

June 2002

Developing and Modernising Primary Care in Prisons

Further copies of this document are available from:

Department of Health

PO Box 77

London SE1 6XH

Tel: 08701 555455

Or online at www.doh.gov.uk/prisonhealth

Contents

Contents	1
Executive Summary	2
Chapter 1: Introduction	4
Chapter 2: The vision of Primary Care in Prisons	7
Chapter 3: Developing Primary Care	9
Chapter 4: Practical Support	15
Chapter 5: Change in prison health – making the linkages	18
Chapter 6: References	22
Appendix A: The structure of Primary Care within the NHS	23
Appendix B: Improving standards in Primary Care in the NHS	25
Appendix C: A pictorial representation of Prison Health Policy Unit & Task Force Work	26

Executive Summary

This document provides a framework for the development of primary care within prisons in England. The guidance offers practical advice and support about how changes and benefits can be achieved over the next 2–3 years. It does not endorse one particular model for service delivery but highlights the key principles and characteristics of a good primary care service.

The document also contains some practical generic and specific examples of primary care development within prison primary care settings. In addition there is also a simple checklist against which prisons and PCTs may wish to self assess current primary care provision and identify gaps and weaknesses for priority development.

A significant amount of change in prison health services is already taking place. Some prisons provide good primary care services but there are also those where primary care is under developed and struggling to meet the needs of prisoners.

Good primary care is the essential foundation on which any good health care system is built and this is especially the case in prison settings. A well trained and effectively managed primary health care team can make a tremendous contribution to improving the overall quality of health and health care services for prisoners.

Any developments in primary care in prisons should take full account of developments in the wider health care system. The strategy for primary care in prisons is to increase integration with primary care planning and development through the local Primary Care Trust (PCT). The government recently issued its vision for the delivery for primary care services through the publication of *'Delivering the NHS Plan – next steps on investment, next steps on reform'* (April 2002).

To achieve sustained improvements, prisons and PCTs will need to tackle four key strategic areas:

- Developing primary care teams
- Developing primary care services
- Developing primary care partnerships and networks
- Developing primary care infrastructure

Local Prison Health Steering Groups (PHSG) and the development of Health Improvement Programmes (HIMPS) provide an ideal opportunity to ensure that change is effectively planned and managed across the range of prison health services.

Improving primary care in prisons will have many benefits, including:

- Health care needs of prisoners are better met
- Recruitment and retention levels of key staff are increased
- Increased opportunities to achieve better value for money
- Greater flexibility in the provision of services
- Better integration with the wider health care system including mental health services, secondary care and specialist services
- Improved interface with the rest of the prison

The development of primary care is taking place at a time of huge change in prison health services. Recent publications about the development of mental health services, health promotion, nursing and doctors will all support the development of primary care for prisoners.

Regional Prison Health Task Force Teams (RTFTs) will expect to see evidence of plans for primary care services in prison HIMPs as these are developed and reviewed as outlined in the 'Guidance on Developing Prison Health Needs Assessments and Health Improvement Plans' (2002)¹ Summary action plans will be required to ensure that all prisons have set clear objectives around improving primary health care for prisoners.

This document does not encompass Wales where a different process of structured change is currently ongoing. A complementary strategy, which provides a framework for the development of primary care in the Welsh context, will be published in due course.

1. Guidance on Developing Prison Health Needs Assessments and Health Improvement Plans. Prison Health Task Force and Policy Unit 2002.

Chapter 1: Introduction

The purpose and direction of primary care in prison has been shaped by The Future Organisation of Prison Health Care.

“Healthcare in prisons should promote the health of prisoners; identify prisoners with health problems; assess their needs and deliver treatment or refer to other specialist services as appropriate. It should also continue any care started in the community contributing to a seamless service and facilitating throughcare on release. The majority of health care in prisons is therefore of a primary care nature. However, healthcare delivery in prisons faces a significant number of challenges not experienced by primary care in the wider community” (1999)²

The purpose of this document is to provide a framework for developing and modernising primary care in prisons, and to set primary care services for prisoners in the context of the wider NHS primary care development agenda.

Prisons and Primary Care Trusts have responsibility for developing primary care and this guidance should inform the development and delivery of local prison HIMPs.

Primary care does not exist in isolation and plans for primary care improvement must be seen against the context of wider service, workforce and infrastructure changes taking place in areas such as mental health, health promotion, workforce and information technology. In chapter 5 – ***Change in Prison Health – Making the Linkages*** – the impact of these linkages is explored in more detail.

Throughout this document, there are examples of good practice and innovative ways of delivering service, intended to offer ideas and encouragement for early and sustained improvement in primary care. The starting point for service planning is a robust assessment of need. A variety of primary service models are likely to be acceptable in meeting the variable needs of different prisons.

² The Future Organisation of Prison Health Care Report by the Joint Prison Service & NHS Executive Working Group, Dept of Health, March 1999.

What is primary care?

At its simplest, primary care is the first level of contact for individuals seeking health care. For most people that means the care given by their general practitioner and the multidisciplinary team that works from their general practice. These health professionals are seen as the ‘gatekeepers’ of the NHS, providing health promotion, care and treatment, and referring to and conducting patients through other parts of the NHS.

Although different in setting, primary care in prison is no different in substance. For many prisoners, consultation with the doctor, nurse or other primary health care team members is likely to be the extent of contact with prison health services as the majority of prisoners’ health needs will be met by primary care as they would be in the wider community.

In the next 2–3 years, primary care in prison will be shaped by wider changes in the implementation of the NHS Plan and primary care strategy. The development of PCTs will provide staff the opportunity to deliver improvements and make better use of resources.

NHS Plan

The government published the *NHS Plan* in summer 2000. This is a ten-year plan for modernising the NHS and it plans to put primary care centre stage. In addition the government have just published a further paper called *Delivering the NHS Plan – next steps on investment, next steps to reform*.

The aim is:

- to move health care closer to the patient wherever possible
- shift the emphasis away from hospital-based treatments
- more preventative care
- better health education, self-awareness and chronic disease management in the community.

There should be increased emphasis on multidisciplinary team working and improved sharing of information between professionals. Primary care will no longer be centred entirely on face to face GP consultations. A range of professionals encompassing new roles will take an ever more significant part in proceedings e.g. more nurses and other professional will be able to provide and monitor treatment.

The profile and development of primary care in prison will be further reinforced by the changes in organisational arrangements that place Primary Care Trusts centre stage with substantial commissioning and provider responsibilities. Primary Care Trusts have clear partnership responsibilities to work with prisons to plan and deliver improvements to all health services.

Need, opportunity and resources

Analysis of prison Health Needs Assessments (HNAs) and HIMPs confirmed that primary care was prioritised for improvement and Prison Health Steering Groups have been asked to give priority to primary care improvement. Such priority has been regularly reinforced by Governors, Health Care managers and staff who recognise the importance and opportunity to modernise and develop primary care.

In some prisons there will be a mismatch between current levels of service provision and need. In such circumstances, there may be opportunities to remodel services and it is possible that such remodelling would generate financial savings for reinvestment and or improved value for money.

Chapter 2: The vision of Primary Care in Prisons

Primary Care within a prison should develop needs based health services in partnership with their local NHS providers that deliver effective evidence based care to both individual prisoners and the prison population as a whole.

This chapter provides a vision of good primary care in prisons for the next 2–3 years. The vision has been considerably shaped by established strategies of NHS primary care, the experience of early HNAs and HIMPs, prison service health care standards and the views of people working in primary care inside and outside of the prison.

As part of its primary care strategy, the NHS has set out principles of good primary care

- **Fairness**

Services should not vary widely in range or quality across the country

- **Accessibility**

Services should be reasonably accessible to people who need them, regardless of their age, sex, ethnicity or health status

- **Responsiveness**

Services should reflect users' needs and preferences, and the health and social needs of the local population

- **Efficiency**

Services should be based on research evidence of clinical effectiveness and resources should be used efficiently". (www.doh.gov.uk/pricare)

The above definitions and principles provide clear markers around the development of primary care in prisons.

Following the Primary Care Conference in November 2001 the prison service wanted the normalisation of primary care in prisons. This is then to be based on the principles and characteristics of good quality primary care described above. This guidance does not dictate one particular model of primary care because no single model will fit every prison and PCT. It does highlight the advantages of working in partnership to modernise primary care services for the whole prison.

The future of primary care in prison is integration with the planning and development of primary care within the local PCT so that increasingly good primary care in prison should be indistinguishable from good primary care in the community.

Chapter 3: Developing Primary Care

Primary care within prisons needs to develop in line with the NHS vision of improving services based on the development of primary care services, teams and networks.

To deliver the vision of primary care in prison, prisons and PCT's will need to plan and deliver change in four key areas:

- Developing primary care teams
- Developing primary care services
- Developing primary care partnerships and networks
- Developing primary care infrastructure

3.1 Developing primary care teams

To ensure that all care, treatment and support is of the highest quality, all professionals working in primary care should be knowledgeable about the health conditions present in primary care, skilled in their treatment and knowledgeable about the people they are providing services for.

Typically, primary care within a prison is provided by:

- Doctors- must hold a Joint Committee on Postgraduate Training in General Practice (JCPTGP) or have Acquired Right to practice
- Nurse practitioners/Nurses/Health Care Officers
- Visiting specialists
- Dentists/dental nurses
- Opticians
- Physiotherapists
- Pharmacists/pharmacy staff
- Chiropodists
- Primary care manager/health care manager
- Administrative and support staff

Many professionals are included in the modern primary care team but not all of the above will be present all of the time. Leadership may be provided by a range of different professionals at particular times, for example, a nurse with a relevant specialist qualification may take the lead in organising and delivering a diabetic clinic.

To ensure continuity of care for the patients it is essential that the primary care team does not work in isolation. The primary care team has a crucial role in guiding patients through to the range of more specialist prison health and NHS secondary/tertiary services. In most instances, the primary care team will be the starting point for assessing the health needs of individual prisoners, planning and co-ordinating packages of care and treatment that best meet those needs. Consequently, primary care has a key role in acting as the gateway for managing the interface with other services such as mental health services, and in ensuring the whole system of health care in a prison works as smoothly and effectively as possible for the benefit of the patient.

The members of the primary care team must be able to work together effectively, and have regular opportunities to meet as a team to discuss both specific patients and more general issues about the provision of health care.

To ensure the team is able to provide care of the highest quality:

- all staff providing the service must be competent in their role and hold appropriate qualifications which they keep up to date
- all professional staff must have current professional registration in their area of expertise
- all treatment and advice must be clinically effective and based on the most up to date research evidence.

Roles of the health care professional are changing. For example nurses are now proactive in health promotion, health education and management of chronic disease. This shift in the balance of roles will provide important opportunities for prisons and PCTs to review the appropriateness of staffing and skill mix arrangements.

3.2 Development of Primary Care services

Whatever model or provider, primary care services in prison should try and ensure:

- Health care addressing the needs of the patients and prisoners
- Quality driven service based on clinical governance
- Staff with the appropriate training providing health care based on patients needs
- Health care that is accessible to all prisoners

- Local NHS involvement
- Integration with the wider prison regime
- Clear management and accountability arrangements

For primary care to be successful it must interface with all other areas of health care activity, including cross-cutting initiatives on issues such as workforce development and information. This can be seen in Fig 1.

Primary Care and the Wider Health Agenda

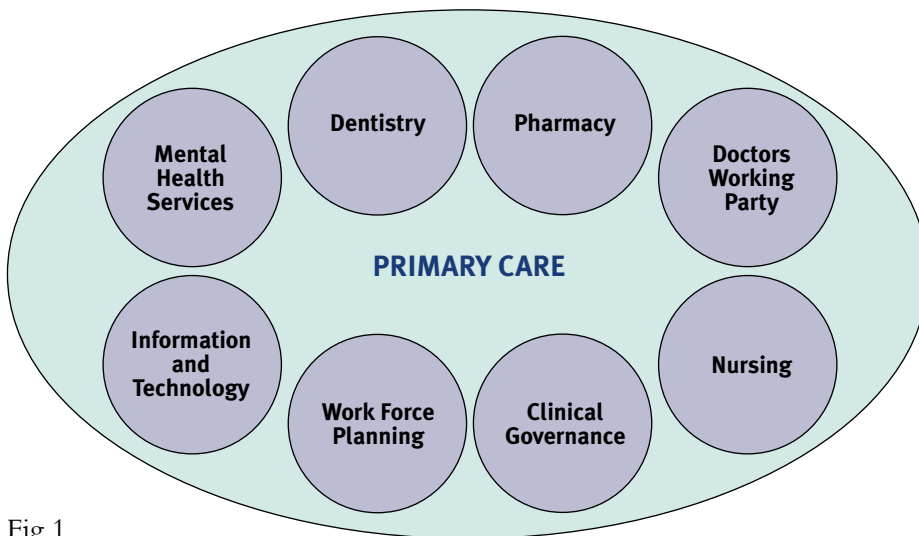


Fig 1

The range and quantity of primary care provision must reflect the health needs of the prison population. Working closely with the local PCT, it should be possible to review the level of need, drawing on existing Health Needs Assessments, and identify the best mix of primary care services within the available resources.

To avoid inequalities in service delivery, care provided must be based on agreed standards and protocols. The NHS has introduced new national standards through National Service Frameworks, NICE Guidelines and Clinical Governance (explained later in the document) and these will have an impact in shaping plans for improvement along with guidance and standards produced specifically for the prison service (PSOs, PSIs and Health Care Standards).

Within the NHS, initiatives such as NHS Direct have been introduced to change and improve access to services. Again within primary care in prison, there will be opportunities to review access to services. With the right support and empowerment the patient may be able to decide on the most appropriate route to access care. It is not always necessary for the patient to see the GP; other options available include nurse led clinics and self medication for very common ailments (e.g. headaches). The various choices for a patient are illustrated in Fig 2.

Patient Choice/Self Referral

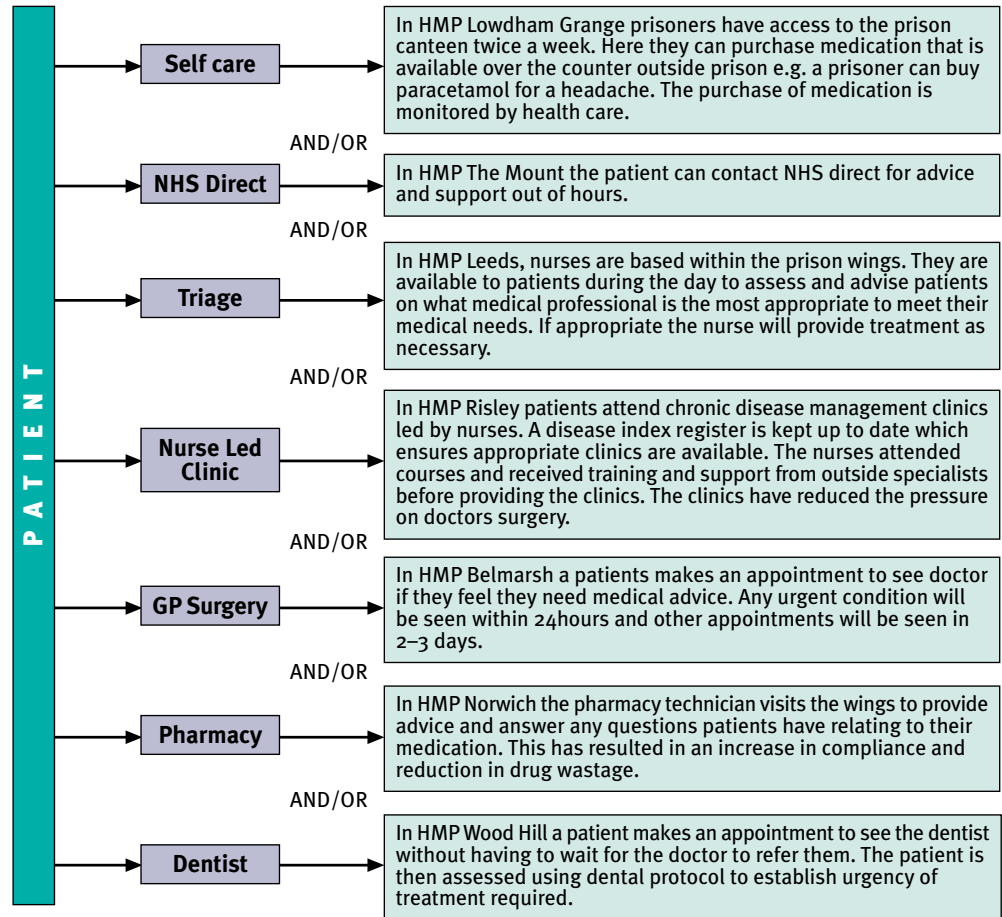


Fig 2

When the patient is seen by a health care professional, a range of treatment pathways are available. An example of a patient pathway can be see in Fig 3.

Example of patient pathway when consulting GP

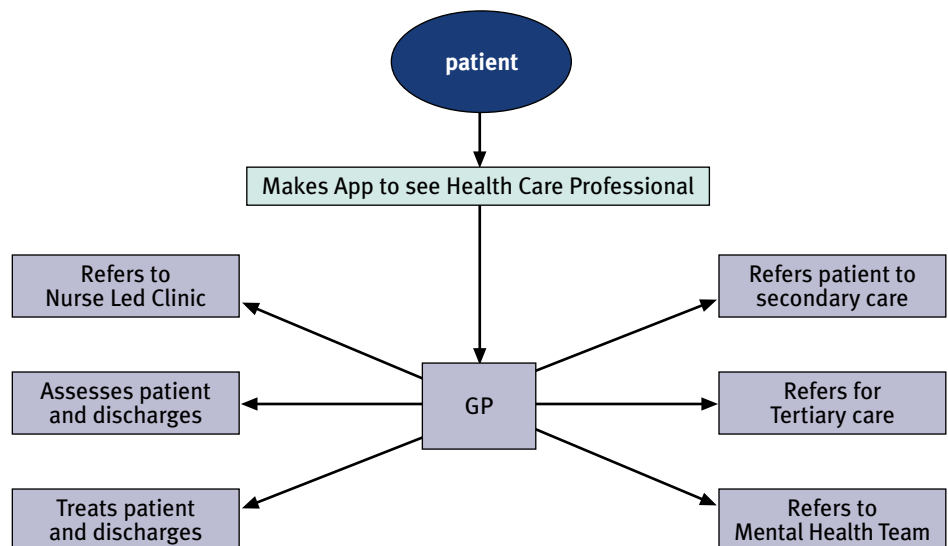


Fig 3

3.3 Developing Primary Care Partnerships and Networks

Partnerships and strong networks will provide the essential foundations on which to develop a modern, patient centred primary care service. As with any partnership, time and effort will need to be devoted to developing strong relationships at all levels with NHS providers, local authorities and private providers as local circumstances dictate. The Prison Health Steering Group (PHSG) offers the ideal means of engaging and co-ordinating the contribution of existing and potential providers see Fig 4.

Prison Health Steering Group

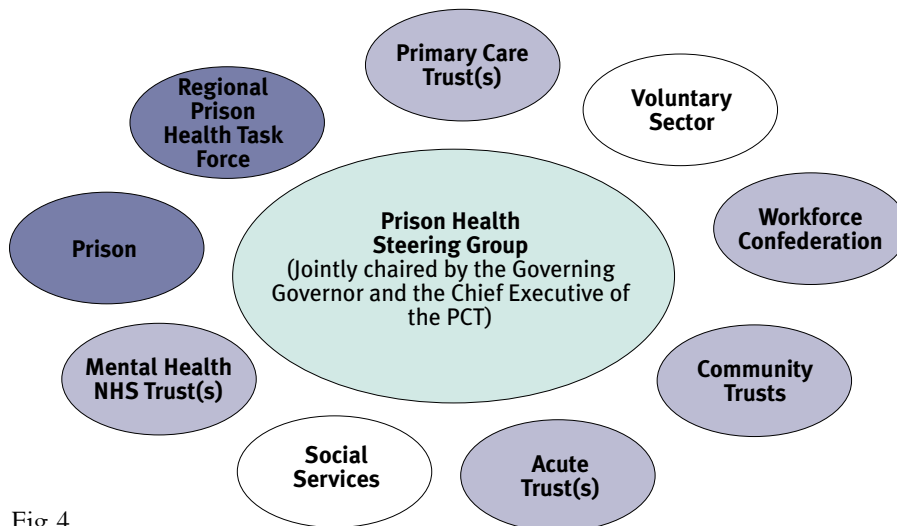


Fig 4

Developing partnership working with your local PCT and NHS will also reduce professional isolation. Networks are very appropriate in achieving a way forward. They allow an exchange of knowledge, skills, information and experiences between organisations. Every prison will be at different stages of developing their primary care models and effective networks will provide a vehicle to share learning and experience between health care centres.

The development of networks can have many benefits both for the professional and to your health care team. The following are the main networks available

- **Professional**

Making more use of existing professional and other networks, examples include local primary care nurse forums and clinical governance groups.

- **Institutional**

Opportunities for sharing ideas and sense of purpose within single institutions

- **Local/Regional**

Sharing experience, good practice, how to make things happen

- **National**

Occasional national meetings to hear and feed back about policy possibilities and proposals (complete feedback loops)

3.4 Developing the primary care infrastructure

Good primary care requires good supporting infrastructure. Without such basics as modern reliable information and IT systems and safe, fit for purpose facilities, the development of primary care may be impeded but the deficit is not an absolute barrier.

The Prison Health Task Force & Policy Unit are working with the Prison Service's "Quantum" Information Management & Technology (IM&T) modernisation team to pilot primary care information systems in seven prisons. These systems will cover patient records, appointment system, diagnosis and prescribing. The pilots will inform decisions about the future procurement and rollout of primary care information systems in prisons.

Primary care facilities and equipment should mirror those available in the community. With the aim of 'normalisation', primary care accommodation in prison should be provided to the same standard as NHS primary care facilities. Advice and information about primary care design and accommodation standards is available from your local PCT and/or RTFT.

Some prisons already provide good standards of flexible, fit for purpose primary care accommodation. For many, however, further work and resources are required to deliver the necessary improvements.

As part of the drive to create the right conditions and support for the development of primary care and other services, new health care contracting arrangements are being jointly developed with the Procurement Unit. These new arrangements sit more comfortably alongside the partnership approach whilst strengthening the rigour of service specifications and contracts. These new arrangements are being piloted at a small number of establishments and guidance is expected in autumn 2002.

Chapter 4: Practical Support

This section is designed to provide practical support to prisons relating to the development and improvement of their primary care services.

There are some practical generic examples of primary care development within prison primary care settings. In addition there are also some specific examples from prisons.

Drawing on existing good practice, the following simple checklist can be used by prisons and PCTs to self assess current primary care provision and identify gaps and weaknesses for priority development.

4.1 Good practice in developing primary care in prisons – Generic

- Location of doctors' surgeries in the most appropriate place. Some prisons have surgeries located on the wings, instead of the health care centre, and this arrangement can offer easier access for patients and minimise the need for prisoner movements.
- Structured appointment system to ensure manageable numbers of patients in health care at any one time.
- Matching NHS targets for appointments system in the prison [i.e. patients will be able to see a primary care professional within 24 hours, and a doctor within 48 hours].
- Ensure outside specialists are only contracted to see patients when patients can attend the sessions.
- Some prisons have developed chronic disease management clinics in response to their HNA (e.g. chronic heart disease, asthma and diabetes clinics). Some have specially trained an existing member of staff, whilst other prisons have employed specialist nurses from the community part time to provide specialist clinics.
- Increased support and education of health care staff to permit extended provision of in-house services [e.g. minor surgery and phlebotomy].
- Health care staff given opportunities to work with a local NHS provider – e.g. on rotations or part-time postings – to reduce professional isolation.
- Health care staff defined into clear primary care and mental health teams. This has facilitated changes in duty rotas to allow appropriately skilled teams to work when and where their skills are required (e.g. practice nurses working in primary care using and developing their expertise).

Good practice in developing primary care in prisons – Specific

- Holme House is working in partnership with the local PCT. An F grade prison nurse has membership on the Practice Nurse Forum, ensuring stronger links between prison and NHS primary care.
- HMP Kirklevington and NHS Direct are working together and as a result inmates have access to a phone on every wing that will connect them to NHS Direct at certain times through out the day.

4.2 Self Assessment Checklist

Prison health care centres can assess their development in primary care by using this self assessment check list.

Management

● All staff are registered with their appropriate professional body	
● All GPs are on the PCT supplementary list	
● Named person responsible for liaising with their local PCT	
● Lead member of health care staff identified for Clinical Governance	
● Action plan identified to establish a primary care team and clearly define the services provided	
● Combined impact of mental health strategy and modernising of primary care has led to a reduction in bed occupancy for in-patient beds?	
● Regular health care meetings to improve internal communication	
● Current provision of health care reviewed with multidisciplinary team. Most appropriate patterns of provision identified in line with NHS plan, e.g. acceptable to wait 48 hours for routine GP appointment	
● Staff have agreed PDPs, which are reviewed as part of appraisal discussions, and are supported in achieving them	
● Chronic disease registers are in place or are being developed	

Professional

<ul style="list-style-type: none"> ● Evidence of integration between Prison Service and local NHS, to encourage transfer of skills among staff and reduce professional isolation, and to facilitate exchange of information 	
<ul style="list-style-type: none"> ● Establish links with nursing directorate both within the PCT and local acute Trust. This will provide direct links to professional support, clinical supervision and opportunities for updating skills e.g. spending time in A&E to practice suturing 	
<ul style="list-style-type: none"> ● Close links between the prison doctors and the Professional Executive Committee (PEC) within the local PCT to provide professional support and advice. 	
<ul style="list-style-type: none"> ● Appropriate skilled staff working in primary care, based on review of required skillmix 	

Clinical Governance

<ul style="list-style-type: none"> ● Clinical Governance prison lead is a member of local PCT Clinical Governance group 	
<ul style="list-style-type: none"> ● All services and procedures underpinned by clinical governance 	

Service

<ul style="list-style-type: none"> ● Nurse led clinics provided (e.g. chronic disease management, health education and promotion) to meet the assessed needs of the population 	
<ul style="list-style-type: none"> ● Working with the NHS so as to facilitate the implementation of National Service Frameworks (NSFs) and NICE guidelines 	
<ul style="list-style-type: none"> ● Primary care service providing a clearly established gatekeeping function for access to more specialised services 	

Chapter 5: Change in prison health – making the linkages

Primary care in prison sits at the very centre of prison health care providing the essential ‘glue’ linking the different strands of service together thereby ensuring the effective co-ordination and delivery of complex packages of care.

This last chapter briefly describes the wider changes taking place in prison health and their likely impact and contribution to primary care. Any development proposals need to be considered against this wider backcloth of change. Locally, the PHSG provides the ideal forum for joining up these various strands of change into coherent and deliverable action plans across the whole health system.

This action must be supported with a HNA of the local prison population, which is reviewed annually in partnership with the local NHS provider. The Health Care Standard also states that each prison must have a clear and observed policy statement about what primary care services are available to prisoners and also who is responsible for providing them.

Some prisons have started to work with their NHS colleagues and are currently working on innovative new ways of delivering primary care that meet the needs of the patients but also empower the staff delivering the service. This information can be shared by increasing and expanding networks to different prisons and NHS colleagues and can be supported by Regional Task Force Teams.

Every prison, working with its local NHS partner will have completed a Health Needs Assessment (HNA) by the end of March 2001 and will be currently working on a review of the HNA due for completion by September 2002. These assessments should have, as a minimum, identified the basic health needs within each prison. Prison HIMP Action Plans should identify priorities and robust plans for improvement in 6 key areas:

- Primary Care
- Substance Misuse
- Mental Health
- Dental
- Health Promotion
- Workforce Development

The ‘*Guidance on Developing Prison Health Needs Assessment and Health Improvement Plans*’ (Prison Health Task Force & Policy Unit, February 2002), will inform the development of prison HIMPs. The key features of recent guidance, along with its relevance to and impact on primary care, are described below.

5.1 Clinical Governance & NHS Partnership

Clinical governance was introduced in 1999, to ensure that all services provided in the NHS are based within a framework ensuring high standards and quality for all.

Clinical governance has been 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.”(1998)³

All changes in primary care and any clinical care service must be built on the principles of clinical governance. Clinical governance should be the foundation that all change is built upon.

PCTs will be actively working with their primary care teams to ensure these standards are achieved. There is no detailed national template for delivering clinical governance, and arrangements need to be both locally owned and appropriate to local health systems. Prisons should link as closely as possible with local systems for developing clinical governance in primary care.

To provide support and initial direction nationally, the Prison Health Policy Unit and Task Force published a clinical governance discussion document for prisons in February 2001, followed in January 2002 by the good practice document for prison health services ‘*Clinical Governance – getting started*’. RTFTs are working to raise awareness of clinical governance in prisons and to provide practical support in developing appropriate local arrangements – contact your Regional Team for more information. A formal Prison Service Order on clinical governance will be issued later in 2002.

³ Department of Health (1998) A First Class Service: quality in the new NHS. Health Service Circular: HSC(98)113. Department of Health London.

5.2 Doctors working party

The 'Report of the Working Group on Doctors Working in Prisons' was published on 14 December 2001 by the Prison Health Task Force & Policy Unit. The report was commissioned by Home Office/Department of Health Ministers in response to concerns that doctors working in prisons remained isolated from developments in the wider NHS and that measures must be taken to improve the training, recruitment and retention of doctors to this challenging area of work. The Report – which has been fully accepted by Ministers and the Prison Service – made 50 recommendations. These can be grouped into 5 broad areas:

- Pay, Terms and Conditions
- Training and Continuing Professional Development
- Structure of Health Care
- Qualifications
- IT

A key theme of the report is the recognition that the focus of work for doctors in prisons should be on primary care; that the NHS must make proper provision for the secondary care needs of the prison population. In order to strengthen partnership between the NHS and Prison Service, and reduce the professional isolation of doctors, prison doctors will now also be required to work for one session a week in an outside NHS practice.

5.3 Workforce

The Prison Health Task Force & Policy Unit are working with the Prison Service Directorate of Personnel to develop the prison health workforce and infrastructure to support health care delivery. The project will also involve partnership with the NHS (including Workforce Development Confederations) to ensure that staff working in prisons receive proper support and development opportunities.

Greater flexibility for employing staff may occur when health care teams are defined into their appropriate roles. It is acknowledged that there may be some very sensitive issues to deal with where re-profiling work indicates the need for a more appropriate skill-mix in the future.

Empowering current staff in particular areas of clinical interest with appropriate support and training, can both improve services and help retain and develop staff.

It is recognised that there is a national shortage of both GPs and nurses and flexible working will not in itself resolve all the current recruitment problems. The government has set up new workforce planning systems to ensure that the NHS and other healthcare providers have enough staff to meet future demand.

5.4 Mental Health

A Strategy for Developing and Modernising Mental Health Services in Prisons – ‘*Changing the Outlook*’ – was published by The Prison Health Task Force & Policy Unit in December 2001. This document clearly outlines the vision for mental health services in line with the National Service Framework for Mental Health and relevant NHS Plan commitments. Primary care services will support this by providing an effective level of primary mental health intervention for patients who require it and referring when necessary to specialist mental health services.

5.5 Health Promotion

A strategy for developing health promotion in prisons ‘*Health Promoting Prisons: A Shared Approach*’ was published by the Prison Health Task Force & Policy Unit in April 2002. The document sets out a framework for a whole prison approach for the development of health promotion services over the next 3–5 years. The strategy recognises the important role members of the primary care team have with developing and promoting the health of prisoners.

Chapter 6: References

Department of Health (2000). The NHS Plan. London Department of Health

Department of Health (2002). Delivering The NHS Plan – next steps on investment, next steps to reform. London Department of Health

HM Inspectorate of Prisons (1996). Patient or Prisoner? A Discussion Paper, London Home Office

HM Prison Service (1999). The Future Organisation of Prison Healthcare. London Home Office

HM Prison Service/ NHS Executive (2000). Improving Healthcare Services For Prisoners. London; Department of Health

HM Prison Service/NHS Executive (2000). Nursing in Prisons

Prison Health Task Force and Policy Unit (2002). Guidance on Developing Prison Health Needs Assessments and Health Improvement Plans

Prison Health Task Force and Policy Unit (2002). Health Promoting Prisons: a shared approach

Prison Health Task Force and Policy Unit (2001). Changing the Outlook. A Strategy for Developing and Modernising Mental Health Service in Prisons

Prison Health Task Force and Policy Unit (2001). Report of the Working Group on Doctors Working in Prisons

Appendix A: The structure of Primary Care within the NHS

The pace of change in the NHS is very fast and if you are not part of the organisation it can be very difficult to keep abreast of all new developments which can become problematic when trying to achieve partnership working. The following is a very brief account of the structure and regulating bodies in Primary Care for the NHS.

The Government published its white paper '*The New NHS: modern, dependable*' at the end of 1997. This White Paper contained plans to abolish GP fundholding and create new local organisations, led by health professionals, for commissioning health services. The new organisations were called Primary Care Groups (PCGs) and were first established in April 1999. PCGs could also apply to become Primary Care Trusts (PCTs), with powers to provide primary and community health services as well as commission secondary care for the local population.

The publication in 2001 of '*Shifting the Balance of Power*' set an accelerated timescale for all PCGs moving to PCT status. From April 2002 there are over 300 PCTs, and one remaining PCG which will move to Care Trust status later in 2002. The average population per PCT is between 150,000–200,000. In addition, PCTs can apply to become Care Trusts, which can commission and deliver social care as well as health services.

28 Strategic Health Authorities (StHAs) replaced the existing 95 Health Authorities on 1 April. StHAs no longer commission local health services, as that responsibility has been devolved to PCTs, but they are responsible for performance managing the PCTs and Care Trusts in their area.

Improving your access to NHS Primary Care

- The government has pledged that it wants to make primary care more responsive to people's needs. In an effort to take the strain off GP practices and improve patient access Primary Care walk-in centres were launched in April 1999. These are a series of nurse led centres where patients can drop in for advice and treatment of minor illness and injuries.
- The NHS Direct telephone helpline is now available to all of England and Wales. Anyone can call the number and the person is transferred to a nurse. The nurse then advises the patient what course of action to take, based on their own knowledge and skills and advice drawn from a computerised system based on clinical evidence. Small-scale piloting work is currently exploring the applicability of NHS Direct to certain types of prison – for example in providing discipline staff with advice on prisoner health care issues “out of hours” in establishments without 24 hour health care cover.

Appendix B: Improving standards in Primary Care in the NHS

The Government has placed great emphasis on efforts to improve clinical quality in the NHS generally, including in primary care. Developments which have a particular impact on primary care include:

- The establishment of National Service Frameworks (NSFs) and the National Institute of Clinical Excellence (NICE), set a clear framework of quality standards for the NHS:
 - NSFs set out targets and standards and suggested models for services for particular patients within a fixed timeframe. NSFs have been established in key clinical areas to help drive quality and reduce variations in the standard of healthcare. They have so far been developed for coronary heart disease, mental health, diabetes and older people, and others are under development.
 - NICE was set up in 1999 to act as a nation-wide appraisal body to assess and advise on the clinical and cost effectiveness of different interventions.
- The introduction of clinical governance, to provide a clear framework for quality assurance and quality improvement in NHS organisations. Progress is assessed externally by the Commission for Health Improvement (CHI), in addition to existing management mechanisms.
- The government has recently announced its intention to establish a new health inspectorate. The new inspectorate will bring together the work of CHI with the private healthcare functions of the National Care Standard Commission and the health value for money work of the Audit Commission. Legislation to establish this new inspectorate will be introduced as soon as parliamentary time allows.
- The establishment of a new National Clinical Assessment Authority, to provide support for doctors who may be experiencing problems with their professional performance and improve patient protection;
- The development of Health Improvement Programmes (HIMPs), documents which are developed in consultation with local partners and which set out a three-year programme for addressing locally identified health improvement priorities.

Appendix C: A pictorial representation of Prison Health Policy Unit & Task Force Work



The drive to modernise health services for prisoners requires partnership action, by the Prison Service and NHS, across three major areas:

- Developing the workforce and infrastructure to support health care delivery; professional development, information (including communications) and capital;
- Focusing on improvements to specific clinical services; including health promotion, substance misuse and mental health; and in this document primary care
- Strengthening systems for managing and monitoring change; clinical governance, health care standards and performance monitoring mechanisms.

