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Prison Health Partnership Survey 2006: Final Report

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Executive Summary

This survey of the prison health partnerships was commissioned by the national Prison Health team in order to inform both its review of the process of transferring prison health services to the NHS in public sector prisons, and its assessment of the progress of individual partnerships. The survey took the form of a questionnaire to the PCT prison health commissioning lead for each partnership in April 2006. The questionnaire requested that it be completed in consultation with both sides of the Prison/PCT partnership. The questionnaire stated that the names of individual partnerships completing the questionnaires and the associated raw data would be supplied to the national Prison Health team. It is likely that the extent of consultation by the PCT commissioning leads with members of the partnership boards varied. The "partnership-level" response rate reported here is 96% (81/84), which includes 98% (120/123) of prisons included in the transfer.

The prison health partnerships recorded their key objectives, and the extent to which they had been realised. Some of the partnerships viewed their objectives solely in terms of managing the transition of commissioning responsibility, and some identified an objective of improving prison healthcare provision to make it equitable with provision for the wider local community.

Partnerships rated the extent to which the partnership board is developing prison healthcare effectively, using a five point scale. Overall, 64% (52/81) gave a positive rating of 4 or 5, compared to 31% providing a neutral rating of 3, and 5% giving a more negative rating. A higher proportion of the partnerships that went live in 2004 gave the most positive rating of 5, compared to those that subsequently went live (33% and 11%, respectively). It is taking time for the partnerships to become sufficiently established to impact on the development of prison healthcare, which entails establishing relationships, reviewing options and implementing new practices.

Partnerships typically expressed confidence in the extent to which prisoners requiring healthcare have benefited from the prison health partnership, with 77% (59/77) giving a positive rating. The most common important change in healthcare provision for prisoners introduced since the partnership was formed related to improvements in primary care services including enhanced GP availability and out-of-hours cover (accounting for 18%, 46/254, of the total reported changes). The next most commonly cited changes relate to staff (and particularly nurses, including quality, skill-mix, training, integration with PCT) and enhanced mental health services.

The partnerships are working to adapt and apply PCT clinical governance arrangements to the prison settings and clinical risk is typically viewed as being managed effectively when existing PCT standards have been implemented. The partnerships' comments relating to managing cultural differences suggest that those partnerships that rate themselves highly are characterised as having a strong shared commitment to addressing differences and promoting dialogue, while recognising that progress may be hard to win. The partnerships ratings of the extent to which their work will be affected by the imminent restructuring of health and prison services, indicate a dominant theme of uncertainty about the likely impact of restructuring, and PCT reconfiguration in particular.

Partnerships giving a high rating about the extent to which prison healthcare is effectively integrated into PCT plans and activity, reported implementing healthcare provision which is comparable with provision to the wider local community. Low rating partnerships commented on the need to raise the priority attached to prison healthcare either within the PCT, or both PCT and prisons. Assessment of the overall experience of each partnership, by reviewing all the data supplied in each questionnaire and applying a composite measure of rating responses, suggests that 16% (13/81) of the partnerships were facing particular challenges.

Partnerships were asked to record what they considered to be the three most significant risks for prison healthcare in the next 12 months. Three risks dominated the responses. Concern about funding, staffing and reconfiguration were each reported by more than half the partnerships, and together accounted for 57% (142/247) of all cited risks. To some extent, the risks are related; PCT reconfiguration may give rise to changes in key personnel, which could leave organisations with weaker relationships and consequently potentially increased financial risks. The issue of the extent to which there is an agreed approach to sharing the financial risks associated with the transfer, generated the highest proportion of negative rating responses (27%). Overall, the issue of risk sharing is characterised as an important component of a wider agenda which, to the extent that it involves both PCTs and prisons, is influenced by the quality of communication and understanding between organisations.

The survey provides a 'snap shot' picture of the views of the prison healthcare partnerships. At the level of individual partnerships, the data will provide a basis for dialogue about the progress to date and future development. At an aggregated level, the data provide a basis for identifying key issues facing prison healthcare. While the transfer of responsibility for prison health to PCTs has been completed, the challenges of delivering higher quality services are ongoing.

Background

The completion of the transfer of prison health services to the NHS in public sector prisons in April 2006 provided an opportunity for the national Prison Health team to review the process and look more closely at the progress of individual partnerships. As the first part of this review, the national Prison Health team commissioned the Health Services Management Centre to undertake a survey of the Prison Health Partnerships. The survey took the form of a questionnaire (see appendix), which was emailed to the PCT prison health commissioning lead for each individual partnership. The questionnaire request that the questionnaire be completed in consultation with both sides of the Prison/PCT partnership.

Three caveats about the survey data need to be borne in mind:

- The questionnaire stated that the names of individual partnerships completing the questionnaires and the associated raw data would be supplied to the national Prison Health team. By requesting partnerships to identify themselves, it is inevitable that some of the responses supplied will be constrained. It is likely that this issue will not have affected the responses in a uniform way.
- The link with the partnerships was the PCT prison health commissioning lead identified by regional or strategic health authority leads, and it is likely that the extent of consultation with members of the partnership boards varied. Some partnerships sought views on their responses from a range of stakeholders, while it is apparent that some responses represent the perspective of the commissioning lead. In a small number of responses, the views of stakeholders were not reconciled, but supplied separately, which gave insight into the range of views expected about the different issues raised. When more than one rating was supplied for a question, the mean value was calculated and rounded down to the nearest whole number.
- The survey elicits participants' views about a range of issues related to the working of the partnerships. These views provide insight into the performance of the partnerships. However, the relationship between participants' views about performance and actual performance may vary to some extent across the responses.

Having noted these caveats, care is needed not to place too much weight on the survey findings as basis for assessing the performance of individual partnerships. Nevertheless, the survey provides a 'snap shot' picture of the views of the prison healthcare partnerships, which can be used to identify partnerships at each end of the performance range.

The commissioning responsibility for prison healthcare transferred to the local or lead PCT for a first-wave of prisons in April 2004. Thirty-four prisons (including the recently formed HMP Warren Hill) were included in the first-wave, and they formed partnerships with 18 lead PCTs. In April 2005, all but three of the remaining prisons joined a second wave. The second wave included 86 prisons and 63 lead PCTs. The third wave included three prisons and three PCTs. The total number of prisons and lead PCTs across the three waves is 123 and 84 respectively.

Questionnaire Findings

Questionnaire response rate

Eighty-one completed questionnaires were returned. Two of these 81 questionnaires were received for different partnerships within the same PCT, and so the "partnership-level" response rate is 96% (81/84). This response represents 98% (120/123) of prisons included in the transfer. The response rates by wave are shown in table 1.

Table 1 Questionnaire response rate by wave and the prisons included

wave	Partnership-level response rate	prisons included
First	100% (18/18)	100% (34/34)
Second	95% (60/63)	97% (83/86)
Third	100% (3/3)	100% (3/3)
Total	96% (81/84)	98% (120/123)

The questionnaire was emailed to PCT commissioning leads in April and the initial deadline for return of responses was 1 May. Sixty-six completed questionnaires were returned by 19 May 2006. Following further contact with non-respondents, a further 15 completed questionnaires were returned by 31 August 2006. Hence, the majority of responses were recorded in April/May.

Partnership board meetings

Partnerships were asked how many times the partnership board met in 2005. The mean number of meeting was 5.5, and median number was 4.5. The most common number of meetings was four, and 30% (24/81) of the partnerships reported holding four partnership board meeting in 2005. The range was one to 14 meetings. One of the two partnerships in which the board met once commented *"once formally – but many, many informal meetings with Prison and PCT"*. A number of other partnerships which held few board meetings in 2005 commented on the role of more frequent informal meetings. However, one partnership, noted that *"two [meetings] went ahead with no representation from the PCT"* [no 22]. The number of board meeting was not correlated with the partnerships' assessment of their effectiveness in developing prison healthcare, which is reported below.

Objectives and progress, and issues

The prison health partnerships were asked to record their key objectives. Some of the partnerships provided comparatively detailed accounts of their objectives. The following description illustrates the type of account which incorporates both process issues associated with the transfer of commissioning responsibility, and outcomes to "promote the health and wellbeing of prisoners":

> *"To oversee the transfer process, along with the development of a Prison Health Delivery Plan and commissioning strategy. In undertaking this, the Board will: Drive the Transfer process. Drive the implementation of the approved Prison Health Delivery Plan and commissioning strategy. Monitor and be accountable for the delivery of healthcare in the prison. Develop and influence policies which will promote the health and wellbeing of prisoners. Receive reports from the sub groups, and to steer and monitor their work programmes - the sub groups are; Finance. Workforce and HR. Mental Health. Substance Misuse. Health. Health Promotion - covering oral health, sexual health. Receive financial information and to make best value decisions based on that information. Link into nationwide strategic arrangements and working groups/networks. Support the development of Clinical Governance arrangements and to monitor the quality of health care through arrangements. Work together to solve problems and organisational differences creatively and pragmatically. To ensure robust workforce plans & HR processes are in place and discuss with staff. Ensure that the provision of health care for prisoners is in line with NHS health standards." [no 5]*

Some partnerships recorded their objectives more succinctly and exclusively in terms of the change in commissioning process: *"To ensure the smooth transition"* [no 55]. Other partnerships noted specific clinical objectives, such as:

> *"To commission primary care GPs into the prison doctor service and to commission PCT out of hours services." [no 63]*

For the purpose of this report, an interesting aspect of the recorded objectives is the contrast between those partnerships which view their objectives solely in terms of managing the transition of commissioning responsibility, and those which identify an objective of improving prison healthcare provision to make it equitable with provision for the wider local community.

> *"To ensure that Healthcare provision in the prison is comparable to that delivered to the PCT population" [no 27]*

> *"To set the strategic direction of healthcare services within the prison; to ensure they were equitable with services available in the wider community; to provide clear governance and accountability for decision making relating to healthcare." [no 20]*

> *"… To secure a comprehensive healthcare provision which was the equivalent of care in the community and operated to the same clinical governance standards as other primary health care teams in the county." [no 1]*

The partnerships commented on the extent to which the key objectives had been realised, and the level of detail provided varied considerably. For the purpose of comparison across the partnerships, the proxy measure of the extent to which the partnership board is developing prison healthcare effectively is helpful, and this is reported below. Similarly, the partnerships were asked to record the key issues that have influenced progress, and the level of detail provided varied considerably. For the purpose of this report, a more accessible and related comparison is possible in terms of the most significant risks for prison healthcare, and these are reported below.

The effective development of prison healthcare by partnership boards

Partnerships were asked to rate the extent to which the partnership board is developing prison healthcare effectively, using a five point scale (figure 1). At one extreme, a rating of 1 indicated "Strongly disagree: the board has not contributed to development", while at the other extreme, a rating of 5 indicated "Completely agree: the board has driven excellent developments". Overall, 64% (52/81) of the partnerships gave a positive rating of 4 or 5, compared to 31% (25/81) of partnerships providing a neutral rating of 3, and 5% (4/81) giving a more negative rating of 2 (figure 1).

Figure 1 "The partnership board is developing prison healthcare effectively"

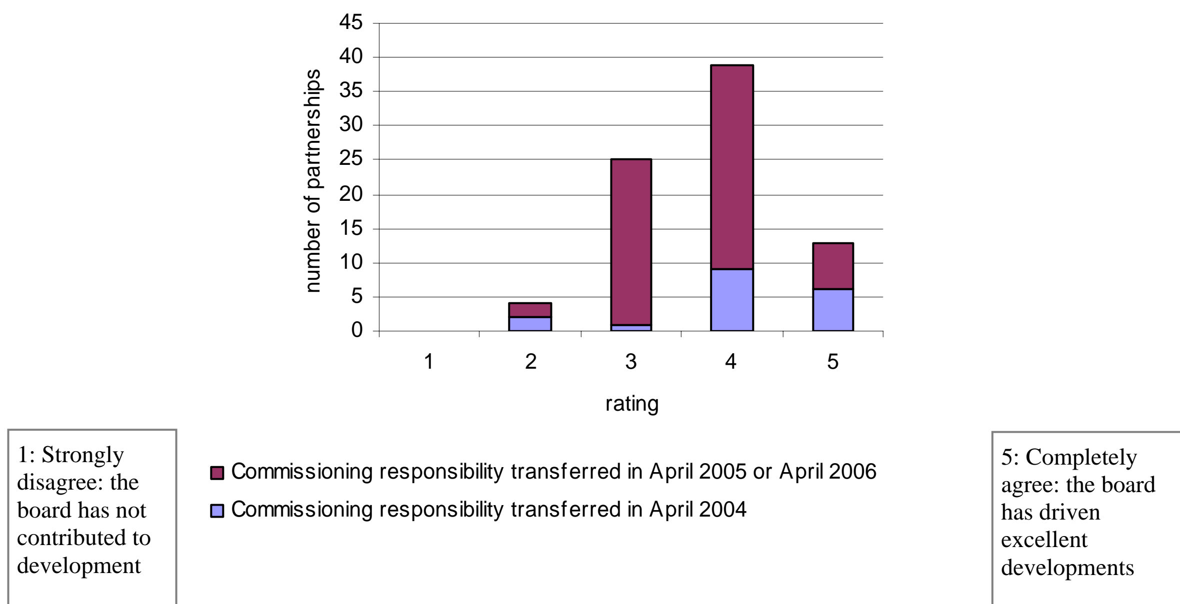


Figure 1 shows a marked difference in the pattern of responses between the partnerships that went live in 2004, and those that went live in 2005 or 2006. Thirty-three percent (6/18) of the first wave

partnerships reported the most positive rating of 5, compared to 11% (7/63) of the partnerships from the subsequent waves. This difference in the pattern of ratings provided by the first and subsequent wave partnerships illustrates a key theme from the survey; that it takes time for the partnerships to become sufficiently established to impact on the development of prison healthcare.

For example, one of the 5 rating partnerships [no 63] from the first wave reported that its key objectives were to commission primary care GPs into the prison doctor service and to commission PCT out-of-hours services. Both of the objectives were reported to have been achieved, but both innovations were implemented in the second half of the partnership's second year (November 2005 and February 2006, respectively).

Similarly, one of the 4 rating first-wave partnerships [no 20] reported that it had used competitive tenders to introduce new providers for pharmacy, dentistry and an integrated primary care service. The process for the pharmacy and dentistry services was started in its first year and implemented during 2005/6. Tendering for the integrated primary care service was initiated at the beginning of 2005/6 and implemented in April 2006, following a period of familiarisation and model assessment during the previous year.

One first-wave partnership [no 58], which covers three prisons, reported a rating of 3 (figure 1). It noted that the partnership board initially lacked sufficient engagement, and that action had been taken to re-establish it as *"focused and proactive"*. Despite this experience, which is likely to have impeded its development to some extent, the partnership's positive account of its progress suggests that in the context of prison healthcare, two years is a short timeframe for realising change:

> *"They have all been met over the last two years and changes to service delivery and staffing have been (or are being) implemented where possible following the evidence gathered from these processes".*

The experience of the first-wave partnerships suggests that it may be too early to assess the impact of the second-wave partnerships. In addition to time required to establish relationships, review options and implement new working practices, other factors may be influential. For example, one of the 5 rating partnerships [no 38] from the first wave reported that most objectives

> *"have been met or are close to being met. The key issue now is whether we will have sufficient funding to continue with developments. ... [In] the first year we had access to generous funding and significant progress was made. In year 2 we have witnessed a significant slow down due to lack of growth monies".*

At the time of the survey, funding was the dominant risk reported by the partnerships (see below), and to the extent that funding has become less generous, second and third wave partnerships may find it more difficult to emulate the progress made by the first-wave partnerships.

A factor influencing the key issue of the timescale required for changing working practices is the extent of historical collaboration on which the partnership could draw. Another of the 5 rating first-wave partnerships [no 1] illustrates the role of reported that its key objectives had been realised *"to a considerable degree, but we still have some way to go"* despite its considerable shared history: *"we have more than 6 years of collaborative working invested in developing constructive working relationships and planning service provision"*.

Two of the first-wave partnerships reported significant limits in the extent to which the partnership boards were able to effectively develop prison healthcare [nos 61 and 9]. The response from one of these partnerships [no 61] recorded views from up to five individuals, and a mean rating of 2:

> *"Considerable improvements over the last two years, but still some way to go."*
> *"PCT both commissions and provides and this created a governance muddle - this should change with the new PCT Structure."*
> *"The board lacks clear and specific strategic direction and tends to concern itself with the operational detail."*

A wider range of issues were reported to have influenced progress, including; successive changes in senior PCT leadership, finances *"we did not inherit a break even budget"*, difficulty in recruiting high quality staff, differences in culture and in priority, understanding and commitment to the partnership service level agreement (SLA).

The other 2 rating first-wave partnership [no 9] covered two prisons, and it reported taking action intended to increase effectiveness:

> *"The partnership board continues to evolve in terms of the roles and responsibilities of the respective partners. A recent decision has been taken to separate the ... [two prisons'] partnership boards, bringing greater focus to commissioning and performance management issues in relation to improving healthcare."*

Again, a wider range of issues were reported to have influenced progress:

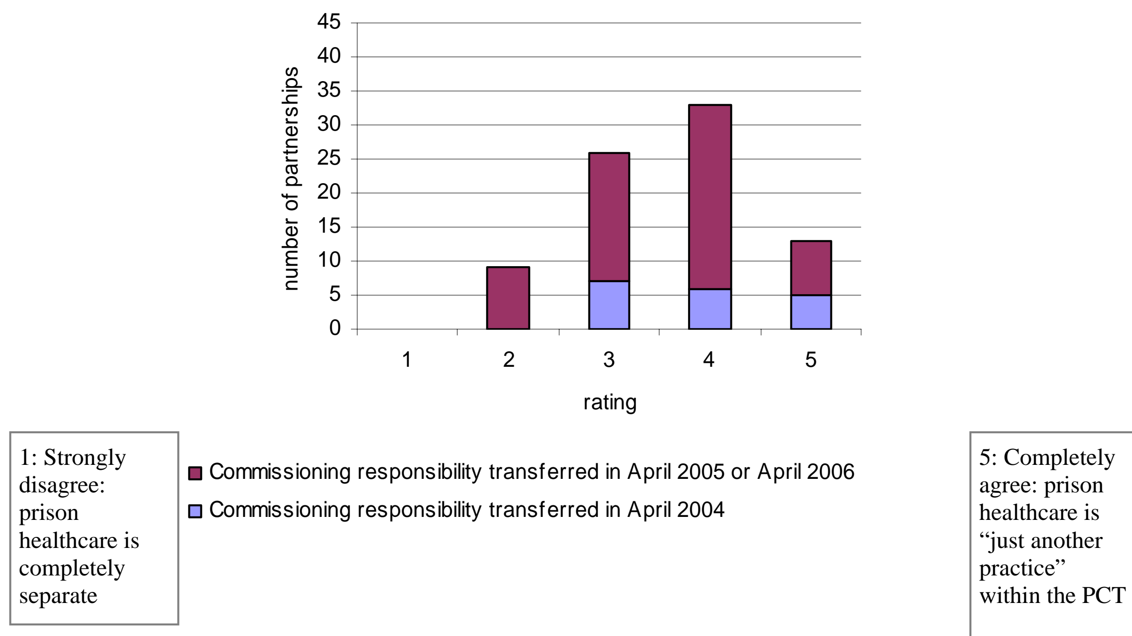
> *"Lack of financial management control and performance management within prison health. Prison healthcare management and disciplinary procedures. Complex nature of prisons and volume of prisoners throughout in each. Lack of clarity in terms of clinical accountabilities and responsibilities. Wider NHS agenda through Patient Led NHS, and financial concerns have impacted on how prison health is prioritised."*

The partnerships' rating of the extent to which their partnership boards are developing prison healthcare effectively provides a key 'snap shot' measure of the progress by April/May 2006. As noted above, the majority of partnerships gave a positive rating of this measure, and only 5% (4/81) gave a comparatively negative rating of 2 (figure 1). Further measures of high and low performing partnerships are provided in the section beginning on page 27.

Integration of prison healthcare into PCT plans and activity

Partnerships were asked to rate the extent to which prison healthcare is effectively integrated into PCT plans and activity, using a five point scale (figure 2). At one extreme, a rating of 1 indicated "Strongly disagree: prison healthcare is completely separate", while at the other extreme, a rating of 5 indicated "Completely agree: prison healthcare is 'just another practice' within the PCT". Overall, 57% (46/81) of the partnerships gave a positive rating of 4 or 5, compared to 32% (26/81) of partnerships providing a neutral rating of 3, and 11% (9/81) giving a more negative rating of 2 (figure 2).

Figure 2 "Prison healthcare is effectively integrated into PCT plans and activity"



The first-wave partnerships rating themselves as 5 in terms of integrating prison healthcare effectively into PCT plans and activity cited evidence including the integration of prison practices through implementation of nGMS and QOF processes, and implementing and maintaining practice management IT systems in line with non-prison practices [nos 12 and 63]. In the words of one of these partnerships [no 4]:

> *"The PCT does view the Prison as 'another practice' and a lot if not more attention is given to the development of prison healthcare"*

The view that achieving comparable services required extra effort being expended is echoed by several of the subsequent wave partnerships, which rated themselves 4 on this integration issue:

> *"Prison healthcare is becoming another practice within the PCT, but dedicated separation is necessary to ensure focus and stability of funding during times of financial strain." [no 31]*
> *"Whilst prison health is accorded the same importance as other PCT services, there is a degree to which is treated differently in a positive way, ie specifically protected budget." [no 8]*

Subsequent wave 5 rating partnerships also cite a strong commitment to integration. In one partnership this reflected in the establishment of quality measures:

> *"The service specification agreed for 2006/7 identifies key performance targets for the prison health care, similar to those seen with General Practice (QOF)..."*

Although the extent to which it is early days for assessing integration is apparent:

> *"Prison Healthcare is fully integrated into PCT business ... . Staff working on the ground probably yet to 'feel' the reality of integration ..." [no 33]*

A first-wave 3 rating partnership [no 38] was cautious about the extent to which integration could be viewed in terms of prisons becoming 'just another practice', but acknowledged the role of integrating practice management software:

> *"... we are some way off having the prisons being identified as just being another practice. Prison are unique and as such will require different approaches to developing and setting up systems. Once ...[practice management software] is up and running this will go some way to 'standardising' general practice in the three prisons."*

Negative consequences of reconfiguration were also apparent, for high rating (4) partnerships:

> *"More integration is still to happen its been on hold this year due to PCT reconfiguration no one is sure about groups and work streams i.e. Which are merging?" [no 5]*

And low rating (2) partnerships:

> *"There is still more work to be done for this to be achieved fully. ... We are seeing some change now but another year we should be well on the way with restructure, period of stability, appointment of Head of Health Care/Health Care Manager ...." [56]*

However, another 2 rating partnership saw PCT reorganisation in a more positive light:

> *"PCT reorganisation may provide opportunity to strengthen" [18]*

More generally, the partnerships rating themselves as 2 in terms of integrating prison healthcare effectively into PCT plans and activity commented on the need to raise the priority attached to prison healthcare either within the PCT, or both PCT and prisons:

> *"The development plans and aspirations for Prison health are now incorporated into the LDP but whether it is afforded the same priority and commitment to integrate into mainstream planning and activity is questionable. It still feels like a service which sits in isolation and the momentum with which the PCT need to recognise it as a key area of service need and a major responsibility has not been realised." [47]*

> *"It has been difficult to engage PCT staff in prison healthcare" [42]*

> *"Good working relationships have been developed between lead individuals, this needs to be 'generalised' through all of the organizations" [59]*

> *"The plans for the future of the prison development is under review … . Currently there is limited integration between the prison and the PCT" [22]*

Clinical governance

Partnerships were asked to rate the extent to which there is a shared clinical governance framework which ensures that locally identified clinical risk is managed effectively, using a five point scale (figure 3). Overall, 64% (51/80) of the partnerships gave a positive rating of 4 or 5, compared to 28% (22/80) of partnerships providing a neutral rating of 3, and 9% (7/80) giving a more negative rating of 1 or 2 (figure 3). One partnership did not record a rating, but noted that *"the PCT manages clinical risk to patients through the clinical governance structures and prison health is fully integrated into this structure"*.

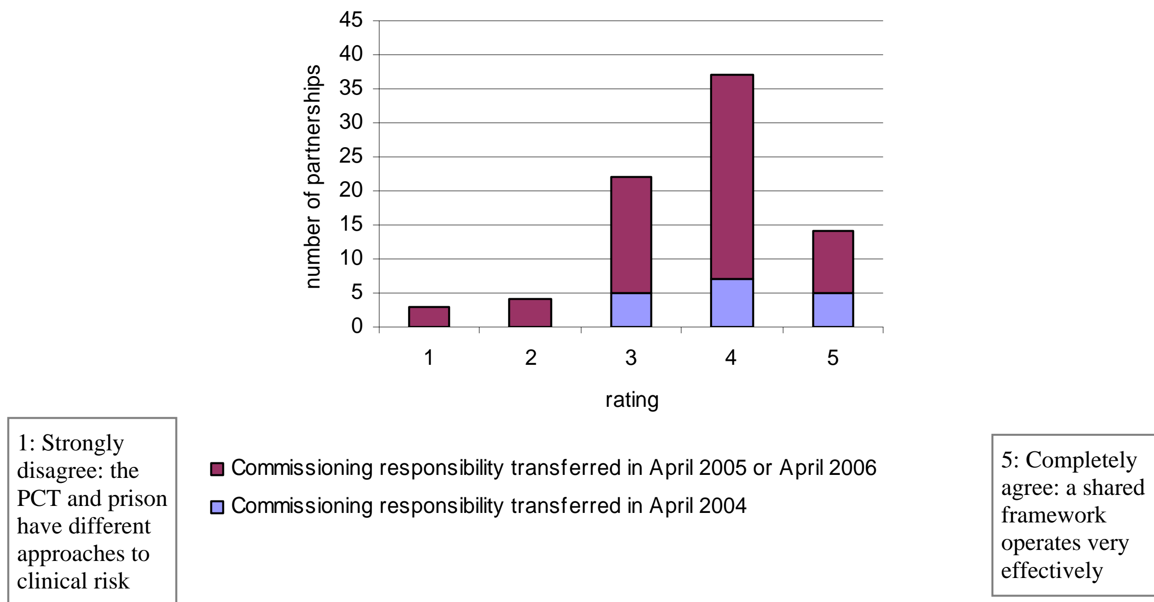
A common theme of the comments made by the partnerships is that they are working to adapt and apply PCT clinical governance arrangements to the prison settings. Clinical risk is typically viewed as being managed effectively when existing PCT standards have been implemented. The following comments illustrate the views of first-wave partnerships:

> *"Operates successfully with each respective PCT governance arrangements." [no 58]*

> *"Clinical Governance lead and the Risk Manager for the PCT attend regular CGC meetings at HMP …. The prison have access (and use) EMIS and Sentinel (Client information system as SUI reporting system) which directly feed into the PCT auditing committee. HMP … have adopted the standards for better health and clinical governance framework as promoted by the PCT." [no 41]*

> *"The prison whilst having their own clinical framework have done so in accordance with PCT policy, and are incorporated where appropriate in PCT arrangements for managing clinical risks." [no 9]*

Figure 3 "There is a shared clinical governance framework which ensures that locally identified clinical risk is managed effectively"



Several first-wave partnerships noted challenges, however, including a lack of evidence relating to the effectiveness of clinical governance arrangements, a lack of medical leadership, and the need to change current structures. Second-wave partnerships noted specific initiatives, which were viewed as contributing to good progress, such as:

> *"… The development of regular Drug & Therapeutic meetings have had a marked effect with dealing with risks, many of which were related to medicines management" [no 10]*

However, the extent of the task of changing clinical governance arrangements in prisons remains considerable:

> *"… Clinical risk traditionally has been very different in Prison Health and this extends to Health & Safety. We are now progressing with a joint approach." [no 49]*

> *"…There can be conflict between clinical risk and security, e.g. needle exchanges and this needs to be worked through. The PCT approach is more compatible with NHS ethos than its predecessor." [no 43]*

> *"We struggle with significant event audit, it is not as simple as it can seem to those working outside prisons." [no 15]*

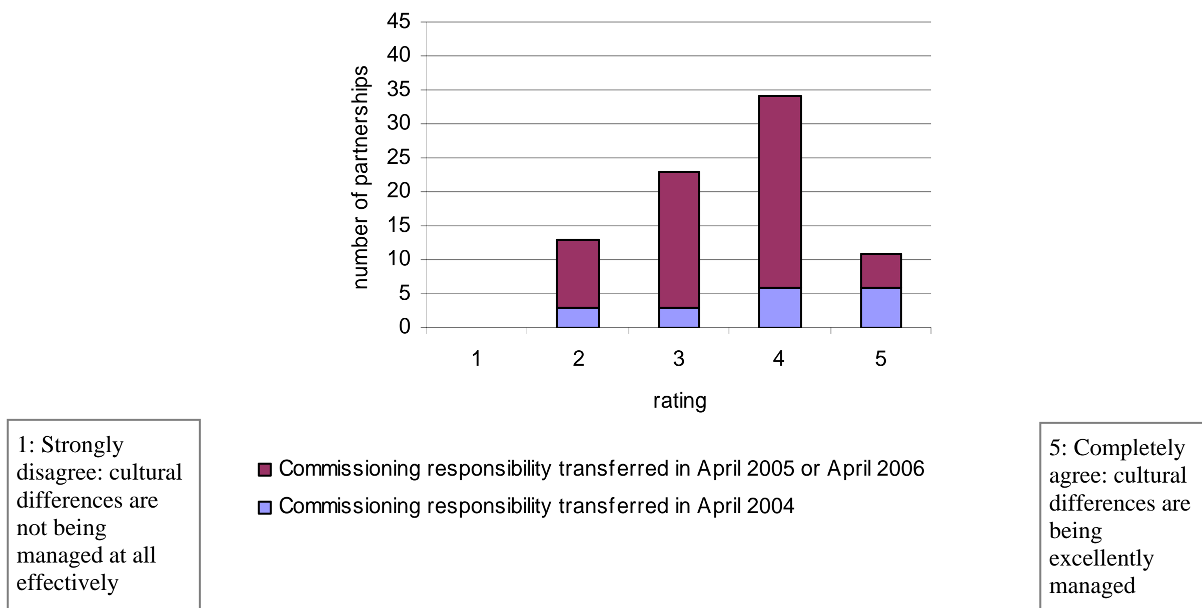
Partnerships having made comparatively little progress tend to have not moved beyond the planning stage, and in one case this was attributed to changes in personnel. One of the second-wave partnerships rating itself as 1 noted:

"All risk assessments within the prison are based on the prison frameworks, no PCT frameworks are adopted currently." [no 22]

Culture

Partnerships were asked to rate the extent to which cultural differences between organisations are being managed effectively, using a five point scale (figure 4). Overall, 56% (45/81) of the partnerships gave a positive rating of 4 or 5, compared to 28% (23/81) of partnerships providing a neutral rating of 3, and 16% (13/81) giving a more negative rating of 2 (figure 4). A higher proportion of first-wave partnerships gave the highest rating of 5, compared to the subsequent waves (33%, 6/18, and 8%, 5/63, respectively).

Figure 4 "Cultural differences between organisations are being managed effectively"



The partnerships' comments relating to managing cultural differences suggest that those partnerships that rate themselves highly are characterised as having a strong shared commitment to addressing differences and promoting dialogue, while recognising that progress may be hard to win. For example, two 5 rating first-wave partnerships noted:

"They ARE being managed BUT this does not mean the process is easy or always successful. Newly appointed NHS staff working in the prisons may not agree. The day to day operational problems associated with delivering a NHS service in the prisons is extremely challenging!" [no 38]

"Cultural differences have been evident but I think they are now being managed extremely well, whilst acknowledging they won't go away." [no 20]

Constructive dialogue has been developed by holding regular meetings and multi-organisation away days, and through 'quick win' initiatives such as developing substance misuse/drug strategies. Partnerships rating 3 illustrate the challenges facing frontline staff:

"Cultural conflict continues to place both organisations at risk. It was underestimated how much in a busy local prison the regime of the prison would affect nurses in particular ability to practice in line with their professional responsibilities. Outdated practices that are not nursing tasks still take up a significant period of time and impact on staff's enthusiasm and motivation." [no 17]

"There is progress but it is slower that we would have wished. Existing health staff appear to resist many of the changes that should be introduced. This is a management challenge that we will gradually overcome." [no 49]

Low rating partnerships demonstrate comparatively little shared understanding, to the extent that the wider effectiveness of the partnerships is called into question:

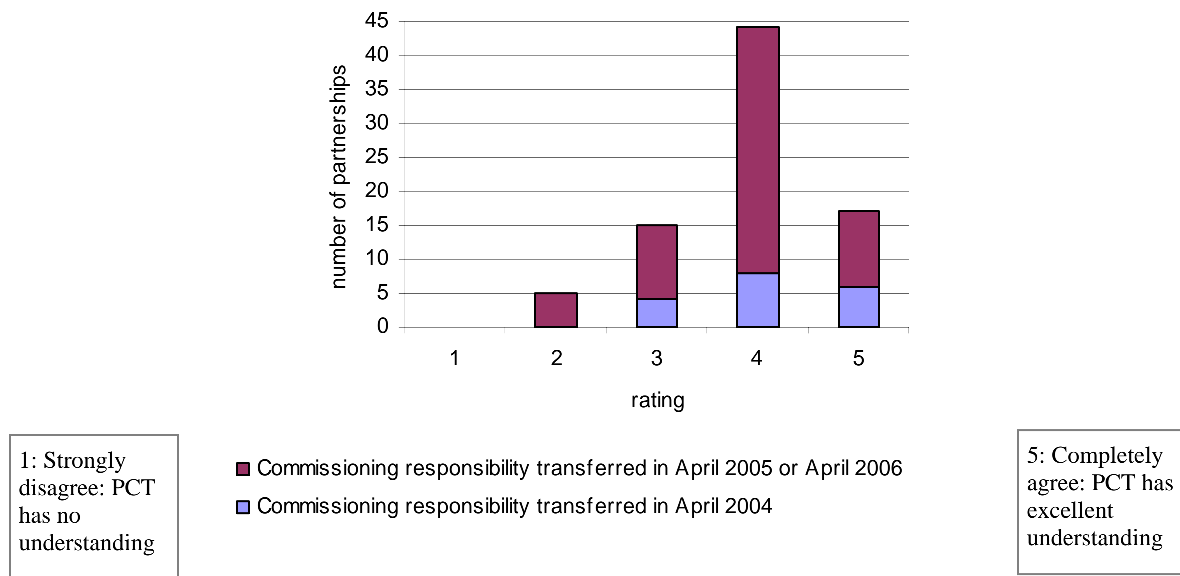
"Suggest that the cultural differences within the two organisations have been underestimated. Whilst there is recognition of the differences, it is still hard for NHS clinicians to understand the Prison Services response to certain actions and vice versa. Health in some respects still sees itself as not prioritised within prisons, and it is unclear that the NHS taking on commissioning has improved/or isolated more relationships within the wider prison despite improvements in the standards of care delivered. Set up always [will] be difficult to manage in spite of skills and efforts of partners, and there needs to be acknowledgement that conflicts will continue in terms of the partnership, and individuals working within it." [no 9]

"There seems some confusion around roles and responsibility within the two organisations regarding the prison health agenda. The Scheme of Delegation and process around decision making and responsibility/accountability is not clear and often misunderstood/misinterpreted." [no 47]

The future prison healthcare agenda

Partnerships were asked to rate the extent to which the PCT understands the future prison healthcare agenda, using a five point scale (figure 5). Overall, 75% (61/81) of the partnerships gave a positive rating of 4 or 5, compared to 19% (15/81) of partnerships providing a neutral rating of 3, and 6% (5/81) giving a more negative rating of 2 (figure 5).

Figure 5 "The PCT understands the future prison healthcare agenda"



Three partnerships suggested or implied that a more appropriate question would relate to the prisons' understanding of the PCT or prison healthcare agenda. The partnerships' positive ratings are reflected in their comments on this issue, with many expressing confidence. The following partnership's comment provides a good summary of the challenge:

> *"Individuals with the PCT understand the future prison healthcare agenda …as effectively as anyone else does given the uncertainties and newly evolving policies and guidance." [no 31]*

Having a good understanding of the future agenda was often linked to close collaboration between organisations and the efforts of key individuals. The complexity of the agenda given the evolving national policy context was highlighted:

> *"As much as anybody understands the prison healthcare agenda more importantly the pct understands the need to 'bring on' prison healthcare. Inspite of PSO/PSI's that constantly say what h/c should provide whether operation[al] or clinical with no extra resources or consultation that is actually listened to by the prison healthcare policy makers." [no 6]*

> *"This is an ongoing learning curve with the prison model changing constantly. Location of drug strategy, formation of NOMS, introduction of Custody Plus etc. all lean towards a need to re-establish the PCTs understanding of the provision of healthcare in those contexts etc." [no 41]*

Several 4 rating partnerships were cautious in their comments:

> *"We profess that we understand, but the delivery of standards to which we aspire is perhaps taking longer than anticipated." [no 53].*

> *"The PCT entirely understands the high needs of the prison population and the associated risks. We have a vision of future healthcare service delivery, however, the massive PCT agenda, particularly in the context of enormous financial pressures, has the potential to pull PCT staff away from this work." [no 20]*

Some 4 rating partnerships sought greater regional or national clarity to support their work:

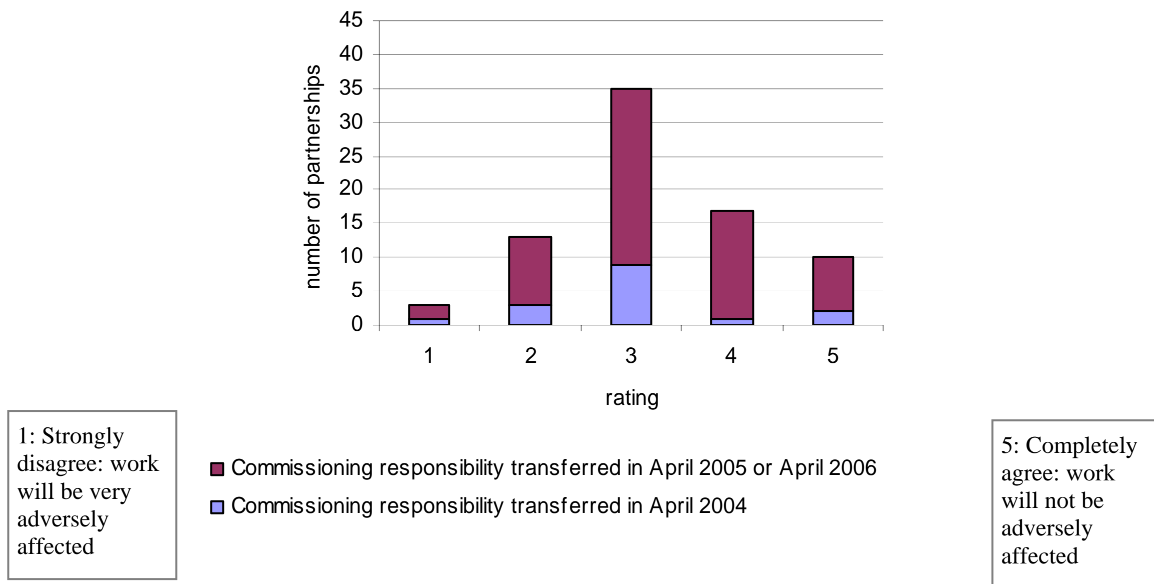
> *"It is not clear whether the National Prison health team has a clear view on the agenda for the future of prison health, and in the wider NHS context where prison health sits within the reconfiguration of SHAs and PCT under a patient led NHS. The PCT is clear about improving health outcome, but less certain about wider SHA/NHS agendas for prison health." [no 9]*
>
> *"… [the agenda] is not something all the Board are aware of, due to the regional team not yet fully operational and not fully able to provide the vision and direction necessary to allow cascading within the organisation." [no 65]*
>
> *"Improved communication from the centre (DoH/Prison Health) could improve this." [no 62]*

However, several partnerships also noted the positive role that regional support and learning sets and conferences had played in raising awareness. The lowest rating partnerships recognised a need to spread understanding beyond a few key staff, and in one case this was linked to a *"lack of urgency and drive around ownership"*.

The restructuring of health and prison services

Partnerships were asked to rate the extent to which the work of the partnership will not be adversely affected by the imminent restructuring of health and prison services, using a five point scale (figure 6). Three partnerships did not record a rating on this issue. Overall, 35% (27/78) of the partnerships which provided a rating gave a positive rating of 4 or 5, compared to 45% (35/78) of partnerships providing a neutral rating of 3, and 21% (16/78) giving a more negative rating of 1 or 2 (figure 6). The partnerships' comments show that the most frequent rating of 3 typically represents a dominant theme of current uncertainty about the likely impact of restructuring, and PCT reconfiguration in particular. Nineteen percent (3/16) of the first-wave partnerships gave a positive rating compared to 39% (24/62) of those from the subsequent waves. The three positive first-wave responses were all received in July/August and this may indicate a reduction in uncertainty relating to this issue since April/May.

Figure 6 "The work of the partnership will not be adversely affected by the imminent restructuring of health and prison services"



The comparatively optimistic comments of second-wave partnerships may reflect that the timing of the restructuring is closer to being concurrent with the development of the partnerships. To the extent that first-wave partnerships are more likely to have implemented initiatives, they are more susceptible to disruption.

The following comments illustrate the views of 5 rating partnerships:

> *"The P Board is already considering the opportunities and risks to returning to a cluster Board and has organised a workshop across the 4 prisons to being initial talks." [no 21]*

> *"Discussed at Partnership Board. No-one can see any problems that can't be resolved" [no 36]*

> *"Partnership Group share re-structuring agendas of respective organisations and work towards minimising affect on commissioning prison healthcare" [no 26]*

> *"The work will be benefited by the restructuring as the prison is clearly identified in both agendas" [no 22]*

Uncertainty was expressed in terms of the potential impact on funding, staffing and priorities:

> *"There will be inevitable loss of organisational senior memory, significant pressures for resources and differing healthcare experiences and regimes in the constituent parts of the proposed new PCT" [no 19]*

"…Different personalities and priorities might emerge, so whilst we have a strong foundation it does not guarantee anything for the future" [no 8]

"Outcome dependant upon final PCT configuration and level at which responsibility for Prison Healthcare is vested. There is a real risk that if prison healthcare is a small part of a PCT Executive Director's portfolio and if there is no named lead at senior level then momentum would be lost." [no 39]

Service Level Agreements and financial risk sharing

Sixty-four percent (50/77) of the first and second wave partnerships reported having had their service level agreement (SLA) for 2005/06 signed off by the PCT chief executive and prison governor (table 2). Some of the partnerships that have not signed off their SLA for 2005/06 provided explanatory comment such as the following from a second-wave partnership:

"Not a specific document of this type, but we have a Memorandum of Agreement for Partnership Working that was agreed in November 2004. Specific SLAs are signed off between the PCT and other healthcare provider organizations" [no 8]

Table 2 Has the partnership's service level agreement for 2005/06 been signed off by the PCT chief executive and prison governor?

	First-wave partnerships (2004)		Second-wave partnerships (2005)		Total	
	%	number	%	number	%	number
Yes[1]	56	10	67	40	64	50
No	44	8	27	16	31	24
Other[2]	0	0	7	4	5	4
Total	100	18	100	60	100	78

1 This includes two SLAs signed off by a PCT director other than the chief executive.
2 This includes two 'Do not know' responses and two cases where a SLA had been signed for one of two prisons covered by the partnership.

Fifty-six percent (45/81) of the partnerships reported having an agreed recovery plan for over or under spends (table 3). Table 3 shows that fewer first-wave partnerships have recovery plans compared with the partnerships from subsequent waves, although the difference is not significant.

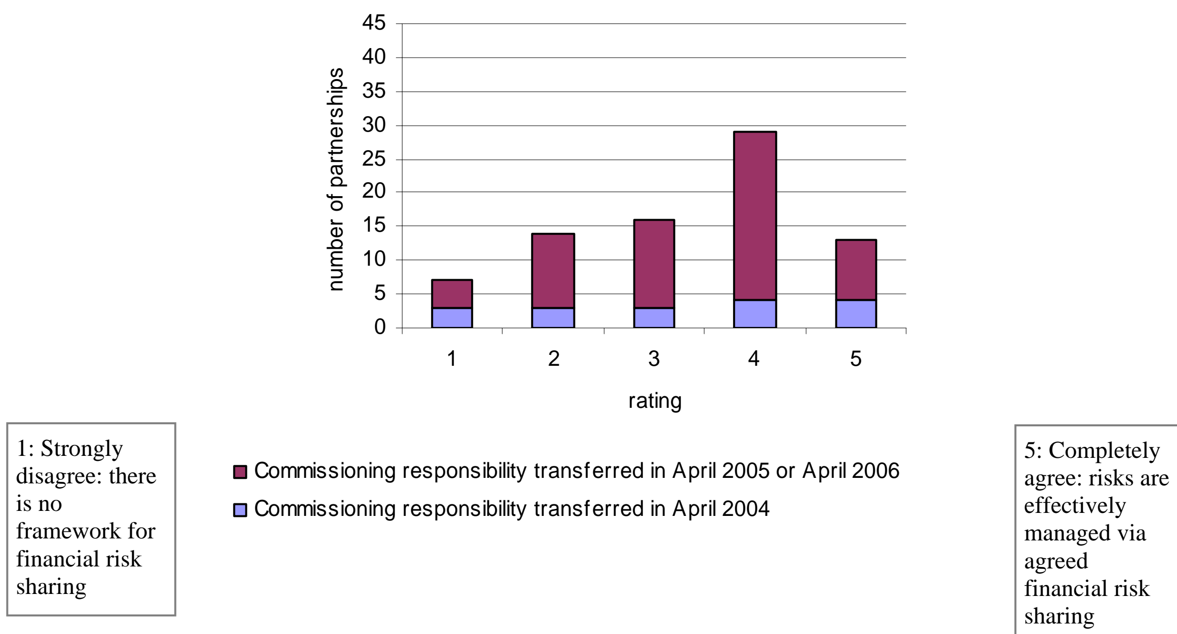
Table 3 Does the partnership have an agreed recovery plan for over or under spends?

	First-wave partnerships (2004)		Subsequent-wave partnerships (2005 and 2006)		Total	
	%	number	%	number	%	number
Yes	39	7	60	38	56	45
No	50	9	29	18	33	27
Other[1]	12	2	11	7	11	9
Total	100	18	100	63	100	81

1 This includes three 'Do not know' responses and six cases where a comment was made instead of a 'yes' or 'no' response, such as *"On budget no recovery plan required"*.

Partnerships were asked to rate the extent to which there is an agreed approach to sharing the financial risks associated with the transfer, which ensures that financial risks are being managed effectively, using a five point scale (figure 7). Two partnerships did not record a rating on this issue. Overall, 53% (42/79) of the partnerships gave a positive rating of 4 or 5, compared to 20% (16/79) of partnerships providing a neutral rating of 3, and 27% (21/79) giving a more negative rating of 1 or 2 (figure 7). Figure 7 shows a particularly wide distribution of ratings across the five point scale, and this variation is reflected in the range of comments made by the partnerships on this issue.

Figure 7 "there is an agreed approach to sharing the financial risks associated with the transfer which ensures that financial risks are being managed effectively"



Two partnerships did not provide a rating, and one of these noted:

> *"there are no 'shared' financial risks. The funding for prison health has transferred to the PCT, who therefore hold risk." [no 12]*

This perspective was echoed by some other partnerships. For example, a first-wave partnership with a rating of 2 commented:

> *"What incentive has the prison governor to share OUR financial risk. This year we have faced significant financial risk which has been compounded by one of he prisons opening another wing without appropriate allocation of resources to healthcare to cope with additional demand. I don't believe the financial risk has been shared. Prison governors too face financial risk as their budgets are cut. I believe if they had some financial flexibility they may have helped us with the prison health overspend." [no 38]*

A number of partnerships indicated that a transfer of financial risk was being staged:

> *"For the financial year 05/06 the Prison and PCT accepted joint financial responsibility for the performance prison health care budget. This no longer applies in the second year 06/07." [no 48]*

Low-rating partnerships suggested that unpredicted cost pressures could prove problematic to manage:

> *"The budget is very tightly managed to ensure neither organisation has a financial risk. However if something unexpected arose, there would undoubtedly be disagreement about sharing of cost pressures." [no 20]*
> *"To the present we have been expected to operate within our allocated budget and have succeeded in doing so. There is currently no risk sharing agreement in place - nor has any future arrangement been discussed." [no 1]*

Furthermore, there are examples of management arrangements being affected by a lack of appropriate data:

> *"Unable to get accurate financial data to allow proper oversight and interrogation at PPB level, despite frequent requests for this. The current overspend was identified at a late stage and there was insufficient consideration given earlier to enable the development of contingencies. ..." [no 61]*
>
> *"The PCT had concerns prior to the transfer regarding the budget transferred as if was felt to be underfunded. Despite taking action to reduce healthcare expenditure to within allocated budget, we have still overspent. Commissioning arrangements are very different to other commissioned services as PCT are at times having to micromanage the service. Lack of accurate and timely information from prison finance has meant budgetary monitoring and control very difficult. PCT, like all NHS organisations, is under pressure to reduce costs. The prison do not appear to fully understand this or support the PCT in reducing costs." [no 13]*

Nevertheless, other partnerships appear to have been more successful:

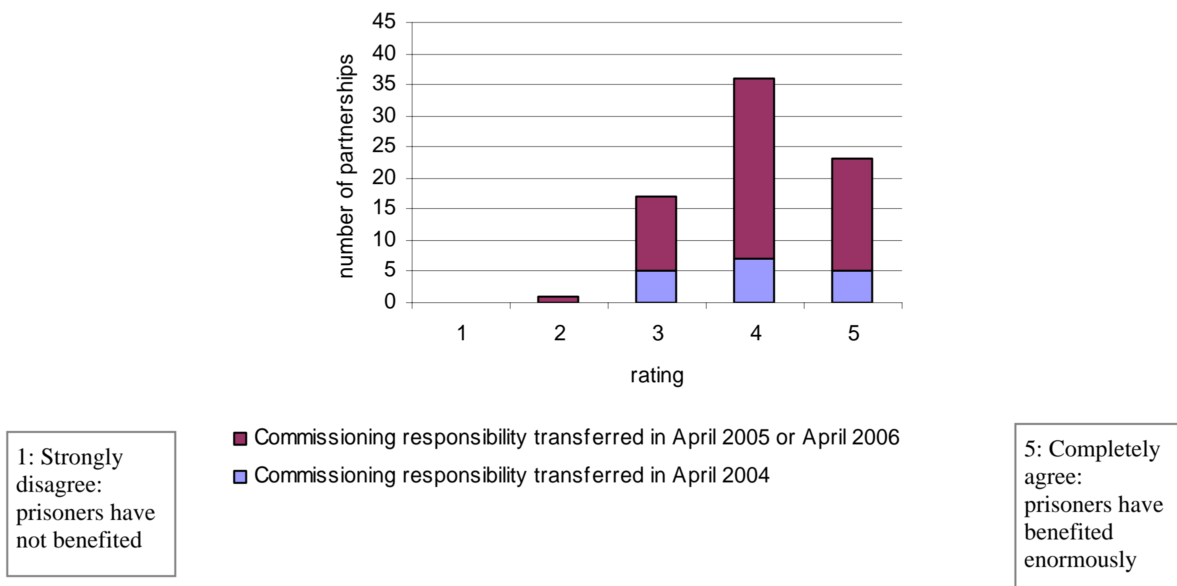
"We had the situation in September 2005 of a predicted overspend of approx £166k. An action plan was put into place and the financial risk managed." [no 29]

Overall, the issue of risk sharing is currently characterised as an important component of a wider agenda which, to the extent that it involves both PCTs and prisons, is influenced by the quality of communication and understanding between organisations.

Impact on healthcare for prisoners

Partnerships were asked to rate the extent to which prisoners requiring healthcare have benefited from the prison health partnership, using a five point scale (figure 8). Four partnerships did not record a rating on this issue. Overall, 77% (59/77) of the partnerships which provided a rating gave a positive rating of 4 or 5, compared to 22% (17/77) of partnerships providing a neutral rating of 3, and 1% (1/77) giving a more negative rating of 2 (figure 8).

Figure 8 "Prisoners requiring healthcare have benefited from the prison health partnership"



Many of the partnerships cited particular innovations in healthcare delivery in support of the positive ratings, including GP services, out-of-hours cover, pharmacy provision, drug misuse, mental health, dentistry, GUM, female and male health, smoking cessation, long term conditions and access to secondary care.

The following first-wave partnerships illustrate the confidence in beneficial change for prisoners:

"Prisoners now have access to primary and secondary care services that are equivalent to those available to our community populations." [no 12]

"Both the GP service and the GP out of hours service bring healthcare up to date and in line with the general level of care available in the wider community." [no 63]

These positive views are echoed by second-wave partnerships:

"A much wider, more comprehensive range of health care services are now provided at the Prison than was ever the case in the past." [no 55]

"Service provision has changes rapidly and the quality of care is moving towards the services provided in the community." [no 17]

Some partnerships cited supporting evidence in the form of a reduction in complaints and audits:

"Improvements have been very evident in all areas of healthcare. Prisoner feedback from the 2005 Prison Health Needs Analysis demonstrate this." [no 35]

Other partnerships noted a need to improve methods for assessing prisoner benefits or emphasised that more time was required in order for existing plans to be implemented. One partnership was ambivalent, noting that prisoners had *"benefited in some ways, lost out in others"*.

Changes in healthcare provision

In response to the question "If applicable, what are the three most important changes in healthcare provision for prisoners introduced since your partnership was formed?", 91% (74/81) of the partnerships listed at least three changes in healthcare provision, one partnership listed two changes, two partnerships recorded one change each, and four second or third-wave partnerships did not record any changes in healthcare provision. Table 4 summarises the changes reported by the partnerships. The most common changes relate to improvements in primary care services including enhanced GP availability and out-of-hours cover, and these accounted for 18% (46/254) of the total changes. The next most commonly cited changes relate to staff (and particularly nurses, including quality, skill-mix, training, integration with PCT) and enhanced mental health services. These issues each accounted for 13% and 12% of the changes reported respectively. Table 4 shows that a wide range of changes in the provision of healthcare for prisoners was reported by the partnerships.

Table 4 If applicable, what are the three most important changes in healthcare provision for prisoners introduced since your partnership was formed?

changes	All changes	
	percentage	number
Primary care services, including GP provision and out-of-hours cover	18	46
Staff related, including quality, skill-mix, training, integration with PCT	13	32
Mental health services	12	30
Unspecified clinical services, includes reviews and integration with PCT provision	7	17
Management, including leadership, planning and partnership working	7	17
Medicines management, detoxification and substance misuse	6	15
Clinical governance and protocols	6	15
Dentistry	5	12
Facilities and equipment	4	11
Prisoner involvement, including forum, survey and attitudes to	3	8
Nurse-led clinics	3	7
Access to healthcare	3	7
GUM clinics	2	6
Screening, including at reception, well man, discharge assessment, and for secondary care	3	7
IT related	2	5
Other, including health promotion, funding, smoking cessation, chronic disease management, awareness, podiatry, obesity	7	19
Total	100	251

The most important challenges for improving healthcare for prisoners

Partnerships were asked to record what they considered to be the three most important challenges for improving healthcare for prisoners in the next 12 months. The responses are summarised in

table 5. The most common challenges relate to staffing issues, including recruitment and retention, roles, skills and morale (14%, 34/242, of all reported challenges). The next most commonly reported challenges related to pharmacy services, drug treatment and substance misuse services, and mental health services.

Table 5 What do you consider to be the three important challenges for improving healthcare for prisoners?

challenges	All changes	
	percentage	number
Staff: recruitment and retention, roles, skills and morale	14	34
Pharmacy, drug treatment and substance misuse	11	27
Mental health services	11	26
Developing healthcare services and facilities	10	23
Funding constraints and financial management	8	20
Partnership working, strategy development, working arrangements	7	18
Commissioning and implementing new contracts	6	14
organisation change, reconfiguration within PCTs and prisons	5	12
IT related, clinical information and practice software	5	11
standards compliance and clinical governance	4	9
Integration, efficiency, quality	3	7
Cultural change and barriers	2	6
health promotion and prevention	2	6
Access to services including secondary care	2	6
Prison population: pressure on and changes in	2	5
Dentistry	2	4
Sexual health	2	4
Other, including litigation, infection control, transfers, decency	4	10
Total	100	242

The most significant risks for prison healthcare

Partnerships were asked to record what they considered to be the three most significant risks for prison healthcare in the next 12 months. Most partnerships reported three risks and several reported either two or more than three risks. One partnership did not report any risks. In total, 244 risks were reported and they are summarised in table 6.

Three risks dominated the responses. Concern about funding, staffing and reconfiguration together accounted for 57% (142/247) of all cited risks. To some extent, the risks are related; PCT reconfiguration may give rise to changes in key personnel, which could leave organisations with weaker relationships and consequently potentially increased financial risks.

The most common reported risk related to funding. Funding accounted for 23% (58/247) of all the risks identified, and was cited by 72% (58/81) of partnerships (table 6). As a proportion of the risks listed first, funding accounted for 35% (28/81) of issues raised. Funding was most frequently expressed in terms of a lack of finances, linked to a range of factors including inadequate allocations, service improvements, or specific risks. For example, one partnership reported *"with a new configured organisation there is a risk to the Memorandum of Understanding being honoured"*. Concern about funding was not limited to the level of resources available, but included their use, as one partnership noted *"Failure to manage finances effectively"*.

Directly linked to funding was a risk of the policy change to transfer the cost of escorts and bed watching to PCTs, which was cited by 9% (7/81) of the partnerships, and is listed separately in table 5.

Staffing-related issues was the second most common risk, accounting for 18% (44/247) of all risks, and cited by 54% (44/81) of partnerships (table 6). The key factor was recruitment and retention, particularly in relation to implementing Agenda for Change. Additional specific issues are illustrated by the following reports:

> *"HR issues with transferred staff e.g. long term sickness absence, recruitment managing staff within different organisational policies and procedures"*
>
> *"Recruitment of the right calibre of staff and the time it takes for security clearance"*
>
> *"Implementing the recommendations of the skill mix review"*

Table 6 What do you consider to be the three most significant risks for prison healthcare in the next 12 months?

Risk	All risks		Percentage of partnerships reporting risk
	percentage	number	
Funding constraints, financial risk and management	23	58	72
Staffing: recruitment and retention, Agenda for Change, personnel changes, staff sickness and morale	18	44	54
PCT or wider NHS reconfiguration	16	40	49
Challenges relating to new service implementation	5	13	16
Partnership working, conflicting agendas and cultural differences	4	11	14
Focus, disengagement and distraction	4	10	12
Change in prisoner group and numbers, Custody Plus	4	11	14
Cost implications of escorts and bed watching	3	7	9
Infection control	3	7	9
Mental health	2	6	7
Lack of clinical accommodation, capacity	2	6	7
Clinical leadership	2	5	6
Inadequate IT infrastructure	2	4	5
Other	10	25	
Total	100	247	

PCT or wider NHS reconfiguration was similar to the staff-related issues in the frequency of being identified by partnerships as a risk (table 6). The comments made by partnerships often emphasised the risk of PCT reconfiguration disrupting existing relationships and therefore damaging momentum:

> *"Any restructuring with PCTs and the risk of losing both the impetus and experience seen in developing partnerships over the past few years and the Provider/Commissioner split"*

"Trust between new PCT area and establishment"

"Reorganisation of health services and PCTs and not loosing sight of them"

"PCT mergers causing disruption to the relationship between the PCT and the Prison"

"NHS Reconfiguration - loss of momentum"

"Poorly managed restructuring of NHS organisations"

Although risks relating to funding, staffing and reconfiguration dominated the responses, table 6 shows the range of other concerns reported by at least four partnerships. The most frequently cited issue related to the working of the partnership itself, and risks associated with managing conflicting agendas and cultural differences (reported by 14%, 11/81, of partnerships). A similar proportion of partnerships reported risks relating to focus, disengagement and distraction. This issue is, in part, linked to PCT reconfiguration, but, as the following examples show, it is not limited to PCTs:

"PCT staff taking their eye off the ball"

"Disengagement from prison senior management team"

Furthermore, there was appreciation of the risk of prison healthcare suffering from becoming a generally lower priority as new arrangements become routine, as the following first-wave partnership illustrates:

"A belief that now transfer is complete the specialist needs of prison health will be less of a priority for both establishment Governors and NHS, leading to the return in some areas of isolation and reactive based, rather that needs based service"

Low and high performing partnerships

A direct measure of the performance of the partnerships is provided by the survey's rating question on the extent to which the partnership board is developing prison healthcare effectively (figure 1 on page 7). Thirteen 'high' performing partnerships provided a rating of '5' for the extent to which the partnership board is developing prison healthcare effectively (nos 1, 4, 6, 10, 12, 21, 25, 31, 35, 36, 38, 63 and 65). Similarly, four 'low' performing partnerships (nos 9, 18, 51 and 61) provided a rating of '2' for the extent to which the partnership board is developing prison healthcare effectively.

By reviewing all the data supplied in each questionnaire response as a whole it is possible to assess the overall experience of each partnership, and compare this assessment with these partnerships'

ratings of 'effectiveness'. This review suggests that in addition to the four partnerships which rated themselves as 2, a further four partnerships should more appropriately be rated as 2 (nos 47, 54, 42, 22), shown in figure 10. For example, the transfer of responsibility for prison health in partnership 22 occurred in April 2005, and the questionnaire for this partnership noted that "action plans are being devised … following a review of prison health service by the PCT in April 06". The response noted limited integration between the prison and PCT, no PCT representation at the two partnership board meetings held in 2005, and no previous engagement from the PCT. The partnership rated itself as '4' to indicate the extent to which the partnership board is developing prison healthcare effectively.

In order to provide a further measure of performance for each partnership, a composite mean rating score was calculated for the six rating statements shown in box 1. The mean values were assigned to one of 11 bands between the minimum '0' and maximum '5' values, and the resulting distribution is shown in figure 2.

Box 1 Rating statements using in the composite measure of performance

Rating statement
The PCT understands the future prison healthcare agenda
There is a shared clinical governance framework which ensures that locally identified clinical risk is managed effectively
Prison healthcare is effectively integrated into PCT plans and activity
Cultural differences between organisations are being managed effectively
There is an agreed approach to sharing the financial risks associated with the transfer which ensures that financial risks are being managed effectively
The work of the partnership will not be adversely affected by the imminent restructuring of health and prison services

Figure 9 suggests that 'low' performing partnerships could be defined in terms of a composite mean rating score of less than 3. Similarly, 'high' performing partnerships could be defined as a composite mean rating score of more than 4. The 12 low performing partnerships identified through this method are shown in figure 10. These partnerships include the four which provided a rating of '2' to indicate the extent to which the partnership board is developing prison healthcare effectively. In addition, this group includes three of the four partnerships identified as low performers in terms of the overall experience of each partnership, assessed by reviewing all the data supplied in each questionnaire response as a whole.

Figure 9 Distribution of partnerships' composite mean rating scores

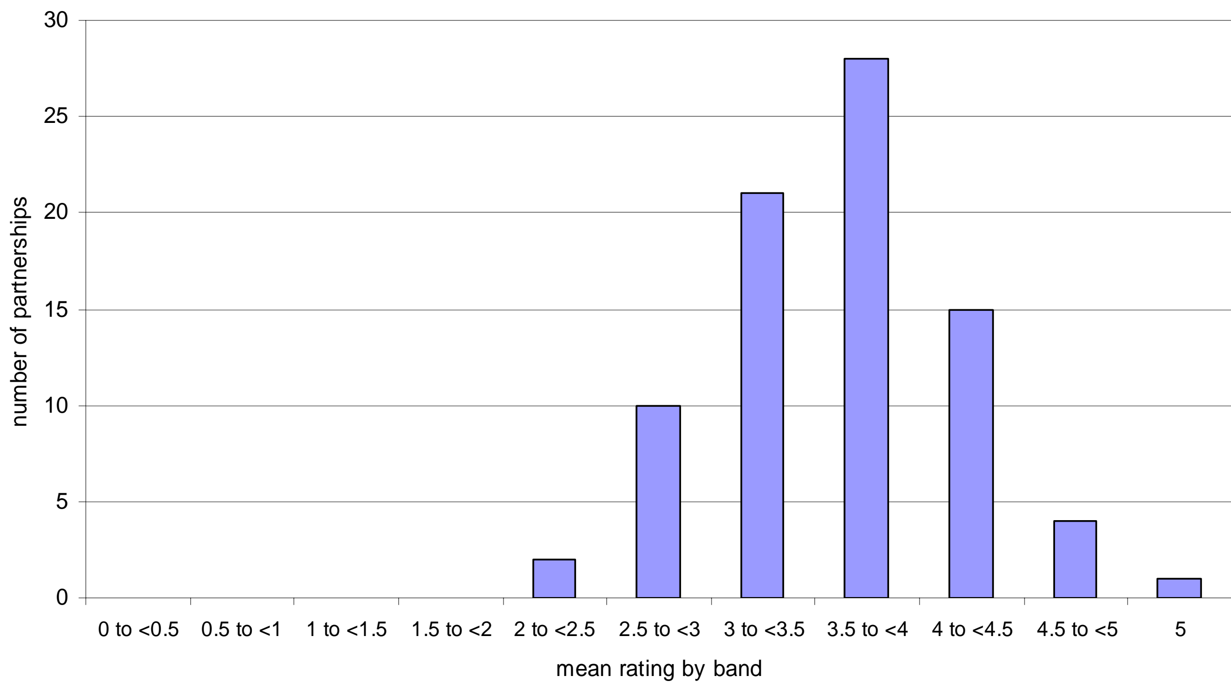


Figure 10 The 13 low performing partnerships identified using three different measures

Partnership reference number	Measure of performance			Year of transfer	composite rating	effectiveness rating
	effectiveness rating less than 3	composite rating less than 3	low performer assessed by review			
9	✓	✓		2004	2.7	2
61	✓	✓		2004	2.7	2
11		✓		2005	2.8	3
18	✓	✓		2005	2.3	2
22			✓	2005	3.2	4
32		✓		2005	2.7	3
40		✓		2005	2.8	3
47		✓	✓	2005	2.5	3
51	✓	✓		2005	2.5	2
54		✓	✓	2005	2.7	3
56		✓		2005	2.3	4
67		✓		2005	2.8	3
42		✓	✓	2006	2.8	3

Five other partnerships are included in figure 10: The questionnaire response for partnership number 56 noted that barriers to realising objectives were being addressed, and these included key

management appointments. It also noted that "developments are currently on hold" due to the PCT's financial deficit in 2005/06. This partnership rated itself as '4' to indicate the extent to which the partnership board is developing prison healthcare effectively and its composite mean rating is 2.33 (which is the equal lowest score recorded for two partnerships). Partnership number 32 noted that "a large amount of 'catching up' is required but there have been some very positive developments" and that there were "generally good working relationships between PCT and prisons". Partnership number 40 noted specific challenges including inadequate budgets. The partnership commented: "in 2004 there had only been tenuous contact between the prisons and the PCT and I think the partnership has developed in a positive manner." Partnership number 67 noted that good progress had been made on specific areas of service delivery, while acknowledging that "additional work is required in areas around integrated governance and risk sharing". The issues of clinical governance and financial risk also featured in the response from partnership number 11, along with the long term sickness of key staff.

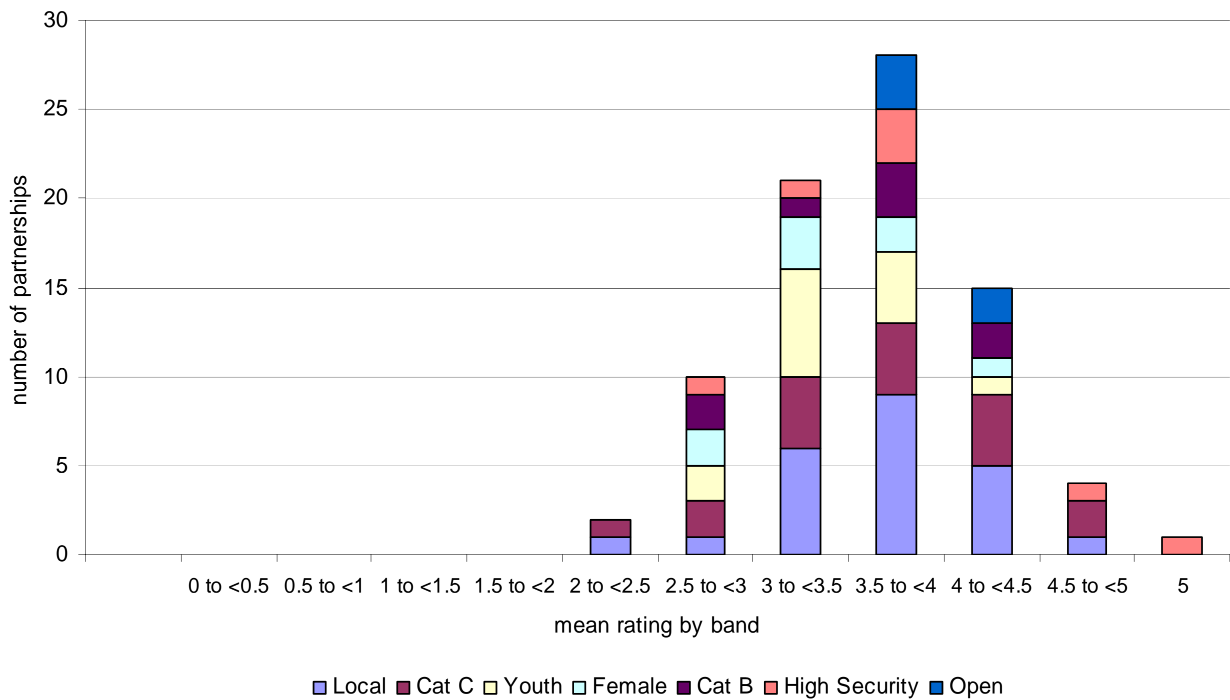
In total, figure 10 includes 13 'low' performing partnerships. These partnerships cover a range of transfer periods (two in 2004, 10 in 2005 and one in 2006) and a range of prison categories.

Each partnership was allocated to a category representing the type of prison(s) it covered, as shown in the key to figure 3. Where a partnership covered more than one prison, a hierarchy was used. For example, a partnership including category B and category C prisons is recorded as 'category B'. A partnership including female and male prisons is recorded as 'female', except for the two partnerships covering a larger number of male prisons.

Figure 11 shows that these categories of partnership are represented across the range of performance measured in terms of the composite mean rating score. For example, partnership number 18 is classified as 'local' and appears at the lowest end of the range in figure 11 (scoring 2.3). At the other extreme, the partnership number 69 is also classified as 'local' and has a score of 4.8. Figure 11 shows that the small number of partnerships classified as 'open' had similar rating scores.

The composite mean rating score provides an alternative to relying on the partnerships' ratings of the extent to which the partnership board is developing prison healthcare effectively. In the case of the low performing partnerships, it allows a mechanism for identifying partnerships which did not give a comparatively negative rating of 2 for effectiveness.

Figure 11 Distribution of partnerships' composite mean rating scores by category of prison(s)



In the case of high performing partnerships, the mean rating score provides an alternative to relying on those partnerships which rated themselves as 5 for effectiveness (figure 1). For example, defining 'high' performing partnerships as those with a composite mean rating score of more than 4 identifies 12 partnerships shown in figure 12. This list includes just five of the 13 partnerships that rated themselves as 5 for effectiveness, and one that rated itself as 3 for this measure.

Figure 12 also shows the partnerships with a rating of 5 for effectiveness and with a composite score of 4 or less. One feature of these partnerships is that a majority cover more than one prison. It may be that in this context, respondents may be more likely to rate the partnership as very effective despite acknowledgement of specific challenges. These survey responses as a whole suggest that the partnerships are confident about progress while underlining ongoing issues to be addressed.

When seeking to identify the highest performing partnerships, those listed in figure 12 provide a starting point. Together these 20 partnerships represent a range of experience, including half (9/18) the first wave partnerships, and prison types. It is likely that these characteristics, along with the partnerships' individual issue-specific strengths recorded in their survey responses, will influence which partnerships are chosen to represent high performance.

Figure 12 The 20 high performing partnerships identified using the composite and effectiveness ratings

Partnership reference number	Measure of performance		Year of transfer	composite rating	effectiveness rating
	effectiveness rating of 5	composite rating more than 4			
1	✓		2004	3.3	5
35	✓		2004	3.3	5
38	✓		2004	3.5	5
12	✓		2004	3.8	5
6	✓	✓	2004	4.2	5
58		✓	2004	4.2	3
63	✓	✓	2004	4.3	5
72		✓	2004	4.4	4
69		✓	2004	4.8	4
25	✓		2005	3.8	5
31	✓		2005	3.8	5
36	✓		2005	3.8	5
4	✓		2005	4.0	5
5		✓	2005	4.2	4
45		✓	2005	4.2	4
10	✓	✓	2005	4.3	5
26		✓	2005	4.5	4
65	✓	✓	2005	4.5	5
16		✓	2005	4.7	4
21	✓	✓	2005	5.0	5

Discussion

The survey provides a 'snap shot' picture of the views of the prison healthcare partnerships. At the level of individual partnerships, the data will provide a basis for dialogue about the progress to date and future development. At an aggregated level, the data provide a basis for identifying key issues facing prison healthcare. While the transfer of responsibility for prison health to PCTs has been completed, the challenges of delivering high quality services are ongoing.

The rating responses summarised in table 7 illustrate the range of strengths and concerns expressed, from the high level of confidence in the benefit to prisoners to considerable uncertainty about the potentially negative impact of the organisational restructuring during 2006/07.

Table 7 Summary of the responses to the rating questions

	Mean rating	Positive ratings 4 and 5	Neutral rating 3	Negative ratings 2 and 1
		% (number)	% (number)	% (number)
Prisoners requiring healthcare have benefited from the prison health partnership	4.1	77% (59/77)	22% (17/77)	1% (1/77)
The PCT understands the future prison healthcare agenda	3.9	75% (61/81)	19% (15/81)	6% (5/81)
The partnership board is developing prison healthcare effectively	3.8	64% (52/81)	31% (25/81)	5% (4/81)
There is a shared clinical governance framework which ensures that locally identified clinical risk is managed effectively	3.7	64% (51/80)	28% (22/80)	9% (7/80)
Prison healthcare is effectively integrated into PCT plans and activity	3.6	57% (46/81)	33% (26/81)	11% (9/81)
Cultural differences between organisations are being managed effectively	3.5	56% (45/81)	28% (23/81)	15% (12/81)
There is an agreed approach to sharing the financial risks associated with the transfer which ensures that financial risks are being managed effectively	3.3	53% (42/79)	20% (16/79)	27% (20/79)
The work of the partnership will not be adversely affected by the imminent restructuring of health and prison services	3.2	35% (27/78)	45% (35/78)	21% (16/78)

The comparison of the first-wave partnerships with the subsequent waves suggests that the first-wave partnerships are beginning to realise their objectives and provide an important source of learning for the younger partnerships. Timescale is an important factor. It is taking time for the partnerships to become sufficiently established to impact on the development of prison healthcare. Partnerships have commented on the need to establish relationships and review options before implementing new working practices. This factor suggests that the second-wave partnerships will catch-up with the comparatively high performing first-wave partnerships during 2006/07. However, many of the first-wave partnerships had a history of partnership working in their areas which motivated them to go first wave and helped them to meet the readiness criteria. Therefore, their reported success may be a factor of a well-embedded culture of partnership working pre-dating transfer, rather than a function of having two years rather than one since the transfer.

The wide range of responses on financial risk sharing indicate very different views about what budget transfer means in terms of risk: some partnerships report working on the basis that as the budget has gone to the PCT then all the risk lies with the PCT, whereas others still see a role for some sort of framework for sharing risk. In some partnerships the risk sharing appears to be because some of the cost drivers are under the control of the prison, while in others it is due to a staged transition. Overall, the issue of financial risk sharing is currently characterised as an important component of a wider agenda which, to the extent that it involves both PCTs and prisons, is influenced by the quality of communication and understanding between organisations.

The most commonly reported risk for prison healthcare related to funding and was cited by 72% (58/81) of partnerships. Funding was most frequently expressed in terms of a lack of finances, linked to a range of factors including inadequate allocations, service improvements, specific risks and the management of available resources. Concern about funding, staffing and reconfiguration together accounted for 57% (142/247) of all cited risks. To some extent, the risks are related; PCT reconfiguration may give rise to changes in key personnel, which could leave organisations with weaker relationships and consequently potentially increased financial risks.

The survey findings suggest that some partnerships would benefit from national support relating to specific themes such as financial risk sharing and financial management more generally. Similarly, a common theme of the comments made by the partnerships is that they are working to adapt and apply PCT clinical governance arrangements to the prison settings. The extent to which existing PCT standards have been implemented is variable, and there appears to be considerable potential

for supporting partnerships develop clinical governance arrangements and measures of effectiveness.

The survey was undertaken on the basis that the names of individual partnerships completing the questionnaires and the associated raw data would be supplied to the national Prison Health team. It is likely that this approach will have influenced the openness of the contributions. Nevertheless, the responses have illustrated a range of experience and highlighted challenges which provide a basis for shared learning and future development.

The extent of consultation by the PCT commissioning leads with members of the partnership boards about the questionnaire varied. Some partnerships sought views on their responses from a range of stakeholders, while it is apparent that some responses represent the perspective of the commissioning lead. Any future questionnaires seeking partnership-level responses should ideally be administered over a longer time period in order to promote wide participation in each response. Nevertheless, the overall response rate of 96% (81/84) is satisfactory.

The questionnaire data could form a useful baseline against which to monitor future progress of the partnerships. In addition, a questionnaire could be developed as a tool for rapidly eliciting views on future policy innovations as they emerge.

Appendix: survey questionnaire

University of Birmingham

Health Services Management Centre

Prison Health Partnership Survey of Participants

The completion of the transfer of prison health services to the NHS in public sector prisons this month provides an opportunity to review the process and look more closely at the progress of individual partnerships. This will assist the national Prison Health team to identify the areas which require further work and to inform future policy development.

As the first part of this review, the national Prison Health team has commissioned the Health Services Management Centre to undertake a survey of Prison Health Partnerships. The survey will take the form of this questionnaire which is being sent to the PCT prison health commissioning lead for each individual partnership. The questionnaire should take approximately 25 minutes to complete, and as this will provide an important opportunity to feed in your views, we hope that you will feel this is a good use of your time. We would request that the questionnaire be completed in consultation with both sides of the Prison/PCT partnership. The survey does not require NHS research ethics committee approval.

Names of individual partnerships completing the questionnaires and the associated raw data will be supplied to the national Prison Health team and used as detailed above. A report which will not name individual partnerships will also be produced for Prison Health and we anticipate that this information will be published on the HSMC website.

We are extremely grateful for your contribution to this piece of work and hope that you will find the results useful.

Please return the completed questionnaire by Monday 1 May 2006.

If possible, please email it to h.s.t.mcleod@bham.ac.uk

Alternatively, post to

Dr Hugh McLeod
Research Fellow
Health Services Management Centre
University of Birmingham
Park House, 40 Edgbaston Park Road
Birmingham B15 2RT

or fax to Hugh McLeod on 0121 414 7051

Please contact Hugh McLeod (h.s.t.mcleod@bham.ac.uk or tel 0121 414 7620) if you have any questions about this questionnaire.

Thank you for your help.

General

1 What is the **name of the PCT and prison(s)** in your prison health partnership?

2 When did commissioning responsibility for prison healthcare transfer to the PCT? (please underline)

April 2004 / April 2005 / April 2006

3 How many times did the partnership board meet in 2005?

Objectives and progress, from your perspective

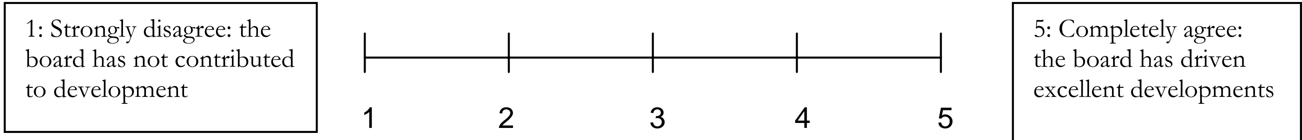
9 What were the key objectives of your prison health partnership?

10 To what extent have the key objectives been realised?

11 What are the key issues that have influenced progress?

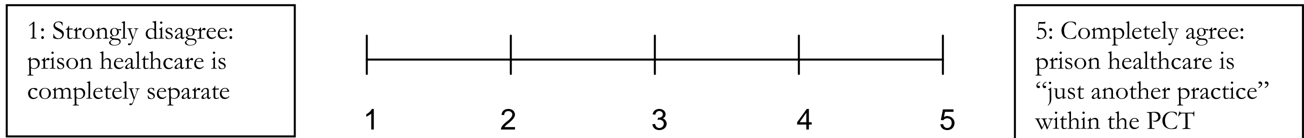
In response to the following statements, please indicate your views by underlining the appropriate number on the five point scale

12 “The partnership board is developing prison healthcare effectively”



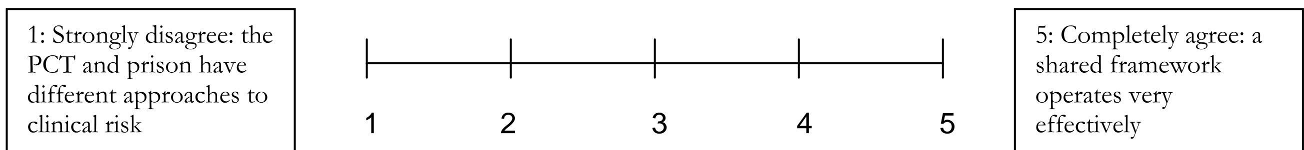
Comments/evidence:

13 “Prison healthcare is effectively integrated into PCT plans and activity”



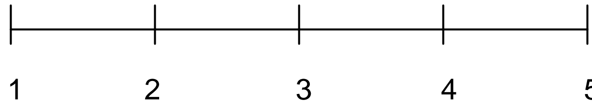
Comments/evidence:

14 “There is a shared clinical governance framework which ensures that locally identified clinical risk is managed effectively”



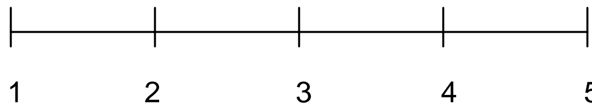
Comments/evidence:

15 "Cultural differences between organisations are being managed effectively"

1: Strongly disagree: cultural differences are not being managed at all effectively	 1 2 3 4 5	5: Completely agree: cultural differences are being excellently managed

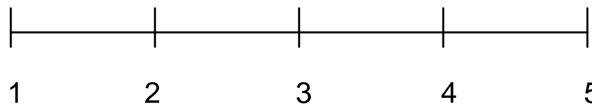
Comments:

16 "The PCT understands the future prison healthcare agenda"

1: Strongly disagree: PCT has no understanding	 1 2 3 4 5	5: Completely agree: PCT has excellent understanding

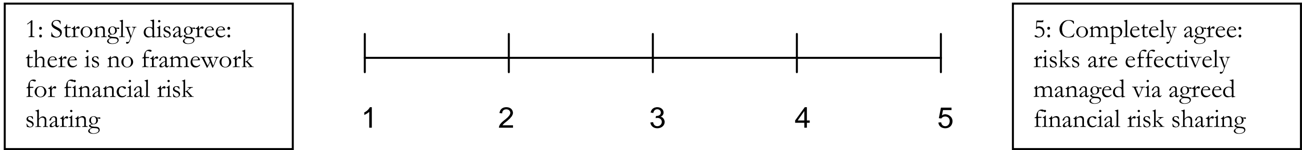
Comments:

17 "The work of the partnership will not be adversely affected by the imminent restructuring of health and prison services"

1: Strongly disagree: work will be very adversely affected	 1 2 3 4 5	5: Completely agree: work will not be adversely affected

Comments:

18 “there is an agreed approach to sharing the financial risks associated with the transfer which ensures that financial risks are being managed effectively”



Comments/evidence:

19 Has the partnership’s service level agreement for 2005/06 been signed off by the PCT chief executive and prison governor?

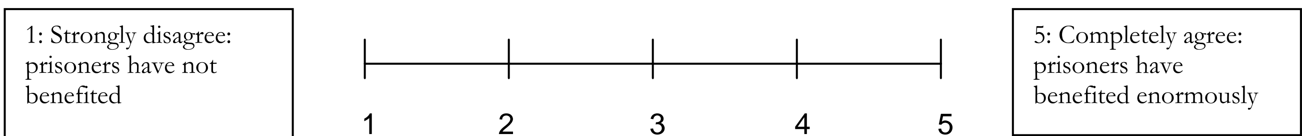
Yes / No / Do not know

20 Does the partnership have an agreed recovery plan for over or under spends?

Yes / No / Do not know

Impact on healthcare for prisoners

21 “Prisoners requiring healthcare have benefited from the prison health partnership”



Comments:

22 If applicable, what are the three most important changes in healthcare provision for prisoners introduced since your partnership was formed?

1

2

3

23 What are the three most important challenges for improving healthcare for prisoners in the next 12 months?

1

2

3

24 What do you consider to be the three most significant risks for prison healthcare in the next 12 months?

1

2

3

25 Please add any other comments you wish to make here:

Thank you for your help.