Memorandum of understanding between HM Inspectorate of Prisons and the Healthcare Commission

October 2005

Preamble

1. The objective of this memorandum of understanding (MoU) is to set out the framework agreed by HM Inspectorate of Prisons (the Inspectorate) and the Healthcare Commission (the Commission) for cooperation and communication in relation to the inspection of health services in places of detention. The specific roles and responsibilities of both organisations are set out at Annex A.

2. The details of those in the Inspectorate and the Commission responsible for the operation of this MoU appear at Annex B.

3. The MoU presupposes that issues will normally be dealt with through established processes and provides for each organisation to seek to resolve issues at the earliest opportunity.

Scope of the memorandum

4. The Inspectorate has a statutory duty to inspect healthcare and substance use within custodial settings as part of its annual criteria-based inspection programme. The Commission has statutory responsibilities to inspect healthcare provision in England. The Inspectorate and the Commission have agreed to work together to develop this MoU, which defines their respective roles and how they will collaborate and work together in respect of healthcare inspections. This MoU sets out how the *Standards for Better Health* issued by the Department of Health will be applied within a prison setting and how the two inspectorates can contribute to reducing the overall burden of inspection through joint working and sharing of relevant information.

5. The MoU defines the circumstances and the processes through which the Inspectorate and the Commission will cooperate when carrying out their functions. It does not seek to compromise either the Inspectorate's independence or the Commission's statutory role to assess performance and review and inspect the

quality and effectiveness of healthcare. This MoU includes the practical arrangements designed to ensure that the relationship is effective and that together the two organisations meet their aims and objectives, particularly where there are overlapping interests or responsibilities. It sets out the processes that the two organisations will follow for:

- the coordination of activity
- sharing information and specific concerns
- monitoring of the implementation of inspection recommendations

6. The Commission is a signatory, but the Inspectorate is not a signatory to the Concordat between bodies inspecting, regulating and auditing healthcare in England. However, the Inspectorate and the Commission agree to work together following the principles of the Concordat. In particular, decisions about collaborative working between the Inspectorate and the Commission will be subject to the following general principles:

    - the Inspectorate and the Commission will respect each other's independent status and will cooperate when necessary or appropriate

    - the Inspectorate and the Commission will work in partnership and will be governed by the need to deliver maximum benefits to those using health and other public services

    - the Inspectorate and the Commission will work together when this contributes most to improvements in services

    - the Inspectorate and the Commission will work together to encourage the development of consistent, high quality, accurate information about NHS care wherever it is delivered and will rely on intelligent data to focus and support their work programmes

    - the Inspectorate and the Commission will be open and transparent in their decisions about when and where it is considered appropriate for them to work collaboratively

7. The Commission is a signatory to the Concordat between bodies inspecting, regulating and auditing health and social care in Wales. The principles of the Welsh Concordat are similar to that in England and will apply broadly to relationships between the Commission and the Inspectorate relevant to their respective duties in Wales.

8. In relation to prison settings, the Commission's locus is in relation to governance arrangements for the commissioning of prison health services by primary care trusts (PCTs). Arrangements set out in this MoU will cover, where appropriate and relevant, the private prison sector by virtue of the fact that healthcare provided in a private prison setting will come within the Commission's jurisdiction, as any private healthcare provider(s) will be registered with the Commission.

9. In addition, when healthcare is commissioned or provided by the NHS, the National Health Service (Complaints) Regulations 2004 SI 1768 must be met. This means that prisoners have the right to access the NHS complaints procedure. Separate guidance is being produced on the handling of prison healthcare complaints where the NHS commissions services. The guidance does not apply to private prisons or prisons in Wales.

Background

10. The programme for inspections by the Inspectorate is determined on the dual basis of chronology and risk assessment. The Inspectorate has a commitment to inspect fully each adult establishment every five years (three years for juveniles, IRCs and STHFs) followed some 12 to 36 months later by an unannounced inspection. Announced inspections result in a full range of recommendations that require an action plan to be put in place after two months and revised after 12 months.

11. Unannounced inspections are usually shorter (two to three days) and use fewer inspectors. The type of unannounced inspection is decided on the basis of risk assessment using the intelligence system to determine both the depth and frequency of inspection. The primary objective of a follow up inspection is to assess the progress made in relation to the recommendations following the previous inspection but can also be used if the risk assessment process indicates there are frailties in particular areas.

12. Usually the Inspectorate inspects healthcare and substance use within the overall prison inspection, although there is a precedent for the service to be inspected separately following risk assessment. Inspection is against a set of criteria known as “expectations” and there is currently work underway to map these against the outcomes in the new DH standards.

13. In undertaking this work, inspectors are assisted by colleagues from the Adult Learning Inspectorate and Ofsted. The arrangements in relation to the inspection cycle are subject to annual review.

14. Until April 2004 the provision of primary care in prisons was the sole responsibility of the prison service. The NHS provided mental healthcare. Since then, there has been a two year programme to achieve full devolution of the commissioning of healthcare to the NHS by April 2006 (except in the case of private prisons). By then, NHS standards should apply to healthcare for prisoners and the commissioning functions of PCTs of prison health services should be subject to the same governance arrangements as currently exist for PCTs.

15. Following devolution, the prison governor will continue to be responsible for the overall health and welfare of prisoners and health services will have to be delivered within the security framework of the prison.

16. The primary care trust’s local delivery plan and the prison health delivery plan should be consistent in terms of commissioning and provision priorities.

17. The Commission may also be invited to undertake inspection and assessment work from bodies providing healthcare outside of its England-wide statutory remit – for example, the Channel Islands, the Isle of Man, Northern Ireland and other non-UK territories - as well as bodies such as Defence Medical Services.

Sharing information

18. The working relationship between the Inspectorate and the Commission will be characterised by regular contact and open gathering and exchange of information. A supporting protocol for sharing information may be agreed between both parties.

19. Each organisation will respect and maintain the confidential nature of documents and information provided to them. In sharing information, the Inspectorate and the Commission will adhere to the requirements of the relevant law, codes of practice and protocols relating to the sharing of information. Subject to these, the two bodies may exchange information likely to assist in the functions of both. Examples of types of information include:

    - performance information on PCTs within which there are places of detention
    - data on trends, approaches and initiatives and other concerns relevant to the shared aims of both organisations
    - guidelines and procedures relating to the respective interests of each organisation
    - data and trends in relation to complaints received by the Commission as a result of prisoners in England using the NHS complaints procedure

20. It is possible that either organisation will receive information, which bears upon the other's responsibility. Given the overriding need to protect the interests of patients, it is important that both organisations, through this agreement, encourage a culture of mutual trust and understanding, and are willing to share relevant information. The interests of the patient/public should remain paramount and where issues relate to the fitness to practise of healthcare professionals, this information should be referred to the appropriate regulatory body for further investigation. Nothing in this MoU seeks to preclude the Inspectorate from taking action that is justifiable to safeguard prisoners and/or staff.

21. It is recognised that there may be issues relating to fitness to practise of employees of either the commissioners and/or providers of healthcare that emerge during the course of an inspection. While neither inspectorate would be directly involved in such matters, both would ensure that the other is appropriately informed of such issues.

Confidentiality

22. In the course of work between the organisations, there may be times when information will be shared on the basis that it is not disclosed either publicly or to other organisations (such as early drafts of reports, guidance or standards). Each organisation will respect such requirements. This is subject to the duty of confidentiality owed by each organisation to those providing them with confidential personal information.

Potential areas for collaboration:

The inspection and monitoring process

23. The inspection of healthcare and substance use in places of detention will continue as now with no increase in inspection burden, but with a more integrated approach.

24. The Inspectorate will inform the Commission of the annual announced inspection programme once it has been finalised. Similarly, the Commission will notify the Inspectorate of its proposed review and monitoring programme. Discussions between the Inspectorate and the Commission at the joint inspection planning group will determine which inspections will be jointly undertaken. Inspections will fall broadly into three main types:

Announced HM Inspectorate of Prisons inspections

25. These will be led by the Inspectorate, which will inspect and report on the health outcomes for prisoners within the prison. An associate of the Commission will be invited to join the inspection and make judgements on the arrangements for and effectiveness of the PCT commissioning of the healthcare services.

Healthcare Commission - inspections or reviews of a PCT

26. These will follow one of the following formats, either:

    (a) a Commission inspection or review of a PCT where the PCT is responsible for commissioning healthcare for a prison(s) and which includes a prison(s) which has not been inspected by the Inspectorate within the past 18 months (or a shorter timescale, if deemed appropriate by the joint inspection planning group) or has been subject to a change in its category or status. The Commission will lead these and health inspectors from the Inspectorate will inspect the healthcare in prison(s) as set out under paragraph 25 above

or

    (b) a Commission inspection or review of a PCT, where the PCT is responsible for commissioning healthcare for a prisons(s) and, which includes a prison(s) which has been inspected by the Inspectorate in the past 18 months unless otherwise determined by the joint inspection planning group, when the findings of the inspection report will be accepted and the Inspectorate will not re-inspect healthcare within the prison

27. The joint inspection planning group will meet quarterly to ensure implementation of the agreed work programme. Eight weeks before the Inspectorate undertakes an announced inspection, the head of operations, resourcing, scheduling and new business will ensure that the Inspectorate is notified of details of the Commission's associate, who will be given relevant pre-inspection information by the Inspectorate. The Inspectorate will then contact the relevant area manager of the Commission responsible for the PCT to confirm inspection arrangements.

28. The Commission's associate will be responsible for giving feedback to the PCT prior to the inspection debrief.

29. The Commission's associate will submit a draft report to the Inspectorate's health inspector within three working days of completing the inspection.

30. The Inspectorate will send a copy of all draft inspection reports to the head of operations resourcing, scheduling and new business approximately eight weeks following the conclusion of the inspection, so that any factual inaccuracies in the reports can be clarified. The head of operations resourcing, scheduling and new business will forward the draft inspection report to the Commission's relevant area manager, who will share the report with the PCT. Draft reports will also be sent to the prison service area mManager or the office for contracted prisons and the governor or director of the prison.

31. The Inspectorate will send a final draft (embargoed) report simultaneously to the relevant head of operations resourcing, scheduling and new business, the director general of the prison service, the prison service briefing unit or the relevant prisons service department at least four or five working days prior to publication. A letter will be sent to the prison service area manager and the governor for the prison asking that an action plan be drawn up within two months of publication of the report and returned to HM chief inspector of prisons. A copy of this letter will be sent to the head of operations resourcing, scheduling and new business.

32. Where the final report identifies issues that relate to the PCT the area manager will ensure that an action plan is drawn up by the PCT manager with responsibility for commissioning healthcare in the prison within two months of publication of the report and returned to the Inspectorate head of health inspection. A copy of this letter will be sent to the area manager or the office for contracted prisons and the head of juvenile group at the prison service.

33. For Commission-led inspections, the lead associate from the Commission will contact the lead inspector for the Inspectorate to finalise details. The Inspectorate will be responsible for debriefing the head of healthcare/governor of the prison at the end of the inspection and will be available for debrief with the PCT responsible if required. The Inspectorate will submit a draft report to the lead associate from the Commission within three working days of completing the inspection.

34. For Inspectorate-led inspections, copies of the most recent Inspectorate reports together with any relevant intelligence/action plans will be sent to the relevant head of operations, resourcing, scheduling and new business as part of local working arrangements. Copies of reports following unannounced inspections of prisons by the Inspectorate will also be sent to the head of operations, resourcing, scheduling and new business.

35. Staff from each organisation will be responsible for their own travel and administrative arrangements during inspections. Each organisation will be responsible for any costs associated with their inspectors and associates.

External communication issues

36. The Inspectorate and the Commission will also inform each other of external communications related to the performance of prison healthcare. This could include:
    - the timing of press releases and any other publications relevant to the inspection process
    - involvement, as appropriate, in conferences and other public discussions
    - assistance in the dissemination of information about good practice in prison healthcare

Reconciliation of disagreement

37. Any disagreement between the Inspectorate and the Commission will normally be resolved at working level between the relevant officials. If this is not possible, it may be referred upwards through those responsible for operating this MoU, up to and including the HM chief inspector of prisons and the chief executive of the Commission who will jointly be responsible for ensuring a mutually satisfactory resolution.

Review of the MoU

38. The joint inspection planning group will review the MoU in September 2006. The review will be reported to the HM chief inspector of prisons and the chief executive of the Commission who will then agree on changes to this memorandum as required.

Signed…… **Signed……**

Anne Owers
Chief Inspector
HM Inspectorate of Prisons

Anna Walker
Chief Executive
Healthcare Commission

Date:

Date:

Annex A

Roles and responsibilities of the Inspectorate and the Commission

The Inspectorate

The Inspectorate was established as an independent inspectorate in 1980. It carries out its functions under section 5A of the Prison Act 1952 as amended by section 57 of the Criminal Justice Act 1982. Its main statutory functions are to inspect and report to the Secretary of State on conditions for and treatment of those detained in prison establishments in England and Wales and immigration removal centres in England, Wales and Scotland. In addition, the Inspectorate inspects, by invitation, prison establishments in Northern Ireland, the Channel Isles and certain Commonwealth territories, as well as immigration short-term holding facilities, the Military Corrective Training Centre, Colchester, and the Sovereign Base Areas, Cyprus.

In determining the inspection programme, HM chief inspector will use her judgement and expertise in deciding what to inspect, how inspections should be carried out, what the findings should be and whether an inspection is to be announced or unannounced. She will also publish the methodology against which she inspects places of detention including how the findings are supported.

The Commission

The Commission was established under the Health and Social Care (Community Health and Standards) Act 2003. Its legal name is the Commission for Healthcare Audit and Inspection. The Commission has the overall function of encouraging improvement in public health and healthcare in England and Wales and is required to pay particular attention to:

- the availability of, access to and quality and effectiveness of healthcare
- the economy and efficiency of the provision of healthcare
- the availability and quality of information provided to the public about healthcare
- the need to safeguard and promote the rights and welfare of children and the effectiveness of measures taken to do so.

The Commission's main statutory functions include:

- carrying out reviews and investigations of the provision of healthcare and the arrangements to promote and protect public health, including studies aimed at improving economy, efficiency and effectiveness in the NHS
- promoting the coordination of reviews and assessments undertaken by other bodies
- publishing information about the state of healthcare across the NHS and the independent sector, including the results of national clinical audits
- reviewing the quality of data relating to health and healthcare

and in England only:

- reviewing the performance of each local NHS organisation and awarding an annual rating of that organisation's performance
- regulating the independent healthcare sector through annual registration and inspection
- considering complaints about NHS bodies that they have not been able to resolve through their own complaints processes
- publishing surveys of the views of patients and staff

ANNEX B

Focal points of contact

The Inspectorate	Miss Elizabeth Tysoe Head of Health Inspection Ashley House 2 Monck Street London SW1P 2BQ Tel 020 7035 2138
The Commission	Sue Ward Head of Operations Resourcing, Scheduling and New Business Healthcare Commission Finsbury Tower 103-105 Bunhill Row London EC1Y 8TG Tel 020 7448 1792