How CQC regulates

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

Provider handbook

July 2015

The Care Quality Commission is the independent regulator of health and adult social care in England

CQC's purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve.

CQC's role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and publish what they find, including performance ratings to help people choose care.

Our values

- Excellence – being a high-performing organisation
- Caring – treating everyone with dignity and respect
- Integrity – doing the right thing
- Teamwork – learning from each other to be the best we can.

Her Majesty's Inspectorate of Prisons (HMI Prisons)

HMI Prisons' purpose

HMI Prisons ensures independent inspection of places of detention, reports on conditions and treatment and promotes positive outcomes for those detained and the public.

HMI Prisons' role

The statutory responsibility of the HM Chief Inspector of Prisons is to report on the treatment of and conditions for prisoners in England and Wales and immigration detainees in the United Kingdom (UK). HMI Prisons also inspects court, police and customs custody facilities with Her Majesty's Inspector of Constabulary (HMIC), and secure training centres with Ofsted. By invitation, HMI Prisons inspects some military detention facilities and places of detention in other jurisdictions.

HMI Prisons' principles

Ensuring human rights is at the heart of its work. HMI Prisons is the coordinating body for the UK's National Preventive Mechanism (NPM), which monitors places of detention in the UK under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

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Foreword from CQC's Chief Inspector of Primary Medical Services and Integrated Care

CQC's role in monitoring, inspecting and regulating health care in secure settings is important. People who use services in secure settings are generally more vulnerable because they rely on authorities for their safety, care and wellbeing, 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.

Our new approach to regulating care in prisons, young offender institutions and immigration removal centres will support CQC and HMIP to develop a holistic and coherent view of health within these settings. CQC will hold providers to account but we will also work together with HMIP to identify wider health issues within secure settings. This will be facilitated by the strong working relationship we have with HMIP in this sector. I am confident that the new approach draws on the strength of our respective organisations and recognises the expertise that we both have in this area.

Professor Steve Field CBE FRCP FFPHM FRCGP

Chief Inspector of Primary Medical Services and Integrated Care, CQC

Supporting statement from HMIP's Chief Inspector of Prisons

We know that the previous histories of people in all types of detention mean that their health is likely to be worse than that of the population as a whole – and all too often the general environment in places of detention does little to promote good health.

Good healthcare that is equivalent to that available in the community is important not just in caring for people while they are detained but also in helping promote constructive, healthy lifestyles after release that benefit the whole community.

Inspection has an important role in helping to ensure this happens. At HMIP we know that the effectiveness of inspection is enhanced when agencies work together. The method we outline in this handbook is designed to further integrate our respective approaches with the intention of continuing to assure good health and social care outcomes for detainees and avoid duplication of inspection activity.

Nick Hardwick CBE

HM Chief Inspector of Prisons

Introduction

This handbook describes our approach to regulating and inspecting health and social care in prisons and young offender institutions (YOIs) (prisons for young people aged 15-21), and health care in immigration removal centres (IRCs) (holding centres for detainees awaiting decisions on their residency status or deportation following an unsuccessful application). In this document we refer to these as ‘secure settings’.

Our approach has been developed through consultation and pilot testing. We have worked with HMIP, providers and organisations with an interest in our work to develop it.

We will continue to learn and adapt as we put our approach into practice. However, the main aspects of our approach, such as the five key questions we ask of all services and the key lines of enquiry for each of these questions, will remain constant.

A joint approach

CQC and HMIP will work together with a shared aim to protect and promote the interests and rights of people who use health and social care services in secure settings. A focus of the new approach to inspection is to gather and use the experiences of detainees, and the views of their families and those close to them about the quality of their care. When we carry out a joint inspection, CQC and HMIP remain separate bodies with separate powers and functions.

- HMIP’s responsibilities are to inspect and report on conditions for, and treatment of, those detained in prisons and other places of custody.
- CQC’s responsibilities are to monitor, regulate and inspect the providers of health care within secure settings. From April 2015 this will include adult social care provision.

Although CQC has the legal right to inspect registered health care providers, we enter secure settings under the powers granted to HMIP.

As independent monitoring and inspecting bodies, CQC and HMIP both have responsibilities as members of the UK's National Preventive Mechanism (NPM) to prevent ill treatment of people in prison. The NPM is required under the international human rights treaty and the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

Jointly, we will hold providers to account and we will work together to identify wider health issues within secure settings. In IRCs, for example, one critical issue relates to how general staff, not primarily employed by a registered provider, deal with people who are at risk of suicide or self-harm.

The approach will allow CQC and HMIP to share information, reduce duplication and minimise the burden on providers. It will bring together:

- CQC's operating model, including the five key questions we ask about services.
- Elements of HMIP's criteria for assessing the treatment of detainees and conditions in secure settings, known as 'expectations'.
- The Royal Colleges' 'Healthcare Standards for Children and Young People in Secure Settings'.

This will ensure a robust and consistent inspection framework which our inspectors will use to assess services.

Our initial focus is on prisons, YOIs and IRCs because since April 2013 the health services in these settings are all commissioned in the same way through NHS England and our inspections of these settings are conducted with HMIP. The Care Act 2014, which came into force in April 2015, gives local authorities the responsibility for assessing the social care needs of all adults who are in custody in their area and providing or commissioning care and support to meet identified needs. The Care Act 2014 does not cover IRCs so our inspection approach covers both health and adult social care (for people aged 18 and over) in prisons and YOIs but only health care in IRCs. The approach set out in this handbook is based on the same principles and key questions which underpin our inspections of both health and social care providers in the wider community.

1. Our framework

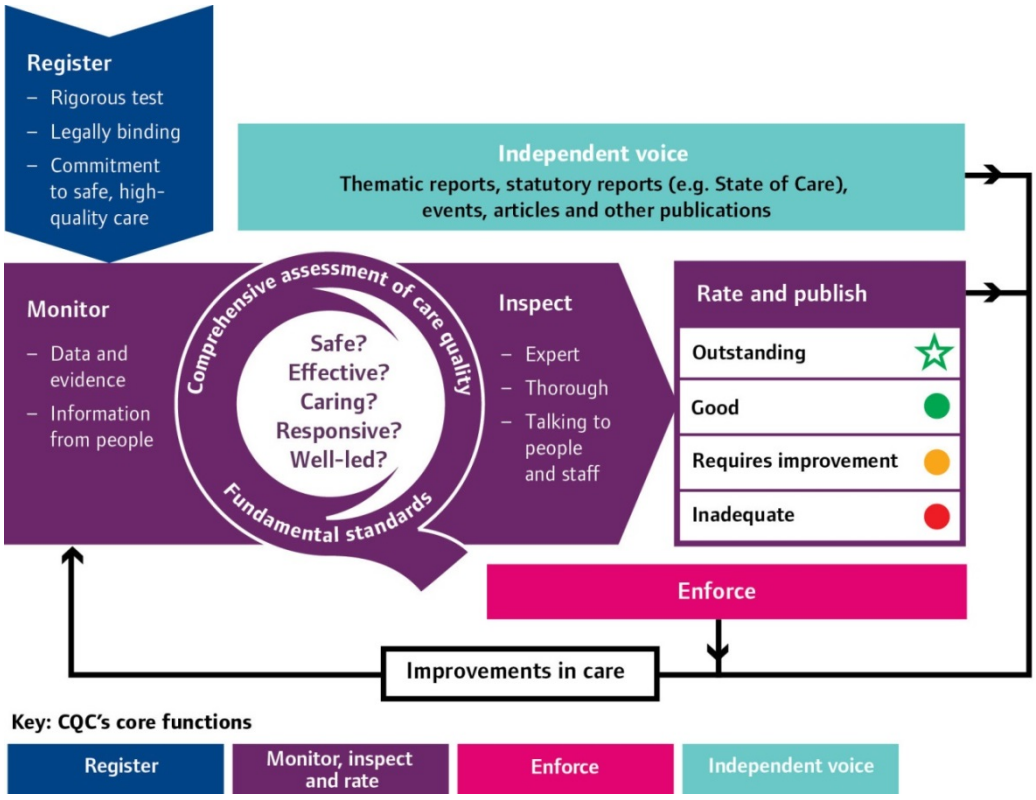
CQC's operating model

Although we inspect and regulate different services in different ways, some common elements guide our operating model across all our work. These include:

- Registering those that apply to CQC to provide services.
- Continuous monitoring of local data, shared intelligence and risk assessment.
- Using feedback from the general public and people who use services to inform our judgements about services.
- Inspections carried out by experts.
- Information for the public on our judgements about care quality.
- The action we take to require improvements and, where necessary, the action we take to make sure those responsible for poor care are held accountable for it. Our enforcement policy sets out how we will do this.

Our model is underpinned by the new fundamental standards that came into force on 1 April 2015. We have published Guidance for providers on meeting the regulations to help providers understand how they can meet the new regulations.

Figure 1: CQC's overall operating model



Please note that this is the overall CQC operating model and, unlike some sectors that CQC regulates, we will not be rating services provided in secure settings from 2015/16, although we may do so in the future.

While we are adopting the principles and key elements of the overall operating model in our new approach to inspecting in these secure settings, some of the details will be different to the methods used in other sectors that we regulate.

Registering those that apply to CQC to provide services

Before a provider can begin to deliver services, they must apply to CQC for registration and satisfy us that they are meeting a number of registration requirements.

Registration assesses all new providers, whether they are organisations, individuals or partnerships, to see if they have the capability, capacity, resources and leadership skills to meet relevant legal requirements, and are therefore likely to demonstrate that they will provide people with safe, effective, caring, responsive and well-led care.

There are usually multiple providers of health and social care in secure settings. Not all are required to register with CQC because many of the services, such as counselling and specialist psychological therapy services, are outside the scope of registration, just as they are in the wider community.

All providers of regulated activities within prisons, YOIs and IRCs must apply for registration with CQC. Sometimes the provider will need to register the prison, YOI or IRC as a location but this is not always the case and will depend on whether the service provided meets the criteria set out in our guidance: 'What is a location?'.

From April 2015, in addition to health care, there will be providers of adult social care within prisons and YOIs that may need to apply for registration with CQC.

Intelligent use of data, evidence and information to monitor services

To make the most of the time that we are on site for an inspection, we must make sure we have the right information to help us focus on what matters most to people. This will influence what we will look at, who we will talk to and how we will configure our team. We will analyse data from a range of sources including information from detainees, HMIP, other stakeholders and service providers. We will also use the information we gather as evidence when we make our judgements about the standards.

Inspections

CQC will work with HMIP and inspect every provider who delivers registered services within the secure setting during a scheduled prison inspection. This is a significant increase in inspection activity for CQC. In line with HMIP's current scheduling framework, prisons are inspected at least once every five years. In practice, inspections are intelligence led and are often more frequent; we will usually inspect a prison at least every two to three years. We will inspect young offender institutions (YOIs) annually and immigration removal centres (IRCs) at least once every four years, and usually every two years.

CQC can carry out responsive inspections based on intelligence from CQC or HMIP or any concerns about a service. CQC will lead the inspections with support from HMIP where necessary.

Joint inspection framework

CQC and HMIP have worked together to create a joint inspection framework for health and social care services within secure settings. The joint inspection criteria maps HMIP's 'expectations' and the Healthcare Standards for Children and Young People in Secure Settings to CQC's five key questions to create a standard set of key lines of enquiry (KLOEs).

Having 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.

Inspection 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.

HMIP and CQC inspectors will record evidence using a shared template that addresses CQC's five key questions.

The five key questions CQC ask

To get to the heart of people's experiences of care, the focus of CQC inspections is on the quality and safety of services, based on the things that matter to people. 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.
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.

HMIP's expectations

HMIP inspects secure establishments against criteria for assessing the treatment of detainees and conditions in secure settings, known as 'expectations concerning outcomes for detainees'. HMIP expects the standard of health services provided to detainees to be equivalent to that which they would expect to receive elsewhere in the community. Expectations are organised around four 'healthy establishments tests':

- Safety – prisoners, particularly the most vulnerable, are held safely
- Respect – prisoners are treated with respect for their human dignity
- Purposeful activity – prisoners are able, and expected, to engage in activity that is likely to benefit them
- Resettlement – prisoners are prepared for their release into the community and effectively helped to reduce the likelihood of reoffending.

Health care standards for children and young people in secure settings

The Royal College of Paediatrics and Child Health, The Royal College of General Practitioners, The Royal College of Nursing, The Royal College of Psychiatrists, The Faculty of Public Health and The Faculty of Forensic and Legal Medicine developed standards to facilitate the provision of equitable and high-quality health services for young people in secure settings. The standards cover:

- Entry and assessment
- Care planning
- Universal health services
- Physical health care and intervention
- Mental health and neuro-disabilities care and intervention
- Substance misuse care and intervention
- Transfer and continuity of care
- Health care environment and facilities
- Planning and monitoring
- Multi-agency working
- Staffing and training.

Types of inspection

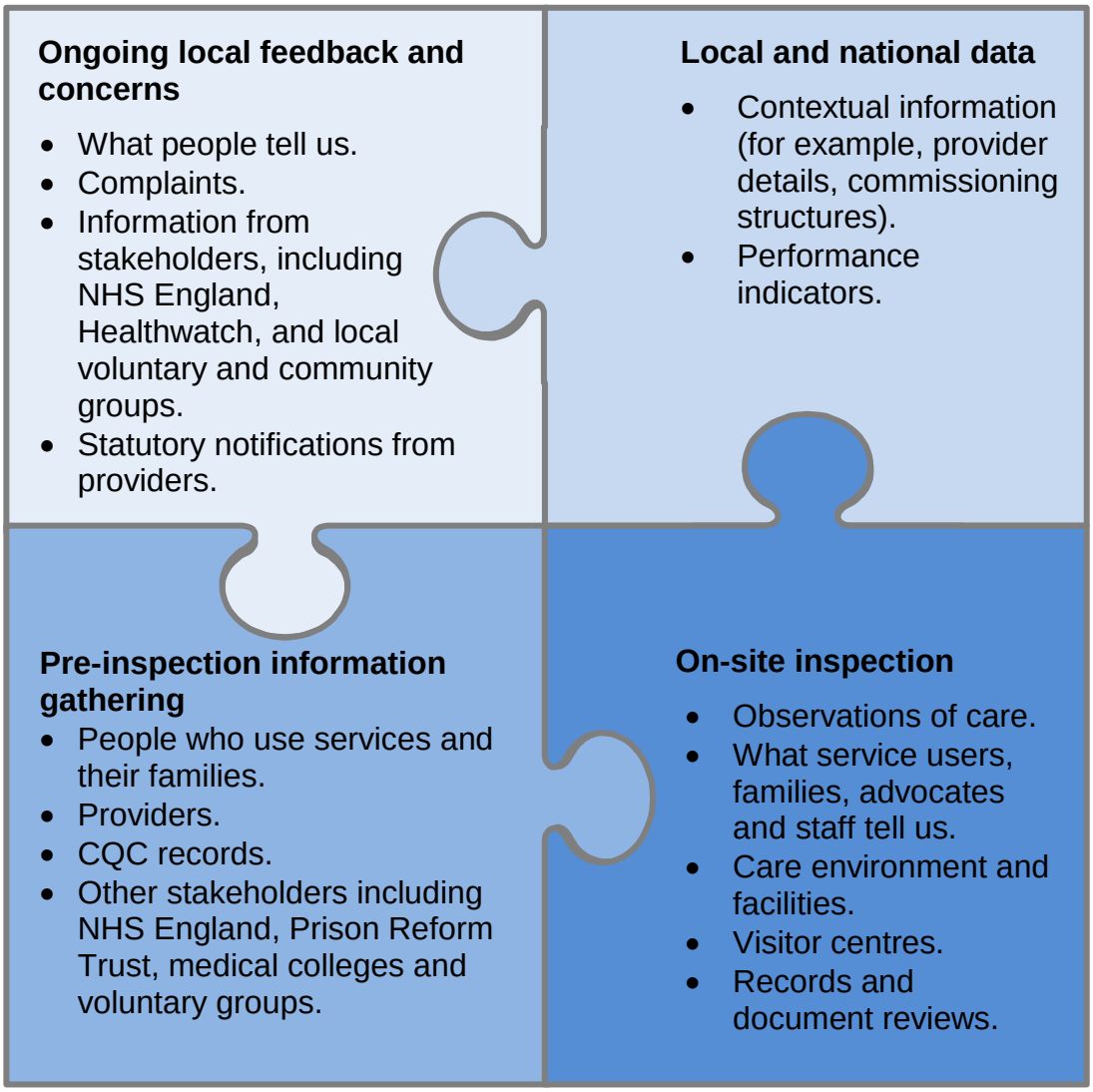
Our inspections are at the heart of our regulatory model and focus on the things that matter to people. There are three types of inspection:

Type of inspection	Description
Comprehensive	• Led by HMIP (HMIP lead on inspection of all outcomes for detainees, not just health outcomes). • Reviews providers of health care services in a secure setting in relation to CQC and HMIP's joint inspection framework. • HMIP's inspection of the secure setting will usually last two weeks. These inspections are usually unannounced. During the first week HMIP researchers will conduct a confidential survey with a random sample of detainees including information about health care services. CQC inspectors will join the inspection team in the second week to inspect registered care providers. • The Ministry of Justice decrees that prisons are inspected every five years but in practice, inspections tend more frequent. Inspections will usually take place at least every 2-3 years. • In IRCs, inspections will usually be carried out every two years and in YOIs, inspections will be annual.
Focused (section 5)	• Led by CQC. • Follow up to a previous inspection or respond to a particular issue or concern. • May not look at all areas of the joint inspection criteria KLOEs. • Team size and composition depends on the focus of the inspection. • The inspection may be unannounced. • Usually lasts 1-2 days.
Themed	• To raise issues at a national level. • To look in more depth at a particular question about the quality of care. • To gather evidence of what good care looks like to set clear expectations about good care.

Sources of evidence

Inspection teams will use evidence from four main sources to answer the KLOEs.

Figure 2: The four main sources of evidence



Making judgements

Inspection teams base their professional judgements on all the available evidence. Judgements 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. The KLOEs, prompts and characteristics are based on the regulations and enable inspection teams to assess whether care is safe, effective, caring, responsive and well-led and to identify any breaches of the fundamental standards.

This approach ensures we make consistent, authoritative judgements on the quality of care. We consider the weight of each piece of relevant evidence. In most cases we need to verify our evidence with other sources to support our findings.

When we have conflicting evidence, we will consider its source, how robust it is and which is the strongest. We may conclude that we need to seek additional evidence or specialist advice in order to make a judgement.

Ratings

The government introduced new legislation in 2014 to enable CQC to rate most of the providers it regulates, however, it did not include certain services including those provided in secure settings. 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 CQC. However, we do not rate them separately on the services they provide in secure settings.

Where providers also deliver care within the wider community, CQC inspectors carrying out inspections within secure settings will ensure that any relevant information, whether positive or negative, about providers and their services is shared with the CQC relationship holder for that provider. The CQC relationship holder will then consider how this information will impact on the assessment of that provider and what, if any, action is necessary in relation to that provider.

Equality and human rights

The promotion of equality and human rights, and the prevention of ill treatment, are at the core of both CQC's and HMIP's approaches to inspection.

The nature of detention means that it is largely out of sight of the public. This puts detainees in a more vulnerable situation where they rely on authorities for their safety, care and wellbeing. Detainees may be subject to the use of restraint or force whilst in a secure setting for the safety of themselves and others, and these decisions need to be made carefully and with transparent justification. It also means that, unlike the general population, they are unable to choose their place of care. All of this makes monitoring, inspection and regulation even more important, guaranteeing them care at a level that is equivalent to the rest of the population.

As independent monitoring and inspecting bodies, CQC and HMIP both have responsibilities as members of the UK's National Preventive Mechanism (NPM) to prevent ill treatment of people in prison. The NPM and the powers of its members to independently monitor detention is set out in the international human rights treaty – the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

CQC promotes equality, diversity and human rights. Respecting diversity, promoting equality and ensuring human rights will mean that everyone using health and social care services receives good quality care. CQC has developed a human rights approach to regulation which looks at a set of human rights principles – fairness, respect, equality, dignity, autonomy, the right to life and rights for staff – in relation to the five key questions we ask. Using an approach that is based on rights that people hold rather than what services should deliver also helps us to look at care from the perspectives of people who use services.

HMIP seeks to ensure human rights standards are maintained across the different detention settings it inspects and its expectations are underpinned by international human rights standards.

Monitoring the use of the Mental Capacity Act

The Mental Capacity Act (2005) is a crucial safeguard for the human rights of people who might (or might be assumed to) lack mental capacity to make decisions, in particular about consenting to proposed care or treatment interventions. This is applicable within secure settings, for example prisons, as it is in the wider community. The Mental Capacity Act (MCA) provides the essential framework for balancing autonomy and protection when staff are assessing whether people aged 16 and over have the mental capacity to make specific decisions at the time they need to be made. This refers specifically to the capacity to consent to, or refuse, proposed care or treatment.

The MCA clearly applies where a health service within a prison, YOI or IRC works with a detainee who may have cognitive difficulties due to dementia, an acquired brain injury or a learning disability, for example. Providers must also recognise that a person may lack mental capacity for a specific decision at the time it needs to be made for a wide range of reasons, which may be temporary, and know how they should then proceed.

In particular, we will look at how and when mental capacity is assessed and, where people lack mental capacity for a decision, how that decision is made and recorded in compliance with the MCA.

We acknowledge that restraint may be used in different circumstances within a prison, YOI or IRC. Detainees may be subject to the use of restraint whilst in a secure setting for the safety of themselves and others. These decisions, whilst not necessarily covered by the MCA, need to be made carefully and with transparent justification. Where restraint is used specifically to deliver necessary care or treatment, we will look for evidence that it is in the best interests of someone lacking mental capacity, is proportionate and complies with the MCA.

Monitoring the use of the Mental Health Act

Together with HMIP we inspect the range of mental health services provided in prisons, YOIs and IRCs. Issues relating to the application of the Mental Health Act may arise in the context of assessments and requests for individuals to be moved from a prison, YOI or IRC to mental health hospital services (using section 47/48 of the Mental Health Act).

Concerns, complaints and whistleblowing

Concerns raised by detainees, those close to them, and staff working in services, provide vital information that helps us to understand the quality of care. We will gather this information in four ways:

- Using information about individual concerns, issues raised at detainee forums or complaints from people who contact us directly or from the prison complaints system.
- Encouraging voluntary organisations that support detainees and their families to share information with CQC on a regular basis.
- Asking national and local partners, including NHS England and HMIP, to share with us concerns, complaints and whistleblowing information that they hold.
- Requesting information about concerns, complaints and whistleblowing from providers themselves.

We will also look at how health and care providers handle concerns, complaints and whistleblowing in every inspection. A service that is safe, responsive and well-led will treat every concern as an opportunity to improve, will encourage its staff to raise concerns without fear of reprisal, and will respond to complaints openly and honestly.

HMIP has an agreed protocol setting out how it will work with Independent Monitoring Boards and the Prisons and Probations Ombudsman to ensure that detainees, or people acting on their behalf, can speak with inspectors without any fear of sanctions or prejudice.

2. How we work with others

Good relationships with stakeholders allow better access to qualitative and quantitative information about services, as well as local evidence about people's experience of care. Local relationships also provide opportunities to identify good practice and to work with others to raise standards.

CQC and HMIP working together

The primary goal in working together is to promote improvement in health and social care services in custodial settings and in people's experiences of them, to improve outcomes. This is set out in detail in a memorandum of understanding between CQC and HMIP.

Where health care or social care are provided as part of an offender service, then HMIP will lead in ensuring that the offender service meets expectations, including those which relate to health and social care. CQC will lead in ensuring that health and social care providers comply with registration regulations.

There will be regular dialogue between HMIP and CQC to ensure that any concerns are shared and reflected in the comprehensive inspection schedule. HMIP will take the lead in scheduling inspections. CQC will have the opportunity to comment on and to influence the draft schedule.

HMIP and CQC will share relevant information on an ongoing basis and not just in advance of scheduled inspections.

The timing and scope of a focused inspection (see section 5) following up on areas of concern will be more flexible and will be based on the nature of the concerns.

Where providers also deliver care within the wider community, CQC inspectors carrying out inspections within secure settings will ensure that any relevant information, whether positive or negative about providers and their services, is shared with the CQC relationship holder for that provider. The CQC relationship holder will then consider how this information will impact on the assessment of that provider and what, if any, action is necessary in relation to that provider.

Working with detainees

People's experiences of care are vital to our work; they help to inform when, where and what we inspect. However, we recognise that service users in secure settings are generally in a more vulnerable situation and may find it difficult to voice concerns about their care. They may also have different access to methods of communication compared to in the wider community. Therefore, we will continue to adapt our engagement processes for health and justice. Through consultation with key stakeholders we are exploring ways by which we can engage with this unique user group, either through expanding the remit of existing channels or by developing new methods.

We may gather and analyse information from detainees through:

- Comments and feedback sent to CQC from individual detainees and their families.
- Making use of evidence from prisoner councils/forums.
- Engaging with organisations that represent or act on behalf of detainees.
- Encouraging feedback from local Healthwatch.

Working with providers

Service providers routinely gather and use information from people who use services, their families and other representatives. We will use this information, including data about complaints and how they are managed.

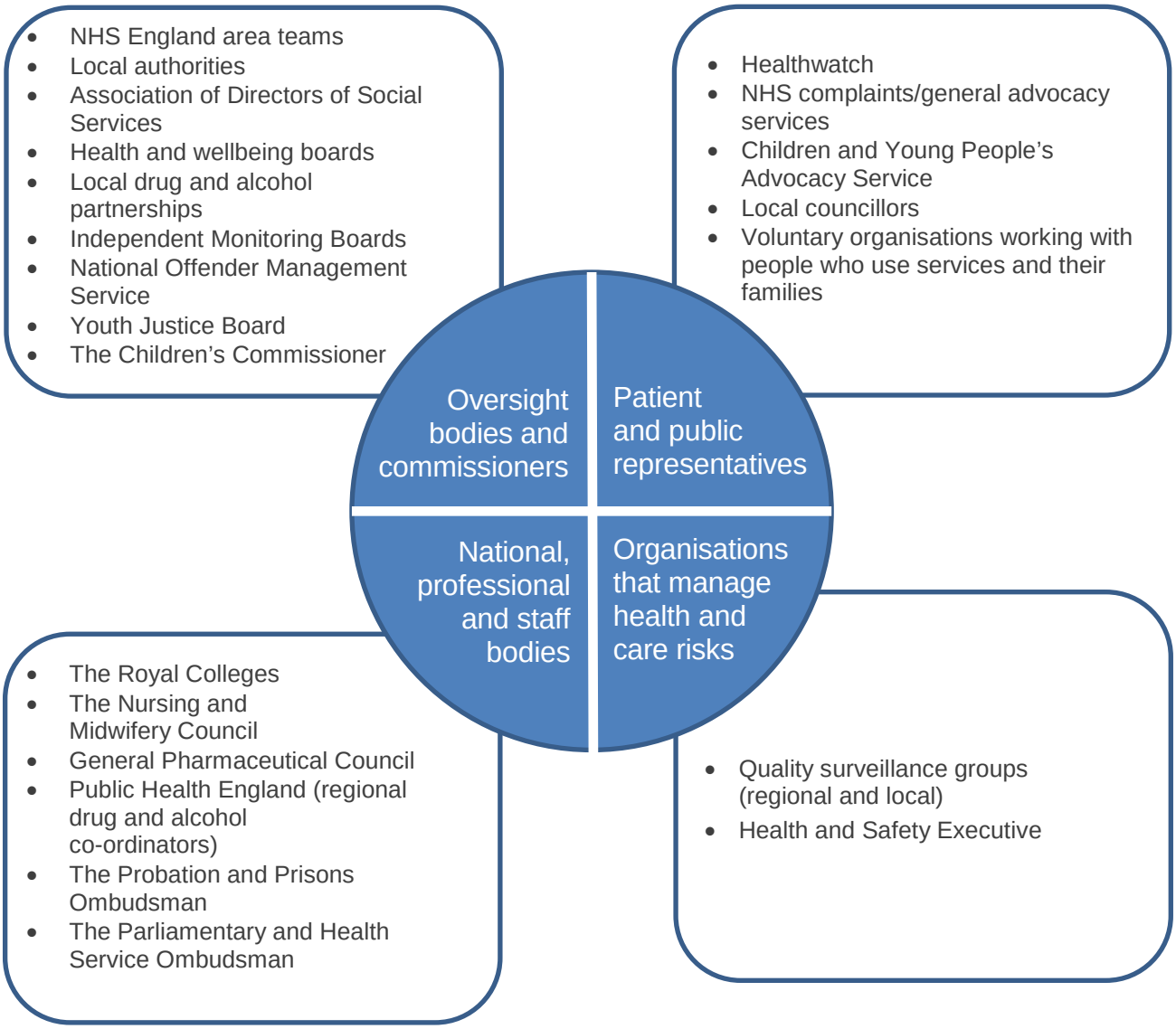
Working with other organisations

Many national organisations we work with have information about providers and people's experiences of health and social care in prisons, YOIs and IRCs. We want to make the best use of their evidence and our inspectors and inspection managers will have an on going relationship with these stakeholders. This includes working closely with oversight bodies and commissioners, national, professional and staff bodies, patient and public representatives and organisations that manage health and care risks. These organisations are detailed in figure 4.

It 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. We ask them to share with us the information that they hold. These include:

- Voluntary organisations working in the secure setting.
- Voluntary organisations supporting families in the community.

Figure 4: How we work with local and national organisations



3. Planning the inspection

To make the most of the time that we are on site for an inspection, we must make sure we have the right information to help us focus on what matters most to people. We also use information that we gather before the inspection as evidence when we make judgements.

Use of data

We will analyse data from a range of sources, including information from detainees, stakeholders and providers.

We will compile a data pack, which helps to inform the inspection planning and provide some evidence against the KLOEs. We will arrange the data packs around the five key questions and incorporate information from various sources including NHS England, Public Health England, HMIP and the National Offender Management Service, as well as information held by CQC.

Gathering the views of detainees in advance of inspection

A key principle of our approach to inspecting is to seek out and listen to the experiences of detainees and those close to them, including the views of people who are in vulnerable circumstances or who are less likely to be heard. The purpose of this is to improve our understanding of the issues that are of most concern to people. CQC staff will usually join the HMIP staff in the second week of the inspection. HMIP will begin to gather people's experiences of care in the first week of the inspection through:

- A survey about health care services (data will be shared with CQC).
- Holding focus groups with detainees (conducted by HMIP and attended by CQC).
- Displaying posters during the inspection signposting people who use health and social care services within the secure setting to an HMIP number which they can call to discuss their care. Concerns will be passed to CQC.

As well as this, CQC will engage with other stakeholders who gather the views of people who use services in secure settings. These may include:

- Advocacy groups, including the Children and Young People's Advocacy Service on YOIs
- Healthwatch
- Voluntary organisations.

We may also ask Clinical Commissioning Groups and NHS England area teams to provide information. We may also telephone the families of people receiving health care in the secure setting to gather their views.

Information from recent inspections

We will gather information from recent inspection reports where services are run by providers who also provide care services in the wider community.

The inspection team

The HMIP inspection team will lead the inspections with input from CQC inspectors, pharmacists and other professionals.

Unannounced inspections

Inspections are usually unannounced, meaning the prison is informed 30 minutes in advance. Very occasionally there will be announced inspections, often where there have been particular concerns.

When CQC needs to carry out follow up inspections, HMIP will inform the prison governor in advance but ask that information is not shared with the health care providers. This allows the CQC inspection team to gain access to the secure setting without HMIP necessarily being present.

4. Site visits

Site visits are a key part of our regulatory framework, giving us an opportunity to talk to detainees, staff and other professionals about their experiences. Visits allow us to observe care being delivered and review people's records to see how their needs are managed, both within and between services.

Inspection teams will spend a number of days on site, within the two-week prison inspection, inspecting the secure health care setting. The scope of the inspection will include all care providers. This will be a significant increase in inspection activity.

The start of the visit

On arrival at the site, HMIP inspectors will hold an introductory meeting with registered managers of health care providers, and sometimes the prison governor, to explain:

- Who the inspection team are.
- The scope and purpose of the inspection, including our relevant powers and the plan for the day.
- How we will escalate any concerns identified during the inspection.
- How we will communicate our findings.

Gathering evidence

The inspection team use the joint inspection framework and any concerns identified through the preparation work to structure their site visit and focus on specific areas of concern or potential areas of outstanding practice. They collect evidence against the KLOEs using the methods described below.

Gathering the views of detainees during the site visit

We will gather the views of detainees and those close to them while on site through a range of methods which may include:

- Speaking individually with detainees and their families.
- Attending prisoner forums.
- Encouraging detainee representatives, including listeners and recovery champions, to gather feedback to inform inspections.
- Using comment cards.
- Attending visitor centres for discussions with families.

Gathering the views of staff

The inspection team will speak with staff while on site. On all inspections, we are likely to speak to the following people:

- Health and social care staff
- Administrative staff
- Non-clinical prison staff.

The CQC inspection team will offer to talk to current and former whistleblowers during the inspection period.

Other inspection methods and information gathering

Other ways of gathering evidence on site may include:

- Tracking patients through their care pathway.
- Reviewing records.
- Reviewing operational policies and supporting documents.
- Talking with visiting health and social care professionals and advocates.

We recognise that records may include very private and personal information, including information about relationships, mental health and sexual health. We have recently published information describing why we look at medical records during our inspections and how we will do this. You can find this information here.

Continual evaluation

Throughout the inspection the team will review the emerging findings together. This ensures the team are up to date with all issues and can shift the focus of the inspection if new areas of concern are identified. It also enables the team to identify what further evidence might be needed in relation to a line of enquiry and what relevant facts might still be needed to agree a judgment.

Feedback on the visit

At the end of the inspection visit, the inspection team meets with the prison governor and their invited audience, which is usually the senior management team. The care providers are also invited to this meeting to receive high-level initial feedback and examples.

The meeting will cover:

- Thanks for support and contributions.
- Explaining findings to date, but noting that we will need to do further analysis of the evidence before we can reach final judgements on all the issues.
- Explaining how we will make judgements.
- Explaining the next steps, including challenging factual accuracy in the draft report, final report sign-off and publication.

5. Focused inspections

There will be circumstances when CQC will carry out a smaller focused inspection rather than a full comprehensive inspection using the joint inspection methodology, for example, in response to concerning information about a provider. Focused inspections do not usually address all of CQC's five key questions or look at all of the joint inspection criteria; they focus on the areas indicated by the information that triggers the focused inspection. They will usually last one or two days and may be announced or unannounced.

Areas of concern

We will undertake a focused inspection when we are following up on areas of concern including:

- Concerns that were originally identified during a comprehensive inspection and have resulted in enforcement or compliance action.
- Concerns that have been raised with us through other sources, such as information from monitoring of local data, family members, advocates, voluntary groups, staff or stakeholders.

Change of service provider

We may also undertake a focused inspection when there will be a change in a service provider, such as a takeover or merger or an acquisition of a service.

The focused inspection process

Although they are smaller in scale, focused inspections broadly follow the same process as a comprehensive inspection. They may include looking at data, gathering information from other organisations and the use of specialists.

The reason for the inspection determines many aspects, such as the scope of the inspection, when to visit, what evidence needs to be gathered, the size of the team and which specialist advisers to involve. These visits may be announced or unannounced, depending on the focus of the inspection.

Where CQC needs to carry out unannounced focused inspections of named providers. HMIP will inform the prison governor in advance but ask that information is not shared with the health care providers. This allows the CQC inspection team to access the secure setting, without HMIP necessarily being present.

Following the focused inspection CQC will produce and publish a report on our inspection findings and recommendations. We will share the report with HMIP.

6. Reporting, quality control and publication

Reporting

After each comprehensive inspection, CQC and HMIP will produce a joint report in clear, plain English. This report will cover all aspects of the prison, YOI or IRC. The contribution of the CQC team will focus on health and adult social care. The report will name all of the CQC registered care providers at that setting and comment on the quality of care from specific providers.

Our joint reports will focus on what our findings mean for the people who use the service. We will describe the good practice we find, as well as any concerns we have. We will produce 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 the regulations and the actions that we require from providers.

Quality control

Consistency is one of the core principles that underpins all our work. We have put in place an overall approach across CQC to embed consistency in everything we do. The key elements of this are:

- A strong and agreed core purpose for CQC.
- A clear statement of our role in achieving that purpose.
- Consistent systems and processes to underpin all our work.
- High-quality and consistent training for our staff.
- Strong and consistent quality assurance processes.

We will work with HMIP to ensure that we have an agreed joint approach to quality assuring reports and ensuring that underlying evidence is robust.

Publication

There will be a separate page on the CQC website for each prison, YOI and IRC from which the joint HMIP/CQC report will be accessible.

Where providers also carry out care in other settings which would be inspected and reported on separately, the CQC page for that provider will include a note advising that the provider also provides care within a prison, YOI or IRC which is inspected separately under our joint inspection framework with HMIP together with a link to the joint report.

7. Enforcement and actions

Types of action and enforcement

New regulations came into force from April 2015. These are more focused and clear about the care that people should expect to receive than the previous regulations.

We have published guidance for existing registered providers and managers, and those applying for registration, to understand what they need to do to meet the regulations. These regulations include fundamental standards, below which the provision of regulated activities and the care people receive must never fall.

CQC has a remit to inspect against these regulations and ensure enforcement action is taken when they are breached. CQC inspectors will ensure that the necessary evidence is gathered to effectively enforce the regulations with care providers in secure settings.

Where we have identified concerns we decide what action is appropriate. The action we take is proportionate to the seriousness of the concern and whether there are multiple and persistent breaches.

Where the concern is linked to a breach of regulations we have a wide range of enforcement powers given to us by the Health and Social Care Act 2008, as amended by the Care Act 2014. Our enforcement policy describes our powers in detail and our general approach to using them.

Where we identify breaches of regulations we will set them out in an appendix to the report. We will also aim to write to the provider concerned within two weeks of the end of the inspection, setting out the breaches and any associated enforcement action.

We may recommend areas for improvement even when a regulation has not been breached.

We follow up on any concerns or enforcement action. If the necessary changes and improvements are not made, we can escalate our response, gathering further information through a focused inspection. However, we always consider each case on its own merit and we do not rigidly apply the enforcement rules when another action may be more appropriate.

Responding to inadequate care

We will intervene if people appear to be at risk of harm or providers appear not to be meeting the regulations, including the fundamental standards. We will start with whatever level of intervention will achieve our purpose of protecting people who use the service or holding providers and individuals to account, or both.

In addition to our statutory powers, we also work with HMIP and other regulators and oversight organisations to ensure that they take appropriate action on any concerns that we have identified, where that is more proportionate or likely to be more effective than CQC acting on its own.

Challenging the evidence

Providers can challenge the factual accuracy of reports and make representations about the evidence in warning notices.

Factual accuracy check

Providers will have an opportunity to comment on the factual accuracy of reports. They can challenge the accuracy and completeness of the evidence on which judgements have been made. This process will be managed by HMIP and the prison governor. Any factual accuracy comments that are upheld may result in a change to a judgement.

Warning Notice representations

If we serve a Warning Notice, we give providers/registered persons the opportunity to make representations about the matters raised. The content of the Notice will be informed by evidence about the breach that is in the inspection report. Under our process for factual accuracy checks and Warning Notice representations, unresolved issues can be escalated to managers in CQC who were not involved in the inspection.

Complaints about CQC

We aim to deal with all complaints about how we carry out our work promptly and efficiently. This includes complaints about members of our staff or people working for us.

You should complain to the person that the provider has been dealing with, because they will usually be the best person to resolve the matter. If you feel unable to do this, or you have tried and were unsuccessful, you can call, email or write to us. Our contact details are on our website.

We will write back within three working days to say who will handle the complaint.

You will receive a response from us in writing within 15 working days saying what we have done, or plan to do, to put things right.

If you are not happy with our response, you must contact our Corporate Complaints Team within 20 days. The contact details are on our website.

The team will review the information about the complaint and the way we have handled it. In some cases, we may ask another member of CQC staff or someone who is independent of CQC to investigate it further. If there is a more appropriate way to resolve the complaint, we will discuss and agree it with you.

We will send the outcome of the review within 20 working days. If we need more time, we will write to explain the reason for the delay.

If the complainant is still unhappy with the outcome of the complaint, they can contact the Parliamentary and Health Service Ombudsman. Details of how to do this are on the Parliamentary and Health Service Ombudsman website.

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Appendix A – Key lines of enquiry

Please note that the prompts and characteristics are not exhaustive and should be read in conjunction with CQC's published provider guidance on fundamental standards. As described on page 11 of the provider handbook, this joint assessment framework is based on CQC's five key questions, HMIP's 'expectations and the Healthcare Standards for Children and Young people in Secure Settings.

Safety

KLOE	Prompts	Characteristics
S1. What is the **track record** on safety of health care provision?	1. Has the service demonstrated that it is safe over time?	Performance shows a good track record and steady improvements in safety.
	2. Do staff understand their responsibilities to raise concerns, record and report safety incidents, concerns and near misses, and to report them internally and externally?	Openness and transparency about safety is encouraged. Staff understand and fulfill their responsibilities to raise concerns and report incidents and near misses; they are fully supported when they do so.
	3. How well is safety monitored using information from a range of sources and across all care settings?	Monitoring and reviewing activity enables staff to understand risks and gives a clear, accurate and current picture of safety.
S2. Are **lessons learned and improvements made** when things go wrong?	1. Are detainees told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result?	When something goes wrong, people receive a sincere and timely apology and are told about any actions taken to improve processes to prevent the same happening again.

	2. When things go wrong, are thorough and robust reviews or investigations carried out? Are all relevant staff and detainees involved in the review or investigation?	When something goes wrong, there is an appropriate thorough review or investigation that involves all relevant staff and detainees.
	3. How are lessons learned and is action taken as a result of investigations when things go wrong?	Improvements to safety are made and the resulting changes are monitored. Opportunities to learn from external safety events are also identified.
	4. How well are lessons learned to make sure action is taken to improve safety beyond the affected team/service?	Lessons are learned and communicated widely to support improvement in other areas as well as services that are directly affected.
S3. Are there **reliable systems, processes and practices** in place to keep people safe and safeguarded from abuse?	1. Have the systems, processes and practices, which are essential to keep detainees safe, been identified, put in place and communicated to staff?	There are clearly defined and embedded systems, processes and standard operating procedures to keep detainees safe and safeguarded from abuse. These: • Are reliable and minimise the potential for error. • Reflect national, professional guidance and legislation. • Are appropriate for the setting. • Are understood by all staff and implemented consistently. • Are reviewed regularly and improved when needed.
	2. Are staff trained in the safety systems, processes and practices?	Staff have received up-to-date training in all safety systems.

	3. Is implementation of safety systems, processes and practices adapted for different care settings if needed, monitored and improved when required?	Detainees are only subjected to force which is legitimate, limited to the physical intervention required to protect the individual and others from harm, used as a last resort and for no longer than necessary. When detainees are physically restrained, it is for the minimum amount of time necessary, by trained staff using approved techniques. Following restraint, prisoners are appropriately monitored and supported. Detainees are located in special or unfurnished accommodation, or placed in mechanical restraints or strip clothing, only as a last resort and are subject to measures which protect their human dignity.
	4. Are there arrangements in place to safeguard adults and children (in YOIs or IRCs) from abuse that reflect relevant legislation and local requirements and includes protection for vulnerable groups? Do staff understand their responsibilities and adhere to safeguarding policies and procedures?	Safeguarding is given sufficient priority. Staff take a proactive approach to safeguarding and focus on early identification. They take steps to prevent abuse from occurring, respond appropriately to any signs or allegations of abuse and work effectively with others to implement protection plans. There is active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations. The facility provides a safe and secure environment which reduces the risk of self-harm and suicide. Children are properly protected in a safe environment. All staff safeguard and promote their welfare. Young people are protected from abuse through clear safeguarding policies and procedures. Staff working with young people receive training in safeguarding and child protection. Child protection procedures conform to the law. Staff understand and apply them to ensure that children remain safe.

	5. How are standards of cleanliness and hygiene maintained?	There are comprehensive infection control procedures, including infection control audits, in place.
	6. Are reliable systems in place to prevent and protect people from healthcare associated infections and communicable diseases?	The secure setting has a comprehensive policy on communicable disease control. All detainees receive information about health promotion and the control of communicable diseases.
	7. Does the design, maintenance and use of facilities and premises keep people safe?	Detainees, particularly adults at risk, are provided with a safe and secure environment which protects them from harm and neglect. The environment and regime safeguard detainees' physical and mental health and appropriate levels of support, care and treatment are available.
	8. Does the maintenance and use of equipment keep people safe?	All health equipment is safe, appropriate and meets standards laid down by the regulatory bodies.
	9. Do the arrangements for managing waste and clinical specimens keep people safe?	There are effective arrangements in place for managing waste and clinical specimens.
	10. Do arrangements for managing medicines keep people safe?	There are effective medicines management arrangements in place. There are arrangements in place for detainees to access required medication at the correct times of the day.
	11. Are people's individual care records written and managed in a way that keeps people safe?	There is a systematic and planned approach to the management of health records on site. Practices and processes recognise the need for patient confidentiality.

S4. How are **risks to detainees** assessed, and their safety monitored and maintained?	1. How are staffing levels, skill mix and caseloads planned and reviewed so that detainees receive safe care and treatment at all times, in line with relevant tools and guidance, where available?	Staffing levels and skill mix are planned, implemented and reviewed to keep people safe at all times. Staffing levels are managed to ensure continuity of service by appropriate health care professionals and to meet the needs of detainees.
	2. How do actual staffing levels compare to the planned levels?	Any staff shortages are responded to quickly and adequately.
	3. Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively?	Risk assessments are person-centred, proportionate and reviewed regularly. Staff recognise and respond appropriately to changes in risks to detainees. Where a young person is identified as at risk of harm or urgent health concerns are identified, immediate and continuing action is taken to safeguard the young person.
	4. How do staff identify and respond appropriately to changing risks to people who use services, including deteriorating health and wellbeing, medical emergencies or behaviour that challenges?	Risks to people who use services are assessed, monitored and managed on a day-to-day basis. These include signs of deteriorating health, medical emergencies or behaviour that challenges. Detainees receive support from a health care professional after restraint procedures. Staff know who to contact in an emergency, including for incidents of self-harm, violent behaviour and first aid.
	5. How do arrangements for staff handovers and shift changes keep people who use services safe?	There are effective handovers and shift changes to ensure staff can manage risks to detainees.
S5. How well are potential risks to the service **anticipated** and **planned** for in advance?	1. What arrangements are in place to respond to emergencies and major incidents? How often are these practised and reviewed?	Plans are in place to respond to emergencies and major situations. All relevant parties understand their role and the plans are tested and reviewed.

	2. How is the impact on safety assessed and monitored when carrying out changes to the services or the staff?	Risks to safety from service developments, anticipated changes in demand and disruption are assessed, planned for and managed effectively.

Effective

KLOE	Prompts	Characteristics
E1. Are detainees' needs assessed and care and treatment delivered in line with legislation, standards and **evidence-based guidance**?	1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).	Detainees have access to good quality health care, and neither mental nor physical health should be adversely affected by living in the secure setting.
	2. Do people have their needs assessed, their care goals identified and their care planned and delivered in line with evidence-based, guidance, standards and best practice? How is this monitored to ensure compliance?	Detainees are cared for by a health service that accurately assesses and meets their health needs while in the secure setting and which promotes continuity of health and social care on release. Detainees' immediate health and social care needs are recognised on reception and responded to promptly and effectively. Detainees in IRCs who claim to be under 18 are promptly assessed by Social Services and properly cared for while in the centre. Detainees at risk of self-harm or suicide receive personal and consistent care and support to address their individual needs and have unhindered access to help. Detainees dependent on drugs and/or alcohol receive clinical treatment which is safe, effective and meets individual needs. Detainees' individual health care needs are addressed through a range of care services. Detainees are cared for by a pharmacy service that assesses and meets their needs and is equivalent to that in the community. Detainees are cared for by a dental health service that assesses and meets their needs and is equivalent to the standard and range in the community.

KLOE	Prompts	Characteristics
		Detainees who have been the victim of abuse, rape, torture or domestic violence are identified and supported to address their specific needs. Detainees with immediate health needs, vulnerabilities or who are at risk of harm to self or others are identified promptly on arrival at the secure setting. Effective systems are in place to identify and support all young people who are parents or expectant parents. A range of evidence-based: • Mental health interventions • Physical health intervention • Neuro-disability interventions (neuro-disability is an umbrella term for conditions associated with impairment involving the nervous system and includes conditions such as cerebral palsy, autism and epilepsy) • Substance misuse interventions is offered and delivered according to individual needs. Detainees assessed as requiring secondary care services are able to access them without undue restrictions to ensure continuity of care. Pregnant detainees and detainees with children are fully supported throughout their time at the prison by appropriately trained custody staff. Health services assess and meet the needs of parents and children in detention.

KLOE	Prompts	Characteristics
	3. Is discrimination, including on grounds of age or disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation avoided when making care and treatment decisions?	Detainees of all: • Ethnic groups • Nationalities • Religious groups with disabilities (both physical and mental impairments and learning disabilities and difficulties) • Sexual orientations are treated equitably and according to their individual needs. Women detainees, transgender detainees, young adults and older prisoners are treated equitably and according to their individual needs.
	4. How are people's nutrition and hydration needs assessed and met?	Detainees have a varied, healthy and balanced diet which meets their individual needs, including religious, cultural or other special dietary requirements.
	5. Are the rights of people subject to the Mental Health Act (MHA) protected and do staff have regard to the MHA Code of Practice?	Where people are subject to the Mental Health Act (MHA), their rights are protected and staff have regard to the MHA Code of Practice.
E2. How are detainees' care and treatment **outcomes monitored** and how do they **compare** with other services?	1. Is information about the outcomes of detainees' care and treatment routinely collected and monitored?	Information about detainees' care and treatment, and their outcomes, is routinely collected and monitored. This information is used to improve care. Outcomes for detainees are positive, consistent and meet expectations. There are clear clinical governance arrangements in place which facilitate continuous service improvement by using and analysing information sources such as inspection reports, peer review, critical incident reports, complaints, best practice and clinical audits.

KLOE	Prompts	Characteristics
	2. Does this information show that the intended outcomes for detainees are being achieved?	Intended outcomes are achieved.
	3. How do outcomes for detainees compare to outcomes in the community?	Monitoring shows that outcomes for detainees are at least equivalent to the wider community.
	4. Is there participation in relevant local and national audits, benchmarking, accreditation, peer review, research and trials?	There is participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services, benchmarking, peer review and service accreditation.
	5. How is information about detainees' outcomes used and what action is taken as a result to make improvements?	Accurate and up-to-date information about effectiveness is shared internally and externally and is understood by staff. It is used to improve care and treatment and people's outcomes.
	6. Are staff involved in activities to monitor and improve detainees' outcomes?	Staff are actively involved in monitoring and improving outcomes for detainees. Each secure setting has a comprehensive physical health strategy outlining the contributions of all staff to supporting and improving the physical health and wellbeing of young people and acknowledging the close relationship between mental and physical health.
E3. Do health care **staff** have the **skills, knowledge and experience** to deliver effective care and treatment?	1. Do staff have the right qualifications, skills, knowledge and experience to do their job when they start their employment, take on new responsibilities and on a continual basis?	Staff are qualified and have the skills they need to carry out their roles effectively and in line with best practice. There are appropriately qualified and skilled health care staff to meet the needs of the young people in the secure setting.
	2. How are the learning needs of health care staff identified and addressed?	The learning needs of health care staff are identified and training is put in place to meet these learning needs. Health care staff have an annual appraisal and receive clinical and managerial supervision.

KLOE	Prompts	Characteristics
	3. Are health care staff encouraged and given opportunities to develop?	Health care staff are supported to maintain and further develop their professional skills and experience. Health care staff have access to an on going and regularly updated programme of professional development. Staff mandatory training is up to date.
	4. What are the arrangements for supporting and managing health care staff? (This includes one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.)	Staff are supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal.
	5. How is poor or variable staff performance identified and managed? How are staff supported to improve?	There is a clear and appropriate approach for supporting and managing staff when their performance is poor or variable.
E.4 How well do **staff, teams and services work together** to deliver effective care and treatment?	1. Are all necessary staff, including those in different teams and services, involved in assessing, planning and delivering detainees' care and treatment?	When detainees receive care from a range of different staff, teams or services, this is coordinated. All relevant staff, teams and services are involved in assessing, planning and delivering people's care and treatment.
	2. How is care delivered in a coordinated way when different teams or services are involved?	Staff work collaboratively to understand and meet the range and complexity of detainees' needs. Detainees experience collaborative and consistent health care. Information is shared on entry and health assessments are effectively coordinated with other agencies so that detainees are not repeatedly asked to give the same information. There is a clear pathway for managing referrals where a health need is indicated. Service planners/providers/commissioners, including those responsible for mental health, substance misuse, public health and children's services, and the secure setting work

KLOE	Prompts	Characteristics
		collaboratively to ensure the provision of appropriate and high quality health care for detainees. Young people receive care from services that work collaboratively to ensure that the team working around the young person has all of the information they need to meet the young person's health and wellbeing needs in a way that preserves the young person's privacy and confidentiality. Health care staff provide appropriate support to staff working with detainees to foster a culture of multidisciplinary working and partnership and ensure the whole secure setting operates as a health promoting environment. The secure setting has access to, and receives support from, a multidisciplinary physical health care team appropriate to the needs of detainees.
	3. Do staff work together to assess and plan ongoing care and treatment in a timely way when detainees are due to move between teams or services, be transferred to another secure setting or be removed or released?	Detainees with continuing health and social care needs are prepared and assisted to access services in the community prior to their release. Detainees with drug/alcohol problems are prepared for release and have access to appropriate support and continued treatment in the community. Pre-release harm-minimisation programmes (alcohol, smoking and drugs) are offered to young people to raise awareness of the dangers of post-release drug use and the risks of overdose. Appropriate contraception and advice on safer sexual practices is offered and provided for young people leaving the secure setting. Services promote continuity of health and social care on release.

KLOE	Prompts	Characteristics
E5. Do staff have all the **information they need** to deliver effective care and treatment?	1. Is all the information needed to deliver effective care and treatment available to relevant staff in a timely and accessible way? (This includes care and risk assessments, care plans, case notes and test results.)	Staff can access the information they need to assess, plan and deliver care to people in a timely way.
	2. When people move between teams and services, are transferred to another secure setting or are removed or released, is all the information needed for their on going care shared appropriately, in a timely way and in line with relevant protocols?	Staff can access the information they need to assess, plan and deliver care to people in a timely way, particularly when people move between services or during transition. Continuity of care for detainees in IRCs is not compromised by inappropriate or frequent moves.
	3. How well do the systems that manage information about detainees support staff to deliver effective care and treatment? (This includes coordination between different electronic and paper based systems and appropriate access for staff to records.)	When there are different systems to hold or manage care records, these are coordinated.
E6. Is people's **consent** to care and treatment always sought in line with legislation and guidance?	1. Do staff understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004?	Consent to care and treatment is obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004. Before intervention begins, physical health, mental health, neuro-disability and substance misuse needs are assessed, a health care plan is developed and consent is sought.
	2. How are detainees supported to make decisions?	People are supported to make decisions and, where appropriate, their mental capacity is assessed and recorded.
	3. How and when is a person's mental capacity to consent to care or treatment	People are supported to make decisions and, where appropriate, their mental capacity is assessed and recorded.

KLOE	Prompts	Characteristics
	assessed and, where appropriate, recorded?	
	4. When people lack the mental capacity to make a decision, do staff make 'best interests' decisions in accordance with legislation?	When people aged 16 and over lack the mental capacity to make a decision, 'best interests' decisions are made in accordance with legislation.
	5. How is the process for seeking consent monitored and improved to ensure it meets responsibilities within legislation and follows relevant national guidance?	The process for seeking consent is appropriately monitored.
	6. Do staff understand the difference between lawful and unlawful restraint practices?	Is restraint proportionate and does it comply with the Mental Capacity Act 2005?
	7. Is the use of restraint of people who lack mental capacity clearly monitored for its necessity and proportionality in line with legislation, and is action taken to minimise its use?	The use of restraint is understood and monitored, and less restrictive options are used where possible.

Caring

KLOE	Prompts	Characteristics
C1. Are detainees treated with kindness, **dignity**, **respect** and **compassion** while they receive care and treatment?	1. Do staff understand and respect detainees' personal, cultural, social and religious needs, and do they take these into account?	Detainees are treated with respect in a professional and caring manner which is sensitive to their diverse needs, by appropriately trained staff.
	2. Do staff take the time to interact with detainees and those close to them in a respectful and considerate manner?	Detainees are treated with humanity and respect for their human dignity at all times. Relationships between detainees and staff are positive and courteous.
	3. Do staff show an encouraging, sensitive and supportive attitude to detainees and those close to them?	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.
	4. Do staff raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes?	Staff promote a respectful and safe environment, in which each of the distinct protected characteristics of detainees is recognised and addressed with respect and dignity.
	5. How do staff make sure that people's privacy and dignity is always respected, including during physical or intimate care?	Detainees benefit from health services which are safe and accessible and which maintain decency, privacy and dignity and promote their wellbeing.
	6. When detainees experience physical pain, discomfort or emotional distress do staff respond in a compassionate, timely and appropriate way?	People are treated in a compassionate, timely and appropriate way at such times.
	7. Do staff respect confidentiality at all times?	People's privacy and confidentiality is respected at all times.

KLOE	Prompts	Characteristics
C2. Are detainees and those close to them **involved as partners** in their care?	1. Do staff communicate with people so that they understand their care, treatment and condition?	Detainees understand and are fully involved in their health assessments. Staff spend time talking to detainees, or those close to them. They are communicated with and receive information in a way that they can understand. Detainees understand their care, treatment and condition.
	2. Do staff recognise when detainees and those close to them need additional support to help them understand and be involved in their care and treatment and enable them to access this? (This includes language interpreters, sign language interpreters, specialist advice or advocates).	Staff enable detainees to access additional support to help them to understand and be involved in their care and treatment.
	3. How do staff make sure that detainees and those close to them are able to find further information or ask questions about their care and treatment?	Staff help detainees to get the information they need about their care and treatment.
	4. Are detainees and those close to them routinely involved in planning and making decisions about their care and treatment?	There are clear procedures for gaining consent to health assessments and interventions. Detainees are involved and encouraged to be partners in their care and in making decisions, with any support they need. Detainees and staff work together to plan care and there is shared decision-making about care and treatment. Detainees understand the importance of healthy living and personal fitness.

KLOE	Prompts	Characteristics
C3. Do detainees and those close to them receive the support they need to **cope emotionally** with their care, treatment or condition?	1. Do staff understand the impact that a detainee's care, treatment or condition will have on their wellbeing and on those close to them, both emotionally and socially?	Staff help detainees and those close to them to cope emotionally with their care and treatment.
	2. Are detainees given appropriate and timely support and information to cope emotionally with their care, treatment or condition?	Staff respond compassionately when people need help and support them to meet their basic personal needs as and when required. They anticipate people's needs.
	3. Are detainees empowered and supported to manage their own health, care and wellbeing and to maximise their independence?	People are enabled to manage their own health and care when they can, and to maintain independence.

Responsive

KLOE	Prompts	Characteristics
R1. Are **services planned** and delivered to meet the needs of detainees?	1. Is information about needs used to inform how services are planned and delivered?	There is a comprehensive health promotion strategy in place across the secure setting. There is a clear role for health services in the secure setting that is set out in a comprehensive health strategy for the secure setting. Each secure setting has a comprehensive mental health and neuro-disability strategy outlining the contributions of all staff to supporting and improving the mental health and wellbeing of young people.
	2. How are commissioners, other providers and relevant stakeholders involved in planning services?	The planning of care and treatment is coordinated with commissioners and other providers. Service planning/commissioning is responsive to the needs of the young people in the secure setting.
	3. Do the services provided reflect the needs of detainees and do they ensure flexibility, choice and continuity of care?	Detainees can access the full range of services and regime activities. Services are planned and delivered in a way that meets the needs of detainees. The importance of flexibility, choice and continuity of care is reflected in the services. Detainees have prompt access to a range of psychosocial interventions and services, which are consistent with the assessed needs of the population. Detainees have access to the services and support they need to meet their health and wellbeing needs including physical health, mental health, substance misuse and neuro-disability. The secure setting has access to, and receives support from, a substance misuse team appropriate to the needs of the young

KLOE	Prompts	Characteristics
		people. The secure setting has access to, and receives support from, a multidisciplinary Child and Adolescent Mental Health Service (CAMHS) team appropriate to the needs of the young people. The secure setting works closely with, and has access to, a range of services and agencies appropriate to the health needs of the young people in the secure setting. Detainees have access to confidential advice and education about safer sexual practices and contraception within the context of relationships. Antenatal and postnatal services equivalent to those provided in the community are available for pregnant young women. Where people's needs are not being met, this is identified and used to inform how services are planned and developed Each young person has a comprehensive and holistic health care plan within ten days of their arrival in the secure setting, demonstrating an integrated approach to physical health, mental health, substance misuse and neuro-disability. The health care plan is not an isolated event, but part of a continuous process, with emphasis placed on ensuring actions in the health care plan are being taken forward and monitored at regular intervals. Detainees receive prompt health care and intervention to improve their health outcomes. Detainees have access to 24-hour emergency medical (physical and mental) and dental services. Treatment in the community is considered for detainees in IRCs whose physical and mental health needs cannot be managed in the secure setting.

KLOE	Prompts	Characteristics
	4. Are the facilities and premises appropriate for the services that are planned and delivered?	Detainees undergo assessment and treatment in an environment that is psychologically, emotionally and physically safe, and have a clear understanding of the treatment process. Health services are delivered in locations which are safe, fit for purpose and have the necessary facilities.
R2. Do services take account of the **needs of different people**, including those in vulnerable circumstances?	1. How are services planned and delivered to take account of the needs of different people, for example on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation?	The needs of different people are taken into account when planning and delivering services (for example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation).
	2. How are services planned, delivered and coordinated to take account of people with complex needs?	Detainees with health care needs requiring 24-hour nursing care are supported by health staff and accommodated in appropriate facilities that meet their individual needs. Detainees with common mental health problems are recognised and supported by health staff and specialist services at the prison, and have unhindered access to help in pursuing recovery. Detainees' severe and enduring mental health needs are recognised and supported by health staff and specialist services at the prison, and they have unhindered access to help.
R3. Can people access care and treatment in a **timely** way?	1. Do people have timely access to initial assessment, diagnosis or urgent treatment?	Induction takes place promptly and on its completion all detainees understand how to access available health care Young people receive a timely, comprehensive and holistic health assessment with an emphasis on integrated personalised needs assessment and care which includes an assessment of physical health (within three days of their arrival), mental health (within three days of their arrival),

KLOE	Prompts	Characteristics
		substance misuse (within five days of their arrival) and neuro-disability (within ten days of their arrival). Detainees can access the right care at the right time. Access to care is managed to take account of people's needs, including those with urgent needs. Detainees are aware of the health services available to them and know how to access them.
	2. Is care and treatment only cancelled or delayed when absolutely necessary? Are cancellations explained to people, and are detainees supported to access care and treatment again as soon as possible?	Waiting times, delays and cancellations are minimal and managed appropriately.
	3. Do services run on time, and are people kept informed about any disruption?	Services run on time. People are kept informed of any disruption to their care or treatment.
R4. How are people's **concerns and complaints** listened and responded to and used to improve the quality of care?	1. Do people who use the service know how to make a complaint or raise concerns, are they encouraged to do so, and are they confident to speak up?	Detainees have confidence in complaints procedures, which are effective, timely and well understood. People understand how to make complaints about health care.
	2. How easy is the system to use? Are detainees treated compassionately and given the help and support they need to make a complaint?	Detainees feel safe from repercussions when using complaints procedures and are aware of an appeal procedure. It is easy for people to complain or raise a concern and they are treated compassionately when they do so.
	3. Are complaints handled effectively and confidentially, with a regular update for the complainant and a formal record kept?	Complaints and concerns are always taken seriously, responded to in a timely way and listened to. Improvements are made to the quality of care as a result of complaints and concerns.

KLOE	Prompts	Characteristics
	4. Is the outcome explained appropriately to the individual? Is there openness and transparency about how complaints and concerns are dealt with?	There is openness and transparency in how complaints are dealt with.

Well-led

KLOE	Prompts	Characteristics
W1. Is there a clear **vision** and a credible **strategy** to deliver good quality of care?	1. Is there a clear vision for care and a set of values, with quality and safety the top priority?	There is clear statement of vision for care and values, driven by quality and safety.
	2. Is there are a robust, realistic strategy for achieving the priorities and delivering good quality care?	It has been translated into a credible strategy and well-defined objectives that are regularly reviewed to ensure that they remain achievable and relevant.
	3. How have the vision, values and strategy been developed?	The vision, values and strategy have been developed through a structured planning process with regular engagement from internal and external stakeholders, including detainees, staff, commissioners and others. Strategic objectives are supported by quantifiable and measurable outcomes, which are cascaded throughout the service. The challenges to achieving the strategy are understood and an action plan is in place.
	4. Do staff know and understand what the vision and values and strategy are and their role in achieving them?	Staff in all areas know and understand the vision, values and strategic goals.
	5. Is progress against delivering the strategy monitored and reviewed?	Progress against delivering the strategy is monitored and reviewed.
W2. Does the **governance** framework ensure that **responsibilities** are clear, and that **quality, performance and risks** are understood and managed?	1. Is there an effective governance framework to support the delivery of the strategy and good quality care?	The levels of governance function effectively and interact with each other appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.

KLOE	Prompts	Characteristics
	2. Are staff clear about their roles and do they understand what they are accountable for?	Staff have a clear understanding of their accountabilities.
	3. How are working arrangements with partners and third party providers managed?	Working arrangements with other parties are clearly set out and well managed.
	4. Are the governance framework and management systems regularly reviewed and improved?	The governance framework and management systems are kept under review.
	5. Is there a holistic understanding of performance which integrates the views of detainees, with safety, quality, activity and financial information?	There is a clear and comprehensive view of performance.
	6. Are there comprehensive assurance systems and service performance measures which are reported and monitored, and is action taken to improve performance?	Quality receives sufficient coverage in senior management meetings, and in other relevant meetings. There are processes and information to manage current and future performance. The information used in reporting, performance management and delivering quality care is accurate, valid, reliable, timely and relevant. Integrated reporting supports effective decision-making. A full and diverse range of people's views and concerns are encouraged, heard and acted on. Information on people's experience is reported and reviewed alongside other performance data.
	7. Are there effective arrangements in place to ensure that the information used to monitor and manage quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?	There are processes and information to manage current and future performance. The information used in reporting, performance management and delivering quality care is accurate, valid, reliable, timely and relevant.

KLOE	Prompts	Characteristics
	8. Is there a systematic programme of clinical and internal audit which is used to monitor quality and systems to identify where action should be taken?	Performance issues are escalated through clear structures and processes. Clinical and internal audit processes function well and have a positive impact in relation to quality governance, with clear evidence of action to resolve concerns.
	9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what people say is 'on their worry list'?	There is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.
W3. How does the **leadership** and **culture** reflect the vision and values, encourage openness and transparency and promote good quality care?	1. Do leaders have the skills, knowledge and experience that they need both when they are appointed and on an ongoing basis?	The appropriate experience and skills to lead are maintained through effective selection, development and succession processes.
	2. Do leaders have the capacity, capability, and experience to lead effectively?	Leaders have the experience, capacity and capability to ensure that the strategy can be delivered.
	3. Do the leaders understand the challenges to good quality care and can they identify the actions needed address them?	The leadership is knowledgeable about quality issues and priorities, understands what the challenges are and takes action to address them. Performance information is used to hold management and staff to account.
	4. Are leaders visible and approachable?	Leaders are visible and approachable.
	5. Do leaders encourage appreciative, supportive relationships among staff?	Leaders model and encourage cooperative, supportive relationships among staff so that they feel respected, valued and supported.
	6. Do staff feel respected and valued?	Mechanisms are in place to support staff and promote their positive wellbeing.

KLOE	Prompts	Characteristics
	7. Is action taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority?	Behaviour and performance inconsistent with the values is identified and dealt with swiftly and effectively, regardless of seniority. The establishment demonstrates strong leadership in delivering a coordinated approach to eliminating all forms of discrimination. Leaders at every level prioritise safe, high quality, compassionate care and promote equality and diversity.
	8. Does the culture encourage candour, openness and honesty?	The service is transparent, collaborative and open with all relevant stakeholders about performance. Candour, openness, honesty and transparency and challenges to poor practice are the norm.
	9. Is there a strong emphasis on promoting the safety and wellbeing of staff?	There is a strong emphasis on the safety and wellbeing of staff.
	10. Do staff and teams work collaboratively, resolve conflict quickly and constructively and share responsibility to deliver good quality care?	There is a culture of collective responsibility between teams and services.
W4. How are **detainees**, the **public** and **staff engaged** and **involved?**	1. How are people's views and experiences, gathered and acted on to shape and improve the services and culture?	The leadership actively shapes the culture through effective engagement with staff, detainees and their representatives and stakeholders.
	2. Do staff feel actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture?	The service proactively engages and involves all staff and ensures that the voices of all staff are heard and acted on.

KLOE	Prompts	Characteristics
	3. Do both leaders and staff understand the value of staff raising concerns? Is appropriate action taken as a result of concerns raised?	The leadership actively promotes staff empowerment to drive improvement and a culture where the benefit of raising concerns is valued. Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated in a sensitive and confidential manner, and lessons are shared and acted upon.
W5. How are services **continuously improved** and **sustainability** ensured?	1. When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored?	Service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care. Their impact on quality and financial sustainability is monitored effectively.
	2. Are there examples of where financial pressures have compromised care?	Financial pressures are managed so that they do not compromise the quality of care.
	3. In what ways do leaders and staff strive for continuous learning, improvement and innovation?	There is a strong focus on continuous learning and improvement at all levels of the organisation. Safe innovation is supported and staff have objectives focused on improvement and learning.
	4. Are staff focused on continually improving the quality of care?	Staff are encouraged to use information and regularly take time out to review performance and make improvements.
	5. How are improvements to quality and innovation recognised and rewarded?	Improvements to quality are recognised and rewarded.
	6. How is information used proactively to improve care?	Information and analysis are used proactively to identify opportunities to drive improvements in care.