Escorts and Bedwatches, including constant watches – the link to local care pathways

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The link

- Findings of the survey show a range of clinical activities which initiate E&BW or constant watch episodes.
- Variation over time, between prisons and hospitals, clinicians and cases occur
- Prisons are not empowered in relation to local health communities to make change happen
- Incentives to minimise waste are not intrinsic to systems of care
- The new NHS policy environment still stops at the door of the prison
- Commissioning of care in the secondary sector and in to prisons remains weak
- This issue to be seen in the overall context of prison and NHS health care issues and policy

Clinical analysis

- Escort conditions - Accidents, assaults, MSK, GI, Genitourinary, eyes and ears, self harm and unknown – an A/E profile.
- Tests and procedures – Scans, XRs, dentist, bloods, physiotherapy, minor surgery, dialysis, ECGs, endoscopy, OT, miscellaneous – a GP profile
- Bedwatch conditions – Accidents and self harm, GI, CVS, unknown – prolonged A/E and usual GP medical and surgical admissions
- YOI excess of violence, female estate importance of reproductive health

March 1999 “The Future Organisation of Prison Healthcare” Prison Service and the NHS formal partnership to secure better healthcare for prisoners.

“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, health care delivery in prisons faces a significant number of challenges not experienced by primary care in the wider community.”

Key NHS Policy areas

- Offenders have normal entitlement for scheduled and unscheduled care
- Consider their special needs when developing NHS policy
- New contractor contracts provide a quality framework
- The muddle, disruption and opportunities of CPLNHS, who provides?
- Practice (prison) based commissioning?
- NPfIT

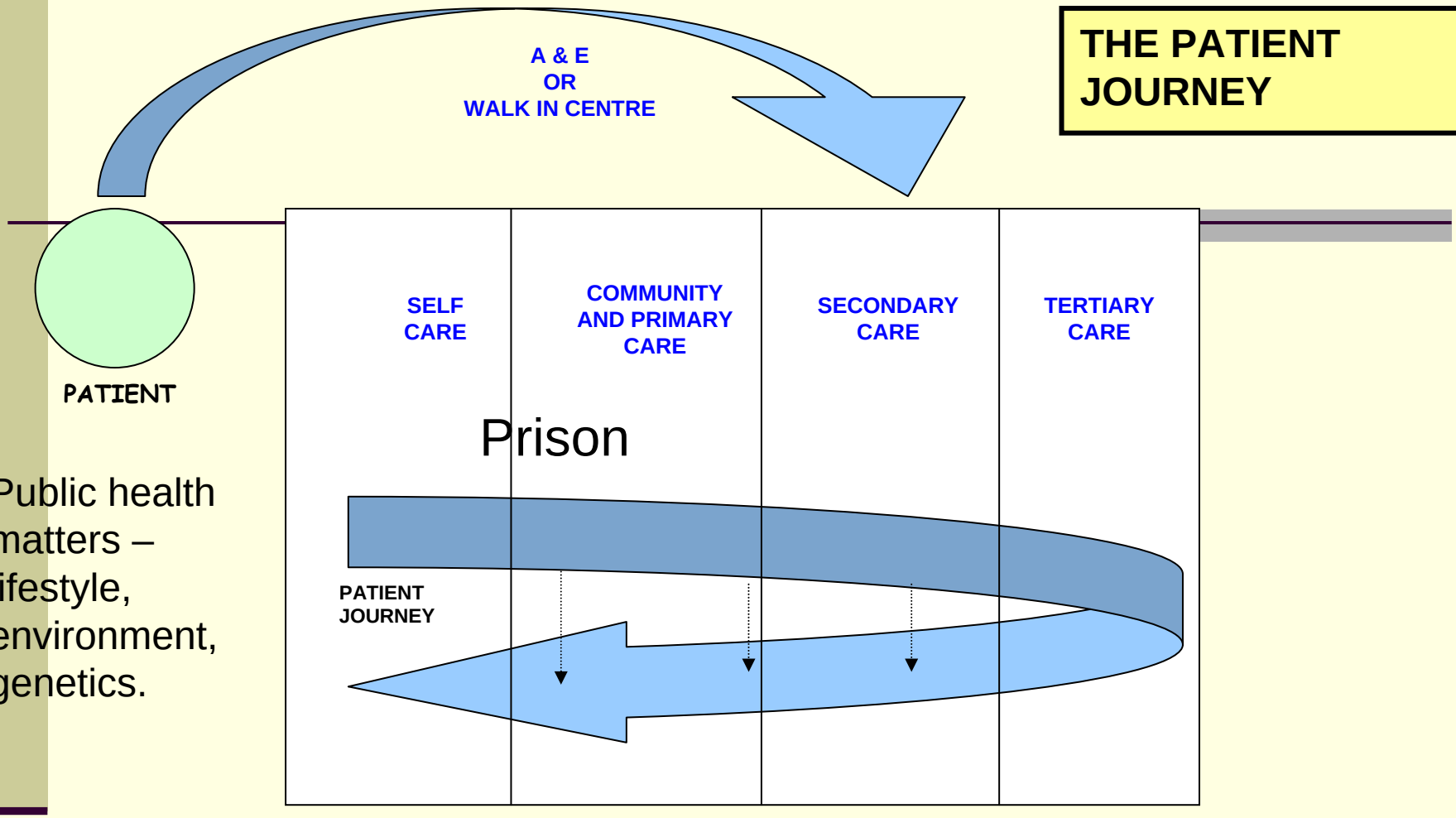
Key NHS Policy areas

- Choosing health and health trainers
- Workforce reform – A4C, new roles.
- Improving service user and public involvement
- Performance management and regulation
- The emerging influence of Health Care Commission, Care Services Improvement Partnership

What are our objectives?

- Improve prisoner experience of healthcare
- Improve access for physically and mentally ill offenders to the NHS
- Reducing costs and wasted resources
- Improving health and healthcare outcomes and reducing health inequalities parameters
- Reduce self harm and suicides in and after prison
- Influencing local health and social care partners
- Continuity of primary and secondary care for offenders
- Raising the profile of offender issues in all local care pathways

THE PATIENT JOURNEY

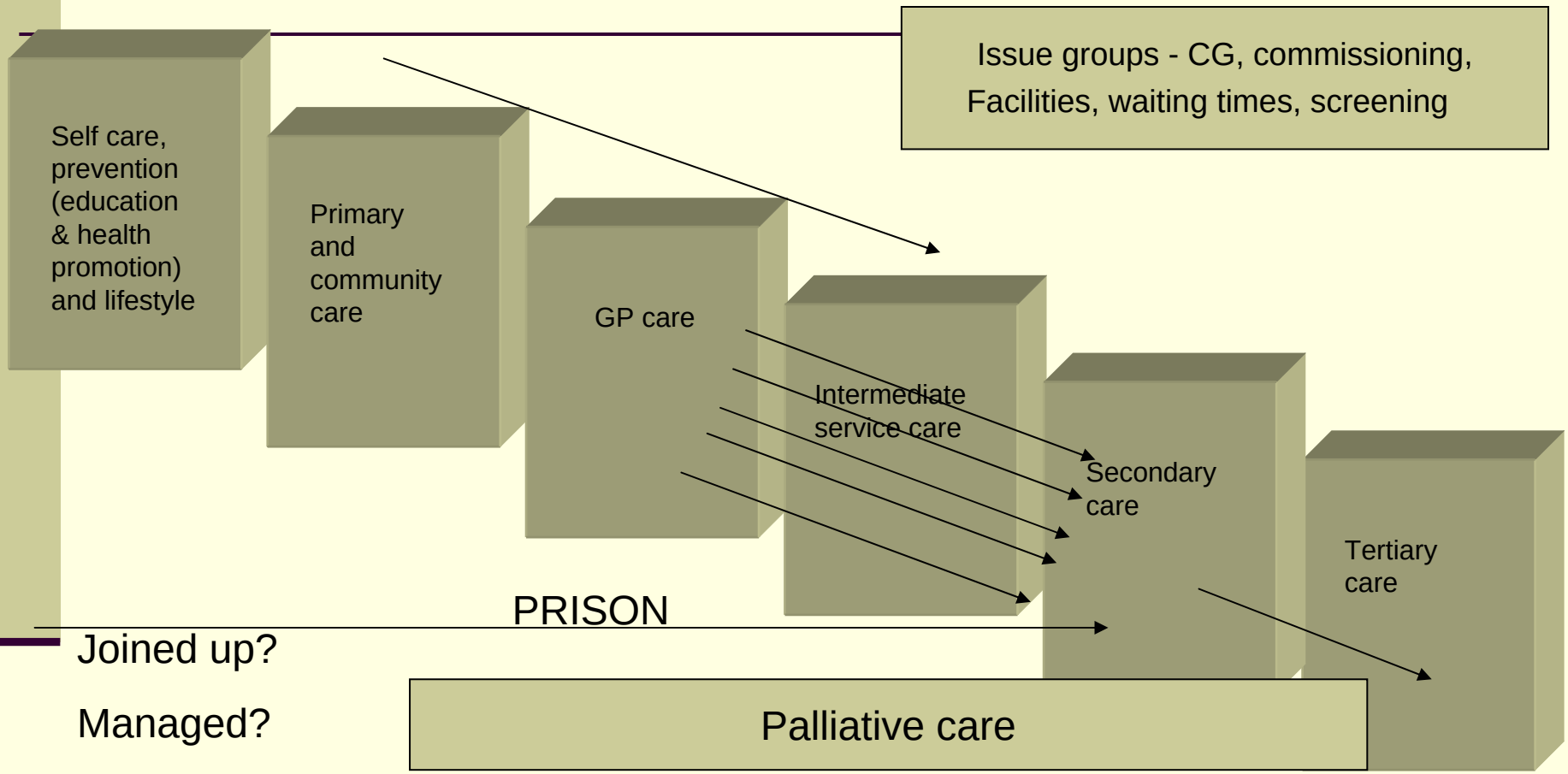


Public health matters – lifestyle, environment, genetics.

Current Organisational Structures (Networks, Boards, Steering Groups, LITs, operational groups etc) may cover patient journey through whole LHC or just smaller portions of it.

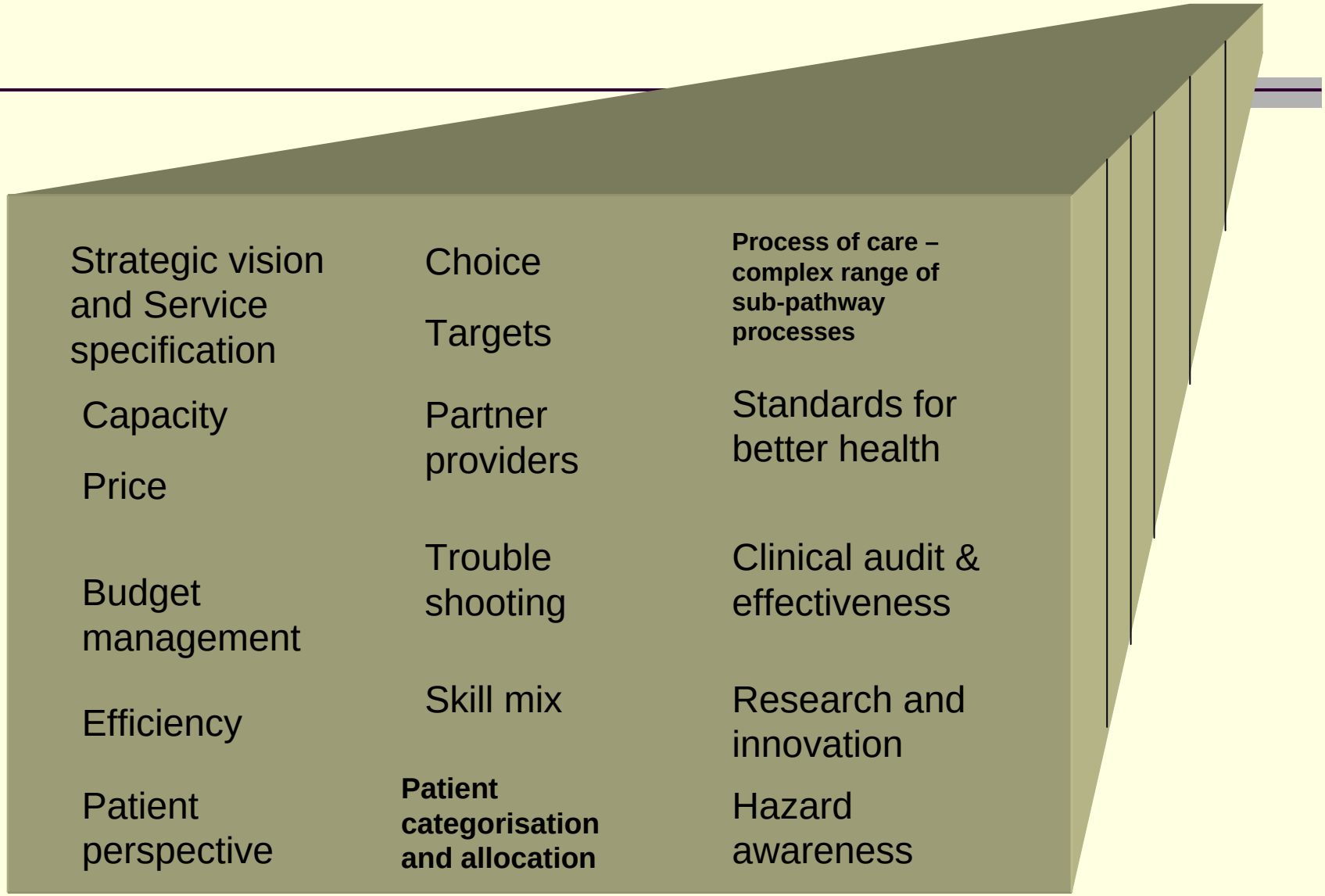
CLINICAL 'NETWORKS' or 'INTEGRATED CARE PATHWAYS' cover the whole patient journey.e.g. Cancer, CHD, Diabetes, Older People, Mental Health.

The integrated care pathway

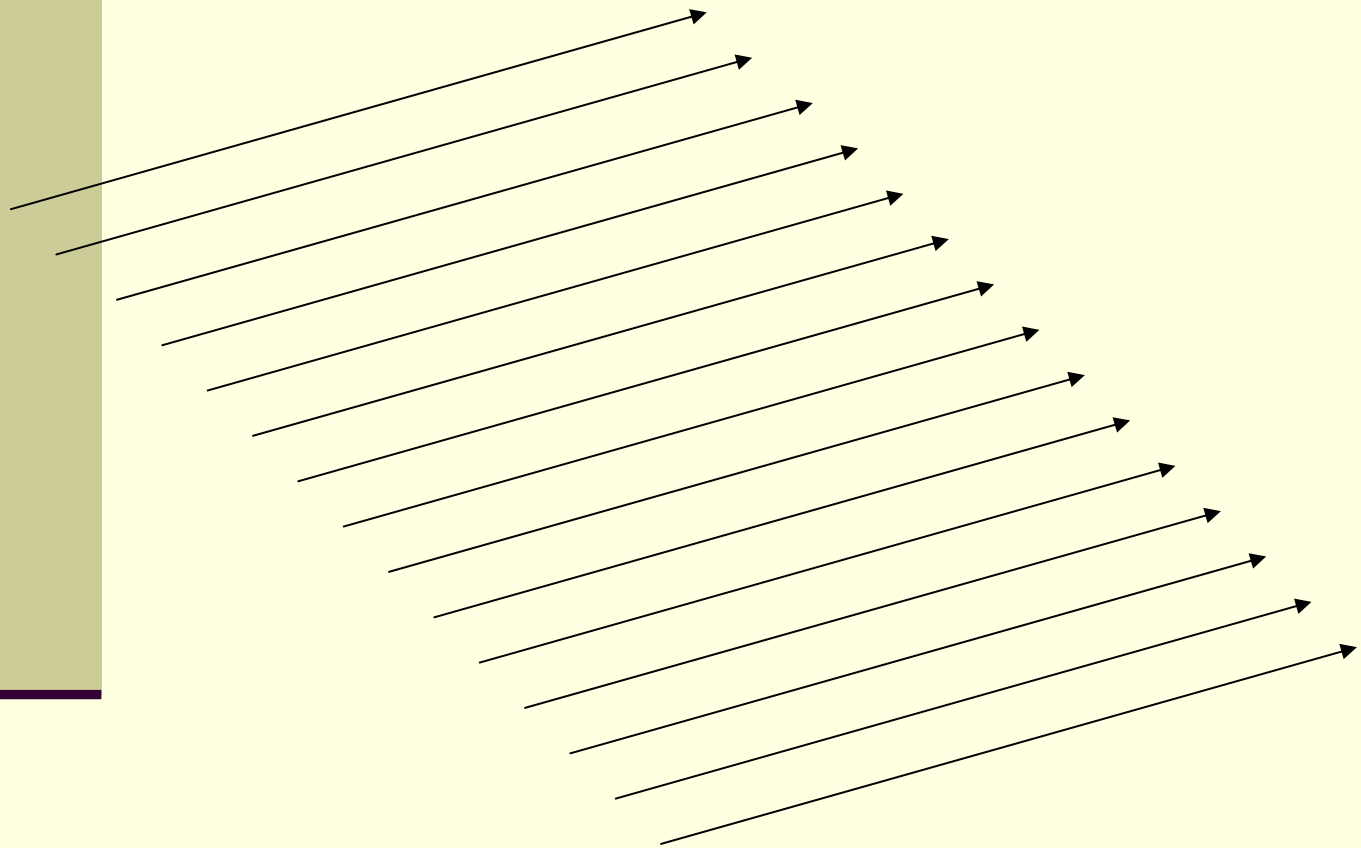


Research, education, workforce, professional interest gp.s

Pathway management issues – the LIT agenda



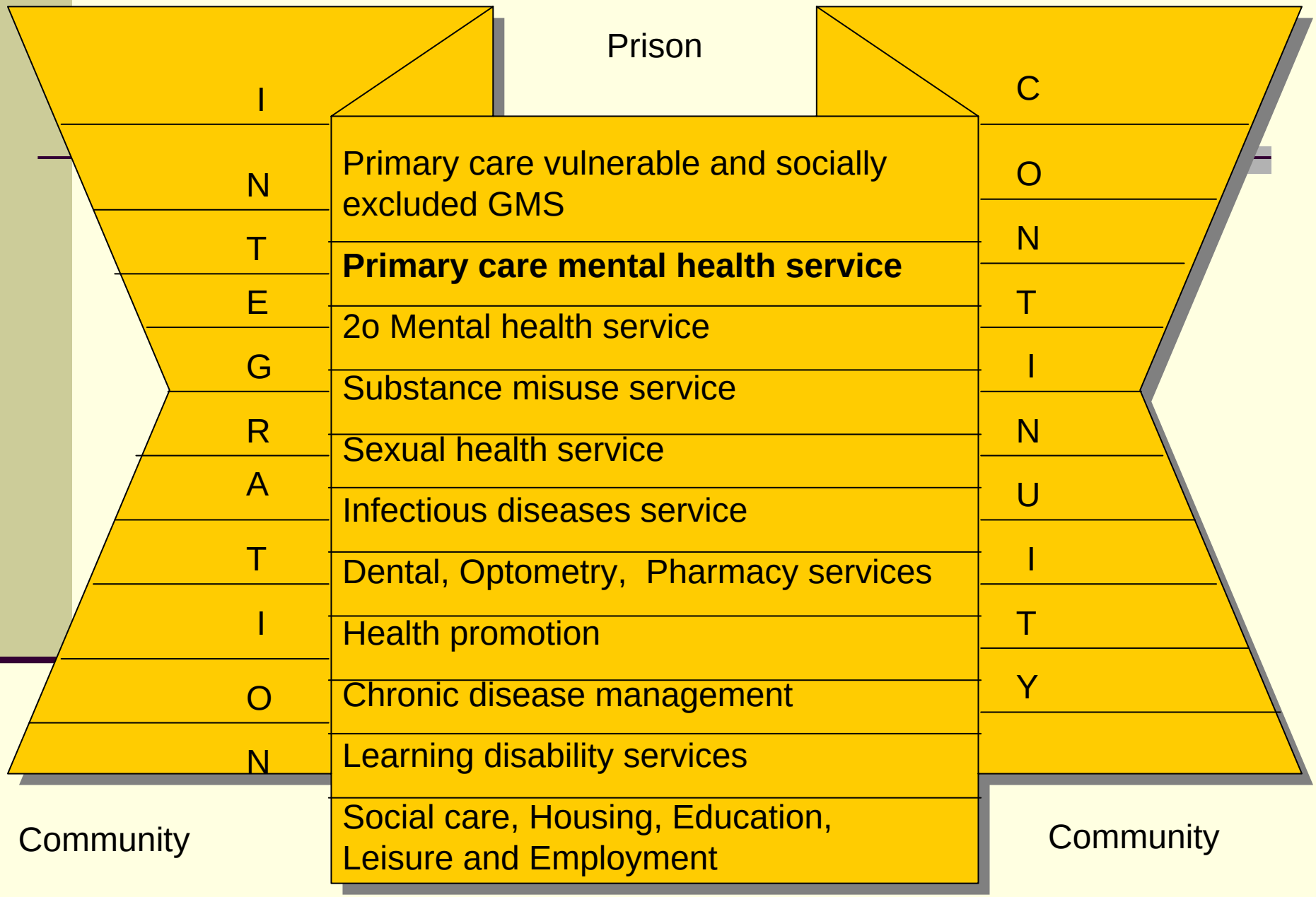
Local health Community – Clinical management framework



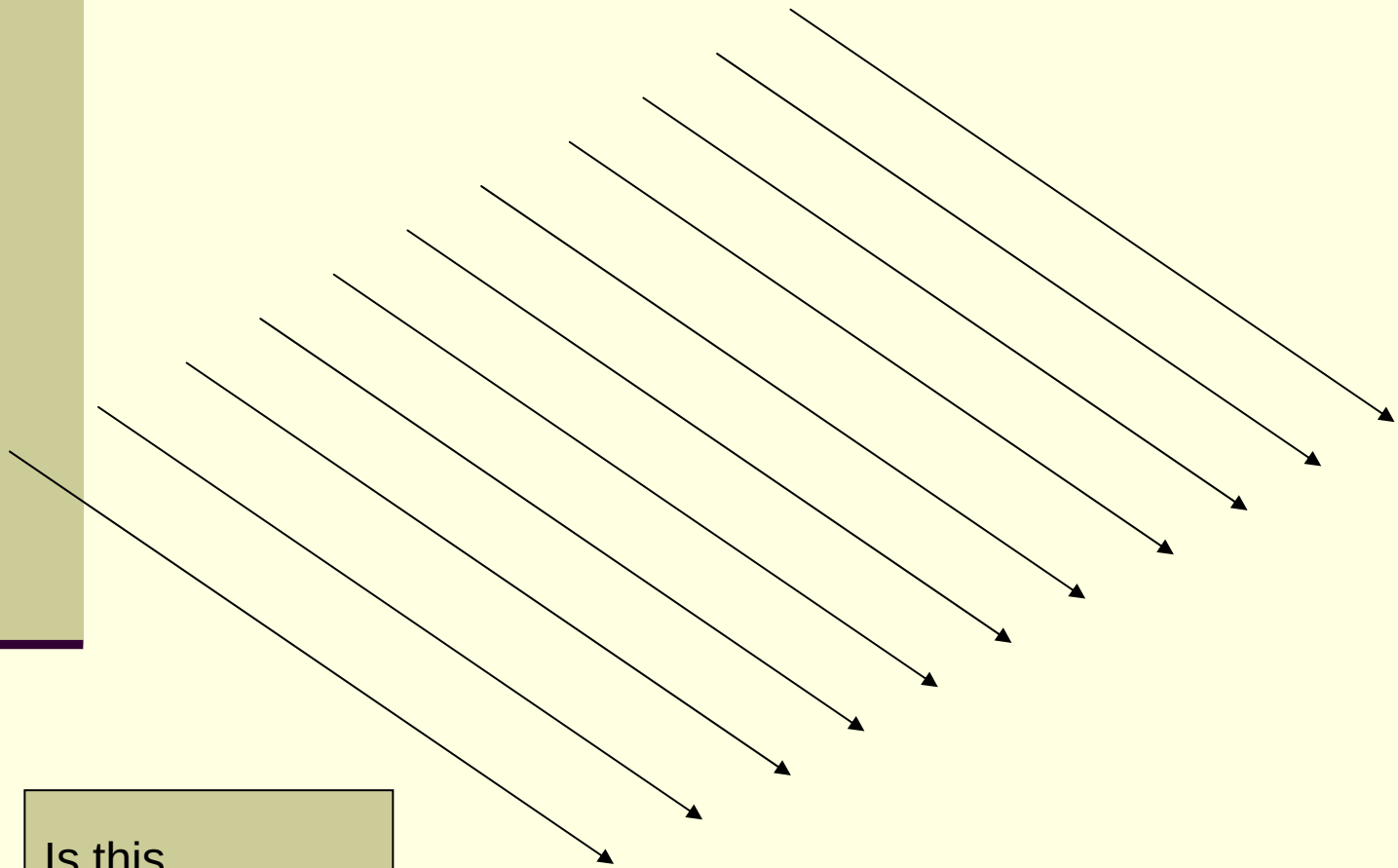
Pathways of care

- Emergency care
- Cancer
- Coronary heart disease
- Diabetes
- Endocrine
- Mental health & learning disability
- substance misuse
- Older people
- Children's health
- Renal
- Sexual & Reproductive health
- Respiratory disease
- Orthopaedics, rheumatology, spinal and trauma, MSK
- Long term neuro conditions & stroke
- Digestive system conditions
- Urology
- ENT & eyes
- Infectious disease
- Specialist commissioning
- **Health and social care in criminal justice**

Are they all there and fit for purpose?


Prison
INTEGRATION
CONTINUITY
Primary care vulnerable and socially excluded GMS
Primary care mental health service
2o Mental health service
Substance misuse service
Sexual health service
Infectious diseases service
Dental, Optometry, Pharmacy services
Health promotion
Chronic disease management
Learning disability services
Social care, Housing, Education, Leisure and Employment
Community
Community

Local Health Community – Clinical management framework

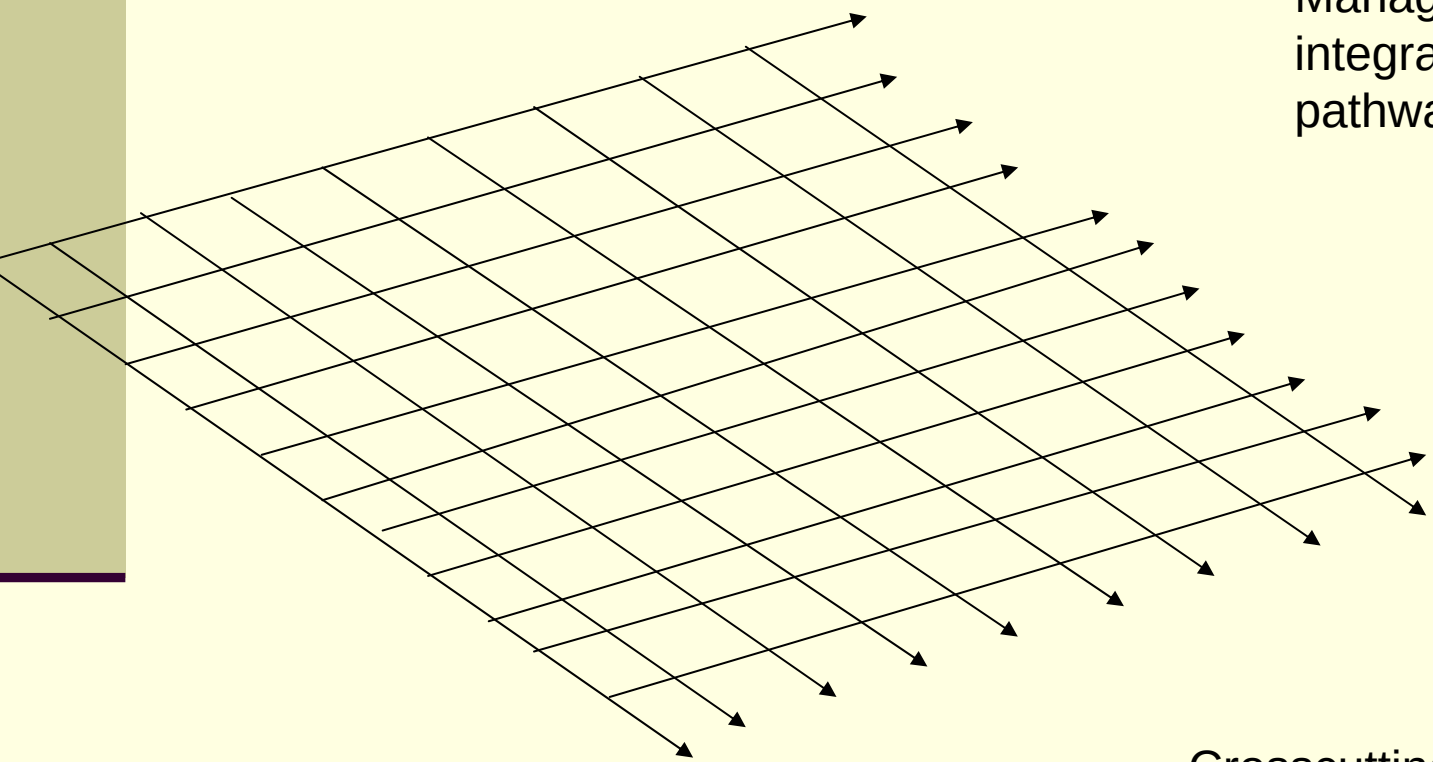


Is this comprehensive?

Cross cutting issues

- Standards for better health –LHC joint approaches
- Choice
- Workforce planning
- Performance monitoring
- Public involvement
- Clinical pathway integration e.g. rehab., diagnostics
- Public health
- Infrastructure IT and buildings and kit
- LHC LDP & financial balance
- Accountabilities and reporting
- Academic issues, HYMS, PGMI, research
- Strategic direction and innovation
- Organisational relationships
- Ethics

Quality Assuring the LHC Clinical management framework – the role of local clinical leadership and planning

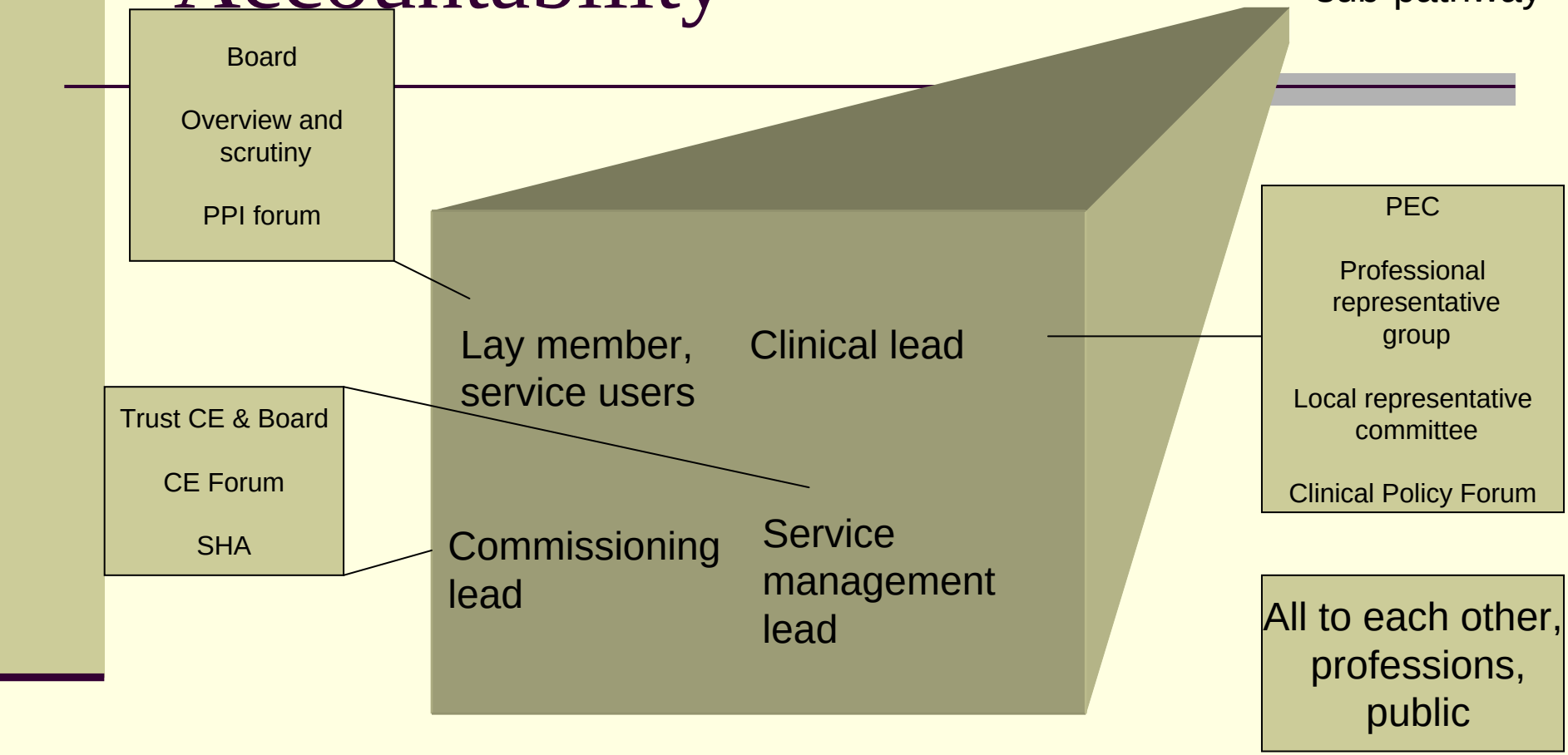


Managed integrated clinical pathways

Crosscutting issues

Accountability

For each pathway or sub-pathway



Accountable individuals resourced and incentivised from appropriate local NHS organisations.

Is there effective delivery of these roles in existing structures? Can they be strengthened and helped to operate more effectively?

ISIP

NCRS

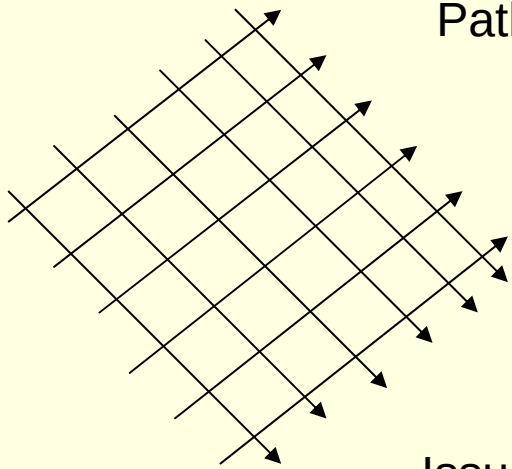
GP2GP

Primary care system

N3

ETP

MoMed



Pathways

Ambulance

Community

PACS

SAP

Issues

Child health

PAS

+Workforce reform

+10 high impact changes

Maternity A&E Theatre

Lorenzo

Mental health

CAB

Practice based commissioning

- A pure form based on a single practice or commonly as a locality, a group of practices and social care teams. Prison to be included.
- Could be either from the prison or by the PCT or a locality on behalf of the prison.
- The PBC group to:
  - know their utilisation of resources,
  - understand their fair share of the resources available,
  - design and commission alternative and more community based, (and cheaper) alternatives to hospital care
  - support care pathway management
- Managing the demand and flow of patients in to the secondary sector, promoting better patient experience and self reliance.

Evidence

- Referral protocols – Prodigy
- National clinical effectiveness – NICE, NSFs
- Learning from each other in the prison health community, and the survey.
- What is usual practice, what is contracted for or usually delivered in primary care.
- Applied utilising technology.
- Local SLAs and protocols of care in support of the commissioning process.

Constant watches

- In health care – for health reasons, healthcare budget pays.
- On the wings – for social or security reasons then prison pays.
- Requires a commissioned, delineated local agreement supported by national principles.
- Which budget pays – primary care, secondary care, psyche?

Conclusion

- Invest to save - telemedicine
- Prison as a vanguard for excellence in social exclusion primary care
- Strengthen the in house capacity to deliver care through powerful commissioning
- Avoid non strategic solutions.
- Part of the awakening in regard to prison health issues for local health communities
- Technology and internationally tested solutions abound.