



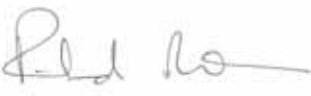
HM PRISON  
SERVICE

**Prison  
Service  
Order**

**ORDER  
NUMBER  
3050**

# **CONTINUITY OF HEALTHCARE FOR PRISONERS**

**CONTINUITY OF HEALTHCARE FOR PRISONERS – EXECUTIVE SUMMARY**

<b>STATEMENT OF PURPOSE</b>	
<p>This PSO contains guidance to improve the continuity of healthcare received by prisoners. It includes guidance on reception, transfer and discharge of prisoners, with particular focus on those with ongoing health needs. The PSO also sets out clinical management of outpatient escorts and NHS inpatient episodes.</p> <p>This PSO applies to all prisoners</p> <p>References to Governors should be taken to include Directors of Contracted-out Prisons.</p>	
<b>DESIRED OUTCOME</b>	
<p>Staff working in prisons will understand and comply with all processes necessary to ensure that continuity of care is improved for prisoners.</p>	
<b>MANDATORY ACTIONS</b>	
<p>This PSO includes a number of mandatory actions relating to:</p> <ul style="list-style-type: none"> <li>• First reception</li> <li>• Information management</li> <li>• Transfer of prisoners</li> <li>• Release/discharge</li> </ul>	
<b>RESOURCE IMPLICATIONS</b>	
<p>There are no additional resource implications with this PSO</p>	
<b>IMPLEMENTATION DATE</b>	<b>28 February 2006</b>
 Richard Bradshaw Head of Prison Health	Area/Operational Manager

**Further advice or information on this PSO can be sought from:**

Susannah Nisbett, Prison Health, 020 7972 2000

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**CHAPTER 1 - INTRODUCTION**

1. This PSO looks at managing continuity of healthcare for prisoners and emphasises the importance of continuity in the success of clinical interventions and treatment. It focuses on the vulnerable points of the system, when the prisoner is moved in to, or out of prison such as entry into custody, leaving and re-entering prison for court visits, transfer to another prison and discharge from custody.
2. The Social Exclusion Unit report, Reducing Re-offending by ex-prisoners put particular emphasis on maintaining continuity on release, and ensuring that prisoners could access health services in the community after a stay in custody. This guidance aims to address some of the issues raised by the report
4. This PSO is equally applicable in Wales although reference throughout the document is to English NHS bodies, policies etc. Where possible, links to comparable Welsh Assembly Government and NHS Wales publications have been included.
5. Guidance and good practice specific to continuity of care for prisoners with mental health problems can be found in the “Offender Mental Health Care Pathway” document which can be accessed on the Department of Health website, [www.dh.gsi.gov.uk](http://www.dh.gsi.gov.uk)
6. Guidance specific to Substance Misuse Treatment can be found at Annex B at the end of this document.

## CHAPTER 2 - RECEPTION

### Retrieving Information

- 2.1 When a prisoner enters reception a new clinical record is created (see 2.5). Efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with. The prisoner's explicit consent should be obtained before doing this, although in exceptional circumstances information may be requested and disclosed without consent. For further information on access to information see [PSI 25/2002 The Protection and Use of Confidential Health Information](#).
- 2.2 If indicated at reception consider as sources for retrieving information:
- Records from previous periods in custody
  - Prisoner's GP
  - Other healthcare services
  - Escort custody groups
  - Police/FME
  - Court
  - OASys
  - Prisoner's family
- 2.3 All medical information must be managed in accordance with relevant legislation and the [NHS Code of Practice on Confidentiality](#).

### Charging for Information

- 2.4 NHS bodies should not normally charge each other and information necessary for the purposes of continuing patient care should not be delayed. Although there has been some uncertainty about whether a fee can legally be charged, as the responsibility for prison health in the public sector comes directly under the umbrella of the NHS, the British Medical Association (BMA) advises that demanding a fee is inadvisable. Further information can be obtained from the BMA's handbook of ethics and law ([link to BMA website](#)). NHS bodies are expected to extend this to include private sector prisons in order to ensure continuity of care for patients.

### New Clinical Record

- 2.5 A new format for the clinical record (formerly inmate medical record IMR) has been developed for use in prisons. The aims of the new record include:
- improving continuity of care between establishments
  - improving clarity and legibility of record
  - identifying pathways of care and audit trails
  - improving communications between clinicians
  - highlighting potentially serious problems in the provision of healthcare to an individual
  - facilitating writing letters to GPs and Hospitals etc.
  - improving production of clinical summaries and a local Chronic Disease Register.
  - determining a way in which the record can contribute to the running of a "brought forward" system for repeat blood tests, follow ups, letters etc.
  - reducing risk of litigation
  - delivering a professional clinical record for the use of the health team and others when it is sent to outside bodies

## First Reception

- 2.6 For a prisoner's first reception into custody, *an initial assessment of the healthcare needs of all newly received prisoners is undertaken within 24 hours of first reception by an appropriately trained member of the healthcare team to identify any existing problems and to plan any subsequent care. A health screen, using the Revised F2169, takes place before the prisoner's first night to primarily detect:*
- *immediate physical health problems*
  - *immediate mental health problems*
  - *significant drug or alcohol abuse*
  - *risk of suicide and/or self-harm*
- 2.7 If immediate health needs are detected, the prisoner is referred to an appropriate healthcare worker or specialist team. *Establishments must draw up evidence based written protocols for management of such referrals. The F2169 must then be added to the clinical record. ([link to Reception PSO](#))*

## Providing a smooth transition to induction

- 2.8 Induction needs to build on the reception process. Good communications between reception and induction staff are essential in order to ensure a smooth transition.
- 2.9 *Governors must ensure that effective communication systems operate between reception and induction so that any relevant information is passed on.*
- 2.10 Reception staff will need to prioritise and ensure effective communication with induction staff about any outstanding needs of prisoners that could not be dealt with during the reception process. A suitable communication system would be a formal handover procedure from reception to induction that avoids any part of the reception process being duplicated or missed.
- 2.11 *There must be systems in place within the prison to provide relevant information about receptions to other departments. ([link to Induction PSO](#))*

## General Health Assessment

- 2.12 *In the week following first reception, every prisoner must be offered a general health assessment. This assessment is equivalent to a primary care assessment when registering with a new practice in the community. Such assessments are not standardised, however the general health assessment should act as an opportunity for:*
- gathering further medical information
  - checking how the prisoner is settling in
  - health education
  - providing information
  - health promotion

## CHAPTER 3 – INFORMATION MANAGEMENT

- 3.1 Effective information sharing with other agencies (in particular the NHS) and within the Prison Service, is key to enabling continuity of care for individuals as they pass from the community to prison and back again.
- 3.2 The smooth and legally appropriate flow of confidential information is one of the essential ingredients in achieving a comprehensive, co-ordinated, seamless and accurate provision of health care to those within the prison service. The increasing emphasis upon and inherent obligations within partnership working makes it imperative to have coherent, flexible and lawful processes for sharing confidential information.
- 3.3 The nature and extent of the obligation to disclose confidential information about service users, between different agencies and within multi-agency teams is governed by a complex statutory and common law framework, allied to a multitude of government policy and best practice guidance.
- 3.4 The SECURE folder and CD Rom sets out all the currently available information on sharing information in the NHS and prisons. It can be accessed by all prison staff and covers the following areas:
  - Information rights in context
  - Data protection acts
  - Consent and confidentiality
  - Using technology and information security
  - Rights of access
  - Effective information sharing

All prisons have been issued with copies of the SECURE pack. Further copies can be obtained by e-mailing [Tracey.harrington@sedc.nhs.uk](mailto:Tracey.harrington@sedc.nhs.uk). Work is also underway to explore providing SECURE in a different format so that it can be read by those without access to a CD Rom.

- 3.5 A separate pack called FOCUS has been developed to cover information rights and management in relation to young people. This can also be obtained as above.

## CHAPTER 4 – Clinical Management of Outpatient ‘Escorts’ and NHS Inpatient Episodes ‘Bedwatches’

### Background

- 4.1 This is an highly significant area of health activity in most prisons. It also puts considerable operational pressures on the prison because of the routine need to provide escorts for patients during their time outside of the prison.
- 4.2 ‘Escorts’ describes the process of prison staff escorting prisoners to and from outpatient appointments, and closely supervising them for the duration of such appointments, to ensure that they behave and do not escape. ‘Bedwatches’ are the constant supervision by prison staff

### Clinical Management

- 4.3 The clinical governance of this area is **particularly** important to maintain an appropriate balance between the demands of patient care and custody. Function 2 of the National Security Framework discusses in detail the security issues and the need to liaise closely with local NHS trusts. [\[intranet link\]](#)
- 4.4 Prison Health Partnership Boards should ensure that the management of outpatient escorts and NHS inpatient bedwatches form part of local clinical governance procedures and that these are reviewed at least annually. Pressures and priorities will vary between individual establishments, however in most cases it will be appropriate to do the following.
- 4.5 Audit local patterns of OPD referral and A&E attendance  
This audit might, in the first instance consider clinical referral patterns and cancellations. Clinical governance links with PCT partners will be particularly important in this process.
  - 4.5.1 The additional operational pressure of the escort in terms of staffing, security and cost, is not present in normal NHS referral. It is therefore particularly important that clinical practice, when referring for specialist opinion, is consistent and follows any appropriate local and national guidelines. Referral patterns should be regularly discussed at establishments’ local forums for clinical effectiveness.
  - 4.5.2 Alternative service models may also be appropriate where patient numbers, security risk and availability of clinical facilities indicate. Such models might include:
    - Members of specialist teams visiting the prison
    - Arranging with local trusts that hospital and A&E waiting times take place in the prison allowing prompt access on arrival.
    - Telemedicine
- 4.6 It is currently common practice for clinicians to visit an establishment under individual arrangements with the prison. Consideration might be given to entering into Service Level Agreements with NHS trusts for this service allowing input from a wider specialist team.



4.7 Ensure local systems are in place so that clinically urgent appointments are given appropriate priority

*Every establishment must have a system in place for identifying priority outpatient referrals to hospital and managing them appropriately. Urgent cancer referrals and other clinically urgent appointments must be given appropriate priority. (see also 5.6)*

4.8 Efficiently manage bedwatches

Cutting delays in the patient journey through hospital is a priority for both NHS trusts and the Prison service. Prisoners represent a patient group where there are clear advantages to all concerned in working through the partnership process to cut delays. The Department of Health has released a toolkit to NHS Trusts on how it may reduce delays and in particular improve timely discharge from hospital ([link to Achieving Timely Simple Discharge from Hospital: A Toolkit](#))

for Wales see [http://www.wales.nhs.uk/documents/WHC\\_2005\\_035.pdf](http://www.wales.nhs.uk/documents/WHC_2005_035.pdf)

4.8.1 Key points in the toolkit for NHS Trusts to reduce delay in discharge include :

- All patients should have a treatment plan within 24 hours of arrival in the hospital
- An expected date of discharge should be set within 24hours of arrival or in many cases before admission for elective patients and communicated to the patient and all staff in contact with the patient.
- The date of discharge should be proactively managed against the treatment plan

4.8.2 Local prison health partnerships will want to consider how they;

- Work in partnership with their local NHS trusts to cut delays for this patient group in their journey through hospital.
- Make sure that the NHS Trust is aware of the levels of care that can be delivered at 'home' [the prison setting for this patient group]
- Improve the levels of care that might be offered in this primary care setting

4.8.3 Clinical governance will have a key role in this process and will need to include.

- Identifying and addressing clinical, environmental and security risk
- Auditing the process and ensuring that the findings are embedded in clinical care
- Ensuring staff have the right competencies through education and training of staff

### **Escorts of Category A Security Risk Prisoners**

4.9 Prisoners at the highest security level who are only located in the High Secure Estate in small numbers present a particular management problem for the prison health partnership locally. Any period outside the prison wall presents particular risks for the public and for external NHS staff.

4.10 The points in this chapter will require particularly careful consideration and there needs to be close liaison with the security department in the prison.

4.11 Prison health partnership boards may wish to consider separately monitoring these escorts and bedwatches within the process outlined in paragraph 4.4 above. Case conferences may be helpful in managing the most difficult cases and best practice shared within the high secure estate.

## CHAPTER 5 – TRANSFER OF PRISONERS

### Background

5.1 There is a significantly high turnover in the prison estate. This is partly due to release from court and short sentences but also due to transfer to other prisons. Transfer is normally to training prisons or the high secure estate if the prisoner is deemed a high security risk. This movement is far in excess of what is seen in average primary care practices and presents special challenges for the continuity of care when patients are transferred.

### Arranging the routine planned transfer of a patient

5.2 Transfers between prisons are generally planned. The [Health Standards for Prisoners](#) performance standard states that the following must take place.

5.3 *Current healthcare needs are assessed and continuity of care ensured when prisoners are transferred between establishments, from establishments to outside NHS hospitals for inpatient care, or released into the community.*

- *Written and observed guidelines are in place setting out the procedures for reception, transfer and release that include:*
- *The identification of physical and mental health problems, indicators of recent substance abuse and the potential for self-harm*
- *Ensuring information on continuing care is conveyed to other establishments on transfer and to NHS hospitals for outpatient and in/outpatient appointments*
- *Information to ensure continuity of care is communicated, with the prisoner's consent, to their GP and/or other responsible community agencies on discharge.*
- *Medication, appropriate to clinical need, is provided to ensure supply until a GP prescription can be obtained*

5.4 Previously prisoners have been passed 'fit' for transfer. In future, local policies should ensure that there are systems in place to ensure appropriate and continuing clinical care in any transfer or release. These should include systems for:

- a) clinical hold
- b) restrictions on transfer
- c) continuity of care between establishments

#### a) Clinical Hold

5.5 Patients may sometimes need to be placed on 'clinical hold' (i.e. withheld from transfer for a period of time for clinical reasons when indicated). This system will require local audit through clinical governance arrangements to ensure that;

- Clinical risk is managed
- The operational running of the prison is not adversely affected by excessive numbers of clinical holds

- 5.6 For instance, it will almost never be appropriate to transfer a patient awaiting urgent cancer referral. Where turnover is high, as in local prisons, it may only be possible to hold those patients with clinically urgent appointments. Training prisons may be able to hold more patients awaiting outpatient appointments.
- 5.7 Patients may sometimes be transferred after having waited a considerable time for hospital treatment. In these circumstances details of the wait should be included in the referral letter from the new establishment to determine whether this may be taken into account at the new hospital. Clinicians should attempt to reach agreement that the waiting time will not be reset when the patient is transferred to a new list.
- 5.8 In exceptional circumstances, prisoners may need to be transferred for security reasons and these may take priority.

**b) Restrictions on Transfer**

- 5.9 Establishments should determine if there are any 'restrictions' on the establishment a prisoner may move to. It has previously been common to 'fit' patients for level I – IV health care and for establishments to set their own criteria for accepting patients without reference or discussion with the wider service. The principles on which any restrictions should be based are as follows.
- i) All establishments should provide the same level of care as a normal general practice. In general therefore, if the patient would be managed at home outside of prison, then the prison should aim to provide health care on the wing community.
  - ii) Transfer on health care grounds should not be requested or reception refused unless it is clearly indicated why the care is outside the bounds of normal primary care and why secondary care cannot be locally provided.
  - iii) Transfer or refusal at reception on health care grounds should therefore be the exception
  - iv) Individual establishment health criteria, if present, must reflect the above and be agreed in writing first with by the Partnership Board (if public sector prison) and with the area office.
  - v) The Partnership Board will be a source of health care advice and will be informed in any of the above cases.
  - vi) The prison service line management will be responsible for any allocation required
  - vii) The sending prison will be responsible for gathering the required information and ensuring standards of continuity of care.
  - viii) Local / remand prisons in particular will need to be familiar with the facilities in relation to physical and mental health provisions and issues relating to referral to their most closely linked training prisons.
- 5.10 Although principle i) above is key there may be sound operational reasons to consider restrictions on transfer. It may not, for instance, be operationally sensible to have routine weekend health care provision at all establishments. Patients who have medication that cannot be held in possession or required daily dressings may need to be restricted from transfer to these establishments.

**c) Continuity of Care between Establishments**

- 5.11 Ensuring continuity of care and the effective communication with colleagues that this implies is essential to patient care and thus central to good practice. This will vary depending on the patients needs.
- 5.12 An up to date patient summary card [significant events/problems page], the clinical record and a sufficient supply of medication will often be all that is required. However, patients with more complex health care needs may require more detailed planning such as communicating directly with the receiving health care team in advance of transfer.
- 5.13 Inter-prison protocols for transfers should be considered where there is a high volume of health-related transfers.

**Transfer of prisoners with disabilities**

- 5.14 Establishments should have a local policy on the management of prisoners with disabilities and an identified Disability Liaison Officer. [PSO 2855 The Management of Prisoners with Physical, Sensory and Mental Disabilities \(link\)](#) gives guidance on the management of prisoners with disabilities.
- 5.15 A disabled prisoner should not normally be located in the health care centre unless there are specific health care reasons for doing so, such as a period of assessment. In general therefore, if the patient would be managed at home outside of prison, then the prison should aim to provide care in the wing community
- 5.16 Section 21 of the Disability Discrimination Act 1995 requires providers to take positive steps in making facilities available to disabled people. If aids are identified that would reasonably be available in the individual's home situation and are required for their health care, then the manager of the local works department should be approached by the healthcare team with regard to provision. In cases of difficulty Area Works Co-ordinators can be approached.
- 5.17 Allocation of prisoners is the responsibility of the Population Management Unit who will need to be appropriately advised.
- 5.18 Disability, in most cases, should not be medicalised and allocation is not primarily a health care matter. The Healthcare team will however need to contribute as appropriate to the patient's health care needs and inform the establishment Disability Liaison officer [DLO] so that they can ensure that the prisoner receives the necessary assistance to enable them to cope with their disability whilst in prison.
- 5.19 Staff need to be clear about the tasks a disabled individual may need assistance with. It is helpful to perform an assessment of their abilities on reception into prison as staff will need to be clear whether tasks can be managed independently in the prison environment. A rating scale may be helpful, an example of this can be found at **Annex A**.
- 5.20 Prison Service Disability Policy Unit, whilst not responsible for allocations, can provide general policy advice in this area.

## Transfer of prisoners with significant health issues

- 5.21 The following guidance should be followed where there is a significant health issue requiring the transfer of a prisoner and local resolution has not been possible. It should only apply if transfer to the NHS is not more appropriate and it does not alter the general principles and normal communication between clinicians indicated above for routine transfers.
- 5.22 The sending establishment will be responsible for ensuring standards of continuity of care and should provide the following information:
- Inmate details including age, offence, date of sentence and tariff
  - Short medical history – including past medical history, current health issues, current treatment
  - Summary of relevant specialist opinion
  - Current health needs – medical/nursing/social care
  - Prison issues relevant to health – e.g. mobility, behaviour, risk of self-harm
  - Any other factors affecting allocation – e.g. dangerousness, requirement for offending behaviour courses
  - Assessment of future health needs
  - The Prisoner's views (with possible exception of Cat A prisoners)
  - Consent of prisoner to release of above information if relevant, e.g. to Lifer Management Unit.
  - Concise summary of health needs. This should focus on practical needs and avoid generalisations such as locate flat or 24-hour health care.
  - Any risk of self-harm information/care plan
- 5.23 The process will vary between cases but may need to include a multidisciplinary case conference. This should involve the patient at relevant points and assessments and participation as appropriate from the NHS, social services or other organisations relevant to the case, including the likely receiving prison. Where the prisoner is on an open ACCT Plan (F2052SH) any case conference must involve the ACCT Case Manager (or Unit Manager in the case of F2052SH).

## Receiving transfers

- 5.24 Receiving a new prisoner, following transfer, is equivalent to registering with a new NHS primary care practice. This process in the community often takes place some considerable time after registering. There are good reasons in the prison system to ensure that prisoners are seen by a member of the health care team before the prisoner's first night of arrival as follows;
- morbidity within the prison population
  - increased risk of self harm and suicide following the stresses of transfer
  - the need to ensure supplies of medication
- 5.25 Whilst reception screening in primary care is not standardised it is expected that during the consultation the health care team 'make such enquiries and undertake such examinations as appear to be appropriate in all the circumstances' as set out in the General Medical Service contract.

- 5.26 Taking into account the morbidity in the prison population it will be appropriate, in addition to general medical issues, to specifically note;
- mental health
  - substance misuse
  - potential for self-harm
- 5.27 The population in each prison will vary in age, gender, ethnic background and morbidity and, in addition, there will be specific local issues that will need to be included in local procedures. *Each establishment must develop a local protocol and procedure for the reception of transfers to its establishment that meets its local needs and is responsive, as appropriate, to changes in population and any significant clinical events.*

**CHAPTER 6 – Significant Life Events Affecting Prisoners' Health**

6.1 As well as arrival in the prison system, transfer and eventual release, there are other situations that may impact significantly on the health of the prisoner.

Events that involve leaving the prison

6.2 Events that require a prisoner to leave the prison and pass back through prison reception can have a significant impact on the health of a prisoner. Examples of such events are as follows:

- Court appearance
- Sentencing at court
- Return from home visit

6.3 *For those prisoners passing through reception, prisons must have protocols in place for screening them for any potential healthcare, or suicide/self-harm issues.*

6.4 In cases where prisoners are released unexpectedly from custody there must be an agreed local protocol, where possible, ensuring continuity of care after release for patients with significant health problems. For example, contacting a prisoners' GP/consultant where known.

Events that happen within the prison environment

6.5 Equally, there are events that happen within the prison environment that can also have a significant impact on a prisoner's health. Examples of such events are as follows:

- Questioning by police
- A bad or missed visit
- Court appearance by video-link
- A bad telephone conversation or letter
- A death of another prisoner/relative

6.6 For those events that take place within the prison, it is not always possible or desirable to monitor all such occasions. *However establishments must ensure that there are systems in place so that prisoners requesting, or identified as needing help from healthcare are made aware of how to access help and are able to receive such help from healthcare within appropriate timeframes.*

## CHAPTER 7 – RELEASE/DISCHARGE

- 7.1 The aim of the partnership arrangements between the Prison Service and the NHS is to provide prisoners with access to the same range and quality of services as everyone else. Through their contact with community health providers, health care staff are usually able to identify appropriate referral routes for individual prisoners, aimed at maintaining continuity of health care on release. It is important that the health care centre is actively involved in planning for the discharge of all prisoners where health care needs have been identified, so that adequate referral arrangements can be made and that the prisoner can be told what these are.
- 7.2 Where a prisoner is receiving medical care which needs to continue after discharge, it is important, as set out in the Transfer and Release Section of the [Health Services for Prisoners Standard](#), that information to ensure continuity of care is communicated, with the prisoner's consent, to his or her GP and/or other responsible community agencies on discharge. (see also para.7.6).
- 7.3 Where a prisoner approaching release has a mental health problem and does not already have a community-based care co-ordinator, healthcare services in the establishment *must* consider whether there is a clinical need to make a referral to the local Community Mental Health Team. In some establishments some other health care staff will be able to do this by referring the prisoner to an in-reach team from a mental health trust. For further information, please see [Offender Mental Health Pathway](#) document.
- 7.4 Some prisoners with disabilities, or who are elderly, may need to have a community care assessment by the Social Services Department for the area in which they will be living on release. Anyone working with a prisoner might identify such a need, which *must* be brought to the attention of the health care centre or the National Probation Service as it is their responsibility to work together to ensure that such referrals to Social Services Departments are made. ([Resettlement PSO](#))

### Help for prisoners to access primary care on release

- 7.5 The challenges of successfully resettling into the community are exacerbated for prisoners with health problems because they may face substantial interconnected barriers in areas such as access to housing and primary care. Primary healthcare can often be a gateway to other services and so the failure to connect with a GP has wide-ranging consequences.
- 7.6 Where a prisoner who is receiving medical care that needs to continue after discharge, does not have an external GP, it is important that health care staff help the prisoner to register with one prior to discharge. Similarly, health care staff must arrange follow-up appointments with NHS providers for all continuing secondary health care needs, and supply medication appropriate to clinical need to ensure supply until a GP prescription can be obtained. ([Resettlement PSO](#))

### Information on Local Primary Care Services

- 7.7 Where prisoners are being released back into the area local to the prison  
Prisons should provide prisoners with lists of local primary care services, including GP surgeries and walk-in centres. The local PCT will be able to provide this information. This may form part of an information pack that also includes contact numbers of drug agencies and other supporters such as Samaritans.



### 7.8 Where prisoners are being released back to a PCT other than the host PCT

If the appropriate IT is available, it may be possible to provide lists of primary care services for areas other than the host PCT. Lists of GP surgeries and walk-in centres local to any stipulated postcode in the country can be obtained from the local information database on the [NHS Direct](#) website. This may form part of an information pack that also includes contact numbers of drugs agencies and other supporters such as Samaritans.

### Provision of NHS Publications

7.9 NHS direct can act as the first point of contact for ex-prisoners in accessing primary care or general advice on healthcare services. NHS Direct produce a “credit card” containing their contact details. Prisons should ensure that these are provided to all prisoners on release. Stocks of the credit card can be ordered via the following numbers:

- In English - DH Publications Orderline on 08701 555 455, quoting product code 29651
- In Welsh - NHS Direct Wales Communications Team on 01792 776252

7.10 Prison healthcare teams should review all mainstream NHS publications that their local PCT provides to patients in the community and consider applying similar provision of material to prisoners, where helpful, prior to their release (e.g. Your Guide to the NHS leaflets).

### Prescription Exemption Forms & Other Benefits

7.11 As part of the resettlement plan for prisoners with a known discharge date, prisons should provide assistance with completion of an HC1 form “Claim for help with health costs”. This will allow those eligible to be discharged with a NHS Prescription exemption certificate. The form takes about three weeks to process and can be ordered from the DH Publications Orderline on 08701 555 455. Prisoners should use their intended home address or contact address if homeless for completing the form.

7.12 Individual prisoners may also be entitled to certain specific benefits, for example, disability living allowance following release. GPs working in prisons may need to contribute to applications.

### Medical References for Prisoners

7.13 For prisoners who have planned release/discharge, *Prison Healthcare Teams must consult with the resettlement unit or housing advice unit at their establishment on the use of medical references for prisoners with housing or resettlement needs.* This will help housing providers to ensure and prioritise appropriate housing discharge. *Prisons must then ensure that any reference accompanies the housing needs assessment, so that the housing authority has all of the relevant information at hand to address housing needs and prevent homelessness.*

### Early Release of Seriously Ill Prisoners

7.14 Each year a number of prisoners fall seriously ill and their release is considered on compassionate grounds. To help the general support of a patient who becomes seriously ill, health care having obtained the patient’s consent, should inform the Governor. Healthcare

should also consider liaising with other support structures within the prison, for example the Chaplain.

7.15 Early release may be considered if one or more of the following apply:

- A patient is suffering from a terminal illness and death is likely to occur soon. There are no set time limits, but 3 months may be considered an appropriate period.
- A patient is bedridden or severely incapacitated. This might include those confined to wheelchairs, paralysed or severe stroke victims.
- Further imprisonment would endanger the prisoners life or reduce his or her life expectancy.

7.16 For further information on the process for the early release of prisoners on compassionate grounds see [Chapter 12 of PSO 6000, the Parole manual](#)

### **Application for early release on medical grounds**

7.17 Consideration should be given and application made for early release in ALL cases where there are appropriate medical grounds.

7.18 Although it is not the function of the healthcare team to carry out the assessment of security risk, the application will be considered on the balance between the care of the patient and the risk to the public. It is therefore essential that information from healthcare that affects the ability of the patient to re-offend is included

- a) The Governor will first need to consider whether the patient's needs can be met by temporary release.
- b) The Governor will need to consider the case in the first instance and then make an application. If there is doubt about whether to submit an application then advice may be sought through the Prison Service Parole Unit.
- c) The Governor should make the application on the patient's behalf, using form 210 including medical and probation reports, to the Parole unit.
- d) The application should be made as early as is practicable so that the case may be considered and any necessary further information obtained. If initially unsuccessful applications may always be reconsidered if the patients condition deteriorates.
- e) When collating health care information;
  - An up-to-date specialist opinion must be included
  - A specialist's prognosis, usually including life expectancy, is essential.
  - Clinicians may be reluctant to give an estimate of life expectancy. Personal contact between health care and the specialist to explain the process will often resolve this issue.
  - This is one instance where it is important to be aware of the offending history in the patient's interest. When the condition has affected the patient physically or mentally so that they would no longer be able to offend then clear details are required. For instance, specific details of weight loss, generalised weakness, loss of mobility, dementia or the

need for hospice care may all be relevant to facilitating release dependant on the previous offending behaviour.

- The need for hospital escorts or services that would normally be provided through primary care in the community, and thus by prison health, are unlikely to be considered as significant factors.
- Conditions that are self-induced, for example following a hunger strike, will not normally qualify a patient for release.
- Arrangements for continuity of care outside of prison must be given.

**ANNEX A**

**RAPID DISABILITY RATING SCALE**

**Overview**

The Rapid Disability Rating Scale can be used to assess the level of patient disability especially in the elderly. It is useful for monitoring over time to see if the patient is improving stable or worsening.

**Rating Completion**

- The scale is completed by a caregiver familiar with the patient.
- Based on the response, points ranging from 1 to 3 are assigned indicating no or slight, moderate and severe impairment.

**Directions**

On the basis of your knowledge about the patient at the present time will you please rate the following items.

<b>Activity</b>	<b>Ability</b>	<b>Points</b>
eating	no assistance	1
	moderate assistance	2
	considerable assistance	3
diet	regular diet	1
	modified regular diet	2
	special diet	3
medications	rarely	1
	occasionally	2
	every day	3
speech	not impaired	1
	moderately impaired	2
	unable to be understood	3
hearing	normal	1
	moderately impaired	2
	deaf	3
sight	normal (with glasses if worn)	1
	moderately impaired	2
	blind	3
walking	no assistance	1
	needs someone's help or uses a crutch or walker	2
	unable to walk	3
bathing	no assistance	1
	moderate assistance	2
	considerable assistance	3
dressing	no assistance	1
	moderate assistance	2
	considerable assistance	3
incontinence	never	1
	occasionally	2
	all of the time	3
shaving	no assistance	1

Activity	Ability	Points
	moderate assistance	2
	considerable assistance	3
safety supervision	never	1
	sometimes	2
	all of the time	3
confined to bed	not at all	1
	part of the day	2
	all the time	3
mentally confused	never	1
	occasionally	2
	all of the time	3
uncooperative	never	1
	occasionally	2
	all of the time	3
depression	never	1
	occasionally	2
	all of the time	3

rapid disability rating scale score = SUM (points for all 16 parameters)

**Interpretation:**

- minimum score 16 indicating no significant disability
- maximum score 48 indicating total disability

**Limitation**

- The scale was developed as a research tool and its use as a clinical instrument was not specifically explored.
- While following the total score can provide a rapid assessment of the patient over time it is also useful to compare the time course for specific items of the scale. If one condition improves while another deteriorates then the total score may not change which may be misleading if a given therapy is being evaluated.

**References:** Linn M.W. *A Rapid Disability Rating*

**ANNEX B****CONTINUITY OF SUBSTANCE MISUSE TREATMENT****Offenders arriving into local prison custody:**

1. Offenders arriving in prison who are identified via the first reception healthcare screen as potentially requiring clinical management of substance misuse should have access to adequate prescribed first night medication.
2. A thorough assessment by a specialist clinician should be undertaken the following morning and information should be gathered from Criminal Justice Integrated Teams, treatment agencies and GPs regarding previous prescribing. Substitute prescribing should then be in line with national guidance for the clinical management of prisoners with substance problems.
3. Joint working protocols between the healthcare, clinical substance misuse service and CARATS should be in place to enable multi-disciplinary care planning and co-ordination.

**Offenders leaving custody, attending court or transferring to another prison.**

1. Consideration must be given to the needs of patients receiving prescribed management of drug dependence on a day when they are due to leave prison custody to attend court.
2. All remand prisoners should receive their opioid substitute medication in the mornings, prior to any attendance at court, and thus provide protection from the emergence of withdrawal symptoms if they are released later in the day.
3. Local protocols should be negotiated between the prison, escort contractors and court administrators for the secure administration of medicines that are prescribed in more frequent doses.
4. The relevant Criminal Justice Integrated Team need to be notified at the earliest opportunity when a patient who is part of the Drug Intervention Programme and receiving clinical management of substance misuse is due to appear in court.
5. The period immediately following release is a time of considerable vulnerability. For patients leaving prison with existent prescribed management of their substance misuse problem, contact should be established with a community service at the earliest opportunity, so that an appointment may be made following release. It is essential that such arrangements are in place prior to prisoner release. For patients with a co-existing serious mental health problem, the procedure outlined in Chapter 7 (paragraph 7.3) of this document must be followed, incorporating the Care Programme Approach.
6. Close working between the clinical, CARAT and Criminal Justice Integrated Team is central to the securing of good integrated care. It is envisaged that in cases where a patient leaves prison on a Friday, he or she may not be seen until early the next week. In such circumstances a community pharmacist should be located to provide an interim dispensing service. In the event of no pharmacy being available, a risk assessment should be conducted to help determine how much take-home medication should be issued to the individual. Routinely it is recommended that 3 days' take home medication is given. In the case of methadone this should be given in three separate bottles. On a holiday weekend further days' medication may be required. Practitioners should ensure the patient is made aware of the facilities that will be available in their local community.

7. Provided they are medically stable, patients who are on a maintenance opioid programme may transfer to a training prison after seven days of clinical management.
8. Patients on a maintenance programme can transfer to open conditions after 28 days of commencement of clinical management.