

March 1999

The Future Organisation of Prison Health Care

*Report by the Joint Prison Service and National Health Service
Executive Working Group*



Executive Summary

This Report sets out the key findings and recommendations of a Working Group of Officials from the Prison Service and the NHS Executive, jointly established by the Home Secretary and the Secretary of State for Health to consider the future organisation of, and ways of improving, prisoners' health care. In particular the Working Group was tasked to consider the recommendation made by Her Majesty's Chief Inspector of Prisons, in the discussion paper '*Patient or Prisoner?*', that the responsibility for providing health care to prisoners should move from the Prison Service to the NHS.

The Working Group endorsed the existing aim for prison healthcare 'to give prisoners access to the same quality and range of health care services as the general public receives from the National Health Service', and has found that there is some good work being done in a number of establishments in that direction. However, looking at prison health care as a whole, this is characterised by considerable variation in organisation and delivery, quality, funding, effectiveness and links with the NHS. No two prisons could be regarded as the same. This situation is largely a product of a historic legacy, *ad hoc* development, and relative isolation from the NHS. Prison healthcare is often reactive rather than proactive, over-medicalised with health needs assessments being the exception. Lack of direction, poor lines of communication and confused accountability resulted in many instances in less than optimal health care delivery. Arrangements for the continuing professional development of healthcare staff were not well established. In general there was no way to monitor effectively the outcomes of care.

To address these weaknesses a substantial programme of change is needed. The Working Group recommends that this be taken forward over the next 3–5 years on the basis of a formal partnership between the Prison Service and the NHS with funding and departmental accountabilities remaining broadly as at present. This approach takes account of the background against which improvements to prisoner health care are being sought, in particular, the reform of the NHS itself; and, the need for the two organisations, the Prison Service and the NHS, to work together to ensure that health and health care are properly integrated into, and influence, regimes, and for continuity of health care on receipt into custody and on release back to the community. It is important that the pace of this change is realistic, reflecting the other pressures

and priorities both in the Prison Service and the NHS. We consider that an overall time scale of five years with a series of milestones would be achievable.

To support this programme of change, the Working Group recommends that:

- Health Authorities and Prison Governors should work together to identify the health needs of prisoners in their area, and to develop Prison Health Improvement Programmes that should form part of the wider Health Improvement Programmes being developed under the NHS reforms. Health needs assessments would begin in Summer/Autumn 1999 and work on Health Improvement Programmes would start early in 2000. This phase should be completed in all areas and by all prisons within 3 years.
- A Task Force should be appointed, to help support prisons and Health Authorities, to drive forward the assessment of health needs, and the changes identified by the Prison Health Improvement Programmes. This should be in place early in 1999 and its programme of work defined no later than Spring 1999.
- A prison health Policy Unit should be created which would replace the current Prison Service Directorate of Health Care. The Policy Unit would be responsible for the development of prison health policy, drawing on, and integrating with, wider national health policies. The Unit would advise the Prisons Board, the NHS Executive, and Ministers about prison health policy. The Head of this Unit would need to be (as is the case with the current Director of Health Care) a member of the Prison Service Executive Committee and Prisons Board, and its staff would need to work closely with staff in the Prison Service and the NHS. It is the view of the Working Group that the Policy Unit would be best placed to achieve its aims if located in the NHS Executive. However, recognising the range of complex issues involved, the Chief Executive of the NHS and the Director General of the Prison Service should establish a small team to consider the feasibility of such a move.

As well as the structural changes summarised above the Report identifies a range of actions intended to address specific weaknesses or issues. Given the problems posed by prisoners with mental health problems it is worth highlighting the following:

- The care of mentally ill prisoners should develop in line with NHS mental health policy and national service frameworks including new arrangements for referral and admission to high and medium secure psychiatric services.
- Special attention should be paid to better identification of mental health needs at reception screening.

- Mechanisms should be put in place to ensure the satisfactory functioning of a Care Programme Approach within prisons and to developing mental health outreach work on prison wings.
- Prisoners should receive the same level of community care within prison as they would receive in the wider community and policies should be put in place to ensure adequate and effective communication and joint working between NHS mental health services and prisons. Health Authorities should ensure that service agreements with NHS Trusts include appropriate mental health services for their local prisoner population.

The partnership approach would mean that the Prison Service would continue to pay for primary care provided within prisons, to ensure consistency of good practice and quality of care throughout the prison estate. The NHS would, as now, be responsible for secondary care; it would ensure that community mental health services reached into prisons (estimated to benefit around 10,000 prisoners), and, as health needs dictate, provide the capacity for mentally ill offenders who required hospital care to have it provided. The cost estimates made in this Report are necessarily tentative: a good deal would depend on the outcomes of the health needs assessments and Prison Health Improvement Programmes. We recognise that specific provision may not have been made for the sorts of potential extra spending identified in this Report. Nevertheless, we see considerable scope for making progress within existing resources. We see the Task Force as being instrumental in forming a picture of total resource need, advising on priorities, and ensuring that the Prison Service and the NHS have information about the resource impacts of change.

The question of whether or not the NHS should assume full responsibility for prisoners' health care should be examined again, when the actions and recommendations set out in this Report have had an opportunity to have an effect, and their impact has been assessed.

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- Most discussions about prison health care consider prisons as distinct entities which have little relevance for or impact on the wider community. This is no longer appropriate. Currently there are 65,000 people in prison in England and Wales, a figure that has been rising over the past few years and that is projected to continue to rise.¹ The number of people who are received into custody in any year is very much larger, being 201,000 persons in 1997. Prisoners are a transient population and most spend only a short time in custody before returning to the wider community taking with them their health and social problems. They are a section of the population that may be difficult to reach in any other situation and for many a spell in prison represents an opportunity for consistent contact with health services. It makes sense therefore that time in prison should be used as an opportunity to ensure that prisoners receive the best healthcare possible. This has advantages for both the individual, the community and the NHS. Good healthcare and health promotion in prisons should help enable individuals to function to their maximum potential on release, which may assist in reducing offending. It should also reduce morbidity in a high risk section of the general population with medium and long term reduction in demands on the NHS. Better quality care together with improved links to the NHS are also likely to help prevent acute breakdown and consequent tragic incidents such as homicides or suicides by people with mental illness.
- Prisoners are not typical of the general population with regards to their health needs, having a disproportionately higher incidence of mental health and drug misuse compared to the general population^{2,3,4}. 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.

‘Good healthcare and health promotion in prisons should help enable individuals to function to their maximum potential on release, which may assist in reducing offending’

1. *Annual Report of The Director of Healthcare 1996–97*. London; HM Prison Service. 1998

2. Bridgwood A, Malbon G. *Survey of the Physical Health of Prisoners 1994*. OPCS 1994. London HMSO.

3. Gunn J, Maden T, Swinton M. *Mentally Disordered Prisoners*. Report commissioned and published by the Home Office 1991.

4. Maden A, Taylor AC, Brooke D, Gunn J. *Mental Disorders in Remand Prisoners*. Home Office. 1995.

The primary purpose of prison is custody and rehabilitation and the need to provide primary health care in such a setting places constraints and duties on doctors, nurses and other health care staff.

3. Historically, prison health care has been organised outside the NHS. This has given rise to questions about equity, standards, professional isolation and whether the Prison Service has the capacity to carry out adequately its healthcare function. These issues have periodically been examined, in particular how best prisoner health care should be organised to deliver appropriate care that meets the needs of the prison population. There has been however, no combined Prison Service and NHS review of prison healthcare. In the light of concerns about prison health care and the potential benefits of improving healthcare for both services it is appropriate that the question of how best to improve healthcare for prisoners is now considered jointly by both the Prison Service and the NHS Executive. The work and conclusions of a joint Prison Service NHS Executive Working Group are the subject of this Report.

Report structure

4. *Section Two* sets out the background and historical context for this review. *Section Three* sets out the terms of reference, membership and approach of the Working Group. *Section Four* describes the key findings and issues to be addressed. The agenda for change and the way forward are contained in *Sections Five and Six*. Specific areas for improvement within the overall agenda for change are discussed in *Section Seven*. *Section Eight* sets out the time scale for change and *Section Nine* describes the impact and outcomes that we would expect our proposals to have. *Section Ten* sets out our overall conclusions and a summary of the key recommendations.

2 Background

5. The Prison Service aims to ensure that prisoners receive an equivalent standard of care to that provided by the NHS. However, there have been criticisms from a variety of sources of the failure of the Service to provide such care. In 1990 partly to address such problems an efficiency scrutiny recommended that the then Prison Medical Service be re-organised along purchaser-provider lines and that the role of the service should be widened to emphasise more strongly the promotion of health.⁵ However, introduction of the purchaser-provider split has met with limited success in addressing issues of standards of care. Since 1990 the failure of the Service to provide appropriate standards of care has been recorded in annual reports and in reports on individual prisons by the Prisons Inspectorate. In 1996 HM Chief Inspector of Prisons (HMCIP) produced a discussion paper *'Patient or Prisoner?'*.⁶ This paper highlighted weaknesses in the current delivery of healthcare to prisoners, in particular relating to quality of care, professional isolation of prison healthcare staff and poor links with the NHS. The Chief Inspector recommended that the NHS should take over responsibility for prison health care and outlined several organisational options designed to achieve this.
6. In the autumn of 1997 the standing Health Advisory Committee (HAC) to the Prison Service published a report on *'The Provision of Mental Health Care in Prisons'*.⁷ The HAC highlighted the uncoordinated way in which mental health care to prisoners was formulated and delivered, and the need for more effective throughcare arrangements to ensure continuity of care following release from prison.
7. In view of the wide ranging concerns about prison healthcare the Home Secretary and the Secretary of State for Health agreed to establish a Prison Service and National Health Service Executive Working Group. The group chaired by Dr Mike Longfield, Director of Healthcare, Prison Service, and Dr Graham Winyard, Health Services Director, NHS Executive, was tasked to work jointly to:
 - Address the issues in *'Patient or Prisoner?'* and other relevant documents

'In view of the wide ranging concerns about prison healthcare the Home Secretary and the Secretary of State for Health agreed to establish a Prison Service and National Health Service Executive Working Group'

5. Report on an Efficiency Scrutiny to the Prison Medical Service. Home Office. 1990.

6. *Patient or Prisoner?: a new strategy for health care in prisons*. HM Inspectorate of Prisons. London; Home Office. 1996

7. *The Provision of Mental Health Care in Prisons*. Health Advisory Committee for the Prison Service. London; Prison Service. 1997.

- Develop practical proposals for change that will deliver care for prisoners equivalent to that of the general population
- Take account of the wider Prison and NHS agendas.
- Take account of the views of the key stakeholders

The Working Group terms of reference, guiding principles and methods of working will be described in the next section.

3

The Joint Prison Service and National Health Service Executive Working Group

Terms of reference and membership

8. The full terms of reference of the Joint Working Group and membership are given in Appendix A.

Guiding principles

Equivalence of care

9. It has been acknowledged for many years that prisoners are entitled to receive the same range and level of health care service as are available in the community, indeed Prison Service Health Care Standards have the stated aim:

‘To give prisoners access to the same quality and range of health care services as the general public receives from the National Health Service.’⁸

10. What exactly does equivalence mean? The European Prison rules⁹ – drawing on the UN Standard Minimum Rules for the Treatment of Prisoners¹⁰ – state that ‘The [prison] medical services should be organised in close relation with the health administration of the community or nation’. This clearly implies that in the UK provision of prison health services should be closely aligned with the NHS. The HAC has in ‘*The Provision of Mental Health Care in Prisons*’ examined the concept of equivalence as it applies to mental health care in prisons. Their view is that equivalence means equivalent health policy, equivalent standards and equivalent delivery of healthcare. Government White Papers about health care in England and Wales consider the health of the population as a whole and do not make a distinction between prisoners and the rest of the community. Being in prison therefore should not remove the rights of prisoners to receive good health care. Prisons should not, either by acts of omission or commission, make it more likely that people become ill, experience a deterioration in their health status, or have access to substandard health care services in comparison to those available in the community. For this reason the principle of equivalence in health care policy, standards and delivery described by the HAC underpins the work presented in this report and is the basis for all its recommendations.

‘To give prisoners access to the same quality and range of health care services as the general public receives from the National Health Service’

8. *Health care Standards for Prisoners in England and Wales*. HM Prison Service. London; Prison Service. 1994.

9. The European Prison Rules. Recommendation Number R(87) 3 of The Committee of Ministers. Council of Europe. 1987.

10. The United Nations Standard Minimum Rules For Prisoners. Resolution adopted 30 August 1955. The First UN Congress on the Prevention of Crime and the Treatment of Offenders. Department of Health 1997.

‘A key part of our work was to examine in some detail information from a broadly representative sample of 38 prisons’

Method of working

11. The broad nature of our remit has meant that we necessarily had to look at a wide range of organisational, professional and staffing issues. To help us in this we have drawn on a range of existing published material including HMCIP inspection reports, Prison Service internal statistics and financial information. We also invited the views of a range of interested stakeholders – including Governors, Prison Service and NHS healthcare professionals, the Prison Officers Association (POA), HAC, Prisons Inspectorate and Boards of Visitors – which were submitted in writing, ascertained during prison visits or given at a Consultative Seminar held on 23 April 1998 (Appendix B) and a Prison Health Care Conference in July 1998.
12. A key part of our work was to examine in some detail information from a broadly representative sample of 38 prisons listed at Appendix C. The aim of this was to:
 - determine the range of organisational models of health care currently in operation in a range of prisons
 - identify successful models of health care
 - determine the range of health care activity undertaken
 - identify examples of good practice
 - explore ways in which good practice could be extended throughout the prison estate.

All prisons in the sample were contacted either by visit or through telephone interview. Thirteen prisons were visited by NHS members of the working group to achieve a better understanding about the nature of health care in prisons and the problems and challenges presented.

13. We were also able to draw on work carried out by external consultants in 13 prisons. These studies provided a range of information, financial, organisational and staff related, as well as recommendations specific to improvement at local level.
14. Since one important option identified by HM Chief Inspector of Prisons was that responsibility for prisoners’ health care should move to the NHS, we were mindful of the changes that the NHS itself had set in motion, and which were described in the White Paper *‘The New NHS Modern and Dependable’*,¹¹ in the Green Paper *‘Our Healthier Nation’*,¹² and in *‘A First Class Service: Quality in the New NHS’*.¹³ These papers set out the path for the organisational development

11. *The New NHS: Modern and Dependable*. London; The Stationary Office. 1997.

12. *Our Healthier Nation – A Contract for Health*. Department of Health. London; Stationary Office. 1998.

13. *A First Class Service: Quality in the New NHS*. Department of Health. London; The Stationary Office. 1998.

of the NHS in which the internal market is replaced with integrated care based on the principles of fair access to a national service; national standards delivered locally through partnerships; quality as the driving force; a rigorous approach to efficiency; public confidence. A key part of the NHS reforms is the establishment of Health Improvement Programmes (HIPs) led by Health Authorities but jointly agreed by all who are charged with planning or providing health and social care. These HIPs are the local strategy for improving health and healthcare and will cover the health needs of the population and the healthcare requirements to meet these needs. HIPs clearly have relevance for prisons.

15. To help us marshal the considerable amount of information before us, and to give some structure to our consideration of the opportunities and options for the future organisation of prisoners' health care, we kept in mind three broad options within which improvements could be sought (Figure 1). These broad options clearly represent a spectrum since even the status quo includes a significant degree of NHS involvement. All options would need to be underpinned by various forms of partnership between the Prison Service and the NHS, and even full transfer of prison healthcare to the NHS would not mean that the Prison Service could distance itself from the responsibility to facilitate and integrate health and health care within prisons.

‘All options would need to be underpinned by various forms of partnership between the Prison Service and the NHS’

Figure 1: Options for Change

- A** **Status quo plus:** that is to add impetus to the present policy of seeking efficiency and other improvements within the existing structure, further increasing the proportion of health care provided by contracts with the private or public sector, and placing rigorous delivery standards on directly managed services using service level agreements;
- B** **Partnership:** to adopt a more collaborative and co-ordinated approach with the NHS supported by a recognised and formal duty of partnership. The Prison Service and the NHS would jointly set health care and other standards. Services could be jointly commissioned on the basis of assessed need and provided by a combination of directly employed prison healthcare staff, the NHS and others. Resources for primary care would remain with the Prison Service
- C** **Full transfer to the NHS:** the complete integration of prison health care into the NHS, transferring both resources and accountability for prisoners' health care.

4

Key Findings and Issues to be Addressed

‘Health care in prisons is characterised by considerable variation in organisation and delivery, quality, funding, effectiveness and links with the NHS’

Summary and key problems

16. It is important at the outset to draw attention to the good work that is being done in a number of establishments, not only because it exists to the credit of the staff involved, but also because it provides examples of what is possible in difficult circumstances. However good practice was all too often dependent on the dedicated efforts and ideas of individuals, working without the support of a coherent strategy or service delivery frameworks. Our field work with the sample of 38 prisons and other information available has convinced us that health care in prisons is characterised by considerable variation in organisation and delivery, quality, funding, effectiveness and links with the NHS. No two prisons could be regarded as the same. While some of this variation may be justified on grounds of health need and the roles that particular establishments play (as between, say, local prisons and training prisons), the current situation is largely a product of a historic legacy and *ad hoc* development. Healthcare is often reactive rather than proactive, over-medicalised and only exceptionally based on systematic health needs assessment. Lack of direction, poor lines of communication and confused accountability resulted in many instances in less than optimal care. In general there was no way to monitor effectively the outcomes of care. These findings are summarised in Figure 2. Detailed findings are set out in Appendices D–H.

Figure 2: Key findings

- Multiple models of healthcare
- Ad Hoc* development and little strategic planning
- Confused lines of accountability and mixed messages
- Variable NHS links. Quality of care variable and difficult to measure
- Focus on illness rather than health
- Focus on process rather than outcome
- Health care generally not based on needs assessments
- Good practice depends on key individuals
- Good skills mix often not best utilised resulting in unfulfilled staff potential
- Lack of supervision, training and continuing development
- Tension between custody and care

17. Within this broad assessment there are a number of specific points that are worth highlighting under the headings of :

- Type and quality of healthcare
- Staffing
- Culture
- Funding
- Management and organisation

The type and quality of healthcare

18. Although there was a wide range of both primary and secondary care services provided for prisoners, with a move towards more primary care services, there was still an over reliance on healthcare beds within prisons and a medicalised model of care. The potential cost benefits of improved care and illness prevention through health promotion have not yet been adequately explored.

19. The quality of healthcare can be measured by the fairness of provision in relation to need, health improvement, effective delivery of appropriate healthcare, efficiency, patient experience and health outcomes. Such an approach is outlined in the NHS document *A First Class Service; Quality in the New NHS*. Quality of care in prisons was difficult to assess due to the lack of relevant clinical information, little clinical audit and the lack of a coherent approach in which care was provided. While a detailed analysis of the quality of care was not possible, using the above approach to quality several important themes emerged:

- Accessibility of healthcare was on the whole good, prisoners having rapid access to primary care and often having only short waits for secondary care; the exceptions to this were dentistry and specialist mental health services. The lack of specialist mental health services in prisons in particular the Care Programme Approach, which will be discussed in further detail later (*paragraph 62*), gave rise to serious concern about the standard of care for prisoners with mental health problems.
- Despite the existence of healthcare standards there was no consistent approach to the delivery of care. Very few establishments in the sample of prisons visited used clinical guidelines. The lack of guidelines together with changing medical and nursing staff meant that the standard of care was variable. Lack of information and audit meant that the effectiveness and appropriateness of this care could not be measured. Variable or absent links with the NHS resulted in many instances in a missed opportunity to share good practice.

‘Quality of healthcare can be measured by the fairness of provision in relation to need, health improvement, effective delivery of appropriate healthcare, efficiency, patient experience and health outcomes’

‘Prisons where nurses had been empowered as organisational managers and clinical leaders appeared to have more consistent and professional delivery of care’

- The efficiency of healthcare is to a degree influenced by the tension between the two imperatives of custody and care. While this is to a certain extent inevitable, better planning and organisation could improve matters. For example, better scheduling of visits by NHS consultants would help improve efficiency and reduce costs.
- There was no systematic way of eliciting the views of prisoners or their relatives on their perceptions of the care they received.
- There was no systematic assessment of health outcomes or health improvement resulting from healthcare received.

Staffing

20. There is no one model (or set of models) for staffing prison health care centres and no consistent model for their management and organisation, or for clinical (medical/nursing) leadership. Prisons where nurses had been empowered as organisational managers and clinical leaders appeared to have more consistent and professional delivery of care. However, the potential to use nurses most cost effectively has in many instances been missed due to inflexible employment practices and inexperience of managing nurses' terms and conditions of employment. Some nursing staff commented that they were often required to perform tasks inappropriate to their skills resulting in less than optimum use of their abilities and hence a less efficient service. Some staff commented that they were not able to realise their full potential.
21. The concept of multidisciplinary team working within prisons was in its early stages and there appeared to be few well embedded management teams. There was evidence in most prisons of skill decay and professional isolation with little organised continuing professional development and study leave given low priority.
22. Some prisons were experiencing difficulty in recruiting medical officers or in persuading local general practices to provide medical cover. This resulted in either inadequate cover or cover provided by doctors who may not have received appropriate training in primary care. Much of the medical officers' time was spent in performing prison related duties such as assessing fitness for adjudication and much time was spent seeing patients who, had the patient been in the community, would have been more appropriately seen by a nurse or other healthcare professional.
23. In general the morale of both nursing and medical staff and of healthcare officers appeared low.

Culture

24. All institutions and organisations have their own culture. Prisons are no exception. In many (but not all) prisons and young offender institutions the healthcare culture is influenced by traditional attitudes, with an emphasis on security and less on nursing practice and health improvement. This was particularly evident where the senior members of staff were of long standing and not nurse qualified. Newly recruited nurses often found it difficult to influence this culture and lacked access to clear lines of accountability to support them. These factors reduced job satisfaction and contributed to poor retention of nursing staff. Similar problems related to medical staff many of whom found difficulty in practising as they would wish to. More worrying were the medical staff who took on board the custom and practice of prison healthcare as the best way to fit in. Medical officers who worked for some of their time as GP principals seemed best equipped to manage the cultural differences and the need to manage the inevitable tensions and pressures of providing healthcare in a custodial setting.
25. The working group found much evidence of fear of change amongst healthcare staff, in particular amongst healthcare officers. Many felt that they were undervalued and had much to offer but were not helped by the system. While change and fear of change are normal, the current uncertainty about the future of prison healthcare is unhelpful.

‘Medical officers who worked for some of their time as GP principals seemed best equipped to manage the cultural differences’

Funding

26. The level of resources allocated to health care appears to be highly variable – see figures 3 and 4. The proportion of a prison’s budget allocated to health care ranges from around 3% to twice or three times that amount. Variations are not accounted for by looking at different types of prison. Budgets were set on the basis of historical allocations without the benefit of need assessments, and in the absence of benchmarks about how much resource health care should consume.
27. Historically, funding for care within prisons (primary care) has been the responsibility of the Prison Service and funding for NHS *inpatient* and *outpatient* care has been the responsibility of the NHS. Funding for NHS visiting consultants and for NHS services reaching into prisons (for example community mental health support in prisons) has been varied. In the main the Prison Service has funded these services but the lack of clarity over who should pay has resulted in difficulties for some prisons. The working group found that this lack of clarity has in some instances meant that prisoners did not receive care or that care was delayed due to arguments over who should pay. This is clearly an unacceptable situation which must be addressed.

Figure 3: Health care expenditure per average daily population (ADP)

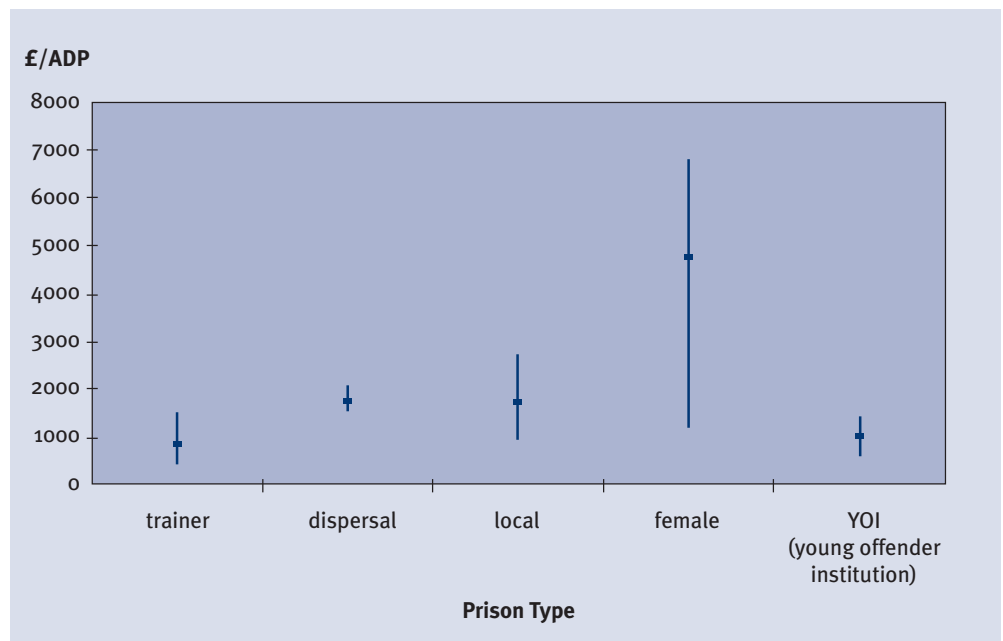
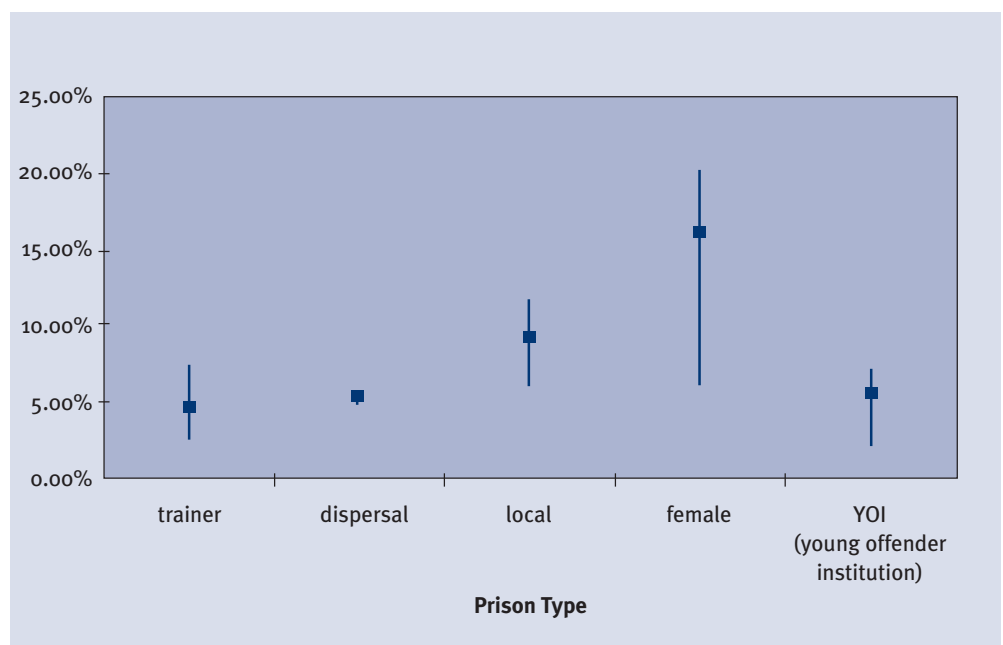


Figure 4: Health care expenditure as percentage of total prison budget



Management and organisation

28. There are problems with the management and organisation of healthcare at national and local levels both within the Prison Service and at the NHS/Prison Service interface.
- At national level the Directorate of Health Care (DHC) does not have direct line management responsibility for area medical and nursing advisers. The management structure is shown in Appendix D. The role of the Directorate of Health Care is one of setting general policy and standards and providing a line for professional advice to the Prisons Board, the Director General and to Ministers. This arrangement divides senior health care staff resources and expertise in a way that is not conducive to the taking of a strategic and consistent approach. It provides the opportunity for as many solutions as there are health care advisers.
 - At local level there was in general a lack of effective communication between healthcare staff, uniformed staff and nursing staff. We found mixed messages and a perception of lack of direction. Within prisons there was also a lack of healthcare management skills or a clearly defined role for a healthcare manager. There appeared to be little thought about the skills and competencies required to manage healthcare effectively. The confusion around management of healthcare within prisons is illustrated by the variety of job titles and backgrounds of those undertaking the management role. For example managers could be doctors, nurses or uniformed officers with the various titles of, Head of Healthcare, Healthcare Governor, Clinical Manager, Nurse Manager, Managing Medical Officer, Director of Healthcare. This lack of clarity was not helpful either to those working in prisons or to those in the NHS working with prisons. The management and organisation of healthcare appeared to be enhanced where there was a designated healthcare manager who had healthcare management skills and links with the NHS.
 - At the Prison Service/NHS interface the many and varied arrangements and contracts for both primary and secondary care at local level meant that good links with the NHS are essential. Unfortunately there were often no consistent or systematic links. Even in those instances where prison healthcare was contracted out to an NHS Trust links with General Practices or Health Authorities were lacking. There appeared to be few formal meetings or a planned shared approach to healthcare. At national level many of the health policy functions relating to health care simply duplicate those in the NHS resulting in inefficient use of manpower. There is a need to reconcile these issues.

‘The confusion around management of healthcare within prisons is illustrated by the variety of job titles and backgrounds of those undertaking the management role’

29. The findings detailed above represent a substantial challenge which will be impossible to tackle outside of an explicit and effective national framework that addresses, in a systematic fashion and over the long term, the fundamental weaknesses identified.

Constraints and opportunities

30. We set out, in *paragraph 15, figure 1*, three broad options – the status quo, partnership, full transfer to the NHS – within which we were considering our findings and proposals for change. However in thinking about these options we have sought also to identify those other factors or parallel developments that represent, in our view, particular constraints or opportunities for change that need to be taken into account. In the main we see these as being:

- The need to cope with the diversity of a prison estate comprising small and large establishments, serving different roles, widely distributed geographically, most managed directly but a small and growing number by the private sector. The difficulties and opportunities for engaging with the NHS vary between urban prisons and those in rural communities
- Health care being provided in the custody context. The prison population, as has already been noted, presents some health problems, e.g. drug addiction, mental disorder, in a more extreme form. The facts of custody and the regulated nature of prisoners' lives mean that prisons are atypical settings in health care terms and give rise to special ethical considerations
- Most health care will need to continue to be delivered inside the prison, and be linked into regimes. The framework for change should avoid introducing managerial or other divisions that would undermine the role of the Governor as being the person accountable for the whole institution
- The pool of appropriately qualified staff is limited. The Service's health care staff represent a considerable bank of skill that needs to be developed and appropriately allocated, recognising the changing roles implied by the detailed recommendations made below

‘Health care staff represent a considerable bank of skill that needs to be developed and appropriately allocated’

- The developments within the NHS, described in the White Paper ‘*The New NHS – Modern and Dependable*’, The Green Paper – ‘*Our Healthier Nation*’ and ‘*A First Class Service: Quality in The New NHS*’, themselves point to fact that the organisation with which prison health care needs to break down barriers is under transition.

Objectives

31. We consider that the objectives of any new organisational and accountability framework should be:
- To ensure that health care provided within prisons is appropriate to need and of comparable quality to that outside prison
 - To ensure that appropriate health care is not disrupted by entry to prison, by movement between prisons or upon release.
 - To reduce re-offending where that is attributable to health status (e.g. resulting from mental illness or substance abuse) and to use the opportunities presented by time spent in prison to tackle factors that can contribute to social exclusion.
 - To have the capacity to deal effectively with the problems of the current isolation of prison health, to manage the constraints and take advantage of the opportunities described above.

‘We do not consider that the current arrangements for prison healthcare will provide the opportunity or incentive for change’

Options analysis

32. A detailed analysis of the three broad options judged against the above objectives and other more detailed criteria was carried out. (See Appendix I).
33. We have already noted that the three broad options set out in *paragraph 15, figure 1* represent a spectrum of NHS involvement. The key assessment is the extent to which the NHS needs to be involved and the pace at which this should be achieved. We do not consider that the current arrangements for prison healthcare will provide the opportunity or incentive for change.
34. An important question faced by the Joint Working Group was whether responsibility for prison health care including funding should move from the Prison Service to the NHS. That this should happen was recommended by HM Chief Inspector of Prisons, who argued that it was *sine qua non* for the necessary improvements and provision of health care to prisoners to NHS Standards. In our view there are a number of practical reasons why such a change would not be appropriate in the short term:

‘Neither the NHS nor Prison Service can provide health care for prisoners without the co-operation of the other’

- The NHS is itself driving forward a radical and comprehensive programme for change, and we would be concerned about asking it to lead directly in an area from which it has hitherto been at some distance, and about the priority that it could, in practice, give to it
 - There is a risk that it would result in a dividing line within prisons with health care staff becoming isolated or marginalised, as a result of differences in management philosophy and culture, and differing views about the nature of regimes
 - The need for the two organisations to understand how to work together while minimising the potential for disruption of existing services
 - A move of around 2000 health care staff from the Prison Service to the NHS in the short term would present substantial industrial relations and other difficulties
 - Neither the NHS nor Prison Service can provide health care for prisoners without the co-operation of the other. Placing all the responsibility for what must be a joint service on one agency is likely to result in perverse incentives, as is currently the case.
35. However, we consider that healthcare services delivered to prisoners will need to take a form that ensures:
- health care standards are the same as those in the NHS, including access to treatment, availability of specialist back-up, current good practice procedures and comparable outcomes
 - professional isolation of health care staff is minimised, implying availability of professional supervision, opportunity for career moves between prison and NHS, access to in-service training, informal professional networks and research
 - care is distinct from custody
 - arrangements exist to ensure continuity of care on entry to prison, transfer between prisons, and on release.

This means that the NHS will need to take an active part in the organisation and provision of services in prisons. This needs to be done in a way that does not undermine the important contribution that the prison regime can make to the health and wellbeing of prisoners or discourages the prison management from giving due weight to healthcare.

36. For these reasons, for the time being, the broad division of funding responsibilities between the Prison Service and the NHS should not radically change: the Prison Service remaining responsible for the primary care delivered in prisons and the NHS for community mental health and visiting NHS specialist support reaching into prisons, and secondary care provided in NHS hospitals.
37. In order for the objectives set out in *paragraph 31* to be achieved a formal partnership between the Prison Service and the NHS will be required. This should ascribe clear duties and responsibilities to both organisations. Joint working and partnership will be necessary to deal effectively with the challenge that providing health care to prisoners in prisons presents. Health care will need to continue to be provided by a variety of models but this should take place within the context of the local planning that health authorities will in future, as part of the NHS White Paper reforms, be required to carry out (*paragraph 14*). **We recommend that health care in prisons is delivered through a formal partnership between the NHS and the Prison Service.**

‘Joint working and partnership will be necessary to deal effectively with the challenge that providing health care to prisoners in prisons presents’

6

Recommended Way Forward: A Prison Service NHS Partnership

Prisons and Health Authorities

38. We would see this partnership taking place at several levels. At local level it would take the following form (figure 5):

- Health Authorities and prisons would be jointly responsible for identifying the health needs of prisoners. As part of the NHS White Paper Health Improvement Programmes (HIPs), Health Authorities and prison managers (governors with their healthcare managers and area managers) will need to agree a local prison health improvement strategy. This would take account of the need to provide appropriate primary health care within prisons drawing on both internal and external resources such as community nurses, community mental health teams and Primary Care Groups; for secondary care within NHS hospitals either as out-patients or in-patients; and for continuity in health care when prisoners are released back to the community. The prison health improvement strategy would draw on reference healthcare models of the kind discussed below in *paragraph 74*. The prisons and Health Authorities would jointly plan and commission the provision of needs based prison health care aiming for seamless provision between the prison and the community. Action arising from the health improvement strategy will need to take the form of long term service agreements between the prison, the Health Authority and healthcare providers.
- In resource terms the Prison Service should continue to meet the costs of primary health care provided within prisons (and where a specialist NHS consultant visit is made to the prison as a result of security or administrative considerations rather than health need). The NHS would cover the cost for that inpatient and outpatient care provided outside. *Specialist* mental health services to prisons would be covered as part of the Health Authority long term service agreements with mental health providers for continuity of care in their area. This will include psychiatric visiting consultants (though medical reports for courts should as at present be paid for by the Prison Service). Costs of mental health services of a primary care nature would met by the prison.

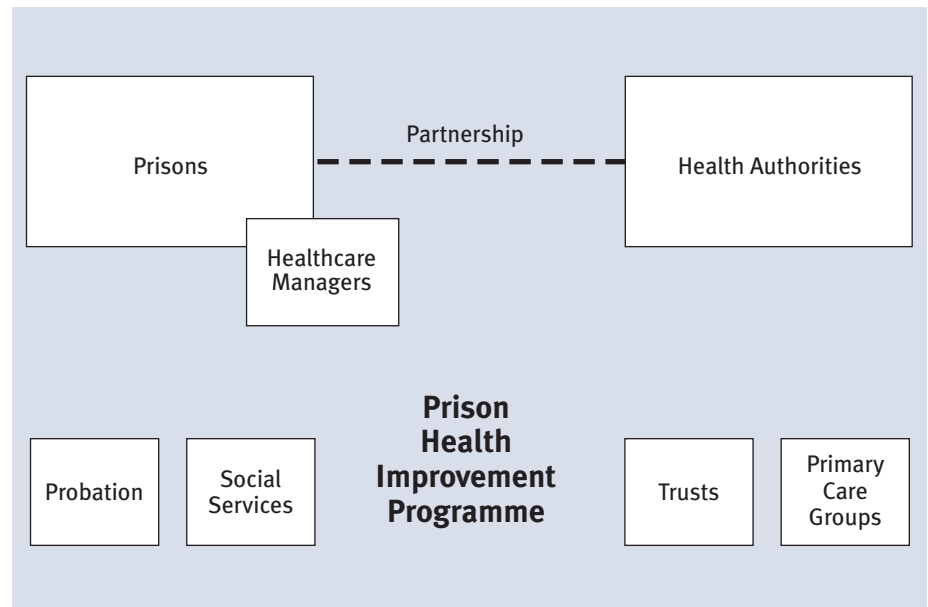
‘Prisons and Health Authorities would jointly plan and commission the provision of needs based prison health care aiming for seamless provision between the prison and the community’

- Although initially these arrangements might rely heavily on the existing prison healthcare organisation we would envisage that progressively over time the NHS would be the main provider through Primary Care Groups and Trusts with primary care funded by the Prison Service. We do not rule out the use of the private health care sector where such arrangements can be shown to represent quality and efficiency of care to NHS standards and are integrated, as appropriate, with the NHS.
- We would also see that clustering of services, for example to meet the needs of geographically related prisons or for commissioning specialist tertiary services, might be appropriate in organisation and value for money terms.
- The prison or prisons concerned and the relevant Health Authority would review progress against each prison health improvement strategy periodically and jointly at least once a year. This would take place against a background of performance management and monitoring which would include specific healthcare key performance indicators to help drive forward change.

‘The prison or prisons concerned and the relevant Health Authority would review progress against each prison health improvement strategy periodically and jointly at least once a year’

39. There is a potential friction point in these arrangements, between prisons and health authorities, arising from the implications of health needs assessments for prison and Health Authority budgets and manpower requirements. We do not think that this would be unmanageable: the prisons’ health improvement strategies will need to represent realistic plans about the pace at which change could be introduced, and we make recommendations below about that. However, if a matter fails to be resolved at local level, it would need to be considered at regional or national level by the Prisons Board or NHS Executive and ultimately, by Ministers.

Figure 5: Organisation at local level



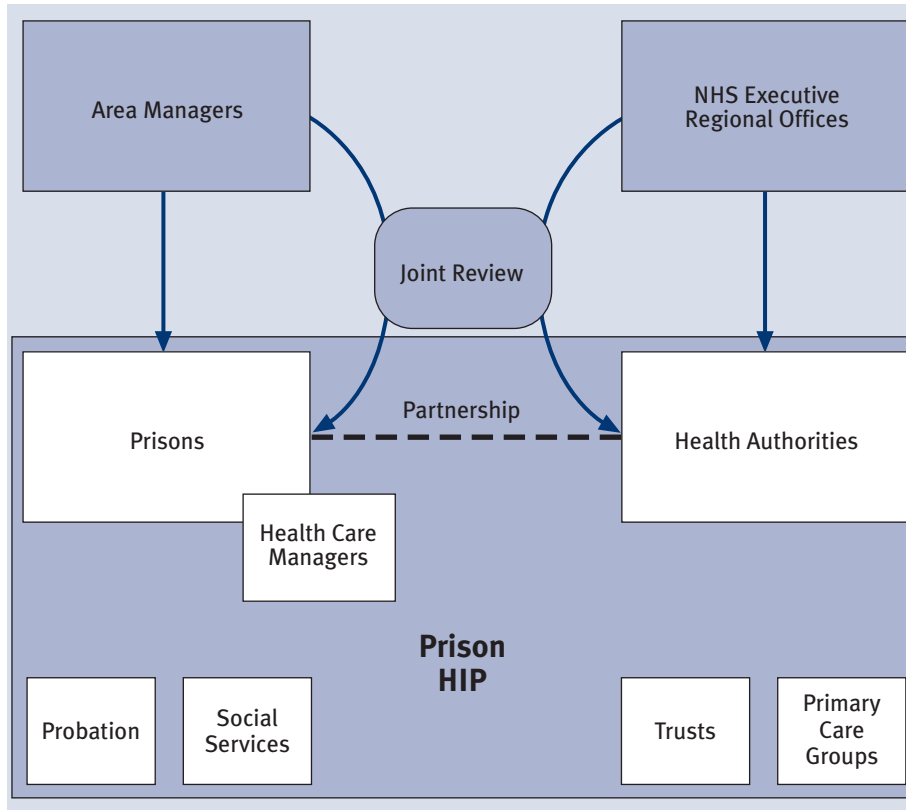
‘We continue to see a need for healthcare advice to prisons and co-ordination and monitoring at a regional level’

Prison Service Area Managers and NHS Executive Regional Offices

40. We have already noted (paragraph 28) that current arrangements are unsatisfactory and lead to poor co-ordination and a lack of coherent direction. We continue to see a need for healthcare advice to prisons and co-ordination and monitoring at a regional level. In keeping with the partnership arrangements to be put in place at local level, the NHS Executive Regional Offices and Prison Service Area Managers supported by a Task Force (see paragraph 47-52 below) would (figure 6):

- Carry out an annual joint review of the progress towards the health improvement programme made by prisons and health authorities in their region/area
 - Monitor the local action to strengthen partnerships
 - Provide access to advice and support for prison governors and health authorities
 - Develop plans for commissioning tertiary services including access to medium and high secure psychiatric services for clusters of prisons
41. To ensure that the Prison and NHS bodies co-operate in the above areas it will be necessary that these points are covered in Prison Service business planning guidance and in relevant NHS guidance.

Figure 6: Organisation at regional level



NHS Executive and Prison Service Directorate of Health Care

42. The agenda for change that we set out in this Report also needs to be driven and managed at national level, to ensure that the right policies and guidance are in place and that the levers for change are effective. We see the following functions as needing to be carried out centrally:

1. The development and communication of a clear strategic direction for prison healthcare, taking into account not only health care delivery but also the special workforce and training and information technology issues identified in this Report
2. The adoption or adaptation where necessary, of Department of Health and Welsh Office health policies and objectives, so that they may be applied in a custodial context.
3. Commissioning of research to support policy development and implementation
4. The provision of advice to Ministers on policy and Parliamentary business in relation to policy for healthcare in prisons.
5. Representation of health issues and the health dimension at the most senior level within the Prison Service, that is through membership of the Executive Committee and Prisons Board. In particular we see a need to ensure that the development of all Prison Service policy and operational initiatives take account of their likely effect on prisoners' health and well being.

‘The agenda for change that we set out in this Report also needs to be driven and managed at national level’

6. Leadership and support for implementing change

This points to a continuing role for a specialist headquarters unit with responsibilities in these areas. At present some of these functions fall to the Directorate of Health Care. However, as currently structured and located outside the Department of Health we do not consider that it will be able to deliver all of the objectives set out in this report.

43. We see the need for two distinct strands of work, a Policy Unit responsible for areas 1 to 5 above and a focused Task Force to lead and support the radical change that will be needed on the ground.

‘We see the need for two distinct strands of work, a Policy Unit ... and a focused Task Force’

National Policy Unit

44. We have set out above the functions of a Policy Unit. We believe that this unit should not attempt to duplicate work that is properly part of the wider health function within the Department of Health. The question remains where would a Policy Unit be best placed? There are two options: within the Prison Service (as is the case with the Directorate of Health Care) or within the NHS Executive. The key principle is that close working relationships between the Policy Unit and colleagues in the NHS Executive and Prison Service are developed.
45. We consider that a Policy Unit located within the NHS Executive is more likely to be successful in establishing the necessary linkages and relationships that we have described, linking in particular to the wider health policy development function of the Department of Health. However, in order that the Prisons Board continues to receive the necessary advice on health matters we would expect that the head of this Unit should be a member of the Prison Service Executive Committee and Prisons Board and be accountable to the Director General of the Prison Service. Staff of the Policy Unit will need to maintain close relationships with policy staff in the Prison Service.
46. **We recommend that a Policy Unit to carry out the functions described should be established. The Policy Unit would replace the current Directorate of Health Care.** We recognise however, that there is a range of complex issues such as defining responsibility between two sets of ministers and determining how these should be discharged, and of sharing information across departments. These issues need to be explored in greater detail than we have been able to do. **We recommend that Ministers ask the Chief Executive of the NHS Executive and the Director General of the Prison Service to establish a small team to consider the feasibility of siting the Policy Unit in the NHS Executive together with the manpower, functions, resources, operational lines, accountability and detailed timing.**

A Task Force

47. While the arrangements at local, regional and national level described above represent, in our view, a necessary step, a concerted change programme would also be required at all levels to co-ordinate action and to help underpin the process of change through management and support to the key actors: The Prison Service, prisons, Health Authorities, Area Managers, NHS Executive Regional Offices, Trusts, Primary Care Groups, Probation Service and voluntary organisations. **We recommend that the necessary leadership and support for change be provided through the creation of a Task Force.**
48. A Task Force would:
- Support and aid delivery of the development agenda for prison healthcare and identify and help remove barriers to change, and provide professional support as appropriate.
 - Act in an advisory capacity at all levels, helping to support the reviews described in *paragraph 40*.
 - Facilitate links between the Prison Service and NHS at all levels
 - Disseminate good practice
49. To achieve these objectives the Task Force would need vision and leadership. The head of the Task Force would need to command the confidence of Ministers, members of the NHS Executive and Prisons Board and of senior managers in both the NHS and Prison Service. We would see the Task Force as operating as a multidisciplinary team, comprising persons with management, clinical, contracting and public health skills and a good understanding of the organisation of the Prison Service and the NHS so that they can operate effectively as change agents and also facilitate the necessary cultural shifts. It would include the functions of existing area health and nursing advisers within the Prison Service. We would see the Task Force as having discretion to determine how best to begin the developmental agenda with prisons – it may for example choose to start the process with demonstration site prisons, with specific types of prison or to tackle a geographical region.
50. It is envisaged that the Task Force would be time limited to a period of 3-5 years after which time its role would be subsumed into local structures and systems as the recommendations of this report become established. At that time the Task Force would produce a report on the progress achieved. This would inform a further joint review by the NHS Executive and Prison Service of the issues considered in this report including the question of whether responsibility should be transferred wholly to the NHS.

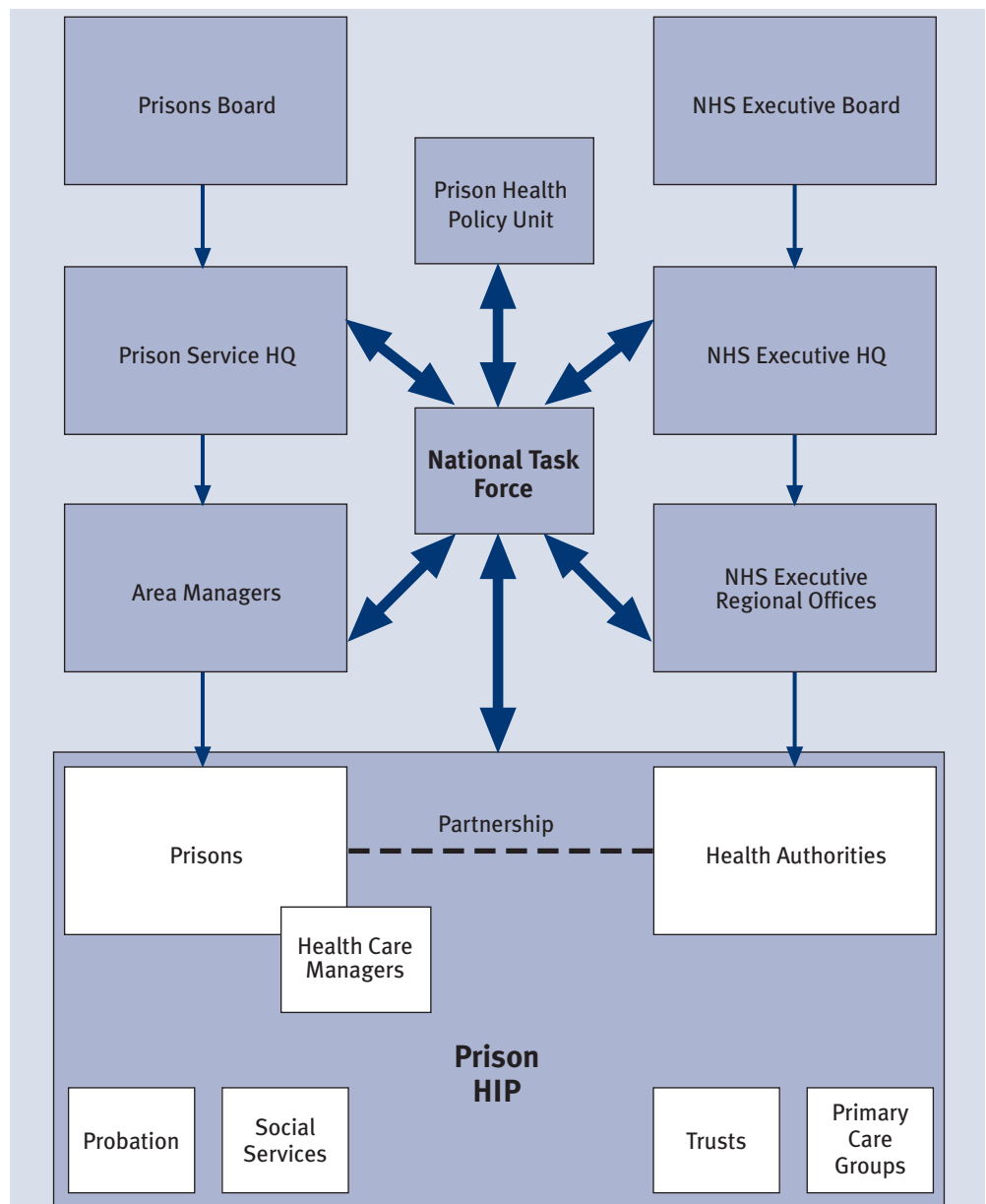
‘We would see the Task Force as operating as a multidisciplinary team, comprising persons with management, clinical, contracting and public health skills and a good understanding of the organisation of the Prison Service and the NHS’

51. The function of the Task Force as identified is separate from the function of the Policy Unit. Therefore we would expect that the head of the Task Force would be accountable and have ready access to the directors of the NHS Executive and the Prison Board and would be jointly appointed by the Chief Executive of the NHS Executive and the Director General of the Prison Service. There would be a need for a close working relationship between the Policy Unit and Task Force. The relationships of the Task Force are shown in figure 7.

‘The head of the Task Force would be accountable and have ready access to the directors of the NHS Executive and the Prison Board’

52. **We recommend that the team looking at the establishment of the Policy Unit (paragraph 46) should also organise the establishment of the Task Force including advising Ministers on the terms of reference, manpower needs and recruitment of the Head of the Task Force.**

Figure 7: Task Force and its relationships



53. In the light of the key findings presented above and the agenda for change, the working group identified thirteen broad areas where specific action is required within the proposed organisational framework.

Needs assessments

54. Healthcare delivered in prisons is not planned on the basis of need. Few prisons in the sample studied had carried out comprehensive health needs assessment of their population. Assessing the health needs of prisoners is a prerequisite for determining the type and degree of health care required and the starting point for determining the outcomes of care. Unless health needs assessments are undertaken a focus for developmental work cannot take place. The lack of health needs assessments is a fundamental problem that must be addressed. However, health needs assessments take time and specialised skills to be of value and ways must be found of ensuring that the necessary skills and resources are made available.

Action: Health needs assessments of the prison population should be carried out jointly with Health Authorities in the context of the broader organisation recommendations made above. A needs assessment template from the Health Needs Assessment Series should be commissioned.

‘The assessment of health status on reception into prison is the key to the care that a prisoner will subsequently receive’

Reception health screening and discharge planning

55. The assessment of health status on reception into prison is the key to the care that a prisoner will subsequently receive. Carried out well by competent staff, the assessment should result in an accurate plan of care for the individual. At present it is not uncommon for the initial assessment to be carried out under extreme time constraints by staff with limited knowledge. The initial assessment should be followed up with a full health appraisal by a doctor within a specified time following reception. A high standard of record keeping with shared care plans and, where relevant, integration with the prisoner’s sentence plan, are also likely to improve continuity of care. Access to prisoners’ previous health records e.g. GP or drug service, would also improve the clinical and other management of prisoners. Reception screening needs to be seen as a constructive exercise of greater importance which contributes to the planning

for effective care in individual cases, and to the assessment of health needs and the planning of services overall. Likewise, at the end of a prison sentence adequate assessment and plans for discharge should be carried out to ensure continuity of healthcare.

Action: A review of the purpose and process of the current reception screening should be carried out nationally with a view to providing guidelines for a more comprehensive assessment, staggered over the first days in custody. Health screening and action arising from it should help inform a prisoner's sentence plan. Arrangements for discharge planning should also be reviewed.

‘We were also struck by the frequent use of prison healthcare centres to manage prisoners who failed to cope on the prison wings and for whom social support would be more appropriate than medical care’

Primary care

56. We have already stated that the majority of health care that needs to be delivered in prisons can be classified as primary care (*paragraph 2*). It is vital that this care reflects the development of primary care within the community, where good practice illustrates that patients are best served when there is a team of professionals providing a range of skill mix in the services offered. We were also struck by the frequent use of prison healthcare centres to manage prisoners who failed to cope on the prison wings and for whom social support would be more appropriate than medical care. A way needs to be found to provide this support outside the health centre drawing on the skills of the multidisciplinary health team. This is discussed further in *paragraph 68*. It is impractical for doctors to deliver the complete package of care. At present the medical officer in prisons performs many inappropriate tasks and shoulders the majority of responsibility for care. Statutory duties and prison rules are not geared for effective delivery of primary care. They do not recognise the responsibilities of each healthcare team member and lead to inappropriate use of time. There should be a move away from specific roles for doctors and a move towards professionally led healthcare teams to include such skills as social work, occupational therapy and environmental health where appropriate. While it is essential that a health care physician be at the centre of such teams the other skills required should be based on the clinical need within the prison. All members of the primary care team should be appropriately qualified.

Action: There should be a focus on primary care within prisons and a move towards the establishment of primary care teams configured according to need. All primary care physicians should have appropriate training in general practice.

57. While prisoners had good access to primary care this did not always meet their needs in terms of health promotion and disease prevention: all too often primary care was reactive and process orientated. There are already developing health promotion initiatives within prisons and these should be extended.

Action: We would encourage the developments already taking place with regard to health promotion and recommend that health care and health more generally, form an appropriate and integral part of prisoners' regimes, taking a proactive approach to the services provided in the light of assessed prisoner health needs

‘While prisoners had good access to primary care this did not always meet their needs in terms of health promotion and disease prevention’

58. Within the area of primary care, dentistry and pharmacy services deserve special mention. All prisons surveyed had dental health service provision, principally provided on a sessional basis by a local dental practitioner. Waiting times for dental care were often lengthy, especially in local prisons because of high levels of demand to address high levels of untreated morbidity amongst prisoners. Dental services expenditure is not subject to professional audit.

Action: Dental health and dental health promotion should be included in needs assessment and health improvement plans. Methods should be adopted to enable all expenditure for dental services to be audited.

59. We noted two main models of pharmacy provision, with some prisons acting as cluster centres for the provision of pharmacy while others met their pharmacy needs through contracts with the NHS or private sector. Audit of pharmacy services was patchy. We would see pharmacy services to be an integral part of healthcare delivery and this points firmly towards pharmacy services being obtained through the NHS.

Action: As service agreements with the NHS are developed these should include pharmacy.

Secondary care

60. Secondary care is currently provided to prisoners in a variety of ways through a variety of contracts. A review of NHS contracts with prisons commissioned by the Department of Health¹⁴ showed that often contracts were set without reference to healthcare need and that there is no way to monitor the quality of care provided.

Action: Future service agreements should be explicitly linked to NHS quality standards and only introduced following an assessment of need. Referral guidelines should be drawn up locally and service agreements should be actively managed and reviewed. This should be carried out within the broader organisational recommendations described above.

Action: All secondary care should be provided in accordance with NHS National Service Frameworks as they are developed.

‘Future service agreements should be explicitly linked to NHS quality standards and only introduced following an assessment of need’

61. At the moment Health Authorities are responsible for the costs of secondary care for a prisoners in a prison in their area only after the prisoner has been there for six months. Prior to that the Health Authority in whose district the prisoner lived before entry in to prison, is responsible. This rule has proved to be the cause of considerable difficulty and delay in making appropriate care available.

Action: The ‘District of residence’ rules need to be examined with a view to simplifying them.

Mental health

62. There is a very high incidence of mental health problems amongst prisoners resulting in major morbidity.¹⁵ Mental health problems were one of the commonest causes of admission to prison health centres. Despite the size of the problem the working group found that models of healthcare to cope with mental illness in prisons were underdeveloped, that healthcare screening arrangements did not identify mental illness and that there was inadequate care planning for the mentally ill. We recognise that, as in the community, the majority of health care provision for mental illness should fall to primary care supported by specialist staff such as occupational therapists, counsellors and where appropriate community mental health teams. However, this specialist support was often lacking. There was little community mental health care team involvement in prisons and an over reliance on prison healthcare centre

14. Contracts between the NHS and the Prison Service. Report to the Prison Health Care Working Group. Dr T Exworthy. London. 1998.

15. Psychiatric Morbidity Survey of Prisoners. ONS. 1998.

inpatient beds. Less than one third of the prisons sampled had a formal contract with a mental health provider, three quarters had no community support and only one prison was supported by a community mental health team funded by the NHS. These findings are in agreement with those described in the HAC report on mental health.

Action: The care of mentally ill prisoners should develop in line with NHS mental health policy and national service frameworks including new arrangements for referral and admission to high and medium secure psychiatric services.

Action: Special attention should be paid to better identification of mental health needs at the reception screening.

Action: Mechanisms should be put in place to ensure the satisfactory functioning of a Care Programme Approach within prisons and to developing mental health outreach work on prison wings.

Action: Prisoners should receive the same level of community care within prison as they would receive in the wider community and policies should be put in place to ensure adequate and effective communication between NHS mental health services and prisons. Health Authorities should ensure that service agreements with NHS Trusts include appropriate mental health services for prisoners with appropriately qualified staff.

‘The care of mentally ill prisoners should develop in line with NHS mental health policy and national service frameworks’

Quality of care

63. One of the biggest weaknesses of the present system of delivery of healthcare in prisons is that there is no effective way to ensure the delivery of quality care and to measure its outcome. Healthcare standards as they presently exist are in the main related to processes of care and not to clinical outcomes. While the issue of quality of care is becoming more prominent a systematic approach to quality has yet to be developed. Since we are aiming for equivalence of care for prisoners it makes sense that the approach to quality outlined by the NHS is adopted by the Prison Service. This approach involves setting quality standards through national service frameworks and evidence based guidelines, delivering quality standards through lifelong learning, professional self regulation and clinical governance; and monitoring standards through a national performance framework.
64. A key element of the NHS approach to quality is clinical governance. This is described by the NHS as a framework through which an organisation is accountable for continuously improving the quality of their services by

‘Prisons should designate a clinician responsible for ensuring that systems for clinical governance are in place and that regular reports on clinical care are produced for the governor’

creating an environment in which excellence in clinical care will flourish. It mirrors corporate governance and has four main components:

- clear lines of responsibility and accountability for the overall quality of care
- a comprehensive programme of quality improvement activities
- clear policies aimed at managing clinical risk
- procedures for all professional groups to identify and remedy

There are clearly ways in which this approach would benefit prison health care delivery.

Action: The Prison Service should adopt the NHS approach to quality set out in ‘*A First Class Service*’.

Action: Prisons should designate a clinician responsible for ensuring that systems for clinical governance are in place and that regular reports on clinical care are produced for the governor. As the head of the prison the governor is ultimately responsible for assuring the quality of services provided in the prison.

Action: In order to deliver clinical governance Governors and their designated clinicians will need to liaise closely with Health Authorities, NHS Trusts and Primary Care Groups.

The role of nurses and health care officers in a multidisciplinary team

65. The role of nurses in prisons needs to be based on a more flexible and effective model of nurse competencies, focusing on the impact that nurses can make on health promotion and illness prevention. Psychiatric nurses with experience of forensic settings, risk management, the management of violence and skills in therapeutic approaches such as cognitive therapy would greatly improve the care of mentally disordered offenders.
66. It is generally accepted that:
 - There is a national shortage of trained nurses and the extent to which the Prison Service is successful in recruiting nurses depends on the Service’s image and the perception that the nursing profession has on the opportunities and career structure that is offered.
 - The custodial setting is unlikely to prove attractive to many, and the current isolated nature of prison health care must be regarded as a significant disincentive. Barriers to effective recruitment and retention need to be removed.

- All staff profiles should be based on health needs analysis to ensure that capabilities to tackle the health problems are developed.
- Opportunities for multidisciplinary working, involving professions supplementary to medicine, e.g. occupational therapists, should be exploited.
- Flexible roles incorporating multi-skilling would also enhance care in small establishments with few health care staff.

67. Given the wide variation in size and type of prison establishments it would be difficult to be precise about the model of nursing services. However, nursing leadership needs to be supported overtly by governors and other managers. In particular nurses must be enabled to practice within their ethical framework, the Code of Professional Conduct¹⁶. A new national strategy for nursing in the NHS is currently being prepared following widespread consultation. It is essential that nursing in prisons reflects the standards the NHS is striving to achieve. The national strategy is expected to enhance and strengthen the contribution of nurses within a multi-professional, multi-agency approach.

Action: The role of nurses in prisons needs to be based on a more flexible and effective model of nursing competencies. Nurse care in health care centres should be led by qualified nurses who should have ready access to the Governor's senior management team. Models of clinical supervision for nurses should be introduced.

68. Health Care Officers play a valued, valuable and committed role in the provision of health care to prisoners. Some are qualified nurses while others have a range of skills used in support of healthcare. They represent a substantial pool of skills, both interpersonal and health related. In many cases however, nursing provision was not always led by appropriately qualified staff. Underpinned by the principle of equivalence, it is the view of the Working Group that healthcare of a nursing nature should be led by qualified nurses. We see this as supportive of the general move towards separating custodial and nursing functions. We recognise that this will have a significant impact on the existing Health Care Officers. Those Health Care Officers who satisfy selection criteria should be enabled to undertake nurse training in the light of assessed health needs and skill shortages. For those who do not wish or are unable to acquire nursing qualifications we would see appropriate therapeutic roles in the context of developed regimes for dealing with prisoners with mental disorder, and supporting initiatives to provide community mental health support and social care in prisons. In the multidisciplinary healthcare team, health care officers have a key role to play.

‘The role of nurses in prisons needs to be based on a more flexible and effective model of nursing competencies’

‘Health Care Officers play a valued, valuable and committed role in the provision of health care to prisoners’

16. Code of Professional Conduct For the Nurse, Midwife and Health Visitor. United Kingdom Central Council For Nursing, Midwifery and Health Visiting Third Edition. June 1992.

Action: Health Care in prisons should move to a position where custodial and nursing functions are separate. Health care officers should be encouraged to take up roles as described above and to receive appropriate vocational training.

Doctors

69. Vocational Training Regulations for general practitioners implemented in 1981, and more recently the European Directive introduced into United Kingdom legislation in 1995, made it impossible for any doctor to work in general practice in any capacity within the NHS, including locum or assistant posts, without having either a certificate from the Joint Committee on Postgraduate Training for General Practice (JCPTGP) or an Acquired Right. Since 1997 no consultant may be appointed to the NHS without a Certificate of Completion of Specialist Training and entry in the specialist register held by the General Medical Council. The fact that these assurances do not apply to prison medical staff is an unacceptable anomaly if the principle of equivalence is to apply. A recent recommendation from the Chairman of the three Medical Royal Colleges Working Party on Education and Training for Doctors in Prison is that no further doctor should be appointed to the Prison Service to undertake any kind of primary care, who does not hold at least a JCPTGP certificate or its equivalent.¹⁷

‘No further doctor should be appointed to the Prison Service who is to undertake any kind of primary care, who does not hold at least a JCPTGP certificate or its equivalent’

Action: The working group supports the recommendation of the Three Colleges that no further doctor should be appointed to the Prison Service who is to undertake any kind of primary care, who does not hold at least a JCPTGP certificate or its equivalent. Existing doctors not holding a JCPTGP should be encouraged to undergo appropriate retraining either as a generalist or if appropriate a specialist.

70. In addition to ensuring that doctors have the required competencies these competencies must then be maintained. This is considered below.

Training and development

71. The healthcare training and development needs of healthcare officers have been discussed above, but all healthcare professionals working in prison need continuing professional development. This is necessary not only to meet statutory and professional obligations but also to reap benefits in maintaining

17. Report of the Working Party of The Three Medical Royal Colleges on the Education and Training of Doctors in the Health Care Services for Prisoners. Royal College of Physicians, Royal College of General Practitioners, Royal College of Psychiatrists. 1992.

and enhancing competence and improving patient care. The prison health care service is isolated from the mainstream of NHS development and at present training and development of health professionals is patchy. We are not persuaded that the current arrangements, though including some important and useful initiatives such as the Diploma in Prison Medicine, represent a clearly articulated strategy for meeting the training needs of all health care professionals working in prisons. Those managing health care in prisons also need to have access to training and guidance on the effective and economic employment, deployment and management of nursing and other staff, and in the effective use of other resources.

Action: A strategy for continuing professional development of health professionals working in prisons should be formulated, implemented and monitored. This strategy should be in line with the NHS and Prison Service human resources strategies and with any recommendations from the Royal Colleges and other professional bodies.

‘More needs to be done by the various professional Royal Colleges and the UKCC, to bring more doctors and nurses into contact with prison medicine during their period of training’

72. The number of vacancies for prison doctors has for some considerable time been running at around 15–20. The Service clearly has difficulty in attracting doctors of the right quality. In part this must be attributed to the poor image of prison medicine within the medical profession generally, and the perception that a prison doctor has few, if any, career prospects. Our recommendations about the general organisation of prisoners’ health care and the involvement of the NHS will go some way towards remedying these problems.

Action: More needs to be done by the various professional Royal Colleges and the UKCC, to bring more doctors and nurses into contact with prison medicine during their period of training, to broaden the knowledge and understanding of prison medicine, and to help make easier the movement of doctors and nurses between work in prisons and the NHS. In addition the creation of ‘job swaps’ with the NHS would also benefit staff and reduce the erosion of skills.

Workforce planning

73. We recognise that the increasing demand for nurses, doctors and other staff trained in mental health care implied by our recommendations will not easily be met in the short term, especially if account is taken of the other initiatives designed to improve mental health provision in the community, and the inner cities in particular, which can be expected to draw on the same limited pool of skilled staff. However, many of the recipients of mental health care are frequently to be found moving between the community and prison, and back,

and our recommendation should be considered as complementing community initiatives. Coupled with effective continuity of care arrangements we would expect more effective care overall that would contribute to a reduction in crime.

Action: The NHS, in planning for the number of training places for nurses and doctors and professions allied to medicine, needs to take account of the needs of prison health care, to ensure that a sufficient number of persons with appropriately relevant skills are available in future. Regional Educational Development Groups (REDGs) and consortia should consider the needs of individual prisons.

‘We see the need for reference models for particular types of prisons’

Management and organisation of health care centres

74. We have commented earlier that we found a great variety of models of health care provision and organisation. We do not regard variety in itself as being the problem – differences are inevitable due to the different sizes of prisons and roles – rather that what was in place appeared to be the result of history and ad hoc development, as opposed to a rational application of resources on the basis of assessed need. Governors need flexibility for the models of healthcare in their prisons and there will never be one perfect model of care applicable to all prisons. However, taking the present categorisation of health care centres (see Appendix D) as being broadly indicative of the type of ‘cover’ that is needed, we see the need for reference models for particular types of prisons, for example:

- Establishments such as local prisons with in-patient facilities and 24 hour cover. These prisons acting as reception and allocation centres, with a high throughput of prisoners, play a key role, holding at any one time a very substantial proportion of prisoners (40%);
- Training prisons, where the health needs, particularly in those of lower security category, are not so acute as to require the presence of health care staff over 24 hours. The prison population in these establishments is more static;
- Young offender and women’s prisons because they give rise to some special considerations;

75. We would not see these models as being wholly prescriptive. They should capture those elements of best practice in organisation and delivery of health care, which would be regarded as needing to apply in common at national level. They should also give an indication of benchmark costs so as to guide operational managers about what is expected when setting budgets. We would see governors as continuing to have discretion about how such arrangements were implemented locally, to meet local needs, but that departures from the reference model would need to be explained and justified. Where health care is purchased from an external provider the reference models should serve both to

guide contractors in formulating their service proposals, and a basis on which the Prison Service would judge such proposals.

76. We would see the reference models as covering particularly critical roles such as a health care manager, the standards of service, for example the NHS Patient Charter, the ethos in health care centres and the use of its resources, patient information, as well as such other organisational guidance as would be appropriate for the particular type of health care centre. We would see the role of a specialist healthcare manager as being particularly important to develop in view of the expanding involvement of the NHS and the need for joint working on a health improvement strategy and service agreements. Some healthcare centres may not be of a large enough size to warrant a specialist manager, in these cases managerial arrangements with clusters of prisons should be developed.

Action: Appropriate reference models should be devised for Local Prisons, Training Prisons, Young Offender Institutions and Female establishments. The management arrangements for healthcare in a prison should be led by specialist healthcare manager appointed on the basis of their experience of working in a health care setting and evidence of their competence as managers.

Information

77. Prisoner health information systems need to address two main needs
- Transfer of information between prisons, from the NHS to prisons and from prisons to the NHS
 - The appropriateness, validity and both clinical and managerial utility of data.

The flow of information between the Prison Service and the NHS is not systematised. On many occasions prison staff may not be aware of serious illness or of ongoing care being received by a prisoner who enters prison. This adversely affects health care delivered in prison, continuity of care and has had in some cases tragic consequences. Sometimes a spell in prison may be the only time that a person has received consistent healthcare. On return to the community it is important that this good work is not undone. Information needs to flow from the NHS to prisons and vice versa. Continuity of care and appropriate planning cannot take place unless the right information is available to the right persons at the right time.

‘Information needs to flow from the NHS to prisons and vice versa. Continuity of care and appropriate planning cannot take place unless the right information is available to the right persons at the right time’

Action: There is a need for protocols to be developed for transfer and sharing of relevant health care information between the NHS and prisons. Prison health care centres should be connected to the NHS Net to facilitate this process and to ensure that prison health information remains in step with developments in the NHS. All developments in information sharing should bear in mind the principles on confidentiality set out in the Caldicott Review.¹⁸

78. There is no shortage of information collected on health care, however this consists mostly of activity data which has little clinical utility to staff on the ground. It is often seen as useless by those collecting it and appropriate information is often unavailable to monitor the delivery of care. Audit as a result is poorly developed and unable to determine the clinical outcomes of care.

Action: The type and quantity of healthcare information collected should be reviewed and a data set developed that would enable monitoring of health outcomes in line with that developed in the NHS. Data collected should include both managerial and clinical data supported by appropriate information technology systems. Healthcare centres should have access to decision support IT equivalent to that in NHS primary care.

79. Financial information is not collected in a consistent form by prisons making cost estimations difficult.

Action: A programme of benchmarking costs should be instituted. This together with better information on need and health outcomes, would facilitate a move towards needs based funding.

Research and development

80. We have formed the clear view that research and development in prison health needs to be expanded and co-ordinated with other research initiatives both within the Prison Service and the NHS. This requires a clear programme of research involving the appropriate Research Councils (e.g. the Medical Research Council), and should take into account the results of the health needs assessments and the improvement plans that health authorities and prisons will be devising.

Action: A coherent programme of research to support the prison health development agenda should be devised and implemented.

‘A coherent programme of research to support the prison health development agenda should be devised and implemented’

¹⁸ Report of the review of patient identifiable information. The Caldicott Committee. Department of Health. London. 1997.

8 Time Scale For Change

81. We recognise that the recommendations and action points in this Report represent an ambitious agenda for change. It is important that the pace of this change is realistic reflecting the other pressures and priorities both in the Prison Service and the NHS. We consider that an overall time scale of five years with a series of milestones would be achievable.
82. The feasibility, functions and manpower review of the proposed prison health Policy Unit would commence **December 1998**.
83. A Health Needs Assessment Template would be commissioned and need to be completed by **Spring/Summer 1999**.
84. The Task Force should be appointed early 1999 and a programme of work defined no later than **Spring 1999**.
85. A key recommendation of this report (*paragraph 38*) is that Governors and Health Authorities should:
 - Undertake an assessment of the health needs of the prison population
 - Devise a health improvement programme covering both prevention and care provision
 - Draw up a commissioning plan for provision of all primary healthcare services and health promotion activity for the prison taking account of available resources, and for secondary services to be provided in prisons.

It would be reasonable to expect needs assessments to begin Summer/Autumn 1999 and work on health improvement programmes to begin early 2000. This phase should be completed in all areas within 3 years. There would need to be a continuing communication between the prison and the Health Authority to review and update the plan on a regular basis. The ability of health authorities to respond to the change agenda will depend to some degree on the type and number of prisons within their area. Appendix J details the number of prisons within each Health Authority in England.

‘We recognise that the recommendations and action points in this Report represent an ambitious agenda for change. It is important that the pace of this change is realistic’

86. Service agreements for provision of healthcare services for the prison should be drawn up on the basis of the commissioning plan. These agreements should specify arrangements for training, education, audit, Research and Development, and clinical governance. Service agreements might be with the NHS Trusts or Primary Care Groups or could take the form of contracts with the independent sector.

This phase might be in place in all areas within 5 years (e.g. to allow for recruitment and training of additional staff in shortage specialities). Partial implementation could be achieved more quickly.

87. Within this broad time frame, initial progress can be built on as the partnership develops and expertise increases. Some prisons and Health Authorities may find implementation easier than others and implementation here may therefore be quicker than anticipated.

9

Impact and Outcomes of the Proposals

Expected Outcomes

88. By the end of the 5 year period we would expect that:

- Every prison would have a health improvement plan based on assessment of need
- The majority of care would be provided through NHS bodies
- Healthcare staff working in prisons should meet professional standards of training
- Health services in prisons would be fully integrated with those in the community with consequent improvements in throughcare
- There would be more effective use of resources and less unjustified variation between prisons
- Health care would be making a full and effective contribution towards improving the health of prisoners.

We believe that such outcomes would go a long way towards meeting our objectives set out in *paragraph 31*.

Measuring progress

89. There are several ways in which progress with the change agenda and ultimately the improvement of the health of prisoners may be measured:

- Attainment of the milestones described
- Joint annual review by prisons and Health Authorities of the prison HIP
- Joint annual review by Area Managers and NHS Executive Regional Office
- An annual report of the Task Force
- Performance management systems both within the NHS and Prison Service with local monitoring of service agreements
- Information on health outcomes and quality of care
- Final report of the Task Force

What will it cost?

90. Appendix H gives our assessment of current prison health care costs, and how these might be impacted by our recommendations. We see our proposals as having a broad and cumulative effect on the way health care is organised and delivered. It has not been possible to disaggregate the financial information available to us in ways that would allow an assessment of the cost impact of all the individual recommendations. To meet the objectives of this Report we are sure will mean some redeployment and rationalisation of existing resources both by the Prison Service and the NHS. We would see some of the changes being able to be financed through expected efficiency gains. The projected costs are therefore intended to be illustrative of the potential sums that might be needed and are not intended to be comprehensive. In any case, future health care budgets would need to be guided by the health needs assessments, and it is not possible at this stage to be more precise than the broad impact outlined below. **We recommend that the Task Force review the collective resource impact of the health needs assessments and resulting prison health improvement programmes, and provide advice to the Prisons Board and the NHS Executive on priorities and on whether additional funds would be needed.**

91. We have said in *paragraph 36* that the broad division of funding responsibilities between the Prison Service and the NHS should not radically change. We believe that our proposals would broadly mean that for:

The Prison Service:

- The £85 million (1996/97 figure) spent on prison health care by prisons reflects the broad base line within which to begin looking for improvements in organisation and delivery of primary health care to prisoners. (This figure excludes the cost of prison drug treatment programmes of various kinds, which are separately organised and do not, with the exception of detoxification, fall on health care budgets).
- However, in order to bring all prisons to standards of good practice (to be exemplified through reference models of the type we recommended in *paragraph 74*) might need up to a further £30 million for which no provision currently exists.

‘To meet the objectives of this Report we are sure will mean some redeployment and rationalisation of existing resources both by the Prison Service and the NHS’

The NHS:

- Health Authorities will play a new role in assessing prisoners' health needs and helping prisons commission services through Primary Care Groups and Trusts.
- Secondary health care services will continue to be provided as at present, and health services to offenders with mental health problems improved through community mental health teams reaching into prisons at a cost of about £6 million per year. We estimate that, at any one time, about 10,000 prisoners would benefit.
- We know that there are currently many prisoners awaiting transfer to medium and high security hospital facilities. This number is likely to rise due to better recognition of mental illness but we have been unable to quantify it, which would in any case be influenced as a result of the better mental health services within prisons recommended in this Report. The NHS will need to take this into account in its planning and resource allocation for mentally disordered offenders as part of the general improvement expected under the new mental health strategy.
- The costs of the Policy Unit and the Task Force would be offset by the headquarters costs of the current Directorate of Health Care and medical and nursing advisor functions (about £4 million per year). However we would see additional support coming from the NHS in terms of the expected closer integration of prison health care into NHS training programmes, research and development and health care information technology.

10 Conclusion

‘The Working Group recommends that a Prison Service NHS partnership at all levels is the most practicable way of delivering equivalence of healthcare to prisoners’

92. Our Report has examined evidence from a variety of sources to analyse the pertinent issues around the delivery of healthcare for prisoners. We believe that the analysis of the problems presented is both bold and honest. Based on this the Working Group recommends that a Prison Service NHS partnership at all levels is the most practicable way of delivering equivalence of healthcare to prisoners. An ambitious agenda for change has been proposed, facilitated in its early stages by a Task Force, and key milestones for measuring progress have been identified.
93. Change will not be without its problems but evidence from those consulted suggests that change is expected and clarity about what that change will be, and how it will be implemented, will help improve morale. It is important that change builds on the pool of skills and expertise of those currently working in both the Prison Service and the NHS. The success of the change agenda will depend ultimately on the enthusiasm and commitment of all those involved in health care of prisoners.

Summary of Key Recommendations and Action Points

Recommendations	Paragraph
We recommend that health care in prisons is delivered through a formal partnership between the NHS and the Prison Service	37
We recommend that a prison health Policy Unit be established. The Policy Unit would replace the current Directorate of Health Care.	46
We recommend that Ministers ask the Chief Executive of the NHS and the Director General of the Prison Service to establish a small team to consider the feasibility of siting the Policy Unit in the NHS Executive together with the manpower, functions, resources, operational lines, accountability and detailed timing.	46
We recommend that the necessary leadership and support for change be provided through the creation of a Task Force.	47

Recommendations	Paragraph
We recommend that the team looking at the establishment of the Policy Unit should also organise the establishment of the Task Force including advising Ministers on the terms of reference, manpower needs and recruitment of the Head of the Task Force.	52
We recommend that the Task Force review the collective resource impact of the health needs assessments and resulting prison health improvement programmes, and provide advice to the Prisons Board and the NHS Executive on priorities and on whether additional funds would be needed	91

Action Points	Paragraph
Action: Health needs assessments of the prison population should be carried out jointly with Health Authorities in the context of the broader organisation recommendations made above. A needs assessment template from the Health Needs Assessment Series should be commissioned.	54
Action: A review of the purpose and process of the current reception screening should be carried out nationally with a view to providing guidelines for a more comprehensive assessment, staggered over the first days in custody. Health screening and action arising from it should help inform a prisoner’s sentence plan.	55
Action: There should be a focus on primary care within prisons and a move towards the establishment of primary care teams configured according to need. All primary care physicians should have appropriate training in general practice and be on the specialist register.	56
Action: We would encourage the developments already taking place with regard to health promotion and recommend that health care and health more generally, form an appropriate and integral part of prisoners’ regimes, taking a proactive approach to the services provided in the light of assessed prisoner health needs.	57
Action: Dental health and dental health promotion should be included in needs assessment and health improvement plans. Methods should be adopted to enable all expenditure for dental services to be audited.	58
Action: As service agreements with the NHS are developed these should include pharmacy.	59

Action Points	Paragraph
<p>Action: Future service agreements should be explicitly linked to NHS quality standards and only introduced following an assessment of need. Referral guidelines should be drawn up locally and service agreements should be actively managed and reviewed. This should be carried out within the broader organisational recommendations described above.</p> <p>Action: All secondary care should be provided in accordance with NHS National Service Frameworks as they are developed.</p>	60
<p>Action: The ‘District of residence’ rules need to be examined with a view to simplifying them.</p>	61
<p>Action: The care of mentally ill prisoners should develop in line with NHS mental health policy and national service frameworks including new arrangements for referral and admission to high and medium secure psychiatric services.</p> <p>Action: Special attention should be paid to better identification of mental health needs at the reception screening.</p> <p>Action: Mechanisms should be put in place to ensure the satisfactory functioning of a Care Programme Approach within prisons and to developing mental health outreach work on prison wings.</p> <p>Action: Prisoners should receive the same level of community care within prison as they would receive in the wider community and policies should be put in place to ensure adequate and effective communication between NHS mental health services and prisons. Health Authorities should ensure that service agreements with NHS Trusts include appropriate mental health services for prisoners with appropriately qualified staff.</p>	62
<p>Action: The Prison Service should adopt the NHS approach to quality set out in ‘<i>A First Class Service</i>’.</p> <p>Action: Prisons should designate a clinician responsible for ensuring that systems for clinical governance are in place and that regular reports on clinical care are produced for the governor. As the head of the prison the governor is ultimately responsible for assuring the quality of services provided in the prison.</p> <p>Action: In order to deliver clinical governance Governors and their designated clinicians will need to liaise closely with Health Authorities, NHS Trusts and Primary Care Groups.</p>	64

Action Points	Paragraph
<p>Action: The role of nurses in prisons needs to be based on a more flexible and effective model of nursing competencies. Nurse care in health care centres should be led by qualified nurses who should have ready access to the Governor’s senior management team. Models of clinical supervision for nurses should be introduced.</p>	67
<p>Action: Health Care in prisons should move to a position where custodial and nursing functions are separate. Health care officers should be encouraged to take up roles as described above and to receive appropriate vocational training.</p>	68
<p>Action: The working group supports the recommendation of the Three Colleges that no further doctor should be appointed to the Prison Service who is to undertake any kind of primary care, who does not hold at least the JCPTGP. Existing doctors not holding the JCPTGP should be encouraged to undergo appropriate retraining either as a generalist or if appropriate a specialist.</p>	69
<p>Action: A strategy for continuing professional development of health professionals working in prisons should be formulated, implemented and monitored. This strategy should be in line with the NHS and Prison Service human resources strategies and with any recommendations from the Royal Colleges and other professional bodies.</p>	71
<p>Action: More needs to be done by the various professional Royal Colleges and the UKCC to bring more doctors and into contact with prison medicine during their period of training, to broaden the knowledge and understanding of prison medicine, and to help make easier the movement of doctors and nurses between work in prisons and the NHS. In addition the creation of ‘job swaps’ with the NHS would also benefit staff and reduce the erosion of skills.</p>	72
<p>Action: The NHS, in planning for the number of training places for nurses and doctors, needs to take account of the needs of prison health care, to ensure that a sufficient number of persons with appropriately relevant skills are available in future. Regional Educational Development Groups (REDGs) and consortia should consider the needs of individual prisons.</p>	73
<p>Action: Appropriate reference models should be devised for local prisons, training prisons, Young offender Institutions and female establishments The management arrangements for healthcare in a prison should be led by specialist healthcare manager appointed on the basis of their experience of working in a health care setting and evidence of their competence as managers.</p>	77

Action Points	Paragraph
Action: There is a need for protocols to be developed for transfer and sharing of relevant health care information between the NHS and prisons. Prison health care centres should be connected to the NHS Net to facilitate this process and to ensure that prison health information remains in step with developments in the NHS. All developments in information sharing should bear in mind the principles on confidentiality set out in the Caldicott Review.	78
Action: The type and quantity of healthcare information collected should be reviewed and a data set developed that would enable monitoring of health outcomes in line with that developed in the NHS. Data collected should include both managerial and clinical data supported by appropriate information technology systems. Healthcare centres should have access to decision support IT equivalent to that in NHS primary care.	79
Action: A programme of benchmarking costs should be instituted. This together with better information on need and health outcomes would facilitate a move towards needs based funding.	80
Action: A coherent programme of research to support the prison health development agenda should be devised and implemented.	81

1

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Appendix A: Terms of Reference and Working Group Membership

Terms of Reference

‘The NHS Executive and the Prison Service to consider jointly the future delivery of health care to prisoners, and to report on the arrangements and time scale for achieving the objective of delivering the same range and standards of service to prisoners as that provided by the NHS; the agreed arrangements to incorporate the aim of making prisons healthy settings; the recent reports of HMCIP and the HAC mental health sub-committee on prisoner health care to be taken into account, and overall to make the most effective use of available resources. The group would to test its findings on a wider audience with a seminar in 1998, thereafter making a report to the NHS and Prisons Boards, and Ministers, with options and recommendations.’

Working Group Members

NHS Executive/Department of Health

Dr Graham Winyard, Director of Health Services NHS Executive –
Joint Group Chairman

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Mrs Fenella Tayler, policy on delivery of health care, Directorate of Health
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External Members

Professor Denis Pereira-Gray, Royal College of General Practitioners

Dr John Reed, HM Inspectorate of Prisons

Dr John O Grady, Chairman Health Advisory Committee

Appendix B: List of those who attended the Consultative Seminar

Minister and Special Adviser

George Howarth MP, Parliamentary Under Secretary of State, Home Office
Norman Warner, Home Secretary's Special Adviser

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Dr John O'Grady, Health Advisory Committee to the Prison Service

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Nicola Mahood, Salford Mental Health Services

Professor Glyn Lewis, Professor of Community and Epidemiological
Psychiatry, University of Wales College of Medicine

Dr Ruth Wallis, Lambeth Southwark and Lewisham Health Authority

Gill Stephens, Assistant Chief Nursing Officer, Department of Health

Val Barker, Senior Development Manager, Communicable Diseases, Wakefield
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Dr Lois Lodge, Deputy Director of Public Health, South Thames
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Dr Susan Bailey, Consultant in Adolescent Forensic Psychiatry, Prestwich
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Dr Ken Snider, NHS Executive Northern and Yorkshire Regional Office

Dr Emmet Larkin, Leicester Mental Health Service

Dr Connie Smith, Parkside NHS Community Trust

Dr Jim Paris, NW Lancaster Health Authority

Dr Clive Richards

Dr Sarah Barker and Mr Ron de Witt, Leeds Health Authority

Carl Petrowfsky, NHS Executive, Anglia and Oxford Regional Office

Eileen Best, Mental Health Coordinator, North West Thames Regional Office

Margaret Best, Director of Nursing and Quality Enhancement, North Durham NHS Trust

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Suzanne Trotter, Midwife, Enfield and Haringay Health Authority

Dr Olwen Williams, Anglia Clinical Audit and Effectiveness Team

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Dr Ian Cameron, Leeds Health Authority

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Others

Sir David Ramsbotham, HMCIP

Maggi Lyne, nursing adviser, HMIP

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Mike Boyle, Mental Health and Criminal Cases Unit, Home Office

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Dr Porteous, Board of Visitors Secretariat

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Trevor Pollock, Northern Ireland Prison Service

Barrie Wilcox, Welsh Office

Grahame Cave, HAC

Professor Terence Morris, Howard League for Penal Reform

Stephen Shaw, Prison Reform Trust

Graham Sandell, HAC and NACRO

Denis Valentine, NACRO

Brian Caton, Assistant Secretary, and Pete Cartwright, the Prison Officers' Association

Graham Mumby-Croft, Prison Governors' Association

Dr Paddy Keaveney, BMA

Mr Glenn Davenport, IPMS

Dr P Snowden, Royal College of Psychiatrists

Professor Bassendine, Royal College of Physicians

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Dr Robert Hedley, Postgraduate Medical Education Office, University of Nottingham

Steve Taylor, SCODA

Tracey Westley, UKCC

Appendix C: Prison Sample

Prisons examined by working group

Prison Type	Prison	ADP	Remand	Sentenced No. Inmates	Throughput	Throughput/ ADP
Cat B Trainer	Albany	431	0%	100%	433	1.0
Cat B Trainer	Dartmoor	575	0%	100%	642	1.1
Cat B Trainer	Garth	517	0%	100%	361	0.7
Cat B Trainer	Nottingham	205	0%	100%	128	0.6
Cat B Trainer	Swaleside	512	0%	100%	470	0.9
Cat C Trainer	Stafford	603	0%	100%	1017	1.7
Cat C Trainer	Stocken	408	0%	100%	512	1.3
Cat D Trainer	Ford	435	0%	100%	1198	2.8
Dispersal	Long Lartin	360	0%	100%	370	1.0
Dispersal	Wakefield	631	0%	100%	152	0.2
Female	Holloway	294	50%	50%	2749	9.4
Female	Styal	241	0%	100%	579	2.4
Local	Canterbury	270	58%	42%	1474	5.5
Local	Cardiff	620	36%	64%	4635	7.5
Local	Elmley	643	25%	75%	1826	2.8
Local	Leeds	830	56%	44%	7591	9.1
Local	Liverpool	1233	34%	66%	6525	5.3
Local	Manchester	1133	56%	44%	4941	4.4
Local	Winchester	540	38%	62%	2163	4.0
Local	Wormwood scrubs	1063	27%	73%	4340	4.1
Private (Local)	Doncaster	914	59%	41%	6112	6.7
Local	Parc*	500				
Local/YOI	Northallerton	248	50%	50%	1532	6.2
YOI	Lancaster farms	463	35%	65%	1784	3.9
YOI	Reading	217	76%	24%	1602	7.4

*newly opened

Prisons where detailed studies were carried out by external consultants

Prison Type	Prison	ADP	Remand	Sentenced	Throughput Of Inmates	Throughput/ADP
Cat B Trainer	Blundeston	395	0%	100%	441	1.1
Cat C Trainer	Downview	283	0%	100%	312	1.1
Cat C Trainer	Lindholme	653	0%	100%	1466	2.2
Cat C Trainer	Wayland	540	0%	100%	1245	2.3
Cat C Trainer	Wealstun	549	0%	100%	1246	2.3
Female	Askham Grange	115	0%	100%	283	2.5
Local	Durham	597	35%	65%	2388	4.0
Local	Highdown	671	25%	75%	3228	4.8
Local	Norwich	555	26%	74%	3484	6.3
YOI	Hatfield	159	0%	100%	774	4.9
YOI	Low Newton	613	62%	38%	2230	3.6
YOI	Moorland	644	0%	100%	1111	1.7
YOI	Wetherby	207	0%	100%	485	2.3

Appendix D: Current Organisation of Prison Health Care

There are 134 prison service establishments for both young and adult offenders, and men and women. The majority, 128, are directly managed; 6 are contractually managed on behalf of the prison service by the private sector. In 1997/98 there were about 230,000 receptions into prisons, and on 31 March 1998 the average daily population was about 62,000, representing a rise of about 9.5% on the previous year. This trend that has continued and the figure on 31 August 1998 stood at 65,771.

The health care for convicted and remand prisoners has historically been funded and organised separately from the NHS, being the responsibility of the prison administration within the Home Office. The 1952 Prisons Act and the Prison Rules both make statutory requirements for provision for the care of prisoners' mental and physical health in both general and specific terms.

A mix of directly appointed personnel and a range of contracted individuals and services deliver health care. The majority of prisons have a directly appointed full-time medical officer (MO), or a part-time MO usually appointed from a local GP practice. A mix of health care officers (HCOs – mostly discipline staff with health care training) and/or nursing grades provides nursing services. Specialist services such as psychiatry or dentistry tend to be provided by visiting NHS specialists. In a proportionately small number of prisons, and all contractually managed prisons, medical services are provided by contracted staff from local GP practices/NHS Trusts, or private providers.

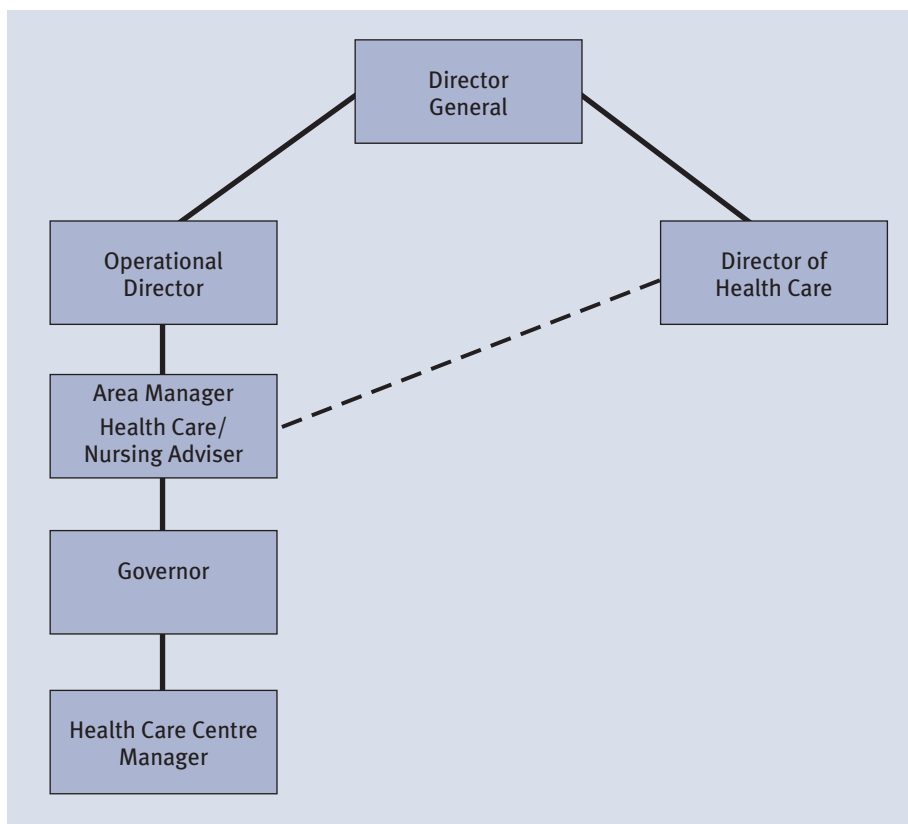
Local provision is currently organised around prison health care centres. There are 4 categories according to the level of service provided:

Health Care Centre Type	Level Of Service Available	No. Of Centres On 31. 3. 98	No Of Staff
1	Day time cover, generally by part time staff	36	145
2	Day time cover, generally by full time staff	33	219
3	Health care centre has in-patient facilities with 24 hour nurse cover	61	1490
4	As for type 3 but also serves as a national or regional assessment centre	4	172

The Governor is primarily responsible for the prison health care centre and line manages the staff who work there. As part of the general thrust of devolution of management responsibility that the service has seen in the last few years, Governors are not obliged to follow any one particular model. The details about how any one type of health care centre is organised therefore vary both in management, staffing mix and number. The costs for health care provided within the prison walls are borne against prison budgets. In contractually managed prisons health care is the responsibility of the Director, to be provided against a specification that forms part of the contract.

Area Managers supervise groups of establishments, line managing prison governors. Along with their general management role for the efficient and effective running of their establishments, they also have responsibility for the organisation and delivery of health care in their area. They are advised and supported in this role by 6 area medical health advisers and two nursing advisers. The Director of Health Care does not have direct line management responsibility for health care staff working in prisons nor for the area health and nursing advisers. The role is one of setting general policy and standards and for providing a line for professional advice to the Prisons Board, the Director General and to Ministers. An overview of management line and accountability is shown at figure D.1.

Figure D.1: Line management accountability for prisoners' Health Care

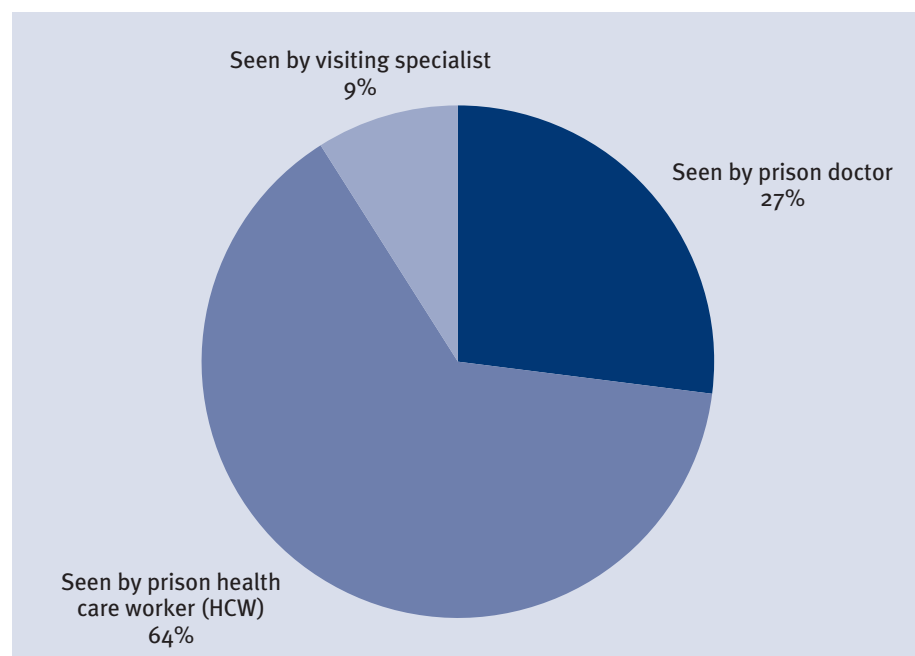


Appendix E: Health Activity Data

This appendix draws together a variety of health activity data in prisons that give an indication of the volume, type and level of health care provision. They quantify, therefore, the types of services that the resources identified in Appendix H currently buy.

During the period April 1996 to March 1997 staff providing health care in prisons handled over 2 million consultations with inmates. About two thirds of these involved contact with health care officers or nurses, 27% with prison doctors and about 9% with NHS specialists visiting prisons. See Figure E1.

Figure E1: No of inmate healthcare staff contacts 1996/97
Total =2.086 million



Primary care consultation rates and admission to prison healthcare centres show a marked variation between different types of prison with the rate in women's prisons and dispersal prisons being considerably higher. Figures E2 and E3. The primary care consultation rate is considerably higher than that found in the community.

Figure E2: Consultation rates in prison sample

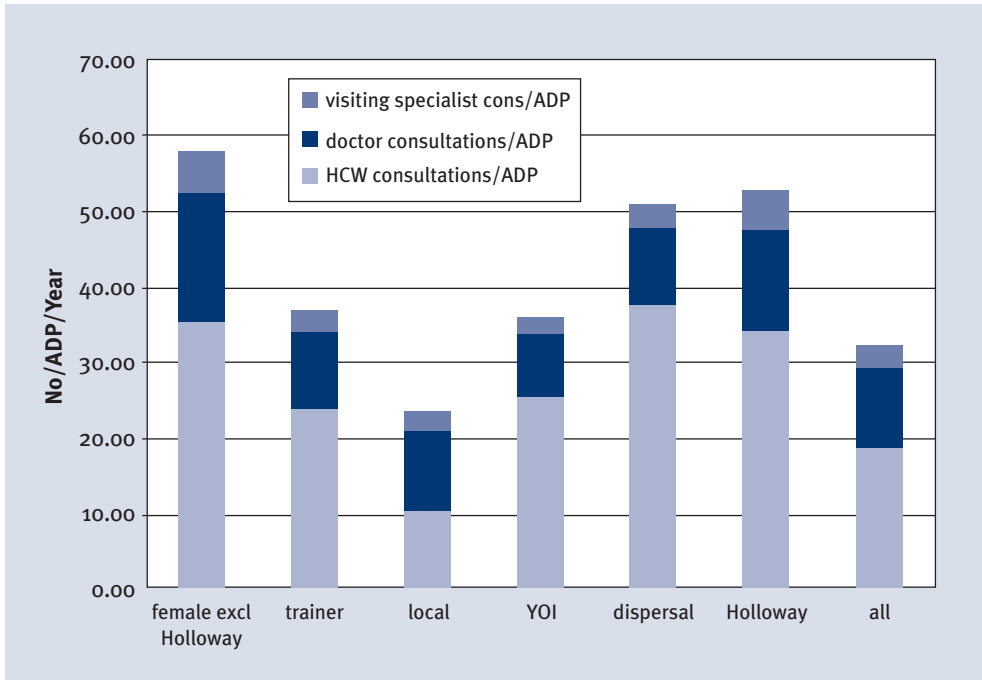
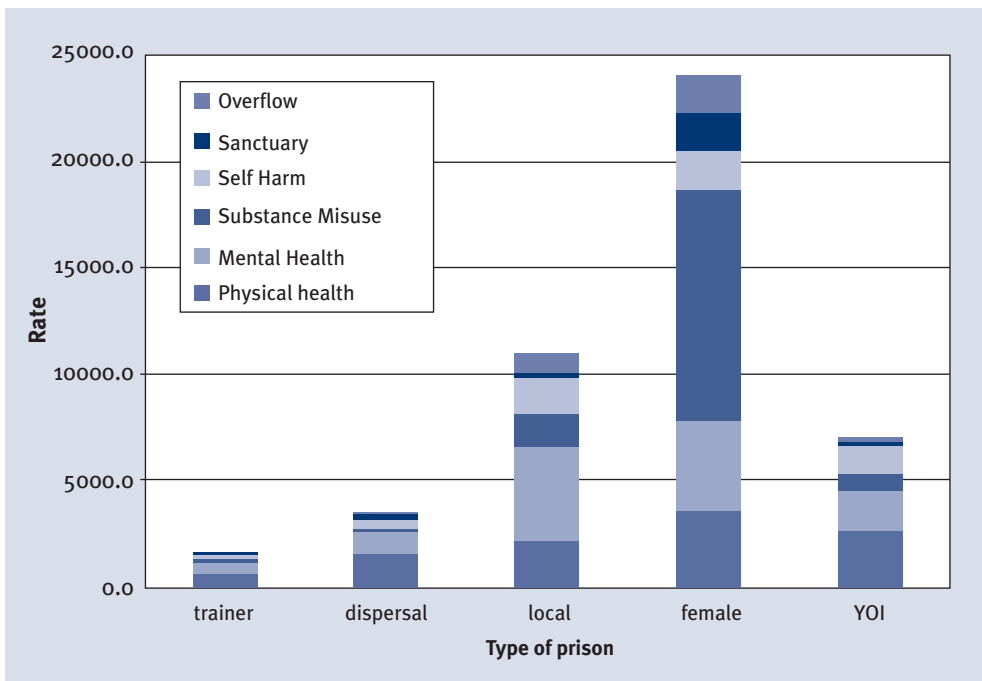


Figure E3: Rates of in-patient admissions in prison health care centres per 1000ADP



Secondary care for prisoners in prisons was carried out by visiting NHS specialists from a variety of specialties. The high proportion of psychiatry and dental consultations should be noted. Figure E4.

In around 30,000 cases prisoners received treatment in NHS hospitals as out-patients, in-patients or at accident and emergency departments. Figure E5. These rates are comparable to those found in the community.

Figure E4: Sessions provided in prison by visiting NHS specialists 1996/97

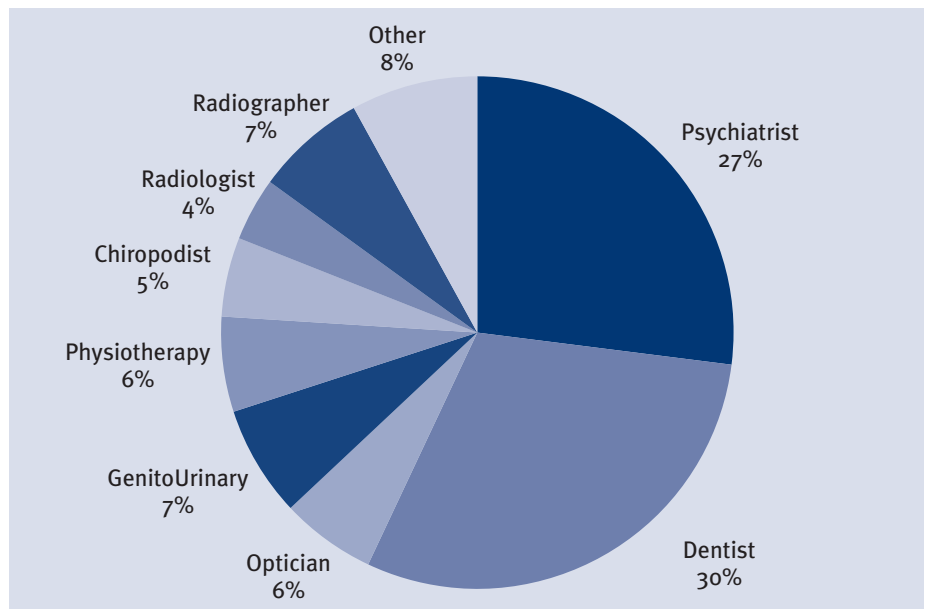
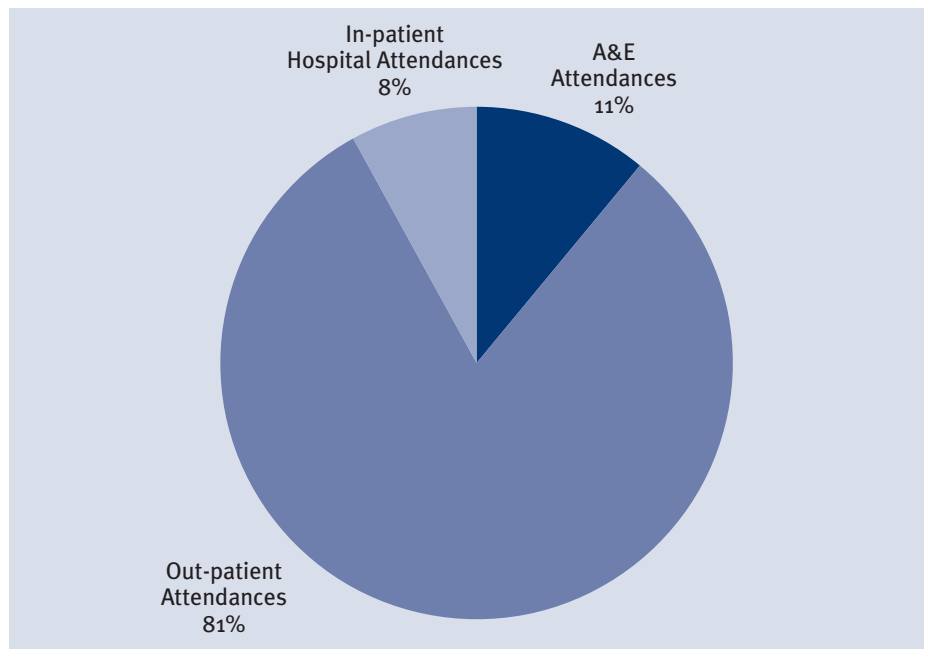


Figure E5: Treatment outside prison 1996/97 (Total No = 29213)



Appendix F:

Models Of Care In The Prison Sample

A key part of the work of the Working Group was to examine information from a sample of 38 prisons to:

- determine the range of organisational models of health care in prisons
- identify successful models of health care
- determine the range of health care activity undertaken (See Appendix E)
- identify examples of good practice
- explore ways in which good practice could be extended throughout the prison estate.

This appendix sets out the range of models of care identified. While no single model of care was considered to be 'ideal', examples of models considered to provide an acceptable level of care from which we can learn are described.

Broad categories of models identified

Our visits to prisons, confirmed that there is a good deal of variation in the models of care provided in prisons. No two prisons were the same. Nevertheless, it was possible to broadly classify models of care into the following types:

- A.** One or more directly employed full time prison doctors supported by a mix of health care officers and nurses provide primary care. Specialist care is provided by external NHS specialists. A variety of local contractual arrangements exist to support this requirement. The prison may have its own pharmacy service, or share with one or more others; in some cases pharmacy is provided under contract with external organisations either in the public or private sector. This is the model that is typical in most local and remand prisons
- B.** Primary care is provided by NHS General Practitioners who are employed by the prison to work a set number of sessions within the prison, again supported by a mix of health care officers and nurses, with other services provided as at (A). This applies to predominantly smaller establishments.

- C. Primary care contracted out to a local general practice who provide full time medical services again supported as at (A).
- D. The entire health care service in prison is met by an external organisation, for example a private sector provider or an NHS Trust. These examples are relatively few, mostly in contractually managed establishments though there are some cases in the directly managed sector of the prison estate.
- E. Primary care provided by clustering arrangements between several prisons

While the broad types serve as a general description, it is possible to find examples where elements of the above models apply in different combinations or proportions, with, for example, General Practitioners complementing and supporting the work of directly employed doctors, while some services are contracted out entirely.

The above models of care have been described in relation to the medical composition of care rather than the nursing composition. This is because the nursing composition was more variable. It is true to say that in a few establishments health care is nurse-led for example in HMP Doncaster; however this is not generally the case. The Service's nursing policy published in 1992 set targets to increase the total number of non-medical health care workforce from 1300 in 1992 to about 1750 by the year 2000, with the mix comprising 50% nurses and 50% health care officers some of whom would also hold nurse qualification. The skill mix overall would be 75% with registered nursing qualifications and 25% health care officers without registration.

The 1992 policy was predicated on change being brought about through natural wastage. Between 1991 and 1997, the proportion of nurses in the health care officer/nurse workforce increased from 14% to 44%. Registered nurses have been recruited but without a meaningful assessment of the knowledge and skills required. Their particular competencies have not often been utilised to the full. The policy contained an aspiration that 'in future, all nursing care' would be 'under the supervision of a first level registered nurse'. Many health care managers and team leader posts, however, continue to be held by Senior and Principal Health Care Officers or Governor grades without nursing registration. In 31 March 1998, 11 establishments reported having no registered nurses in clinical or supervisory posts.

A further difficulty has been the requirement in the 1992 policy that nurses and health care officers fulfil a 'dual clinical and custodial role'. These roles are different and in a clinical setting can result in a blurring of the ethical principles and standards that should apply to all health care given in prisons. A consultation paper on changes to the 1992 policy, published and disseminated widely within the service and to selected outside bodies, in October 1997 produced no clear consensus.

Examples of models of healthcare

Within the broad classification of models of care identified the Working Group sought to identify examples or elements of good practice where the quality of care could be considered to be of a reasonable standard aiming for equivalence with the NHS. A detailed investigation of the quality of care at each establishment was not practicable within the timing and resources available. However, to enable some estimation of the quality of care to be made a number of proxies for quality were used:

- positive comments on healthcare from independent HMCIP inspections
- presence of a health needs assessment
- audit mechanisms in place
- good range of staff, skills and services
- strong links with the NHS
- health promotion activities undertaken
- integration of healthcare with prison regime

In order to be considered as providing an acceptable service prisons had to demonstrate most if not all of the above proxies. In addition a healthcare service fully contracted out to the NHS was considered a priori to be providing equivalence with the NHS.

Of the prisons sampled there were many examples of elements of good practice. However, several of these prisons demonstrated not only aspects of good practice, but learning points in terms of how health care was managed and organised (see Table F1). It is important to note that these prisons are **not** being held up as 'ideal' models. In addition we could only consider models from the sample of prisons. There may have been other models in the rest of the prison estate that would have demonstrated other equally useful models of care. However, the examples chosen represent models of care from which we can learn something about an important aspect of care which may be more widely applied. The models of care at these prisons and their learning points will now be described in more detail.

Table F1. Prisons demonstrating aspects of good practice

Prison	Model Type
HMP Parc	Healthcare contracted out to NHS
HMP Northallerton	Healthcare contracted out to NHS
HMP Long Lartin	Primary care contracted out to local General Practice
HMP Doncaster	Full time medical officer supported by local GPs
HMP Nottingham	Local GP employed part time by prison

HMP Parc

HMP Parc is a contractually managed private local prison. Health care is fully contracted out to Bridgend NHS Trust with health care activity in the prison being managed by the forensic directorate. Health care is provided by trained nurses and a full time medical officer all employed by the Trust. An organisational chart is shown at figures F1 and F2. Parc illustrated several important points:

- Strong management
- Strong health culture and links to NHS Trust
- Strong links to mental health services
- Service development and training
- Nurse led primary care

However, it also illustrated some deficiencies:

- Poor links with Health Authorities
- Poor links with local primary care
- Health promotion in its infancy
- Initial teething problems with integrating the health and custody cultures

Parc is a relatively new prison and prior to opening much effort and time had been put into planning how healthcare would be delivered. There was a significant lead in time before opening the prison with 18 months of meetings with senior health managers and prison officials. The learning curve for healthcare arrangements was described as ‘steep’ and the work involved should not be underestimated. It is important to note that contracting out care to one NHS agency – in this case an NHS Trust– does not automatically mean that standards of care are comparable to the NHS in all aspects. Parc had little input from the Health Authority or local GPs. Primary care medical services were provided by a full time medical officer rather than a GP. In addition total involvement of the NHS had its own problems in terms of integration of cultures. Prison health must be seen as integral to the workings of the prison

and not an add on. Parc nursing and medical staff commented that the involvement and support of the governor had been vital in beginning to learn how to learn to work together, but that everyone recognised that there was still work to be done.

Figure F1. HMP Parc

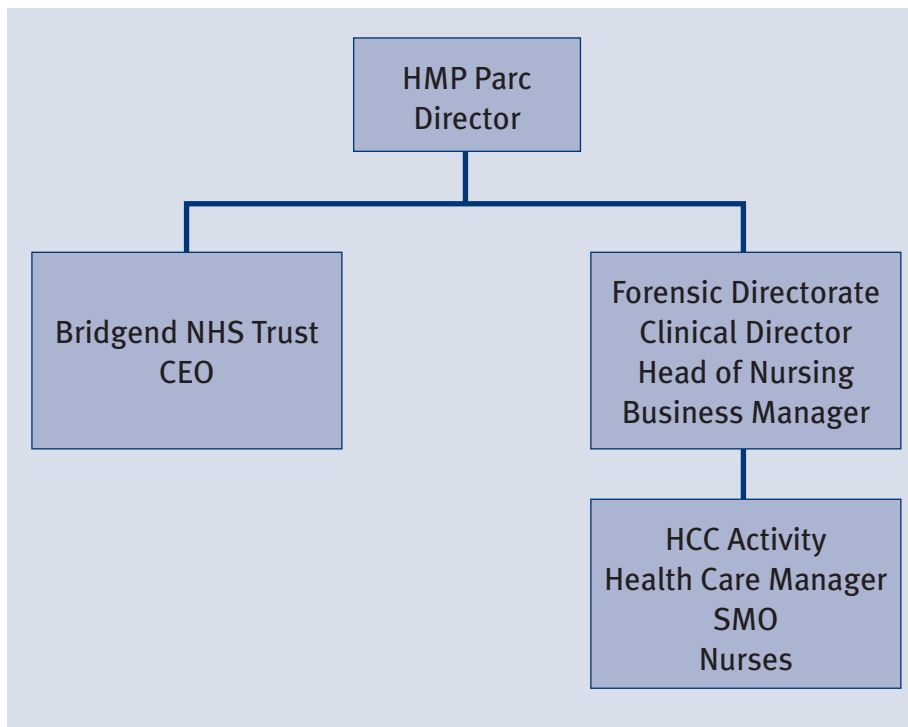
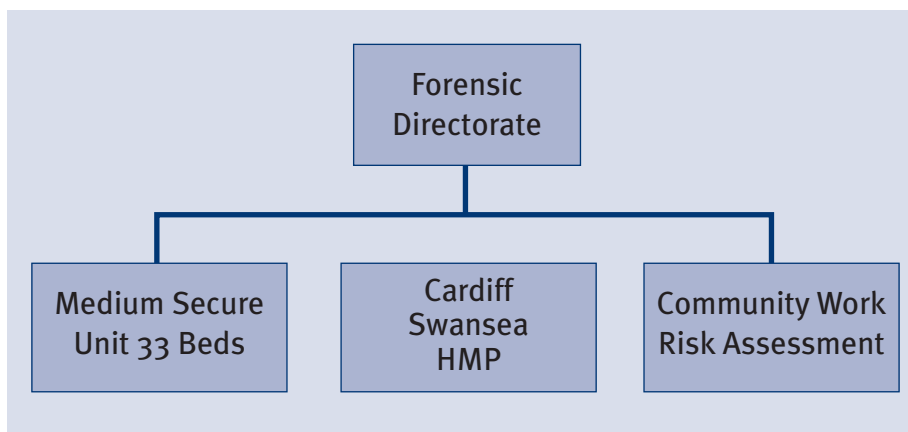


Figure F2.



HMP Northallerton

HMP Northallerton is a directly managed prison for young offenders. The governor has contracted out health care to the local NHS Trust. The healthcare centre has eight nurses but healthcare is managed by a healthcare officer. The organisational chart is shown at figure F3.

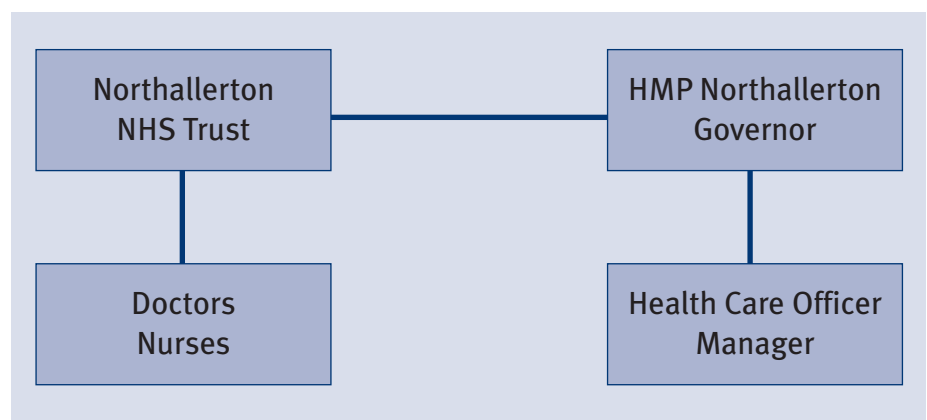
- Northallerton demonstrated several good points:
- Excellent clinical nurse leadership
- Very good relationships between custody and nursing staff
- Strong links to NHS Trust *management* with committed Trust manager
- Good throughcare for prisoners with strong efforts to maintain links with outside agencies

Northallerton however also demonstrated several weaknesses:

- Staffing numbers were low
- Primary Care was provided by a Trust Consultant not a local GP
- There was no Health Authority involvement
- The nursing staff were not maintaining *professional* links with the Trust for development and clinical supervision

Northallerton again demonstrated that contracting out care to one NHS Trust will not necessarily guarantee that other relevant bodies such as Health Authorities will be involved. Northallerton clearly demonstrated the beneficial effect of a motivated nurse on integrating health into the prison regime and showed how the NHS and Prison Service could begin to work together.

Figure F3. HMP Northallerton



HMP Long Lartin

Long Lartin is a high security dispersal prison. Primary care has been contracted out to a local General Practice which provides full medical cover. The General Practice appointed a full time doctor to work within the prison. The prison service employs nurses and health care officers. The organisational chart is shown in Figure F4.

Long Lartin demonstrated several good points:

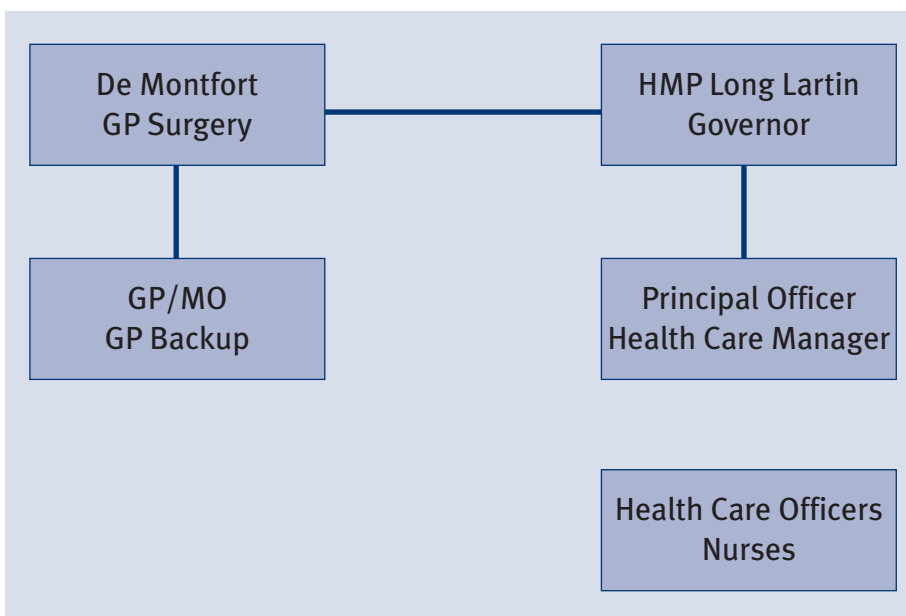
- Dynamic GP able to maintain professional links with general practice
- Primary care to NHS standards
- Full cover by practice partners
- Commitment of governor to health

On the other hand:

- The GP provided clinical care but no managerial input.
- There was a steep learning curve for the GP practice
- Some frustrations and conflicts remained due to the differences in cultures between medical staff and custody staff

The learning point for Long Lartin was that it is possible to contract out primary care to a General Practice and to provide care to NHS standards in a way that benefits patients but reduces professional isolation of staff.

Figure F4 HMP Long Lartin



HMP Doncaster

HMP Doncaster is a privately managed local prison. Primary care was provided by a vocationally trained GP employed by the prison. In addition the medical officer held a clinical assistant post outside the prison. Local GPs provided additional care. Healthcare was nurse led and managed. The care function was separated from the custodial function. The custody staff working in the health centre were managed by the nurse manager. The organisational chart is shown in figures F5 and F6.

Good points were:

- Medical officer maintains links with the NHS
- Nursing care provided by nurses
- Nurse led and managed
- Medical officer relieved of managerial duties and free to concentrate on clinical care
- Needs assessment underway
- Contracts related to need
- Staff appeared well motivated and enthusiastic

In the time spent at Doncaster it was difficult to highlight significant weak points. The learning point offered by Doncaster is the successful way in which healthcare is managed by a nurse manager and the separation of the nursing and custodial function. The role of the manager is crucial to the organisation and delivery of care.

Figure F5 HMP Doncaster

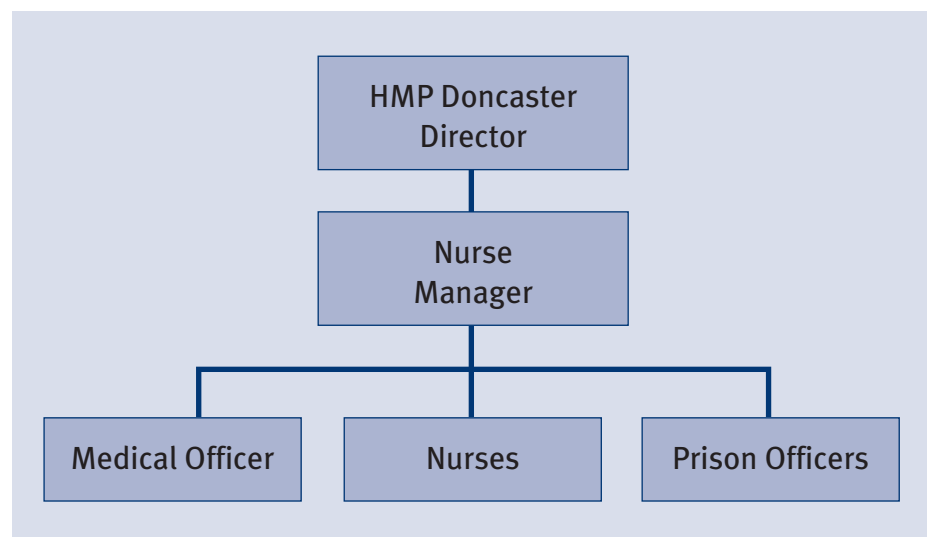
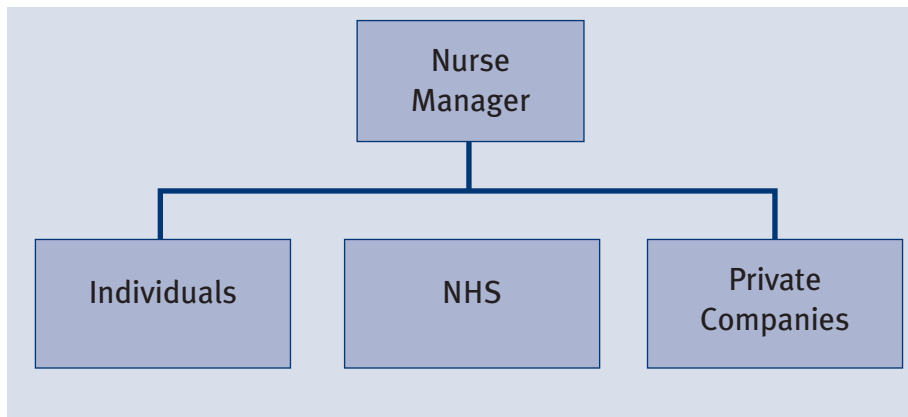


Figure F6



HMP Nottingham

HMP Nottingham is a local prison. Primary care is provided by a part time directly employed GP and a mix of nurses and healthcare officers. The excellent links of the GP with the local NHS trusts and Health Authority has meant that the NHS was reaching into the prison with subsequent improvement in care especially relating to community mental health services.

Points of note are:

- Good two way NHS/Prison links
- Primary care led service
- Medical Officer not professionally isolated
- Enthusiastic committed health care officer

Weak points are:

- Some difficulties integrating health culture with custody culture

Nottingham demonstrates the importance of good NHS links in improving health care delivery, in particular mental health services, and in reducing professional isolation.

Appendix G: Stakeholder Views

Methods

A variety of methods were used to consult stakeholders about the proposals for change to the delivery and organisation of prison health care:

- In the prisons sampled the Working Group used a semi structured interview to ascertain the views of the Governor, Medical Officer and Health Care Manager in each prison. Those interviewed were asked about the achievements in healthcare in their prison, problems experienced in delivery of care, possible solutions and barriers to change. They were also asked about their view on where ultimate responsibility for healthcare should lie and about the future organisation at local and national levels.
- A seminar was held in April 1998 with an invited audience of stakeholders representing the broad interests of prisons and the NHS (See Appendix B). Members of the Working Group presented early findings and options for change. These findings were then considered by small groups of participants facilitated by members of the Working Group. Feedback from each group was presented at a plenary session.
- Prison Service staff were consulted via an article in 'Briefing', an in-house monthly briefing paper, informing staff of topical developments, in January 1998. The options being considered by the joint working group were set out, and views on each invited either in writing or orally.

In addition to these formal methods views of many individuals were ascertained by informal discussions on prison visits or by contact with Prison and Health Service bodies. The members of the Working Group were by virtue of their wide backgrounds able to relay the views of other colleagues not consulted formally.

The semi structured interviews in the prison sample

As would be expected the views of the different stakeholders were mixed. However, common themes ran through most responses Tables G1-7.

Table G1. Main problems

- Considerable mental health morbidity
- Lack of good primary care and health promotion
- Staff shortages
- Good skill mix of healthcare staff but not best utilised
- Staff morale low
- Lack of relevant healthcare information
- Communications poor at most levels
- Cultural misunderstandings
- Variable or absent links with NHS
- NHS not having capacity or desire to be involved

Table G2. Main achievements

- Introducing new skills including nursing
- Team work beginning to develop
- Introducing special programmes such as suicide awareness
- Assessing healthcare needs
- Coping in a crisis
- Developing good links with NHS

Table G3. Barriers to change

- Confused lines of accountability
- Lack of coherent management structure
- Few links with the NHS
- Irrelevant information collected which is unhelpful and a distraction from key issues
- Repetitive tasks and emphasis on process rather than outcomes
- Unclear purpose
- Difficulties of understanding the cultural differences between those providing custody and care
- Uncertainty about the future

Table G4. Possible solutions

- Better communications at all levels
- Training and development of staff
- Team building
- Health needs assessments should be carried out
- Appropriate IT to support care should be introduced
- An explicit management and accountability framework should be developed
- Links with the NHS should be developed – ‘*Prisons reaching out and NHS reaching in*’

Table G5. The way forward at local level

- Governor must have key role
- Healthcare should be primary care led
- Prisons should be treated as part of the wider community
- Health Authorities and prisons should work together to assess health needs

Table G6. The way forward at national level

- National links between the NHS Executive and the DHC should be developed
- There should be joint standard setting
- Clear lines of organisational and clinical accountability should be developed
- There should be a clear career structure for doctors nurses and healthcare officers
- Best practice should be shared

The Consultative Seminar

Feedback from those attending the seminar showed a broad agreement with the proposals of the Working Group for the future organisation of prison health care and with the need to integrate prison health with that healthcare provided in the community. On the structure and organisation of healthcare the following points were raised:

- The new organisation should be set in the context of health rather than health care
- The lines of accountability must be explicit
- Functions of the different tiers of management should be explicit
- Mechanisms for partnerships should be explicit
- The funding mechanisms should be clear
- An effective information system should be developed
- There is a need for sensitive approach to the management of change
- Change should be carried out rapidly to ensure momentum of this review is maintained
- Standards of care should be the same as those in the NHS
- Recruitment, training and professional standards need urgent attention
- The healthcare officer role needed to be clarified and developed to include new roles in areas such as social care

The HAC representatives strongly endorsed the principle of shared ownership of prison healthcare between the NHS and the Prison Service.

The Prison Service

Around eight written responses were received from those reading 'Briefing'. A very wide range of points was covered by these responses, but one common thread was the view that the NHS, in its widely-perceived under-funded state, was not in a position to improve alone on the standards of health care currently delivered to prisoners by the Prison Service. Another commonly voiced point was the concern over the Health Care Officer role, and whether this body of expertise in the care of offenders was going to be dispensed with. In addition the view was expressed that in some instances prisoners probably received better and faster care than if they were in the community.

Appendix H:

The Cost of Health Care in Prisons

Current Costs

Assessing the current cost of prison health care did not prove to be a straightforward task. Financial information is not recorded in a form that readily lends itself to separating out health care costs. In estimating the current monetary provision we therefore relied on an examination of the costs of the prisons in our sample held at Prison Service Headquarters, cross checking against the information obtained from the prisons themselves through consultancy studies or our own survey results. The assessments are given in more detail in Annex 1 of this appendix.

Briefly our estimate shows that establishments will have spent in 1997/98 about £85 million on prisoners' health care, with £62 million of that being pay. In making these assessments we have kept separate information about Holloway prison which was part of our prison sample. In many ways this prison was so different (which in itself we think warrants particular examination) from the other prisons that to include it as part of the statistical analysis would have led to misleading results. The level of existing health care expenditure represents a significant input of resource which, given the variation we have identified, we cannot be confident represents the most cost effective use.

Headquarters costs are estimated to be £4 million accounting for the prisoner health care costs within the Directorate of Health Care (£3.25 million) and the Area Health and Nursing Advisers (£0.75 million). The Service also spent in 1997/98 about £12 million (half through centrally provided funds) on drug treatment programmes of various kinds, provided by outside agencies. These services clearly make an important contribution towards meeting the health needs of those with drug addiction or substance misuse problems. However these costs are not generally associated with health care budgets, and, though we would see the services as continuing, they represent a constant for the purposes of this report and we have accordingly factored them out. Figure H1 shows the estimated health care expenditure by prison in the sample, illustrating the considerable variation both in terms of the proportion of the total prison budget that health care consumes and the cost per prison place. Figure H2, which is based on headquarters accounts information, shows the broad divisions of non-pay expenditure on services and goods purchased.

Figure H1: Expenditure by Prison in sample

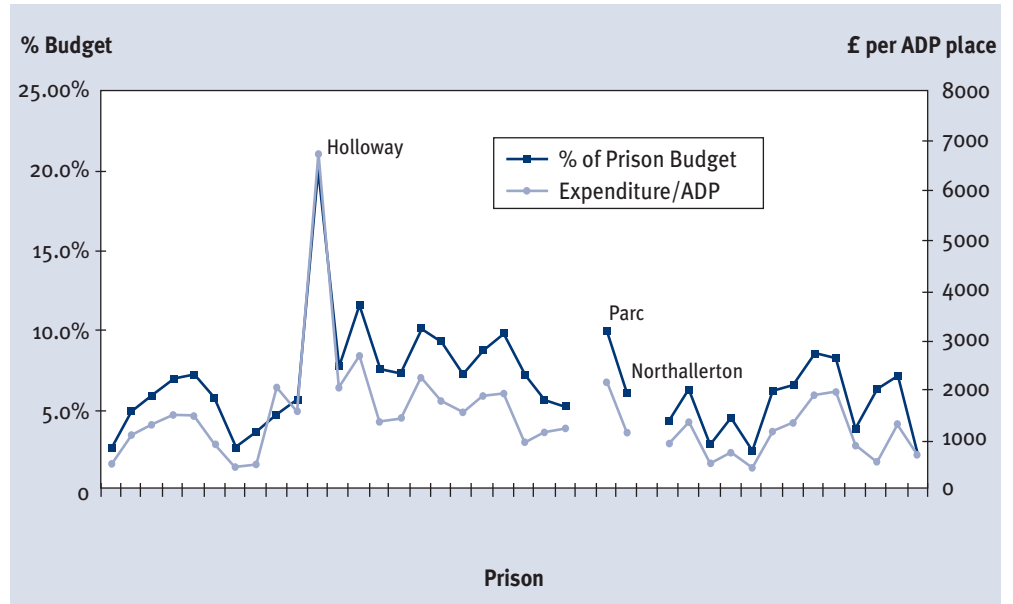
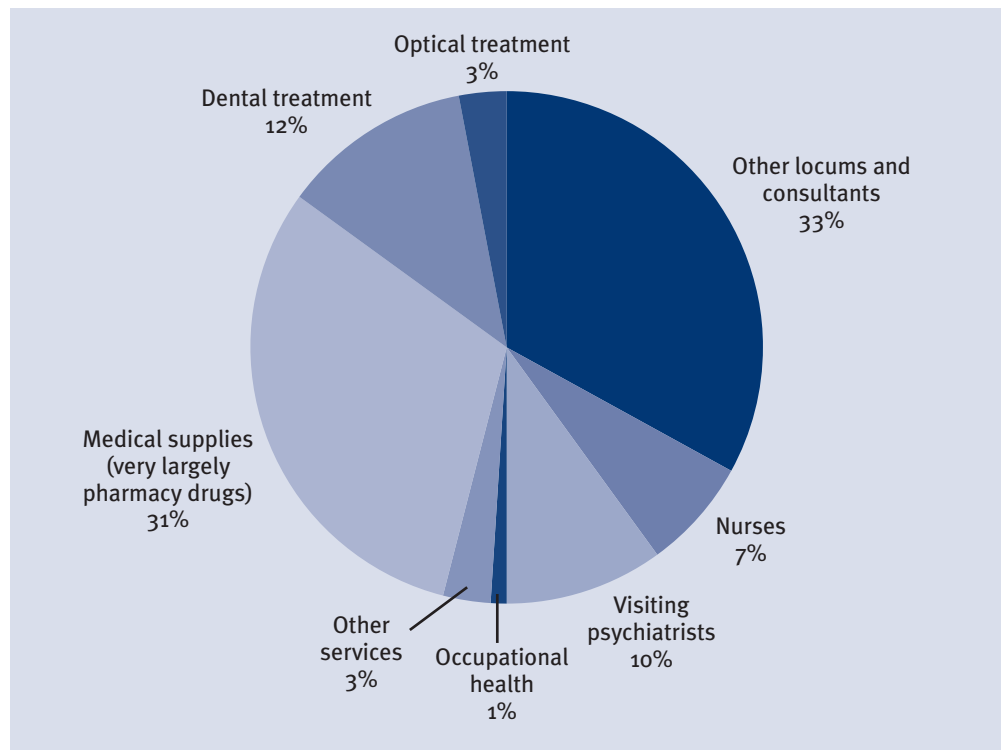


Figure H2: Breakdown of health care costs other than pay 1996/97



The cost impact of our proposals

Delivery of improved care

We have said earlier in our report that there were health care centres which had many elements of good practice. Their costs could be used to give an indication of the impact, in national terms, of replicating that kind of provision across all establishments. There were also some examples of health care and associated services (e.g pharmacy) being provided under contract by the NHS, and, again, these could represent benchmark costs of the NHS becoming sole provider. While in most cases we could see that such provision was not ‘ideal’, the costs represented a practical, market-tested benchmark of NHS type provision to a prison service specification, that, if applied throughout the Prison service would provide a more uniform and broadly more acceptable standard. However, as noted in the Report *paragraph 62*, the provision for mentally disordered offenders falls significantly short of that needed to meet prisoners’ needs. We do not think that current good practice models in the Prison Service give adequate recognition to this deficiency, and so their costs would not cover the provision of this service.

Figure H3 shows the projected costs of providing improvements to prison health care based on a range of models as discussed above, and compared to the cost of current provision. All the models, A to D, involve the NHS to some degree:

Model A draws what we saw at on Doncaster Prison

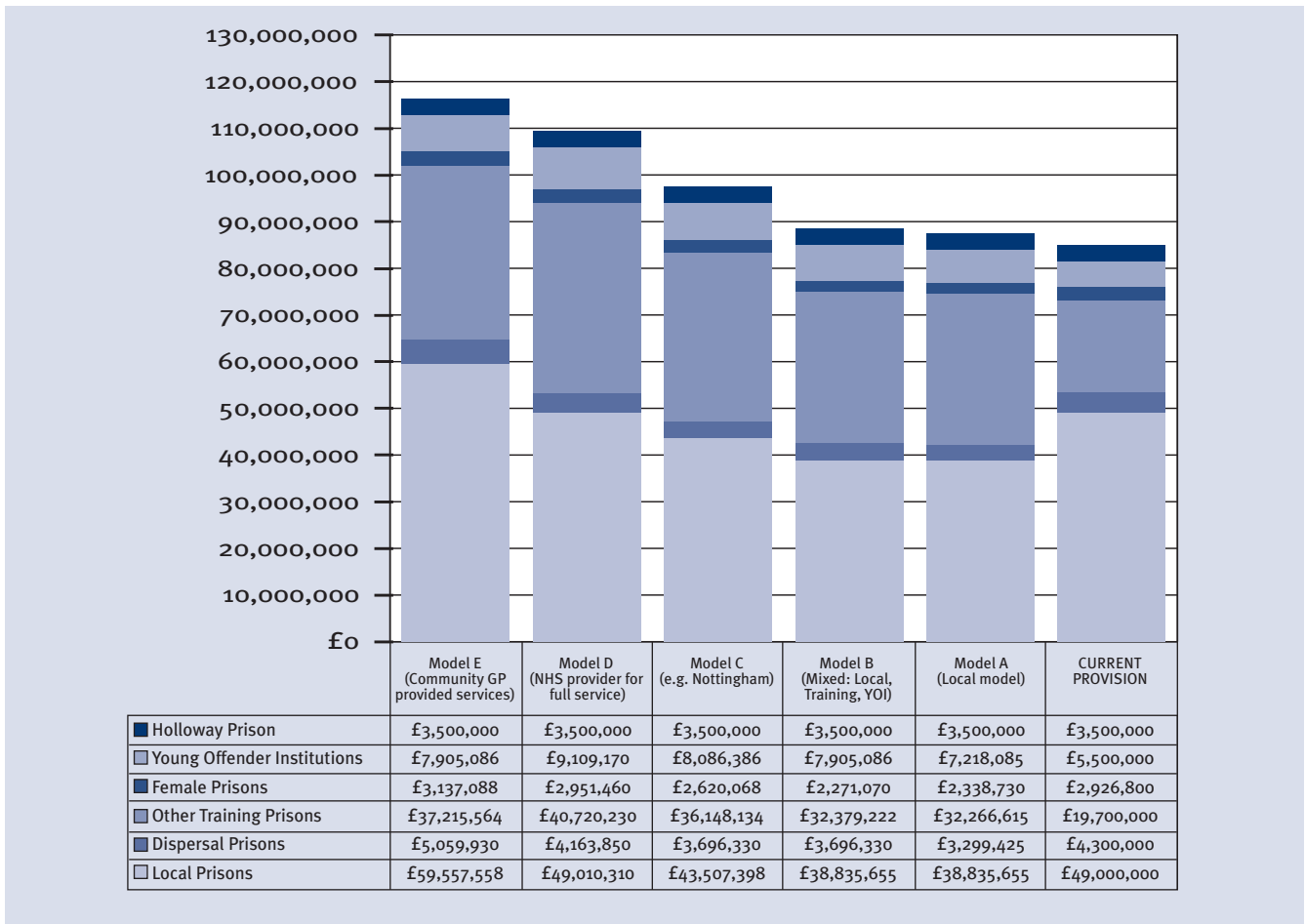
Model B represents a more differentiated approach based on Doncaster, Nottingham and also including Ford as an example of an open prison, reflecting these different types of establishments

Model C is based on the arrangements at Nottingham with Community general practitioners providing clinical services in the prison, while other health care staff are directly employed.

Model D reflects a service where trained nurses and a full time medical officer provide health care; all are employed by a Trust (for example Parc)

Model E reflects a service where primary care is contracted out to a local General Practice (for example Long Lartin).

Figure H3: Projected costs for an improved service at establishments



To put the comparison on the same footing, the costs include a ‘discipline element’, that is make allowance for security staff within the health care centre, where there is a full separation of roles between the custodial and health care function. The estimates consider a number of combinations reflecting, in particular, the different requirements of local prisons and training prisons. Local prisons act as reception and assessment centres. They have a high throughput of inmates, between 4–9 times the average daily population in a year, with a mix of remand and sentenced prisoners. By contrast, training prisons tend to have fairly static populations of sentenced prisoners.

Figure H3 also shows the proportionate health care cost for locals, training, female, young offender and dispersal prisons. The costs of Holloway prison have been kept separate also for the reasons given above. All the costs are based on the population statistics at the end of December 1997.

There will be some new activities that can be expected to call on NHS resources:

- The new role that Health Authorities will play in assessing prisoners' health needs
- Annex 2 to this Appendix sets out our analysis of the costs of improving services to mentally disordered offenders. We estimate that about 10,000 prisoners would benefit from community mental health teams reaching into prisons at a cost of £6 million. Potentially more mentally ill prisoners (of various security categories) may require transfer to hospital.

Headquarters costs

We have also looked at two aspects of our proposals, the Prisons Unit and the Task Force, which we see as a critical first step on the road to improving health care. We would not see the new Prisons Unit as replicating all the functions of the current Directorate of Health Care. By drawing on the policy machinery and expertise of the NHS Executive there should be scope for efficiency. Nor would it be sensible to continue with separate health care and nursing advisor functions, given that these roles would be subsumed within the Task Force. The total resource available from within the Prison Service for Prisons Unit and Task Force activities is about £4 million (that is, the budget of the Directorate of Health Care minus the Health & Safety, Fire Safety and Occupational Health section, but including the pay costs of the health and nursing advisor functions). This is a starting point from which to begin to bring about the changes needed. We tentatively see this sum as being apportioned:

- £1.0 million for pay costs for a Task Force team comprising around 20 persons (Prison Service and NHS staff)
- £0.6 million for the pay costs of a Prisons Unit comprising around 12 persons (Prison Service and NHS staff)
- £2.4 million to support national training initiatives, research and development into prisoner health care, and monitoring and other information systems. This sum, however, is unlikely to be enough and will need to be matched by the NHS, either directly or through contributions from appropriate programmes.

There will be some transitional costs. The precise level will depend on the extent to which redeployment of staff can take place.

Appendix H Annex 1: Estimates of the Current Monetary Provision for Prison Health Care

Table H1 below shows statistical information for the sample of prisons in the study. 'HC expenditure' is the estimate of total healthcare expenditure derived from information from the prison interviews or consultancy studies where this is higher than the 'FCA (finance control and accountancy) estimate' which was based on Headquarters accounts.

Table H1. Statistical information on sample of prisons

Type Of Prison	HC Expenditure/ Prison Budget		HC Expenditure Per ADP		FCA Estimate Of HC Expend/ADP		FCA Estimate Of Staff Cost/ADP	
	Avg.	S.D.	Avg.	S.D.	Avg.	S.D.	Avg.	S.D.
Dispersal	0.0526	0.0069	1831	349	1668	580	1292	237
Female (excluding Holloway)	0.0701	0.0111	1633	626	1633	626	759	554
Local	0.0839	0.0158	1754	475	1821	389	1452	283
YOI	0.0509	0.0176	984	310	984	310	673	306
Trainer	0.0468	0.0171	916	417	828	382	515	282
Whole sample	0.0625	0.023	1332	581	1274	588	906	508

Differences between prison types are significant at the 0.01% level. The female prison staff cost appears anomalous: average staff numbers per ADP are similar to dispersal and local prisons but apparent rates of pay are low (staff cost/No. of staff = £14,000 for Askham Grange, £18,500 for Styal, compared with median £32,183 for the whole sample).

On the basis of these averages, estimated costs for the whole prison estate are shown in table H2:

Table H2. Projected overall cost £ million

Prison Type	ADP	HC Expenditure	FCA Estimate	Staff Cost
Dispersal	2435	4.46	4.06	3.15
Female (ex Holloway)	1431	2.34	2.34	1.09
Local	28661	50.27	52.19	3.59
YOI	5327	5.24	5.24	3.59
Trainer	23813	21.81	19.72	12.26
Whole sample	61668	84.12	78.57	55.87
S.D.		35.83	36.26	31.33
Sum of individual types		84.12	83.55	61.7
S.D.		16.98	14.58	10.7
95% CI		50.85-117.4	54.97-112.13	40.72-82.67

Similarly, on the basis of staff numbers per ADP in the sample, we can estimate numbers of health care staff in the total prison estate, which when compared with actual numbers gives an indication of how representative the sample was, at least in respect of the staff profile: This is shown in table H3

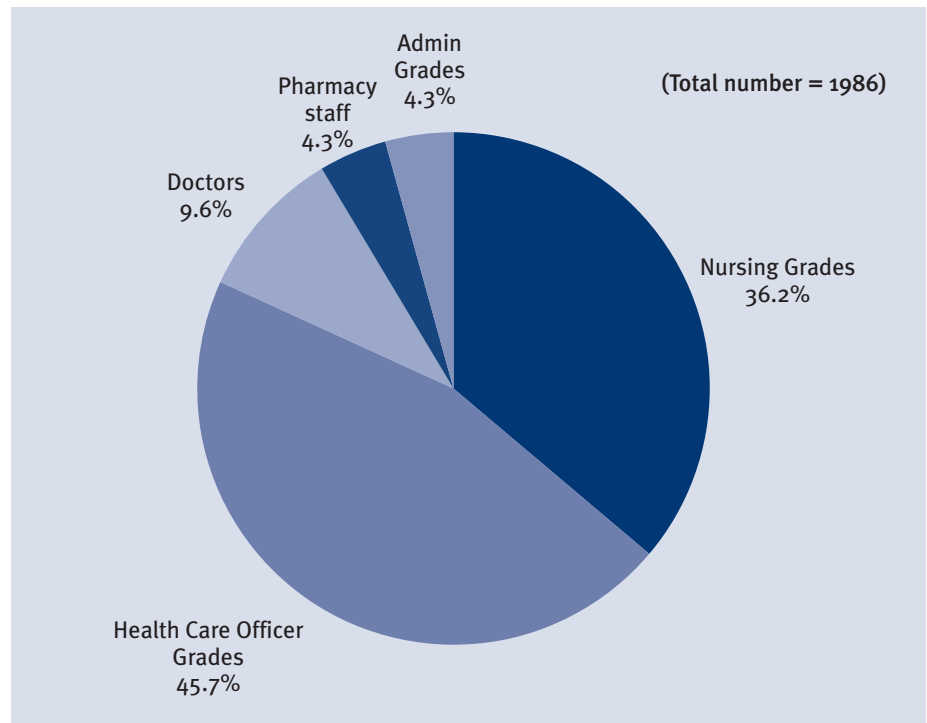
Table H3: Projected overall staff numbers based on sample

Prison type	ADP	No of Doctors	No of Nurses	No of Health Care Officers (HCOs)	Nurses+ HCOs
Dispersal	2435	5.3	33.8	50.7	84.7
Female (excluding Holloway)	1432	3	63.2	0	63.2
Local	28661	125.5	458.6	699.3	1160.8
YOI	5327	5.5	87.4	52.2	140.1
Training prisons	23813	49.5	145.3	254.8	402.4
Whole sample	61668	165.9	857.2	937.4	1794.5
S.D.		144.9	795.5	715.3	1029.9
Sum of individual types		188.8	788.1	1057	1851
S.D.		83.8	298.6	342.6	471.8
95% confidence interval		24.6-353.0	202.9-1373.4	385.5-1728.5	926.3-2775.6
Actual totals (excluding Holloway prison)		185	667	906	1573

Looking at Table H3, it is clear that there is much greater variation in staffing numbers than costs. Some of this could be due to different part-time working practices across the estate. The estimate of number of doctors agrees well with actual numbers, but both nurse and HCO numbers are lower than expected on the basis of the sample. See figure H4. Overall, the estimate of non-medical

staff is 18% higher than actual numbers, though the difference is not statistically significant given the extent of variation.

Figure H4 Health Care staff employed on 31 March 1997



Appendix H Annex 2: NHS Costs Per Person of Community Mental Health Services

This annex details how the costs of providing community mental health support within prisons were estimated. Costs were derived for use with point prevalence data from, for example, the studies by Gunn et al. These, as well as the number of prisoners receiving psychiatric treatment at the month end give an estimate of the expected number of prisoners with a mental disorder at any point in time. The costs given below are therefore the annual cost of having a service in place to provide appropriate care for one person with a mental disorder at any given time.

Costs per expected case per year

Primary care:	
consultations	£34
prescriptions	£53
Total	£87
Secondary care:	
non-residential health care services as provided by community mental health team	£522-768
non-residential component of services provided to mentally ill people in residential care as appropriate to a service level agreement with the NHS for prisoners	£550

Assumptions, sources and derivation of costs

Primary care:

'Burdens of Disease', NHS Executive, 1996 estimated that 3.6% of all general medical expenditure and 5.2% of the 71% of general pharmaceutical expenditure that could be allocated to a diagnostic group was spent on mental illness. Uprating the 1995–6 GMS expenditure to 1996–7, and adding the GDS gross expenditure of £1323.1m and GOS gross expenditure of £237.2m, general medical expenditure was around £4,483m. Gross general pharmaceutical expenditure was £4780.3m in 1996–7. Assuming the

unallocated general pharmaceutical expenditure to be distributed in the same proportion as allocated (which is probably an under-estimate), we estimate £410m is spent on treating mental illness in primary care. Note this includes patient contributions, since these would be charged to the Prison Service for prisoners.

The OPCS Psychiatric Morbidity Survey found 14% prevalence of any mental disorder (in adults under 65). If it is assumed that the prevalence is similar in older people (there is evidence that it is higher, but also that a smaller proportion is treated), the total number of people with mental disorder is around 5.3 million. Of these, 604,000 are under the care of secondary services, leaving 4.70m in primary care alone. Consequently, each person with mental illness costs £87 for primary care on average.

Secondary Care:

The most detailed data source is DH 'Quarterly monitoring' returns; we have used the data for quarter 3 of 1996. **Note: these data relate to HA expenditure and the activity that is purchased. While it is used in internal monitoring, it is not audited or checked by statisticians, and should not be quoted publicly.**

Expenditure on mental health services is broken down into in-patient care, outpatient care, NHS-funded residential care, day care and community nursing. We assume that only community nursing and health care provided to those in residential care are relevant to costs to the Prison Service.

At the end of quarter 3, 1996, there were 604,200 people under care of the secondary services. From the activity data, we estimate that they were receiving the following services:

Hospital in patient care	32,100	(number of places, from recorded occupied bed days)
Residential care	10,200	(number of places, from recorded occupied bed days)
Outpatients	158,000	(from first and total attendance's, assuming fortnightly appointments for those referred by a GP and monthly appointments for long-term continuing care for others)
Day-care	22,000	(from total attendance's, assuming 4 attendance's per person per week)

The number covered by community nursing (and other community services) is less straightforward. While we have the total number of contacts (5.3m in 1996–7), these will be distributed according to individual need and there is no available average of the frequency of contact. Similarly, we have the number of first contacts (530,000 in 1995–6), but without knowing how long on average a client remains on the books this gives only an upper limit to the point prevalence.

As an upper limit, we assume that all those under care of secondary services but not in hospital or NHS-funded residential care receive community nursing and other community services; the number was 562,000 persons in 1996–7. Essentially the same number (563,000) of first CPN contacts is estimated from the total number of CPN contacts assuming the number of contacts per first contact remains the same as in 1995–6. As a lower limit, we assume that all those under care of the secondary services who are not receiving any other service are the ones receiving community nursing; this was 382,000 in 1996–7. This ignores the people who are on the books of a multidisciplinary service including the NHS, but whose care programme consists only of residential care or social care funded through social services. However, there is evidence that most people receive more than one type of service. Another complication is that we are not sure whether expenditure on psychiatrists or psychologists based in community mental health teams is counted under ‘community nursing’ or as an overhead within the ‘hospital in-patient’ or ‘out-patient’ categories of expenditure. However, we assume that the CMHT work which would be charged to the Prison Service in a contract with an NHS trust to provide CMHT services corresponds to what that trust would count under ‘community nursing’. Then the cost per person for the upper limit of persons receiving a service would be £522 and for the lower limit £768.

There is additional evidence available from the Royal College of Psychiatrists Research Unit residential care study, reported by Chisholm *et al.*, *Br. J. Psychiatry*, 1997, **170**, 37–42. They found the average cost of non-residential services over all facility types from long-stay in an acute hospital ward to staffed care home to be £44 per week outside London and £46 per week in London. There is evidence from the TAPS hospital reprovision study about the detailed breakdown of the costs of community services that is received by the mentally ill in residential care. From this we estimate that 41% of these costs are services for which the NHS would be responsible (e.g. acute in-patient stays, outpatient and day hospital attendances). 36% are services such as education, leisure activities, and sheltered workshops, which would independently be provided in a prison, leaving the remaining 23% as items that could be part of a mental health care service. The cost of these items would thus be about £550 per patient year.

Appendix I: Prison Health Care Option Appraisal

Options and Objectives

This appendix sets out our consideration of the costs and benefits of the three main framework options described at paragraph 15 of the main report.

- A status quo plus:** that is to add impetus to the present policy of seeking efficiency and other improvements within the existing structure, further increasing the proportion of health care provided by contracts with the private or public sector, and placing rigorous delivery standards on directly managed services using service level agreements;
- B partnership:** to adopt a more collaborative and co-ordinated approach with the NHS supported by a recognised and formal duty of partnership. The Prison Service and the NHS would jointly set health care and other standards. Services could be jointly commissioned on the basis of assessed need and provided by a combination of directly employed prison healthcare staff, the NHS and others. Resources for primary care would remain with the Prison Service
- C full transfer to the NHS:** the complete integration of prison health care into the NHS, transferring both resources and accountability for prisoners' health care.

The starting point, Status Quo or 'do-nothing' position is not to contain everything within the prison service; this has already been found to be unsatisfactory and some prisons are improving their health care by moving away from this and involving the NHS. Consequently, the Status Quo is a state in which a prison service system is gradually changing to a mixed provision, but in an unplanned way as individual prison governors or prison or health care staff push for change. The main options for the future are therefore either to:

- Allow continued *ad hoc* change from a prison-based system to one involving partnership with the NHS, as at present, or
- Introduce special requirements or change the management structure or provide other incentives or influences to speed up the move to a partnership approach or other specified model

Moving away from the Status Quo could take one of two broad forms:

- Introduce new structures and incentives to encourage (or require) partnership between the prison service and the NHS
- Make prison health care solely the responsibility of the NHS

The other possibility, making prison health care solely the responsibility of the prison service, has already been found not to work, and would run counter to the findings of this Report, as well as all the other assessments about how well prison health care has performed in the past.

It is also worth underlining that while the costs (described in Appendix H) must be taken into account in deciding on the way forward, there is much that can be done to improve prison health care within the existing resources available to the Prison Service and the NHS.

The costs identified in Appendix H, are estimated on a rather narrow organisational basis and are illustrative rather than definitive. While undoubtedly some extra money will be needed, there will be scope to take some of the recommendations forward as part of other initiatives, for example on mental health provision in the NHS and regimes in the Prison Service. The real choice to be made, as between the broad options under consideration, is which is more likely to deliver the improvements needed in the short to medium term. Also given that the options in reality represent a spectrum, the process could be (and in practical terms would have to be) evolutionary. We see the objectives against which proposals for change are to be judged as being:

- To ensure that health care provided within prisons is appropriate to need and of comparable quality to that outside prison
- To ensure that appropriate health care is not disrupted by entry to prison, by movement between prisons or upon release
- To reduce re-offending where that is attributable to health status (e.g. resulting from mental illness or substance abuse) and to use the opportunities presented by a prison sentence to reduce social exclusion.
- To have the capacity to deal effectively with the problems of the current isolation of prison health, to manage the constraints and take advantage of the opportunities described above.

Criteria

There are three aspects of health care that can be considered separately and to a large extent independently:

- delivering services
- assessing need, planning and commissioning services
- accountability for funding streams and management

In each case, the aspect of the service can be:

- provided entirely within the prison service
- provided by prison service and NHS working together
- provided entirely by the NHS

Appraisal of options against the objectives can most easily be achieved by considering the three aspects outlined above (delivery, commissioning and accountability) against more limited goals which relate to specific ways in which the overall objectives can be approached for that aspect of the service.

Delivery of services

We assume that these need to include the following:

- Social support: this would not normally be the responsibility of the NHS; where it has implications for health, e.g. in mental health care, the NHS would work with social services or voluntary organisations who would provide it. In prison, we assume this would be provided by Health Care Workers, perhaps working with voluntary organisations, prison chaplains, etc., and perhaps implying a review of their role; it could be a significant issue in mental health care, where a visiting specialist (e.g. Community Psychiatric Nurse) would need to work with whoever provides social care
- Care which substitutes for informal care in the community, primarily nursing, or self-care, such as medication. This necessarily entails a cost to statutory services, which in the community is met by relatives or friends, and by the individual. However, where provided by qualified staff it could reduce the need for referral to the NHS for minor conditions. (There is evidence from our sample of prisons that this happens at present, e.g. referral rates to A&E are slightly lower than for the same age band in the general population)
- Consultations with a doctor, equivalent to visiting a GP in the community. The doctor could be a member of the prison staff or a GP working under contract to the prison. For some conditions, consultation with nurses may be more appropriate, as happens outside the prison.

- Health promotion services that are convenient to provide in a custodial setting but would not normally be provided in the community. They might substitute for messages which outside prison would come through the mass media or workplace health promotion schemes; they would also include dental and optical examination, which would be the responsibility of the individual outside prison.
- Specialist services which are rarely needed in the community, but are so commonly needed in prison that provision is justified within the prison health centre, e.g. services for personality disorder or addiction
- Services from external specialists provided in clinic sessions within the prison, including the equivalent of domiciliary community mental health team assertive outreach in the community. We assume these will continue to be provided by NHS specialists under contract).

For most of the above services, service providers could be

- (a) employees of the prison, managed by a health care manager responsible to the prison governor;
- (b) NHS staff or independent contractors normally working within the NHS, providing services under contracts agreed between them (or their NHS managers) and the prison governor; or
- (c) NHS staff or independent contractors normally working within the NHS, providing services under contracts agreed between them (or their NHS managers) and the Health Authority or Primary Care Group responsible for health care in that prison.

In terms of broad overall options:

- Option A **equates** to most staff falling in group (a), though with a small but growing proportion of (b)
- Option B **equates** to Health Care Workers remaining in group (a); nurses would be in groups (a) or (b), with opportunity to move between prison and NHS; other staff would be in (b)
- Option C **equates** to all health care staff being in group (c)

Criteria for service delivery are:

- health care standards should be the same as those in the NHS, including access to treatment, availability of specialist back-up, current best practice procedures and comparable outcomes
- professional isolation of health care staff should be minimised, implying availability of professional supervision, opportunity for career moves

between prison and NHS, access to in-service training, informal professional networks and research

- care should be distinct from custody
- there should be arrangements for continuity of care on entry to prison, transfer between prisons, and on release

Assessing health need, planning and commissioning services

There is a need to ensure that internal staffing and the scope of external contracts are appropriate to the scale of need, in particular, recognising the high level of psychiatric morbidity in prisoners. Service planning should also include assessing the quality of services provided and taking steps to maintain or improve this, and making judgements about the effectiveness and efficiency of the available sources of health care and employing or contracting accordingly

Assessment of health need and planning services may be done

- (a) By prison staff, drawing on their past experience and their detailed knowledge of prison conditions. However, they are not well placed to know about current best practice in treatment or have detailed knowledge of the strengths and weaknesses of local NHS providers.
- (b) By prison staff and the Health Authority or Primary Care Group working together.
- (c) By a Health Authority or Primary Care Group. They would have general population epidemiological data to draw upon, and would be well placed to judge local providers, but are likely (in the short term) to lack detailed knowledge of the special needs of prisoners.

In terms of broad overall options:

Option A **equates** to (a), to the small extent that any formal needs assessment is done at present

Option B **equates** to (b)

Option C **equates** to (c) or (b) if the Health Authority chooses to consult the prison

Criteria for service planning and commissioning are:

- to identify accurately the need for health care, taking account of epidemiological evidence for the general population and evidence of special needs of prisoners, and also special local factors including the characteristics of the specific prison population
- to arrange the most effective and efficient combination of prison staff and NHS services to meet the identified needs
- to monitor the quality and adequacy of the services provided, and take account of these in future planning

Accountability

This needs to cover:

- Source of funding and accountability for its use, including management of health care activity directly provided within the prison, and placing and monitoring contracts.
- Professional responsibility for healthcare decisions
- Responsibility for decisions concerned with the interface between health care and custody, i.e. the extent to which considerations of impact on health care are allowed to influence the custodial practices and vice versa, and who decides.
- Funding could be channelled (a) through the prison service to the individual prison, as at present, or (b) as part of the weighted capitation allocation to the HA or Primary Care Group. Accountability for use of these funds implies that the same agent is responsible for placing contracts for delivery of services, including defining what is to be provided and monitoring compliance.
- If funding and primary accountability are through the prison governor, who is also responsible for custodial matters, he or she must then also take responsibility for managing the interface between health care and custody. If funding and accountability for health care are the responsibility of the NHS, then this interface will have to be managed by negotiation between them and arbitration at a higher level if needed.
- Professional accountability for healthcare decisions would have to rest with medical staff. There is no reason in principle why professional responsibility for staff should coincide with management their day-to-day activities, but it would clearly create the potential for conflict if, for example, nurses are responsible professionally to the NHS and managed by a prison health care manager responsible to the prison governor. Such conflict would be less likely if nursing were to be contracted in from the NHS so that both clinical and managerial responsibility lay with the NHS.

Criteria for management and accountability are:

- There should be clear lines of accountability for funding and provision of services
- There should be incentives to improve the quality of health care, either implied in the structure or easily included
- The scope for perverse incentives should be minimised
- Overall: in addition, there are some general objectives which apply in each of the above areas:
 - I. transitional costs and management costs within the new arrangements should be minimised
 - II. undesirable impacts on staff should be minimised, including capacity of existing staff to manage and work through the change and needs for recruitment or redundancy
 - III. the likelihood that the desired change will be achieved within a reasonable time scale should be as high as possible

Conclusion

Tables I1, I2 and I3 set out the assessment of the broad options against the criteria listed above against the headings of delivering services; assessing health need, planning and commissioning services; and, accountability. Judged against the need to secure improvements in the short to medium term, the partnership option appears more likely to deliver change, and better able to control the risks both to the Prison Service and the NHS.

Comparison of Options

Table I1 Delivery of Services

Option	Objectives for delivery			Overall Objectives			
	NHS standards	Professional isolation	Care separate from custody	Continuity of care	Extra costs	Staffing issues	Probability of change
A – prison staff only	No	Yes	No incentive to separate	Access to medical records difficult	£30 million for improved primary care services + £6 million for improved mental health services	Minimal apart from isolation	Low - no incentive in system
B – NHS under contract from prison	Yes (as contract permits)	Can be avoided	Dependent on relations between governor and health care manager	Yes (in principle)	£30 million for improved primary care services + £6 million for improved mental health services	Benefits, nurses and doctors; more difficult task for health care manager (HCM); potential redundancy or loss of role for Health Care Workers	High provided governors given incentive to contract with NHS
C – NHS under contract from HA/PCG	Yes	No	Yes	Access to prison records may be difficult	£30 million for improved primary care services + £6 million for improved mental health services	Benefits; nurses and doctors; potential for conflict between governor and HCM, potential redundancy or loss of role for Health Care Workers	Low: not a high priority for Health Authorities or primary care commissioners unless specific performance targets; substantial need for management re-education

Table I2 Needs assessment and commissioning

Option	Objectives for Needs Assessment and Commissioning			Overall Objectives		
	Identification of standards	Assessing available services and planning delivery	Monitoring	Extra costs	Staffing issues	Probability of change
A – Prison only	Likely to neglect mental illness and health promotion	Dependent on skills of health care manager no incentives to improve	Lack of comparators outside prison	Up to £3.5 million if commissioned from Health Authority or academics	Minimal?	No incentive to improve; some incentive to underestimate need
B – Joint prison – Health Authority	Most likely to be accurate	Good - able to use experience in health commissioning and knowledge of prison	Best opportunity to combine evidence from providers and Prison	Up to £3.5 million – could be lower if prison evidence makes some HA activity unnecessary	Minimal	High; still need for Health Authorities to learn about prison needs but prison staff can help this
C – Health Authority/ Primary care group	Likely to underestimate mental illness and substance misuse	Good. Able to use experience gained in commissioning other health care; potential conflict over social environment	Dependent on information from Prison	£3.5 million	Potential for conflict between commissioner and governor over health – custody interface	High, but delay while commissioners learn special characteristics of prisons (1–2yrs?)

Table I3 Funding and accountability

Option	Objectives for accountability			Overall Objectives		
	Clear lines of accountability	Incentives to improve quality	Lack of perverse incentives	Extra costs	Staffing issues	Probability of change
A. Funding to prison Governor accountable for health care	Yes	Only if specific performance targets	Incentive to neglect health care	No additional management cost	Potential conflict for health staff	Low - lack of incentives
B. Funding for primary care to prison; NHS also responsible for health care	No	Yes via NHS input	Incentive for NHS To overstate need	Extra cost for joint working; reducing cost for DHC	Support for frontline staff; loss of role for DHC	High
C. NHS given funding and full responsibility for health care	Yes	Yes	Incentive for Health Authority to divert funds for Prison to acute medicine	Extra cost for additional Health Authority management posts. Most of DHC cost eliminated	Support for frontline health staff; potential conflict with custody staff; loss of role for DHC	Moderate - pressure for quality to improve but Health Authorities /PCG might allocate inadequate funds
Variant C. Funding to NHS; prison also responsible for health care	No	Uncertain	Likely disagreement over use of staff and adequacy of funding allocated by Health Authorities/PCG	Extra costs for joint working and additional Health Authorities management; some reduction in DHC cost	Support for frontline Staff	Uncertain

Appendix J: Number of Prisons by Health Authority

We do not expect our proposals to impact on health authorities uniformly. The distribution of prisons among Health Authorities is not even. See figures J1 and Table J1. Forty one health Authorities have no prisons located in their area. Sixteen health authorities have between 3 and 5 prisons located in their areas. One Health Authority has 8 prisons catering for over 2800 prisoners. The impact will depend on the population of the Health Authority. For most Health Authorities the impact of providing non psychiatric healthcare is expected to be very small (less than 0.5% of their budget). Figure J2 shows the differential impact in resource terms on Health Authorities providing additional mental health services expressed as a percentage of their current mental health expenditure. While we should not wish to understate the problems that would be faced by a few health authorities we should not wish that they be exaggerated. And subject to the needs of particular prisons, there is the opportunity to rationalise services and apply economies of scale.

Figure J1 Distribution of prisons among health authorities

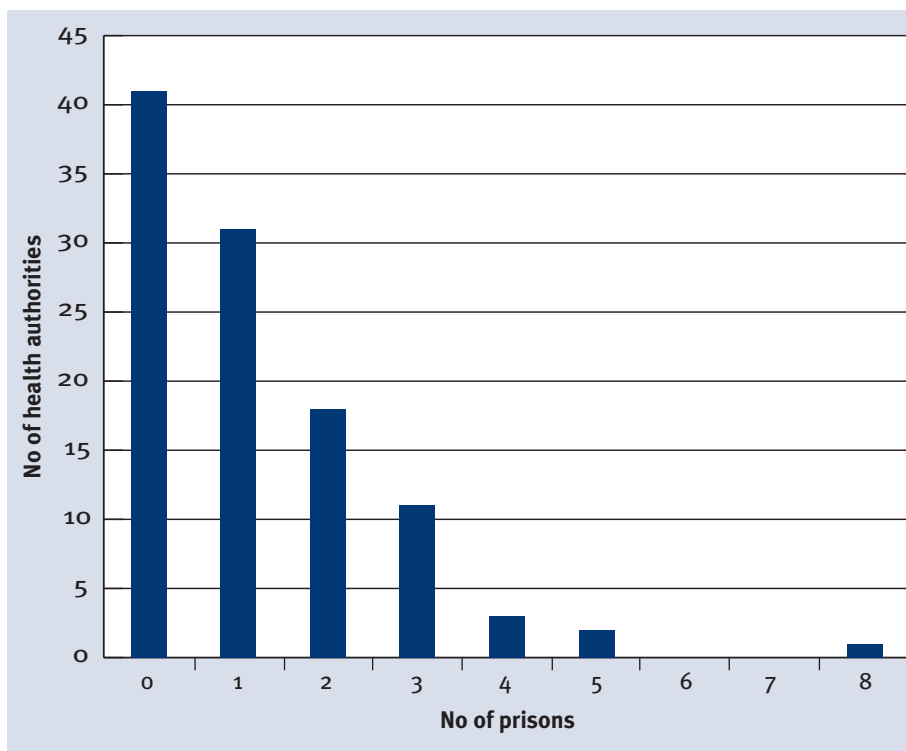


Figure J2: Expected cost of additional mental health services for prisoners as % of health authority mental health expenditure

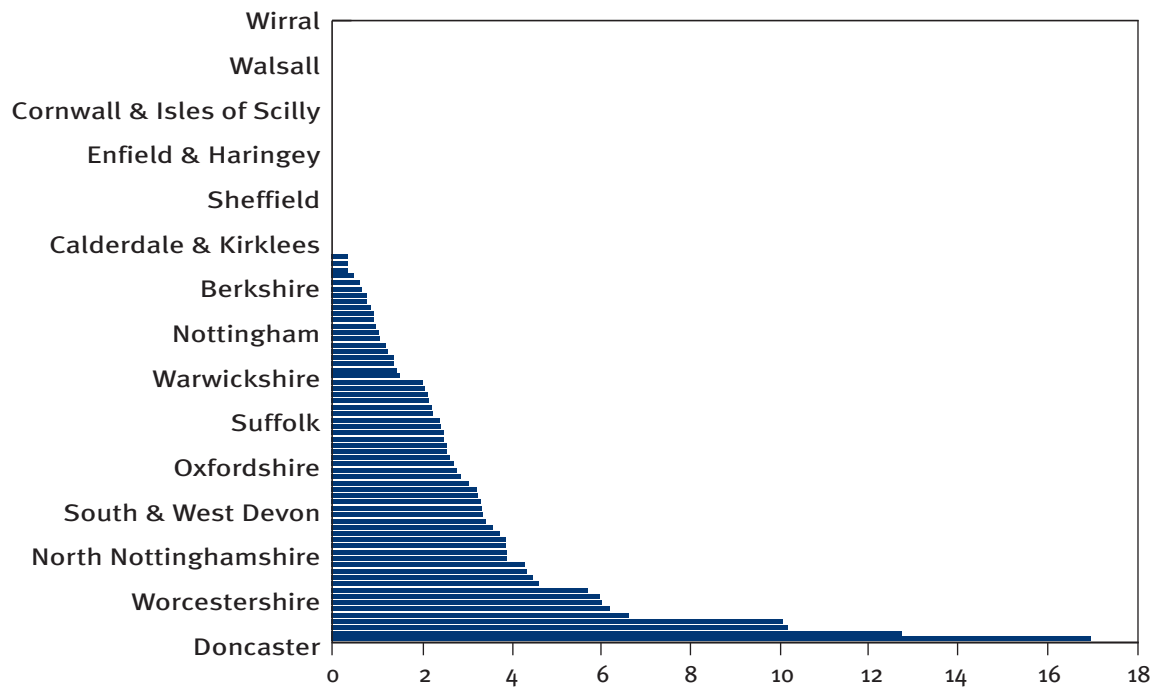


Table J1. Number of prisons by Health Authority

HA	RHA	No. of Prisons	ADP
Avon	South & West	1	539
Barking & Havering	North Thames	0	0
Barnet	North Thames	0	0
Barnsley	Trent	0	0
Bedfordshire	Anglia & Oxford	1	346
Berkshire	Anglia & Oxford	1	221
Bexley & Greenwich	South Thames	1	766
Birmingham	West Midlands	1	1000
Bradford	Northern & Yorkshire	0	0
Brent & Harrow	North Thames	0	0
Bromley	South Thames	0	0
Buckinghamshire	Anglia & Oxford	3	1287
Bury & Rochdale	North West	1	356
Calderdale & Kirklees	Northern & Yorkshire	0	0
Cambridge & Huntingdon	Anglia & Oxford	1	592
Camden & Islington	North Thames	2	1253
Cornwall & Isles Of Scilly	South & West	0	0
County Durham	Northern & Yorkshire	4	1800
Coventry	West Midlands	0	0
Croydon	South Thames	0	0
Doncaster	Trent	4	2428
Dorset	South & West	5	1888
Dudley	West Midlands	0	0
Dyfed Powys (Wales)	–	0	0
Ealing, Hammersmith & Hounslow	North Thames	2	1963
East & North Hertfordshire	North Thames	0	0
East Kent	South Thames	3	716
East Lancashire	North West	0	0
East London & The City	North Thames	0	0
East Norfolk	Anglia & Oxford	2	1212
East Riding	Northern & Yorkshire	3	1276
East Riding	Northern & Yorkshire	0	0
East Surrey	South Thames	0	0
East Sussex	South Thames	1	362
Enfield & Haringey	North Thames	0	0
Gateshead & South Tyneside	Northern & Yorkshire	0	0
Gloucestershire	South & West	3	750
Gwent (Wales)	–	2	274
Hertfordshire	West Midlands	0	0
Hillingdon	North Thames	0	0
Isle Of Wight	South & West	3	965
Kensington, Chelsea & West Minster	North Thames	0	0
Kingston & Richmond	South Thames	1	164
Lambeth, Southwark & Lewisham	South Thames	1	589
Leeds	Northern & Yorkshire	3	1625

HA	RHA	No. of Prisons	ADP
Leicestershire	Trent	5	2393
Lincolnshire	Trent	3	1011
Liverpool	North West	1	1270
Manchester	North West	1	1114
Merton, Sutton & Wandsworth	South Thames	3	1821
Morecambe Bay	North West	2	713
Newcastle & North Tyneside	Northern & Yorkshire	0	0
North & East Devon	South & West	1	447
North And Mid Hants	South & West	1	544
North Cheshire	North West	2	953
North Cumbria	Northern & Yorkshire	1	500
North Derbyshire	Trent	0	0
North Essex	North Thames	1	436
North Nottinghamshire	Trent	1	520
North Staffordshire	West Midlands	1	118
North Wales (Wales)	–	0	0
North West Anglia	Anglia & Oxford	1	499
North West Lancashire	North West	2	1119
North Yorkshire	Northern & Yorkshire	3	860
Northamptonshire	Anglia & Oxford	1	313
Northumberland	Northern & Yorkshire	2	933
Nottingham	Trent	2	424
Oxfordshire	Anglia & Oxford	2	899
Portsmouth & South East Hants	South & West	2	247
Redbridge & Waltham Forest	North Thames	0	0
Rotherham	Trent	0	0
Salford & Trafford	North West	0	0
Sandwell	West Midlands	0	0
Sefton	North West	0	0
Sheffield	Trent	0	0
Shropshire	West Midlands	2	628
Solihull	West Midlands	0	0
Somerset	South & West	1	207
South Cheshire	North West	1	246
South & West Devon	South & West	2	1172
South Derbyshire	Trent	0	0
South Essex	North Thames	1	125
South Glamorgan (Wales)	–	1	649
South Humber	Trent	0	0
South Lancashire	North West	2	1273
South Staffordshire	West Midlands	3	1060
Southampton & South West Hants	South & West	0	0
Southern Derbyshire	Trent	1	466
St. Helens & Knowsley	North West	0	0
Stockport	North West	0	0
Suffolk	Anglia & Oxford	3	1086

HA	RHA	No. of Prisons	ADP
Sunderland	Northern & Yorkshire	0	0
Tees	Northern & Yorkshire	2	859
Wakefield	Northern & Yorkshire	2	851
Walsall	West Midlands	0	0
Warwickshire	West Midlands	1	498
West Glamorgan (Wales)	–	1	279
West Hertfordshire	North Thames	1	609
West Kent	South Thames	8	2834
West Pennine	North West	0	0
West Surrey	South Thames	2	447
West Sussex	South Thames	1	441
Wigan & Bolton	North West	1	502
Wiltshire	South & West	1	286
Wirral	North West	0	0
Wolverhampton	West Midlands	2	1067
Worcestershire	West Midlands	4	1428