



GUIDANCE NOTES

Prison Health Performance and Quality Indicators

DH INFORMATION READER BOX

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Introduction

The healthcare of prisoners is the responsibility of the NHS. Following publication of the final report of the NHS Next Stage Review (High Quality Care for All¹), launched by Lord Darzi in June 2008, there is a drive to improve the quality of healthcare generally within the wider NHS. Delivering high-quality healthcare in prisons is a contribution to reducing health inequalities specifically and improving the health of the whole community in general. Last year, Offender Health issued a set of Prison Health Performance Indicators (PHPIs)² to guide strategic health authorities (SHAs), primary care trusts (PCTs) and prisons in judging their own performance in delivering healthcare services to prisoners. This year, in line with measures being developed in the wider NHS, Offender Health has redeveloped the PHPIs to become broader indicators of the quality of healthcare in prisons, as well as the performance of individual parts of health services. They will now be referred to as **Prison Health Performance and Quality Indicators (PHPQIs)**. This development means that services will be able to assess how appropriately the needs of prisoners are met, how well commissioned services map to health priorities identified through a rigorous health needs assessment, and how stakeholders, especially prisoners, value these services.

World Class Commissioning³ is a national programme developed by the Department of Health (DH) that seeks to deliver better health and well-being, better care and better value for all through intelligent and effective commissioning of health services by PCTs. Commissioning assurance is a system to drive and support performance to ensure that health outcomes are improving. Commissioning assurance is a nationally consistent system, led by SHAs, that sets itself developmental but challenging outcomes to achieve. Outcomes should reflect the overall improvement in the health and well-being of the population. Performance is assessed by a combination of self-assessment, feedback from partners and evidence for a review of data. These PHPQIs fit very well into the wider commissioning assurance process as they allow commissioners to assure themselves that services provided are designed following an appropriate assessment of need and judged against a measurable improvement in health indicators in the population in prisons.

These guidance notes have been developed by the 2009 Prison Health Performance and Quality Indicator Working Group, deriving its membership from the Department of Health, the Prison Service, SHAs, PCTs and mental health trusts, and expertise from public health, women's services, children's services, patient groups, and equality and diversity teams.

1 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

2 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079860

3 <http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm>

These voluntary indicators build upon the preliminary data set as used in the 2007/08 indicators and are designed to form a continuous representation of progress within prison healthcare units. Amendments and adjustments to the indicators this year are as a result of extensive discussion with key stakeholders within the field and building upon the experiences of the first year's data collection.

It should be noted that, where possible, the intention is to move towards gathering evidence to support the data set using the emerging electronic information systems within prison healthcare units. As such, where such a system exists, healthcare units are encouraged to interrogate these systems to provide evidence to validate these indicators. SHA and regional Offender Health leads are encouraged to use such data systems as part of the evidence-gathering exercise to validate the results. Offenders Health is working with primary care colleagues to explore, in the future, how a system such as the Quality and Outcomes Framework (QOF)⁴ may be used to provide information to support continuous quality improvement in prison health, nationally and in local health economies.

In the meantime, until all prisons are using electronic systems, a significant proportion of prisons will require SHA, PCT and Offender Health regional lead support to validate and verify their results before submitting them to the SHA and from there to DH for reporting purposes.

Key to the effective administration and use of these indicators is the involvement of the SHA and the prison/PCT Partnership Board. Regions are encouraged to ensure that the involvement of all key stakeholders is achieved.

It should be noted that in this year's guidance notes each section now contains a supporting evidence section. It is suggested that teams validating the individual prison results use this checklist to ensure that the evidence is of a standard required to allow for comparison between prisons during the reporting period.

The indicators and guidance notes for 2009 contain a number of specific indicators relevant for young offender institutions (YOIs). The intention is to develop further indicators in future years in line with the forthcoming Health and Social Care Strategy for Children and Young People in Contact with the Youth Justice System. For this year some additional references relevant for YOIs have been added to the guidance.

A change to the wording of the mental health numeric indicators is noted this year as are the addition of a number of indicators and the removal of others. For a full list of changes, please contact Offender Health, Department of Health.

4 DH launched a public consultation on 30 October 2008 on the future development of the QOF. A copy can be found in the DH website consultation section at http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_089778

PART 1. Performance Indicators

AREA: SAFETY

1.1 Patient Safety

Green Indicator

There is a formal system in place that protects patients through identifying and learning from all patient safety incidents and other reportable incidents, **and** improvements are made in practice based upon local and national experience and information derived from the analysis of such incidents.

Rationale

Healthcare organisations protect patients through the use of systems that identify and learn from all patient safety incidents and other reportable incidents. By seeking to identify the root cause and likelihood of repetition the potential to avoid incidents in the future and improve standards is increased. Such a system protects patients and staff.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- PCT risk register containing direct reference to prison healthcare
- Evidence of recording of patient safety incidents and formalised feedback to ensure that remedial action is taken to address issues/improve services
- Evidence that significant events, such as deaths in custody, have an agreed joint action plan and that this has been discussed at the prison/PCT Partnership Board with activity being reviewed regularly over a 6–12-month period
- In YOIs, evidence that any findings or recommendations from reports of the Local Safeguarding Children Board, and action plans arising from these, have been communicated across the organisation
- Evidence of communication with staff groups concerning incident feedback
- Evidence of practice/process change as a result of incident feedback.

Literature and references

- Building a Safer NHS for Patients: Implementing an organisation with a memory (DH 2001)
- NICE Guidelines: The Interventional Procedures Programme (Health Service Circular 2003/011)
- The Health and Social Care Act 2008: Code of Practice for the NHS on the Prevention and Control of Healthcare Associated Infections and Related Guidance (DH 2009)
- PSO 3810 – Health and Safety Arrangements for Consultation with Staff (Guidance note 03/2006)

- PSO 3801 – Health and Safety Policy Statement
 - PSO 1301 – Death in Custody
 - PSO 2710 – Death in Custody
 - PSI 36/1998 – Investigating a Death in Custody
 - National Patient Safety Agency (NPSA) – With safety in mind: mental health services and patient safety, July 2006 <http://www.npsa.nhs.uk/nrls/alerts-and-directives/directives-guidance/mental-health/>
 - NPSA – Building a memory: preventing harm, reducing risks and improving patient safety, July 2005 <http://www.npsa.nhs.uk/nrls/alerts-and-directives/directives-guidance/building-memory/>
 - Safety first: a report for patients, clinicians and healthcare managers (DH 2006) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062848
 - 'Getting over the wall': How the NHS is improving the patient's experience (DH 2004)
 - Section 113 Health and Social Care (Community Health and Standards) Act 2003
 - NHS (Complaints) Amendment Regulations 2009
 - PSI 14 (2005) – Handling complaints about prison healthcare
 - Principles of Good Complaint Handling (Parliamentary and Health Service Ombudsman 2008)
 - Making Experiences Count outcomes framework document (DH 2008) <http://www.dh.gov.uk/mec>
 - Making Experiences Count toolkit (DH 2008) <http://www.dh.gov.uk/mec>
 - Common themes from analysis of 120 Prisons and Probation Ombudsman (PPO) reports http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_085026
 - Investigating fatal incidents <http://www.ppo.gov.uk/fatal-incident-investigation/the-process/index.html>
- In addition, for YOIs:
- PSO 4950 – Regimes for Juveniles
 - National Service Framework for Children, Young People and Maternity Services (DH 2004)
 - Statutory Guidance on Making Arrangements to Safeguard and Promote the Welfare of Children under section 11 of the Children Act 2004 (HM Government 2005)
 - Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (HM Government 2006)
 - Children Act 2004, sections 11, 13 and 14

Amber Indicator

There is a formal system in place that protects patients through identifying all patient safety incidents and other reportable incidents; **however**, there is no system to ensure that improvements are made in practice based upon local and national experience and information derived from the analysis of incidents.

Red Indicator

There is **no** formal system in place that protects patients through identifying and learning from all patient safety incidents and other reportable incidents.

PART 1. Performance Indicators

AREA: SAFETY

1.2 Healthcare Environment

Green Indicator

All of the following conditions are applicable:

- The prison healthcare centre and clinical areas are fully integrated with PCT environmental monitoring systems.
- There is evidence of regular infection control audits.
- The healthcare centre is not the default location for prisoners with physical disabilities.
- The rights of patients to privacy and confidentiality are respected in all consultations.
- The prison healthcare facility is assessed by the head of healthcare as being clean to NPSA (Standards for Better Health) standards.

Rationale

The NHS is working to spread best practice, including looking at a whole-systems approach to reducing healthcare-associated infections. It is also working with patients and the public to identify ways that should help to improve their confidence about the safety and effectiveness of the healthcare environment.

The elements identified within this indicator are derived from the Patient Environment Action Team (PEAT) programme checklist and mapped to Core Standards. PEAT was

established to assess NHS hospitals in 2000, and has been managed by the NPSA since 2006. The vision of the NPSA is to lead and contribute to improved, safe patient care by informing, supporting and influencing healthcare individuals and organisations.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- Distinct evidence of inclusion in PCT arrangements for environmental monitoring
- Systems in place for the prevention, segregation, handling, transport and disposal of waste to be properly managed to minimise risk to patients, staff and the public
- Evidence (through questioning of staff and patients) that the healthcare unit provides services in environments that are supportive of patient privacy and confidentiality
- Evidence that care is provided in clean environments, in accordance with the national specification for clean NHS premises and the relevant requirements of the Health Act 2008: Code of Practice for the Prevention and Control of Healthcare Associated Infections
- Steps have been taken to ensure that all prisoners with disabilities have full access to all healthcare facilities and programmes

- The head of prison healthcare has assessed the premises in the previous three months and considers their cleanliness to be up to the standards of the NPSA (mapped to Standards for Better Health).

Literature and references

- NPSA, The national specifications for cleanliness in the NHS: a framework for setting and measuring performance outcomes, April 2007 <http://www.npsa.nhs.uk/nrls/improvingpatientsafety/cleaning-and-nutrition/national-specifications-of-cleanliness/>
- DH, The Health Act 2008: Code of Practice for the Prevention and Control of Healthcare Associated Infections http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139336
- NPSA, Design for Patient Safety: A system-wide design-led approach to tackling patient safety in the NHS <http://www.npsa.nhs.uk/nrls/improvingpatientsafety/design/>
- The King's Fund, Enhancing the healing environment http://www.kingsfund.org.uk/current_projects/enhancing_the_healing_environment/ehe_in_prisons.html
- NPSA, Patient Environment Action Teams (PEAT) – Mapping PEAT to Core Standards <http://www.npsa.nhs.uk/nrls/improvingpatientsafety/cleaning-and-nutrition/peat/>

Amber Indicator

The prison healthcare facility is assessed by the head of healthcare as being clean to NPSA (Standards for Better Health) standards but **only three** of the following conditions are applicable:

- The prison healthcare centre and clinical areas are fully integrated with PCT environmental monitoring systems.
- There is evidence of regular infection control audits.
- The healthcare centre is not the default location for prisoners with physical disabilities.
- The rights of patients to privacy and confidentiality are respected in all consultations.

Red Indicator

Only three or less of the following conditions are applicable:

- The prison healthcare centre and clinical areas are fully integrated with PCT environmental monitoring systems.
- There is evidence of regular infection control audits.
- The healthcare centre is not the default location for prisoners with physical disabilities.
- The rights of patients to privacy and confidentiality are respected in all consultations.
- The prison healthcare facility is assessed by the head of healthcare as being clean to NPSA (Standards for Better Health) standards.

PART 1. Performance Indicators

AREA: SAFETY

1.3 Medicines Management

Green Indicator

Prison medicines management, including sections on the safe and secure handling of medicines and in-possession practice, forms a distinct element in the Prison Health Delivery Plan and infrastructure of the PCT.

Rationale

The indicator links the key recommendations in *A Pharmacy Service for Prisoners June 2003*.⁵ The remaining recommendations slot into place within one or more of these elements. The suggestions for evidence are based on the DH guidance plus evidence included in a recent regional assessment on performance against the DH recommendations.

Inclusion of prison medicines management in PCT operational plans forms the building block for an effective infrastructure for the commissioning, monitoring and delivery of medicines management services in prisons. Specifically mentioned in the DH document (recommendation 19), effective delivery of the PCT plan is likely to be via a **prison-focused Medicines Management Committee** which is linked to the Medicines Management Committees within the PCT.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- Completion and regular review of an overall risk assessment/audit for medicines management (prescribing and supply processes)
- A formal incident reporting mechanism from prisons into the PCT reporting systems that incorporates and encourages the reporting of medication-related incidents
- Formal process for considering the risks and incidents identified resulting in changes to minimise these risks
- Risks identified from the above should be included in the PCT Risk Register.
- In-Possession Policy ratified by the PCT and prison via Medicines Management Committee and Prison Health Partnership Board
- In-Possession Risk Assessment Tool in use by the prison (usually at reception or at a specified time post-reception). The tool should be reviewed regularly at specified intervals and any incidents relating to the use of the tool (e.g. security or clinical) should be included in the incident reporting processes in Medicines Handling and Risk (see first bullet point, above)
- The views of service users on the effectiveness of medicines management policies are sought and acted upon

⁵ *A Pharmacy Service for Prisoners (2003) Department of Health*

- Access to over-the-counter medicines via the items on the mandatory list developed by Prison Health in November 2005.⁶

Literature and references

The DH guidance forms the basis for the indicator. However, the principle of this guidance was to provide, as far as possible, the medicines management services to prisoners that are available in the community and the wider NHS. This not only includes the services available in community pharmacies, but also those in health centres, GP practices and hospitals where medicines are available.

Related policy documents that are relevant to improving medicines management services in their broadest sense include:

- Choosing health through pharmacy (DH 2005)
- A Vision for Pharmacy in the New NHS (DH 2003)
- Implementation of NICE Guidelines and Technology Appraisals in prisons
- Implementing the new Community Pharmacy Contractual Framework: Information for Primary Care Trusts (DH 2005 (draft))
- Quality and Outcomes Framework (DH (nGMS contract) updated January 2006): clinical and medication-related outcomes should apply to prisoners
- A Self Care Challenge: A Strategy for Pharmacists in England (Royal Pharmaceutical Society of Great Britain 2006)
- Clinical Management of Drug Dependence in the Adult Prison Setting (DH 2006)
- Medicine Matters: A guide to the mechanisms of the prescribing, supply and administration of medicines (DH 2006)
- Building a Safer NHS for Patients: Improving medication safety (DH 2004)
- Medicines Management: A resource to support implementation of the wider aspects of medicines management for the National Service Frameworks for Diabetes, Renal Services and Long-Term Conditions (DH 2004).

Amber Indicator

Prison medicines management, including sections on the safe and secure handling of medicines and in-possession practice **currently does not** form a distinct element in the Prison Health Delivery Plan and infrastructure of the PCT, but action is being taken to address this.

Red Indicator

Prison medicines management, including sections on the safe and secure handling of medicines and in-possession practice **currently does not** form a distinct element in the Prison Health Delivery Plan and infrastructure of the PCT, and **action is not being taken** to address this.

6 DH Prison Health PSI 45/2005: Addition of Self Care Items to Canteen Lists

PART 1. Performance Indicators

AREA: CLINICAL AND COST EFFECTIVENESS

1.4 Chronic Disease and Long-Term Conditions Care (Incorporating General Medical Services QOF)

Green Indicator

PCT-commissioned services in prison (including commissioned social care services) are working towards the delivery of chronic disease care being at the same standard of process and outcomes as is required by the National Service Frameworks for diabetes, coronary heart disease (CHD) and long-term conditions, mental health etc. A formal approach has been developed and is being implemented.

Rationale

Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services based on what assessed research evidence has shown provides effective clinical outcomes. NICE technology assessments and the National Service Frameworks provide a good practice base from which to deliver equivalence of service for all NHS users, including prisoners. This indicator seeks to assure commissioners of services that work is in progress to ensure that services delivered within prisons are at an equal standard to those delivered within the wider community.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- a formal action plan (document) outlining the activities, resources and timescales necessary to deliver chronic disease care to the standards required by the National Service Frameworks
- evidence of implementation of the plan (minutes of implementation meetings, evidence of task completion, evidence of plan review and reformulation)
- all QOF indicators for General Medical Services QOF are applicable, where infrastructure allows.

Literature and references

- National Service Frameworks on diabetes, CHD and long-term conditions
- NICE guidelines on chronic obstructive pulmonary disease, chronic heart failure, epilepsy, dyspepsia, hypertension, types 1 and 2 diabetes, multiple sclerosis, management of post-myocardial infarction in primary care, tuberculosis and Parkinson's disease
- Quality and Outcomes Framework Guidance
http://www.dh.gov.uk/en/Healthcare/PrimaryCare/Primarycarecontracting/QOF/DH_4125653
- Standards for better health D2 (DH 2006)

- National Service Framework for Children, Young People and Maternity Services (DH 2004)

Amber Indicator

PCT-commissioned services in prison (including commissioned social care services) are working towards the delivery of chronic disease care being at the same standard of process and outcomes as is required by the National Service Frameworks for diabetes, coronary heart disease and long-term conditions, mental health etc. A formal approach has been developed **but has yet to be** implemented.

Red Indicator

PCT-commissioned services in prison (including commissioned social care services) are working towards the delivery of chronic disease care being at the same standard of process and outcomes as is required by the National Service Frameworks for diabetes, coronary heart disease and long-term conditions, mental health etc. **No** formal approach has been developed.

PART 1. Performance Indicators

AREA: CLINICAL AND COST EFFECTIVENESS

1.5 Continuity of Case Management

Green Indicator

The prison/PCT partnership, working with social services (or children's services in the case of YOIs), is prioritising this aspect of care delivery and is working in a whole-systems way to identify and address all obstacles to full continuity of care as offenders move through the criminal justice system.

Rationale

Patients in prison often have many complex and varied health and social care needs requiring a co-ordinated approach to support from a number of disparate agencies. A large number of individual agencies may be involved with a patient at any one time both within prison and on release into the community. The regularity of patient movement across the prison estate and the necessary security restrictions placed upon certain individuals means that at times, continuity of treatment or assessment programmes may be disrupted. Such disruption can be mitigated by effective care planning and liaison. In particular, contact with the Office of Categorisation and Allocation (OCA)⁷ is important to ensure that a smooth transition between establishments takes place. This indicator aims to provide evidence that action is being taken to improve care continuity and reduce the impact of, often necessary, short notice movements.

It should be increasingly recognised that offender healthcare continuity, especially in relation to secondary care, is a paramount consideration when offender movements in the system are planned. The duty of clinical professionals in ensuring that key clinical information is appropriately transferred should also be increasingly emphasised.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- all patients have an up-to-date care plan and indicate a planned care approach
- all patients' records have a clear note of appointments
- within the care plan, reference is made directly to discharge planning/arrangements
- there is evidence that liaison between OCA and the healthcare centre takes place on a regular basis
- where available, primary care clinical IT systems are used effectively to support care continuity
- in YOIs, there is evidence that healthcare and other specialist health staff are regularly involved in sentence and discharge planning meetings.

⁷ This is the department that deals with security categorisation and transfers of prisoners between prisons and with any court or police issues.

Literature and references

- PSO 3050 – Continuity of Healthcare for Prisoners
- PSO 6200 – Transfers
- PSO 6400 – Discharges
- PSO 2710 – Follow Up to Death in Custody
- Promoting Continuity of Care for People with Severe Mental Illness Whose Needs Span Primary, Secondary and Social Care (Department of Health Research Findings Register (ReFeR))
- Maternity Matters: Choice, access and continuity of care in a safe service (DH 2007)
- Prisoners' access to PALS (Patient Advice and Liaison Services) and ICAS (Independent Complaints Advocacy Service) (DH 2005)
- PSI 14/2005 – Handling complaints about prison healthcare

For YOIs, in addition:

- PSO 4950 – Regimes for Juveniles
- National Service Framework for Children, Young People and Maternity Services (DH 2004)
- Youth Justice Board (YJB) National Standards (2004)

- When to share information: Best practice guidance for everyone working in the youth justice system (DH 2008)
- Youth Resettlement: A Framework for Action (YJB 2006)
- Lewis E and Heer B, Delivering Every Child Matters in Secure Settings. A practical toolkit for improving the health and well-being of young people (National Children's Bureau 2008)

Amber Indicator

There is **limited**⁸ evidence that the prison/PCT partnership, working with social services (or children's services in the case of YOIs), is prioritising this aspect of care delivery and is working in a whole-systems way to identify and address all obstacles to full continuity of care as offenders move through the criminal justice system.

Red Indicator

There is **no** evidence that the prison/PCT partnership, working with social services (or children's services in the case of YOIs), is prioritising this aspect of care delivery and is working in a whole-systems way to identify and address all obstacles to full continuity of care as offenders move through the criminal justice system.

⁸ 'Limited' indicates that although there is a stated intention to work using a whole-systems approach, plans are in an early stage of development or there is limited engagement with all key players involved in the planning and delivery of care.

PART 1. Performance Indicators

AREA: CLINICAL AND COST EFFECTIVENESS

1.6 Discharge Planning

Green Indicator

Post-discharge health and social care arrangements form a distinct part of a wider discharge and resettlement plan focusing upon the support needs of the offender, including healthcare input to dedicated plans such as final Assessment, Care in Custody and Teamwork (ACCT) case reviews (prior to discharge).

Rationale

A key element of reducing re-offending is the effective co-ordination and continuity of services on discharge from prison. The most effective discharge planning addresses the seven pathways to reduce re-offending. These are: accommodation, education, health, drugs, finance, children and families, and attitudes, thinking and behaviour. This indicator addresses the contribution that health and social care arrangements make in the wider plan.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- For the three months prior to the reference date, a sample of at least 30% of discharge plans (or transfer plans in cases where establishments do not discharge into the community) should be reviewed to evidence that they contain reference to health and social care arrangements.
- Where no specific arrangements are identified, a discharge plan from healthcare should be available.
- In YOIs, there is evidence that healthcare and other specialist health staff are regularly involved in discharge planning meetings.

Literature and references

- Reducing re-offending by ex-prisoners (Social Exclusion Unit Report 2002)
- PSO 2300 – Resettlement
- PSO 6400 – Discharge
- Managing Variation in Patient Discharge (NHS Institute for Innovation and Improvement) <http://www.nodelaysachiever.nhs.uk/CaseStudies/CaseStudyItems/CSJB08Managing+variation+in+patient+discharge.htm>
- End-to-end offender management (National Offender Management Service) <http://noms.homeoffice.gov.uk/managing-offenders/end-to-end/>
- Standards for Better Health, Fifth Domain, D11 (DH 2004)
- PSO 4950 – Regimes for Juveniles
- YJB National Standards (2004)

- Youth Resettlement: A framework for action (YJB 2006)
- National Service Framework for Children, Young People and Maternity Services (DH 2004)
- When to share information: Best practice guidance for everyone working in the youth justice system (DH 2008)
- Lewis E and Heer B, Delivering Every Child Matters in Secure Settings. A practical toolkit for improving the health and well-being of young people (NCB 2008)

Amber Indicator

Post-discharge health and social care arrangements **are included in separate** discharge and resettlement plans focusing upon the wider support needs of the offender, including healthcare input to dedicated plans such as final ACCT case reviews (prior to discharge).

Red Indicator

Post-discharge health and social care arrangements **are not included in any** discharge and resettlement plans focusing upon the wider support needs of the offender, including healthcare input to dedicated plans such as final ACCT case reviews (prior to discharge).

PART 1. Performance Indicators

AREA: CLINICAL AND COST EFFECTIVENESS

AREA: GOVERNANCE

1.7 Clinical Governance

Green Indicator

There are joint clinical governance arrangements in place (between the prison and the PCT), which facilitate continuous service improvement by the utilisation and analysis of key information sources such as: critical incidents, complaints, best practice and clinical audit, audit of death in custody and HM Inspectorate of Prisons (HMIP) action plans. There is evidence of communication of these improvements across the organisation.

Rationale

Clinical governance may be defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Clinical governance concerns both clinical and non-clinical staff, and acknowledges everyone's contribution to the patient's experience. For example, good integrated governance combines and creates consensus around the concerns of clinical staff, security staff, managers, patients and their families. The availability of information sources on which to base decisions is key to effective governance. It is assumed throughout this indicator that the PCT will have clinical governance arrangements. This indicator measures the availability of reference material to support the clinical governance process.

The Making Experiences Count consultation and the Early Adopter Programme indicated that learning from feedback from compliments, comments, concerns and complaints should be fed into clinical governance arrangements in order to support ongoing improvements in service delivery.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- A report is presented on a regular basis to the Prison Health Partnership Board in relation to complaints, comments, compliments and concerns (the 4Cs).
- The report identifies an action plan containing confirmed implementation and completion dates.
- The minutes of the PCT clinical governance meetings are shared with the Prison Health Partnership Board and the core integrated governance group.
- Death in custody reports, where the PCT commissions the service, go to the PCT board.
- Learning outcomes from Serious Untoward Incident reviews are shared with the Prison Health Partnership Board and the healthcare unit.

- In YOIs, evidence that learning outcomes from serious case reviews and reports into child deaths carried out by the local Safeguarding Children's Board are shared with the Prison Health Partnership Board and the healthcare unit.

Literature and references

- PSO 3100 – Clinical Governance
- PSO 7035 – Research Applications and Ethics Panel
- NHS Clinical Governance Support Team – <http://www.appraisalsupport.nhs.uk/>
- Clinical Governance Responsibilities and Lead Roles in Primary Care Trusts (NHS 2006)
- Integrated Governance Handbook (DH 2006)
- PSO 1301 – Investigating Deaths in Custody
- PSO 2710 – Follow-up to Deaths in Custody
- PSI 36/1998 – Investigating a death in custody
- S 113 Health and Social Care (Community Standards Act 2003)
- PSI 14/2005 – Handling complaints about prison healthcare
- Principles of Good Complaints Handling (Parliamentary and Health Service Ombudsman 2008)
- Making Experiences Count Outcomes Framework Document 2008 (DH 2008) <http://www.dh.gov.uk/mec>

- Making Experiences Count toolkit (DH 2008) <http://www.dh.gov.uk/mec>
- PSO 4950 – Regimes for Juveniles
- Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004 (HM Government 2005)
- Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (HM Government 2006)
- Children Act 2004, sections 11, 13 and 14

Amber Indicator

There are joint clinical governance arrangements in place (with the PCT), which facilitate continuous service improvement by analysis of key information sources such as: critical incidents, complaints, best practice and clinical audit, audit of death in custody and HMIP action plans. **However all key information sources are not readily available.** There is evidence of communication of these improvements across the organisation.

Red Indicator

There are joint clinical governance arrangements in place (with the PCT), which facilitate continuous service improvement by analysis of key information sources such as: critical incidents, complaints, best practice and clinical audit, audit of death in custody and HMIP action plans. **However all key information sources do not exist.** There is evidence of communication of these improvements across the organisation.

PART 1. Performance Indicators

AREA: GOVERNANCE

1.8 Corporate Governance

Green Indicator

Partnership arrangements are sufficiently robust to ensure joint decision-making, effective management of resources, effective information sharing, audit and service development. The arrangements ensure compliance with the joint aims and objectives of the parties.

Rationale

Good corporate governance for PCT/Prison Health Partnership Boards is defined as a robust process to ensure clarity of purpose, transparency in decision-making and clear lines of accountability.

Since April 2006 full devolution of commissioning responsibility for healthcare to those primary care trusts which host prisons has been in operation. These PCTs are expected to work closely with their prisons to discharge this commissioning responsibility in a way that meets both the health and custodial needs of prisoners. There is a responsibility for the PCT and the prison to have formal arrangements in place to ensure that service provision fulfills all the tenets of good governance. The national partnership arrangement states that "Prison/PCT partnerships will be expected to target investment and improvement on priorities identified in local Health Needs Assessments and local planning processes". Other providers of services may be included in this partnership, such as the local mental health service provider or, for YOIs, children's

services. This indicator measures the robustness of these partnerships.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified.

- There is a Prison Health Partnership Board in place, co-chaired by the Governing Governor and the chief executive of the PCT (or appropriate deputies), which meets on a regular basis.
- The Partnership Board has agreed and signed off a Prison Health Delivery Plan.
- The Partnership Board regularly monitors the range of NHS services available to the prisoners and ensures that they are appropriate to their needs. Such review is recorded in the minutes of the Partnership Board.
- The Partnership Board ensures that prisoners have access to statutory agencies investigating complaints, inspecting services, and providing advocacy services for prisoners. This is recorded in the Partnership Board minutes.
- The Partnership Board must demonstrate that they have considered and reacted appropriately to all legitimate complaints, concerns or recommendations made by statutory and voluntary agencies concerned with the health and welfare of prisoners, via annotations in the action plans.

- The Partnership Board is required to publish agendas and minutes of meetings and/or a report of the proceedings of the Board in a publicly accessible format, e.g. corporate website of the PCT or SHA.
- For YOIs, there is evidence that the Partnership Board is in communication with children's services planning partnerships.

Literature and references

- National partnership agreement on the transfer of responsibility for prison health from the Home Office to the Department of Health (DH 2003)
- National partnership agreement between the Department of Health and the Home Office for the accountability and commissioning of health services for prisoners in public sector prisons in England (DH 2007)

For YOIs:

- Promoting mental health for children held in secure settings: A framework for commissioning services (DH 2007)
- Statutory guidance on inter-agency co-operation to improve the wellbeing of children: children's trusts (HM Government 2005)
- The Local Government and Public Involvement in Health Act 2007
- Delivering health and well-being in partnership: The crucial role of the new local performance framework (Communities and Local Government and DH 2008)

- Joint planning and commissioning framework for children, young people and maternity services (DfES/DH 2006)

Amber Indicator

Partnership arrangements are sufficiently robust to ensure joint decision-making, effective management of resources, effective information sharing, audit and service development. **However** full engagement of all parties has not been achieved.

Red Indicator

Partnership arrangements are insufficient and do not adequately support joint decision-making, effective management of resources, effective information sharing, audit and service development.

PART 1. Performance Indicators

AREA: GOVERNANCE

1.9 Information Governance

Green Indicator

Healthcare units have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of it appropriately when no longer required, **and** has policies relating to effective information sharing, **and** systems are in place to ensure that appropriate consent is obtained from prisoners in relation to the use of their confidential information, **and** staff receive regular training in the appropriate management of patient information.

Rationale

The effective management of records and information is a fundamental component of safe, secure and effective healthcare delivery. In recent years, the majority of negative service audit reports and critical incident feedback relate to poor information governance. The transfer of responsibility to PCTs has provided the opportunity for healthcare units to address many of their information governance shortfalls. Human rights, data protection and mental capacity legislation set the foundations of how information governance is to be managed. For children and young people, information sharing is vital to safeguarding and promoting their welfare.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- a health records policy
- an information sharing policy (amended for local use)
- a patient information consent form
- a patient information consent policy
- an identified individual who is assigned responsibility for records management
- staff training records to indicate that they have undertaken training in the management of confidential information
- an audit of healthcare information management in the prison to demonstrate compliance with the relevant legislation
- staff in YOIs have access to guidance on information sharing relevant to children and young people.

Literature and references

- Confidentiality: NHS Code of Practice (DH 2003)
- Data Protection Act 1998
- Freedom of Information Act 2000
- Mental Capacity Act 2005

- PSI 25/2002 – The protection and use of confidential health information in prisons and inter-agency information sharing
- PSO 9010 – IT Security
- PSOs 9020 and 9020a – The Data Protection Act 1998 and the Freedom of Information Act 2000
- PSO 2520 and The Prison and Probation Ombudsman
- Standards for Better Health, C9, C13
- DH Information Governance Toolkit <https://www.igt.connectingforhealth.nhs.uk/>
- DH KnowledgeBase <https://www.igt.connectingforhealth.nhs.uk/KnowledgeBaseList.aspx?tk=2550471799&Inv=5&cb=16%3a16%3a16>
- Good practice in consent: achieving the NHS plan commitment to patient-centred consent practice (HSC 2001/023)
- Seeking Consent: Working with People in Prison (DH 2002) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008751
- PSI 38/2002 – Guidance on Consent to Medical Treatment
- Access to Health Records Act 1990 http://www.opsi.gov.uk/acts/acts1990/ukpga_19900023_en_1

For YOIs:

- PSO 4950 – Regimes for Juveniles, chapter 2 and Annex D

- When to share information: Best practice guidance for everyone working in the youth justice system (DH 2008)
- Information Sharing: Guidance for practitioners and managers (DCSF 2006)

Amber Indicator

Healthcare units have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of it appropriately when no longer required, **and** has policies relating to effective information sharing, but **there are no** systems in place to ensure that appropriate consent is obtained from prisoners in relation to the use of their confidential information, **and staff do not** receive regular training in the appropriate management of patient information.

Red Indicator

Healthcare units have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of it appropriately when no longer required, but **there are no** policies relating to effective information sharing, **and no** systems are in place to ensure that appropriate consent is obtained from prisoners in relation to the use of their confidential information, **and staff do not** receive regular training in the appropriate management of patient information.

PART 1. Performance Indicators

AREA: GOVERNANCE

1.10 Financial Governance

NB – This indicator does NOT contain an Amber Indicator.

Green Indicator

All of the following elements are evident:

- Finance plans are based on the prison health delivery plan and the prison healthcare budget and are accepted by the PCT Director of Finance and the Partnership Board.
- The spend against the budget profile is transparent and maintained within acceptable limits.
- Processes are in place within the prison and PCT to review expenditure against the plan, including for escorts and bedwatch support.

Rationale

Accountability for sound financial management and good financial governance lies ultimately with the PCT Chief Executive as Accountable Officer. All members of NHS boards, including Partnership Boards, share responsibility for delivering corporate objectives including the delivery of financial and performance targets.

The 2006 partnership survey indicated that the issue of financial risk sharing and financial governance is characterised as an important component of a wider agenda, which, to the extent that it involves both

PCTs and prisons, is influenced by the quality of communication and understanding between organisations. Such understanding is facilitated by the adoption of a jointly developed and agreed prison health delivery plan.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- a prison health delivery plan with clear priorities identified
- transparent arrangements to monitor finance
- transparent arrangements to monitor escorts and bedwatch spend
- evidence of commitment by the governor and the PCT to reinvest in healthcare where savings are achieved from the healthcare budget.

Literature and references

- National partnership agreement on the transfer of responsibility for prison health from the Home Office to the Department of Health (DH 2003) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4072327

- Escort and bedwatch costs: transfer of funding from HM Prison Service to primary care trusts (DH 2007) http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_072316
- Prison Health Partnership Survey 2006: Final report (DH 2007) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074560
- Delivering excellence in financial governance (DH 2003) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006437

Red Indicator

At least **one** of the following elements is **not** evident:

- Finance plans are based on the prison health delivery plan and the prison healthcare budget and is accepted by the PCT Director of Finance and the Partnership Board.
- The spend against the budget profile is transparent and maintained within acceptable limits.
- Processes are in place within the prison and PCT to review expenditure against the plan, including for escorts and bedwatch support.

PART 1. Performance Indicators

AREA: GOVERNANCE

1.11 Personal Development Plans

Green Indicator

Each staff member has an up-to-date personal development plan, which is reviewed on a regular basis, no less than every six months; this personal development plan contains specific reference to the training needs of the individual and the organisation.

Rationale

In order to continue to deliver high-quality care, staff should be equipped with the appropriate skill set and knowledge for the roles they fulfil. The organisation will obtain optimum benefit from the staff resource if knowledge and skills are tailored to the service purpose.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- The designated audit person should access all staff records and identify the following:
 - a personal development plan
 - a dated review (six months prior to the reference date)
 - reference to an individual's training needs
 - identification of links to organisational development plans.

Where staff are not directly employed by the organisation conducting the audit, prior arrangements should be made with their employing authority and audit responsibility delegated to them.

Literature and references

- Personal Learning Plans – The Doctors Working in Prisons guide (DH 2003)
- PSI 29/2003 – Clinical appraisal for doctors employed in prisons
- Clinical Supervision in Prison Nursing – getting started (DH 2002)
- The NHS Knowledge and Skills Framework (NHS KSF) (DH 2004)
- Skills for Health (DH 2007)
- PSI 09/2003 – Abolition of mandatory training
- Changing Workforce Programme (DH 2007)
- The HR in the NHS Plan: A Prison Health Workforce Perspective and Briefing (DH 2005)

For YOIs:

- PSO 4950 – Regimes for Juveniles
- YJB National Standards (2004) – Standard 10

- National Service Framework for Children, Young People and Maternity Services (DH 2004)
- Promoting Mental Health for Children Held in Secure Settings: A Framework for Commissioning Services (DH 2007)
- 2020 Children's Workforce Strategy (DCSF forthcoming)

The core and specific dimensions in the NHS Knowledge and Skills Framework are:

1. Communication
2. Personal and people development
3. Health, safety and security
4. Service improvement
5. Quality
6. Equality and diversity.

The following advice was developed by NHS staff at Staff Survey workshops, run by NHS Employers (<http://www.nhsemployers.org/>):

- Link the appraisal timetable to the organisation's annual planning cycle and make sure that the process is reviewed at board level.
- Consider mandatory training for both parties involved in the appraisal process, with regular refresher training – this should include guidance on what a 'well-constructed' appraisal looks like.
- Spot check appraisal documents and audit personal development plans to ensure that the agreed approach is being applied consistently.

- If your trust's score is low, consider carrying out 'discovery interviews' with staff to get more information on the problems which can then be considered as part of the appraisal process.
- Establish a directory of training opportunities mapped to the core dimensions of the Knowledge and Skills Framework, and ensure that it is accessible to all staff to help inform appraisal discussions.
- Limit the maximum number of staff that managers have to appraise – ideally a maximum of 12 staff members per manager, depending on the level.
- Ensure that the appraisal is a continuous process through regular one-to-ones with direct reports.

Amber Indicator

Each staff member has an up-to-date personal development plan which is reviewed on a regular basis, no less than every six months; this personal development plan **does not** contain specific reference to the training needs of the individual and the organisation.

Red Indicator

Each staff member **does not** have an up-to-date personal development plan.

PART 1. Performance Indicators

AREA: GOVERNANCE

1.12 Workforce

Green Indicator

A joint workforce plan is in place, which is coherent with the prison health delivery plan. This plan is based upon up-to-date demand assessment, review of recruitment and retention, current workforce reviews and includes optimising opportunities for joint training across organisational boundaries.

Rationale

As the staff groups delivering healthcare to prisoners come from a variety of organisations and professional backgrounds, a joint approach to planning and training various aspects of this resource is recommended. Recruitment and retention have often been problematic within prison health. Modernising the way in which staff work and the roles they undertake will help to achieve optimum workforce capability.

Suggested supporting evidence

A current, written joint workforce plan is available, or the workforce plan forms a distinct part of a wider multi-agency strategic document. Specific mention within the plan should be made of how the partners aim to maximise joint training opportunities.

To support this indicator, it is suggested that the following evidence be identified:

- a current workforce plan, or

- a distinct section within a wider multi-agency strategic document that relates to the prison health workforce, and
- a staff training schedule, demonstrating multi-agency joint training.

Literature and references

- Mental Health Services – Workforce Design and Development: Best Practice Guidance (DH 2003)
- Healthcare skills toolkit (DH 2003)
- Modernising workforce planning (DH 2003) <http://www.dh.gov.uk/en/Policyandguidance/Humanresourcesandtraining/Modernisingworkforceplanninghome/index.htm>
- A workforce response to local delivery plans: A challenge for NHS Boards (DH 2005)
- Changing Workforce Programme (DH 2007)
- Workforce Planning FAQ (DH 2007)
- Workforce Improvement Themes (NHS Modernisation Agency 2007)

Amber Indicator

A joint workforce plan is in place, which is coherent with the prison health delivery plan. This plan is based upon up-to-date demand assessment, review of recruitment and retention and current workforce reviews but **does not** include optimising opportunities for joint training across organisational boundaries.

Red Indicator

A joint workforce plan is **not** in place.

PART 1. Performance Indicators

AREA: ACCESSIBLE AND RESPONSIVE CARE

1.13 Equality and Human Rights

Green Indicator

The planning and delivery of healthcare within the prison meets the needs of the individual and the diverse prison population, with specific reference to the six strands of equality and diversity.

Rationale

There are six strands of diversity identified within DH policy – namely, age, gender, sexual orientation, disability, race and religion. In order to provide a service that is both equitable and sensitive to individuals' requirements, reference to the diversity of the population served by healthcare providers within prisons needs to be made. Not only do services need to be planned to take account of an individual's requirements and to safeguard human rights, but to provide a high standard of personalised care and service, staff need to have an understanding of the distinct needs, preferences and choices of the populations they serve.

'Personalising services means making services fit for everyone's needs, not just those of the people who make the loudest demands. When they need it, all patients want care that is personal to them. That includes those people traditionally less likely to seek help or who find themselves discriminated against in some way. The visions published in each NHS region make

clear that more support is needed for all people to help them stay healthy and particularly to improve the health of those most in need.'

High Quality Care for All – NHS Next Stage Review

This indicator supports the core standard for better health (C7) that managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the healthcare organisation. It focuses particularly on section E, i.e. that healthcare organisations challenge discrimination, promote equality and respect human rights.

Suggested supporting evidence

To support this indicator, it is suggested that the following evidence be identified:

- 24-hour access to interpreter services, with interpreters trained to DPSI⁹ standards
- evidence of a robust equality and diversity action plan which contains:
 - evidence of population needs assessment (six strands)

- evidence of a training strategy for healthcare staff
 - instructions on improving access to interpreter services
 - robust data collection
 - reference to Standards for Better Health C7E
 - robust equality impact assessment
 - evidence of consultation with prisoners
 - evidence of joint working between prison's DRO and the healthcare unit
 - evidence that the range of literature available to patients is accessible in formats appropriate to the population
 - evidence that the design of the facilities allows access to people with physical disabilities or there are plans in place to provide people with physical disabilities access to healthcare facilities appropriate to their needs
 - staff records contain reference to recent (within the last 18 months) diversity training.
- Literature and references*
- Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England (DH 2003)
 - PSO 4630 – Immigration and Foreign Nationals
 - PSO 2800 – Race Equality
 - Disability Discrimination Act 2005
 - Standards for Better Health, Fourth Domain, Patient Focus (DH 2006)
 - Race Relations Act 1976
 - Human Rights Act 1998
 - Sex Discrimination Act 1975
 - PSI 14/1999 – Prisoners with Disability, Management
 - Implementing race equality in prisons, a shared agenda for change (HMPS CRE 2003)
 - The NHS Plan (DH 2000)
 - Mental Health and Social Exclusion (ODPM 2004)
 - Breaking the Cycle: Taking stock of progress and priorities for the future (Cabinet Office Social Exclusion Unit 2004)
 - Disability Strategy (HMPS 2004) http://www.hmprisonservice.gov.uk/assets/documents/10000510Disability_Strategy_Document.doc
 - Health Care Standards Unit – Standard C7E – Equality and Diversity http://www.hcsu.org.uk/index.php?option=com_content&task=view&id=214&Itemid=109
 - Single Equality Bill – Proposals <http://www.communities.gov.uk/publications/communities/frameworkforfairnessconsultation>

- High Quality Care for All – NHS
Next Stage Review Final Report
[http://www.dh.gov.uk/en/
Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/
DH_085825](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825)

Amber Indicator

The planning and delivery of healthcare within the prison **does not fully meet** the needs of the diverse prison population but a comprehensive needs assessment has been undertaken and there are plans in place to address the identified issues.

Red Indicator

The planning and delivery of healthcare within the prison **does not fully meet** the needs of the diverse prison population **and there is no evidence** of a comprehensive needs assessment.

PART 1. Performance Indicators

AREA: ACCESSIBLE AND RESPONSIVE CARE

1.14 Service User Involvement

Green Indicator

The views of service users, their parents/ carers (including prison staff) and others are sought and taken into account in designing, planning, delivering and improving healthcare services. Formal procedures are in place to ensure involvement and such involvement is documented accordingly.

Rationale

Section 11 of the Health and Social Care Act 2001 places a duty on NHS trusts, PCTs and SHAs to make arrangements to involve and consult patients and the public in service planning and operation, and in the development of proposals for changes.

This is a statutory duty, which means consulting and involving service users:

- not just when a major change is proposed, but in ongoing service planning and delivery
- not just in the consideration of a proposal, but in the development of that proposal.

Patients feel involved in their care when they are treated as equal partners, listened to and properly informed. Privacy and time for discussion are both required to achieve this. Benefits include greater confidence, reduction in anxiety, greater understanding of personal needs, improved trust, better relationships with professionals and positive health effects.

Section 113 of the Health and Social Care (Community Health and Standards) Act 2003 provides for the Secretary of State for Health to make provision about the handling and consideration of complaints about the NHS through regulations. New regulations for handling health and social care complaints are scheduled to come into force in 2009 following the Making Experiences Count consultation and the Early Adopter Programme. These indicated that arrangements to receive feedback from compliments, comments, concerns and complaints should:

- provide easy access
- deliver a person-centred approach
- encourage service users to comment.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- formal forums where service users may provide feedback (i.e. patient forums, service user groups, questionnaires for parents etc.)
- formal patient feedback evaluation forms which are administered following a complaint
- evidence of a risk assessment and planning in relation to an individual's complaint and its resolution

- information about how to make a complaint, comment, compliment or express a concern about the services which is freely available throughout the establishment
- information that is accessible and available in a range of languages that reflect the population in the prison
- formal recording of advocacy service access in the complaint documentation
- recording of PALS/ICAS contact in the PCT's data system – i.e. DATIX, Safeguard or equivalent
- a published equality impact assessment.
- Section 113 of the Health and Social Care (Community Health and Standards) Act 2003
- NHS (Complaints) Amendment Regulations 2009 (in effect as of 1 April 2009)
- PSI 14 (2005) – Handling complaints about prison healthcare
- Principles of Good Complaints Handling (Parliamentary and Health Service Ombudsman 2008)
- Making Experiences Count Outcomes Framework Document 2008 (DH 2008) <http://www.dh.gov.uk/mec>

Literature and references

- PSO 2510 – Prisoner request and complaints procedures
- For YOIs, PSO 4950 – Regimes for Juveniles
- Access to PALS and ICAS for prisoners (DH 2005, letter Gateway 5557)
- Standards for Better Health, 5th Domain – C17 (DH 2004)
- Strengthening Accountability – Involving Patients and the Public: Policy Guidance Section 11 of the Health and Social Care Act 2001 (DH 2003)
- Building on the best: Choice, responsiveness and equity in the NHS (DH 2003)
- Getting over the wall – How the NHS is improving patient experience (DH 2004)
- Making Experiences Count Toolkit (DH 2008) <http://www.dh.gov.uk/mec>
- National Service Framework for Children, Young People and Maternity Services (DH 2004)

Amber Indicator

The views of service users, their parents/ carers (including prison staff) and others are sought and taken into account in designing, planning, delivering and improving healthcare services. **There are no** formal procedures in place to ensure involvement and such involvement is documented accordingly. Arrangements are in place to address this.

Red Indicator

The views of service users, their parents/ carers (including prison staff) and others are sought and taken into account in designing, planning, delivering and improving healthcare services. **There are no** formal procedures in place to ensure involvement, such involvement is documented accordingly, **and no** arrangements are in place to address this.

PART 1. Performance Indicators

AREA: ACCESSIBLE AND RESPONSIVE CARE

1.15 Health Needs Assessment

Green Indicator

A baseline health needs assessment has been completed using a structured assessment tool. There is evidence that the health needs assessment has been reviewed and amended within the last 12 months by the Director of Public Health of the local PCT (or appropriate deputy), as appropriate to the establishment. It **also** contains agreed annual health priorities, which are published in the local prison health delivery plan and signed off by the prison governor and the Chief Executive of the local PCT.

Rationale

Prisoners have complex health needs and a higher burden of disease than their peers in the community, e.g. HIV infection, blood-borne virus infection, respiratory tract infections, etc. Prisoners also experience higher levels of mental health problems and addiction to drugs and alcohol. Prisoners often have had poor access to structured primary care services in the community prior to incarceration. Imprisonment represents an opportunity to understand health needs and meet those needs appropriately, both in prison and beyond.

The aims of a health needs assessment are to gather information to plan, negotiate, change services for the better, to improve health in other ways, and to build a picture of current services, i.e. a baseline (University of Birmingham 2000).

This indicator aims to ensure that health needs assessments are kept up to date and, with the rapidly changing prison population, are as relevant and contemporary as possible. The indicator also stresses the collaborative role all partners have in ensuring that the assessment takes into account the wide range of services.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- structured health needs assessment (for example using the University of Birmingham toolkit)¹⁰
- health priorities identified and published in the local prison health delivery plan
- annual refresh of the health needs assessment by the Director of Public Health of the local PCT (or appropriate deputy).

Literature and references

- Guidance – Healthcare in Prisons: a healthcare needs assessment (University of Birmingham 2000)
- Guidance on developing prison health needs assessments and health improvement plans <http://www.bham.ac.uk/hsmc>

¹⁰ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008653

- Toolkit for health care needs assessments in prisons (University of Birmingham 2000)
- Standards for Better Health (DH 2004)
- The Local Government and Public Involvement in Health Act 2007
- Delivering health and well-being in partnership: The crucial role of the new local performance framework (Communities and Local Government and DH 2008)

Amber Indicator

A baseline health needs assessment has been completed using a structured assessment tool. There is evidence that the health needs assessment has been reviewed and amended within the last 12 months by the Director of Public Health of the local PCT (or appropriate deputy), as appropriate to the establishment. It **does not** contain agreed annual health priorities, which are published in the local prison health delivery plan and signed off by the prison governor and the chief executive of the local PCT.

Red Indicator

A baseline health needs assessment has been completed using a structured assessment tool. There is **no** evidence that the health needs assessment has been reviewed and amended within the last 12 months by the Director of Public Health of the local PCT (or appropriate deputy), as appropriate to the establishment.

PART 1. Performance Indicators

AREA: ACCESSIBLE AND RESPONSIVE CARE

1.16 Comprehensive Range of Services Collected Quarterly

Green Indicator

The complete range and capacity of healthcare services, which have been identified as necessary within the health needs assessment and through service user involvement, are provided to the prisoner population.

Rationale

The aims of health needs assessment are to gather information to plan, negotiate and change services for the better. This indicator requires evidence that once needs are identified then services are provided to address those needs. This indicator also illustrates that a degree of planning has gone into the provision or facilitation of access to the services.

Suggested supporting evidence

A comprehensive health needs assessment exists which identifies required access to services to meet needs of the population. Service availability is then measured against this requirement. The service may not be provided by the healthcare unit, but the healthcare unit or prison will ensure that the patient accesses that service.

To support this indicator it is suggested that the following evidence be identified:

- Health priorities identified from the health needs assessment
 - Action plan to meet identified health needs drafted and approved by Partnership Board
 - Assessment of progress against published project plan to meet needs identified in action plan
 - Health priorities identified in the health needs assessment and in the action plan are used to inform service specification for any new commissioning arrangements in the prison.
- Literature and references*
- PSO 3550 – Clinical Services for Substance Misusers http://pso.hmprisonservice.gov.uk/PSO_3550_clinical_services.doc
 - NICE guidance on pre-operative tests, dental recall, skin disorders and wounds and head injuries (available at <http://www.nice.org.uk/guidance>)
 - Developing and Modernising Primary Care in Prisons (DH 2002) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006632
- Structured health needs assessment completed (for example using the University of Birmingham toolkit)

- Strategy for Modernising Dental Services for Prisoners in England (DH 2008)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005989
- A Pharmacy Service for Prisoners (DH and HM Prison Service 2003)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007054
- Changing the outlook: a strategy for developing and modernising mental health services in prisons (DH 2001)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4009699
- Guidance on developing local prison health delivery plans (DH 2003)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4069784

For YOIs:

- National Service Framework for Children, Young People and Maternity Services (DH 2004)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4089114
- Promoting Mental Health for Children Held in Secure Settings: A Framework for Commissioning Services (DH 2007)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_073414

Amber Indicator

A **limited** range and capacity of healthcare services, which have been identified as necessary within the health needs assessment and through service user involvement, are provided to the prisoner population.

Red Indicator

The range and quantity of services provided by the establishment **are determined locally** with **no direct reference** to the health needs assessment.

PART 1. Performance Indicators

AREA: ACCESSIBLE AND RESPONSIVE CARE

1.17 Access and Waiting Times

Green Indicator

Access and waiting times for outpatient first appointments following written referrals of prisoners are the same as those experienced by the general population and are subject to the targets specified within the NHS, namely, 18 weeks for general outpatients appointments, and two weeks for urgent cancer appointments.

Rationale

Standards for Better Health core standard 18 states: 'Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.' Prisoners are members of the population and as such are entitled to the same level of service access as the general population. Difficulties arise due to the significant amount of movement around the estate that many prisoners are subject to. Such movement should not be allowed to have a detrimental effect upon their access to services and subsequent waiting times.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- Evidence that waiting times for first appointment are within the 18-week and two-week targets.
 - Waiting times should be cross-referenced against the published waiting times.
 - Where waiting times fall outside the 18-week and two-week targets, evidence of a written plan to address this breach should be in place.
- Literature and references*
- Standards for Better Health (DH 2004)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086665
 - Waiting times for cancer: progress, lessons learned and next steps (DH 2006)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139451
 - Achieving the two-week standard: Questions and answers – How to help you with issues arising from the two-week wait standard (DH 2002)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010373
 - England Summary: Outpatient first appointment data
<http://www.performance.doh.gov.uk/waitingtimes/index.htm>

Amber Indicator

Where access and waiting times for outpatient first appointments following written referrals of prisoners fall outside the targets specified within the NHS, namely, 18 weeks for general outpatients appointments and two weeks for urgent cancer appointments, a plan is in place with the local PCT to address this shortfall.

Red Indicator

Where access and waiting times for outpatient first appointments following written referrals of prisoners fall outside the targets specified within the NHS, namely, 18 weeks for general outpatients appointments and two weeks for urgent cancer appointments, no specific plan is in place with the local PCT to address this shortfall.

PART 1. Performance Indicators

AREA: ACCESSIBLE AND RESPONSIVE CARE

1.18 Prison Dentistry

Green Indicator

Access standards for dental care reflect general access guidance in all of the following areas:

1. Emergency care
2. Urgent care
3. Appointments.

Rationale

Individuals in prison, either on remand awaiting trial or in receipt of a custodial sentence, have been shown to have poorer health, including oral health, than the general population. Many prisoners enter prison with extensive and long-standing oral neglect. Substance misuse and smoking also pose a particular challenge to dental health. Methadone contributes to higher than average levels of tooth decay and gum disease and smoking is a risk factor in mouth cancer. Prisoners with substance misuse problems are likely to report toothache very soon after entering prison, as the pain is no longer inhibited by the analgesic properties of the drugs they had previously been taking.

The Strategy for Modernising Dental Services for Prisoners in England (DH 2003) identifies three key access standards:

- **Emergency care**, for example severe facial trauma and severe bleeding, may require access to an A&E department in line with local healthcare provision and subject to local prison security policies.
- **Urgent care** for dental pain and minor trauma will require access to a dentist within 24 hours. Where this cannot be achieved, an appropriate practitioner will see the patient within 24 hours to make an assessment as to the appropriate course of action.
- **Appointments** for routine care will not normally exceed six weeks from the time of asking.

This indicator examines if these standards are in place.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified.

- Individual patient records in cases where emergency care was required indicating that access to an A&E department was achieved.
- Individual patient records identifying the date and time of referral to the dentist or the appropriate practitioner that indicate less than 24 hours have elapsed from referral in cases of dental pain or minor trauma.

- Individual patient records identifying the date of referral to the dentist and date of first appointment. The period between the two dates should not exceed six weeks.
- A formal action plan identifying how the prison will move towards the standards set out in the dental strategy.

Literature and references

- Reforming prison dental services in England – A guide to good practice (OPM 2005)
http://www.opm.co.uk/resources/papers/health/prison_dental_reportWEB.pdf
- Strategy for modernising dental services for prisoners in England (DH 2003)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005989
- Evaluation for the Impact of the National Strategy for Improving Prison Dental Services in England (PHRN 2006)
<http://www.ohu.ac.uk/downloads/01%20Final%20Prisons%20report.pdf>

Amber Indicator

Access standards for dental care **do not** reflect general access guidance in all areas, but there **is** an action plan in place to achieve the access standard.

Red Indicator

Access standards for dental care **do not** reflect general access guidance in all areas, and there **is no** action plan in place to achieve the access standard.

PART 1. Performance Indicators

AREA: ACCESSIBLE AND RESPONSIVE CARE

1.19a Substance Misuse Activities – IDTS Establishments

Green Indicator

Service assessed as green by National Treatment Agency for Substance Misuse quarterly review (4th Quarter, January–March 2009).

Rationale

The National Treatment Agency for Substance Misuse, in alliance with the NHS Strategic Health Authority, carries out a quarterly regional IDTS performance assurance appraisal that incorporates indicators of quality across the following domains:

Local commissioning structure
Treatment effectiveness, integration and governance
Harm reduction
Workforce development
Transfer to CJITs on release
User involvement
Carer involvement

Suggested supporting evidence

Completed report from National Treatment Agency on IDTS drug treatment plan progress – Quarter 4 2008/09.

Literature and references

- Clinical management of drug dependence in the adult prison setting (DH 2006)
- Drug misuse and dependence: UK guidelines on clinical management (DH 2007)
- Integrated Drug Treatment System The First 28 Days: Psychosocial Support (National Offender Management Service 2008)
- Guidance on the management of dual diagnosis in prisons (DH, at press)
- IDTS Frequently asked questions (NTA 2007) http://www.nta.nhs.uk/areas/criminal_justice/idts_faqs.aspx
- Models of care for treatment of adult drug misusers (NTA 2006)
- Types of treatment (NTA 2007) http://www.nta.nhs.uk/about_treatment/Types_of_treatment.aspx
- PSO 3601 – Mandatory Drug Testing
- PSO 3605 – MDT Samples
- PSO 3620 – Voluntary Drug Testing
- PSO 3550 – Clinical Services for Substance Misusers
- PSO 3625 – Testing of External Drug Workers
- Report to National Treatment Agency on IDTS drug treatment plan progress – 2008/09 (NTA 2008)

- PSO 3630 – Counselling, Assessment, Referral, Advice and Throughcare Services (CARATs)
- PSI/2005 – Drug Treatment and Self Harm

Amber Indicator

Service assessed as amber by National Treatment Agency for Substance Misuse quarterly review (4th Quarter, January–March 2009).

Red Indicator

Service assessed as red by National Treatment Agency for Substance Misuse quarterly review (4th Quarter, January–March 2009).

PART 1. Performance Indicators

AREA: ACCESSIBLE AND RESPONSIVE CARE

1.19b Substance Misuse Activities – Non-IDTS Establishments

Green Indicator

The establishment provides the following:

- access to detoxification, maintenance and naltrexone prescribing in prison
- integrated working with CARAT teams
- collaborative working with mental healthcare.

Rationale

There is firm evidence that opioid maintenance programmes can prevent blood-borne virus transmission, re-offending and drug-related deaths. An integrated approach to drug dependence is widely recognised as the most effective intervention method. A number of research studies have indicated that the use of alcohol and illegal drugs by young people is linked to mental health problems.

Suggested supporting evidence

- Evidence of co-working between CARATs and healthcare teams (including minuted meetings, joint training events).
- Evidence of clinical substance misuse or CARATs participation in mental healthcare planning/care programme approach plans.
- Evidence of prisoners accessing formalised self-help groups (such as Narcotics Anonymous).

- Evidence of user involvement in service development.
- For YOIs, there is evidence that a range of substance misuse services are being delivered in accordance with the YJB National Specification for Substance Misuse Services and YJB guidance on effective practice.

Literature and references

- Clinical management of drug dependence in the adult prison setting (DH 2006)
- Drug misuse and dependence: UK guidelines on clinical management (DH 2007)
- Integrated Drug Treatment System – The First 28 Days: Psychosocial Support (National Offender Management Service 2008)
- Guidance on the management of dual diagnosis in prisons (DH, at press)
- PSO 3601 – Mandatory Drug Testing
- PSO 3605 – MDT Samples
- PSO 3620 – Voluntary Drug Testing
- PSO 3550 – Clinical Services for Substance Misusers
- PSO 3625 – Testing of External Drug Workers

- PSO 3630 – CARATs
- PSI/2005 – Drug Treatment and Self Harm

For YOIs:

- PSO 4950 – Regimes for Juveniles, chapter 3
- National Specification for Substance Misuse for Juveniles in Custody (YJB 2004)
- KEEP (Key Elements of Effective Practice): Substance Misuse (YJB 2008)
- An Assessment of the Substance Misuse Project (Galahad SMS Ltd 2007)
- Youth Alcohol Action Plan (DCSF 2008)
- Drugs: protecting families and communities. The 2008 drug strategy (HM Government 2008)

Amber Indicator

The establishment provides only the following:

- access to detoxification and maintenance prescribing in prison

plus one of the following two:

- integrated working with CARAT teams
- collaborative working with the mental health secondary care service.

Red Indicator

No access to detoxification or maintenance prescribing.

PART 1. Performance Indicators

AREA: ACCESSIBLE AND RESPONSIVE CARE

1.20 Alcohol Screening, Intervention and Support

Green Indicator

All prisoners are screened for problem drinking using a recognised screening tool **and** a full range of interventions is available, including:

brief advice; structured treatment; access to the social and life skills and/or personal development modules on alcohol awareness; and access to peer support for people with drink problems.

Rationale

Harmful, hazardous and dependent drinking are all relatively common problems among people entering prison. There is good evidence that brief advice can help individuals to reduce harmful or hazardous levels of drinking. People who are physically dependent on alcohol can require more intensive forms of treatment. Alcohol problems are ameliorated by the combined effect of a breadth of psychological and social interventions. It is important therefore that health providers work in alliance with wider interventions programmes and reintegration services in prisons and beyond. People with severe drinking problems have been found to have benefited from involvement in self-help groups.

Suggested supporting evidence

In order to validate the response to this indicator, you should be able to identify:

- an up-to-date list of staff members who had participated in training for assessing and treating individuals engaged in problem drinking
- evidence of the use of a formal screening tool such as AUDIT
- evidence that at least 80% of prisoners scoring 8 or more on an AUDIT screen receive brief advice
- evidence of prisoners accessing formalised self-help groups (such as Alcoholics Anonymous)
- evidence of participation of patients in structured specific alcohol treatment programmes
- evidence of collaborative working between healthcare and other prison departments including education and training, and offender management to deliver comprehensive services to individuals with drink problems
- for YOIs, there is evidence that a range of substance misuse services are being delivered in accordance with the YJB National Specification for Substance Misuse Services and YJB guidance on effective practice.

Literature and references

Alcohol Misuse Interventions: Guidance on developing a local programme of improvement (DH 2005)

Alcohol Treatment and Interventions Good Practice Guide (HMPS and DH 2004)

AUDIT (Alcohol Use Disorders Identification Test) <http://www.library.nhs.uk/mentalHealth/ViewResource.aspx?resID=279989>

Models of care for alcohol misusers (MoCAM) (NTA 2006) http://www.nta.nhs.uk/publications/documents/nta_modelsofcare_alcohol_2006_mocam.pdf

HM Government (2008) National Indicators for Local Authorities and Local Authority Partnerships: Handbook of Definitions (NI 20, NI 38, NI 39, NI 40, NI 41, NI 42)

Safe. Sensible. Social. The next steps in the National Alcohol Strategy (HM Government 2008) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_075218

For YOIs:

- PSO 4950 – Regimes for Juveniles, chapter 3
- National Specification for Substance Misuse for Juveniles in Custody (YJB 2004)
- KEEP (Key Elements of Effective Practice): Substance Misuse (YJB 2008)
- An Assessment of the Substance Misuse Project (Galahad SMS Ltd 2007)

- Youth Alcohol Action Plan (DCSF 2008)
- Drugs: protecting families and communities. The 2008 drug strategy (HM Government 2008)

Amber Indicator

Prisoners are screened for problem drinking using a recognised screening tool **and** they receive brief advice and support where necessary, delivered by appropriately trained individuals. A limited range of interventions is available.

Red Indicator

Apart from the standard reception screening, prisoners are not routinely screened for problem drinking using a recognised screening tool.

PART 1. Performance Indicators

AREA: ACCESSIBLE AND RESPONSIVE CARE

1.21 General Health Assessment

Green Indicator

Following First Reception all prisoners are offered a general health assessment, and this has either 100% take-up or has recorded in 100% cases the reason for the prisoner not accepting the health screen.

Rationale

Studies indicate that on entering the prison system, prisoners have complex health needs and their health status is generally poorer than a comparable non-prisoner population. A large proportion (up to 50%) of prisoners are either not registered with a general practitioner or do not have active records with a GP. The general health assessment screen offers an ideal opportunity to assess these individuals and provide treatment for previously untreated conditions. The screen also supports the placement of the individual within the establishment and provides information to allow effective planning and targeting of future services. It is recognised that individuals may refuse to have a health screen, but it must be recorded that they have been offered and refused it, including the reason for refusal. This will allow the prison to develop strategies for improving the take-up of the general health assessment.

Suggested supporting evidence

Percentage of prisoners who take up the offer of general health assessment as a proportion of total receptions.

Numerator

Number of first receptions into prison in the three months prior to the reference date.

Denominator

Number of prisoners receiving general health assessment in the three months prior to the reference date or recorded as having refused assessment.

Data Source: LIDS/NOMiS Clinical Recording

Literature and references

- PSO 2700 – Suicide Prevention and Self Harm Management
- Reception screening and mental health needs assessment in a male remand prison (Gavin et al 2003)
- ACCT (Assessment, Care in Custody and Teamwork) Plan 2007
- Healthcare Screening – Zahid Mubarek Inquiry <http://www.zahidmubarekinquiry.org.uk/articlefb55.html?c=516&aid=3740>

For YOIs:

- PSO 4950 – Regimes for Juveniles
- YJB National Standards (10.12, 10.13, 10.49)

- National Service Framework for Children, Young People and Maternity Services (DH 2004)
- When to share information: Best practice guidance for everyone working in the youth justice system (DH 2008)
- Lewis E and Heer B, Delivering Every Child Matters in Secure Settings. A practical toolkit for improving the health and well-being of young people (NCB 2008)

Amber Indicator

Following First Reception all prisoners are offered a general health assessment, and this has a take-up rate of between 90% and 99.9% or has recorded in 90–99.9% cases the reason for the prisoner not accepting the health screen.

Red Indicator

Following First Reception all prisoners are offered a general health assessment, and this has a take-up rate of less than 89.9%.

PART 1. Performance Indicators

AREA: ACCESSIBLE AND RESPONSIVE CARE

1.22 Secondary Health Screen – Prison Transfers

Green Indicator

All prisoners being transferred between establishments have a health transfer screen completed on the day of reception.

Rationale

To aid continuity of care and reduce the number of health transfer errors (medication access, follow-up appointments, medical record transfer), it is important that all prisoners transferred between establishments have a health transfer screen. The extent and complexity of this screen are driven by clinical need.

Suggested supporting evidence

Number of health transfer screens, taking place on the day of reception as a percentage of all transfers into the establishment.

Numerator

Number of health transfer screens for a three-month period prior to the reference day, by individual day, delivered on the same day of reception.

Denominator

Number of transfers received, by individual day, for the three-month period prior to the reference date.

Data Source: LIDS/NOMiS Clinical Recording

Literature and references

- PSI 8/2004 – Transfer and Allocation of Life Sentenced Prisoners
- PSI 26/2006 – Instructions for the Transfer and Allocation of Life Sentence Prisoners
- SO1H – Transfer of Prisoners
- PSO 2700 – Suicide Prevention and Self Harm Management
- Healthcare Screening – Zahid Mubarek Inquiry
<http://www.zahidmubarekinquiry.org.uk/articlefb55.html?c=516&aid=3740>

For YOIs:

- PSO 4950 – Regimes for Juveniles
- YJB National Standards 2004 (10.12, 10.13, 10.49)
- National Service Framework for Children, Young People and Maternity Services (DH 2004)
- When to share information: Best practice guidance for everyone working in the youth justice system (DH 2008)
- Lewis E and Heer B, Delivering Every Child Matters in Secure Settings. A practical toolkit for improving the health and well-being of young people (NCB 2008)

Amber Indicator

90% of prisoners being transferred between establishments have a health transfer screen completed on the day of reception.

Red Indicator

Less than 90% of prisoners being transferred between establishments have a health transfer screen completed on the day of reception.

PART 1. Performance Indicators

AREA: ACCESSIBLE AND RESPONSIVE CARE

1.23a Services for Children and Young People (YOI Only)

NB – This indicator has three sections relating to access to a comprehensive child and adolescent mental health services (CAMHS), safeguarding, and transition to adult settings.

Rationale

Comprehensive CAMHS

The Government is committed to the development of a fully comprehensive CAMHS in all areas as part of PSA 12 (improving health and well-being). The mental health needs of young people in secure settings are known to be considerable, severe and complex. These young people manifest the full range of mental health problems and disorders, with rates of psychosis, self harm and suicide well above those for other children and young people. It is therefore very important that young people in YOIs should have access to a comprehensive CAMHS, which explicitly covers mental health promotion, prevention, early intervention treatment and management of problems that have been identified as a result of expert assessment.

Safeguarding

Guidance and legislation have now established that health services, health staff and all staff working within YOIs have a duty to safeguard and promote the welfare of children. Within a secure setting safeguarding covers issues such as suicide, self harm, bullying, harm from staff and visitors, and promoting emotional well-being.

Safeguarding needs to be embedded within all aspects of the regime.

Transition

There is a marked distinction between the regimes of the young person's and adult estates. Transfer between the estates due to a prisoner's increase in age is often a difficult transition, and can lead to both emotional distress for prisoners and organisational complexity for the services. Where a patient is receiving treatment from external health and social care sources, there will also be an additional transfer to adult services. A smooth emotional and organisational transition to the adult estate enables the prisoner to settle quickly, reduces stress and subsequent disruption, and ensures continuity of care.

Suggested supporting evidence

Comprehensive CAMHS

- Specialist CAMH staff are providing a regular service to the YOI.
- A range of interventions and therapies is available.
- A sufficient number of specialist CAMHS staff with an appropriate range of skills can be called upon to work in the YOI as required, including highly specialist expertise, such as neuropsychiatry.

- Local CAMHS commissioners and specialist CAMHS staff are familiar with the Framework for Commissioning (DH 2007), and services to the local YOI are specified and performance managed accordingly.
- Commissioning of CAMHS within the YOI is informed by an up-to-date and comprehensive needs assessment.
- Specialist CAMHS staff provide consultation, training and supervision to caseworkers, personal officers and officers on the wings.
- CAMHS staff have systems in place for information sharing with CAMHS in the home areas of individual young people.

Safeguarding

- A written safeguarding policy exists which is compliant with government guidance and PSO 4950.
- There is a Safeguarding Children Committee which meets regularly.
- Membership of the Safeguarding Children Committee is multi-disciplinary and includes healthcare representatives.
- The Safeguarding Children Committee has clear reporting lines into senior management decision-making forums and other multi-agency meetings concerning vulnerable children and young people in the establishment.
- Safeguarding in the establishment clearly covers suicide and self harm, bullying and violence between young people, and harm from staff and visitors.
- Safeguarding includes the development of activities to promote well-being.
- Evidence that the policy and procedures are being followed, for example: minutes of the Safeguarding Children Committee meetings.

Transition

A written policy relating to the transfer of prisoners should be available. There should be evidence of a transfer plan, indicating the range of agencies that should be contacted to ensure continuity. There should be evidence of contact with the receiving prison. There should be reference within the patient record of both discussions with the patient prior to transfer and contact with outside agencies currently providing support services. Evidence of case conferences prior to transfer would indicate collaboration with other agencies. There should also be evidence of contact with families and carers.

Literature and references

- National Service Framework for Children, Young People and Maternity Services – standards 1–5 and 9 (DH 2004)
- Promoting mental health for children held in secure settings: A framework for commissioning services (DH 2007)
- PSO 4950 – Regimes for Juveniles
- When to share information: Best practice guidance for everyone working in the youth justice system (DH 2008)
- Children Act 2004, sections 10, 11, 13 and 14
- YJB National Standards (10, 11 and 12)

- KEEP (Key Elements of Effective Practice): Mental Health (YJB 2008)
- Youth Resettlement: A framework for action (YJB 2006)
- Resettlement and Aftercare Provision (RAP) Management Guidance (YJB 2005)
- Lewis E and Heer B, Delivering Every Child Matters in Secure Settings. A practical toolkit for improving the health and well-being of young people (NCB 2008)
- Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004 (HM Government 2007)
- Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (HM Government 2006)
- Safeguarding children: The third joint chief inspectors' report on arrangements to safeguard children (2008)
<http://www.safeguardingchildren.org.uk>
- Smallridge P and Williamson A, Independent Review of Restraint in Juvenile Secure Settings (2008)
- A Review of Safeguarding in the Secure Estate (YJB 2008)
- Transition: getting it right for young people. Improving the transition of young people with long term conditions from children's to adult health services (DH 2006)

Green Indicator

(i) Access to a comprehensive CAMHS

The PCT/YOI Partnership, together with the local Children's Trust/Strategic Partnership board, is working to ensure, as a priority, that children and young people in the YOI have access to a comprehensive CAMHS.

(ii) Safeguarding

The YOI's safeguarding committee meets regularly with good attendance by representatives from healthcare and specialist mental health staff.

(iii) Transition to adult settings

There are clear arrangements in place and support available to facilitate young people aged 18 making the transition from the young person's secure estate to adult settings. These arrangements should include protocols for transferring from child and adolescent health and social care services to adult services.

Amber Indicator

(i) Access to a comprehensive CAMHS

There is limited evidence that the PCT/YOI Partnership, together with the local Children's Trust/Strategic Partnership board, is working to ensure, as a priority, that children and young people in the YOI have access to a comprehensive CAMHS.

(ii) Safeguarding

The YOI's safeguarding committee meets regularly but there is inconsistent attendance by healthcare and specialist mental health staff.

(iii) Transition to adult settings

There is evidence of arrangements and protocols being developed to support transition.

Red Indicator

(i) Access to a comprehensive CAMHS

There is no evidence that the PCT/ YOI Partnership, together with the local Children's Trust/Strategic Partnership board, is working to ensure, as a priority, that children and young people in the YOI have access to a comprehensive CAMHS.

(ii) Safeguarding

The YOI's safeguarding committee meets irregularly and there is infrequent attendance by healthcare and specialist mental health staff.

(iii) Transition to adult settings

There are no clear arrangements or support to facilitate young people through transition to the adult estate or adult services.

PART 1. Performance Indicators

AREA: ACCESSIBLE AND RESPONSIVE CARE

1.23b Services for Older Adults (Not YOI Estate)

Green Indicator

Within the prison **all** the following are evident:

- health specific older persons assessment
- joint partnership working, focusing on the needs of older adults, between the healthcare department and the Disability Liaison Officer (DLO)
- a health promotion action group that actively considers the requirements of older adults
- appropriate aids and/or adjustments are in place to allow older people to access the full range of regime activities.

Rationale

The NHS and the Prison Service are working in partnership to ensure that prisoners have access to the same range and level of health services as the general public. At any time 700 people in prison are aged over 60. They have a wide range of health and social care needs, both while in prison and on release. Over 1,000 people aged over 60 leave prison every year.

A pathway to care for older offenders: A toolkit for good practice has been informed by two important documents: the National Service Framework for Older People published by the Department of Health in 2001, and the HM Inspectorate of Prisons thematic review *'No problems – old and*

quiet': *Older prisoners in England and Wales*, published in December 2004.

It is well established that health, social and welfare needs increase with age, wherever people may be living, so the need to institute a formal and routine assessment process for older offenders must be established in order to provide appropriate and decent care both within the prison system and following release back into the community.

The pathway is set out in steps that follow the assessment process from referral and appropriate care in the prison setting, following choices within regimes and activities, through to timely preparation for release and support into the community.

The key to successfully implementing the pathway to care for older offenders is strong partnership working between all sections of the criminal justice system including health, social care and welfare providers.

This indicator identifies the key elements of the pathway and sets the base for prisons considering adopting in the future.

Suggested supporting evidence

- There is evidence that a specific age sensitive assessment tool is being used. This will be both on first admission and on a person reaching the age of 55 while in custody.

- Examples of joint needs assessments and the preparation and delivery of care packages.
- Evidence that specific older person sensitive programmes/regimes are in place.
- Evidence that physical aids are available and that there have been adaptations to the environment of the prison to meet the needs of the older prisoner.

- A pathway to care for older offenders: A toolkit for good practice (DH 2007) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079928
- 'No problems – old and quiet': Older prisoners in England and Wales <http://inspectorates.homeoffice.gov.uk/hmiprison/thematic-reports1/hmp-thematic-older-04.pdf>

Literature and references

- National Service Framework for Older People (DH 2001) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066
- Dignity in Care (DH 2006) <http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Socialcare/Dignityincare/index.htm>
- Securing better mental health for older adults (DH 2005) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4114989
- Managing Older Prisoners at HMP Wymott (HMPS Prison Service Journal) <http://www.hmprisonservice.gov.uk/resourcecentre/prisonservicejournal/index.asp?id=3836,3124,11,3148,0,0>
- PSI 21/2001 – National Service Framework for Older People

Amber Indicator

Within the prison only two or three of the following are evident:

- health specific older persons assessment
- joint partnership working, focusing on the needs of older adults, between the healthcare department and the DLO
- a health promotion action group that actively considers the requirements of older adults
- appropriate aids and/or adjustments are in place to allow older people to access the full range of regime activities.

Red Indicator

Within the prison, apart from the identified role of the DLO, there is no evidence of specific older persons assessments, ready access to aids or adjustments to the environment that consider the needs of older adults.

PART 1. Performance Indicators

AREA: ACCESSIBLE AND RESPONSIVE CARE

1.23c Services for Adult Women

Green Indicator

Planning and delivery of services to the women's prison population makes reference to the requirements of adult women and young female offenders (aged 18–21), with direct reference to the Gender Equality Duty (2007), the PSI Gender Equality Impact Assessment for Prisoners (2008), PSO 4800 Women Prisoners, and the National Service Framework for Women Offenders.

Rationale

The NHS and the Prison Service (NOMS) are working in partnership to ensure that women prisoners have access to the same range and level of health services as the general public. At any time there are around 4,500 women in prison. Of these, 66% are mothers with dependent children under 18. Over 17,700 children a year are separated from their mothers by imprisonment, while just 5% of women prisoners' children remain in their own home once their mother has been sentenced. These women have very specific health and social care needs, both while in prison and across the whole of the CJS system, that need addressing not only for themselves but for their families as well.

It is important that there is strong communication between prison healthcare staff and their colleagues in NHS and social care organisations in the community. This will ensure continuity of care when the women are released into the community from prison

and will aid appropriate access to their continuing health and social care needs.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- a comprehensive health needs assessment
- evidence that the needs assessment contains specific reference to the Gender Equality Duty
- links in healthcare establishment plans to the Women Offenders NSF and the toolkit for working with women offenders
- evidence that patients' care plans focus on issues of dependents and support networks.

Literature and references

- National Service Framework for Women Offenders <http://noms.justice.gov.uk/news-publications-events/publications/strategy/NSF-Women-08>
- Offender Management Guide to Working with Women Offenders <http://noms.justice.gov.uk/news-publications-events/publications/guidance/OM-Guide-Women>
- Government Response to the Corston Report <http://www.justice.gov.uk/publications/gov-resp-corston-review.htm>

- Health of Women in Prison Study (University of Oxford 2006) <http://www.publichealth.ox.ac.uk/units/prison/2007-02-13.6702780065/view>)
- Gender Equality Duty <http://www.equalities.gov.uk>
- PSI 2008/040 – Gender Quality Impact Assessment (Prisoners)
- HMPS Standard 22: Health Services for Prisoners
- Women at Risk (CSIP 2006) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4126680
- Mainstreaming Gender and Women's Mental Health (DH 2003) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4072067
- Positive Practice: Positive Outcomes: A Handbook for Professionals in the Criminal Justice System working with Offenders with Learning Disabilities (CSIP 2007) <http://kc.csip.org.uk/viewresource.php?action=viewdocument&doc=98519&grp=1>

Amber Indicator

Planning and delivery of services to the women's prison population makes reference to the specific requirements of adult women and young female offenders, but this is done in a less informal manner with no direct reference to the Gender Equality Duty (2007), the PSI Gender Equality Impact Assessment for Prisoners (2008), PSO 4800 Women Prisoners and the National Service Framework for Women Offenders.

Red Indicator

Planning and delivery of services to the women prison population **does not** make reference to the specific requirements of adult women and young female offenders.

PART 1. Performance Indicators

AREA: MENTAL HEALTH

1.24 Section 117

Green Indicator

All prisoners returning to prison from any other mental health facility following treatment under the Mental Health Act (including sections 3, 37, 47 and 48) are accompanied by a section 117 aftercare programme.

Rationale

Section 117 gives the statutory authorities a duty to make arrangements for a person's continuing support and care. It applies to people who have been detained under sections 3, 37, 47 or 48. Aftercare should be planned with the patient, their family and carers, as well as professionals, looking at both health and social care needs. Section 117 ensures continuity of care. The type of aftercare required will depend on the health and circumstances of the individual. Section 117 gives considerable discretion to health and local authorities as to the nature of the services that can be provided. As people move through the prison estate their mental health record may be lost from area to area; it is therefore imperative that the healthcare unit sources previous mental health history.

Suggested supporting evidence

Numerator

Number of patients in the three months prior to the reference date returning to prison following treatment under the Mental Health

Act with an active section 117 aftercare programme.

Denominator

Number of patients in the three months prior to the reference date returning to prison following treatment under the Mental Health Act.

Literature and references

- Mental Health Act 1998 (2007)
- Aftercare under section 117 of the Mental Health Act (Mind information) <http://www.mind.org.uk/Information/Legal/s117.htm#def>
- Mental Health Act 1983 Code of Practice (HMSO 1999) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4074961.pdf
- PSI 03/2006 – Transfer of prisoners to and from hospital under sections 47 and 48 of the Mental Health Act 1983
- Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons (DH 2001) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009699

- Offender Mental Health Care Pathway (DH 2005) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4102231
- National Service Framework for Children, Young People and Maternity Services (DH 2004)

Amber Indicator

75% of all prisoners returning to prison from any other mental health facility following treatment under the Mental Health Act (including sections 3, 37, 47 and 48) are accompanied by a section 117 aftercare programme.

Red Indicator

Less than 75% of all prisoners returning to prison from any other mental health facility following treatment under the Mental Health Act (including sections 3, 37, 47 and 48) are accompanied by a section 117 aftercare programme.

PART 1. Performance Indicators

AREA: MENTAL HEALTH

1.25 Care Programme Approach Audit

Green Indicator

A formal care programme approach (CPA) audit has been undertaken within the last 12 months that is based on robust information and multi-agency involvement. An action plan has been developed that assigns responsibility to individuals and organisations and there is evidence of plan evaluation and outcomes, or an evaluation has been planned.

Rationale

'Whole systems approaches should support CPA. Services and organisations should work together to: adopt integrated care pathway approaches to service delivery; improve information sharing; establish local protocols for joint working between different planning systems and provider agencies. The role of commissioners is key in ensuring a range of services to meet service users' needs and choices...

The quality of assessment and care planning should be focused on improving outcomes for service users and their families across their life domains. Attention to local audit; performance management; national regulation; and issues of equalities is needed to ensure equitable outcomes for all...

Local audit and monitoring will continue to be essential components of measuring the quality of service provision and CPA.'

Refocusing the care programme approach: Policy and positive practice guidance (DH 2008)

Continuity of care is essential when the care setting changes, and is often identified as having been lacking when untoward incidents have occurred. The care co-ordinator has a key role in keeping the 'story' together across the care pathway, and the care plan should be the key reference document irrespective of where care is being delivered, added to and amended by the care co-ordinator as dictated by the care needs in each setting.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- formal CPA audit
- evidence of multi-agency involvement and sign-off
- a robust system for collecting CPA information
- clear links between CPA audit and reporting to the Partnership Board
- an evaluated action plan or a plan with a planned evaluation date falling within 12 months.

Literature and references

- Refocusing the Care Programme Approach: Policy and Positive Practice Guidance (DH 2008)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647
- Effective care co-ordination in mental health services: Modernising the care programme approach – A policy booklet (DH 1999)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009221
- National Service Framework for Mental Health (DH 1999)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4009598
- Reviewing the Care Programme Approach 2006: A consultation document (DH 2006) http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_063354
- Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons (DH 2001)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009699
- Offender Mental Health Care Pathway (DH 2005)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4102231
- An audit pack for monitoring the Care Programme Approach (DH 1998)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008226
- National Service Framework for Children, Young People and Maternity Services (DH 2004)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4089114

Amber Indicator

A formal CPA audit has been undertaken within the last 12 months that is based on robust information and multi-agency involvement. An action plan has been developed that assigns responsibility to individuals and organisations but there is **no** evidence of an evaluation being undertaken or planned.

Red Indicator

No formal CPA audit has taken place within the last 12 months.

PART 1. Performance Indicators

AREA: MENTAL HEALTH

1.26 Suicide Prevention

Green Indicator

All of the following apply:

- There is evidence of collaborative working between the Safer Custody lead and the healthcare lead.
- There is explicit reference to the prevention of suicide (strategy) and the effective management of self harm within the prison health delivery plan.
- There is evidence of managed information sharing between the prison and healthcare unit to reduce the risk of suicide.

Rationale

Almost 600 people die in custody each year. Many of these deaths are due to natural causes but a great many others are as a result of apparent suicide attempts and other non-natural causes.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- A clear record that where a prisoner reporting for/being treated for injuries that could be the result of violence or self-harm, the basic details are forwarded to Safer Custody for follow-up.
- A clear record that where there is an abuse/misuse of IP medication, Safer Custody are informed.

- Where an ACCT or local anti-bullying document is opened, Healthcare are alerted to watch for any suspicious/self-harm injuries.
- There is a system in place to alert wings/ Safer Custody that a change has taken place whenever there is a significant change in medication/prescription, particularly for those with open or previously opened ACCT forms.
- There is a weekly violence reduction meeting attended by healthcare.
- Evidence to indicate that when Safer Custody are alerted to a person being on an ACCT after arriving from another prison they alert healthcare.
- Evidence that healthcare alert Safer Custody if they suspect bullying.
- A system whereby any unexplained injury is referred to Safer Custody.
- Healthcare attend the Safer Custody meetings.
- Healthcare attend the public protection meetings.
- Healthcare have an identified lead nurse to liaise with Safer Custody.
- Evidence of joint initiatives between healthcare and Safer Custody in relation to suicide prevention.

- A protocol exists for the sharing of information between the prison and the PCT.
- Evidence that healthcare staff ensure that any offender who is located on the segregation unit is given a proper assessment to ensure that the segregation unit is the most suitable location to manage the offender.
- Evidence that the healthcare staff and the mental health in reach team attend all ACCT reviews.
- Evidence that those members of staff who work on the segregation unit have undertaken a mental health awareness course.
- Evidence that healthcare staff attend safeguarding committee meetings in YOIs.
- Evidence that staff in YOIs have access to guidance on information sharing relevant to children and young people.
- PSO 2700 – Suicide prevention and self harm management
- NICE guidance on depression and self-harm (NICE 2004/050)
- Forum for Preventing Deaths in Custody <http://www.preventingcustodydeaths.org.uk/>
- Guidance on the safer detention & handling of persons in police custody (Home Office 2006) http://police.homeoffice.gov.uk/publications/operational-policing/Safer_Detention_and_Handlin1.pdf

In YOIs:

Literature and references

- NICE clinical guideline on self harm, GC16 (NICE 2004) (para 1.6.2)
- National Suicide Prevention Strategy for England (DH 2002) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009474
- National Service Framework for Mental Health (DH 1999) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598
- PSO 4950 – Regimes for Juveniles
- National Service Framework for Children, Young People and Maternity Services (DH 2004) (specifically Standard 5)
- When to share information: Best practice guidance for everyone working in the youth justice system (DH 2008) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_084703
- Statutory Guidance on Making Arrangements to Safeguard and Promote the Welfare of Children under section 11 of the Children Act 2004 (DfES 2005) <http://www.everychildmatters.gov.uk/resources-and-practice/IG00042/>
- Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (HM Government 2006) <http://www.everychildmatters.gov.uk/resources-and-practice/IG00060/>

- Children Act 2004, sections 11, 13 and 14
- YJB National Standards (2004) – Standard 10 (10.8, 10.13, 10.20, 10.21, 10.27, 10.49, 10.52)
- Safeguarding children: The third joint chief inspectors' report on arrangements to safeguard children (Ofsted 2008) <http://www.safeguardingchildren.org.uk>

Amber Indicator

Two of the following apply:

- There is evidence of collaborative working between the Safer Custody lead and the healthcare lead.
- There is explicit reference to the prevention of suicide (strategy) and the effective management of self harm within the prison health delivery plan.
- There is evidence of managed information sharing between the prison and healthcare unit to reduce the risk of suicide.

Red Indicator

Only one of the following applies:

- There is evidence of collaborative working between the Safer Custody lead and the healthcare lead.
- There is explicit reference to the prevention of suicide (strategy) and the effective management of self harm within the prison health delivery plan.
- There is evidence of managed information sharing between the prison and healthcare unit to reduce the risk of suicide.

PART 1. Performance Indicators

AREA: MENTAL HEALTH

1.27 Access to Specialist Mental Health Services

Green Indicator

The prison has access, on a needs-led basis, to all of the following specialist mental health services: Dual Diagnosis, Personality Disorder Services (adult prisons only), Women's Mental Health Service (female estate only), Child and Adolescent Mental Health Services (YOI estate only), Early Intervention in Psychosis, Crisis Resolution Home Treatment, Learning Disability Services and Brief/ Structured Psychotherapeutic Interventions.

Rationale

Surveys have shown that as many as 90% of prisoners have a diagnosable mental illness, substance misuse problem or, often, both. Among young offenders and juveniles that figure is even higher, 95%. It has also been shown that mental illness can contribute to reoffending and problems of social exclusion. Every prison working with its local PCT should look critically at the mental health needs of its inmates, and consider how far existing provision meets those needs. This indicator identifies a range of specialist mental health services which, if they all were accessible to the patient (depending upon need), would contribute significantly to a person's recovery.

Suggested supporting evidence

The healthcare unit should be able to identify clear access and referral pathways for each of the indicated services appropriate to the client group they support.

Literature and references

- National Service Framework for Mental Health (DH 1999)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4009598
- PSO 2400 – Democratic Therapeutic Communities
http://pso.hmprisonservice.gov.uk/PSO_2400_democratic_therapeutic_communities.doc
- NICE guidance on Bipolar disorders, Eating disorders, OCD, PTSD and Schizophrenia
<http://www.nice.org.uk>
- Personality disorder: No longer a diagnosis of exclusion – Policy implementation guidance for the development of services for people with personality disorder (DH 2003)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4009546
- Mental Health Policy Implementation Guide (DH 2001)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4009350

- Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons (DH 2001)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4009699
- Organising and Delivering Psychological Therapies (DH 2004)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4086100
- Treatment Choice in Psychological Therapies and Counselling: Evidence Based Clinical Practice Guideline (DH 2001)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4007323
- Women's Mental Health Strategy (DH 2004)
http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/DH_4002408
- Children Act 2004, sections 10 and 11
- YJB National Standards (2004) – Standard 10, 11 and 12
- KEEP (Key Elements of Effective Practice): Mental Health (YJB 2008)
- Youth Resettlement: A Framework for Action (YJB 2006)
- Resettlement and Aftercare Provision (RAP) Management Guidance (YJB 2005)
- Lewis E and Heer B, Delivering Every Child Matters in Secure Settings. A practical toolkit for improving the health and well-being of young people (NCB 2008)

Amber Indicator

The prison has access, on a needs-led basis, to **at least three** of the following specialist mental health services: Dual Diagnosis, Personality Disorder Services (adult prisons only), Women's Mental Health Service (female estate only), CAMHS (YOI estate only), Early Intervention in Psychosis, Crisis Resolution Home Treatment, Learning Disability Services and Brief/Structured Psychotherapeutic Interventions.

Red Indicator

The prison has access, on a needs-led basis, to **fewer than three** of the following specialist mental health services: Dual Diagnosis, Personality Disorder Services (adult prisons only), Women's Mental Health Service (female estate only), CAMHS (YOI estate only), Early Intervention in Psychosis, Crisis Resolution Home Treatment, Learning Disability Services and Brief/Structured Psychotherapeutic Interventions.

For YOIs:

- National Service Framework for Children, Young People and Maternity Services (DH 2004)
- Promoting Mental Health for Children Held in Secure Settings: A Framework for Commissioning Services (DH 2007)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073414
- PSO 4950 – Regimes for Juveniles

PART 1. Performance Indicators

AREA: MENTAL HEALTH

1.28 Primary Care Mental Health

Green Indicator

A primary mental health service triages referrals to secondary mental health services and offers a full range of primary mental health psychotherapeutic interventions to all suitable service users in partnership with GP and primary healthcare, including access to CAMHS and services for older adults, where applicable.

Rationale

The assessment and delivery of appropriate and effective mental healthcare is a complex undertaking. There is ample evidence that individuals in custody are one of the most acute and challenging client groups for mental health practitioners. The ability of a service to direct clients to primary mental health practitioners provides significant opportunity for enhanced recovery and positive outcomes. The concept of equivalence of access to healthcare is measured here, with a particular emphasis on access to mental healthcare. This indicator also stresses the central role the GP plays in this access and provision and recognises the support necessary for primary care practitioners to provide a comprehensive service.

Additionally, the concept of 'stepped care' should be considered here when reviewing suitable interventions. Stepped care is defined by Bower and Gilbody (2005) as a model of healthcare delivery with two fundamental features. First, the

recommended treatment within a stepped care model should be the least restrictive of those currently available, but still likely to provide significant health gain. Second, the stepped care model is self-correcting.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- evidence of joint planning of service provision between primary healthcare services and secondary mental health services
- formal commissioning documents demonstrating a sustainable service
- evidence of adoption of the offender mental health care pathway
- a comprehensive needs assessment
- a formalised triage process from primary to secondary care.

Literature and references

- Fast-Forwarding Primary Care Mental Health (DH 2007) http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Mentalhealth/DH_4001917

- A National Service Framework for Mental Health (DH 1999) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598
 - Health Promoting Prisons: A Shared Approach: PSI 24/2002 (DH 2002) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006230
 - NICE guidance – mental health and behavioural conditions <http://guidance.nice.org.uk/topic/behavioural>
 - Mental Health Primary Care in Prison (WHO) <http://www.prisonmentalhealth.org/>
 - Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons (DH 2001) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009699
 - Offender Mental Health Care Pathway (DH 2005) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4102231
 - Effective Practice INSET Tutor Pack: Mental Health (B151) (YJB) <http://www.yjb.gov.uk/Publications/Scripts/prodList.asp?idCategory=15&menu=item&eP=>
 - Mental Health Needs and Provision (Full Report) (D69) (YJB) <http://www.yjb.gov.uk/Publications/Scripts/prodView.asp?idproduct=256&eP=>
 - Bower P and Gilbody S, Stepped care in psychological therapies: access, effectiveness and efficiency. British Journal of Psychiatry (2005) 186: 11–17 <http://bjp.rcpsych.org/cgi/content/full/186/1/11>
- For YOIs:
- National Service Framework for Children, Young People and Maternity Services (DH 2004)
 - Promoting Mental Health for Children Held in Secure Settings: A Framework for Commissioning Services (DH 2007) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073414
 - PSO 4950 – Regimes for Juveniles
 - Children Act 2004, sections 10 and 11
 - YJB National Standards – Standards 10, 11 and 12 (YJB 2004)
 - KEEP (Key Elements of Effective Practice): Mental Health (YJB 2008)
 - Youth Resettlement: A Framework for Action (YJB)
 - Resettlement and Aftercare Provision (RAP) Management Guidance (YJB)
 - Lewis E and Heer B, Delivering Every Child Matters in Secure Settings: A practical toolkit for improving the health and well-being of young people (NCB)

Amber Indicator

A primary mental health service triages referrals to secondary mental health services but **cannot provide** a full range of primary mental health psychotherapeutic interventions to all suitable service users in partnership with GP and primary healthcare, including access to CAMHS and services for older adults, where applicable.

Red Indicator

Primary mental healthcare is provided **only** by a GP.

PART 1. Performance Indicators

AREA: PUBLIC HEALTH

1.29 Vaccination/Immunisation Policy

Green Indicator

As a matter of policy and practice, all prisoners are offered vaccinations appropriate to their age and need, which has been identified as part of the health needs assessment or its refresh. Specific generic issues that need to be addressed include: MMR, meningitis C, hepatitis B (see specific indicator), BCG, pneumococcal vaccination, and seasonal influenza vaccine. Female establishments should also address the need for HPV vaccine.

Rationale

Prisoners are a diverse population and differ by age, sex, ethnicity, country of origin and their experiences of health and disease. Primary prevention is an important public health principle and immunisation against infectious diseases is a cornerstone of good preventive practice. Because prisoners differ, their needs for vaccinations differ. It is clear from the evidence, such as it is, that many British-born prisoners miss out on routine childhood immunisations and other required vaccines. Foreign-born prisoners may not have been exposed to common childhood diseases in the UK and/or may not have been vaccinated in childhood due to being raised in resource-poor countries. Periods of imprisonment may therefore serve as a health-promoting opportunity and should be used to identify the healthcare needs of vulnerable prisoners, including their need for vaccinations. Any prison immunisation policy should be evidence-based and rooted

in the most recent health needs assessment conducted in the prison in partnership with the commissioning PCT to identify individuals at risk of infections and their need for vaccination. Risk assessment of individual prisoners to determine their vaccine needs should also be undertaken by competent nurse practitioners and/or doctors. The current UK guidelines on immunisation against infectious diseases (*The Green Book*) are available in print or to download (see reference below) and should be the primary source of information on all issues in relation to vaccinations. The Health Protection Agency has also produced guidelines on vaccination requirements of prisoners; these are available at <http://www.hpa.org.uk> under the Prison Infection Prevention Team page. Advice on vaccination for HIV-infected individuals is available from the British HIV Association (see reference below).

Suggested supporting evidence

To support this indicator, it is suggested that the following evidence be identified:

- a completed health needs assessment that describes the vaccine requirements of the population of the prison
- a written vaccination policy that reflects the needs identified in the health needs assessment

- clinical audit of practice against standards stated in the vaccination policy, including assessment of the vaccine requirements and prison-based vaccine exposure of a random sample of prisoners, which is not less than 20% of the total average annual throughput of the prison.

Amber Indicator

A health needs assessment has been conducted or refreshed within the current year and identifies the vaccine requirements of the prison population. A policy is under development to ensure that all prisoners are offered vaccinations appropriate to their age and need. Specific generic issues that need to be addressed include: MMR, meningitis C, hepatitis B (see specific indicator), BCG, pneumococcal vaccination, and seasonal influenza vaccine. Female establishments should also address the need for HPV vaccine.

Red Indicator

A health needs assessment has **not** been conducted or refreshed within the current year **or**, if it has been, it does **not** address the vaccine requirements of the prison population and/**or no** policy exists or is under development to ensure that all prisoners are offered vaccinations appropriate to their age and need.

Literature and references

- Immunisation against infectious disease: The Green Book (DH 2006) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079917
- Afza M et al, Schedule for vaccination of prisoners and young offenders in South Staffordshire (HPA 2008) http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1209023458513
- Gill J, Aston R, Vyse A J, White J M, Greenwood A, Susceptibility of young offenders to measles and rubella: an antibody prevalence study using oral fluid samples. *Commun Dis Public Health* (2002) 5(4): 314–7
- Glaser J B, DeCorato D R, Greifinger R, Measles antibody status of HIV-infected prison inmates. *J Acquir Immune Defic Syndr* (1991) 4: 540–1
- Rubella outbreaks in prisons – New York City, West Virginia, California. *MMWR* (1985) 34: 615–8
- Immunisation guidelines for HIV-infected adults (British HIV Association 2006) <http://www.bhiva.org>
- Use of combined hepatitis A and B vaccines in injecting drug users and prisoners (HPA) http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1221722411163
- Offender Health Guidance on Chickenpox & Shingles Infection Control in Prisons, Places of Detention & Immigration Removal Centres (HPA 2008) http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1204186195209
- Infection Inside: The Prison Infectious Disease Quarterly (HPA) <http://www.hpa.org.uk/web/hpaweb&Page&HPAwebAutoListName/Page/1203582653471>

- Reports and publications – Prison Infection Prevention Team (HPA)
<http://www.hpa.org.uk/webw/hpaweb&page&hpawebautolistname/page/1191942126463?p=1191942126463>
- <http://www.immunisation.nhs.uk>
- Pneumococcal Vaccination (HPA 2007)
http://www.hpa.org.uk/infections/topics_az/pneumococcal/vaccine/vaccine.htm
- Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006)
<http://www.nice.org.uk/CG033>
- Control and prevention of tuberculosis in the United Kingdom: Code of Practice 2000. Joint Tuberculosis Committee of the British Thoracic Society (Thorax 2000) 55 (11): 887–901 <http://thorax.bmj.com/cgi/reprint/55/11/887>
- Shooting Up – Infections among injecting drug users in the United Kingdom 2007 – An update: October 2008 (HPA 2008) http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/195733837406?p=1191942172215

PART 1. Performance Indicators

AREA: PUBLIC HEALTH

1.30 Hepatitis B Vaccination of Prisoners

Green Indicator

The prison is reported by the HPA's Prison Infection Prevention Team's national surveillance programme to be achieving hepatitis B vaccine uptake of 80% or more by all new eligible and consenting prisoners received into the establishment in the three months prior to the reference date.

Background and rationale

Hepatitis B (HBV) is an infection caused by a blood-borne virus (BBV), i.e. transmitted by exposure to infected blood or body fluids from needle sharing among injecting drug users (IDUs) or needle-stick injury, through vaginal or anal intercourse, or from mother to baby. Many individuals who are infected will clear the virus from their bodies without any further consequences but for some the infection persists with the risk of damage to the liver. The risk of developing chronic hepatitis B infection depends on the age at which infection is acquired. Chronic infection occurs in 90% of those infected perinatally but is less frequent in those infected as children (20–50% in children between one and five years of age). About 5% or less of previously healthy people, infected as adults, become chronically infected (Hyams, 1995).

The risk is increased in those whose immunity is impaired. Around 20–25% of individuals with chronic HBV infection develop progressive liver disease, leading to cirrhosis and an increased risk of developing hepatocellular carcinoma (liver cancer).

These individuals also remain infectious and therefore may be a source of onward transmission of HBV.

In England and Wales, acute hepatitis B cases are reported to the HPA. There was a substantial deterioration in the quality of hepatitis B reporting in 2004 and data for 2004 to 2006 are unavailable. However, in 2003 injecting drug use was the main risk associated with hepatitis B infection, accounting for 34% of individuals with a known risk factor in England, and 27% in Wales. In 2006, 21% (677 of 3,240) of the current and former IDUs who took part in the Unlinked Anonymous Prevalence Monitoring Programme survey in England, Wales and Northern Ireland had antibodies to the hepatitis B core antigen (anti-HBc, a marker of previous or current hepatitis B infection); this was similar to the level seen since 1995. Laboratory reports of acute HBV infection have increased among IDUs while decreasing in other populations (HPA, 2006).

There is a significant overlap between the prison population and the population of IDUs in the community:

- There are around 40,000 problematic drug users in prison at any one time, which is about half of the standing prison population.
- Approximately 55% of new prisoners test positive for Class A drugs on admission (rising to 80% in some instances).

- Most IDUs are incarcerated at least three times during their lifetime, while over 40% have been in prison at least five times.

Therefore, prison is both a setting in which there may be a significant number of people infected with hepatitis B and where large numbers of people at risk of infection can be offered vaccination using a safe and effective vaccine.

Furthermore, by vaccinating high-risk individuals in prisons, there will be a health gain to the wider community by preventing cases of acute hepatitis B among IDUs. Since the Scottish Prison Service introduced its HBV vaccination programme to all inmates in 1999, there have been no outbreaks of acute HBV infection among IDUs in Scotland.

The HPA's Unlinked Anonymous Prevalence Monitoring Programme has consistently reported prisons as the single most important source of hepatitis B vaccine for IDUs, significantly outperforming all other sources such as GPs, drug treatment units, needle-exchange clinics etc. Modelling work performed by Offender Health and the HPA has predicted that high coverage of the hepatitis B programme in prisons in England and Wales will lead to a significant reduction in risk of outbreaks of acute hepatitis B among IDUs in the community, similar to that seen in Scotland earlier.

We are therefore working towards achieving as high an uptake as possible among consenting eligible prisoners passing through prisons in England and Wales.

Advice on completion of the quarterly surveillance forms is available from the Prison Infection Prevention Team, Health Protection Agency, Centre for Infections, 61 Colindale

Avenue, London NW9 5EQ or at <http://www.hpa.org.uk>

Suggested supporting evidence

- The prison has a written immunisation policy which states that all new prisoners are advised about hepatitis B infection, assessed for need for vaccine (either no good evidence of previous infection or completed vaccination course elsewhere) and then offered vaccine on a day 0, 7, 21 regimen beginning at, or close to, the time of reception.
- The prison participates in the HPA's Prison Infection Prevention Team's national surveillance programme by completing the surveillance forms as requested and reporting their activity.
- The prison is reported by the HPA to be achieving 'Green' for the previous quarter in the quarterly surveillance reports published on the Prison Infection Prevention Team's webpage at <http://www.hpa.org.uk>

Literature and references

- Immunisation against infectious diseases: The Green Book (DH 2006) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079917
- Hutchinson S J, Wadd S, Taylor A, et al, 2004. Sudden rise in uptake of hepatitis B vaccination among injecting drug users associated with a universal vaccine programme in prisons. *Vaccine* 23:2 210–214

- Unlinked Anonymous Prevalence Monitoring Programme (HPA) http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1201767906472
- Sutton A J, Gay N J, Edmunds W J, et al 2006. Modelling the hepatitis B vaccination programme in prisons. *Epidemiology and Infection* 134, 231–242.
- Hepatitis B – general information (HPA 2007) http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1195733758963?p=1191942171120
- Infection Inside: The Prison Infectious Disease Quarterly: <http://www.hpa.org.uk/web/hpaweb&Page&HPAwebAutoListNamePage/1203582653471>
- Reports and Publications – Prison Infection Prevention Team: <http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1191942126463?p=1191942126463>
- Shooting Up – Infections among injecting drug users in the United Kingdom 2007 – An update: October 2008 (HPA 2008) http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_c/1224833091685
- Prison infection control guidelines (Essex HPU 2007) <http://www.hpa.org.uk/essex/publications/PrisonJan07.pdf>

Amber Indicator

The prison is reported by the HPA's Prison Infection Prevention Team's national surveillance programme to be achieving hepatitis B vaccine uptake of between 50% and 80% by all new eligible and consenting prisoners received into the establishment in the three months prior to the reference date.

Red Indicator

The prison is not participating in the HPA's Prison Infection Prevention Team's national surveillance programme, irrespective of self-reported Hepatitis B vaccine uptake.

Or:

The prison is reported by the HPA's Prison Infection Prevention Team's national surveillance programme to be achieving hepatitis B vaccine uptake of less than 50% by all new eligible and consenting prisoners received into the establishment in the three months prior to the reference date.

PART 1. Performance Indicators

AREA: PUBLIC HEALTH

1.31 Health Promotion Action Groups

Green Indicator

Health promotion action groups (HPAGs) exist within the partnership and have appropriate stakeholder membership of the local health community. Within the local delivery plan there is a health promotion strategy which specifically addresses the needs of the prison population and there is evidence of activity within, and benefit from, all the following areas: mental health promotion and well-being; smoking cessation/reduction; healthy eating and nutrition; healthy lifestyles including relationships; and drug and other substance misuse.

Rationale

The Prison Service has a responsibility in partnership with the NHS to ensure that prisoners have access to health services that are broadly equivalent to those the general public receives from the NHS. This means that prisons should already provide health education, patient education, prevention and other health promotion interventions within that general context (PSO 3200). This indicator highlights five key areas of focus for the HPAGs and requests evidence that activity takes place and that benefits are derived from that activity.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- The HPAG exists and that membership is drawn from the local health community including healthcare, catering, physical education, general education, substance misuse services, chaplaincy and mental health services.
- A strategy exists which has direct reference to all five of the specified areas with action plans and notes of evaluation presented to HPAG meetings.
- Benefits may be measured through the collection of formal patient feedback, completion of smoking cessation programmes, increase in demand for healthy food options, reduction in referrals for stress and anxiety support from mental health teams, increase in take up of CARAT and drug treatment programmes, reduction in referrals for sleep disorders and general feedback from prison staff.

Literature and references

- National Service Frameworks for Cancer, Mental Health & CHD <http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/index.htm>
- PSO 3200 – Health Promotion
- PSO 3801 – Health and Safety Policy Statement
- Mental Health Promotion in Prisons (WHO 1998) <http://www.euro.who.int/document/E64328.pdf>

- Health Promoting Prisons: A Shared Approach (PSI 24/2002)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006230
- Choosing Health: Making healthy choices easier (DH 2004)
<http://www.dh.gov.uk/en/publichealth/Choosinghealth/index.htm>
- A to Z of drug misuse guidance and publications
<http://www.dh.gov.uk/en/Publichealth/healthimprovement/Drugmisuse/index.htm>
- Guidance on Developing Prison Health Needs Assessments and Health Improvement Plans (DH 2002)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006651
- Acquitted: Best practice guidance for developing smoking cessation services in prisons (DH 2003) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005383
- Stop Smoking support in HM Prisons: the impact of nicotine replacement therapy – executive summary and best practice checklist by Susan Macaskill and Paul Hayton (DH 2006) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4134515
- National Service Framework for Children, Young People and Maternity Services (DH 2004)

Amber Indicator

HPAGs exist within the partnership and have appropriate stakeholder membership of the local health community. Within the local delivery plan there is a health promotion strategy which specifically addresses the needs of the prison population and there is evidence of activity within, and benefit from, **three or four** of the following areas: mental health promotion and well-being; smoking cessation/reduction; healthy eating and nutrition; healthy lifestyles including relationships; and drug and other substance misuse.

Red Indicator

HPAGs exist within the partnership and have appropriate stakeholder membership of the local health community. Within the local delivery plan there is a health promotion strategy which specifically addresses the needs of the prison population and there is evidence of activity within, and benefit from, **fewer than three** of the following areas: mental health promotion and well-being; smoking cessation/reduction; healthy eating and nutrition; healthy lifestyles including relationships; and drug and other substance misuse.

PART 1. Performance Indicators

AREA: PUBLIC HEALTH

1.32 Sexual Health

Green Indicator

The sexual health of prisoners is supported by all five of the following.

That prisoners:

- are aware of means of accessing condoms in prisons
- access the social and life skills modules on sex and relationship education (SRE) or similar
- have access to a genitourinary medicine (GUM) service (either provided externally or in house)
- have access to a chlamydia screening programme
- have access to barrier protection and lubricants.

Rationale

Addressing the sexual health of prisoners supports the Prison Service's strategy for preventing the spread of communicable diseases in prison, offering harm minimisation information and treatment for substance misusers.

A clear link between sexual ill health, poverty and social exclusion is identified, as is the unequal impact of HIV on gay men and certain ethnic minorities.

Genital chlamydia trachomatis is the commonest sexually transmitted infection (STI) in England. Genital chlamydial infection is an important reproductive health problem. Of infected women, 10–30% develop pelvic inflammatory disease (PID). A significant proportion of cases, particularly among women, are asymptomatic and so are liable to remain undetected, putting women at risk of developing PID.

The national strategy states that some groups need targeted sexual health information and HIV/STI prevention because they are at higher risk, are particularly vulnerable or have particular access requirements; within this group they identify prisoners.

Suggested supporting evidence

Evidence that **all** the identified services are available to prisoners in the establishment either on site or via referral mechanisms. It should be possible to demonstrate that all five areas can be accessed.

Literature and references

- Better prevention, better services, better sexual health – The national strategy for sexual health and HIV (DH 2001) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003133

- Choosing Health: Making healthy choices easier (DH 2004) <http://www.dh.gov.uk/en/Publichealth/Choosinghealth/index.htm>
- Competencies for providing more specialised sexually transmitted infection services within primary care – Assessment Toolkit (DH 2006) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139358
- Effective sexual health promotion toolkit (DH 2002) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005141
- House of Commons Hansard debates for 24 May 1994 <http://www.publications.parliament.uk/pa/cm199394/cmhansrd/1994-05-24/Writtens-2.html>
- The National Chlamydia Screening Programme (NCSP). (DH 2007) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4118418
- 10 high impact changes for genitourinary medicine 48 hour access (DH 2006) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074104
- Chlamydia (*Chlamydia trachomatis*) (HPA 2007) <http://www.hpa.org.uk/web/HPAweb&Page&HPAwebAutoListName/Page/1191942172070?p=119194217070>

Amber Indicator

The sexual health of prisoners is supported by **at least three** of the following.

That prisoners:

- are aware of means of accessing condoms in prisons
- access the social and life skills modules on sex and relationship education (SRE) or similar
- have access to a genitourinary medicine (gum) service (either provided externally or in house)
- have access to a chlamydia screening programme
- have access to barrier protection and lubricants.

Red Indicator

The sexual health of prisoners is supported by **at least two** of the following.

That prisoners:

- are aware of means of accessing condoms in prisons
- access the social and life skills modules on sex and relationship education (SRE) or similar
- have access to a genitourinary medicine (gum) service (either provided externally or in house)
- have access to a chlamydia screening programme
- have access to barrier protection and lubricants.

PART 1. Performance Indicators

AREA: PUBLIC HEALTH

1.33 Communicable Disease Control

Green Indicator

The prison has a comprehensive written policy on communicable disease control, including an outbreak plan and pandemic flu plan developed in partnership with the local health protection unit (HPU) (and other prisons in the HPU's area) and signed off by the prison's Governing Governor, the chief executive of the PCT and the lead consultant for communicable disease control (CCDC) for prisons in their region. The prison has an Infection Control Link Nurse who has specific responsibility/training in infection control. The prison's Link Nurse attends meetings with the local HPU every six months.

Rationale

The impact of a communicable disease on the population of an establishment, including the staff, is significant, not just encompassing the healthcare management of the disease but also affecting the operational integrity of the prison. It is important that a co-ordinated plan is developed between all significant parties concerned with senior manager support. Prevention of outbreaks is seen as a key priority for prisons and prison healthcare, necessitating effective liaison between the prison and the local HPU. This indicator reviews the development and operation of outbreak plans, with a specific focus on pandemic flu plans, and it requires the prison to work in partnership with key stakeholders.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- It should be possible to identify a specific, comprehensive policy relating to communicable disease control.
- The policy should contain an outbreak plan and have specific reference to procedures in relation to pandemic flu.
- Signatures of the current Governing Governor, PCT chief executive and the lead CCDC for prisons in the region should be evident.
- It must be possible to identify a named Infection Control Link Nurse for the prison and there should be evidence of attendance at six-monthly HPU meetings.

Literature and references

- All Health Protection Units (HPA 2007) <http://www.hpa.org.uk>
- Reports and Publications – Prison Infection Prevention Team: <http://www.hpa.org.uk>
- Pandemic Influenza (HPA 2007) <http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1191942171181?p=1191942171181>
- Infection control in the community study (HPA 2002) <http://www.hpa.org.uk>

- Prison infection control guidelines (Essex HPU 2007) <http://www.hpa.org.uk/essex/publications/PrisonJan07.pdf>
- Major Outbreak plan – Example (Essex HPU 2005) <http://www.hpa.org.uk>
- Outbreak of isoniazid resistant mycobacterium tuberculosis in North London 1999–2004 (HPA 2004) <http://www.hpa.org.uk>

Amber Indicator

The prison has a comprehensive written policy on communicable disease control, but **this does not** include an outbreak plan or pandemic flu plan developed in partnership with the local HPU (and other prisons in the HPU's area) and signed off by the prison's governing governor, the chief executive of the PCT and the lead CCDC for prisons in their region. The prison has an Infection Control Link Nurse who has specific responsibility/training in infection control. The prison's Link Nurse attends meetings with the local HPU every six months.

Red Indicator

The prison has a comprehensive written policy on communicable disease control, but **this does not** include an outbreak plan or pandemic flu plan developed in partnership with the local HPU (and other prisons in the HPU's area) and signed off by the prison's governing governor, the chief executive of the PCT and the lead CCDC for prisons in their region. The prison **does not** have an Infection Control Link Nurse who has specific responsibility/training in infection control.

PART 1. Performance Indicators

AREA: PUBLIC HEALTH

1.34 Exercise

Green Indicator

All prisoners are offered the opportunity to engage in a range of physical exercise programmes appropriate to their health needs. These programmes have been developed and operated in consultation with the healthcare unit and contain a range of interventions which are tailored to support the cardiovascular, respiratory, physical rehabilitation, weight reduction and mental health well-being of prisoners.

Rationale

NICE fully endorses the importance of physical activity as a means of promoting good health and preventing disease, and the consequent need to develop comprehensive, multi-sectoral strategies (including innovative approaches) to promote physical activity as part of daily life. NICE also acknowledges that physical activity has a range of benefits beyond direct health outcomes, such as contributing to community cohesion and addressing the needs of vulnerable groups and communities.

It is often difficult within prison to engage freely in a range of suitable physical activities which promote health and well-being. Working alongside prison colleagues, healthcare staff would be able to promote recovery and health-related activities appropriate to the individual's health needs.

Suggested supporting evidence

To support this indicator it is suggested that the following evidence be identified:

- On the reference date a sample of patients records should be reviewed.
 - Reference to their requirements and access to exercise should be evident.
 - There should be evidence of jointly arranged and managed programmes within the prison aimed at enhancing patients' well-being and recovery through exercise.

Literature and references

- PSO 4250 – Physical Education
- PSO 4275 – Time in the Open Air
- Physical activity (Nice 2006)
<http://guidance.nice.org.uk/PHI2>
- Choosing Health: Making healthy choices easier (DH 2004)
<http://www.dh.gov.uk/en/Publichealth/Choosinghealth/index.htm>
- PSO 4950 – Regimes for Juveniles
- YJB National Standards (2004)
- Lewis E and Heer B, Delivering Every Child Matters in Secure Settings. A practical toolkit for improving the health and well-being of young people (NCB 2008)

Amber Indicator

All prisoners are offered the opportunity to engage in a range of physical exercise programmes appropriate to their health needs. These programmes have been developed with reference to the wider health needs of prisoners but **not** in consultation with the healthcare unit; however they do contain a range of interventions which are tailored to support the cardiovascular, respiratory, physical rehabilitation, weight reduction and mental health well-being needs of prisoners.

Red Indicator

All prisoners are offered the opportunity to engage in a range of physical exercise programmes, but these programmes have **not** been developed with reference to the wider health needs of prisoners and consist mainly of generic gym sessions.

Part 2. Mental Health Numeric Indicators

All Collected Quarterly

2.1 Initial Assessment

Total number of prisoners in the last quarter who received an initial psychiatric assessment, where the Mental Health Act criteria for transfer are met.

2.2 Second Assessment

Total number of prisoners in the last quarter who received a second psychiatric assessment.

2.3 Second Assessment – Suitability of Provider Facility

Total number of prisoners in the last quarter who received a second psychiatric assessment and were assessed as not suitable for transfer, because the provider facility was not suitable and the patient needed re-referring to a more suitable provider facility.

2.4 Second Assessment – Not Suitable for Transfer

Total number of prisoners in the last quarter who received a second psychiatric assessment and were assessed as not suitable for transfer, because transfer was deemed clinically inappropriate under the Mental Health Act.

2.5 Second Assessment Waiting Times

Number of prisoners in the last quarter who have been waiting for a second psychiatric assessment, for the following time periods:

- 2 weeks or less
- 3–4 weeks
- 5–8 weeks
- 9–12 weeks
- 13–20 weeks
- More than 20 weeks.

2.6 Transfer Wait

Total number of mental health transfers in the last quarter where the waiting time fell within the following time periods, from acceptance as suitable for transfer under the Mental Health Act to actual transfer.

- 2 weeks or less
- 3–4 weeks
- 5–8 weeks
- 9–12 weeks
- 13–20 weeks
- More than 20 weeks.

2.7 Transfer Management in Segregation

Total number of prisoners in the last quarter who were accepted for transfer and were managed in segregation prior to transfer.

2.8 Mental Health Act Transfers Section type

Total number of prisoners in the last quarter who were subject to the following sections of the Mental Health Act:

- Section 47 (sentenced)
- Section 48 (unsentenced)
- Sections 35, 36, 37 and 38.

2.9 Care Programme Approach

Total number of patients on CPA during the last quarter.



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