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Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure and detained settings to inform future health interventions and prioritisation in England

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Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure & detained settings to inform future health interventions and prioritisation

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Glossary of abbreviations

BBV	Blood-borne virus
CAMHS	Children’s and Adolescents Mental Health Service
CYPSE	Children and Young People’s Secure Estate
CJS	Criminal Justice System
CQC	Care Quality Commission
CRCs	Community rehabilitation companies
CSU	Commissioning Support Unit
DH	Department of Health
HJIPs	Health and Justice Indicators of Performance
HJIS	Health and Justice Information Service
HMIP	Her Majesty’s Inspectorate of Prisons
HNAs	Health needs assessments
HWBB	Health and wellbeing boards
IRC	Immigration removal centre
JSNAs	Joint strategic needs assessments
MoJ	Ministry of Justice
NICE	National Institute for Health and Care Excellence
NOMS	National Offender Management Service
NPA	National Partnership Agreement
PALS	Patient Advice and Liaison Service
PbR	Payment by result
PCT	Primary care trust
PPDs	Prescribed places of detention
PPO	Prison and Probation Ombudsman
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
TB	Tuberculosis
USA	United States of America
WHO	World Health Organization

Executive summary

Background and context

Through the 2015/16 remit letter, the Department of Health (DH)¹ commissioned Public Health England (PHE) to undertake a rapid review of evidence of improvements in health outcomes for people in secure and detained settings of NHS commissioned health services with a view to inform the DH's future prioritisation for work in the area. The time point at which this evidence review occurred coincided with ten years of commissioning of prison health services by the NHS in England & Wales.(1)

This change from the Ministry of Justice was initiated by the report *The Future Organisation of Prison Healthcare* (2) in response to the findings of a highly critical report by Her Majesty's Inspectorate of Prisons (HMIPs) in 1996 (3). A paper on these prison health reforms, published in the *American Journal of Public Health* in 2006 (1), reflected on the benefits on prison health of transfer of responsibility to the DH and the NHS measured against the state of prison healthcare outlined in the HMIP report (3). The paper cites benefits of health commissioning to include greater transparency, evidence-based assessment of health needs, tackling professional isolation, improving the quality of care and integration of prison populations into wider public health programmes.

Methodology

The methodology used in the rapid review of evidence conformed to best practice guidance in PHE's publications' standard and was approved by our Science & Strategy Team. A literature review (see [Appendix A](#)) found 376 articles, of which 82 were assessed as relevant (based on title and abstract), by a Health and Justice NHS Commissioner lead and a Consultant in Public Health Specialist (Health and Justice), who were part of the review team. These articles were then rapidly appraised by a post-doctoral researcher to identify common and emerging themes. The initial outcomes of the review of the papers were then reviewed by the National Health and Justice Team, PHE, to ensure comprehensiveness and relevance.

Due to the limited evidence in the peer-reviewed published literature, the evidence-review process was supplemented with a qualitative research strategy, using the themes identified as good practice in the literature, cross-referenced to the matrix for analysis developed by the Health Inequalities National Support Team (HINST) (4) (see [Appendix B](#)). Qualitative data was gathered through more than 40 one-to-one interviews with key informants. (For more detail on key informants and stakeholders see [Appendix C](#)). By using an appreciative enquiry into the

¹ <https://www.gov.uk/government/publications/phe-remit-letter-2015-to-2016>

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approach, discussions were built on identified areas of strength in order to develop possible solutions for areas of improvement, and therefore help identify future commissioning priorities.

Findings from the peer-reviewed literature

More than 80 papers published in the peer-reviewed literature were systematically reviewed (see [Appendix D](#)). There was a very limited number of papers identified on immigration detention or other prescribed places of detention and so the report is highly skewed to prison settings (as had also been agreed with the DH on the onset of the review). The populations studied included adult men and women, as well as children and young people.

The literature review identified a limited number of published papers directly relevant to our research question with limited evidence on linkage between models of commissioning and health improvement among people in prisons, with no direct comparisons between different commissioning models. In many cases, the articles focused on poor practice and from this, the reviewer drew conclusions about what “good” would look like.

The evidence review identified that a high-quality prison healthcare system had the following attributes:

- increased accessibility to effective health and social care
- improved continuity of care for people as they transition between prison and the community
- greater emphasis on meeting mental health needs
- improved quality of data and greater information sharing to enable performance management and more efficient and effective services
- greater resources (financial and workforce)
- strong leadership and collaborative working between organisations
- more robust evidence base on what works and what is cost effective
- greater inclusion of the views of people in prison and their families and the prison workforce in determining how healthcare is delivered

These findings were then mapped against the key themes of the HINST analytical matrix (4) (see [Appendix B](#)), to inform the qualitative discussions with key informants.

There were also a number of **emerging themes** in the literature, which were not directly reflected in the analytical matrix but were subsequently reflected in the qualitative interviews:

- **linking into wider care pathways and community structures/services:** challenges about linking work in prisons and other secure settings into wider work, for example, around integrated offender management, community safety partnerships, joint strategic needs assessment (JSNA) and health and wellbeing boards
- that neglecting the health and wellbeing of people in prisons has **negative implications on the wider society** (eg through escalating costs of healthcare, associated criminal activity of untreated substance dependence and/or mental health needs)

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- the importance of early intervention (for example, to prevent children and young people coming into contact with the Criminal Justice System (CJS) ending up in custody as well as the opportunity to improve health and wellbeing of those already in custody)
- improved health and wellbeing as a positive mediator of change in criminal behaviour
- the impact of the prison environment (eg time out of cell in purposeful activities; access to employment, education and training opportunities; and access to exercise and nutritious diets) on health and wellbeing

Findings

The consensus view of the majority of key informants was that prison healthcare services have undergone ‘transformation’ during the ten-year time period of NHS commissioning of prison healthcare since 2006, leading to significant improvements in quality of care.

Current Strengths

Partnership Work: It was generally thought that the National Partnership Agreement (NPA)² between PHE, NHS England and the National Offender Management Service (NOMS) has improved engagement. The NPA clearly sets out the functions and accountability of each agency and details the different levels of governance required across the agreed partnership agenda as well as shared priorities.

Professional development of healthcare staff working in prison health services:

- the employment of professional healthcare staff with nationally recognised qualifications and membership of professional bodies is enabling a rise in clinical standards and accountability. Further specific professional development training and resources for prison healthcare professionals has been developed by the Royal College of Nursing (RCN)³ and the Royal College of General Practitioners (RCGP)⁴ particularly, but also by other royal colleges with better training and continuous professional development opportunities linked to professional development programmes
- recognised need for the development of new models of care with an appropriate skill mix to meet identified need and the use of new and different practitioners eg nurse prescribers, pharmacy assistants and social care support workers
- many interviewees considered that Health Education England (HEE)⁵ should be an active partner in the agenda to inform training, education and recruitment and retention of staff

² <https://www.gov.uk/guidance/healthcare-for-offenders#national-partnershipNPA-agreement>

³ <https://www.rcn.org.uk/get-involved/forums/nursing-in-criminal-justice-services-forum>

⁴ <http://www.rcgp.org.uk/clinical-and-research/clinical-resources/resources-for-gps-working-in-secure-environments.aspx>

⁵ www.hee.nhs.uk

Transparency:

- robust contract monitoring and performance reporting by commissioners of providers was seen as a significant step forward in improving transparency
- the Health and Justice Indicators of Performance (HJIPS)⁶ were acknowledged as contributing significantly to future development in this area but it was recognised that the system was still in development
- Inspectorate reviews: Her Majesty's Inspectorate of Prisons (HMIP)⁷ and the Care Quality Commission (CQC)⁸ were cited as positive examples of testing how standards were being met. The outcome of serious incidents, for example, deaths in custody and Prison and Probation Ombudsman (PPO) reports, were seen as a positive 'shared learning' approach to not repeating mistakes
- complaints/PALs systems were regarded as a very useful method of monitoring services and achieving improvements. Service user feedback/evaluation systems, eg service exit feedback, is highly valued as a means of improving services

Improving quality of healthcare: The contractual requirement to implement national evidence-based practice and standards (eg NICE recommendations) was seen as a positive improvement in the delivery of high quality services. Challenges around continuity of care were recognised as was the need to improve cost effectiveness and cost savings of programmes were identified as areas for further development.

Systematic understanding of needs at population level - health needs assessment (HNA): The requirement to have a formal health and wellbeing needs assessment⁹ to inform commissioning and service provision is widely recognised as a driver of quality improvement.

The prisoners' voice/ peer-led health improvement: The increasing engagement of service users as part of formal HNAs as well as working with providers to feedback on services is generally seen as a driver for quality improvement. The work on the 'lived experience' led by NHS England (see illustrative practice p46) was highlighted as a very positive move forward. Peer mentoring was seen as a positive method of enabling access to services.

Liaison and diversion:¹⁰ This was seen as a positive programme, which is currently being rolled out across England. The Bradley Report (5) recommendations were identified as a positive driver for this programme resulting in the principle "care not custody, care in custody, and care after custody".¹¹ This was acknowledged as informing NHS England's approach to

⁶ <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/03/hj-comms-ints-refresh.pdf>

⁷ <https://www.justiceinspectorates.gov.uk/hmiprison>

⁸ www.cqc.org.uk

⁹ <https://www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit>

¹⁰ <https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion>

¹¹ <https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/news/#treasury>

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care along the criminal justice pathway and in particular, its linking with community-based services and offending and re-offending behaviour.

Areas for further improvement

Relationship between prison regime and healthcare – Developing a Whole Prison Approach (6) was recognised as important in addressing health and wellbeing of both prisoners and staff, but concerns were expressed about how prison staffing levels and security/operational issues (eg lock down/time in cell) impacted on prisoner access to healthcare as well as wider education, training and work programme or access to health care including secondary care services in the community. This has recently been reflected in the Chief Inspector for Prison's Annual Report (7).

Links with the wider community within the health and justice areas of work is needed, including a link between custody and community, supported by local partnerships with agreed population health outcomes.

Data & intelligence: Whilst the value of datasets like Health and Justice Indicators of Performance (HJIPs) and the health informatics system (SystemOne)¹² and the National Drugs Treatment Monitoring System (NDTMS)¹³ were recognised, concerns were expressed about data quality (validity, reliability) and consistent/complete use of READ codes which impacted on use of these metrics for HNAs and performance management. Linking with wider community needs assessments was also recommended.

Self-management and peer-led services: Supporting prisoners through self-management programmes needs further development with systems and scale: for example, through the further development of the Health Trainer Model in the CJS.¹⁴ This would build on the Prime Minister's Asset Based Model (8), which would harness the skills and experience of offenders and use them effectively. As well as using **informal networks within prison** (including peers and family members) to improve health and wellbeing.

¹² <http://systems.hscic.gov.uk/healthandjustice>

¹³ <https://www.ndtms.net>

¹⁴ A Strategy for Offender Health in the South West <http://healthtrainersengland.com/wp-content/uploads/2014/05/OH-Strategy-for-HT-in-CJ-System-for-the-SW-FINAL-versioin-28-07-10.pdf>

Evaluation of the Health Trainers in Prison Workbook <https://www.shu.ac.uk/research/specialisms/hallam-centre-for-community-justice/reports/evaluation-of-the-health-trainers-in-prison-workbook>

A Guide to Implementing the New Futures Health Trainer Role across the Criminal Justice System <http://www.ohrn.nhs.uk/resource/Policy/NewFuturesHealthTrainer.pdf>

New Futures Health Trainers: An Impact Assessment http://eprints.lincoln.ac.uk/2535/1/OHTR_final2.pdf

Evaluation of Rochdale Offender Health Trainers Demonstration Project

https://www.uclan.ac.uk/research/explore/projects/assets/rochdale_probation_oht_evaluation_report.pdf

Evaluation of the Leicestershire and Rutland Probation Trust Health Trainer Service

Final Report: <http://www.icpr.org.uk/publications-team/criminal-justice-agencies-and-services/evaluation-of-the-leicestershire-and-rutland-probation-trust-health-trainer-service.aspx>

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Proactive/early intervention services: Including access to interventions, active case-finding, screening and immunisation programmes as well as diagnosis/treatment of mental health needs to avoid more advanced disease (which is costly as well as harmful), or self-harm/suicide. This programme of work would also support the development of more cost effective services.

Impact of prison workforce (continuity, skills, attitudes, education, own health) on health of people in prison and the need for workforce development.

Equitable Resourcing: Challenges were identified around the inadequacy of commissioning budgets to meet the high needs of the population and/or cope with in-year or new demands not associated with specific resources.

Increasing the responsiveness of services: the heterogeneity and complexity in the prison population means people in prison with different characteristics (eg age, gender) require different healthcare solutions – not one-size-fits-all

Conclusion

The review demonstrated there had been significant improvements in the quality of healthcare in prison settings (see **Appendix G**). Using the HINST matrix to analyse these findings enabled the reviewers to determine that these factors significantly contribute to achieving improved health outcomes for this population. It is acknowledged that improving health outcomes is a journey of continuous improvement and therefore areas were also identified for future priority (see **Appendix F**).

Introduction

Only a small number of Western European states currently commission prison healthcare via health ministries, most notably among them the UK which has the longest and most extensive experience (England and Wales since April 2006, Scotland since November 2011 and Northern Ireland since April 2012) but also France, Italy, Norway & Sweden. From January 2016, Finland also transitioned to direct commissioning by the health service. Among most other Western European states, ministries of justice/interior commission prison healthcare. Because of this long experience, the UK's prison healthcare system is cited in the international literature as a model of good practice. A paper on prison health reforms in England and Wales, published in the *American Journal of Public Health* in 2006, reflected on the benefits on prison health of transfer of responsibility to the Department of Health and the NHS, measured against the state of prison healthcare outlined in a highly critical report by HMIP in 1996. The paper cites benefits of health commissioning to include greater transparency, evidence-based assessment of health needs, tackling professional isolation, improving the quality of care and integration of prison populations into wider public health programmes.

Through the 2015/16 remit letter¹, the Department of Health (DH) commissioned Public Health England (PHE) to undertake a rapid review of evidence of improvements in health outcomes for people in secure and detained settings of NHS commissioned health services with a view to inform the DH's future prioritisation for work in the area.

Since the recent announcement in February 2016 by the then Prime Minister(8) of a new programme of prison reform, which was followed up in May 2016 in the Queen's Speech to Parliament,¹⁵ this work is now seen as central to providing evidence to policy makers on the needs and requirements for effective health services in prisons, especially in relation to mental health and drug treatment services. Further, the work is also of interest internationally due to the paucity of data in the published peer-reviewed literature and the UK's leading role in prison public health internationally.

The review included a rapid analysis of the evidence of effective commissioning practice and the available data to demonstrate any quantifiable improvements. Findings from the literature review (see [Appendix D](#)) were matched to themes identified in the Health Inequalities National Support Team (HINST) matrix 'Commissioning for Better Health Outcomes to address Health Inequalities' (4) which was used as the conceptual framework to analyse the findings (see [Appendix B](#)). It was acknowledged at the onset, that the review of evidence and the ability to detect any impact on health outcomes would be extremely limited by the lack of published literature and data on health metrics for people in secure and detained settings during the current financial year. Therefore, data obtained through the literature review was

¹⁵ <https://www.gov.uk/government/news/biggest-shake-up-of-prison-system-announced-as-part-of-queens-speech>

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supplemented by interviews with key informants to explore current practice and areas for further focus to improve health outcomes.

Prison health commissioning – a history and policy context

Summary

The Home Office historically provided, managed and funded healthcare in prisons. In 1999, the NHS Executive and HM Prison Service published *The Future Organisation of Prison Healthcare*, (2) which proposed transferred responsibility for commissioning of prison health to the NHS. In April 2006, the responsibility for prison healthcare commissioning formally transferred from the Home Office to the NHS, via primary care trusts. This led to policy development which would support and enhance the principle of equivalence, ie that people in prison should receive healthcare according to their needs and equivalent to the standard of care provided to people in the wider community (9).

Chronology

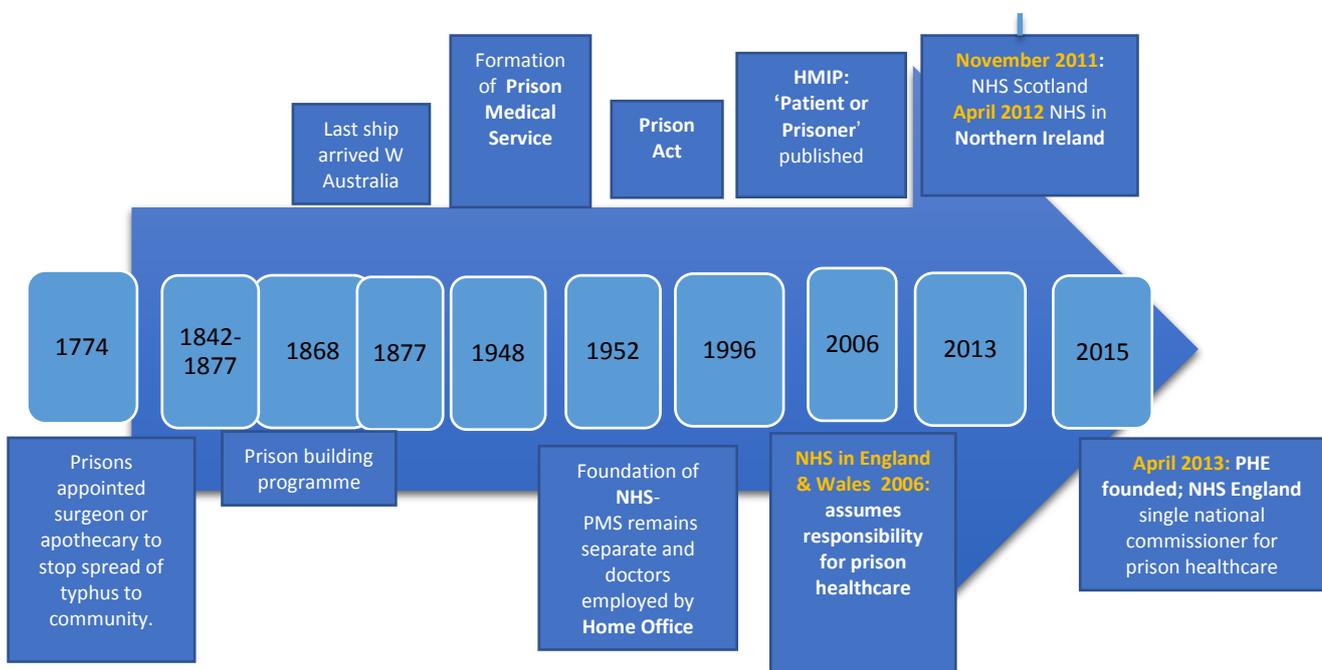


Figure 1: Timeline of key events and policy landmarks leading current settlement regarding commissioning and provision of healthcare for people in prisons in the UK
In November 1996, Sir David Ramsbotham, the Chief Inspector of Prisons, stated in *The Report of Her Majesty's Chief Inspector of Prisons - April 1995–March 1996* (3),

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‘So concerned are we about a number of aspects of prison healthcare, that we have conducted a separate study into it, publishing a discussion document, entitled, Patient or Prisoner?’

The Terms of Reference for the study was to *‘consider healthcare arrangements in prison service establishments in England and Wales with a view to ensuring that prisoners are given access to the same quality and range of health care services as the general public receives from the NHS’.*

The following are the key recommendations from the study (10) which formed the bedrock for future developments:

- the standard of healthcare requires improvement – this approach should be supported by additional resources, audit and evaluations
- an increased provision of care for people with mental health problems is required and a recognition that prisons can exacerbate existing and trigger new mental health problems
- all nurses should hold a professionally recognisable nursing qualification
- prison healthcare staff should be able to access the same professional opportunities for development and experience as all NHS qualified staff, through belonging to mainstream provision of health care. This would also reduce professional isolation
- doctors and healthcare staff working in prisons have become isolated, with little training and limited management support. NHS commissioning of prison healthcare would enable continuous professional development, peer support and professional registration
- various population groups require specific differential policies, eg mental health and substance misuse
- all prisoners requiring health care must be seen as patients and receive the same access to services and provision of care as provided in the community, ie equivalence and the mainstreaming of prison healthcare services
- healthcare managers should be trained with a good understanding of how healthcare should be provided and managed in a prison and linked to the NHS
- there is a need to recognise the interdependence of health care in prisons and wider health care provision
- a whole prison approach is required, which recognises the role of the healthy environment, ‘confidence, integrated policies, a safe place to work and care for all is necessary for staff and patients’

In addition, the *Patient or Prisoner* (10) report identified the main benefits of NHS commissioning:

- continuity in planning between the NHS and the prison service
- public health issues examined and linked to wider issues local to the prison
- common standards between the two services
- continuity of healthcare between prison and the wider community

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- healthcare staff trained to work in either prison or the NHS
- a common system of audit and evaluation
- a common commitment to evidence-based practice
- a common commitment to setting and improving standards

This report and discussion document built upon earlier reports (11-15) which had made similar recommendations but had not achieved the desired action for change. The numbers of prisoners with mental health problems were of particular concern but the report also recognised that this was, '*a huge subject with considerable resource implications*'. In conclusion, the report sets out a very strong case for transferring prison healthcare commissioning to the NHS and detailed how this might be achieved over a period of transition. It also stressed the need for a partnership approach, the implementation of national standards and the development of a healthy prison environment.

In order to further clarify levels of need, a report into the Psychiatric Morbidity Among Prisoners (16) was published in 1998. This work confirmed that up to 90% of prisoners experienced a diagnosable mental illness, substance misuse issues or both. This figure rose to 95% in young people.

The following year a joint working group reported their findings in *The Future Organisation of Prison Healthcare* (17), which recommended that a formal partnership should be created between the NHS and the Prison Service in order to ensure that: '*Prisoners should receive the same level of community care within prison as they would receive in the wider community*', i.e. *the principle of equivalence*.'

The above statement reflects the provision set out in Principle 9 of the United Nations General Assembly document Basic Principles for the Treatment of Prisoners (18) which states: '*Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation*'.

In 2001, the Department of Health published *Changing the Outlook: A strategy for developing and modernising mental health services in prisons* (19). This document introduced the concept of Prison Mental Health In-Reach teams to deliver mental health services equivalent to community mental health services. This was a step change in the equivalence agenda.

In September 2002, the Home Office announced that funding responsibility for healthcare within the prison service would become part of the NHS no later than April 2006 (20). Eighteen NHS primary care trusts (PCTs), which were responsible for commissioning local NHS services, completed a self-assessment against six criteria for readiness: local leadership, partnership working, modernisation plans, finance, workforce and sharing learning. Regional consultation followed before recommendations were made to Ministers. As a result, three waves of transfer were agreed and the DH took over funding responsibility for prison primary health care from April 2003.

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The National Partnership Agreement on the Transfer of Responsibility for Prison Health from the Home Office to the Department of Health, was published in April 2003 (21). This set out the high-level agreement between the two government departments and the expected process required to achieve an effective transfer by 2006. In addition, the Department of Health Responsible Commissioner Guidance (22) announced that, *'Under the new arrangements, the Responsible Commissioner for a prisoner's secondary care is normally the Primary Care Trust [NHS] PCT in which the prison is located, not the prisoner's home PCT, as was previously the case.'* This enhanced the PCT's ownership of the prison within their community.

Funding for primary health services in prisons was transferred to the first wave of primary care trusts on 1 April 2004. Funding for NHS secondary care services for prisoners remained in the existing PCT budgets. By April 2006 all prison health commissioning had transferred to the NHS and each PCT established a Partnership Agreement with the prison to establish responsibilities, prioritise developments and manage performance. These transfers were only for the public estate and private prisons were not included in the process.

Confident Communities in a Secure Britain – The Home Office Strategic Plan 2004 – 2008 (23) set out the government's aim to reduce crime and re-offending. This built on plans set out in the 2000 Comprehensive Spending Review, *Prudent for a Purpose* (24) and was followed by the *National Reducing Offending Action Plan 2004* (25) and the *National Reducing Offending Delivery Plan 2005* (26). These documents set out the creation of the National Offender Management Service (NOMS), the need for local partnership working and end-to-end offender management (27).

In 2007, *Who Pays, Establishing the Responsible Commissioner* was published,(28) setting out a framework for establishing commissioning responsibility for individual care within the NHS, ie determining who pays for a patient's care. This included people in prisons. Also in 2007, the responsibility for commissioning Escort and Bedwatch services for prisoners requiring hospital treatment was transferred to the NHS. In addition, a revised National Partnership Agreement was published which stated that: *'PCTs should commission health services of the same range and quality as the general public receives in the community.'*(29)

In the same year, the WHO published a report: *Health in Prisons: A WHO guide to the essentials in prison health* (6, 30), which recommended a whole prison approach to the care and the promotion of health and wellbeing of those in custody. This guide recommended that in order to create the best conditions for good health and effective health care, prisons should adopt a whole prison approach and provide:

- a healthy environment and a culture of care and rehabilitation
- an atmosphere in which prisoners feel safe in the company of other prisoners and staff
- opportunities for prisoners to talk to other people in confidence
- opportunities, through visits, to maintain family links
- information about the prison routine

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- ways to keep loneliness and boredom to a minimum
- adequate food, opportunities for exercise and access to fresh air
- sufficient privacy, adequate light, ventilation, heating (and sometimes cooling) and access to sanitation in the cell or barrack

During this period, a new government department, the Ministry of Justice, was created (2007) and responsibility for prisons and the probation service transferred from the Home Office. This set the scene for further development around care pathways into and out of prison. In the same year, the Secretary of State for Justice, Jack Straw, invited Lord Keith Bradley to lead an independent inquiry into the diversion of offenders with mental health problems or learning disabilities away from prison into other more appropriate services.

The Bradley Report was published in 2009 (5) and extended the focus of prison health into a care pathway approach which commenced outside the prison, ie police custody being the first point of contact within the CJS. The independent report examined the extent to which offenders with mental health problems or learning disabilities could, in appropriate cases, be diverted from prison to other services and the barriers to such diversion. The review recognised the growing consensus that prison may not be the right environment for those with severe mental illness and that custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide.

The Bradley Report (5) broadly recommended improved assessment, at the earliest possible opportunity, for example through the courts, within prison and then “through the gate” following a prison sentence, for people with mental health problems or learning disabilities in the CJS, and improved continuity of care. An important focus was the establishment of Criminal Justice Mental Health teams to ensure early identification and assessment, along with improved information sharing and, ultimately, better informed charging, prosecution and sentencing decisions. In the longer term, the impact may be that more offenders can be treated in the community, ensuring that those individuals who must be in prison can receive targeted, effective care while they are there.

The report sets out a direction of travel recognising the importance of setting good governance structures in place, at local and national levels, to set this work in progress.

In the government’s response (31), David Hanson, Minister for Justice, said, ‘*He [Lord Bradley] has recognised the considerable progress already made in reforming health services for offenders. Prison health is now embedded in the NHS and delivered in partnership.*’

Following Lord Bradley’s work, considerable effort to develop liaison and diversion services and improved access to healthcare in police custody and in magistrates and crown courts took place, which is still being developed today. The agreement of a co-commissioned (Ministry of Justice and the DH) approach to offenders diagnosed with a severe personality disorder, followed in 2011(32). This work is also still being implemented and is now co-commissioned by NOMS and NHS England under The Offender Personality Disorder

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Pathway Strategy (33) and is being cited as an example of a 'co-commissioning' model which is being looked at today in context of prison reform.

The creation of NHS England in April 2013 brought about the direct commissioning function for healthcare in the following settings (9): prisons, secure children's homes, secure training centres, immigration removal centres, liaison and diversion services, preparation for the transfer of police custody healthcare commissioning and sexual assault referral centres. A new National Partnership Agreement between NHS England, NOMS and PHE was developed (34) with an annual review planned. Also in 2013, the WHO produced *Good Governance for Prison Health in the 21st Century* (35) - a policy brief on the organisation of prison health, which among other statements, confirms that:

'Prison health services should be at least of equivalent professional, ethical and technical standards to those applying to public health services in the community.'

In 2015 an agreement was also developed in relation to Health and Wellbeing Services for Children Placed in the Children and Young People's Secure Estate (36)

These developments continued to evolve the principle of equivalence, which informed a wide range of policy developments leading to the current position, (see Appendix E)

Overview of the methodology

At first stage, a rapid review of evidence was undertaken, which conformed to best practice guidance in PHE's publications' standard and was approved by the PHE Science & Strategy Team (see appendix A). Findings from this literature review were matched against the key themes of the 'Commissioning for Best Population Level Outcomes' (4) matrix designed by the HINST to improve population health outcomes for people who experience health inequalities. This validated the use of the matrix as conceptual framework to inform the second stage interviews as well as its use as a basis for analysis.

The HINST matrix has been tested in more than 70 English health systems, and has shown that substantial progress can be achieved in making an impact in the short, medium and long term in relation to inequalities in mortality and life expectancy through a focus on existing services. Because of this, the matrix gives focused consideration to gaining maximum benefit from delivery of interventions for which there is strong evidence of effectiveness. In addition, there is a deliberate emphasis wherever possible, on improving access to services of a scale that will impact on bringing about a population level improvement in health outcomes.

The concepts and themes identified by the rapid evidence review were therefore summarised and analysed through a framework analysis – using a matrix developed by the HINST(4) (see [Appendix B](#)). This informed the lines of enquiry used in the one-to-one interviews with key informants and stakeholders.

The detail is illustrated in the diagram in Appendix B with the title 'Commissioning for Best Population Level Outcomes'. (4)

In summary, the framework balances two sets of factors that determine whether optimal outcome can be achieved at population level from a given set of personal health interventions. (See [Fig. 2](#))

The right side of the diagram enables commissioners to identify the best services available for their population. The left side allows commissioners to consider whether what is commissioned and delivered best meets the needs of all people in the local population. Attention to both sides of the diagram will help make sure that all services are effective and engaged with and used by all people in contact with the CJS.

The central elements of the diagram are concerned with making sure that when the most effective services/interventions are identified that are fully acceptable, accessible and effective in terms of take-up and compliance, there is adequate capacity to meet the need. Effective leadership and networks are needed to keep all these elements under review to gain continuous improvement and equality of morbidity and mortality outcomes

Achieving Improved Population Outcomes for People in Detained Settings

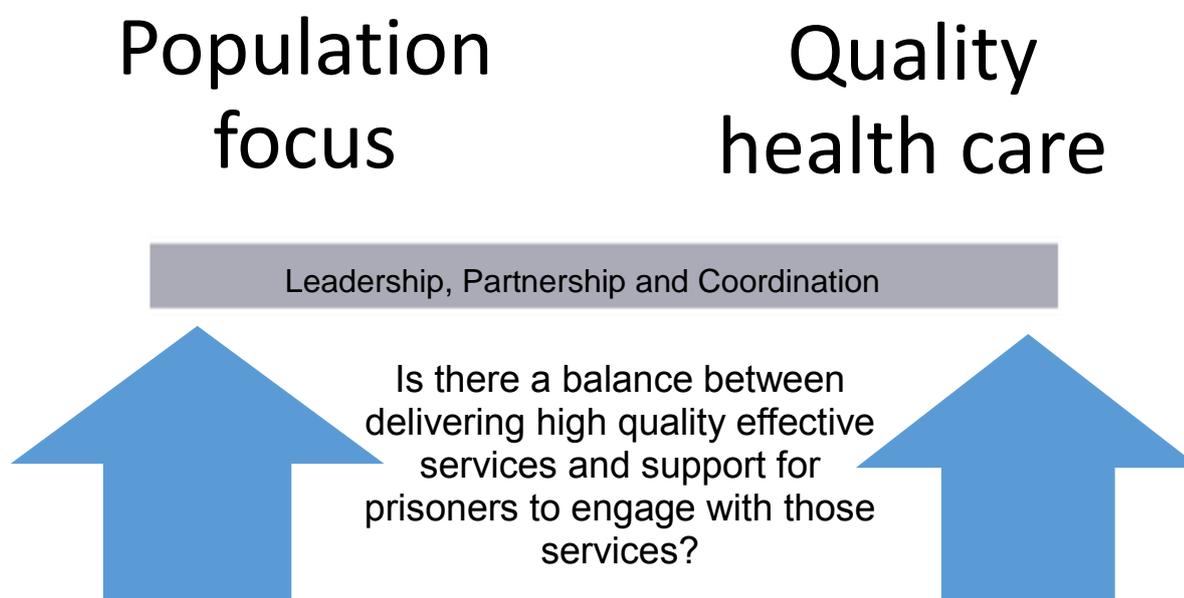


Fig 2: Analytical framework adapted from the HINST Model

At the second stage of the research, one-to-one interviews were undertaken with key informants (see [Appendix C](#)) by a Consultant in Public Health (Health & Justice) and the Head of Health and Justice Commissioning, NHS England, South, South West. Lines of enquiry were shaped by the HINST matrix and were designed to facilitate deliberation to create a mutual dialogue between the researchers and delegates. This approach offered an opportunity to consider different points of view and come to a reasoned decision (37). The overall purpose of using key informants was to gather opinion on what is known to be effective commissioning and provision of health care in a prison setting and any possible barriers to application. Discussions were focused around pre-agreed themes (established from the literature search and learning from work by the HINST (4)). By also using an appreciative enquiry approach (38) discussion was built on identified areas of strength to develop possible solutions for areas of improvement and to help identify future commissioning priorities.

Experts were sought from a range of service providers, NHS commissioners, public health professionals, including local authority leaders and PHE Health & Justice specialists working in centres and regions, NOMS and Ministry of Justice (MoJ), and third-sector organisations, including those nationally recognised as providing a prisoner

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voice. They were chosen because they represented an element(s) of the breadth of study (see [Appendix C](#)).

The study was reviewed by the PHE Research Ethics and Governance Group (PHE REGG) and approved at the outset of the review. It was agreed that ethics approval was not needed, as people in detained settings were not being interviewed.

The concepts and themes in the data were summarised and analysed through the HINST framework analysis (4).

Literature review: What is the evidence that the commissioning of health care within prisons is effective and efficient?

Methods

Rapid evidence review

A rapid evidence review was used to provide a “streamlined approach to synthesizing evidence in a timely manner... for the purpose of informing emergent decisions faced by decision makers in health care settings (38).

The evidence summary was based on the UK Government Social Research Service recommendation of a question led approach.¹⁶ An “impact” or “what works?” question was agreed, which in this case was “what is the evidence that the commissioning of health care within prisons is effective and efficient?” This methodology conformed to best practice guidance as outlined in Public Health England’s publications’ standard.

Search strategy

The search strategy ([Appendix A](#)) used terms to describe the population that covered the prison setting (eg ‘prisoner’ and ‘inmate’), health outcomes known to be disproportionately high among people in contact with the criminal justice system (eg substance abuse and mental health) as well as terms that covered the judicial process (eg legal system and criminal justice). These were combined with terms for commissioning and delivery of healthcare including ‘health services research’, ‘commission’, ‘healthcare quality’ and ‘care in custody’. All search terms were looked for in the title and abstract fields. The Boolean operators ‘AND’ and ‘OR’ were used, alongside truncation, phrase searches and proximity operators.

The following databases were searched: CINAHL, Embase, Medline, PsychINFO, Social Policy & Practice and NHS Evidence. Grey literature searches were undertaken on NHS Evidence using a condensed version of the search strategy. Only papers published between 1995 and 2015 and in the English language were included in the study; research papers from all geographical settings were included.

¹⁶ <https://www.gov.uk/government/publications/uk-nsc-evidence-review-process/appendix-f-requirements-for-uk-nsc-evidence-summaries>

Data extraction

The results of the search strategy were reviewed by two experts in the health & justice field to select the relevant articles. We considered articles to be relevant if the title and/or abstract suggested that the article discussed the impact of healthcare systems on improving health outcomes for people in contact with the criminal justice system. This approach enabled us to consider a breadth of articles which included both male and female populations, populations of all ages, and a range of health and wellbeing topics. Whilst the purpose of the literature review was to understand the commissioning of healthcare in prisons, we did not exclude papers that were set in the wider criminal justice system (eg secure hospitals, probation, courts).

A post-doctoral researcher read each relevant paper (or, due to time constraints, the abstract and or title if the full article was not available) and extracted information on country, setting, study design and participants and identified relevant themes. These themes were recorded against the 13 themes outlined in the Health Inequalities National Support Team framework (4) in order to establish that the framework adequately identified all prison related factors, which would achieve population health outcomes for people in detained settings (and therefore was an appropriate analytical framework). **Table 1** summarises these 13 themes. Any themes not covered by this framework were recorded separately and classified as “emerging themes”.

Table 1 Summary of the 13 themes produced by Health Inequalities National Support Team to understand what needs to be done by commissioners and providers to further improve population health and wellbeing.

A) Challenge to providers		B) Population focus	
1	Known intervention efficacy	6	Known population needs
2	Local service effectiveness	7	Expressed demand
3	Cost effectiveness	8	Equitable resourcing
4	Accessibility	9	Responsive services
5	Engaging the public	10	Supported self-management
11	Adequate service volumes		
12	Balanced service portfolio		
13	Networks, leadership and co-ordination		

Results

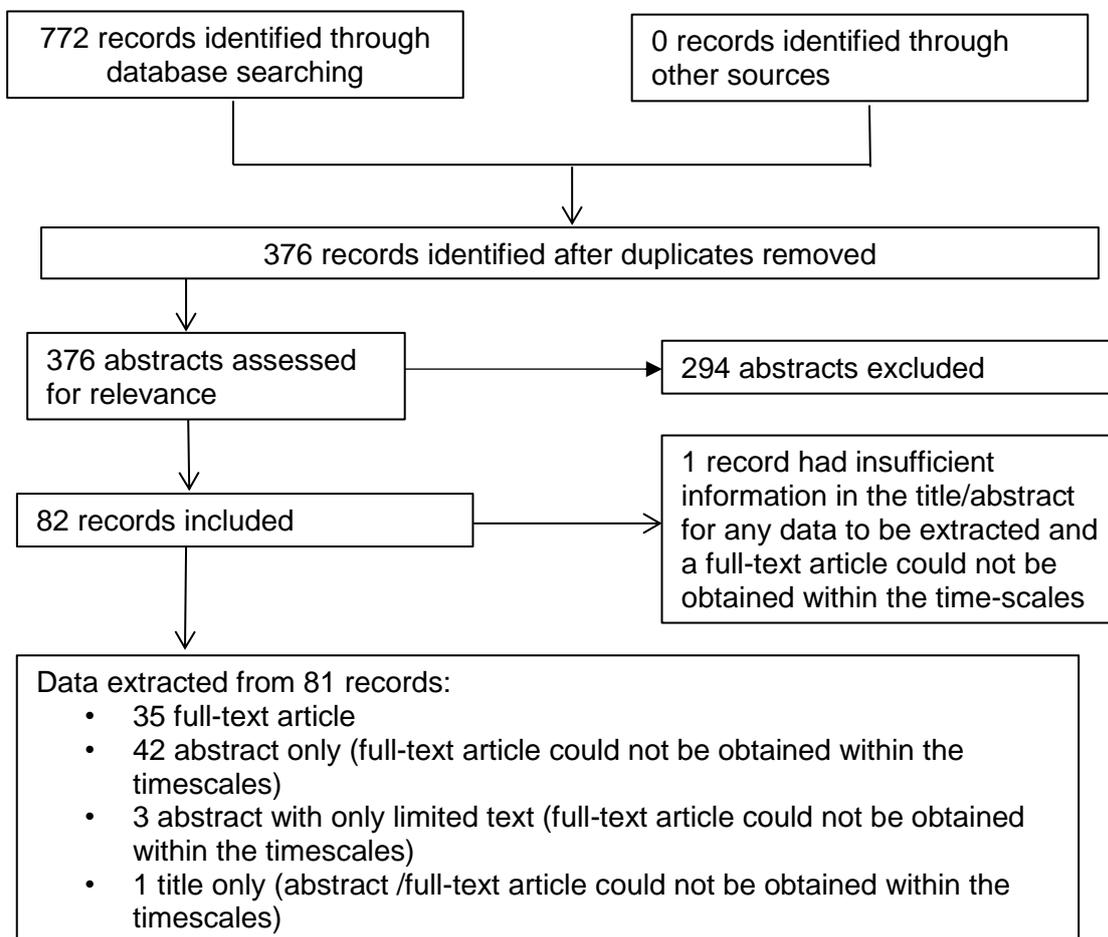
Selection of relevant articles

Figure 3 describes the flow of articles through the different phases of the rapid review. The literature search identified 376 articles, of which 82 were relevant. The full paper was used to extract data from 35 articles (43%); but due to time constraints the abstract alone was used for 45 articles (55%) whilst 1 article (1%) had no abstract and therefore the title alone was

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used (39). The remaining 1 article (1%) had insufficient information in the title or abstract for data to be extracted (40)

Figure 3. Flow of information through the different phases of the rapid review



Summary of the articles

A summary of the 82 relevant articles is available in [Appendix D](#). The articles covered a range of settings including youth offending teams, courts, community, secure hospitals, probation and the criminal justice system as a whole but the most common setting was prison. The articles studied populations across Europe, New Zealand and Australia and the USA but predominantly studies were based in the UK or the USA. The populations were predominantly adult men in prison but a number of studies focused specifically on women, young people, prisoners resettling back into the community, older prisoners and professionals (for example, people working in health care and housing). Some studies also selected participants based on their health needs; a number of these studies specifically focused on people with poor mental health and a smaller number included only those with specific chronic conditions (eg diabetes).

Themes to improve population health and wellbeing

All 13 of the themes outlined by the Health Inequalities National Support Team framework (Table 1) were included across the 81 papers (from which data were extracted) but some themes had greater prominence than others.

Few studies examined the commissioning process itself, but instead looked at what an effective commissioning process should be aiming to achieve to improve health and wellbeing outcomes for people in prison, their families, the prison workforce and the wider community. In addition, few studies tested specific interventions to determine whether they were clinically or cost-effective in improving health and wellbeing outcomes and reducing health inequalities.

The majority of articles focused on describing the high levels of poor health observed in the population groups studied, compared with the general population (Theme 6, Table 1), and poor practice. From these observations the authors drew conclusions about what "good" would look like. These conclusions included the need for:

A more robust evidence base on what works and what is cost effective (Themes 2 and 3)

An important discussion about the effectiveness of local service provision focused on whether there was equivalence of care, not only between people in contact with the criminal justice system and the general population, but also whether services were equally effective at supporting different groups of people within the CJS in particular older people, women and those with mental health needs (41-49). A more general discussion was had about the poor quality of evidence on what works and the lack of information about what is cost effective (50-52).

Increased accessibility to effective health and social care for people in prison and after release into the community (Theme 4, Table 1).

A large number of studies focused on the (lack of) accessibility to effective health and social care for people in contact with the criminal justice system (53-67). Discussions on accessibility were focused on cost (in US populations only) (41, 68), denied access (69), timely access (52), improved access for specific groups (eg women, people with substance misuse and alcohol problems, and complex patients with a range of needs (5, 70) and increased access to health and social care services in the community (71-73), in particular on release from prison (46, 74). Discussions on this theme also covered accessibility to services which influence the wider determinants of health (eg employment) (75) and the co-location of health and justice services (eg within youth offending teams (76) as a solution to improve accessibility to health and social care in the community).

Greater inclusion of the views of people in prison and their families and the professional workforce across organisations in determining how healthcare is delivered (Theme 5)

Those articles which included a qualitative approach tended to include the views of prisoners (41, 60, 62, 64, 77, 78) or those recently (or about to be) released from prison (72, 79-84), those on probation (71) or more broadly those in contact with the criminal justice system (85). Fewer studies included the views of professionals (51, 61, 62, 71, 73) or family and (ex-) partners(41, 82). The Bradley Report (5) included a wide consultation including the "citizens' voice". People's views were sought on a wide range of topics including management of physical (64) or mental health (5), dying in prison (41) transitioning between prison and the community (79, 80, 83), service user satisfaction measures (85), primary care (60), quality of healthcare services (73, 77, 81), peer mentoring/peer based interventions (51, 81, 84), roles of healthcare professionals (61), how health and justice systems best work together (62) and the experience of older people entering prison (78).

Importance of understanding health and social care needs and recognising that people in contact with the criminal justice system have different needs and that these needs change (Theme 6)

As already stated, a large number of the articles described the health and social care needs of people in contact with the criminal justice system (5, 42, 47, 55, 58, 62, 69, 74, 76-79, 85-91). Different needs were highlighted through specific studies focusing on young offenders (76), older prisoners (47, 88), women (42, 88), people in different levels of secure detention (eg low and medium secure hospitals) (42), and people with mental health needs (5, 85). A smaller number of articles focused on how health needs change within a population; for example during the transition from prison back to the community (55), or as services change within a detention setting (58). Finally, two studies discussed the actual process of, and potential for improving, how needs were measured (77, 87)

Improved continuity of care for people as they transition between prison and the community (Theme 12)

The majority of the articles which covered this theme discussed the problems of continuity of care as people transition from prison into the community (46, 47, 55, 56, 62, 66, 70, 73, 74, 81, 92-97). This discussion was broadened out in one article to a focus on the need for "end-to-end" management (in particular when addressing mental health needs/care) across the criminal justice system pathway (5).

Improved quality of data and greater information sharing to enable performance management and more efficient and effective services (including comparison of care between prison and community settings) (Themes 1 & 12)

Articles described the lack of good quality relevant data available both nationally and locally (42, 69, 85, 98) the lack of modern information management/information

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technology (IT) systems (9, 99, 100) and the limited sharing of information (50). This lack of a shared picture through routine information systems and data was mirrored in some articles with a discussion about the ambiguity from professionals working within health and justice as to their roles and responsibilities (62, 78).

Greater resources and more equitable resources to meet need (Theme 8)

A small number of studies discussed inadequate resources (43, 89) and the potential for reduced resources to compromise clinical care (73). In some articles greater emphasis was placed on the equity of access for specific groups - in particular according to gender, learning disability and geography (56, 70) – or individuals (5).

Leadership and collaborative working between organisations (Theme 13)

A large number of papers discussed the importance of leadership (50, 67), vision (48, 49) and “joined-up”/“partnership” working (5, 46, 47, 63, 67, 70, 71, 85, 93, 97, 101-104) between organisations/individuals including the client (98). In one article, the idea of a partnership approach was expanded on such that the health of the community outside of prisons was considered a desirable aim of prison health care (88). The need for a more integrated commissioning model (9, 62, 78); was also highlighted.

Additional themes

A number of identified themes were not clearly captured within the 13 themes as outlined by the Health Inequalities National Support Team Framework. These “emerging themes”, which are summarised below, fell into three general categories:

Firstly, those themes which acknowledge the negative impact of the environment and culture in prison (and other criminal justice settings) on commissioning effective and efficient healthcare.

- the **impact of the prison environment and regime** (eg time out of cell in purposeful activities; access to employment, education and training opportunities; and access to exercise and nutritious diets) on health and wellbeing (53, 57, 61, 64, 88) concerns about potential breaches of security and discipline in prisons, together with anxiety about data security and a culture that gives low priority to health were seen as barriers to implementing health information technology in prisons (99)

Secondly, those themes that acknowledged that the health and wellbeing of people within the criminal justice system and those in the community are interdependent and that neglecting the health and wellbeing of people in prisons through ineffective and inefficient commissioning practices has negative implications on the wider society.

- **linking into wider care pathways and community structures/services:** challenges about linking work in prisons and other secure settings into wider work,

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eg around integrated offender management, community safety partnerships, joint strategic needs assessment and health and wellbeing boards

- that neglecting the health and wellbeing of people in prisons has **negative implications on the wider society** (eg through escalating costs of healthcare and associated criminal activity of untreated substance dependence and/or mental health needs) (69)
- **improved health and wellbeing** as a **positive mediator of change** in criminal behaviour (105)

Thirdly, those themes that acknowledge the importance of focusing on prevention and early intervention to prevent a custodial sentence or to prevent health and wellbeing needs escalating.

- **preventing children and young people** coming into contact with the criminal justice system (93)
- **intervening earlier to improve the health and wellbeing** of people already in contact with the criminal justice system (106)

Discussion: Relating to the literature review

Main findings

The articles included in this rapid review, published in the peer-reviewed literature, predominantly focused on male prison populations in the UK and USA. Of those articles that additionally selected people based on their health needs, the focus was mental health (rather than physical health) needs. The articles tended not to critically examine the commissioning process but describe the (poor) health of the population in criminal justice settings (compared with the general population) and the existing poor practice. From this, authors drew conclusions about what “good” would look like. This review, therefore, whilst it cannot definitely state based on available evidence, what does work well, it can and does suggest that there is substantially more work to be done to ensure that the commissioning of healthcare within prisons is effective and efficient, that it meets health needs appropriately and in a timely way to achieve a good outcome equivalent to the standard of care available to people in the wider community. More importantly, the articles also give us an indication of where to best concentrate these efforts: these include accessibility of health and social care, continuity of care, quality of data and information sharing, greater resources, leadership and collaboration, and a stronger evidence-base (including more qualitative work) on which to base commissioning decisions.

Limitations of the study

The use of a rapid evidence assessment, rather than a systematic review methodology, the use of abstracts (rather than full-text articles) to extract the data, and limiting the search strategy to articles published in the English language only might mean that some relevant research papers and themes were not identified. The need for the evidence to be produced within a limited time frame and with limited resources determined these pragmatic approaches. The two researchers who reviewed the literature search results and selected papers for inclusion in the study are experts in the health and justice field. They confirmed that the range of literature reviewed was good, providing confidence that the search had been sufficiently inclusive. The breadth and relevance of the findings was confirmed through early review by the Health & Justice Team, PHE. The focus of the literature review was primarily on prisons, as there is a greater source of data and longer period of direct commissioning of health by the NHS (since 2006 in England) in this setting. This may limit the relevance of the review conclusions for other criminal justice settings including immigration detention and the Children and Young People’s Secure Estate for which NHS England is also the responsible healthcare commissioner. Furthermore, as a number of the relevant articles focused on populations based outside of the UK, in particular in the USA, the findings may not be generalisable to England.

These limitations were considered when initially devising the methodology and therefore the researchers agreed to use a qualitative approach with key informants to strengthen

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the review findings. The research methodology also enabled engagement with key stakeholders on future policy development.

Additional themes

The emerging themes captured in the review provide a useful insight into the complexities of commissioning effective and efficient healthcare within criminal justice settings.

On the one hand, the prison environment, culture and regime can be seen as a barrier, conflicting with optimal healthcare, whilst on the other hand it is often cited as the setting in which some people have had effective and sustained contact with healthcare services.

There are many examples within the articles of the false dichotomy between the health of people within the CJS and the general population. There is a growing consensus that neglecting to improve the health and wellbeing of people in contact with the CJS will have a negative impact on the health and wellbeing of the general population, for example, through associated criminal activity of untreated substance dependence and/or mental health needs. Furthermore, there is a need to recognise that the majority of individuals in secure and detained settings will eventually return to the community and effective commissioning needs to respond to this transition. Finally, there is an opportunity to diagnose, treat or even prevent disease (for example through active-case finding and screening programme or vaccination programmes) which could avoid costs to the NHS in treating the longer term health consequences of undiagnosed health problems (eg associated with the late diagnosis of HIV or hepatitis C infection) or even protect the wider population from infectious diseases found more commonly among prison populations (eg TB).

In the literature reviewed, there is a call for a more preventative approach. These range from earlier interventions to prevent children and young people developing criminal behaviours to intervening earlier with people in contact with the criminal justice system to prevent their health and wellbeing needs escalating.

Interviews

The concepts and themes identified by the rapid evidence review were summarised and analysed through a framework analysis – using a matrix developed by the HINST (4), designed to improve population health outcomes for people who experience health inequalities. This informed the lines of enquiry used in the 1:1 interviews with key informants.

Population focus

Knowing your population needs

Questions: Is there a realistic assessment of the health needs of the prison population/criminal justice population locally? Is it segmented in any way to ensure needs are understood across the population? And is the level and type of service provided to meet these needs? Is there a comprehensive gap analysis? Are there sufficient resources to meet this need?

The health needs assessments (HNAs) completed by commissioners prior to commissioning or re-commissioning a service, were generally seen as the most detailed approach and only available mechanism to identify needs in a set environment, eg a named prison or immigration removal centre. The annual refreshing of the HNA was also thought to capture and reflect fluctuating and new need. The PHE template¹⁷ was generally appreciated and used to achieve a standard approach. However, there was a general reflection that HNAs are not detailed and specific enough to accurately identify core need and are based on poor quality data. This reduced their effectiveness to meet actual need.

Example of illustrative practice

The health & justice commissioning teams in Yorkshire and Humber, supported by the Yorkshire and Humber PHE Centre health & justice specialist lead have worked to streamline the traditional HNA process to make it more comprehensive, consistent, comparable and dynamic using a rolling programme of annual updating.

The original concept was to produce mass produced data-driven reports, using the national toolkit to set the structure and content of the HNAs, and used the toolkit's prevalence data. But as the process evolved, qualitative elements were built in through meetings with the provider and service users.

Outcomes: The first 4 HNAs (of the 12) have been completed and signed off with the providers. Initial feedback from commissioner and provider at Lindholme suggests that the process and the product had been invaluable. A robust, efficient process has now

¹⁷ <https://www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit>

been developed, to which all partners are committed – co-operation and co-production have been key. The use of HJIPs has initiated data improvements and improved understanding of the indicators which has led to additional positive outcomes for commissioners and providers. For further information on the HNA template see <https://www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit>

Questions were also raised about whether there were sufficient links made, through the template process, with the wider community joint strategic needs assessment (JSNA). However, it was generally acknowledged that HNAs of specific establishments and community JSNAs are two separate systems which do not currently link, even though the population is often shared. '*HNAs should be able to feed into the JSNA but they do not link at the moment*'. It was recommended that local community governance structures could oversee this link.

The complexities of 'tracking' people post release to measure long-term outcomes (and the associated impact of healthcare commissioning within prisons) was raised as a difficulty to assessing the ongoing needs of this population. Generally, it was agreed that those who leave the CJS and remain 'under-served' and who are at high risk of reoffending due to health related issues, will be identified by local authority assessment of health inequalities. However, it was agreed that the identification of links between health and offending would be beneficial. For those people still in touch with the community-based CJS, the needs assessments undertaken by community rehabilitation companies (CRCs) and the National Probation Service (NPS) were seen as helpful to define support needs in the short-term post release.

It was felt that police custody provided a good opportunity for screening individual needs as first point of contact with the CJS, eg compulsory drug testing, with the requirement for the individual to attend further appointments. However, it was thought that disclosure of serious health issues was unlikely in this setting, unless done in a very sensitive way in a confidential environment.

It was acknowledged that the new system of performance reporting, Health & Justice Indicators of Performance (HJIPs)⁶ initially established in all prisons (but expanding to include sexual assault referral centres (SARCS), the Children and Young People's Secure Estate and the Liaison and Diversion Service), is still evolving and will make a very positive contribution to this agenda. However, there remain current key issues around data quality, accessibility of reports and transparency. In addition, the transition to a new, comprehensive Health and Justice Information System (HJIS)¹⁸ will improve data capture and reporting, but it was agreed that confidence in the system had to be established so that reliable and accurate reporting could be achieved; the 'One Truth'.

¹⁸ <http://systems.hscic.gov.uk/healthandjustice>

The following specific concerns were expressed about the current HJIPs:

- there was not an obvious set baseline on what constitutes an acceptable level of information or a target of good performance
- inaccuracies of data may be due to operator error as they may have limited understanding of what is being asked for and therefore the data may be interpreted incorrectly e.g. what missing data means
- the lack of a feedback loop to support greater provider compliance as they would be able to see the value of the system
- lack of standardisation of input eg different READ codes being used.
- No direct access – an aggregated summary to commissioners is available in some regions, although this is now a developing analysis function within the national Commissioning Support Unit (CSU) contract
- too many indicators with a lack of understanding of the purpose of collecting them
- the need for a greater focus on outcomes

Expressed demand

Question: Are prisoners who need the services able to present to services in a timely and appropriate fashion through informing, educating and supporting the population?

There is a perceived absence of proactive/early intervention services in custody, which means that signs and symptoms often seemed to be left until they develop into a more serious state, eg self-harm and suicide prevention. The need for managed/early interventions/prevention services, eg blood-borne virus (BBV) opt-out, diabetic eye screening and older person clinics, were identified as a means of reducing escalation of need and responding in a timely and appropriate way to expressed need.

Example of illustrative practice

Blood-borne Virus Opt-out Testing Programme for Adult Prisons in England

People in prison have a high prevalence of infection with blood-borne viruses (BBV) but have traditionally been under-tested. Prior to 2010, levels of BBV testing in English prisons did not exceed 4% of the prison population. To improve testing and treatment of BBVs in prisons, a formal partnership agreement between PHE, NHS England and the NOMS introduced a national 'opt-out' testing policy in adult prisons in 2014. Three phases of implementation have been planned between April 2014 and March 2017 in over 30 Pathfinder Prisons, from which key findings will be used to inform BBV testing in prisons across the country.

Evaluation of the first phase of implementation in 11 prisons found that between April and September 2014 over 20% of new receptions were tested for hepatitis B, hepatitis C and HIV compared to only 11% of new receptions tested for hepatitis C and HIV (and 12% for hepatitis B) prior to the programme. The complete results of the phase 1 evaluation and phase 2, (expected August 2016) can be found on the PHE Health & Justice website:

<https://www.gov.uk/government/publications/early-lessons-learnt-from-opt-out-blood-borne-virus-testing-policy-in-prisons-summary-report>.

The evaluation of phase 3 prisons is scheduled to commence in mid-September with the final results to be published in Q4 of 2016-17.

PHE, NHS England and NOMS are collectively determined to continue to improve the coverage of testing for BBVs among people in prison which is a major step to addressing this public health concern, not only in prison populations but in the wider community. As of February 2016, more than half of the prison estate in England is implementing BBV opt-out testing, with the remaining prisons expected to introduce testing by Q4 of the current financial year.

Contact: Health & Justice Team, PHE health&justice@phe.gov.uk

It was also highlighted that a lack of understanding of health/healthcare by prison staff inhibit appropriate presentation to services

Police custody was also identified as an opportunity for offering proactive services, eg sexual health and substance misuse. Local partnerships between local authorities and the Office of the Police and Crime Commissioner were seen as important to further developing these services to meet needs. However, confidentiality and the time/space to disclose sensitive issues were common themes where need was expressed but the time restraints on service delivery did not always support this.

Person-centred care was a key issue expressed by interviewees. This was particularly pertinent to meet the different needs of people with learning disability, learning difficulties and autistic spectrum conditions. Interviewees felt that engaging with individuals with specific needs was an opportunity for positive engagement, which was often missed. These discussions led into considerations for addressing and responding to the generally low levels of literacy within the secure and detained estate to enable prisoners to present to services in a timely and appropriate way. The introduction of easy-read literature was considered to be very important.

Previous work to introduce systematic and standardised learning disability screening processes was highlighted as only being continued in some regions so that any information gained was not consistent. Links/care pathways back into community services was also felt to be patchy, which was said to be due to community services offering different thresholds for service delivery, *'If (a person) is in contact the service is excellent, but for many this did not happen'*. However, it was reported that it was *'working well where it exists'*. This was thought to happen because it included local screening questions which were developed in partnership with local learning disability services. These would help learning disability services to identify and support the person if they met their service eligibility criteria.

Peer mentoring and the use of informal networks was seen as a positive method of enabling access to services, particularly for prisoners with learning disabilities/learning difficulties, to help with areas such as understanding processes, accessing healthcare and good diet. However, to be effective it was recognised that it had to be of sufficient system and scale to achieving population outcomes. Issues of sharing information and disclosure/confidentiality were also raised. Training for all was identified as a prerequisite prior to any service commencement. It was also felt that the skills and experience of prisoners would be harnessed and used to mutual benefit through peer support/mentoring services via Transforming Rehabilitation.¹⁹

The HMIP report *Life in Prison: Peer Support: A Findings Paper* (2016) (107) was referenced by interviewees, which reported that peer support is used widely in prisons and its importance is recognised in many of the prisons inspected. It was seen as being an effective and readily available source of support for prisoners for a variety of issues, and can be a beneficial activity for the prisoner peer supporters themselves. The report provides a large number of examples of peer education programmes across the estate.

Example of illustrative practice

The Irish Red Cross Community Based Health and First Aid (CBHFA) in prisons programme was introduced into Wheatfield Prison, Dublin, Ireland, in 2009 as an action research approach to solving a public health management problem identified by a newly-appointed healthcare and nursing manager.

It was developed as a partnership between the Irish Prison Service (IPS), the Irish Red Cross (IRC) and the Educational Training Boards of Ireland (ETB). The programme approach of CBHFA in action was implemented over a 12-month period and then internally evaluated in 2010.

The successful outcomes have led the IPS Health Care Directorate to seek the expansion of the programme to other prisons in Ireland. By the end of 2014, the programme was introduced in all 14 prisons in Ireland.

www.redcross.ie/cbhfa.

The **British Red Cross** has adopted prisons as 'at-risk' settings to their community programme and have started to pilot models of working in Wales, Northern Ireland, Scotland and England. A number of these pilots have drawn upon the Republic of Ireland model to develop a wider, peer-education health programme. Director of Education, British Red Cross 0161 888 8940.

¹⁹ <https://www.gov.uk/government/publications/2010-to-2015-government-policy-reoffending-and-rehabilitation/2010-to-2015-government-policy-reoffending-and-rehabilitation>.

Responsive Services

When prisoners present to services, do they get equal access to timely beneficial interventions according to need?

It was recognised by interviewees that people are in contact with the CJS at different parts of the pathway and that each point provides an opportunity to understand and respond to the health needs identified. However, it was acknowledged that not one-size-fits-all and services need to be responsive to different needs, but this is not always reflected in service commissioning and delivery.

In support of this, most interviewees considered the Bradley Report (5) represented landmark changes in the health and justice agenda to support the development of more responsive services. Its recommendations were regarded as still in progress and improvements are still being achieved; “*it is an evolution of service development within an established concept*”. Overall, it was generally agreed that the Bradley recommendations have and still do provide optimism for an improved community/custody interface, although pressures remain where liaison and diversion services are currently not in place, eg at the time of interview the business case for full roll-out (100% coverage) of liaison and diversion was still awaiting agreement by the Treasury and the transfer of commissioning health care in police custody to the NHS is not proceeding.²⁰

It was also generally accepted that the “liaison” aspect of the service is more developed than the “diversion” aspect, ie the ability to identify and diagnose health needs among people in police custody is more successful than the ability to appropriately ‘divert’ people from the CJS care pathway to the health care pathway. This was felt to be due to issues of access to health and social services in the community. Information flows and links between liaison and diversion services and community/custody services were identified as working reasonably well, but access to services outside of the CJS, eg mental health services and primary care, were seen to be poor. Community treatment requirements were also cited as difficult to implement due to the inability to enforce compliance with treatment, the lack of trained/willing health professionals to administer this and access to appropriate services. However, this was recognised as not just a problem faced in the CJS but a general issue of access to these services in the community.

Example of illustrative practice

South West (SW) Liaison and Diversion Information Sharing to Courts

In response to some difficulties in sharing information in courts the SW Liaison and Diversion Service, in partnership with criminal justice stakeholders, created generic mailboxes for the dissemination of liaison and diversion programme assessment

²⁰ Since the interviews, additional funding and an extension of coverage of liaison and diversion to cover 75% of English police force areas has been announced see www.gov.uk/government/news/increased-mental-health-services-for-those-arrested

summaries to all relevant parties in the courts. This allows for the dissemination to the bench, defence and Crown Prosecution Service (CPS) of all information relevant to sentencing decisions from the L&D perspective.

The “go live” date for this service was November 2015. To achieve this, all assessments have the case Unique Reference Number (URN) from the custody record or acquired through the officer in the case. All reports are initially shared with the custody sergeant or Officer In the Case (OIC) to inform charging decisions. This information is then shared with the CPS but will not go into the “bundle” prepared for court should charges be progressed.

Reports for the court are shared using the nationally approved templates. In the absence of consent an alert to the court of the fact an assessment has been completed will be sent. The email boxes are secure and legitimate for information sharing as per NHS England information governance guidance. When sending an email to these mailboxes the subject line MUST read:

“Liaison and Diversion report for Case Unique Reference Number XXXXXXXX”

For further information on the Liaison and Diversion Programme please go to www.england.nhs.uk/commissioning/health-just/liaison-and-diversion

Community rehabilitation companies (CRCs),²¹ although still developing, were thought to provide a more robust link between custody and community and therefore provide a responsive service to meet individual need. However, the payment by results (PbR) contractual agreement has yet to show evidence of success and additionally it was thought to have limited value in helping to resolve complex health needs.

Supported self-management

Are prisoners empowered to make choices about their circumstance and service offer, on the basis of good information and supported to use the service offer to best effect?

It was generally thought that people in prisons could be encouraged to self-manage their treatments more with support, either from a peer mentor/champion or a provider agency, eg voluntary sector/CRC. It was felt that this would build on the Prime Minister’s asset-based model (8), which would harness the skills and experience of people in prisons and use them effectively. In healthcare, this could focus on simple testing and reporting and medicines management, but it was recognised that this would require clear boundaries to be set and recognition of safeguarding requirements.

²¹ Community rehabilitation companies (CRCs) are responsible for the management of low to medium risk offenders in 21 areas across England and Wales. (The previous 35 probation trusts have also been replaced with a single National Probation Service, responsible for the management of high-risk offenders.) The CRCs will also have a new responsibility for supervising short-sentence prisoners (those sentenced to less than 12 months in prison) after release.

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It was raised that both support systems for vulnerable families (eg budget management, transport), and family members who wish to support prisoners (eg letter writing/visits), could be further developed. The need for closer partnership working with families, for example through the Troubled Families Programme (108), with potential mentoring/volunteer support, was identified but with recognition that robust safeguarding procedures would be required.

Service focus

Local service effectiveness

Do service providers maintain high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit?

In general, comments from interviewees reflected a significant improvement in local service effectiveness since the transfer to NHS commissioning of prison healthcare in 2006.

Monitoring

The NHSE commissioners interviewed highlighted that by working to a 'Single Operating Model', using national service specifications, ensured providers are working to agreed national standards. A range of local monitoring processes were described, including the use of performance dashboards with providers and bespoke quality reviews with, for example, NHS England's nursing and quality teams, with follow-up action plans. However, this area was clearly stated by interviewees as being under-developed and there is a need for more robust contract monitoring and performance reporting. It was felt that the current system of HJIPS was still in development and it was hoped that this would provide a more accessible/robust system of monitoring outcomes and fully establish benchmarking.

Education and training of staff

It was identified that the employment of professional healthcare staff with nationally recognised qualifications and membership of professional bodies is enabling a rise in clinical standards and accountability. This is supported by the Royal College of Nursing²² developing a specialised branch of nursing and the Royal College of General Practitioners establishing a Secure Environments Group²³ There are training and continuous professional development opportunities available, for example a Certificate,

²² <https://www.rcn.org.uk/get-involved/forums/nursing-in-criminal-justice-services-forum>

²³ <http://www.rcgp.org.uk/clinical-and-research/clinical-resources/resources-for-gps-working-in-secure-environments.aspx>

Diploma and MSc in Healthcare in the Secure Environments is offered by Lincoln University²⁴, although it was acknowledged that these are limited and are not routinely taken up by all healthcare workers. However, it was reflected that these provide a focus on a more *professionalised* workforce, which has enabled standards to rise via regular clinical supervision and monitoring, eg the implementation of revalidation processes for medical staff. It was also recognised that where prison staff and healthcare staff worked closely together, this helped to promote better understanding of the two systems. An increase in opportunities to share and learn from local innovations was raised to support further learning and development.

Many interviewees considered that it would be very helpful if Health Education England²⁵ was an active partner in the agenda to inform training, education and recruitment and retention of staff.

Inspectorate reviews

Inspectorate reports were felt to be very useful – HMIP⁷ and the CQC⁸ were cited as positive examples of testing how standards were being met and highlighting areas for improvement, which are used alongside other service monitoring reports. However, it was recommended there is a need for a more effective way to measure how the outcomes have been implemented.

The outcome of serious incidents, including Deaths in Custody Clinical Reviews and Prison and Probation Ombudsman Reports,²⁶ were seen as a positive ‘shared learning’ approach to prevent repeat mistakes and to monitor system improvement. However, it was recognised that they were only useful if recommendations are monitored and effectively implemented.

Complaints/patient advice and liaison service (PALS) systems were regarded as a very useful method of monitoring services and achieving improvements. Service user feedback/evaluation systems, eg service exit feedback, is highly valued as a means of improving services. This information would be particularly valuable when triangulated with other monitoring methods.

Meeting clinical standards of care

²⁴ <http://www.lincoln.ac.uk/home/course/hltrlrms/>

²⁵ www.hee.nhs.uk

²⁶ <http://www.ppo.gov.uk/document/learning-lessons-reports>

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The contractual requirement to implement national standards, for example those of the National Institute of Health and Care Excellence (NICE), was seen as a positive improvement in the delivery of high-quality services.

Interviewees were, however, unsure how it is assured that local community services and/or specialised services (ie services outside of the prison settings) required by prisoners are effective/would affect prisoner health outcomes. For example, one concern was the varying availability across the country of secure mental health beds for prisoners requiring transfer under the Mental Health Act (1983).²⁷ This linked to themes of consistency of service provision, recognition of standards and continuity of care, which interviewees hoped to see. Good networks between prison healthcare providers and acute and community healthcare services was noted as essential to support effective pathways, equivalent to care in the community.

Cost effectiveness

Questions: Are the services established which are as affordable as possible at a population level? Are cost savings judged across the whole HC and CJ system?

The theme of cost effectiveness elicited a range of responses covering the various methods of assessing and determining what is cost effective. On the whole, this area was felt to be very underdeveloped.

The use of a market driven/competitive tendering process for services was the dominant theme as a way to ensure procured services provided the best value for money. However, it was noted that as markets fluctuate and if the funding envelope available does not reflect the contractual requirements, the market responds in a negative way by not bidding for services. This can lead to local variations. Some interviewees suggested the use of benchmarking/unit costs as a way forward.

It was suggested that long-term cost benefit analysis was used within the context of the 'spend to save' concept. Some quick wins were highlighted relating to early intervention, for example, the implementation of BBV testing in prison to support wider healthcare costs in the community (see illustrative practice p 34).

Supported self-management programmes were thought to be a good working principle for future development of more cost-effective services, as part of an integrated care approach.

Pooled budgets and co-commissioning were also identified as positive approaches to achieving reduced costs and increased benefits, for example, the Troubled Families Programme (109).

²⁷ <http://www.legislation.gov.uk/ukpga/1983/20/contents>

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However, the discrepancy between a cost-saving for one organisation and the spend of another was seen as an issue. For example, a reduction in reoffending may be achieved by an NHS-funded health intervention but the benefits are seen in the CJS. Shared outcomes across a health and justice system were recommended to resolve this issue and a Vanguard Model of Care for Prisons was suggested as a way forward.

The composition of healthcare teams, particularly in prison but also in liaison and diversion services, was raised many times. This covered the need to develop the appropriate skill mix to meet the identified need and the use of new and different practitioners, eg nurse prescribers, pharmacy assistants and social care support workers. Telemedicine and the 'lead provider' model, that is when one lead provider is commissioned and then works with sub- contracted services to provide a comprehensive service offer, were given as examples of ways by which new, more cost-effective services were being implemented. However, no explicit cost-benefit modelling, eg using medicines management and disease outcomes, were highlighted as being used.

Many interviewees — to support more proactive/preventative care/treatment, in order to avoid costly escalation of need and an emergency response — cited the need for investment in high-quality leadership. An increased focus on planned care versus unplanned care, secondary prevention and early intervention, were seen as positive approaches to achieving value for money and cost effectiveness.

The high dependency on agency and locum staff, particularly in prisons, is widely observed to be poor value for money, both in terms of actual cost and the reduced continuity of care/working knowledge of the local systems, including reporting mechanisms.

Accessibility

Are services designed with the minimum barriers to access, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of that service?

The prison regime and the necessary operational restrictions were seen as major inhibitors to accessing health services, for example, prison lock-down leading to clinics being cancelled. This was acknowledged as being exacerbated by lengthy hospital admissions for physical illness and the need for security bed watches. In-house health services programmes, orientated towards prison settings, eg national screening programmes and good working across organisations, has helped to enable access to community services from prison. The need for prison escorts was perceived as exceeding availability and clinical waiting times are sometimes missed. However, the two-week cancer waiting time was highlighted as usually prioritised. Pressures on the regime were felt to be exacerbated by high levels of staff sickness and it was felt a focus on the health and wellbeing of all staff who work in prisons could help to manage this. Services were described as 'clock/regime centred', rather than 'person centred'.

Example of illustrative practice

Implementation of National Screening Programmes in prisons

All eligible people in prison and other places of prescribed detention are entitled to access all cancer and non-cancer screening programmes for which they are eligible as set out in the Section 7A agreement, service specification No.29. However, concerns were raised by the National Screening Programme Board about the provision of screening services for prisoners. This was understood to be a particular issue for the Bowel Cancer Screening Programme (BCSP), Diabetic Eye Screening Programme (DESP) and Abdominal Aortic Aneurysm Screening Programme (NAAASP).

Screening pathways appropriate to a prison setting, have now been developed by the Health & Justice Team in collaboration with the National Screening Programmes, which aims to increase access to screening within a prison setting. The agreed interim solution was agreed, building on local solutions already tested, until the new Health & Justice Information Service (HJIS) was fully operational, which will allow for information to be transferred between community and prison health care. This solution also included active encouragement of prisoners to register with prison medical providers. (Healthcare summary care records are however transferred manually to a community GP (if registered) on release).

Bowel Cancer, Diabetic Eye Screening and Abdominal Aortic Aneurysm Screening Programme pathways are currently being implemented through NHSE commissioning leads. The key issues such as GP registration and access to NHS number have been temporarily resolved, until the new Health & Justice Informatics System is fully operational. Public information about screening is being reviewed to ensure it is fit-for-purpose within a prison setting and a radio programme is planned. The operational impact of the programmes will be assessed through the routine HJIP reporting. For further information: Health and Justice Team, health&justice@phe.gov.uk

Effective continuity of care/care pathways and Through the Gate ²⁸ programmes were raised as important to improve accessibility but were seen as ‘work in process’ by the CRCs. This would also include early access to services for children and young people who would have benefited from early support, eg access to Children and Adolescent Mental Health Services (CAMHs) rather than ending up in a detained setting, ie ‘care not custody’. This was felt to be particularly pertinent to young care leavers.

The specific needs of prisoners with a learning disability and autistic spectrum conditions, as well as the general low literacy levels experienced by prisoners, to enable them to

²⁸ Through the Gate programmes are designed to help people to settle back into the community after leaving prison. This could include developing a plan to find suitable accommodation ready when released; preparing for work and helping to get a job; finding suitable training and education courses; giving advice on managing money, claiming benefits and dealing with debt

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access services were highlighted by many. It is felt that more work is required to highlight their needs and that a whole system approach (particularly in prisons) would benefit these groups of people, especially regarding more effective communications such as easy-read literature, which would improve access to services. Access to translation and interpretation was not raised as a specific issue but may warrant further investigation.

The planned registration of all prisoners with prison healthcare was seen as a positive development to improve access, ensuring that all people who serve a custodial sentence are registered with a prison GP and primary service quality can be systematically measured.

Accessible patient records, eg the Summary Care Record, were also thought to be an aid to improved information sharing to support clinical interventions. Innovative technology could help with this, for example, the patient passport. This was also felt to improve access for people with low literacy levels.

The lack of access to mental health services in the community and secure mental health beds for prisoner transfers was raised by many interviewees as a specific issue that needs to improve. However, initiatives such as Street Triage²⁹ (see illustrative practice below) in its role to screen and signpost people with mental health problems in the community and its links with liaison and diversion services; the use of telemedicine; and person-centred services orientated to a model of health and wellbeing, were seen as positive developments to improve access.

Access to Child and Adolescent Mental Health Services (CAMHS) for young people in secure children's services was seen as very restrictive, with long waiting times and low referral rates. However, it was acknowledged that the new national funding, which is now available, would help this.

Example of illustrative practice:

Street Triage involves a joint mental health service and policing approach to crisis care. Based on locally agreed protocols, Street Triage aims to support access to appropriate crisis care, to provide more timely access to other health, social care and third sector services, and to reduce the use of police cells as places of safety for s136 detentions.³⁰ For example, a Street Triage response to an incident in Devon resulted in:

- the protection of people from being harmed, protection of the person concerned
- a proportionate policing response
- avoidance of use of unnecessary health services such as an ambulance being deployed

²⁹ <https://www.gov.uk/government/news/extending-the-street-triage-scheme-new-patrols-with-nurses-and-the-police>

³⁰ This section of the Mental Health Act (1983) allows a constable to remove an apparently mentally disordered person from a public place to a place of safety for up to 72 hours for the specified purposes. The place of safety could be a police station or hospital (often a special s136 suite).

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- avoidance of a person being held in custody over night
- avoidance of an unnecessary mental health act assessment
- the provision of the appropriate support going forward.

Further information: www.england.nhs.uk/commissioning/health-just/

Example of illustrative practice

Online resources to provide information for members of the judiciary and court staff

Evidence demonstrates the high number of people with mental health problems in contact with the CJS; while the proportion of people with learning disabilities in contact with the CJS is around four times that of people with learning disabilities in the general population. An independent review, however, found that criminal justice personnel and members of the judiciary received little training to help them recognise when a person might have mental health problems or learning disabilities, or how to ensure the necessary support (5).

In partnership with Rethink Mental Illness, and working closely with the Magistrates' Association, Justices' Clerks' Society and the Judicial College, the Prison Reform Trust developed an online resource to provide information for members of the judiciary and court staff. The resource is illuminated by film clips of people with learning disabilities and mental health problems with direct experience of the CJS. It has also stimulated interest in awareness training, and the Prison Reform Trust has also worked closely with local branches of the Magistrates' Association by providing speakers, many of whom had learning disabilities or mental health problems and were able to talk directly about their own experiences of the CJS. A further development has been the creation of the role of 'champion' by the Magistrates' Association, and most branches now have a mental health and learning disability champion to help ensure their fellow magistrates are kept informed of relevant information and training opportunities

For information: <http://www.prisonreformtrust.org.uk/>

Dental care was another area of concern, especially for people with a substance misuse history. It was highlighted that in prison, demand for dental services is high and a waiting list can easily develop when the prison regime is not able to facilitate attendance at clinics. The rapid movement of prisoners means that they often cannot complete treatment before being moved or discharged. Several interviewees suggested that a reduction in the prison population would enable those with most needs to be treated appropriately.

The eligibility criteria for access to services was seen as a barrier for those people with complex and multiple needs. It was highlighted that for many patients in prisons, their

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levels of need for one problem alone may not cross that threshold (eg low-grade cannabis use) but taken together with other needs (eg hazardous drinking, mild depression/mood disorder plus antisocial behaviour plus unemployment) may compound risks. It was suggested that excluding people in this way negatively affected health outcomes with, for example, increased low-level mental health, substance misuse and alcohol dependency, which can develop into more serious and acute needs and have a negative community dividend.

Conversely, it was highlighted that the eligibility criteria for some community services can exclude people with complex needs, so custody can improve access to services that otherwise might not be available. This is an enhanced access which is above equivalence in the community due to the complex needs identified in the offender population.

Engagement

Questions: Are service users and communities' needs and requirements being placed at the centre of service provision and is there a quality assurance system in place to ensure the services are acceptable?

On the whole the user/patient voice was seen to be a key part of the engagement process for informing service quality and development. Asking people who use services to give feedback on their experiences was seen as an essential part of performance monitoring. Peer support workers, eg for the recovery model in substance misuse and mental health services, are at the core of what most interviewees expect from positive engagement in services. However, it was suggested that asking individuals why they are not engaging with services is also important.

Example of illustrative practice: The Lived Experience

For NHS England Health & Justice direct commissioning, the patient voice is a vital criterion in the commissioning cycle for healthcare services in secure and detained settings. In order to access the patient voice in these, by definition, constrained environments there has been a number of varied approaches to enable the individual patient's opinion to be heard, valued and acted upon.

To achieve this, regional health and justice lead commissioners have a contractual requirement for healthcare providers to canvas patient opinions around their healthcare through regular establishment level forums and feed this into performance meetings with commissioners.

As needs assessments are being completed patient views are sought out against general and specific health provision and service user groups are regularly canvassed for specific in depth scrutiny of activity. For example, a service user led scope of New Psychoactive Substances (NPS) use across a number of prisons has just been completed and fed back to NHS England in order to support our re-focus of the substance misuse service

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specification as well as ensuring that we have a ground level overview of the issues at hand rather than one merely seeped in anecdotes.

A service user representative is a member of the NHS England Health and Justice Clinical Reference Group (CRG) and across a number of subject matter specialist development groups established by the CRG.

The forthcoming NHS England Health & Justice Five year forward view had a specific service user consultation event which fed into the final product, and the Liaison and Diversion Programme (L&D) has a specific shadow board made up of a number of service user groups who have fed into the shaping of the services. Members from the shadow board sit as representatives on the L&D Partnership board and hold the wider board to account.

In addition to the above, the Health & Justice Patient Participation Programme framework has been developed alongside a number of service user groups to support a sustained approach to hearing this particular patient's voice in the co-design of services and the feedback of the patient experience.

For information: www.england.nhs.uk/tag/health-and-justice/

Also expressed by several interviewees was the idea that families should be engaged with the prisoner in the support offered.

Examples of illustrative practice

HMP Thameside have installed basic IT, named Custodial Management System (CMS), into each prison cell, allowing offenders to carry out several transactions/applications normally paper-based in prisons, including enabling patients to send email requests to healthcare staff. The system also allows healthcare staff to respond electronically to requests/applications directly to patients, schedule appointments with specialist clinical staff and update gym/work fitness status. Healthcare staff are also able to conduct and collate patient surveys/user satisfaction feedback online. The system is fully auditable and provides an efficient way of managing patient applications/requests. Contact: thameside.healthcareadmin@nhs.net

Equitable Resourcing

Question: Is the distribution of finance and other resources equitable to outcomes according to need?

It was acknowledged by informants that people in prisons have greater health needs than the general population. However, there appeared to be a lack of evidence used to demonstrate that an appropriate level of resource was available to meet these needs and that health outcomes achieved are equivalent to the general population. For example, understanding of the appropriate level ratio of health care staff to prisoners for specific conditions, compared to the general community.

Commissioning Challenges: Resourcing and adequate service volumes

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Questions: Are service volumes commissioned to meet needs?

Is there a balance of services commissioned within the pathway to avoid bottle necks and delays?

Is there clear leadership and co-ordination so services are commissioned and networked to meet population needs and the population is supported to use services and interventions appropriately?

Are there networks across the whole CJ system with clear leadership involving HC and MoJ/NOMs?

Are population health outcomes agreed across the whole CJ system including reducing offending and reoffending rates?

Are adequate service volumes commissioned across the health care pathway to achieve acceptable access times?

The main comment on adequate service models to meet need, given current budgets, was the necessity for flexible working arrangements, which could be informed by workforce mapping exercises and developing an appropriate skill mix.

This discussion also raised the need for appropriate social care to reflect the growing older population in prisons and the impact of the high prevalence of long-term conditions, requiring more support for self-management and regular clinical review. Improved social care support, commissioned by local authorities, would enable safer functioning and provide an integrated approach to complex care needs. This is beginning to develop in prisons and needs to extend into the 'Through the Gate' programme. It was also recognised that this growth in the older population would increase the need for access to end of life care and palliative care. (This was also reflected as an emergent theme in the literature).

Balanced service portfolio

Question: Is there a balance of services within pathways to avoid bottlenecks and delays?

The interviewers, based on the limited examples of activity identified, considered this as an underdeveloped area in commissioning. However, it was highlighted that there was a need for accessible, comparable data, to measure, for example, waiting times, to enable effective commissioning to take place. This might include waiting times at the medications hatch being perceived to be slower following the implementation of electronic prescribing so that alternative arrangements may need to be made.

It was also recognised that the identification and reasons for bottlenecks and delays in service provision could be usefully used to inform commissioning and help identify developing trends, such as the prevalence of NPS and the outcome of its use both in

custody and the community. In turn, this will also inform and shape policy development and legislation, eg the Psychoactive Substances Act 2016.³¹

Networks, leadership and co-ordination

Question: Does the designated leadership and co-ordination achieve services that are commissioned and networked to meet population need? Is the population supported to use services and interventions appropriately?

A genuine commitment was identified across the system to continue to develop an effective and safe healthcare system. It was generally thought that the National Partnership Agreement (NPA)³² has improved engagement across the three key agencies: PHE, NHS England and NOMS. The NPA clearly sets out the functions and accountability of each agency and details the different levels of governance required across the agreed partnership agenda.

Networks were generally agreed to be a positive means of sharing best practice and gaining peer review and support. However, it was highlighted that the ability to develop networks has declined since 2013 and very few network events now take place outside the nursing and medical professional bodies. Where fora do exist, they were well attended, and seen to provide an excellent opportunity to exchange views, encourage learning, explore issues, and help to build relationships within and across agencies and support best practice. They were reported as appreciated by the attendees.

Example of illustrative practice:

The Veteran network was cited as an example of how networks can work effectively for a specific client group. As well as establishing a positive national profile, the Veteran network collates good news stories and enables multiple support networks, which help individuals to gain confidence as well as helping others. This model could be used to inform similar networks of support for people in custody and following release, for example, 'buddies' in the home area where prisoners will be released.

For further information: www.england.nhs.uk/commissioning/armed-forces/armed-forces-net/

Leadership was seen as a key factor in progressing a whole prison approach. It was recognised, however, that good leadership needs to be nurtured and supported and without a forum for this, organisations can revert into a tick-box culture of contract management. The different outcomes set by partner agencies can also lead to tensions within

³¹ <https://www.gov.uk/government/collections/psychoactive-substances-bill-2015>

³²

partnerships, eg prisons are focused on security but healthcare is focused on health and wellbeing.

Illustrative example of practice

Smoke free prisons and the importance of partnership working

To deliver a smoke free environment, early adopter prisons needed a 'whole' system and a 'whole' prison approach to be effective. Within this programme, partnership working was key in supporting staff and prisoners to develop confidence and use skills, both new and old, to deliver successful outcomes. Combining skills has provided opportunities to work in different ways to establish new, improved and integrated approaches. Progress was monitored by NHSE, PHE and NOMS leads at national, regional and local level, through a single audit system introduced in each prison.

At the time of introduction of this policy, there were very few practical examples of success and therefore an action learning model was adopted. The differences between these earlier adopter sites, enhanced the opportunity to share learning, such as with the creation and dissemination of information around tobacco and stopping smoking; communicating the aims and actions of the project; training of staff and support for prisoners. All of which proved important in maintaining the stable prison environment.

As the programme represents a considerable change in culture for everyone working inside and alongside the prisons, PHE and NOMS delivered a workshop to help health and prison staff to help develop a greater understanding of their roles and those of their colleagues better and how they were integral to each other.

This process also provided prison staff with the opportunity to showcase their interests and ideas, through running events with colleagues from different disciplines. For example, a celebration of National No Smoking Day allowed teams to communicate the opportunities that a wider multi-professional team can implement.

For further information: Health & Justice Team, health&justice@phe.gov.uk

Strategy: Many interviewees did not appear to be aware of the 'golden thread' linking national and local activities within the health and justice areas of work. Similarly, an obvious link between custody and community did not seem to be in place. For example, discussions about offenders and their health needs, whether in custody or the community, did not regularly feature in community safety partnerships and health and wellbeing boards. Good partnership working with police and crime commissioners (PCCs) was reported to be needed.

Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure & detained settings to inform future health interventions and prioritisation

Discussions took place on a One Operational Model approach as promoted by NHS England commissioners.³³ Whilst it was felt to be a good model, it was not yet fully implemented, not clearly understood or experienced. Interviewees seemed to find the approach confusing because a great variety of processes appeared to be in place leading to local variations. 'Fragmentation' of commissioning systems was a common theme, along with constant/perpetual change in personnel and structures across all organisations as well as tensions between national and local priorities – communication, budgets etc. It was felt that crisis management was the 'norm' in some situations and that contracted workforces were under great pressure to deliver what was commissioned within a very tight budget. Performance management was generally felt to be appropriate and robust but more focused on contract monitoring rather than supporting the delivery of health and wellbeing outcomes.

Optimal population outcomes

Question: Are there agreed clinical health and wellbeing outcomes that are desirable, achievable, measurable and align to partnership strategies?

General comments suggested that information/data and performance outcomes should be shared more readily and transparently so that partner agencies can work more effectively together. It was suggested that person-centred outcomes could be expanded into systematic outcomes in order to benefit groups of individuals, eg well-man clinics and sexual health. Examples of suggested outcomes were rates of tuberculosis; mental health and self-harm and suicide rates.

³³ <https://www.england.nhs.uk/commissioning/>

Key findings

Since the transfer of responsibilities to the Department of Health, there has been a significant improvement to the commissioning and provision of health care, leading to better health outcomes for people in prisons. There is limited robust data to quantify this, but the findings from qualitative research has demonstrated that there is a wide range of strengths identified against the key themes of the Commissioning for Best Population Level Outcomes framework used to analyse the findings. The analysis also identifies areas for further improvement (see [Appendix F](#)), which can inform future priorities of work.

Strategy, leadership and partnerships

Strengths

The National Partnership Agreement (NPA)³⁴ was thought to have improved engagement across the three key agencies: PHE, NHS England and NOMS. It clearly sets out the functions and accountability of each agency and details the different levels of governance required across the agreed partnership agenda.

The forthcoming Health and Justice Five Year Forward View publication and the NHS England approach to working to a single model of commissioning were also seen as beneficial to achieve strategic alignment to commissioning for people in contact with the CJS, although recognised as in early stages of implementation.

Areas for further improvement

Links with the wider community

- **strategy**: A ‘golden thread’ linking national and local activities within the health and justice areas of work is needed, including a link between custody and community, for example, with community safety partnerships and health and wellbeing boards
- the development of **population outcomes** from existing person-centred outcomes would help to develop shared outcomes across partnerships and reduce any conflicts of purpose within partnerships, eg prisons are focused on security versus healthcare is focused on health and wellbeing and resolve issues of cost savings across different partners
- a **balanced portfolio of services** needs to be developed and sufficiently resourced to meet need along the care pathways. There is a need for accessible, comparable data, to measure, for example, waiting times, to enable effective commissioning to take place
- effective local **partnerships** including clinical commissioning groups (CCGs), health and wellbeing boards and PCCs are needed to support a wider strategic approach to health and justice.

³⁴ <https://www.gov.uk/guidance/healthcare-for-offenders#national-partnership-agreement>

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- **robust networks** between prison healthcare providers and acute and community healthcare services need to be developed and maintained to support effective pathways and equivalence of care in the community. This would support:
 - more systematic links/care pathways back into community services to provide more consistent and appropriate thresholds for community service, to meet the needs of people when released from prison. Community rehabilitation companies are in an ideal position to provide a more robust link between custody and community, resolve complex health needs, particularly for people with learning disabilities and those with mental health needs and to address wider determinates of health, eg housing and employment
 - mechanisms to assure commissioners that local community services and/or specialised services required by prisoners are effective and provide good health outcomes – the One Operational Model approach as promoted by NHS England commissioners needs to be strengthened to be more clearly understood and experienced
 - the development of the liaison aspect of the liaison and diversion service, including the increase in access to mental health beds in the community

Developing a whole prison approach

A whole prison approach needs to be developed to overcome difficulties accessing health services caused by the prison regime and the necessary operational restrictions. This needs to include a focus on the health and wellbeing of all staff who work in prisons to manage high levels of staff sickness. This needs to be supported by well-developed and supported leadership and clear population outcome agreed across the system. This has recently been reflected in the Chief Inspector for Prison's Annual Report (7).

Data and intelligence

Strengths

Systematic understanding of health needs at population level through the requirement to have a formal health and wellbeing needs assessment to inform commissioning and service provision is widely recognised as a driver of quality improvement. The annual refresh was also thought to capture and reflect fluctuating and new need and the PHE template³⁵ was generally appreciated and used to achieve a standard approach.

Areas for further improvement

³⁵ <https://www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit>

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- to gain greatest benefit from the HNAs, local data quality needs to improve and templates need to be followed
- links need to be increased, as defined through the PHE template, with the wider community JSNA. Local community governance structures could oversee this to ensure alignment of processes
- although the HJIPs was recognised as still in development, the data quality needs to improve and the reports need to be more accessible and transparent, to enable them to be a robust system of contract monitoring, understanding needs surveillance and measuring outcomes

Frontline services

Strengths

- there is a universal recognition of the vast improvement in local service effectiveness since the transfer to NHS commissioning of prison healthcare in 2006
- the employment of professional healthcare staff with nationally recognised qualifications and membership of professional bodies has enabled a rise in clinical standards and accountability
- Inspectorate reports were felt to be very useful to support service development. HMIP and the CQC were seen to be helpful
- complaints/patient advice and liaison services (PALS) systems were regarded as a very useful method of monitoring services and achieving improvements. Service user feedback/evaluation systems, eg service exit feedback, was highly valued as a means of improving services, for example in testing how standards were being met
- the contractual requirement to implement national standards, eg NICE, was seen to improve the delivery of high-quality services

Areas for further improvement

Resources to meet need

Cost effectiveness is an area which requires further development. Areas of development could focus on:

- long-term cost benefit analysis to support a programme of 'spend to save' including activity to analyse return on investment
- the use of the most appropriate skill-mix to meet the identified need and the use of new and different practitioners, eg nurse prescribers, pharmacy assistants and social care support workers, informed by workforce mapping exercises, as well as an understanding of the ratio of staff required to meet needs
- provision of more **proactive/preventative care/treatment**, in order to avoid costly escalation of need and an emergency response, eg the use of telemedicine
- integrated care approach for example a Vanguard Model of Care for Prisons using a 'lead provider' model with **a strong focus on self-care**
- an increase in support systems for families of prisoners and family members supporting prisoners.

Although improved, a further increase in **learning opportunities** could focus on:

- an increase in prison staff and healthcare staff working together to promote better understanding of the two systems
- an increase in opportunities to share and learn from local innovations
- more effective ways of monitoring the implementation of the learning from the inspection reviews is required
- increased engagement of Health Education England as an active partner

Community engagement

Strengths

The 'lived experience' approach led by NHS England was highlighted as a very positive move forward and an important mechanism to engage and understand different perspectives.³⁶

Areas for further improvement

People in contact with CJS interact at different points of the CJS pathway. These opportunities need to be strengthened to ensure their health needs are being met by:

³⁶ Framework for patient and public participation in Health and Justice planned to be published by NHSE

Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure & detained settings to inform future health interventions and prioritisation

- ensuring there is time and space to disclose sensitive issues in police custody and ‘through the gate’ services, provided by adequately trained personnel
- triangulating complaints and Patient Advice and Liaison Services (PALS) results with other monitoring methods, including information from people who did not access services
- developing **peer-led services** at sufficient system and scale across the prison estate to increase access to services and empower people to take control of their health needs

Conclusions and future priorities

The rapid review of evidence of improvements in health outcomes for people in secure and detained settings of NHS commissioned health services identified that that prison healthcare services have undergone ‘transformation’ since 2006. The review highlighted significant improvements in the quality of care supported by strong partnerships; healthcare staff development; increased transparency of services and outcomes; prisoner engagement and liaison & diversion services.(see [Appendix G](#)). Using the HINST matrix to analyse these findings enabled the review to determine that these factors significantly contribute to achieving improved health outcomes for this population and future recommendations (see [Appendix H](#)).

The review also identified seven areas for prioritisation by the Department of Health:

- **whole prison approach**³⁷ focusing on both rehabilitation and resettlement, and giving access to healthcare to a population who would normally be underserved. The work needs to focus on three main components:
 - policies in prisons that promote health
 - an environment in prisons which is actively supportive of health
 - prevention, health education and other health promotion initiatives
- links with **wider care pathways and community structures/services**
- developing **robust data and intelligence**
- increasing the focus on **self-management and peer-led services and proactive/early intervention services**
- **establishing equitable resourcing and responsive services** to meet different needs – recognising one-size-doesn’t-fit-all
- strengthening the focus on **improving health as a positive mediator of change in criminal behaviour**

³⁷ http://www.euro.who.int/__data/assets/pdf_file/0018/249210/Prisons-and-Health,-21-Promoting-health-in-prisons-a-settings-approach.pdf

Appendix A

Knowledge and Library Services: Search results

Search question:

What does effective and efficient commissioning of health care service delivery within prisons look like?

(The focus will be on prisons primarily (as greater source of data and longer period of direct commissioning by NHS [since 2006 in England]) with reference to IRCs and Children and Young People's Secure Estate.)

The review will consider the role of health commissioning in addressing health-related drivers of criminogenic behaviour (care not custody) the quality of healthcare services in secure & detained settings (care in custody) and the impact on continuity of care (care after custody).

Terms used:

Patient/Population/Problem	Intervention	Comparison	Outcome
Prison*, jail*, penitentiary*, correction*, offender*, detainee*, custodial*, inmate*, ex-inmate, former offender*, former inmate*	Health services research, commission, model of care, care pathway*, service delivery, health care quality		Re-offend*, recidivism,
Chronic illness*, mental health, physical health, substance abuse	Care not custody		
Criminal justice, legal system, crime, criminal	Care in custody		

Limits applied:

Age group	Language	Publication type	Time limit
	English		1995 - current

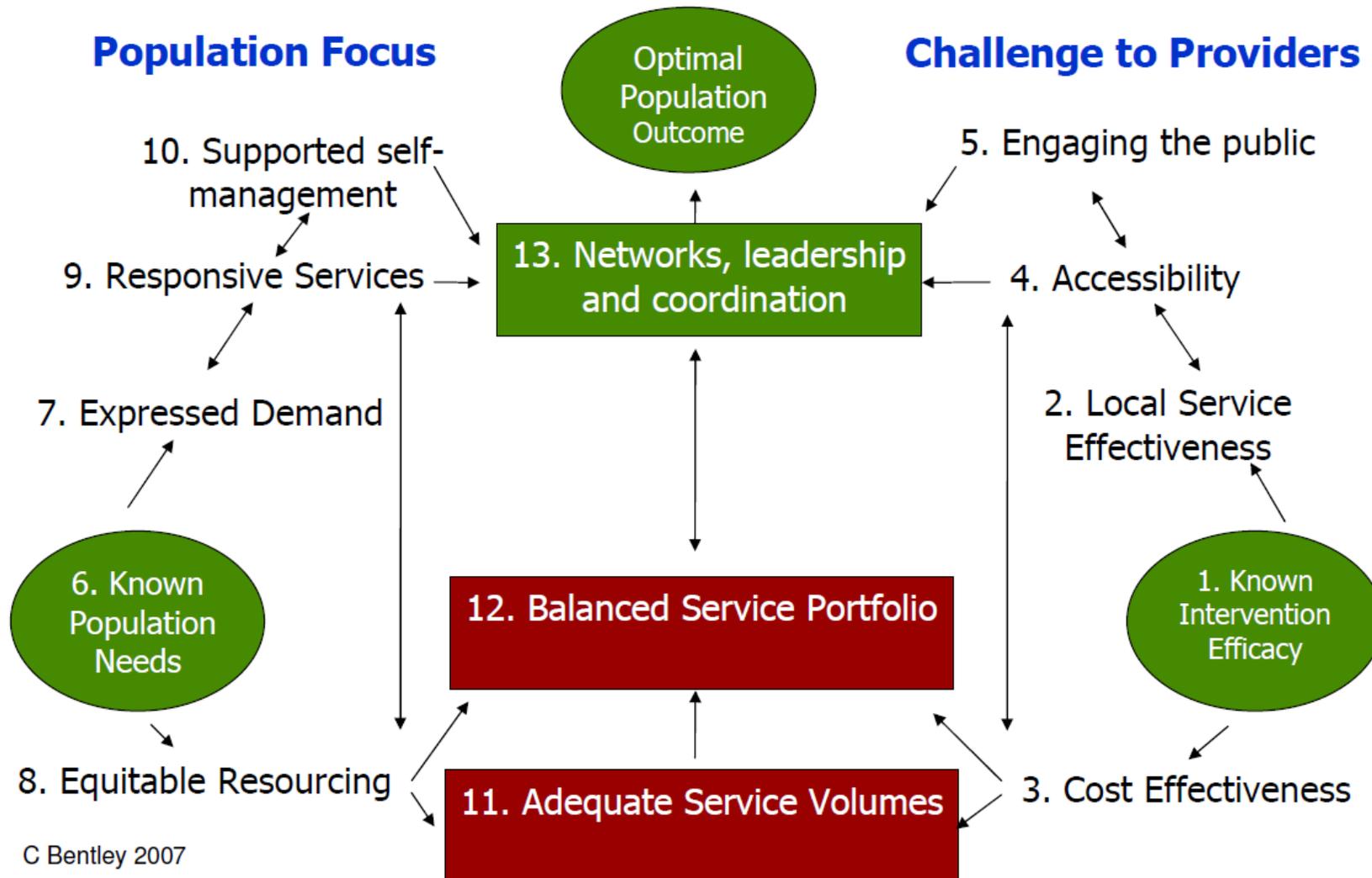
Disclaimer: Although every effort has been made to ensure this information is accurate, it is possible it may not be representative of the whole body of evidence available. Both articles and internet resources may contain errors or out of date information. None of the resources have been critically appraised. No responsibility can be accepted for any action taken on the basis of this information.

Summary of resources searched and results:

Source	Results
NHS EVIDENCE	376
MEDLINE	
EMBASE	
CINAHL	
PSYCINFO	
SOCIAL POLICY & PRACTICE	

Appendix B

Commissioning for Best Population Level Outcomes



Commissioning for best population level outcomes

A CHALLENGE TO PROVIDERS

1. **Known intervention efficacy:** Ensuring that relevant interventions, for which there is strong evidence, are clearly identified, so they become the focus of efforts to make them available equitably to as many people who could benefit as possible
2. **Local service effectiveness:** Ensuring that service providers maintain high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit
3. **Cost effectiveness:** Ensuring that programme elements are as affordable as possible at population level
4. **Accessibility:** Ensuring that services are designed with the minimum barriers to access, balancing a drive to bring services closer to people, with the need for efficiency and effectiveness of that service.
5. **Engaging the public:** Working with service users and communities to ensure that their needs and requirements are placed at the centre of service provision and that quality assurance systems are in place to ensure the acceptability of services to service users
11. **Adequate service volumes:** Commissioning adequate service volumes to ensure acceptable access times.
12. **Balanced service portfolio:** Ensuring a balance of services within pathways to avoid bottlenecks and delays.
13. **Networks, leadership and co-ordination:** Designating leadership and co-ordination to ensure services are commissioned and networked to meet population need and the population is supported to use services and interventions appropriately

B POPULATION FOCUS

6. **Known population health needs:** Ensuring that there is a realistic assessment of the size of the problem locally, and its distribution geographically and demographically. Ensuring that the level and type of service is based upon this assessment.
7. **Expressed demand:** Ensuring that as many people as possible suffering from the problem or its precursors, present to services in a timely and appropriate fashion, through informing, educating and supporting the population.
8. **Equitable resourcing:** Ensuring distribution of finance and other resources support equitable outcomes according to need.
9. **Responsive services:** Ensuring that when people present to services, they are afforded equal access to timely beneficial interventions according to need.
10. **Supported self-management:** Ensuring that where appropriate, service users are empowered to make choices about their circumstances and service offer on the basis of good information, and are supported to utilise the service offer to best effect

Appendix C

Key informants

NHSE
Kate Davies, Head of Health and Justice, Armed Forces and SARC's
Chris Kelly, Asst. Head Health and Justice
Caroline Twitchett, Children's Quality Lead
Sarah Forrest, NHS Commissioner East Midlands
Denise Farmer, Pharmacy lead
Claire Weston, Head of Health and Justice, East Anglia Area Team
Michael McGonnell, Deputy Head of Commissioning, Cumbria and North East
Nicola Seanor, H & J Service Programme manager, Y & H Commissioning Support Unit
Department of Health
Angela Hawley, Youth Offender Health Policy Lead, MHDD Division
PHE
Eamonn O'Moore, National Lead Health & Justice Team, and Director UK Collaborating Centre, WHO Health in Prisons Programme (Europe),
Paul Moore Health and Justice Specialist Lead, Yorkshire and Humber Centre
Rachel Campbell, Health and Justice Specialist Lead, South West England Centre
NOMS
Simon Marshall
Rupert Baillie Acting Head of Health, Wellbeing & Substance Misuse Co-Commissioning (Custody)
Ken Elliott Acting Head of Health, Wellbeing & Substance Misuse Co-commissioning (Community)
Dave Burton – Liaison and Diversion
Home Office
Alan Gibson, Head of Detention Operations, Immigration Enforcement
Community rehabilitation Companies (CRCs)
Denise Butt. Head of Partnerships Thames Valley CRC
Simon Perkins Partnership and Joint Commissioning Manager, Dorset, Devon and Cornwall CRC, acquired by Working Links
Third sector
Christina Marriott, Chief Executive, Revolving Doors Agency
Sean Duggan, Chief Executive, Centre for Mental Health
Malcolm Pearce, Improving Health and Wellbeing
Dave Spurgeon, Research & Development Manager, NACRO
Kate Aldous Clinks Action for Prisoners' and Offenders' Families
Juliet Lyon, Kimmett Edgar and Ryan Harman Prison Reform Trust
Service User Representative
Sophie Strachan
Clinicians
Dr Jake Hard, Chair RCGP secure settings group
Ann Norman Adviser: Criminal Justice/ Learning Disability, Nursing Department, Royal College of Nursing UK
Dr Nicola Lang, DPH London Borough of Sutton
Focus groups
South West Quality and Safety Group

Appendix D

Overview of reviewed papers

Reference	Country	Setting	Study design	Characteristics of participants	Identified themes recorded against the 13 themes outlined in the Health Inequalities Support Team Framework *													Brief description of identified themes	Emerging themes (not covered by the Health Inequalities National Support Team Framework)		
					1	2	3	4	5	6	7	8	9	10	11	12	13				
Adams (2002) Full paper	United States of America	Correctional facilities	Review. Overview of the population in correctional facilities including demographics and health needs	All people in prison				X		X								X		4 = denying access to healthcare 6 = quantifying health care needs 12 = limited surveillance/monitoring so little data	Neglecting the healthcare of people in correctional facilities has implications on the wider society
Adebowale (2010) Abstract	England and Wales	Prison	Review considering options for diverting mentally ill offenders away from prisons to more appropriate alternatives	Mentally ill offenders	X	X													X	1 = effective interventions to reduce harm from mental health 2 = effective services to support people with mental health challenges 13 = Vision for how mental health is considered (and supported) within the justice system	None
Ahalt (2013) Abstract	United States of America	Prison	Review of the ageing prison population and the need for better data	Older prisoners		X	X	X												2 = meeting standards in austerity 3 = lack of cost effective data 4 = timely access	Poor care inside prison has implications for community healthcare provision

Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure & detained settings to inform future health interventions and prioritisation

Reference	Country	Setting	Study design	Characteristics of participants	Identified themes recorded against the 13 themes outlined in the Health Inequalities Support Team Framework *													Brief description of identified themes	Emerging themes (not covered by the Health Inequalities National Support Team Framework)			
					1	2	3	4	5	6	7	8	9	10	11	12	13					
Anaraki (2003) Abstract	United Kingdom	Prison	Qualitative research on modern information technology for health in prisons	Prison staff in four male prisons	X														X		1 = equivalence of data availability 12 = modern information technology lacking in prison primary care	Concerns about potential breaches of security and discipline in prisons, together with anxiety about data security and a culture that gives low priority to health were seen as barriers to implementing health information technology in prisons.
Badger (1999) Full paper	United Kingdom	Prison, special hospitals, secure units	Review on better understanding the needs of offenders with mental disorders and how to meet their needs	Mentally ill offenders																X	13= a consortium approach to strategic planning and commissioning	None

Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure & detained settings to inform future health interventions and prioritisation

Reference	Country	Setting	Study design	Characteristics of participants	Identified themes recorded against the 13 themes outlined in the Health Inequalities Support Team Framework *													Brief description of identified themes	Emerging themes (not covered by the Health Inequalities National Support Team Framework)		
					1	2	3	4	5	6	7	8	9	10	11	12	13				
Bartlett (2014) Full paper	United Kingdom	Low and medium security hospitals	Census / Cross-sectional study to characterise women and compare by security and service provider type	1149 women		X				X								X	X	2 = article queries equivalence of treatment between men and women 6 = characteristics/needs of (and comparisons between) women in low/medium security hospital 12 = limited access to national data 13 = independent versus NHS provision	Devolution of responsibility (lack of national coordination) compromises decision making quality. For example, no national structure to locate beds close to home for women or to cluster women with specialist needs.
Bedard (2009) Abstract	United States of America	Prison	Retrospective study to look at the association between the percentage of medical personal employed under contract and change in mortality	A 'panel of state prisons' from 1979 to 1990															X	13 = Contracting out prison healthcare and mortality	None
Bekaert (2008) Abstract	England	Youth Offending Team	Audit to understand healthcare needs and a pilot of onsite nurse delivered general health	70 clients of a London Youth Offending Team				X		X									X	4 = bringing health services into youth offending teams 6 = general healthcare needs of young offenders 9 = service design meets needs 13 = health not separate to	None

Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure & detained settings to inform future health interventions and prioritisation

Reference	Country	Setting	Study design	Characteristics of participants	Identified themes recorded against the 13 themes outlined in the Health Inequalities Support Team Framework *													Brief description of identified themes	Emerging themes (not covered by the Health Inequalities National Support Team Framework)
					1	2	3	4	5	6	7	8	9	10	11	12	13		
Abstract/Full paper retrieved			provision															wider needs provided by youth offending teams	
Binswanger (2011) Full paper	United States of America	Transition from prison to community	Qualitative study of the health experiences of recently released inmates	29 former inmates within the first two months of their release from prison					X	X							X	5= health seeking experiences/needs/risk perceptions two months after release 6 = health needs in context of complex lives 12 = continuity of care and inadequate preparation for transition	None
Bradley (2009) Full paper	England and Wales	Criminal Justice system	Independent review (The Bradley Report) to examine the extent to which offenders with mental health problems or learning disabilities could, in appropriate cases, be diverted from prison to other services	Offenders with mental health problems or learning disabilities	X	X	X	X	X	X			X	X		X	X	1 = cross-partners analytical report of the evidence 2 = early intervention/prevention/staffing levels and exposure to maintain standards 3 = local examples of cost benefit analysis 4 = access (e.g. for women or those with dual-diagnosis) 5 = wide consultation – including citizens' voice 6 = levels of services 8 = individual approach to ensure equity 9 = responsive services 11 = waiting for mental health assessment and treatment 12 = management across the offender health pathway 13 = joined –up thinking and working	None
Bretschneider	Europe	Prison	Review of the	Ageing										X			X	9 = no specific regulations	None

Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure & detained settings to inform future health interventions and prioritisation

Reference	Country	Setting	Study design	Characteristics of participants	Identified themes recorded against the 13 themes outlined in the Health Inequalities Support Team Framework *													Brief description of identified themes	Emerging themes (not covered by the Health Inequalities National Support Team Framework)		
					1	2	3	4	5	6	7	8	9	10	11	12	13				
(2013) Abstract	(particular focus on Switzerland, England and Wales) and the United States of America		healthcare situation of older prisoners by analysing the relevant national and international legal frameworks	prisoners															address guaranteeing adequate healthcare of ageing prisoners 13 = legal structures needed to ensure adequate healthcare for older prisoners		
Brinded (1996) Abstract	New Zealand	Courts	Review of the first year of operation of a Court Liaison Service	359 persons, representing 418 assessments of mentally ill persons	X	X												X	1 = effective interventions to reduce harm from mental health 2 = effective services to support people with mental health challenges 13 = Vision for how mental health is considered (and supported) within the justice system	None	
Brooker (2009) Full paper	England	Custody	Report outlining the case for improving mental health care across the criminal justice system	Mentally ill people in contact with the criminal justice system	X	X	X		X	X								X	X	1 = insufficient staff training to deal with mental health 2 = lack of performance management framework 3 = costs model for mental health and criminal justice system 5 = service user satisfaction measures 6 = mental health needs 12 = Continuity of care on release / poor data collection 13 = Aligned commissioning with partners	Disjointed commissioning leads to teams working in relative isolation with fragmentation of commissioning for health with poorly co-ordinated ineffective services and a lack of through care.
Buck (2011)	United	Prison	Service	Homeless														X		9= support integration of this	None

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Reference	Country	Setting	Study design	Characteristics of participants	Identified themes recorded against the 13 themes outlined in the Health Inequalities Support Team Framework *													Brief description of identified themes	Emerging themes (not covered by the Health Inequalities National Support Team Framework)	
					1	2	3	4	5	6	7	8	9	10	11	12	13			
Abstract/Full paper retrieved																				
Full paper	States of America		evaluation of a healthcare based intensive management programme to establish plan for specific post-release services	people in prison who have behavioural health disorders (mental illness, substance misuse, or both)															population into primary and behavioural health systems 12 = continuity of care	
Busen (2014) Abstract	United States of America	Transition from prison to community	Overview of an inter-professional education course to address health care needs	Women transitioning from prison to the community					X						X				5 = community learning 10 = education for empowerment	None
Byng (2012) Full paper	England and Wales	Criminal Justice System	Multi-method investigation including interviews, focus groups, health records study and cases studies to examine how health and justice systems best work together to improve health and resettlement	200 offenders (longitudinal interview); 50 offenders (health records study); 5 focus groups and 8 case studies.				X	X	X					X		X	X	4=poor access 5=service users' and professionals' views on healthcare 6=description of health needs 10='spectrum of control' from self-reliance to dependence on services 12=continuity of care / lack of understanding by professionals of their roles in the pathway 13=integration	None
Care Quality	England	Prisons, Young	Provider	All people in		X			X					X		X	X		2 = effectiveness of services is	None

Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure & detained settings to inform future health interventions and prioritisation

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					1	2	3	4	5	6	7	8	9	10	11	12	13			
Commission (2015) Full paper		Offender Institutions and Immigration Removal Centres	handbook. Approach to regulating and inspecting health and social care	secure settings.															a key question 5 = gathering the views of detainees and those close by them during site visits 9 = responsive services 12 = sharing information 13 = how we work with others/joint approach/leadership	
Chavez (2012) Abstract	Unable to extract information	Criminal justice system	Review of addiction treatment programming.	Incarcerated populations in need of opioid treatment and care		X					X								2 = organisation of services to meet national standards 7 = timely access	None
Condon (2007a) Abstract	England and Wales	Prison	Review of prison health and its implications for primary care nursing	All people in prison						X							X		6 = summary of general health needs 11 = primary care provision	None
Condon (2006) Abstract – limited text	England and Wales	Prison	Review of the health needs of prisoners and implications for public health and health promotion	All people in prison						X									6=summary of health needs of prisoners	None
Condon (2007b)	England	Prison	Qualitative study examining	111 prisoners in 12 prisons				X	X										4= problems with access 5= views of prisoners about health services in prison	The prison regime can conflict with

Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure & detained settings to inform future health interventions and prioritisation

Reference	Country	Setting	Study design	Characteristics of participants	Identified themes recorded against the 13 themes outlined in the Health Inequalities Support Team Framework *													Brief description of identified themes	Emerging themes (not covered by the Health Inequalities National Support Team Framework)
					1	2	3	4	5	6	7	8	9	10	11	12	13		
Abstract/Full paper retrieved																			
Abstract			prisoners' views of health services and their own ways of caring for their health in prison																optimal health care, at all points along the prison healthcare journey. Lack of autonomy is a major obstacle to having healthcare needs met
Cropsey (2012) Abstract	United States of America	Criminal Justice System (prison and community correction settings)	Review of the health needs and the capacity of the system to meet those needs.	Adults under correctional control					X						X			6= summary of health needs 11= capacity and techniques to meet needs	Prisons and jails are constitutionally mandated to provide health care; however, community corrections agencies are not federally required to provide health services.
Damberg (2011) Abstract	United States of America	Prison	Review of quality measures used by state and federal prisons	All people in state and federal prisons		X										X		2 = assessing benchmarking data for performance management system 12 = identify existing quality performance indicators	None
Davies (2013) Abstract	United Kingdom	Criminal justices system (prison, other secure	Review of commissioning health care for offenders	All people in contact with the criminal justice system		X											X	2 = staff need to understand commissioning changes for effective service delivery 13 = roles in commissioning	Identified risks such as poor attendance at partnership

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					1	2	3	4	5	6	7	8	9	10	11	12	13			
Abstract/Full paper retrieved		accommodation and community settings)																	healthcare and partnership working	boards and lack of capability and capacity in clinical commissioning groups may effect delivery and engagement
de Viggiani (2006) Abstract	International (with UK focus).	Prison	Review of developments in prison public health	All people in prison		X												X	2 = equivalence of care – greater need to focus on more 'upstream'/prevention interventions in prison settings 9 = responsive services required for public health goals 13= approach to advocating a progressive and more sustainable approach to primary prevention (upstream) commissioning	Prison policies and practice need to become more 'upstream' with an appreciation of the broader determinants of prisoner health; commissioning for prevention
de Viggiani (2012) Abstract	Unable to extract information	Criminal Justice System	Review of the opportunity to use a broader range of assessment technologies to measure health and social need	All people in the Criminal Justice System						X									6 = developing integrated assessment methodologies to best understand need	None
Department of Health (2009) Full paper	United Kingdom	Criminal Justice System	National delivery plan of the Health and Criminal	Adult offenders	X	X		X					X					X	1 = Developing the workforce 2 = performance management frameworks 4 = increasing access	A key driver to achieving change will reply on the

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					1	2	3	4	5	6	7	8	9	10	11	12	13				
			Justice Board																8 = Equity of access – gender, learning disability 12 = continuity of care	approach set out in World Class Commissioning Importance of workforce development	
Durcan (2014) Full paper	United Kingdom	Criminal Justice System	Review of the support offered to people (since 2009) with mental health problems and learning difficulties	People with poor mental health and learning difficulties All ages	X	X	X											X	X	1=efficacy of early interventions 2=standardised model for mental health support in prisons 3 = cost effectiveness of early intervention 12 = continuity of care 13 =partnership working through courts (liaison and diversion) and police custody etc.	Prevention and early intervention are needed to prevent and mitigate severe behavioural problems among children
Eckstein (2007) Abstract	Australia	Prison	Comparison of two cohorts (stable population and “short-stay” prisoners) to examine which had their needs best met	A continuously serving cohort and a cohort of prisoners who had been incarcerated and released during 1996-2001		X				X		X	X							2= effectiveness of services for short and long stay prisoners 6 = assessment of need 8 = inadequate resources 9 = services need to recognise gender differences in need	Stable prison populations and transient prison populations have different service needs (and commissioned services need to be flexible to respond to this)
Exworthy (2011)	International	Prison	Review of the use of the United Nations	All prisoners	X	X		X												1= prisons are not equivalent to the community – beyond equivalence	To continue to enforce a measure of

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Hampton (2015) Full paper	Australia	Prison	Review of prescribing for people in custody	All people in prison		X											X		2 = effective prescribing / treatment plans 12 = preparation for release – continuity of care	None
Homeless link (2011) Full paper	England	Criminal Justice System and Homelessness sectors	Literature review, client focus group, two online surveys and in-depth qualitative research	400 staff members from across relevant sectors and 76 people with an offending history who have homeless needs		X			X								X	X	2 = one-size doesn't fit all 5 = client's input is central 10 = empowerment 12 = access to relevant data 13 = partnership work – which the client is involved in	The importance of co-location of services for cross-sector working
Lehman (2015) Abstract	United States of America	Prison	Study design unclear but participants were randomly allocated to receive an intervention to increase positive decision making skills or usual treatment	1393 soon-to-be released inmates from eight different institutions participating in a therapeutic community substance abuse treatment program.													X		10 = positive decision making skill development	None
Linder (2009) Full paper	United States of America	Prison	Review of the healthcare system and demographic trends with a focus on palliative and end-of-life care	Older prisoners requiring palliative or end-of-life care		X		X	X										2 = equivalence of care 4 = impact of healthcare costs on accessibility of healthcare 5 = implications of dying in prison for the prisoner and his/her family	None
Lynch (2007)	Australia	Criminal Justice	Prevalence	Young people in													X		10 =using prison/contact with	Health is a

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					1	2	3	4	5	6	7	8	9	10	11	12	13			
Abstract – limited text		System	study /Review of health needs of young people in contact with the criminal justice system	contact with the criminal justice system															criminal justice system as a positive opportunity to improve health	mediator of change in the trajectory of young people
MacFarlane (1996) Full paper	United Kingdom	Prison	Review of delivering diabetes care	People in prison with diabetes		X		X						X				X	2= standards of diabetes care 4 = accessibility to diabetes care teams in prison 10 = education to self-manage diabetes 13 = close liaison between prison staff and local diabetes teams	Impact of prison regime on health (e.g. impact of meal times on glucose control in early hours of the morning)
MacRae (2006) Full paper	Scotland	Transition from prison to community	A combination of qualitative and quantitative methods to evaluate the Scottish Prison Service Transitional Care Initiative	Transitional Care was introduced to support short-term prisoners (serving less than 4 years) and remand prisoners with an identified substance misuse problem	X		X	X	X								X		1= evaluating the effectiveness of the Transitional Care Initiative 3=Cost effectiveness of the Transitional Care initiative 4 = facilitating access to community services 5 = qualitative research 11=capacity of existing services to meet demand	None
Mahto (2008) Abstract	United Kingdom	Prison	Service review of a “one-stop sexual health service”	545 female patients	X			X		X									1 = Programmes with known efficacy (e.g. screening and immunisations) 4 = one stop sexual health shop 6 = health needs changing	None

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					1	2	3	4	5	6	7	8	9	10	11	12	13									
Abstract	America		experiences within Medicaid managed care	supervision																						
Powell (2010) Full paper	England	Prison	Ethnographic study of nurses and other prison healthcare staff about their roles and nursing care provided to prisoners	80 healthcare staff in 12 prisons				X	X																	4 = accessibility of healthcare 5 = ethnographic research – staff views and experiences 10 = responsibility for looking after your own health The value of staff's views and experiences (as well as offenders) Conflict between custody regime and healthcare delivery
Reed (1997) Full paper	England and Wales	Prison	Inspections based on a set of "expectations" derived mainly from existing healthcare quality standards published by the prison service and existing ethical guidelines; questionnaire survey of prisoners.	19 prisons	X	X			X	X															X	1=lack of equivalence of care/clinical supervision 2=variation in standards/monitoring inadequate 5=prisoners' views on the quality of health care 6=appraisals of needs assessments 13=no longer should healthcare for prisoners be separate from the NHS Difficulties in staff recruitment
Rieder (2013) Abstract	Geneva	Prison (post-trial)	Case study of a Health Mobile Team as a	People in the six post-trial prison facilities	X	X		X																	X	1=equivalence of care 2=unifying structures to meet standards None

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					1	2	3	4	5	6	7	8	9	10	11	12	13			
Senior (2011) Abstract	United Kingdom	Criminal Justice System	Review	All offenders		X							X						2=equivalence of care 8=allocation of resources to improve offender health	None
Shaw (2007) Abstract	United Kingdom	Prison	Review of current prison mental health service provision	People in prison with poor mental health		X											X		2=equivalence of care 12=evaluation	None
Smith (2010) Title	Unable to extract information	Unable to extract information	Unable to extract information	Unable to extract information	X														1=nursing skill base	None
Smith (2008) Abstract – limited text	England	Young Offender Institution	Case study of child-friendly practices in one institution	Young offenders											X				10 = use of older offenders as mentors	None
Smyer (2009) Abstract	United States of America	Prison	Review of issues around older people in prison	Older prisoners		X													2=equivalence of care	None
Somers (2014) Full paper	England and Wales	Secure hospitals (low and medium security)	Qualitative study of staff to understand the nature and quality of care pathways for women	40 consultant psychiatrists, 7 service managers		X		X	X				X	X			X	X	2 = gaps and blockages in pathway 4=access(to community placements) 5 = qualitative study of healthcare professionals 8= cost-care conflict 9= services which respond to the health history of women (e.g. trauma) 12 = continuity of care to avoid increased feelings of failure and rejection by women; care pathways 13 = repatriation from the independent sector to the	Attitudes to care differ in healthcare staff (e.g. competing concepts of continuity) Idea that continuity of care is not simply about continuity of treatment when leaving prison but also

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					1	2	3	4	5	6	7	8	9	10	11	12	13			
																		NHS	about continuity of staff.	
South (2014) Full paper	England and Wales	Prison	Systematic Review of the effectiveness and cost-effectiveness of peer based interventions to improve health; complimented by expert symposium	57 studies in the effectiveness review and 1 in the cost-effectiveness review (all of poor methodological quality)	X	X	X		X							X			1=evidence based interventions 2=effectiveness (mostly poor quality studies) 3=cost effectiveness (few studies) 5=expert symposium 10=peer-based support	Poor methodological quality of research papers
Souza (2015) Abstract	England	Transition from prison to community	Mixed-methods: prospective longitudinal design and semi-structured interviews to understand pre- and post-release experience	39 male prisoners and their respective (ex-) partners					X							X			5=interviews with prisoners and (ex)-partners 10 = active coping	None
Sue (2015) Abstract	United States of America	Prison	Case study of the development of a student faculty (medical student-delivered) collaborative clinic	Male prisoners	X											X		X	Staff education and training 1=evidence based healthcare 10=diabetes management 12=continuity of care 13=partnership prison and medical school	Partnerships between prisons and medical training programmes: Prison as a valuable educational setting for medical

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					1	2	3	4	5	6	7	8	9	10	11	12	13									
			experiences managing cardiovascular disease risk factors in prison																							
Tobler (2014) Abstract	Unable to extract information	Community	Review of providing care coverage for former inmates	Former inmates				X																	4=reduced access to healthcare on release because of cost and lack of health insurance cover	None
van den Bergh (2010) Abstract	Europe	Prison	Review of women's health in prison	Women		X							X												2=ineffective services for women 8=inequitable- needs focus on the majority (men)	None
Veysey (1997) Abstract	United States of America	Prison	Descriptive study of experiences and processes related to detainees with mental illness	379 prisoners with mental illness from seven prisons		X		X												X	X				2=mental health services do not meet needs 4 = inaccessibility to mental health services on release 12 = continuity of care 13= links between mental health services and the criminal justice system	None
Wang (2010) Full paper	United States of America	Transition from prison to community	Descriptive study of a "Transitions Clinic"	185 patients with chronic medical conditions who had been recently released from prison										X	X						X				9=access based on need 10=lack of self-management skills on release from prison 12=continuity of care	None
Wang (2012) Full paper	United States of America	Transition from prison to community	Randomised Controlled Trial to compare two interventions designed to	200 recently released prisoners who had a chronic medical				X														X			4=increasing accessibility to primary care 13=increasing primary care management to reduce acute care admissions	None

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					1	2	3	4	5	6	7	8	9	10	11	12	13			
Abstract/Full paper retrieved																				
			improve primary care engagement and reduce acute care utilization	condition or were older than 50 years																
Watson (2004) Full paper	International	Prison	Literature review of prison health care	All people in prison						X			X	X				X	6=summary of needs 9=women and older people have distinct needs 10 = lack of autonomy over your own healthcare when in prison 13=partnership; health of the community outside prisons are desirable aims of prison healthcare	Idea that healthy prisons are a contradiction in terms. Telemedicine as a possible mode of delivery of healthcare in prisons
Watson (1993) Insufficient information for any data to be extracted	Unable to extract information	Unable to extract information	Unable to extract information	Those with mental health disorders																Unable to extract information
Whitehead (2006) Abstract	Unable to extract information	Prison	Literature review on the role of nursing in the health promoting prisons	All people in prison		X												X	2=current prison-based nursing services are lacking in structure and resource; nurses must embrace radical health promotion reforms 13=social interaction, cohesion, political action	None
Williams (2012)	United States of America	Criminal Justice System	Review of ageing in the criminal justice	Older prisoners and former prisoners		X				X			X			X	X	2=little known about functional and cognitive status of older prisoners	Impact of the increasing numbers of	

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					1	2	3	4	5	6	7	8	9	10	11	12	13			
Full paper			system															6=needs of older prisoners 9=adapting geriatric models of care for older prisoners 12=continuity of care 13=collaboration	older people within the criminal justice system	
Winterbauer (2013) Abstract	Unable to extract information	Criminal Justice System	Discussion of a conceptual framework – “The Ten Essential Public Health Services model” - for a public health approach to correctional health care	All people in contact with the criminal justice system				X									X	4=access 12= continuity of care	None	
Woodall (2013) Abstract	England	Prison	Qualitative research – interviews and focus groups to understand prisoners’ perspectives on the transition from prison to the community	36 soon-to-be released men in three prisons; some of whom were convicted of sexual offences and based on a vulnerable prisoner unit					X								X	X	5=views of prisoners 12=continuity of care/transition to community 13= opportunities for successful transition could be enhanced by a more ‘joined-up’ settings perspective	Wider determinants of health
Woods (2013) Full paper	Unable to extract information	Transition from prison to community	Exploratory study to understand the role of prevention in promoting continuity of health care in prisoner re-	Prisoners transitioning from prison to the community				X		X							X		4=barriers to re-entry into the community 6=clients’ strengths and needs 12 continuity of care/transitions	None

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					1	2	3	4	5	6	7	8	9	10	11	12	13										
			entry initiatives																								
World Health Organisation (2007) Full paper	Europe	Prison	Handbook guide to the essentials in prison health		X	X	X	X							X		X									1 = programmes with known efficacy (e.g. screening and infectious disease control) 2=standards of health 3=cost-effectiveness 4=access 9=responsive services 11=waiting times 13=leadership and partnership	Health of people working in prisons is also important.
World Health Organisation (2014) Full paper	International	Prison	Handbook giving guidance to professional staff responsible for the health and wellbeing of detainees. Comprehensive summary of what healthcare should look like.	All people in prison	X	X		X							X											1 = programmes with known efficacy (e.g. screening and immunisations) 2 = expected standards based on need 4 = "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation (Principle 9)" 9 = Healthcare should recognise gender-specific healthcare needs	None
Young (2015) Abstract	Australia	Transition from prison to community	Cohort study using qualitative research to understand healthcare contact and utilisation	847 participants recently released from prison					X			X														5= interviews with (ex)-prisoners 7= engagement with primary care early after release increased health service utilisation during critical transition period.	None

Appendix E

Policy context for the current health and justice environment

Key policies

Balancing Act (2013) - produced by the Revolving Doors Agency, the Probation Chiefs Association and PHE³⁸

This briefing paper suggests approaches that directors of public health could use to tackle the local health inequalities of people in contact with the criminal justice system. These include:

- better understanding the specific health needs of those in contact with the criminal justice system
- building on existing partnership working to coordinate the offender health agenda
- working with partners to address other common risk factors and determinants associated with poor health and offending, such as homelessness; developing comprehensive and multi-agency strategies to tackle these problems
- exploring opportunities for joint commissioning with partner agencies to find holistic solutions that meet local need

Crime Prevention Strategy 2010 to 2015 – updated 8 May 2015³⁹

Issue: Any amount of crime in society is unacceptable. Not just because of the human cost, but also the cost to society.

Action: A new approach that involves a shift of power from Whitehall to local communities. The police will be given far greater freedom to do their jobs, and the public more power to hold them to account.

Measure of success: whether crime has fallen.

Methods to reduce crime:

- creating community triggers to deal with persistent antisocial behaviour
- using community safety partnerships and police and crime commissioners, to work out local approaches to deal with issues, including antisocial behaviour, drug or alcohol misuse and re-offending
- establishing the national referral mechanism to make it easier for all the different agencies that could be involved in a trafficking case to cooperate, share information about potential victims and get access to advice, accommodation and support
- producing a new serious and organised crime strategy

³⁸ <http://www.revolving-doors.org.uk/documents/balancing-act/>

³⁹ www.gov.uk/government/publications/modern-crime-prevention-strategy

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- creating street-level crime maps to give the public up-to-date, accurate information on what is happening on their streets so they can challenge the police on performance

Methods to prevent crime:

- creating the child sex offender disclosure scheme, which allows anyone concerned about a child to find out if someone in their life has a record for child sexual offences
- legislating against hate crime
- using football banning orders to stop potential troublemakers from travelling to football matches - both at home and abroad
- legislating to stop cash payments to buy scrap metal and reforming the regulation of the scrap metal industry to prevent unscrupulous dealers buying stolen metal

Drug Strategy 2010 Reducing Demand, Restricting, Supply, Building Recovery: Supporting People to Live a Drug Free Life - Drug Strategy 2010 'A Balanced Approach' Third Annual Review⁴⁰ (February 2015)

This strategy sets out the following aspirations:

- enhancing the current approach to prevent people from using drugs in the first place and early intervention
- tackling the serious and organised criminals importing, manufacturing and dealing drugs
- recovery including wider factors such as employment and housing
- the harms posed by new psychoactive substances - developing legislation for a 'general ban' to prohibit the supply of new psychoactive substances as well as the wider recommendations which cover information sharing, interventions and treatment and education and prevention
- local commissioners maintain appropriate levels of investment in drug and alcohol services to ensure these adequately meet local need

The Harris Review (2015) into self-inflicted deaths in custody of 18-24 year olds⁴¹

This is a wide-reaching review calling for wholesale reform of approach to dealing with young offenders. Observations and conclusions include:

- separation of young people from families and support networks likely to lead to loneliness and exacerbate vulnerabilities
- young adults in prison are not sufficiently engaged in purposeful activity such as education or work
- the experience of living in prison or YOI is not conducive to rehabilitation
- a call for reinvestment and redirection of resources to the health and welfare systems plus community alternatives to custody

⁴⁰ www.gov.uk/government/publications/drug-strategy-2010

⁴¹ www.gov.uk/government/publications/harris-review-self-inflicted-deaths-in-custody

Recommendations include:

- a shift in philosophy towards rehabilitation, with statement to this effect from MoJ
- performance management of prisons to include monitoring of the number of hours prisoners spend out of their cells on purposeful activity
- a new role to be established: the Custody and Rehabilitation Officer (CARO), who should play the important role of a mature adult as part of young offenders' social development as well as ensure better inclusion of families of young adults in managing their vulnerability. (To replace the personal officer scheme.)
- an Individual Custody Plan to be developed for each young adult following a multi-disciplinary, holistic needs assessment (Safety and Vulnerability, Risk Assessment and Support – SAVRAS – process)
- NOMS and healthcare providers to jointly own responsibility for prevention of self-harm and self-inflicted deaths in custody
- Justice Secretary to introduce legislation to create a statutory duty of co-operation with the Prison Service for those organisations that have direct engagement with it

Hepatitis C in the UK (2015)⁴²

This report presents national level data from all four countries on hepatitis C virus (HCV) infection, prevalence, burden of disease, prevention, awareness, testing and diagnosis, and treatment and care. Headlines include:

a) Awareness:

An audit of HCV services in prisons in England has recently been conducted.

An evaluated e-learning package on blood-borne viruses (BBVs) for prison staff in Wales has recently been created.

b) Testing and diagnosis:

- testing for HCV in prisons is increasing but remains low with just 8.6% and 13.7% of receptions to English (2013/14) and Welsh prisons (2014) being tested. The number testing positive remains stable
- a switch from targeted to opt-out (BBV) testing was made in 2014 in 11 'pathfinder' prisons. The programme has been expanded, remains under evaluation and will be fully implemented and validated in 2015-16. Preliminary results suggest increasing awareness of HCV across the prison estate
- reports of HCV to the Public Health Intelligence in Prisons and other Secure Settings Service (PHIPS), increased year-on-year from 2010 to 2013

c) Referral and treatment:

The new system of performance reporting, Health and Justice Indicators of Performance (HJIPs), was introduced in April 2014 to monitor the percentage of those with HCV infection who are referred to a specialist service, and the percentage of those testing HCV and

⁴²www.gov.uk/government/uploads/system/uploads/attachment_data/file/448710/NEW_FINAL_HCV_2015_IN_THE_UK_REP_ORF_28072015_v2.pdf

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polymerase chain reaction or PCR-positive being initially assessed by a specialist who have a treatment plan developed within 18 weeks.

Almost all pathfinder prisons (10/11) provided HCV treatment as an in-reach model.

Her Majesty's Inspection of Prisons (HMIP) reports ⁷

As well as reports on unannounced visits to particular prescribed places of detention, HMIP have published thematic reports/findings papers on the following topics over the past 18 months:

- Behaviour Management and Restraint of Children in Custody
- Changing Patterns of Substance Misuse in Adult Prisons and Service Responses
- People in Prison: Immigration Detainees
- Life in Prison: Peer Support
- Life in Prison: The First 24 Hours in Prison
- Life in Prison: Earning and Spending Money
- Court Custody: Urgent Improvement Required
- Close Supervision Centre System (announced thematic inspection)
- The treatment of Offenders with Learning Disabilities within the Criminal Justice System (Joint report with Her Majesty's Inspectorate [HMI] Probation)
- Transfers and Escorts within the Criminal Justice System
- Resettlement Provision for Adult Offenders: Accommodation and Education, Training and Employment (Joint report with HMI Probation and Ofsted)
- The HMIP report Life in Prison: Peer Support: A Findings Paper (2016) was referenced by interviewees and reported that peer support is used widely in prisons and its importance is recognised in many of the prisons inspected

An Independent Review into the Impact of Employment Outcome of Drug or Alcohol Addiction, and Obesity⁴³

The government has commissioned Professor Dame Carol Black to undertake an independent review into how best to support benefit claimants with potentially treatable conditions, such as obesity or addictions to drugs and alcohol, back into work. The review will consider the evidence and provide the government with a thorough analysis of the options available to support more people suffering from long-term treatable conditions back into work.

The call for evidence period for this review ran from July to September 2015. It is not clear when the final report will be published.

Inspection reports: Care Quality Commission (CQC)⁸

The CQC monitor, inspect and regulate health and social care in the criminal justice system to ensure that people who use services in secure settings receive the same quality of care as the rest of the population. Healthcare services in secure settings

⁴³ www.gov.uk/government/uploads/system/uploads/attachment_data/file/448830/employment-outcomes-drug-alcohol-obesity--independent-review.pdf

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must register with CQC just like any other care service but here are some exemptions for services that are provided under arrangements with government departments.

Services CQC inspect:

- youth offending teams (YOTs) are statutory bodies that include representatives from health, education, police, probation, substance misuse and social services
- secure training centres (STCs) hold young offenders, usually over the age of 15. Offenders under 15 are normally held in secure children's homes, while those over 15 are held in STCs or young offender institutions. There are three STCs in England, two of which hold women
- young offender institutions (YOIs) are run according to many of the same rules and policies as prisons. There are eight YOIs that hold young males in England and Wales
- adult prisons
- immigration removal centres
- police custody

CQC work in partnership with other inspectorates and use different frameworks to inspect different types of service:

- a) Youth offending teams, according to risk, carrying out six full joint inspections per year alongside a programme of short quality assurance visits. Each inspection team includes representatives from CQC, Ofsted, HMI Constabulary and HMI Prisons. In addition, there are 3-4 thematic inspections involving YOTs each year which can be led by any of the participating inspectorates, including CQC. They usually involve visits to at least six YOTs.
- b) Secure training centers, are inspected once a year. Led by Ofsted, these inspections also include representatives of HMI Prisons and CQC.
- c) Young Offender Institutions, Adult Prisons and Immigration Removal Centers. The inspections are led by HMI Prisons, whose responsibilities are to inspect and report on conditions and treatment. CQC is responsible for monitoring, inspecting and regulating health and social care providers
- d) Police custody, CQC work with HMI Probation and HMI Constabulary to inspect services that are provided in police custody. CQC plan to formally set out their approach next year.

Integrated Offender Management ⁴⁴

Integrated Offender Management (IOM) is an approach that brings together representatives from a range of agencies to collectively address local crime and re-offending priorities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together. Local IOM models will vary to reflect local circumstances and priorities.

⁴⁴ www.gov.uk/guidance/integrated-offender-management-iom

Mental Health Taskforce Outcomes (The Five Year Forward View for Mental Health) 2016 (110)

Formed in March 2015, the independent Mental Health Taskforce has brought together health and care leaders, people using services and experts in the field to create a Five Year Forward View for Mental Health for the NHS in England. This national strategy, which covers care and support for all ages, was published in February 2016 and signifies the first time there has been a strategic approach to improving mental health outcomes across the health and care system, in partnership with the health arm's length bodies. The strategy recognises that:

- children, young people and adults who have been in contact with the justice system are more likely to have mental health problems
- organisations - including the NHS, public health, voluntary, local authority, education and (youth) justice services - must work together to promote good mental health and make it easier for people to access high quality care
- NHS commissioning needs to better understand mental health needs, bring together local partners across organisations (including criminal justice), with a clear recognition of the mental health needs of people treated for physical ailments and vice versa
- in the future, commissioners will have the knowledge and skills to embed what is proven to work, and to work in partnership with people using services, carers, and local communities to develop and evaluate innovative new models in a range of settings
- all frontline staff, including those in the criminal justice system, should have basic skills to provide mental health care
- work needs to happen to link data from different public services and agencies (the NHS, social care, education, criminal justice and others) to help identify and meet the full needs of people with mental health problems. Similarly, there should be more national support with the analysis and presentation of raw data to support good commissioning and local planning

The specific recommendation for the Health and Justice Care Pathway is:

'The Ministry of Justice, Home Office, Department of Health, NHS England and PHE should work together to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed.'

This should build on the national roll out of Liaison and Diversion schemes (including children and young people) across England by 2020/21 and the increased uptake of Mental Health Treatment Requirements (diversion through court order to access community based treatment) as part of community sentences for everyone who can benefit from them. It should also improve mental health services in prison and the interface with the secure care system, with continuity of care on release, to support offenders to return to the community.

Prison reform

The former prime Minister spoke at the Policy Exchange on 8 February 2016 (8) to announce proposals for prison reform. Key elements of the proposal include:

- greater autonomy for governors in the way they run their prisons
- creating a prison system that maximises people's live chances when they leave prison
- building new prisons that provide more suitable living and working environments
- focusing scarce resources on preventing crime, therefore breaking the cycle of re-offending
- developing meaningful metrics about prison performance
- co-commissioning for governors and NHS England for drug treatment and mental health
- continuing rehabilitation in the community

Prisons and Prevention – Giving local areas the power to reduce offending – Institute for Public Policy Research 2016⁴⁵

This paper argues that there is an inherent flaw in our criminal justice system: the people who could act to reduce offending have neither the financial power nor the incentive to do so. The reason for this is that many of the services and agencies that could act to reduce offending are organised and controlled at the local level, whereas the budget for prison places is held by central government. The challenge is therefore to 'unfreeze' the resources that are locked up in the prison system, and ensure that local services and agencies are enabled and incentivised to use those resources to both prevent crime and develop alternatives to custody.

The paper identifies that the recent moves to devolve power and resources to groups of local authorities and city mayors could hold the answer to this problem. These proposals would give city mayors and other local leaders the necessary resources, capacity and financial incentives to invest in services that help keep low level-adult offenders out of prison.

Shaw Review into Welfare in Detention of Vulnerable Persons (2016)⁴⁶

This is a review with numerous healthcare related recommendations for reform of the immigration estate, based on a few key general conclusions:

- there is too much detention and it is not particularly effective at ensuring those with no right to remain do leave UK
- detention in and of itself undermines welfare and contributes to vulnerability
- detention must move out of shadow cast by prison service
- shortcomings in identifying vulnerability require urgent reform
- calls for a smaller, more focused, strategically planned immigration estate

Particular to healthcare commissioning:

⁴⁵ <http://www.ippr.org/publications/prisons-and-prevention-giving-local-areas-the-power-to-reduce-offending>

⁴⁶ www.gov.uk/government/publications/review-into-the-welfare-in-detention-of-vulnerable-persons

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- the move to commissioning has been on the whole a welcome ‘journey’
- day-to-day relations between commissioners and service providers needs improvement: Some providers have been frustrated with the inability to see contracts and understand service delivery levels under new arrangements
- early projections of demand outstripped by actual demand
- some legacy issues and new arrangements affecting smooth running of healthcare services
- new commissioning arrangements and changes in providers can both result in short-term problems before improved results are visible

Unlocking potential – a review of education in prison⁴⁷

The Lord Chancellor and Secretary of State for Justice commissioned Dame Sally Coates to complete a review of prison education in England and Wales. The review examined how prison education supports the effective rehabilitation of different segments of prison learners, eg young adults, older prisoners, female offenders, short sentenced prisoners and longer sentence/life sentenced prisoners.

The review also examined the effectiveness of current education provision in prisons and YOIs. It also consider how provision supports learner progression and successful rehabilitation; evidence of what works well and demonstrably supports rehabilitation and options for future models of education services in prisons which emphasise effective rehabilitation of different segments of prison learners.

Whole prison “settings” approach to promoting health draws on three key elements:

1. Prison policies that promote health (eg no-smoking policies).
2. An environment that is supportive of health.
3. Disease prevention, health education and other health promotion initiatives that address the health needs assessed within each prison.

A whole prison approach involves all aspects of prison that touch on the wider determinants of health (such as education and life skills), plus health promotion, health education, patient education and prevention. The whole prison approach aims to address the health and wellbeing of staff, visitors, families and the local community and looks at the whole offender pathway, working with probation services, reducing re-offending partnerships and resettlement teams.

WHO Europe – Good Governance for Prison Health (2013) (35)

This document sets out recommendations on how prison health should be organised, including:

- prison health services should be provided exclusively to care for prisoners and must never be involved in the punishment of prisoners

⁴⁷ www.gov.uk/government/publications/unlocking-potential-a-review-of-education-in-prison

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- prison health services should be integrated into national health policies and systems, and be independent of prison administrations
- governments should employ a whole-of-government approach to prison health
- health ministries should provide and be accountable for health care services in prisons

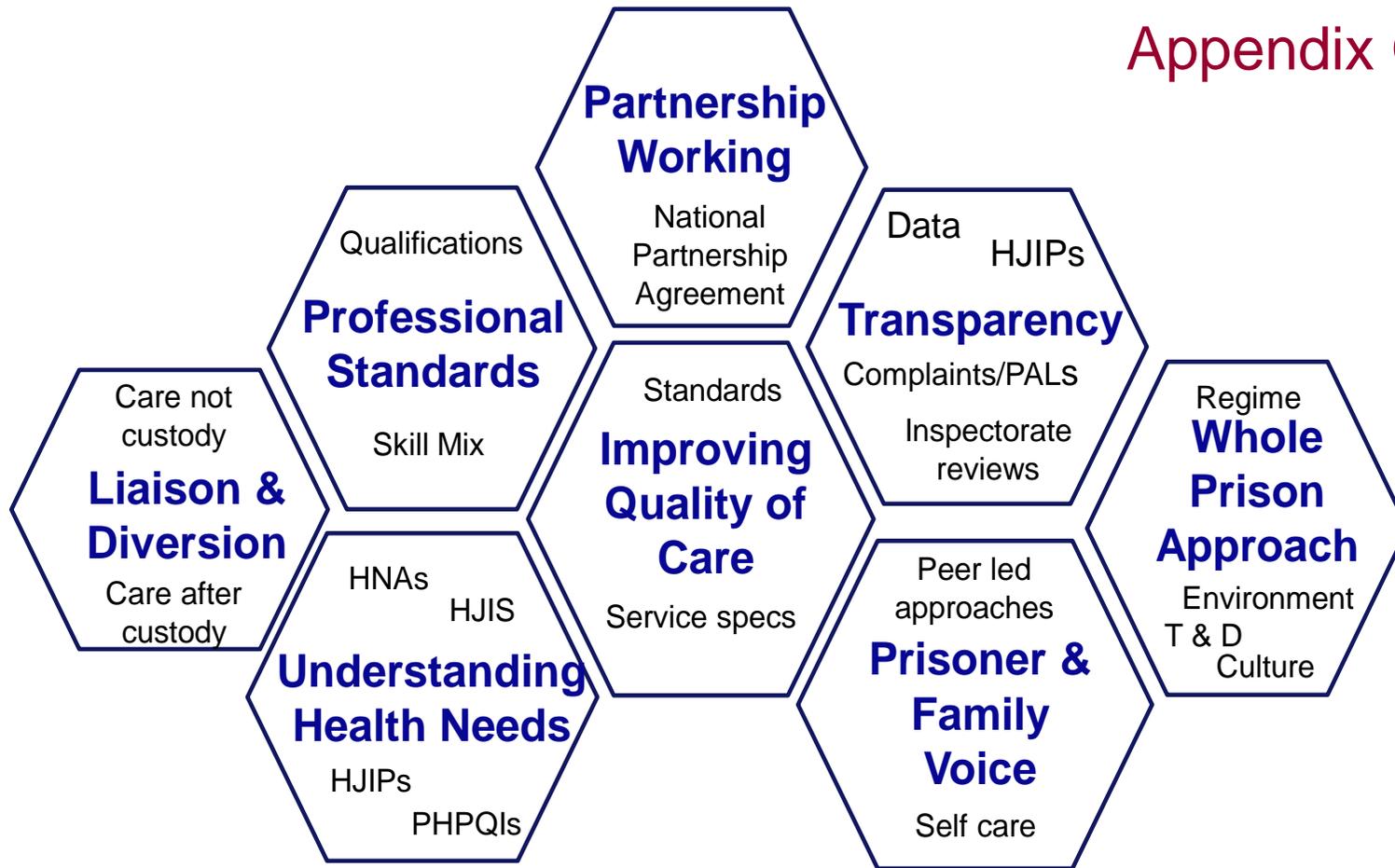
This document states that in many cases across European countries these recommendations, as well as fundamentals of international prison law, are often not put into practice (ie prisoners share the same right to health and wellbeing as any other person).

Appendix F

Summary of areas for improvement



Appendix G



Key areas of improvement in the quality of care since the implementation of NHS commissioning of prison healthcare in 2006

Appendix H

Overview of recommendations

Challenge for Providers

To improve health care **accessibility** by:
Developing a **whole prison approach** which recognises the impact of prison regime on service access

Promoting close working between prison staff and HC providers to develop a common understanding of processes and priorities
Supporting people with Mental Health needs, Learning Disability and Autistic Spectrum conditions.

Focusing on **continuity of care** and 'Through the Gate' programmes

Develop **cost effectiveness** approaches to service development including analysis of Return on Investment; ensuring an appropriate skill mix, and continual focus on primary, secondary prevention and early diagnosis with a strong focus on self-care and family support

Engaged services - Continue on journey of **lived experience**

Achieving Improved Population Outcomes for People in Detained Settings



Networks leadership and co-ordination

- Lead a whole prison approach.
- Develop a golden thread linking a national and local activities including link between custody and community.
- Develop population outcomes agreed across a partnership.
- Ensure a balanced portfolio of services across the pathways
- Develop local partnerships, which include CCGs, HWBB and PCCs support a wider strategic approach.
- Ensure equitable resourcing and responsive services to meet need.

Population focused

Understanding needs: Further develop the HNAs through improved data quality of HJIPs
Develop links with local community needs assessments e.g. JSNAs

Increase provision of **early intervention services**

Engage communities through the Increased the use of **peer mentoring/support** in prisons and through the gate which are systematically applied

Systematic and scaled **self-management programmes** need further development

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