



National Offender  
Management Service



Public Health  
England



## **National Partnership Agreement between:**

**The National Offender Management  
Service, NHS England and Public Health  
England for the Co-Commissioning and  
Delivery of Healthcare Services in  
Prisons in England**

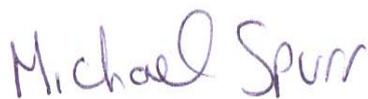
**2015-2016**

# Joint Statement

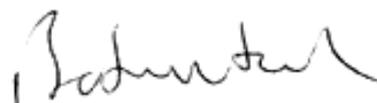
This is an update of the tripartite agreement first published in October 2013. It sets out the shared strategic intentions, joint corporate commitments and mutually agreed developmental priorities for the National Offender Management Service (NOMS), NHS England and Public Health England (PHE) in relation to commissioning and delivering healthcare services in adult prisons in England to April 2016.

We recognise our respective statutory responsibilities and independence, but commit to collaborate and cooperate at all levels within our organisations to achieve our shared delivery commitments and aims of ensuring safe and effective care, which improves health outcomes for offenders, reduces health inequalities, protects the public and reduces reoffending.

Collaboration goes beyond the words written in this document: it must be embedded into the way in which we work together as a tripartite partnership, nationally, regionally and locally. Implicit in signing up to this agreement is an understanding that this collaboration will require not only the contribution of specialist health and justice leads but of a whole organisational response. This may mean working in different ways to enable us to address the challenges that support transformational change and improve outcomes, not only for people detained in prison but also for the wider community.



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# 1. Context and Shared Purpose

## Health and Offending

- 1.1. Offenders are more likely to smoke, misuse drugs and/or alcohol, suffer mental health problems, report having a disability, self-harm, attempt suicide and die prematurely compared to the general population. The links between poor health and reoffending have been long understood. For example, evidence suggests:
  - Drug users are estimated to be responsible for between a third and a half of acquisitive crime<sup>1</sup> and treatment can cut the level of crime they commit by about half;<sup>2</sup>
  - Alcohol is a factor in an estimated 53% of violent crime<sup>3</sup> and Accident and Emergency (A&E) data sharing and targeted interventions have been shown to reduce overall A&E violence related attendances in one study by 40%.<sup>4</sup>
- 1.2. The clear links between the wider determinants of health and factors affecting reoffending such as sustainable housing or employment create a potentially vicious circle. For example, offenders with addiction or mental health problems are more likely to need support with housing, education or employment to change their lives and prevent future victims, yet at the same time research shows these offenders will find it more difficult to access mainstream help than the general population. Increased health inequalities are therefore compounded by greater barriers to accessing services to meet those needs. The specific challenges and health inequalities of those in contact with the criminal justice system have been highlighted recently by the Chief Medical Officer for England.<sup>5</sup>
- 1.3. Just as the evidence base shows both the links between health and crime and the disproportionate levels of health inequalities experienced by those in contact with the criminal justice system, so too there is clear evidence of the efficacy of interventions to improve the health needs of this group, on reductions in crime and better health outcomes. There is also emerging international evidence of the benefits of recognising prison health as a public health issue and the wider 'community dividend' which may be realised by

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<sup>1</sup> MacDonald, Z. Tinsley, L., Collingwood, J., Jamieson, P. and Pudney, S. (2005). *Measuring the harm from illegal drugs using the Drug Harm Index*. Home Office Online Report 24/05

<http://webarchive.nationalarchives.gov.uk/20110218135832/rds.homeoffice.gov.uk/rds/pdfs05/rdsolr2405.pdf>

<sup>2</sup> National Treatment Agency (2012) *Estimating the crime reduction benefits of drug treatment and recovery* [www.nta.nhs.uk/uploads/vfm2012.pdf](http://www.nta.nhs.uk/uploads/vfm2012.pdf)

<sup>3</sup> Office for National Statistics (2015) Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14, Chapter 5: Violent Crime and Sexual Offences – Alcohol-Related Violence [www.ons.gov.uk/ons/dcp171776\\_394516.pdf](http://www.ons.gov.uk/ons/dcp171776_394516.pdf)

<sup>4</sup> Effective NHS Contributions to Violence Prevention: the Cardiff Model (2007) - [www.vrg.cf.ac.uk/Files/vrg\\_violence\\_prevention.pdf](http://www.vrg.cf.ac.uk/Files/vrg_violence_prevention.pdf)

<sup>5</sup> See *Annual Report of the Chief Medical Officer, Surveillance Volume 2012 on the state of the Public's Health*, Chapter 3 - Health and Justice [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/298297/cmo-report-2012.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/298297/cmo-report-2012.pdf)

addressing some of the disproportionate levels of illness identified within the prison population, in particular with respect to issues such as communicable disease control.

- 1.4. The World Health Organisation's Health in Prisons Programme and the Council of Europe at a meeting of prison health experts held in Strasbourg in 2014 endorsed the position that there can be 'no health without justice and no justice without health'<sup>6</sup> by which it was meant that health and justice organisations cannot achieve their respective aims in isolation. It is therefore essential that health and justice organisations with responsibilities for commissioning and delivering services in prisons work together in partnership. Further, wider public health objectives around reducing health inequalities can be achieved through addressing the health needs of people detained in prison as they often return to communities experiencing significant levels of disease, poorer health behaviours and less access to health services.

## A History of Partnership Working

- 1.5. A formal National Partnership Agreement has existed for Offender Health Services in public sector prisons in England since 2003. The original agreement, between the Home Office and the Department of Health, was developed to coincide with the Ministerial decision to transfer responsibility for policy and funding of health care in prisons from HM Prison Service to the Department of Health. A second revised National Partnership Agreement<sup>7</sup> was published in 2007 to coincide with the transfer of responsibility for Escort and Bedwatch services and the start of devolution of responsibility for Prison Health commissioning from the Department of Health to NHS Primary Care Trusts (PCTs) which was completed in 2009. **Annex A** summarises the history of partnership working around the transfer of prison health functions to the Department of Health up to and post 2007.
- 1.6. In 2010 the Coalition Government announced proposals for significant reforms of the way in which Health is commissioned and supported in England which required a new approach and commitment to partnership working between NOMS, NHS England and Public Health England (PHE).

## The Commissioning Landscape for Health and Justice

- 1.7. Section 15 of the **Health and Social Care Act 2012** gives the Secretary of State for Health the power to require NHS England to commission certain services instead of Clinical Commissioning Groups (CCGs). These include 'services or facilities for persons who are detained in a prison or other accommodation of a prescribed description.

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<sup>6</sup> Council of Europe (proceedings of the Expert Meeting on Prison Health, Pompidou Group of the Council of Europe, Strasbourg, May 27, 2014)

<sup>7</sup>[http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh\\_072465](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_072465)

- 1.8. NHS England assumed these powers from **1 April 2013**. The responsibilities of NHS England cover both public and contracted prisons and therefore effectively complete the transfer of responsibility for prison healthcare to the NHS.
- 1.9. NHS England is responsible for ensuring that services are commissioned to consistently high standards of quality across the country, promote the NHS Constitution and deliver the requirements of the Secretary of State's (SoS) Mandate and the Section 7a agreement with NHS England.
- 1.10. NHS England Health and Justice are responsible for commissioning all health services (with the exception of some emergency care, ambulance services, out-of-hours services and NHS 111 services). This includes primary care incorporating dentistry and optometry services, preventive and public health services, secondary care, community services, mental health and substance misuse services as set out in the Section 7a agreement with the SoS, in respect of persons detained in prison, or in other secure accommodation. Commissioning is led by ten teams across four regions (North, South, Midlands and East and London), supported by a small national Health and Justice team.
- 1.11. The Mandate between the Department of Health and NHS England (first published in November 2012 and refreshed in November 2013) sets out key expectations of the Department for NHS England in relation to working with people in prison, including improving the transition between custody and the community and developing liaison and diversion services, specifically

*Developing better healthcare services for offenders and people in the criminal justice system which are integrated between custody and the community, including through development of liaison and diversion services*<sup>8</sup>

- 1.12. The 2013 reforms to the health system in England also abolished the National Treatment Agency for Substance Misuse and the Health Protection Agency, both of which had a key role in services delivered to offenders. Many of the former functions of these agencies are now part of the work of PHE led by a Health and Justice team matrix working within PHE with the Alcohol, Drugs and Tobacco Division and the Wellbeing & Mental Health team.
- 1.13. Through its Health and Justice Team, and Drugs, Alcohol and Tobacco Division, PHE works in partnership with NHS England commissioners in support of their responsibility for commissioning public health functions in prisons, at a national and local level including coordinating activity to monitor and respond to infection outbreaks and their control. In addition to the national teams within the Health and Wellbeing Directorate of PHE, Health and Justice Public Health Specialists and Alcohol, Drugs and Tobacco Leads are working in PHE Centres, allowing local collaboration and cooperation with NHS England, NOMS and a range of other partners including Local Authorities (who commission drugs and alcohol services and NHS Health Checks in the community).

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<sup>8</sup> The Mandate, A mandate from the Government to NHS England: April 2014 to March 2015, Department of Health, November 2013, p26

## The Co-Commissioning and Delivery Partnership Agreement

- 1.14. Health and justice services are interdependent and work together to deliver a system which is safe, legal and decent and which delivers both health and justice outcomes for the prisoner/patient. As independent organisations responsible for commissioning interdependent offender services, it is essential that NOMS and NHS England, both supported by PHE, align their priorities and resources.
- 1.15. The first agreement between NOMS, NHS England and PHE was published in 2013 and marked the start of a new chapter in working in partnership, replacing all previous National Partnership Agreements and related instructions from the Department of Health with respect to healthcare services in prisons in England. This agreement reflects our continued commitment to work together to co-commission<sup>9</sup> and deliver health services which change and save lives.
- 1.16. The agreement is not intended to be legally binding and no legal obligations shall arise from the provisions of the agreement. The purpose of this agreement is to define the partnership roles and responsibilities of the three signatory organisations and to set out joint developmental priorities for the co-commissioning of services and outline accountabilities for delivery to 2016.
- 1.17. NHS England, PHE and NOMS commit to support this agreement corporately and therefore its provisions will apply to all co-commissioning activity and delivery at all levels within the three organisations. Commitments in this agreement therefore need not and should not be re-negotiated in local partnerships as these are also covered by this national agreement. It is also recognised that these commitments will require the contribution not only of health and justice leads within each organisation but of colleagues across different directorates who can help achieve the desired outcome for our shared population.
- 1.18. The agreement shall also apply to sub-contracting and delegated commissioning arrangements (for example commissioning of substance misuse services through a section 75 agreement with a local authority<sup>10</sup>). Contracts for healthcare services in prisons should not seek to replicate commitments in this agreement but instead should reference this, and any local delivery agreements based on it, to ensure consistency of approach and recognise the principle of partnership which this is based on.

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<sup>9</sup> NOMS defines the term co-commissioning to be where two or more commissioning organisations align their commissioning systems and priorities for the purpose of achieving shared outcomes while retaining separate responsibility for managing their own resources to support this. It is not therefore the same as joint commissioning or pooled commissioning, and commissioned resources may be aligned at a strategic as opposed to a service-by-service commissioning level.

<sup>10</sup> These refer to agreements under section 75 of the National Health Service Act 2006 between a local authority and an NHS body in England for either the pooling of funding, or delegation of responsibility for providing prescribed NHS or health-related local authority functions to the other party. Such agreements do not alter the liability of the NHS or local authority for their prescribed functions.

## Scope

1.19. For the purposes of this agreement, the scope of commissioned services includes:

- All healthcare for remand and sentenced prisoners in NOMS Commissioned establishments in England<sup>11</sup> (with the exception of some emergency care, ambulance services, out-of-hours services and NHS 111 services) including:
  - Primary care (including pharmacy, optician & dentistry services);
  - Planned secondary care (including outpatient, diagnostic and inpatient services);
  - Community care services including mental health services;
  - Public health (including health promotion, immunisation and infection control<sup>12</sup> and clinical and non-clinical substance misuse services);
  - Continuity of care through the prison gate into the community;
- Sentenced and remand prisoners over the age of 18 years of age in both public sector and privately managed prisons in England and continuity of care on release back into the community on licence and post-sentence supervision;<sup>13</sup>
- Personality Disorder services for offenders who are high risk of harm (men) and high risk of reoffending (women) which are jointly funded and commissioned by NOMS and NHS England Specialised Commissioning.<sup>14</sup>

1.20. In addition, the following non-commissioned services are also in scope of this agreement:

- Public health advice including on infection control and management of outbreaks of infectious diseases, provided by PHE through its local Centres and supported by the national Health and Justice Team;<sup>15</sup>
- The recommendations by NHS providers, to transfer prisoners under the Mental Health Act 1983 to secure hospital provision, for decision by the Justice Secretary on whether to direct such a transfer, and their subsequent case management as restricted patients by the Mental

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<sup>11</sup> This recognises that HMPS also provides custodial services to the Youth Justice Board and Home Office which will be subject to separate agreements with NHS England. Where HMPS operates establishments with split site functions e.g. young people and young adult YOIs, then this agreement will only apply to services for those over 18 years commissioned by NOMS.

<sup>12</sup> NHS England is supported in this function by Public Health England for prisoners and those on remand. For more information see [www.gov.uk/government/collections/public-health-in-prisons](http://www.gov.uk/government/collections/public-health-in-prisons)

<sup>13</sup> The agreement covers health services for offenders in prisons in England only, recognising that NOMS, unlike NHS England is also responsible for commissioning prison and probation services in Wales. NOMS and the Welsh Government have separate partnership arrangements to cover health services in prisons in Wales. This agreement does however cover services for Welsh prisoners held in English Prisons.

<sup>14</sup> Like health and justice, Personality Disorder services, including those for offenders, are a direct commissioning function of NHS England, but are commissioned as part of Specialised Commissioning as opposed to Health and Justice Direct Commissioning. For more information see [www.gov.uk/government/publications/a-guide-to-working-with-offenders-with-personality-disorders](http://www.gov.uk/government/publications/a-guide-to-working-with-offenders-with-personality-disorders)

<sup>15</sup> For more information see [www.gov.uk/government/collections/public-health-in-prisons](http://www.gov.uk/government/collections/public-health-in-prisons)

Health Casework Section (NOMS) and management of those returned to prison under section 50 of the Mental Health Act.

## Roles

- 1.21. Reducing health inequalities and improving health, wellbeing and justice outcomes for offenders are shared commissioning and delivery goals for NHS England, NOMS and PHE. However, each organisation has different responsibilities and clearly defined roles in achieving these outcomes.

## NHS England

- 1.22. NHS England is a non-departmental public body which operates within the wider health and social care system. Its overarching role is to ensure that the NHS delivers continuous improvements in outcomes for patients within the resources available. NHS England fulfils this role through its leadership of the reformed commissioning system. Working in partnership with Clinical Commissioning Groups (CCGs) and a wide range of stakeholders, it secures better outcomes, as defined by the NHS Outcomes Framework; actively promotes the rights and standards guaranteed by the NHS Constitution; and secures financial control and value for money across the commissioning system.
- 1.23. NHS England has a key role in providing national consistency in areas like quality, safety, access and value for money. In addition to the services PCTs previously commissioned in prisons (i.e. primary care, escort and bedwatch and mental health in-reach services), from April 2013 NHS England became responsible for commissioning planned secondary care, community services, and public health services including substance misuse services in prisons and continued commissioning of dentistry and optometry.
- 1.24. NHS England's single operating model for commissioning health services in prisons and other places of detention is set out in *Securing Excellence in Commissioning for Offender Health*.<sup>16</sup> Published in February 2013, this document was developed in partnership with a wide range of organisations including NOMS. This partnership agreement also adheres to and supports the priorities and commitments in NHS England's *Five Year Forward View*.<sup>17</sup>
- 1.25. To operate as a catalyst to support 'what good looks like' across the health and justice clinical care sector and promote consistent and sustained implementation of quality standards, NHS England has formed a National Health and Justice Clinical Reference Group (CRG). A chair is appointed for a three-year term (currently Dr Linda Harris) and the remaining clinical members are drawn from the 12 senate areas in England and are voluntary appointments. More information about the membership and activities of the Health and Justice CRG can be found on the NHS England website.<sup>18</sup>

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<sup>16</sup> See [www.england.nhs.uk/wp-content/uploads/2013/03/offender-commissioning.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/03/offender-commissioning.pdf)

<sup>17</sup> See [www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf](http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf)

<sup>18</sup> See [www.england.nhs.uk/commissioning/spec-services/npc-crg/health-justice-crg](http://www.england.nhs.uk/commissioning/spec-services/npc-crg/health-justice-crg)

- 1.26. To ensure that commissioned services produce the best outcomes for the health and justice patient population, NHS England Health have developed and are working to a specific patient and public voice strategic plan. This plan identifies the challenges and opportunities of securing meaningful engagement with this population both during their imprisonment and post release and incorporates service user contributions across a number of strategic fora.
- 1.27. For the purposes of this agreement, NHS England is responsible for commissioning and contract/performance management of services for Healthcare in all prisons including:
- **Primary Care Services** - General Practice, Dentistry, Pharmacy, Optometry
  - **Planned Secondary Care Services** - Mental Health services (within the prison setting), Midwifery, Inpatient, Outpatients, Diagnostics
  - **Community Care Services** - Breastfeeding, Cardiac, Continence, Diabetes, End of Life, Health Visiting, Heart Failure, Long Term Conditions (e.g. Huntington's Disease, Cancer), Medicines Management, Mental Health (In-reach), Neurology, Nutrition, Occupational Therapy, Phlebotomy, Physiotherapy, Podiatry, Speech Therapy, Stoma Care, Stroke and Wound Care, Intermediate Care and in-reach District Nursing services
  - **Public Health Services** – Health Needs Assessment,<sup>19</sup> Health Promotion, Immunisation & Vaccination, Infection Control,<sup>20</sup> Sexual Health, Smoking Cessation, Substance Misuse (Alcohol & Drugs)<sup>21</sup>
  - **Screening Services** - Antenatal & Newborn, Adult and Offender specific
  - **Personality Disorder services** for high risk of harm male and high risk of reoffending female offenders which are jointly funded and commissioned by NOMS and NHS England Specialised Commissioning
  - Clinical IT systems and infrastructure
  - Clinical governance and contract management of all healthcare services in public and contracted prisons<sup>22</sup>
  - Funding directly or through contracted providers of:
    - healthcare staff and their related employment duties
    - the acquisition and maintenance of non-fixed free-standing items (e.g. furniture) and non-fixed capital equipment (e.g. trolleys, couches, etc.)
    - new/replacement specialist clinical equipment e.g. X-ray equipment

<sup>19</sup> See [www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit](http://www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit)

<sup>20</sup> NHS England is supported in this function by Public Health England for prisoners and those on remand. For more information see [www.gov.uk/government/collections/public-health-in-prisons](http://www.gov.uk/government/collections/public-health-in-prisons)

<sup>21</sup> As set out in the Section 7a agreement between the Department of Health and NHS England, see

[www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/127242/29-People-in-prison-specification-121025.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127242/29-People-in-prison-specification-121025.pdf)

<sup>22</sup> NOMS have reviewed PSO 3100 - Clinical Governance and will provide updated operational guidance to clarify the difference between the duties of care of Governors and Directors of prisons and responsibility for Clinical Governance through the NHS.

- medical consumables (including pharmacy supplies) and clinical waste management and disposal (including medical sharps)
  - hospital escorts and bedwatches (in accordance with agreed minimum staffing costs)<sup>23</sup>
  - clinical constant supervision.
- Supporting healthcare and custody providers to work together to develop suitable and sufficient arrangements for mutual co-operation and co-ordination for example on those matters of health and safety which arise from joint operations and co-location
  - Quality assurance of service provision
  - Supporting integrated care packages between NHS and local authority funded social care support
  - Tackling wider determinants of health including those which also contribute to reoffending
  - Supporting effective ‘through the gate’ services with transition to the primary care services which NHS England is also responsible for directly commissioning as well as CCG and Local Authority commissioned services in England and Local Health Board commissioned services in Wales on release
  - Clinical recommendations on the need to transfer prisoners under the Mental Health Act with restricted patient status, liaison with the Mental Health Casework Section of NOMS to obtain the decision from the Secretary of State for Justice on whether to direct such transfer, and commissioning of mental health secure services
  - Providing an automatic mental health referral for those charged or convicted of domestic murder
  - Commissioning clinical reviews for deaths in custody in line with Prison and Probation Ombudsman (PPO) instructions
  - Cooperating with and responding to health and wellbeing issues within HM Inspectorate of Prisons (HMIP) and Care Quality Commission (CQC) inspections and reports, Independent Monitoring Board (IMB) reports, Coroner's reports to prevent other deaths, local authority scrutiny panels and PPO investigations
  - Healthcare related complaints
  - Ensuring health contributions to emergency preparedness, contingency planning and incident response

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<sup>23</sup> A review of escort and bedwatch and in-reach services is part of the shared Development Priorities for 2015-16.

- Taking forward the Department of Health Mandate for NHS England, in particular continuity of care for those leaving prison.

## The National Offender Management Service

- 1.28. The National Offender Management Service (NOMS) is an Executive Agency of the Ministry of Justice. Created in July 2008, its purpose is to protect the public and reduce reoffending by delivering the punishment and orders of the courts and supporting rehabilitation by helping offenders to reform their lives. NOMS keeps the public safe by ensuring that around 260,000 offenders are held safely and securely and undertakes the punishment of the courts through custodial (prison) or community sentences delivered by prison and probation providers in both England and Wales.
- 1.29. NOMS is responsible for commissioning and delivering adult offender services, in custody, in the community, and through the prison gate in both England and Wales, including cross-border movement. The Agency is also responsible for delivering both custodial and community services through its public sector delivery arms - Her Majesty's Prison Service (HMPS) and the National Probation Service (NPS). In addition, HMPS is also commissioned by the Youth Justice Board to provide places for youth offenders in Young Offender Institutions (YOIs) and the Home Office to provide Immigration Removal Centres (IRCs). The Agency is therefore both a commissioner and provider of services. These different roles are reflected in the way in which NOMS is organised and the different but complementary roles of Directorates within it.<sup>24</sup>
- 1.30. The Agency commissions over £2 billion worth of custodial services each year including prison management, prison facilities management and works<sup>25</sup> and the Prisoner Escort and Custody Service (PECS) which is responsible for escorting detainees and prisoners between courts and prisons. There are currently 115 prisons in England (and a further 4 in Wales). The management of 14 prisons is contracted to independent providers and the rest are commissioned through a service level agreement (SLA) and run by HMPS.
- 1.31. NOMS also commissions over £1 billion of services each year for offenders in the community from both public and independent providers including the National Probation Service, Community Rehabilitation Companies,<sup>26</sup> Electronic Monitoring, Approved Premises, Bail Accommodation and Support Services and Adult Attendance Centres.
- 1.32. In addition to directly commissioned services, NOMS is involved in co-commissioning over £1 billion worth of services where it is not the lead commissioner but where those services are essential in providing decency and

<sup>24</sup> See 'How the National Offender Management Service works' [www.gov.uk/government/publications/how-the-national-offender-management-service-works](http://www.gov.uk/government/publications/how-the-national-offender-management-service-works)

<sup>25</sup> A competition for the provision of facilities management and works was launched in July 2013 and lots awarded to two providers in November 2014. The new services will commence in 2015.

<sup>26</sup> The National Probation Service and Community Rehabilitation Companies were created by the Offender Rehabilitation Act 2014 which came into force from April 1 2015 replacing and expanding the work of Probation Trusts.

helping to reform and rehabilitate offenders.<sup>27</sup> In England these include learning and skills (BIS/Skills Funding Agency), employment programmes and benefit advice (DWP/Job Centre Plus), and accommodation, family services, and social care (local government). In addition, the Agency also works closely with the Welsh Government as, unlike responsibility for justice, many of the services which offenders in Wales need to access are devolved. Finally, NOMS is also a European Social Fund (ESF) Co-Financing Organisation.<sup>28</sup>

- 1.33. The range of offender services which NOMS commissions is set out in the NOMS Directory of Business<sup>29</sup> which is underpinned by a series of national mandatory minimum service specifications which are published in full.<sup>30</sup> These set out the mandatory minimum outcomes that all service providers commissioned by NOMS must meet in order to ensure that they are legal, safe, secure and decent. They do not set out how, or by whom, services should be delivered. The Agency also publishes information about its future Commissioning Intentions, information to support evidence-based commissioning and a range of practice guidance.<sup>31</sup>
- 1.34. Through the Offender Rehabilitation Act (2014) and Transforming Rehabilitation programme, the Coalition Government is transforming the way in which offenders are managed and rehabilitated.<sup>32</sup> Together these reforms include expanding supervision to those serving less than 12 months, reconfiguring the prison estate to create a network of resettlement prisons, and changing the way that offenders are supervised and supported in their rehabilitation through the creation of a new public sector National Probation Service (responsible for court services and high risk offenders) and contracting with 21 Community Rehabilitation Companies (responsible for medium and low risk offenders in custody and the community and resettlement services) who are paid in part by their results.
- 1.35. It is important for healthcare commissioners and providers to continue to work closely with NOMS commissioners and providers to ensure that there is shared understanding and engagement with these criminal justice reforms. In particular, it is important to ensure that health needs of changing populations held in prisons as a result of these reforms, in particular the creation of Resettlement Prisons<sup>33</sup>, continue to be understood and commissioned provision continues to be aligned.
- 1.36. For the purposes of this agreement, NOMS (including its custodial public sector provider arm (HMPS), contracted prison providers, facilities management and service providers, Community Rehabilitation Companies and, where necessary, drawing on Ministry of Justice Corporate Services) is responsible for:

- Protecting the public and reducing reoffending

<sup>27</sup> For more information see 'An Introduction to NOMS Offender Services Co-commissioning' 2014, chapter 1 'Health and Substance Misuse', [www.justice.gov.uk/downloads/about/noms/Introduction-to-NOMS-offender-services-co-commissioning.pdf](http://www.justice.gov.uk/downloads/about/noms/Introduction-to-NOMS-offender-services-co-commissioning.pdf)

<sup>28</sup> For more information about NOMS CFO activity visit <http://co-financing.org/>

<sup>29</sup> <https://www.gov.uk/government/publications/noms-directory-of-services>

<sup>30</sup> [www.gov.uk/government/collections/noms-directory-of-service-specifications](http://www.gov.uk/government/collections/noms-directory-of-service-specifications)

<sup>31</sup> [www.gov.uk/government/publications/guidelines-for-services-commissioned-by-noms](http://www.gov.uk/government/publications/guidelines-for-services-commissioned-by-noms)

<sup>32</sup> [www.justice.gov.uk/transforming-rehabilitation](http://www.justice.gov.uk/transforming-rehabilitation)

<sup>33</sup> For more information see <https://www.gov.uk/government/publications/resettlement-prisons>

- Provision of safe, decent and secure custody
- Offender and population management including the transfer of prisoners between England and Wales
- Prison capacity management (including decisions to open, expand, re-role or close facilities)
- Determining prison roles, functions and population specifications including location of specialist accommodation and units (such as new inpatient facilities, palliative care or end of life beds)
- The safety and physical security of staff (including healthcare staff) and prisoners including formally setting out through instruction<sup>34</sup> multi-agency safer custody arrangements (including Assessment, Care in Custody and Teamwork (ACCT)) and requirements of all persons operating within or visiting establishments<sup>35</sup>
- Supporting custody and healthcare providers to work together to develop suitable and sufficient arrangements for mutual co-operation and co-ordination for example on those matters of health and safety which arise from joint operations and co-location
- Specifying processes for security clearance of healthcare staff including managing clearances and facilitating necessary access to establishments
- Aligning and integrating the delivery of health and non-health related services within establishments and 'through the gate' including those which support rehabilitation and tackling the wider determinants of health
- Provision of appropriate facilities and services within the establishment for the purposes of enabling and hosting healthcare services including funding<sup>36</sup> and providing as appropriate:
  - new build capital developments and maintenance of building fabric
  - facilities management, works and services<sup>37</sup> including lighting, heating, utilities, telephone services, pest control, fire and security, laundry and cleaning of all healthcare facilities to standards agreed with NHS in line with national guidance

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<sup>34</sup> These include Prison Service Orders (PSOs) ([www.justice.gov.uk/offenders/psos](http://www.justice.gov.uk/offenders/psos)) and Prison Service Instructions (PSIs) ([www.justice.gov.uk/offenders/psis](http://www.justice.gov.uk/offenders/psis))

<sup>35</sup> A review of health related PSIs and PSOs is part of the shared Development Priorities for 2015-16

<sup>36</sup> As part of the shared Development Priorities for 2013-14, reviews will be undertaken of responsibility for future funding of specific healthcare and healthcare enabling services and also current practice for agreeing and funding of constant supervision, see priorities 5 and 9

<sup>37</sup> From June 2015 works and facilities management in Public Sector Prisons will be provided under new contracts managed by NOMS

- ‘enabling’ services for healthcare are<sup>38</sup> including security related functions such as the supervision of medicine management queues and facilitation of prisoner’s attendance at healthcare appointments (including, as necessary, internal escorts or delivery of healthcare appointment slips to prisoners where paper systems are still in use) in line with nationally agreed service specifications
  - non-clinical constant supervision
  - non-clinical IT systems and infrastructure.
- Risk assessments for all escorts and bedwatches, supervision of escorts and bedwatches paid for by NHS England and funding of additional staffing based on assessment of risk (based on national guidance)<sup>39</sup>
  - Access for prisoners to purchase nationally agreed non-prescription medicines, dental products, optical products and other health related items through prison retail services
  - Supporting wider health promotion through non-clinical services such as healthy diet and exercise<sup>40</sup> as part of Health Promotion Action Groups
  - Coordinating NOMS health protection/infection control resilience planning, system monitoring and advice to directly employed staff
  - Complaints relating to the enabling of healthcare services
  - Drug supply reduction strategy and activity
  - Contract management of specific healthcare services in a small number of contracted prisons on behalf of, and with NHS England
  - Personality Disorder services for high risk of harm male and high risk of reoffending female offenders which are jointly funded and commissioned by NOMS and NHS England Specialised Commissioning
  - Case management of prisoners transferred under the Mental Health Act for treatment as restricted patients in secure hospitals.<sup>41</sup>

## Public Health England

1.37. Public Health England (PHE) is an Executive Agency of the Department of Health. PHE exists to protect and improve the nation’s health and wellbeing and reduce health inequalities. It does this through world class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services.

<sup>38</sup> This agreement is formally set out in the published NOMS Service Specification ‘Enablers of National Co-commissioned Services in Prisons’ see [www.gov.uk/government/publications/national-offender-management-service-noms-service-specifications-for-secure-and-decent-custody](http://www.gov.uk/government/publications/national-offender-management-service-noms-service-specifications-for-secure-and-decent-custody)

<sup>39</sup> A review of escort and bedwatch and in-reach services is one of the shared Development Priorities for 2015-16.

<sup>40</sup> Where specialist diet or additional remedial physical exercise is specifically recommended on clinical grounds then this should be funded by the NHS

<sup>41</sup> [www.gov.uk/government/collections/mentally-disordered-offenders](http://www.gov.uk/government/collections/mentally-disordered-offenders)

- 1.38. PHE's Health and Justice Team sits within the Health and Wellbeing Directorate and works with a network of Health and Justice Public Health Specialists based in PHE Centres to specifically support the interface with both NHS England (in relation to both its specific functions under the Section 7a agreement and wider public health functions) and NOMS, at both national and local level.
- 1.39. Support provided by the Health and Justice function (including the Alcohol, Drugs and Tobacco Division) in PHE includes disease surveillance, collection and collation of public health data and intelligence (including the National Drug Treatment Monitoring System), production of evidence-based guidelines, response to incidents and outbreaks, (in partnership with PHE Centre Health Protection Teams, who will lead the response at a local level), supporting Emergency Planning, Resilience & Response (including arranging and leading desk top exercises), and advice to policy makers, commissioners and service providers on addressing public health issues, including substance misuse services. Specifically this includes:
- Developing the evidence-base to support commissioning and service provision through primary research, audit, collection and analysis of data, publication and dissemination of information, reports and research studies
  - Identifying emerging health threats to prisoners and staff working in prisons and providing advice on their management or mitigation
  - Producing evidence-based guidelines and advice on all aspects of public health in prisons, including health protection, health promotion and healthcare public health
  - Developing resources and tools to enable commissioners and service providers to assess the quality of services and how well they meet the needs of the people who use them (including supporting the development of new information systems and Health and Justice Indicators of Performance (HJIPs))
  - Leading the development of disease surveillance and alerting systems to detect outbreaks of infectious diseases in prisons
  - Leading the management and control of outbreaks of infectious diseases
  - Supporting partner organisations in developing and delivering care for people dependent on drugs, alcohol and/or tobacco, including guidance on treatment and management, health improvement activities and collection and collation of intelligence and data through the National Drug Treatment Monitoring System (NDTMS) in prison and in the community
  - Supporting partner organisations in developing and delivering appropriate screening and immunisation programmes according to the

needs of the population and consistent with PHE's role in the wider community

- Supporting emergency preparedness, resilience and response through development of training and exercise resources as well as providing 'structured debriefs' for incidents to capture learning for the wider system
- Supporting partners in conducting health needs assessments or other formal public health activities to assess the health and wellbeing of people in prisons, including developing 'toolkits' and information resources which can be used by those undertaking work with prisons<sup>42</sup>
- Working with partners to ensure continuity of care across the prison estate and on release back to the community
- Supporting both NOMS and NHS England in the performance of their statutory functions as appropriate; and interfacing with Public Health Wales as necessary
- Leading international engagement on prison health through its work as the UK Collaborating Centre to the WHO Health in Prisons Programme (Europe)
- Supporting collaborative working for health across the Devolved Administrations of the UK and with the Republic of Ireland through the Five Nations' Health and Justice Collaboration.

1.40. While PHE has a key role in providing expert public health advice guidance and tools to NOMS and NHS England which support commissioning in the context of this agreement, it does not have any direct responsibility for commissioning or performance management of prison healthcare services, nationally or locally.

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<sup>42</sup> For example see [www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit](http://www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit)

# 2. Joint Outcomes, Principles and Priorities

## Our Approach

2.1. Our approach to joint working is summarised as follows:

Support	Communicate	Review
<ul style="list-style-type: none"><li>• Mutually supportive, both deriving value from it;</li><li>• Develop trust, and an appropriate setting for challenge;</li><li>• Allow us to act independently, where necessary;</li><li>• Understanding and acknowledgment of respective roles and cultures;</li><li>• Influence each other's approaches, as appropriate;</li><li>• Reduce burden where possible.</li></ul>	<ul style="list-style-type: none"><li>• Empower and enable communication at all levels of the organisations;</li><li>• Open and transparent; sharing information in a timely manner, culture of no surprises;</li><li>• Aspire to collectively provide a coherent picture of quality of services to the public.</li></ul>	<ul style="list-style-type: none"><li>• Valued at highest level of organisation, visible leadership, clear accountability and coherent corporate approach;</li><li>• Captured in written documents, co-produced and available to all;</li><li>• Relationship should be kept under review, so we can constantly learn.</li></ul>

## Shared Outcomes

- 2.2. Prisoners should receive an equivalent health and wellbeing service to that available to the general population with access to services based on need.
- 2.3. Health and wellbeing services in prison should seek to improve health and wellbeing (including parity of esteem between services which address mental and physical health), tackle health inequalities and wider determinants of health and contribute to protecting the public and reducing re-offending.<sup>43</sup>
- 2.4. Prisoners should expect to experience improvement in their health and wellbeing, particularly in respect of recovery from substance misuse addiction, mental health problems, management of long-term conditions and access to public health interventions to prevent disease and illness.
- 2.5. Prisoners should expect continuity of care between custodial settings and between custody and community (including across the border with Wales).

<sup>43</sup> This is reflected in the Public Health Outcomes Framework (PHOF) for England, see [www.gov.uk/government/collections/public-health-outcomes-framework](http://www.gov.uk/government/collections/public-health-outcomes-framework)

- 2.6. Prisoners with identified social care needs should expect integrated health and social care which supports as much independence as possible within the constraints of custody.
- 2.7. Prisoners requiring end of life care should be able to make similar choices about their care as the general population can within the constraints of custody.

## Joint Principles

- 2.8. NOMS and NHS England, supported by PHE, have a shared responsibility for the development of health and wellbeing services to prisoners on the basis of a shared local assessment of need, patient involvement and evidence-based practice.
- 2.9. NOMS, NHS England and our providers have a shared responsibility for continuous service improvement supported, where appropriate, by PHE.
- 2.10. NOMS and NHS England will jointly ensure best use of available resources in line with public value and pressures on public spending including exploring jointly funded solutions as appropriate.
- 2.11. Providers to NOMS and NHS England (or Local Authorities where services are commissioned under Section 75 agreements) will be expected to share aggregate and case level information with each other in a way which is appropriate, legal, fair and transparent (supported by Information Sharing Agreements<sup>44</sup>) in order to support offender management and health outcomes. This is essential in terms of preventing suicide and self-harm, protecting the public and reducing reoffending.<sup>45</sup>
- 2.12. Decisions by either NOMS or NHS England which may have a detrimental impact on the services commissioned by the other party (for example PSIs, changes to establishment function, capacity or changes to availability of services) will be discussed at the earliest possible opportunity and whenever possible major changes will be co-designed.
- 2.13. Announcements and communications, in which the other parties to the agreement have an interest, will be consulted on in advance of issue, particularly where these have contractual, financial or reputational implications.<sup>46</sup>
- 2.14. NOMS, NHS England and PHE will jointly identify and agree the management of shared partnership issues and risks at relevant levels between the organisations.

<sup>44</sup> NOMS data sharing expectations are set out in PSI 27/2013

<sup>45</sup> The importance of information sharing for this purpose is set out in the Independent Advisory Panel on Deaths in custody statement on information sharing, see <http://iapdeathsincustody.independent.gov.uk/work-of-the-iap/working-groups/information-flow-through-the-criminal-justice-system/> and in chapter 2 of PSI 64/2011 Safer Custody

<sup>46</sup> One area where this is not possible relates to announcements over decisions to close prison establishments which must be announced by the Secretary of State for Justice in parliament before either staff or partners can be informed.

- 2.15. NHS England and NOMS will support each other's major procurement exercises by jointly developing and sharing health needs assessments and agreeing service outcomes in the spirit of co-commissioning and ensuring alignment between respective providers and their services.
- 2.16. NOMS and PHE will support NHS England activity to promote continuity of care on release from custody through alignment of 'through the gate' offender services and supervision and joining up of NHS England's direct commissioning functions for Health and Justice and Primary Care in the community. To support this, we will strengthen our joint working with Clinical Commissioning Groups and Local Authorities, including through building on new links between prison-based healthcare staff and Community Rehabilitation Companies.
- 2.17. Where the Ministry of Justice continues to contract primary care services in a small number of privately managed prisons, NOMS will work with NHS England to provide necessary access to service providers and information to ensure that NHS England Commissioners and the National Support Team are able to fulfil their commissioning responsibilities for all prison healthcare services and ensure integrated care.
- 2.18. Services will continue to be assessed on the basis of performance, public value and quality. In addition to performance managing services using contract measures, we will introduce and continue to develop the Health and Justice Indicators of Performance (HJIPs) in order to promote shared understanding of service performance and quality alongside other existing process and assurance mechanisms.
- 2.19. NOMS, NHS England and PHE will work together to manage outbreaks of infection and communicable disease control in prisons recognising respective responsibilities for advice, response, planning and delivering interventions with prisoners and staff working in a prison setting.
- 2.20. NOMS, NHS England and PHE will support the development of partnerships at all levels within and between our respective organisations and commissioned providers of services (see section three 'Governance'). We will enable this development through transparency of all relevant financial, performance and strategic planning information and documentation. Establishments and healthcare providers (with input from respective commissioners and managers) will be expected to work together to agree how best to deliver the commitments in this national agreement, including appropriate governance and setting this out in a local agreement.
- 2.21. Services will continue to be subject to independent inspection and challenge by the Care Quality Commission (CQC), HM Inspectorate of Prisons (HMIP), Independent Monitoring Boards (IMBs), Local Authorities, Coroners and the Prison and Probation Ombudsman (PPO) (see section 3). We will work together to facilitate and support complete transparency of the scrutiny of health services and collate and learn from best practice identified.

2.22 NOMS, NHS England and PH E will work together to ensure that prison health issues are appropriately reflected in the development and implementation of wider government policies and initiatives.

## **Joint Development Priorities for 2015-16**

2.23 Consolidating and building on the priorities we identified and commenced work on in 2013-14, we have prioritised eight development priorities on which we will work together in 2015-16:

1. Review and align NHS England and NOMS commissioning systems and strategies to ensure quality services which support health and justice outcomes
2. Strengthen integration of services and continuity of care between custody and the community, including through development of liaison and diversion services
3. Improve the proactive detection, surveillance and management of infectious diseases in prison and improve capability to detect and respond to outbreaks & incidents
4. Reduce levels of smoking amongst prisoners
5. Review the management of medicines and the impact of New Psychoactive Substances (NPS) in prisons to address risk of misuse and resultant harms
6. Strengthen multi-agency approaches to managing prisoners and learning from services and pathways at serious risk of harm and further embed shared learning to continuously improve practice
7. Undertake joint priority services reviews to ensure that best practice is being adopted and promoted
8. Introduce integrated health and social care services for prisoners in line with the Care Act 2014.

2.24. We will address these priorities through task and finish governance structures drawing on a wide range of expertise from both within our three organisations at all levels and from our partners. Many of these priorities will require multi-year activity to achieve the final outcomes we are seeking. As a consequence they include priorities started in 2013-14 which continue. Progress against delivery of our priorities will continue to be monitored by the national Prison Healthcare Board (England).

## **Priority 1 – Review and align NHS England and NOMS commissioning systems and strategies to ensure quality services which support health and justice outcomes**

2.25. We will continue to work together to ensure that our respective commissioning systems and strategies are aligned to ensure that we deliver our shared outcomes. We will bring together our existing priority work streams around developing core service specifications, information sharing and governance and

funding for custodial staff enabling healthcare under a new priority theme which focuses on continuous improvement of alignment and improvement activity.<sup>47</sup> We will expand the scope of this priority from the previous agreement to include a number of additional work streams which have emerged subsequently to recognise our tripartite commitment to these and ensure that they are in scope for our partnership governance.

2.26. In support of this priority we will:

- 1a. Introduce the suite of core NHS England service specifications for Health and Justice services through new competition processes
- 1b. Refresh and align NOMS service specifications, guidance and instructions (e.g. PSIs) to reflect the changed NHS specifications and operating environment including the introduction of Community Rehabilitation Companies (CRCs)
- 1c. Align our information governance (IG) and Information Sharing Agreements (ISAs) to drive transparency and continuous improvement of services
- 1d. Introduce, monitor and refresh at their anniversary Health and Justice Indicators of Performance (HJIPs) to replace Prison Health Performance and Quality Indicators (PHPQIs)
- 1e. Continue to specify a new generation clinical IT system to replace SystmOne by 2016 and improve integration with Justice information systems
- 1f. Develop a national model for the use of 'inpatient' facilities in supporting intermediate care outcomes in line with the reconfiguration of the Prison Estate
- 1g. Manage the realignment of funding for custodial staff enabling healthcare services in prisons.

### *Commitment*

2.27 By April 2016 we will have further improved alignment of NOMS and NHS England commissioning systems and strategies to support front-line service delivery, including:

- Improved shared core specifications, guidance and instructions
- Improved frameworks for information sharing and governance
- A shared view over performance and quality at different levels within our organisations to support continuous improvement
- A shared specification for a second generation clinical IT system with improved integration with NOMS IT systems

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<sup>47</sup> This brings together the 2013 agreement priorities 1, 2 and 5, specifically Priority 1- "Developing core service specifications for prison health and wellbeing services", Priority 2 - "Developing Information Sharing Agreements and processes to drive transparency and continuous improvement of services" and Priority 5 - "Reviewing and clarifying future responsibility for the funding of specific healthcare assets and enabling services".

- Re-alignment of funding in line with organisational responsibilities.

## **Priority 2 – Strengthen integration of services and continuity of care between custody and the community, including through development of Liaison and Diversion services:**

2.28. In line with the expectations set out in the Mandate to NHS England from the Secretary of State for Health, we will bring together a number of existing work streams which prioritise continuity of care and the delivery of services ‘through the gate’ between custody and the community.<sup>48</sup>

2.29. In support of this priority we will:

- 2a. Test new models of ‘through the gate’ substance misuse services in the North West and roll-out the key learning nationally in line with the Transforming Rehabilitation programme
- 2b. Maximise the strategic opportunities from the restructuring of the prison estate and creation of resettlement prisons for health and care services which operate ‘through the gate’
- 2c. Support the business case for funding the national roll-out of Liaison and Diversion services
- 2d. Extend existing and developing local delivery and regional strategic partnership arrangements to include new providers of probation services
- 2e. Strengthen continuity of care across the border between England and Wales including preparing for the new prison opening in Wrexham in 2017
- 2f. Work together with NHS England Primary Care direct commissioning in order to improve the equity of access to quality healthcare services for offenders in Approved Premises.

### *Commitment*

2.30 By April 2016 we will have further strengthened our shared systems and pathways which support continuity of care for offenders through the prison gate and into mainstream community service provision in order to maximise shared outcomes and public value in line with the Mandate to the NHS.

## **Priority 3 – Improve the proactive detection, surveillance and management of infectious diseases in prison and improve capability to detect and respond to outbreaks & incidents:**

2.31 The greater prevalence of infectious disease, especially blood-borne viruses (BBVs) and tuberculosis (TB), amongst prisoners and the ability to deliver

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<sup>48</sup> This priority brings together the 2013 agreement priorities 3 and 6, specifically Priority 3 – “Improving continuity of care across transitions between healthcare services in places of detention and on release in the community including access to healthcare services in Approved Premises as well as cross-border movement between England and Wales” and Priority 6 - “Testing ‘through the gate’ substance misuse services as part of the Transforming Rehabilitation Strategy”

active case finding programmes among traditionally under-served populations in prison, provides an opportunity to make significant improvements to both the health of individuals in prisons and their family and social networks, as well as public health gains for the wider population - the community dividend. By working together, PHE, NHS England and NOMS can build on good partnership working to make a step change in the way we detect and manage infectious disease in prison.<sup>49</sup> Each of the work streams carried over from last year remains a high priority (opt-out testing for BBVs and at or near reception screening for TB) but by bringing them together and adding to them with disease surveillance and emergency planning, resilience and response (EPRR), including detection and management of outbreaks, we are able to strengthen visibility of our tripartite commitment and governance to oversee delivery.

2.32 In support of this priority we will:

- 3a. Continue to improve the detection of TB at or near reception and improve treatment for those who are infected (including provision of Directly Observed Therapy (DOT) and treatment completion in prison and in the community)
- 3b. Continue to implement an 'opt-out' policy for testing for blood-borne viruses (BBVs) and development of care pathways for those found to be infected
- 3c. Strengthen the tripartite commitment to resilience against infectious diseases including the development and testing of outbreak plans and improvement of disease surveillance including notification of infections and outbreaks to Health Protection Teams within PHE Centres
- 3d. Prioritise work to respond to emerging threats where these arise.

### *Commitment*

2.33 By April 2016 we will have measurably strengthened our shared capability to detect and manage infectious diseases in prison. Specifically, we will:

- Improve our proactive detection and shared active case management of TB cases including meeting NICE recommendations regarding appropriate use of digital x-ray machines where provided as part of an active care pathway<sup>50</sup>
- In collaboration with other non-statutory partners and specialist commissioning teams, continue to implement our shared plan to scale up the 'opt-out' model of testing for BBVs building on enhanced activity (including the identification of 'pathfinder prisons') with the ambition of full implementation across the estate by the end of 2016-2017

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<sup>49</sup> This brings together the 2013 agreement priorities 11 and 12, namely Priority 11- "Improving the detection and management of tuberculosis among prisoners at or near reception" and Priority 12 - "Implementing an 'opt out' policy for testing for blood-borne viruses (BBVs) and developing care pathways for those found to be infected"

<sup>50</sup> Identifying and managing tuberculosis among hard-to-reach groups: NICE guidelines (PH37): March 2012  
[www.nice.org.uk/guidance/PH37/chapter/1-Recommendations#recommendation-9-identifying-active-tb-in-prisons-or-immigration-removal-centres](http://www.nice.org.uk/guidance/PH37/chapter/1-Recommendations#recommendation-9-identifying-active-tb-in-prisons-or-immigration-removal-centres)

- Ensure that all prisons have signed off, approved, up-to-date outbreak plans and have tested their responses through exercises
- Ensure timely notification of infections and/or outbreaks to PHE Centre Health Protection Teams and through them to the national Public Health Intelligence for Prisons and Secure Settings Service (PHiPs) Team to allow for effective response and improve disease surveillance.

## Priority 4 – Reduce levels of smoking amongst prisoners

2.34 It has been suggested that up to 80% of people in prisons and those supervised by probation services in the community are estimated to smoke, compared to only just over 20% in the general population.<sup>51</sup> NHS England, PHE and NOMS will continue our 2013 priority<sup>52</sup> to work together to reduce smoking prevalence among prisoners by improving access to harm reduction and support to help people stop smoking.

### *Commitment*

2.35 By April 2016 we will:

- Ensure every prisoner who wants to stop smoking has access to smoking cessation services at the point they need them
- Issue improved/revised Public Health guidance in relation to stop smoking services
- Clarify and reinforce current policy as set out in PSI 09/2007.<sup>53</sup>

## Priority 5 – Review the management of medicines and the impact of New Psychoactive Substances (NPS) in prisons to address risk of misuse and resultant harms

2.36 We will build on our work to date<sup>54</sup> to review the management of prescription medicines working together with professional bodies to tackle abuse of medications and extend this to look at wider issues about medicine management in prisons as well as look at responding to the reported risk in harms from New Psychoactive Substances (NPS) in prisons.

2.37 In support of this priority we will:

5a. Continue to work together with professional bodies to promote changes in prescribing practice and tackle abuse of medications including publication of

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<sup>51</sup> See Bridgwood, A & G Malbon, G (1995) *Survey of the physical health of prisoners*, 1994, HMSO and Brooker, C (2008) *The health needs of offenders on probation caseloads in Nottinghamshire and Derbyshire*, Lincoln: Centre for clinical and academic workforce innovation, University of Lincoln

<sup>52</sup> This was priority 7 in the 2013 agreement

<sup>53</sup> For more information see [www.justice.gov.uk/offenders/psis/2007](http://www.justice.gov.uk/offenders/psis/2007)

<sup>54</sup> "Reviewing the prescribing and abuse of prescription medications" was priority 8 in the 2013 agreement

recommended national prison formularies and implementation tools for specific therapeutic areas including pain relief

- 5b. Review expectations and best practice in the management of prison medicine queues including managing demand and reducing diversion of prescription medicines in order to secure best outcomes for the patient population
- 5c. Review the appropriate range and availability of non-prescription medicines through Prison Retail
- 5d. Explore best practice in addressing the harms of New Psychoactive Substances within the prison setting (NPS) and improve prisoner awareness of health risks associated with use of NPS.

### *Commitment*

- 2.38 By April 2016 we will have strengthened alignment of our systems at all levels in the management and supervision of prescription (and appropriate non-prescription medicines) and improved shared responses to addressing the harms of New Psychoactive Substances in prison.

## **Priority 6 – Strengthen multi-agency approaches to managing and learning from services and pathways for prisoners at serious risk of harm and further embed shared learning to continuously improve practice**

- 2.39 We will build on our work outlined in the previous National Agreement<sup>55</sup> to improve consistency of partnership approaches to implementing practice by clarifying shared pathways for managing prisoners at risk of serious self-harm including primary mental health intervention, use of ACCT, constant supervision and assessment and treatment of prisoners placed in Care and Separation Units. We will aim to build on practice sharing arrangements which support safer custody and produce revised policy and clinical standards for managing segregation rounds guidelines where this is indicated.

### *Commitment*

- 2.40 By April 2016 we will further improve the consistency of approach to managing prisoners at risk of serious self-harm by providing front-line providers with updated joint guidance on the multi-agency responsibilities and pathways for dealing with prisoners pre- and post-crisis.

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<sup>55</sup> This was priority 9 in the 2013 agreement

## **Priority 7 – Undertake joint priority services reviews to ensure that best practice is being adopted and promoted**

- 2.41 We will introduce a rolling programme of joint priority service reviews looking at agreed areas to ensure that best practice is being promoted and adopted nationally by each of our organisations working independently and together.
- 2.42 In support of this priority we will undertake specific reviews of:
- 7a. Demand for, and management of, Escort and Bedwatch services
  - 7b. The role of Health and Justice commissioners with respect to NOMS commissioned Prisoner Escort and Custody Services (PECS)
  - 7c. Strengthening mental health services along the pathway from the community into custody and back into the community.

### *Commitment*

- 2.43 By April 2016 we have ensured that the recommendations of these service reviews have informed necessary changes in delivery practice and where appropriate future commissioning options for escorts and bedwatches, managing the healthcare needs of prisoners and defendants between courts and prisons and mental health pathways through the prison gate.

## **Priority 8 - Introduce integrated health and social care services for prisoners in line with the Care Act 2014**

- 2.44 While responsibility for social care rests with Local Authorities, NHS England has an important role in supporting integrated health and care services for those in prison working together with NOMS.
- 2.45 The Care Act 2014 clarified local authorities' responsibility for social care for prisoners from April 2015.<sup>56</sup> NOMS and NHS England will work together with local authorities, the Department of Health and the Association of Directors of Adult Social Services (ADASS) to implement the Care Act so that prisoners with eligible care and support needs experience integrated and seamless services.
- 2.46 We will invite local authorities to join local and regional prison health governance boards and share and review best practice approaches to the development of integrated health and social care governance for the future. Where agreed locally, integrated health and social care services will be jointly commissioned by NHS England and Local Authorities.

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<sup>56</sup> For more information see [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/315993/Care-Act-Guidance.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf) in particular chapter 17

## *Commitment*

- 2.47 By April 2016 we will have worked together across health and justice commissioning systems to implement the Care Act and developed new partnerships for locally integrated health and social care services for prisons in England.

## 3. Governance

- 3.1 This agreement sets out the basis of shared understanding both for the way in which NHS England, PHE and NOMS will work together and also for the work which we carry out unilaterally on a day-to-day basis in support of the commissioning of health services in prison and ‘through the gate’ into the community. It is essential therefore that it remains a **living document** and has appropriate governance to support this at different levels within our commissioning and delivery systems.
- 3.2 **Annex C** sets out the governance framework for joint working between NOMS, NHS England and PHE. This outlines the tri-laterally agreed governance functions which are expected to exist nationally, regionally and locally while recognising that the specific form and membership of regional and local arrangements should be agreed by the three organisations at the appropriate level within each organisation.

### National Governance

- 3.3 The National Prison Healthcare Board (England)<sup>57</sup> has responsibility for the oversight and on-going management of this agreement. Created in 2013, the Board is co-chaired by NOMS and NHS England and manages delivery of shared priority deliverables (as set out in this agreement), management of system wide partnership risks and their mitigation and acts as the final stage of dispute resolution (see below). The Board also has a key communication role with regional governance structures and through them to local governance. Further details of the Board’s functions are provided in Annex C.
- 3.4 The Board has two standing sub-boards. The Contracted Prison Healthcare Sub-Board (England) has oversight of the co-commissioning and management of healthcare in contracted (private) prisons. The Prison Healthcare Finance Sub-Board (England) has oversight of joint financial interactions and relationships between NOMS and NHS England.
- 3.5 The Board has co-opted the Chair of the Health and Justice Clinical Reference Group (Dr Linda Harris) as an associate member to ensure that the work of the Prison Healthcare Board (England) is informed by clinical expertise. This will ensure that the Board is both able to request and receive inputs from independent clinicians.
- 3.6 To make sure that work to commission services in prisons and through the gate is aligned with wider corporate governance in NOMS and NHS England (including being joined up with oversight of work in other places of detention), the Prison Healthcare Board (England) feeds into both the NHS England Health

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<sup>57</sup> Separate governance arrangements are in place with the Welsh Government to support joint working around offender health in Wales

and Justice Strategic Partnership Delivery Group (and through it to the NHS England Health and Justice Oversight Group) and the NOMS Commissioning Sub-Committee (and through it the NOMS Executive Management Committee).

## Regional and Local Governance

### *Regional Arrangements*

- 3.7 Since the first publication of this agreement in 2013, NHS England, NOMS and PHE have come together in the majority of regions to develop regional strategic co-commissioning and partnership governance structures. These bring together commissioners and senior managers (e.g. Deputy Directors of Custody), together with key partners such as PHE Health and Justice Public Health Specialists and Alcohol, Drugs and Tobacco Leads, to provide oversight of more strategic joint working. In particular, these structures look at many of the issues which impact on local delivery but which are not determined locally such as changes to allocation criteria, prison roles, or the creation of specialist functional places etc. These governance structures between commissioners are intended to complement the provider/operational local delivery board structures. They provide a structure for managing strategic risks and their mitigation, escalated dispute resolution (see below) and for information cascade to and from the Prison Healthcare Board (England).
- 3.8 It is expected that by April 2015, regional strategic co-commissioning and partnership governance arrangements will exist in all parts of England supported by all three parties to the National Agreement to ensure that they are driving forward shared partnership priorities and co-commissioning activity.

### *Local Arrangements*

- 3.9 Providers of custody, healthcare and substance misuse services are expected to come together in Local Delivery Boards (LDBs). These provide structures for looking at all of the interfaces and dependencies between healthcare (including substance misuse) and wider prison custodial functions, including the effectiveness of enabling services and any issues which may impact on improving health and justice outcomes. Membership and operation of these boards should be determined locally, however, they should not seek to duplicate the function or membership of regional strategic structures and should continue to respond to changes in the delivery landscape such as the inclusion of local authorities or social care providers, Community Rehabilitation Companies or facilities management providers.
- 3.10 In working together through Local Delivery Boards, it is important to understand that while prison Governors and Directors need to ensure that they are confident that appropriate clinical governance arrangements are in place for services operating in their establishments, they are not responsible for clinical governance or the management of delivery by healthcare providers (including substance misuse). Nor are they responsible for the contract management of providers which is the responsibility of NHS England. Where NHS England lead commissioners have devolved responsibility for commissioning of substance

misuse services to Local Authorities then they remain accountable for those services. NHS and Local Authority Commissioners should similarly not seek to make demands of prison establishments, facilities management providers or Community Rehabilitation Companies without discussion with the relevant NOMS commissioner.

- 3.11 Local governance arrangements commit resources of NOMS, NHS England and PHE. As such, they must be formally agreed by each organisation through appropriate commissioning/contracting and management lines. For NOMS this means the relevant Deputy Directors of Custody<sup>58</sup> together with the Health, Wellbeing and Substance Misuse Co-Commissioning lead. Partners are encouraged to continue to review local governance arrangements to minimise duplication and ensure arrangements remain lean and fit for purpose for the needs of all partners involved.
- 3.12 The work of Local Delivery Boards should be underpinned by a Local Delivery Agreement which sets out how the National Agreement is being taken forward at a local level to support operational delivery. These should set out local protocols and provide all necessary assurances for delivery between providers operating in the prison (e.g. custody providers, Community Rehabilitation Companies, facilities management providers and healthcare providers including substance misuse). No additional written statements or commitments including SLAs, contract clauses or 'license documents' should be entered into by local partners – this includes between prison operators (public sector and contracted out) and healthcare providers. Any concerns impacting on delivery which cannot be resolved directly between local organisations should be raised using the dispute resolution processes set out in the section below.

## Complaints and Dispute Resolution

### *Making a Complaint*

- 3.13 Concerns originating from prisoners, their families or carers for healthcare (including substance misuse) services received in prisons in England<sup>59</sup> should be dealt with as a complaint.
- 3.14 Complaints which relate to both clinical and non-clinical healthcare matters should be raised via the standard NHS England complaints procedure, details of which are available at [www.england.nhs.uk/contact-us/complaint](http://www.england.nhs.uk/contact-us/complaint). This includes information about how to appeal via the independent Parliamentary and Health Service Ombudsman (PHSO). Complaints which relate to NHS funded care between 2003 and 2013 and pre-date NHS England should also

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<sup>58</sup> Each NOMS prison region has a Deputy Director of Custody (DDC) with responsibility for the line management of public sector prison Governors. In addition, High Security Prisons and the Young People's estate operated by HMPS are managed by separate Deputy Directors. Contracts for Contracted Prisons are overseen by a Deputy Director in the NOMS Commissioning and Contract Management Directorate. A number of NHS Lead Health and Justice Team boundaries do not align with NOMS prison regional boundaries in which case partnership arrangements may require the consent and engagement of all relevant DDCs.

<sup>59</sup> This includes prisoners from Wales who serve all or part of their sentence in an English prison but excludes prisoners from either England or Wales who wish to complain about services while serving all or part of their sentence in a prison in Wales. More information about how to complain to the NHS in Wales is available at: [www.wales.nhs.uk/ourservices/publicaccountability/puttingthingsright](http://www.wales.nhs.uk/ourservices/publicaccountability/puttingthingsright)

use this procedure. This procedure does not include those functions which NHS England is not responsible for commissioning, specifically some emergency care, NHS 111 services, out-of-hours services and ambulance services.<sup>60</sup> Neither does this include social care support which should be raised with the local authority responsible for the assessment and commissioning of care support.

- 3.15 Where a complaint relates to a substance misuse service which has been commissioned by a Local Authority on behalf of the NHS England Lead Health and Justice Team and Justice Lead commissioner, the commissioning Local Authority's complaints procedure should be used. The Lead Health and Justice Team commissioner will be able to advise on the relevant procedure and must be advised of any complaints received by the Local Authority.
- 3.16 Where the complaint relates to health care services in a contracted prison where NOMS contracts these services on behalf of NHS England then a complaints procedure which includes NHS England has been agreed and is available through the prison controller.
- 3.17 Prisoner complaints which do not directly relate to clinical or non-clinical healthcare services for which the NHS is responsible should be raised through the normal NOMS complaints procedure.<sup>61</sup> This includes complaints regarding custody providers, facilities management providers and Community Rehabilitation Companies. The complaints procedure includes information about the appeals process for complaints including via the PPO. The NOMS complaints procedure should also be used for healthcare complaints which relate to incidents prior to 2003 and the transfer of responsibility for prison healthcare to the NHS.
- 3.18 Where a complaint involves both healthcare and non-healthcare elements the healthcare elements of the complaint should be raised through the NHS England complaints procedure, which recognises that the complaint should be registered with the providers of the service in the first instance, and the non-healthcare through the NOMS procedure. The two areas of investigation will run parallel to one another managed through the relevant organisational complaints procedure and the findings reported back to the complainant as required by each procedure. The two investigating organisations will only share their findings during the investigation where one area of delivery impacts on the other and would have had a material effect on the complaint outcome.

### ***Dispute Resolution***

- 3.19 Concerns which relate to operational or resourcing disagreements between commissioners or providers of healthcare services or prison services in NHS England (including Local Authorities where they have commissioned substance

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<sup>60</sup> Complaints about out-of-hours or 111 services should be raised via the prison healthcare team with the Clinical Commissioning Group (CCG) with responsibility for commissioning the service and in the case of ambulance care with the relevant ambulance trust. More information including how to find the relevant CCG is available at:

[www.nhs.uk/choiceinthenhs/rightsandpledges/complaints/pages/nhscomplaints.aspx](http://www.nhs.uk/choiceinthenhs/rightsandpledges/complaints/pages/nhscomplaints.aspx)

<sup>61</sup> For information about NOMS complaints procedures for individual prisoners see [www.justice.gov.uk/downloads/offenders/psipso/psi-2012/psi-02-2012-prisoner-complaints.doc](http://www.justice.gov.uk/downloads/offenders/psipso/psi-2012/psi-02-2012-prisoner-complaints.doc)

misuse services on behalf of NHS England) and NOMS (including custody providers, facilities management providers and Community Rehabilitation Companies), should be dealt with as a dispute if they cannot be resolved locally. Dispute processes should not be used to deal with individual concerns by prisoners or their representatives. These should be dealt with under complaints procedures (see above).

- 3.20 Where a dispute emerges between a provider of healthcare services (including substance misuse services commissioned on behalf of NHS England) in prisons and the management of the wider prison establishment, this should always be raised in the first instance and at the earliest opportunity directly with the other party. Issues should ideally be put in writing and discussed as part of Local Delivery Board arrangements and any resolutions similarly recorded in writing.
- 3.21 Where a dispute between a provider of healthcare (including substance misuse services commissioned on behalf of NHS England) in prisons and an establishment cannot be resolved satisfactorily at the Local Delivery Board level, this should be raised in writing with the NHS England Lead Health and Justice Commissioner (or Local Authority where substance misuse services have been commissioned on behalf of NHS England) and the Deputy Director of Custody (DDC) with responsibility for the establishment. This may be done through the regional strategic partnership governance structures. Resolutions should be recorded in writing. Both the NHS England lead Commissioner (or Local Authority) and DDC may seek appropriate advice from within their wider organisations as appropriate, for example in the case of DDCs, involvement of the relevant NOMS Health, Wellbeing and Substance Misuse Co-commissioner.
- 3.22 In the unlikely event that disputes cannot be resolved at this level, then they should be formally raised in writing by both parties with the National Prison Healthcare Board (England) via the secretariat (see section 4 for details). The Board's decisions will be recorded in writing and will be considered final.

## Independent Scrutiny and Inspection

- 3.23 Healthcare services delivered in prison are subject to a range of independent scrutiny and inspection, the high level function and responsibilities for which are set out below.
- 3.24 **The Care Quality Commission (CQC)** – The CQC is the independent regulator of all health and social care services in England. Its role is to ensure that services meet national standards of safety and care. This remit includes the inspection of prison healthcare services<sup>62</sup> which are required to register with the commission.<sup>63</sup> CQC has a memorandum of understanding with HM Inspectorate of Prisons to ensure that checks are not duplicated.<sup>64</sup> This includes a mapping of all of CQC's regulations to HMIP's expectations and

<sup>62</sup> For more information see [www.cqc.org.uk/content/offender-care](http://www.cqc.org.uk/content/offender-care)

<sup>63</sup> For information about who has to register with CQC see [www.cqc.org.uk/content/what-registration](http://www.cqc.org.uk/content/what-registration)

<sup>64</sup> For a copy of the memorandum see [www.cqc.org.uk/content/offender-care](http://www.cqc.org.uk/content/offender-care)

inspection methodology.<sup>65</sup> In October 2014 CQC published 'Inspecting Together' a signposting statement together with HM Inspectorate of Prisons (HMIP) which signalled the move to a new regulatory model for inspection of the health and justice sector and the intention to publish a Joint Inspection Framework with HMIP.<sup>66</sup> The role and independence of CQC remains unchanged by this agreement.

- 3.25 HM Inspectorate of Prisons (HMIP)** – HMIP is an independent inspectorate, which reports on conditions for and treatment of those in prison, young offender institutions and immigration removal centres.<sup>67</sup> HM Chief Inspector of Prisons is appointed by the Secretary of State for Justice for a term of five years. The Chief Inspector reports directly to the Secretary of State on the treatment and conditions for prisoners in England and Wales and other matters as directed by the Secretary of State for Justice. HM IP has a memorandum of understanding with the Care Quality Commission to ensure alignment of inspection and regulation expectations.<sup>68</sup> Where HMIP has inspected healthcare and found satisfactory performance, CQC will not normally undertake further checks. HMIP may also undertake thematic inspections which relate to health functions. These may be undertaken individually or in conjunction with CQC and others as part of a Joint Thematic. The independence and role of the inspectorate remains unchanged by this agreement.
- 3.26 Prison and Probation Ombudsman (PPO)** – The PPO is appointed by the Secretary of State for Justice and investigates complaints from prisoners and those subject to probation supervision.<sup>69</sup> The PPO is also responsible for investigating all deaths in prison custody and producing Fatal Incident Reports. The PPO publishes Learning Lessons Bulletins which draw together lessons for improving practice based on investigations. The Ombudsman is completely independent of NOMS, HMPS and the NHS. The role and independence of the PPO remains unchanged by this agreement.
- 3.27 Local Authority Scrutiny** – The Health and Social Care Act (2012) extended existing powers of County and Unitary local authorities (so called upper-tier authorities) for health scrutiny functions to review and scrutinise any matter relating to the planning, provision and operation of health services in the local authority's area.<sup>70</sup> Local Authorities can require relevant NHS bodies and health service providers<sup>71</sup> to provide information and attend meetings to answer questions to enable the authority to discharge its scrutiny functions. It can make reports and recommendations to relevant health bodies and health service providers and require those bodies and providers to respond within a fixed timescale to such reports or recommendations and to consult local authorities on proposals for substantial variations to the service in the local authority area.

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<sup>65</sup> For a copy of the expectations see [www.cqc.org.uk/content/offender-care](http://www.cqc.org.uk/content/offender-care)

<sup>66</sup> [www.cqc.org.uk/sites/default/files/20141029\\_health\\_justice\\_inspecting\\_together\\_final.pdf](http://www.cqc.org.uk/sites/default/files/20141029_health_justice_inspecting_together_final.pdf)

<sup>67</sup> [www.justice.gov.uk/about/hmi-prisons](http://www.justice.gov.uk/about/hmi-prisons)

<sup>68</sup> For a copy of the memorandum see [www.cqc.org.uk/content/offender-care](http://www.cqc.org.uk/content/offender-care)

<sup>69</sup> [www.ppo.gov.uk](http://www.ppo.gov.uk)

<sup>70</sup> The Health and Social Care Act 2012 provided a power for County Councils and Unitary Councils Overview and Scrutiny Committees to scrutinise health services. The 2012 Act confers these scrutiny powers on the councils themselves rather than an explicit committee of the council to allow maximum flexibility.

<sup>71</sup> These bodies include NHS England, NHS Trusts/Foundation Trusts, Clinical Commissioning Groups and a body of persons which provides any 'relevant services' including public health.

A Joint Overview and Scrutiny Committee can satisfy these requirements where services are provided to individuals across multiple authorities.

- 3.28 These powers only apply to those bodies named in the Act and do not confer any powers for local authorities to demand access to prisons. NHS England and NOMS are working with the Centre for Public Scrutiny (CfPS) to develop specific guidance for local authorities and those responsible for the direct commissioning or provision of healthcare services in prisons in England. The role and independence of local authorities in undertaking these duties remains unchanged by this agreement.
- 3.29 **Coroner** (Regulation 28 reports) – Under the Coroners and Justice Act 2009, a coroner must conduct an investigation into deaths which occur in custody or otherwise in state detention. This may include the coroner holding an inquest. The Act changed the previous power under rule 43 of the 1984 Coroners Rules to make it a duty to make a report to prevent other deaths under Regulation 28 of the *Coroners (Investigation) Regulations 2013*. Regulation 28 provides that a report must be sent to the Chief Coroner and any other relevant parties the coroner judges appropriate in order to prevent future deaths. Parties written to by the senior coroner have a statutory duty to give a written response within 56 days. Typically such ‘Regulation 28 reports’ will be sent to both NHS England and NOMS and both organisations have individual and coordinated systems for responding in a timely manner and to ensure that learning is captured and disseminated to all relevant staff. The role and independence of the coroner in undertaking these duties remains unaltered by these changes.
- 3.30 **Independent Monitoring Boards (IMBs)** – Inside every prison (and immigration removal centre) there is an IMB. IMB members are independent and unpaid, appointed by the Ministry of Justice to monitor day-to-day life in their local prison or immigration removal centre and ensure that proper standards of care and decency are maintained.<sup>72</sup> This remit includes healthcare provision. The role and accountability of IMBs remains unchanged by this agreement.
- 3.31 **Healthwatch** – Healthwatch is an independent consumer champion for health and social care across England established by the Health and Social Care Act (2012) which came into existence on 1 April 2013.<sup>73</sup> The network is made up of the nationally-focused Healthwatch England leading 152 community-focused local Healthwatch. Together they form the Healthwatch network, working closely to ensure consumers’ views are represented both locally and nationally. Contact details for local Healthwatch are available on the HealthWatch website.
- 3.32 In addition, to scrutiny and inspection arrangements specific to healthcare and custody, health and social care providers remain subject to wider regulation arrangements, for example regulation by the Health and Safety Executive.

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<sup>72</sup> [www.justice.gov.uk/about/imb](http://www.justice.gov.uk/about/imb)

<sup>73</sup> [www.healthwatch.co.uk](http://www.healthwatch.co.uk)

## **Communications Strategy**

- 3.33 NHS England, PHE and NOMS will maintain a joint communications strategy to support and underpin the shared principles and priorities in this agreement.

## 4. Contacts

- 4.1 All queries or questions relating to the operation of this agreement should be directed in the first instance to:

**National Offender Management Service** (and Secretariat for the Prison Healthcare Board (England))

Head of Health, Wellbeing and Substance Misuse Co-commissioning  
Commissioning Group  
Directorate of Commissioning and Contract Management  
National Offender Management Service  
3rd Floor, Clive House  
70 Petty France  
London  
SW1H 9EX

[Health.co-commissioning@noms.gsi.gov.uk](mailto:Health.co-commissioning@noms.gsi.gov.uk)

**NHS England**

Head of Public Health, Armed Forces and their Families and Health and Justice  
Commissioning  
Health and Justice,  
Commissioning Operations Directorate  
Quarry House,  
Quarry Hill,  
Leeds,  
LS2 7UE

[england.healthandjustice@nhs.net](mailto:england.healthandjustice@nhs.net)

**Public Health England**

Director for Health and Justice,  
Public Health England,  
Premier House  
60 Caversham Road,  
Reading,  
RG1 7EB.

[Health&Justice@phe.gov.uk](mailto:Health&Justice@phe.gov.uk)

# Annex A

## Prison Health Commissioning in England – A Brief History

- 1.1 Prior to April 2003, HM Prison Service was responsible for directly managing and delivering its own primary healthcare services in prisons in both England and Wales through the Directorate of Prison Healthcare. However in 1996 an HMIP discussion paper *Patient or Prisoner*<sup>74</sup> identified significant weaknesses with these arrangements and recommended the NHS should take responsibility for prison healthcare. The following year the standing Health Advisory Committee for the Prison Service was similarly critical of *The Provision of Mental Health Care in Prisons*.<sup>75</sup> In response a joint working group comprising of officials from HMPS and the NHS Executive was launched. Reporting in March 1999 ‘*The Future Organisation of Prison Healthcare*’ report<sup>76</sup> recommended that a formal partnership be created between the NHS and the Prison Service based on the previously established principle of equivalence, namely:

*To give prisoners access to the same quality and range of health care services as the general public receives from the National Health Service.*<sup>77</sup>

This statement reflects the provision set out in Principle 9 of the UN (1990) document ‘Basic Principles for the Treatment of Prisoners’ which states:

*Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.*

- 1.2. In 2001 the Department of Health published ‘Changing the Outlook’ which included the proposal to introduce mental health in-reach services into prisons and in September of the following year, Ministers announced that Department of Health would have the responsibility for the funding of primary care services in Public Sector Prisons in England from April 2003.<sup>78</sup>
- 1.3. The principles which would underpin how the two Departments would work together were set out in the document *National Partnership Agreement on the Transfer of Responsibility for Prison Health from the Home Office to the Department of Health* published in April 2003. The agreement superseded a number of then Prison Service Orders (PSOs) and Instructions and became the basis for a number of subsequent Prison Service Instructions (PSIs).

<sup>74</sup> *Patient or Prisoner?: A New Strategy for Health Care in Prisons*, HM Inspectorate of Prisons, London: Home Office 1996

<sup>75</sup> *The Provision of Mental Health Care in Prisons*, Health Advisory Committee for the Prison Service, London: Prison Service 1997

<sup>76</sup> *The Future Organisation of Prison Health Care: Report by the Joint Prison Service and National Health Service Executive Working Group*, HM Prison Service and NHS Executive, London 1999

<sup>77</sup> *Health care Standards for Prisoners in England and Wales*, HM Prison Service; London 1994

<sup>78</sup> Different arrangements are in place in Wales where services in public sector prisons are currently bought by Local Health Boards. Responsibility for commissioning primary care services in HMP Parc, managed under contract, was not transferred and remains part of the overarching PFI contract.

- 1.4. Commissioning responsibility for prison health was subsequently devolved by the Department of Health to Primary Care Trusts (PCTs) between 2004 and 2006. In response, each establishment created a Prison Partnership Board which brought together the management of the prison with PCT commissioners to discuss priorities, performance and delivery issues. Local partnership agreements were developed based on the National Agreement setting out how individual establishments would work with PCT commissioners.
- 1.5. Responsibility for provision of primary care in contracted (private) prisons however did not transfer to the Department of Health and the primary healthcare services in these prisons continued to be provided under contract to the Ministry of Justice.
- 1.6. The transfer of health commissioning responsibility to PCTs marked the start of a series of further reforms and transformation of healthcare services in prisons. In July 2006 the Department of Health began the roll-out of the Integrated Drug Treatment System (IDTS) and in April 2007 the Prison Service announced that it would transfer the responsibility to the Department of Health and PCTs for commissioning Escort and Bedwatch services which escort and supervise offenders taken out of prison to receive hospital care. In recognition of these further changes, a second revised partnership agreement was published by the Department of Health in January 2007 entitled *National Partnership Agreement between DH and Her Majesties' Prison Service for the Accountability and Commissioning of Health Services for Prisoners*.<sup>79</sup>
- 1.7. Shortly after the revised National Partnership Agreement was published (April 2007), responsibility for Prison and Probation Services transferred from the Home Office to the newly created Ministry of Justice (MoJ) and one year later, in April 2008, the former National Offender Management Service (created by the Home Office in 2004) was replaced by a new National Offender Management Service (NOMS) Agency which brought together the headquarters functions of the Public Sector Prison Service (HMPS) and Probation, and became responsible for both commissioning and delivering adult offender services in both custody and the community in England and Wales. The Department of Health's Offender Health Directorate became a shared business function, with representation on the NOMS Agency executive management committee.
- 1.8. Between February and May 2011, the Department of Health and Ministry of Justice consulted on an implementation plan for a new approach to working with offenders who have severe personality disorders (PD).<sup>80</sup> In October 2011 the Ministry of Justice and the Department of Health announced the Coalition Government's intention to take forward a co-commissioned programme to improve the management and psychological health of offenders with severe personality disorders who also present a high risk of serious harm to others. By reshaping the existing Dangerous and Severe Personality Disorder Programme (DSPD), which had operated in three prisons and secure hospitals and the

<sup>79</sup>[http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh\\_072465](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_072465)

<sup>80</sup> For more information on severe personality disorders see [www.personalitydisorder.org.uk](http://www.personalitydisorder.org.uk)

community since 2000, resources would be re-invested on delivering new PD services mainly in prisons and probation.

- 1.9. Further transfers of responsibility between NOMS Agency and the Department of Health continued, the most significant being the transfer of responsibility for commissioning non-clinical substance misuse services (including CARAT services and some accredited Offending Behaviour Programmes) in prisons in England in April 2011. With this transfer, almost all clinical and non-clinical prison healthcare services in England became an NHS responsibility, with the exception of services which continued to be contracted by NOMS in some private prisons.

# Annex B

## Examples of NOMS Service Specifications, Prison Service Orders and Instructions relevant to Healthcare

NOMS is responsible for publishing a range of specifications and instructions which inform the services it commissions and which must be followed by those working in prisons. Where these relate to interfaces with healthcare then the Department of Health/NHS England will be consulted in agreeing the instructions or specification.

Instructions and specifications are published in full on the NOMS website. Examples of some of the mandatory minimum service specifications and orders (PSOs) and instructions (PSIs) which impact on or are impacted on by healthcare services in prisons are listed below.

Service Type	<b>NOMS service specifications</b> <a href="https://www.gov.uk/government/collections/noms-directory-of-service-specifications">https://www.gov.uk/government/collections/noms-directory-of-service-specifications</a>
Secure and Decent Custody	Catering
	Early days and discharge – discharge
	Early days and discharge – induction to custody
	Early days and discharge – first night in custody
	Early days and discharge – reception in
	Enablers of national co-commissioned services in prisons
	External movements and appearances
	Mandatory drug testing
	Mother and baby units
	Nights
	Prisoner discipline and segregation - prisoner discipline procedures
	Prisoner discipline and segregation - segregation of prisoners
	Processing and resolution of prisoner complaints
	Provision of secure operating environment (POSOE) – communication and control room
	Provision of secure operating environment – internal prisoner movements
	Provision of secure operating environment – gate services
	Residential services
	Specialist Units (HSE)

	Visits – conduct visits
	Visits – services for visitors
	Visits – visits booking
Interventions	Rehabilitation Services in Custody

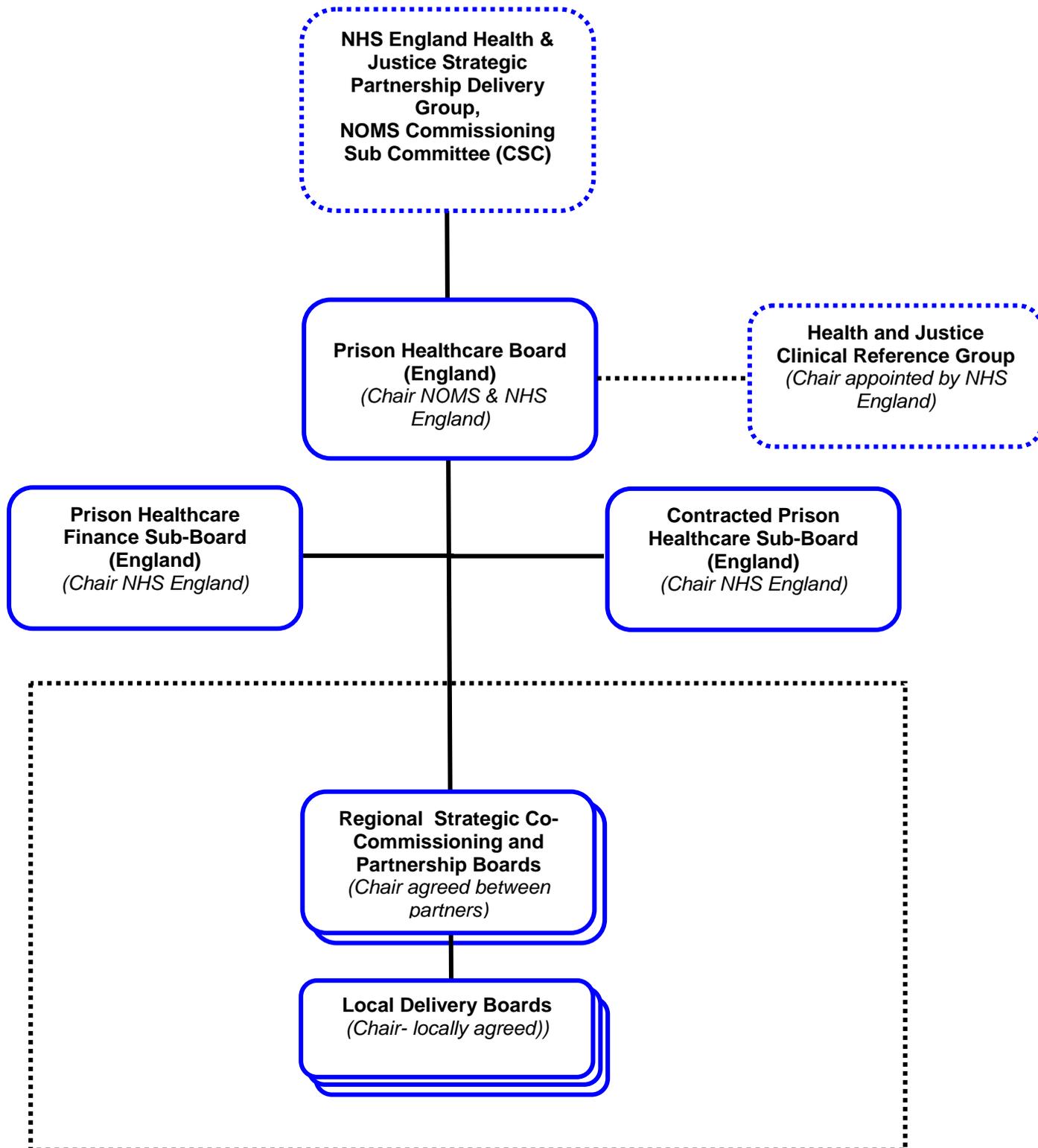
<b>PSO NUMBER</b>	<b>Prison Service Orders (PSOs)</b> <a href="http://www.justice.gov.uk/offenders/psos">www.justice.gov.uk/offenders/psos</a>
0550	Prisoner induction
1025	Communicating information about risks on escort or transfer – the prisoner escort record
1600	Use of force
1700	Segregation
2000	The Prison Discipline Manual: adjudications
2300	Resettlement
2400	Democratic therapeutic communities
3050	Continuity of healthcare for prisoners
3100	Clinical governance – quality in prison healthcare
3200	Health promotion
3550	Clinical services for substance misusers
3601	Mandatory drug testing
3625	Vetting & testing of specialist external drug workers
3842	Radiation safety – dental and medical x-ray equipment
4455	Requests from prisoners to change their name
4800	Women prisoners

<b>PSI NO.</b>	<b>Prison Service Instructions (PSIs)</b> <a href="http://www.justice.gov.uk/offenders/psis">www.justice.gov.uk/offenders/psis</a>
46/2005	Prison drug treatment and self harm
31/2009	Compact based drug testing
44/2010	Catering – meals for prisoners
45/2010	Integrated drug treatment system
07/2011	The care and management of transsexual prisoners
16/2011	Providing visits and services to visitors
24/2011	National Security Framework Night function: management and security of nights
47/2011	Prisoner Discipline Procedures
52/2011	Immigration, Repatriation and Removal Services
58/2011	Physical Education (PE) for Prisoners
62/2011	Procedure for the Transfer From Custody of Children and Young People to and from Hospital Under the Mental Health Act 1983 in England

<b>PSI NO.</b>	<b>Prison Service Instructions (PSIs)</b> <a href="http://www.justice.gov.uk/offenders/psis">www.justice.gov.uk/offenders/psis</a>
<b>64/2011</b>	Management of Prisoners at Risk of Harm to Self, to Others and From Others (Safer Custody)
<b>75/2011</b>	Residential Services
<b>08/2012</b>	Care and Management of Young People
<b>31/2012</b>	National Security Framework Vetting Function - Security Vetting: additional risk assessment criteria following disclosed criminal convictions ex-offenders
<b>03/2013</b>	Medical Emergency Response Codes
<b>07/2013</b>	Occupational Health
<b>18/2013</b>	Determinate sentenced prisoners transferred under the Mental Health Act 1983
<b>27/2013</b>	Data Sharing Policy
<b>38/2013</b>	National Security Framework Ref: NSF 15.4 Reconsideration of Central Vetting Decisions by Exception
<b>01/2014</b>	First Aid
<b>05/2014</b>	Safeguarding of Children and Vulnerable Adults:
<b>07/2014</b>	National Security Framework Ref: NSF 15.1 Vetting Function - Security Vetting
<b>08/2014</b>	North West 'Through the Gate Substance Misuse Services' Drug Testing Project
<b>09/2014</b>	Incident Management Manual
<b>15/2014</b>	Investigations and Learning Following Incidents of Serious Self-Harm or Serious Assaults
<b>23/2014</b>	Prison – NOMIS (Prison National Offender Management Information System)
<b>24/2014</b>	Information Assurance Policy
<b>25/2014</b>	IT Security Policy
<b>27/2014</b>	National Security Framework Ref: NSF 15.5 Vetting Function - Security Vetting: Additional Risk Criteria for Ex-Offenders Working in Prison and Community Settings
<b>32/2014</b>	Drug Appointment and Drug Testing for Licence Conditions and Post-Sentence Supervision Requirements
<b>39/2014</b>	National Security Framework Ref: NSF 15.5 Vetting Function - Security Vetting: Using Offenders as Mentors in the Community and in Custody
<b>42/2014</b>	National Security Framework Ref: NSF 15.2 Vetting Function - Exclusion of Personnel on Grounds of Misconduct
<b>49/2014</b>	Mother & Baby Units
<b>04/2015</b>	Rehabilitation Services Custody
<b>05/2015</b>	National Security Framework Ref: NSF 15.4 Security Vetting: Reconsideration of NOMS Central Vetting Decisions by Exception
<b>06/2015</b>	Policy, Organisation and Summary Arrangements for the Management of Health & Safety
<b>07/2015</b>	Early Days in Custody – Reception In, First Night in Custody and Induction to Custody

# Annex C

## Prison Partnership Governance Model (England)



Governance Body	Chair and Example Membership	Key Functions
<p style="text-align: center;"><b>Prison Healthcare Board (England)</b> <i>(Chair NHS England/NOMS)</i></p>	<p>Co-Chaired by NHS England &amp; NOMS</p> <ul style="list-style-type: none"> <li>• NHS England Regional Health and Justice</li> <li>• NHS England Health and Justice National Support Team</li> <li>• NHS Health and Justice clinical reference group Chair</li> <li>• Public Health England - Health and Justice</li> <li>• Public Health England - Alcohol and Drugs</li> <li>• NOMS Health, Wellbeing and substance Misuse Co-commissioning (Secretariat)</li> <li>• NOMS Commissioning and Commercial Directorate Contracted Prisons</li> <li>• NOMS Commissioning and Commercial Directorate - Commissioning Group</li> <li>• NOMS Public Sector Prisons Directorate (including High Security and Youth Offenders)</li> <li>• NOMS National Operational Services Directorate</li> <li>• NOMS HR Directorate</li> <li>• Associate membership from NHS England patient safety, nursing and medical directorate</li> </ul>	<ul style="list-style-type: none"> <li>• Overall strategic governance for co-commissioning and delivery of health services in prisons and 'through the gate' in England</li> <li>• Ownership of the National Partnership Agreement, including shared delivery priorities</li> <li>• Oversight of national level partnership risks and mitigation</li> <li>• Oversight of national performance and quality</li> <li>• Coordination of infection control information and outbreak responses</li> <li>• Dispute resolution</li> <li>• Manage Interfaces with Wales</li> </ul>
<p style="text-align: center;"><b>Prison Healthcare Finance Sub-Board (England)</b> <i>(Chair NHS England)</i></p>	<p>Chair NHS England</p> <ul style="list-style-type: none"> <li>• NHS England Health and Justice National Support Team</li> <li>• NHS England Lead DoF</li> <li>• NOMS Health, Wellbeing and substance Misuse Co-commissioning (Secretariat)</li> <li>• NOMS Finance</li> </ul>	<ul style="list-style-type: none"> <li>• Oversight of strategic financial inter-relationships including risks and their mitigation</li> <li>• Oversight of planned changes and pressures</li> <li>• Exploration of new opportunities</li> <li>• Dispute</li> </ul>
<p style="text-align: center;"><b>Contracted Prison Healthcare Sub-Board (England)</b> <i>(Chair NHS England)</i></p>	<p>Chair NHS England</p> <ul style="list-style-type: none"> <li>• NHS England National Health and Justice</li> <li>• Deputy Director Custody - Contracted Prisons</li> <li>• MoJ Procurement</li> <li>• NOMS Health, Wellbeing and substance Misuse Co-commissioning</li> </ul>	<ul style="list-style-type: none"> <li>• Compliance with Health and Social Care Act by aligning NHS England responsibilities and NOMS contract responsibilities</li> <li>• Management of risks and their mitigation</li> <li>• Oversight of performance and quality</li> <li>• Issue and dispute resolution</li> </ul>

Governance Body	Chair and Example Membership	Key Functions
<p><b>Regional Strategic Co-Commissioning and Partnership Boards</b> <i>(Chair agreed between NHS England, NOMS and</i></p>	<p>(Name and membership will vary by Region)</p> <p>Chair agreed locally between NHS England and NOMS</p> <ul style="list-style-type: none"> <li>• NHS England Region/ sub region/VSM Health and Justice</li> <li>• NOMS Health, Wellbeing and substance Misuse Co-commissioning</li> <li>• Deputy Director(s) Custody</li> <li>• Public Health England - Health and Justice</li> <li>• Public Health England – Alcohol and Drugs</li> <li>• Local Authorities (where commissioning substance misuse services by agreement on behalf of NHS England)</li> </ul>	<ul style="list-style-type: none"> <li>• Strategic governance for co-commissioning of services in prisons and ‘through the gate’ in region</li> <li>• Management of shared development priorities</li> <li>• Oversight of regional level shared partnership risks and mitigation</li> <li>• Oversight of regional level performance and quality</li> <li>• Issue and dispute resolution</li> </ul>
<p><b>Local Delivery Boards</b> <i>(Chair- locally agreed))</i></p>	<p>(Name and membership will vary by locality)</p> <p>Chair: agreed locally between NHS England, NOMS and Public Health England</p> <ul style="list-style-type: none"> <li>• Prison representatives including Controllers (contracted prisons only)</li> <li>• All healthcare providers (including substance misuse service providers)</li> <li>• Community Rehabilitation Companies (CRCs) (from 2015)</li> <li>• Facilities Management and Works providers (from 2015)</li> </ul>	<ul style="list-style-type: none"> <li>• Joint coordination of delivery of services in establishments including enabling of services</li> <li>• Ownership and oversight of Local Delivery Agreement including any shared development priorities, local protocols and delivery of national or regionally agreed priorities</li> <li>• Oversight and management of local issues, risks and their mitigation;</li> <li>• Continuous improvement</li> <li>• Issue and dispute resolution</li> </ul>

