issues and how the problems associated with these are manifested. If the cause of the addiction is not dealt with in custody, then the problems will continue on release. A cognitive assessment is good for identifying if the young person understands why they are where they are and what is happening to them; knowing this helps to reduce vulnerability.

Once offenders reach 18 years of age and move from the youth estate, they don't get the same level of services for mental health and personality disorder issues. Where there are dedicated transition workers the move can work well. When they are care leavers there are often more services available.[1]

Intercollegiate Standards are being incorporated into the commissioned health services in under 18 establishments. However, there is nothing in particular targeted for the 18 – 24 year olds and the significant reduction in levels of support offered at 18 can have a negative impact.

[1] CQC drew attention to the joint report which highlights the problems of transition but also indicates some good practice examples:
http://www.justiceinspectorates.gov.uk/hmiprobation/inspections/transitions-an-inspection-of-the-transitions-arrangements-from-youth-to-adult-services-in-the-criminal-justice-system-october-2012/

ACCT

ACCT doesn't currently feature heavily in CQC work, although this will be looked at more in the future when healthcare is inspected more holistically by CQC and HMIP. The healthcare contribution to ACCT ought to become part of CQC inspections going forward.

INFORMATION SHARING

Information sharing could be improved for young people coming into a secure setting. An adult equivalent to the Comprehensive Health Assessment Tool (CHAT), which allows for information to be transferred electronically, would be helpful. Often there is only partial information so there is no holistic view of what has taken place or needs to be recognised.

Health Reports, Probation Reports etc, should be sent electronically to a single point of contact to ensure greater level of consistency in IT services and an integrated record. Currently, the lack of shared perspectives means that information does not always align. Different lines of accountability and authority can stop information being shared effectively.

Health is important to the overall well-being of a prisoner. A young adult's state of health and/or mental health might impact on their ability to interact effectively with training or education, so these issues should be considered together and not in silos.

The impact of the secure environment on health is often most critical at the transition points i.e. community to prison and back to community; there is a lack of continuity at these points.

HEALTH AND MENTAL HEALTH

The CQC is working at mapping standards in prisons against CQC standards, as these are currently separate. They are preparing to look at prison health work against 5 domains, which will be mapped to the shared standards, including mental health in-reach services in prisons.

There is a new approach in the community to ensuring that frontline staff meet CQC standards. Professor Steve Field is working to ensure that this is replicated in prison healthcare so that staff have the professional expertise to support the inspection process. Currently there is only one inspector looking at CQC standards, but the CQC aims to have a range of inspectors to match those in the community.

Current inspections are not capturing everything, so they may not give a complete and holistic picture of the quality of health provision in an establishment. CQC are working toward improving the effectiveness of inspections.

Personality Disorder, Autism, ADHD or learning disabilities may not currently be explicitly considered by the CQC in an individual inspection. However, CQC are working with field experts to develop a more comprehensive inspection module to use in prison inspections.

Services from Child and Adolescent Mental Health Services (CAMHS) have improved more recently but there are still concerns that young people can't engage properly without support. Attempts to maintain engagement are not universal and this can lead to an escalation in behaviour problems. The CQC inspects CAMHS in the community, but currently

there is not a sufficient tie-in to these services in the CJS. This link needs to be further developed.

While CQC has not picked up evidence of BME discrimination affecting access to health pathways, they feel there is evidence relating to women and girls. A thematic review that is being published, for example, has found that not enough attention is being given to their sexual exploitation.

It is difficult to safeguard against the misuses and abuse of medication and staff need to be vigilant against the risky aspects and monitor use. The CQC look for evidence of substance abuse and will develop inspections to take on board the role it plays in vulnerability. There are Enforcement Notices to improve compliance around the rules to prevent the trafficking of prescribed medication and New Psychotic Substances.

The CQC has some concerns, which have grown since joint commissioning of health services by NHS England, NOMS and Public Health England. Interventions, for example, seem to be far more to do with management than treatment, particularly for people with short sentences. Also there needs to be continuity of services 'Through the Gate'; the quality and availability of these services is variable. It is best practice to set these up well in advance of the discharge date. If there is no continuity of support, recidivism and a return to custody will result.

The CQC would like to see:

- A more person centred approach to individual needs and this should be linked to universal services in the community;
- A better system for identifying if the needs of the person can be met in the prison setting;
- Notification of release date and time to the prisoner, as a lack of clarity caused great anxiety.

FAMILY ENGAGEMENT

Families have difficulty getting to secure settings. They should be kept in the loop to allow an opportunity for them to support the young person.

CQC think that being far from home can have a negative effect on the well-being of a young person. Large Secure colleges are likely to make these problems worse.

LEARNING FROM A SELF-INFLICTED DEATH IN CUSTODY

Currently there isn't anyone in the CQC with direct responsibility for learning from self-inflicted deaths in custody. CQC will look to include this in integrated inspections with HMIP. It needs to be looked at corporately. The CQC's responsibility is to look at services and there is an accountability gap with no one being responsible with auditing whether recommendations following a death in custody are followed up. A stronger relationship needs to be developed with HMIP so that CQC becomes aware of any health themes that they see developing. One of the issues around this will be getting the right information so that CQC can do something with it. The CQC is not currently able to enter the prison alone but they could go back and inspect with HMIP.

Legislation requiring all CJS to work jointly would be useful. The CQC do not automatically receive Preventing Future Deaths reports and usually only see them through HMIP health inspectors. CQC would like to be properly integrated with the HMIP health inspectors.

ALTERNATIVES TO CUSTODY

There are problems with getting and sharing information. The Forensic Medical Service, delivered in police custody, is patchy and where an 'appropriate adult' is provided this is not always of a good enough standard. A Thematic Report on Police Custody showed problems with adequate training for front line services. The CQC undertake inspections of Police Custody with HMI but they are not as involved as they think they should be.

Although the Comprehensive Health Assessment Tool (CHAT) can provide a lot of information, people are admitted to prisons late at night and not enough time is allowed to review the information. Staff members tend to be tired and so information is not properly considered. Clearer and better quality information could be more effectively understood.

The CQC would like a specific training package for all front line staff in the CJS to enable them to more effectively assess the individual they are speaking to.

There has been an improvement in diversion from custody schemes for young people and young adults, but these are not universally available.