

Nursing in Prisons

Report by the Working Group considering the development of prison nursing, with particular reference to health care officers

I N F O R M A T I O N

General information

Distribution	Health Authorities, Regional Offices, Professional Organisations, Education and Training Consortia, Governing Governors, Prison Health Care Managers, Secure Units.
Contact point	Prison Health Policy Unit, Wellington House 133-155 Waterloo Road, London SE1 8UG
Further copies from	Department of Health PO Box 777 London SE1 6XH Fax: 01623 724 524 or the NHS Response Line 0541 555 455
Catalogue number	22568
Date of issue	October 2000

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Introduction

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In December 1999, a working party was established by Health Minister, Lord Hunt, and Prisons Minister, Paul Boateng, to consider the development of nursing in HM Prisons and the effective re-introduction of prison health care officers as members of a multi-disciplinary health care team. Liz Haggard of the Office for Public Management was asked to Chair the working party and to report to Ministers by mid-March 2000. The working party had steering and reference groups.¹ The working party started work in January and met four times. A larger reference group met for two all day sessions. Visits and individual meetings also took place.

This report outlines the work of the working party and makes recommendations for future action. The report also takes account of the responses received when it was sent out in draft for consultation, and the joint Prison Service/NHS Executive response to the recommendations (Appendix A).

This report builds on the '*Future Organisation of Prison Health Care*', a report by the Joint Prison Service and National Health Service Executive Working Group (Department of Health 1999), and supports its recommendations. The '*Future Organisation of Prison Health Care*' and the announcement in December 1999, which lifted the moratorium on the recruitment of health care officers, confirmed that prison health care should be delivered by a health care team with a range of qualifications and competencies suited to the health needs of prisoners. Such an approach reflects practice in the NHS.

¹ Lists of the membership of the steering and reference groups may be found in appendices C and D.

1a. Objectives

The objectives of the working party were:

- To consider the future prison nursing workforce, with particular reference to health care officers.
- To identify approaches to service delivery that would ensure an integrated nursing workforce best placed to meet the health needs of prisoners.
- To identify the actions needed to meet the health care needs of prisoners and those which have the potential to make rapid improvements to the provision of health care.

1b. Terms of Reference

- To consider the recommendations of *'The Future Organisation of Prison Health Care'* relating to the prison health care workforce, with particular reference to health care officers and nurses, and to identify appropriate ways of delivering health care.
- To receive the findings of the health care officers' study and to make recommendations about the selection, training and continuing development of health care officers.
- To identify problems relating to the recruitment and retention of nursing staff and actions to address nursing staff shortages.
- To consider and make recommendations about the development of nursing practice and career paths in prisons.
- To make recommendations regarding the future training of prison health care managers.
- To identify the potential for involving the voluntary sector in the delivery of health care.
- To aim to report by the end of February 2000, setting out short-term, medium-term and long-term actions that will have a positive impact on the way health care is delivered in prisons and on its quality.

2. Executive Summary

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Broad Findings

Prison Health Care services must:

- make best use of the skills currently available and those that are likely to be available in the future;
- reflect trends in the NHS, particularly those outlined in the Department of Health's Nursing Strategy 'Making a Difference', including the flexible use of staff, modular competency-based training linked to assessed patient need, occupational standards, clinical governance, work patterns and reward; and
- take into account the special nature of the prison setting, the variation in prison populations and the high rate of prisoner movement between prisons.

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Model and Key Recommendations

These recommendations are made on the basis that improvements in the quality of prison health care should be based upon occupational standards that reflect good practice. These should be endorsed by all the key stakeholders and become the bedrock of recruitment, training, and on-going performance management in prison health care.

The Model

We recommend the following model for nursing and health care officer training:

- **Existing and future nurses and health care officers should achieve competencies at the required level through completion of recognised training in custodial health care.**
- **Health care officers should complete modules related to health care and nursing to complement the skills they have already acquired in custodial care.**
- **Nurses should complete modules in custodial care and should also complete certain health care and nursing modules which are relevant to the prison health care environment but in which they may not have previously gained experience or qualifications (e.g. mental health).**

- **The nursing units should be accredited by professional nursing bodies to enable health care officers to gain credits towards nurse registration.**

We recommend that, in addition to the model of training recommended for health care officers and nurses in section 4 of this document, training for discipline officers to become health care officers should include:

- **a mix of residential, on-the-job and distance learning, and workplace mentoring by a competent member of the health care team during the course and for the first six months following completion of the course;**
- **secondments to relevant local NHS services with specified learning objectives; and**
- **an appropriate module six months after completion of the course to consolidate learning and to evaluate whether there are additional training requirements.**

Key Recommendations

- **Immediate work should be undertaken to develop occupational standards for prison health care. This should involve working with a cohort of 20 existing health care officers to develop the occupational standards. These health care officers should be supported to develop their portfolios for accreditation against the occupational standards which will be identified as part of the development work for the NVQ in custodial health care. Training for assessors and funding for preparation time should also be provided.**
- **The previous recommendation will enable the staff and the Prison Service to develop the best approach to training through using the experience of this first cohort of 20 health care officers. The cost of these two recommendations will be approximately £50,000.**
- **A training programme to enable existing and future health care officers, discipline officers and nurses working in prison health care to achieve the NVQ within 1 year of appointment should be developed. The aim should be to have a pilot course starting in September 2000 and courses in place by autumn 2001. Maximum use should be made of distance learning.**
- **The immediate development of a recruitment pack for all posts which emphasises competencies, modular training and continuing development. The inclusion of core job descriptions based on occupational standards and good practice guidelines for staff selection, including minimising the delay caused by security checks to a maximum of one month.**

- **Where there is an urgent need to recruit health care officers, it should be done explicitly in the light of this report and advertisements and recruitment should make clear the necessity of complying with the training requirements once they are in place.**
- **The Policy Unit/Task Force to review, and where necessary redesign, the national core induction training module for staff working in prison health care based upon the occupational standards, which will include the therapeutic management of violence and aggression including ‘Control and Restraint’ (‘C and R’ techniques) . This should be delivered locally wherever possible.**
- **Training Services to work with experienced providers of NHS management development programmes to design and accredit a management development programme with a cohort of 12 health care managers already in post. Results should then be evaluated to develop a training and development programme for health care managers in conjunction with education providers, including the Open University.**
- **A review of the pattern of spending for prison health care training including Training Services, establishments and the former Directorate of Health Care. This should identify ways in which resources may be redirected to meet, in part, the training requirements outlined in this report.**

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3. The Context

Prison population and characteristics

1. There are a total of 135 prisons in England and Wales. In some prisons health care is provided through contractual arrangements with third party providers, particularly in privately managed prisons. The recommendations of this report are relevant to all providers of prison health care and reflect an approach and standard that the Prison Health Policy Unit considers appropriate in all circumstances and establishments.
2. The daily prison population is approximately 64,800 (Home Office Statistics for end of January 1999), a figure which is predicted to rise to 72,900 by 2002. The current throughput of prisoners in a year is approximately 250,000. During the period April 1998 – March 1999, staff providing health care in prisons in England and Wales handled over 2 million consultations with inmates. About two thirds of these consultations (1,557,482) involved contact with a nurse or a health care officer, 27% (610,922) with a prison doctor and 9% (249,780) with a visiting NHS specialist (Annual Prison Health Care Statistics). The prison population is predominantly male and contains a high proportion of heavy drinkers and smokers. As Table 1 illustrates, prisoners suffer from high levels of mental disorder and a significant proportion misuse drugs. They have more active health problems than the population at large and show signs of the adverse health effects of their lifestyles (Birmingham *et al.* 1997; Mason *et al.* 1997).

Table 1 Annual prevalence of self harm and common conditions

Illness / Condition	Total number of inmates	
	1996/7	1998/9
Self Harm Incidents	5,373	7,398
Diabetes	476	768
Known Asthma	3,185	4,730
Known HIV positive inmates	105	43
Notifiable drug addicts	13,181	not available
Non-notifiable drug addicts	8,839	not available

Statistics from 'Nursing in Secure Environments', UKCC 1999

Psychiatric morbidity

3. The Office for National Statistics' study on *'Psychiatric morbidity among prisoners in England and Wales'* (June 1998) identified a large proportion of prisoners with one of a number of mental health disorders. The proportion of respondents with significant neurotic symptoms (anxiety, depression, and phobias) ranged from 39% of male sentenced prisoners to 75% of female remand prisoners. Rates for all prisoner groups were much higher than those in the similar household survey (Men 12%, women 18%). Psychosis, substance misuse, and paranoid and borderline personality disorders were the most common type of disorder. Rates of hazardous alcohol abuse and dependence on drugs in the year before coming into prison were also found to be significantly higher than those in the general population.

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4. Meeting the Health Needs of Prisoners – Occupational Standards

4. In March 1999, following the publication of *'The Future Organisation of Prison Health Care'*, the government recommended that a partnership should be established between the NHS and the Prison Service. This partnership should be underpinned by an assessment of the health needs of prisoners in each establishment.

The benefits arising from this partnership were to include:

- Joint training across prisons and the NHS on prison health care needs;
 - The use of benchmarking in peer review;
 - Sharing of information about efforts to establish a framework for clinical governance; and
 - Access to a wider pool of professional support and supervision.
5. The Working Party supports the recommendations made in *'The Future Organisation of Prison Health Care'* about conducting health needs assessments, the need for the essential redesign and shaping of health care in prisons, and the inclusion of the health needs of the local prison population in local Health Authorities' planning and resource allocation within the annual health improvement planning cycle. Prisons and Health Authorities have been asked to complete a joint health care needs assessment and agree a time-tabled joint prison health plan by March 2001. Models for developing skills and competencies for health care staff should be based upon the findings of the health needs assessments.

Occupational Standards

6. The health needs assessments should provide a means of identifying the occupational standards which would allow the health care team to deliver an appropriate service. There are a number of occupational standards that are clearly core in prison health care, as well as additional ones which vary according to the needs of individual prisons.
7. The working party agrees that the core occupational standards for nurses and health care officers in prison health care, based on those identified by the UKCC in *'Nursing in Secure Environments'* (November 1999), are as follows:
 - Safety and security
 - Assessment and observation, including risk assessment, and risk management to reduce self harm

- Management of violence and aggression
- Therapies and treatments, including cognitive behaviour therapy and psycho- social interventions
- Knowledge of offending behaviour and appropriate legislation
- Report writing
- 'Jail craft' (a term used to describe the prison context and culture)
- Practical nursing skills
- First aid
- Administration and management of medicines

(Based on 'Nursing in Secure Environments', UKCC (Nov 1999))

8. These basic and essential occupational standards cut across the traditional training of registered general and mental health nurses, health care officers and practice nurses. However, the working party also considers these standards to be essential for all staff engaged in prison nursing (i.e. for both registered nurses and non-nurse registered staff) to ensure the development of a competent workforce which is safe to practice. Other occupational standards may include knowledge of substance misuse, IT, communication skills, and an understanding of ethnic and cultural aspects of care.

Competencies

9. The working party agreed that once the required occupational standards have been identified, the occupational standards of team members should be reviewed. Training should be provided where necessary to ensure all nurses and health care officers in the team are competent across the full range of standards (in most instances, this would be at level 3 on the competency assessment criteria identified below). Occupational standards required above this core level may be gained through additional in-house training or through local NHS training.
10. We have defined competence as the knowledge, skill and attitude required for the performance of the occupational standards in a designated role or setting.
11. The competence must be
 - what is agreed is needed for the provision of good care;
 - demonstrated over time in practice in the real work setting; and
 - assessed by a skilled and trained assessor.

12. A competency-based assessment may be at a range of levels according to expertise. Table 2 below illustrates these levels of competency. The level of an individual's competence will depend on their experience and expertise. (For example, a newly qualified RMN/RGN might achieve level 4 on those competencies relating to their area of practice; an experienced health care assistant in the NHS might achieve level 3 in areas relating to their work; a specialist nurse or nurse consultant might achieve level 6. For discipline staff, an experienced senior discipline officer would probably achieve level 6 for 'jail craft', whereas an OSG might achieve level 3.)

Table 2 Competency Assessment Criteria: Levels of Achievement

Cannot do satisfactorily	0
Can do, but not without constant supervision and some assistance	1
Can do satisfactorily but requires some supervision and assistance	2
Can do satisfactorily without assistance and /or supervision	3
Can do satisfactorily without supervision or assistance with more than acceptable speed and quality of work	4
Can do satisfactorily with more than acceptable speed and quality, with initiative and adaptability to special problem situations	5
Can do with more than acceptable speed and quality, with initiative and adaptability and can lead others in performing the task	6

Adapted from FEU Pickup Report – Competency-based vocational Education (1987)

13. To assist in the development of the training, we suggest that a cohort of existing health care officers from across the Prison Service should be identified to "field-test" the programmes and material as it is produced. This would ensure that this approach to training and the materials used meet the needs of both the Prison Service and its staff. This should also enable training to be available by September 2001.
14. This model of occupational standards and core competencies might also be relevant when considering the training of other members of the health care team.
15. **We recommend that the Prison Service should commission a national occupational standards framework for prison nursing.**
16. **We recommend that a cohort of 20 existing health care officers should contribute to the development of the occupational standards. All existing health care officers should then be offered the opportunity to achieve the qualification. Newly appointed health care officers and nurses should be required to achieve this qualification within their probationary year. In exceptional circumstances, this period may be extended by a further six months. £50,000 should be made available to support this work, a cost which could be met by re-focusing the current central training budget for health care.**

5. Training and Assessment of Competence

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17. To ensure that prison health care teams are able to meet most of the daily health care and security requirements of prisoners, we agreed that staff working in prison nursing, including those without a first level nursing registration, should be competent at level 3 (as described in Table 2) across the full range of occupational standards.
18. We expect that most staff working in prison nursing will already be competent at or above level 3 in some areas. Training will be required to ensure all staff reach level 3 across the full range of occupational standards within a locally agreed time scale. We would expect new staff working full-time to reach this level within a year of appointment. Achieving level 3 would provide a foundation for nursing staff upon which further expertise can be built.
19. Specialist skills and knowledge will be developed beyond the level 3 competence according to the needs of the individual establishment. Some of these specialist skills may be provided by other professionals or from outside organisations, such as visiting specialist staff from neighbouring NHS Trusts, although they may be developed in-house if there is sufficient demand. All members of the health care team, having decided to work in prison health care, should accept additional responsibilities and occupational standards, which relate to the setting in which they work.
20. Training can be delivered by a range of organisations and methods, but more use should be made of nationally developed distance learning materials. Training should be accredited by a range of organisations – such as the National Training Organisations (NTOs) and the English and Welsh National Boards (for nursing midwifery and health visiting) – to maximise transferability between the Prison Service and other health service providers. The NTO would be asked to develop an NVQ and the English and Welsh National Boards to award a corresponding certificate in custodial healthcare (or something similar). Wherever possible, training should be multi-disciplinary and provided locally with input from the NHS.
21. If a staff member were not to achieve the required level of competence, after receiving training and support to fill skill gaps and an opportunity to demonstrate a particular competence, their role in the health care team would need to be reconsidered. Progress in achieving the award could be reviewed in the annual appraisal process.
22. Such an approach does not remove the need to put in place adequate induction programmes for new entrants to the prison health care setting. This should be tailored to the needs of the individual and the establishment, within a nationally agreed framework, and it should include an introduction to the occupational standards described above.

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23. National standards for the therapeutic management of violence and aggression (i.e. for 'Control and Restraint' techniques or 'C&R') are currently being developed by a group of national bodies (including the Department of Health, the Mental Health Act Commission, the UKCC and the Prison Service). These techniques will be used in the prison setting, subject to approval by the Prison Service Management Board, and they should be incorporated into health care standards.
24. Core funds will be needed centrally so that education providers with suitable experience can be invited to bid to develop all or some of the training modules. Current expenditure on training should be re-directed to support this approach, although additional initial investment will be necessary to develop the modules.
25. The occupational standards and competency approach will also require trained assessors with suitable experience from within the Prison Service and the NHS. A training plan for assessors will need to be developed and this will also require additional initial investment.
26. **We recommend that the Prison Health Task Force/Policy Unit should commission a training and development framework to prepare staff for working in prison nursing services. In doing so consideration should be given to flexible approaches to providing training using distance learning and other similar models, so that the required standards are achieved within 1 year of appointment for people working full-time.**
27. **We recommend that all health care team staff should receive a nationally agreed induction-training module, delivered locally and completed within one month of appointment. This should be regularly updated and include the centrally agreed core 'Control and Restraint' ('C&R') techniques as part of the training for the therapeutic management of violence and aggression. To ensure that the therapeutic integrity of health care is maintained, this training should be organised in conjunction with the local mental health trust.**
28. **We recommend the following model for nursing and health care officer training:**
 - Existing and future nurses and health care officers should achieve competencies at the required level through completion of recognised training in custodial health care.
 - Health care officers should complete modules related to health care and nursing to complement the skills they have already acquired in custodial care.
 - Nurses should complete modules in custodial care and should also complete certain health care and nursing modules which are relevant to the prison health care environment but in which they may not have previously gained experience or qualifications (e.g. mental health).

- **The nursing units should be accredited by professional nursing bodies to enable health care officers to gain credits towards nurse registration.**

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6. Career Progression

Career progression should be based on the identified needs of the service, the individual's assessed competency and ability to take on more complex or more specialised service roles or management roles.

29. We are keen to see the development of flexible career paths for nurses and health care officers. Career progression should be based on the identified needs of the service, the individual's assessed competency and ability to take on more complex or more specialised service roles or management roles. Training, experience and performance should be nationally accredited to demonstrate its relevance not only to the prison setting but also to other settings outside the Prison Service.
30. We recognise that many nurses will move in and out of prison health care due to the wide variety of job opportunities outside the Prison Service. Training and experience in the prison health care service based on occupational standards is more likely to be seen as career enhancing for nurses and health care officers. We expect that this will attract more people to the work in prison health care, aid recruitment and retention, and support career progression in prison health care, management and other areas of the Prison Service.

7. Health Care Officers' Training and Continuing Professional Development

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31. Prison officers have a unique understanding of the prison setting and the prison population. Those who become health care officers are, and will continue to be, important members of the health care team. They possess a substantial pool of skills, both interpersonal and health-related, and others derived from their custodial experience. They have a unique understanding of the prison setting and the prison population. As improvements are made to prison health services, occupational standards and the competency base will need to adapt so that health care staff remain equipped to provide the quality of service required.
32. In the past, health care officer training was normally provided over a six-month residential period at two large prisons (Wormwood Scrubs and Liverpool). This model may be worth further consideration in the future.
33. **We recommend that, in addition to the model of training recommended for health care officers and nurses in section 4 of this document, training for discipline officers to become health care officers should include:**
 - **a mix of residential, on-the-job and distance learning, and workplace mentoring by a competent member of the health care team during the course and for the first six months following completion of the course;**
 - **secondments to relevant local NHS services with specified learning objectives; and**
 - **an appropriate module six months after completion of the course to consolidate learning and to evaluate whether there are additional training requirements.**
34. Once trained, health care officers should be required to undertake continuing professional development in a similar way to other health care staff. The national Prison Service target of six days training per year per member of staff may disadvantage health care training opportunities for health care officers if they have to 'use' their six days in discipline related training.
35. A recent survey of health care officers (Directorate of Health Care, 1999) showed that 159 (approximately 30%) wished to undertake nurse training. During 1992-8 a number of health care officers trained as registered nurses at an approximate cost of £150,000 per person. This does not represent good value for money for several reasons. First, the training did not take into account health care officers' previous experience. Second, many elements of nurse training programmes may not be relevant to the prison setting. Third,

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the Prison Service should use the increasing flexibility in training nurses proposed by the UKCC to develop a framework which would allow health care officers wishing to train as nurses to have their previous health care officer training and experience accredited. Whether or not the Prison Service recommences funding nurse training for health care officers will depend on the assessment of prisoners' health needs and the skills required to meet these needs, the length of training required and the extent to which some of the training can be delivered by distance learning so that some replacement costs are reduced. All prisons are required to complete these health need assessments by April 2001.

36. The current changes being introduced to nurse training nationally provide opportunities for the future recognition of health care officer training towards nurse registration. The South Bank University is one of 16 national pilot sites involved in the development of the competency framework for the first year of nurse training. The recent appointment of a nurse lecturer/practitioner in prison nursing at South Bank University, in partnership with the Prison Service London Area, will provide an opportunity to develop the training programme for health care officers within this framework. This will support those health care officers who wish subsequently to train as nurses. Existing health care officers may also be assessed against the criteria that emerge for the first year of nurse training as their experience could be accredited and contribute towards nurse training time.

8. Continuing Professional Training and Development

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37. Nurses and health care officers working within prison health care will continue to have training and development needs beyond induction and the occupational standards described above. The UKCC requires nurses to demonstrate the equivalent of five days of study or activity relevant to their area of clinical practice every three years as a pre-requisite for re-registration (Post-Registration Education and Practice (PREP) and Continuing Professional Development (CPD) requirements).
38. We consider this minimum requirement to represent good practice and would urge that this standard also be required of non-nurse registered health care officers. This training should be additional to the mandatory training required by Prison Service establishments. Each establishment should have a specified timed and planned programme of training for its health care staff and this programme should be evaluated by participants and subjected to an annual review. Responsibility for ensuring there is a training programme should lie with the health care service manager. Members of the health care team should have regular training meetings in which all team members participate, to keep abreast of changes in clinical practice. Some meetings should be held jointly with neighbouring prisons and NHS Services.
39. We believe that a multi-disciplinary training schedule, based on the identified needs of each establishment, should be identified and joint training plans for the whole health care team should be introduced. Wherever possible, opportunities to develop the prison health care workforce in partnership with the NHS should be taken and linked to NHS workforce planning, such as the workforce planning being undertaken to support the Mental Health National Service Framework. The training analysis should incorporate an assessment of the current skills of all the health care team and their key training needs as individuals. The training plan should be adequately costed and resourced.
40. The resourcing of training and development for Prison Service nurses and health care officers has been insufficient to meet the needs of the service. The current centralised financial allocation of £100,000 per annum to cover 1800 nurses, health care officers and pharmacy staff across England and Wales is clearly inadequate. However, the full cost of Training Services for the whole Prison Service is £17.5m for 2000-2001 and some re-direction of resources should be possible within this expenditure.

9. Clinical Governance

41. The Governor is responsible for the management and quality of prison health care and has a duty to see that prisoners receive good quality health care. We would not expect Governors to provide direct management and leadership but they should make sure that health care is managed effectively. On this basis Governors have a duty to consider how their establishment can respond to the needs of prisoners, and to ensure that this is included in the local health authority's health improvement plan.
42. However, we believe it is important to recognise that management of health care and governance of health care are two separate issues. The health care manager should be directly responsible to the Governor for the quality of the health care being delivered by the health care team; if it is delivered by an outside contractor, the quality of the service delivered needs to form part of the contract. The health care manager should be part of the senior management team of the prison.
43. Health care services should be organised to:
 - enable the Governor, who is not expected to have clinical expertise or in depth knowledge of health issues, to have assurance of the quality of the health care that is being delivered in the prison for which they are responsible;
 - enable the health care team to deliver acceptable health care and to recruit and retain staff so that these standards are met;
 - ensure that individual members of the health care team work to agreed clinical and professional standards and have access to clinical advice and mentoring from appropriately qualified staff to help them maintain standards in their own clinical area; and
 - give members of prison health care staff, prisoners and their families access to independent advice if they believe there are health care problems that have not been resolved internally.
44. The way in which services are organised will vary according to the size of the establishment, the range of health care staff in post and the strength of the links to local NHS services. Shared clinical governance with local trusts or primary care groups would be more likely to bring objectivity and new thinking. However, the discussions of the working group showed that it was essential for the health care manager to have management skills and access to appropriate training, as well as credibility with the Governor and the health care team staff.

45. In the NHS, a clinician is appointed to ensure clinical systems are in place to safeguard clinical quality and improvement. All health professionals remain responsible for meeting the standards of their own regulatory bodies. Within the prison health care team, health care officers are disadvantaged by not belonging to a regulated professional body with standards which act as a guide to what they should and should not do. Health care officers are, however, expected to work within the requirements of the UKCC Code of Professional Conduct in relation to their nursing duties. The government is already looking at mechanisms to regulate the activity of health care support staff and opportunities may exist within this to develop a model which would offer membership of a regulated professional body to health care officers.
46. **Recognising the importance of health care within the prison context, we recommend that Governors should receive an annual update from the NHS about health care developments within the NHS. There should be a particular focus on current NHS policies, standards and frameworks and guidance about what Governors should expect from health care in prisons.**
47. **We recommend that the Prison Health Policy Unit and Task Force should establish a mechanism which would offer health care officers membership of a professional body. This should be in line with similar developments in the NHS to regulate the activity of health care support staff.**

10. Managing the Health Care Team & Future Training of Health Care Managers

The manager of a health care team requires managerial skills and the ability to work with health care team staff, prison staff, the local NHS and other local services.

48. *'The Future Organisation of Prison Health Care'* stated that the management arrangements for health care in a prison should be led by a specialist health care manager appointed on the basis of their experience of working in a health care setting and evidence of their competence as a manager. Health care management posts should be open to people with skills and competencies in managing health care or the ability to develop those skills. The manager of a health care team requires managerial skills and the ability to work with health care team staff, prison staff, the local NHS and other local services. We recognise that there are already many examples of good practice within prison health care management. Health care managers must be effective and provide the Governor with information about the service provided which gives him/her confidence that:
- the health care needs of prisoners are being met;
 - effective use is being made of resources;
 - health care team objectives are being achieved; and
 - problems and service needs are being identified and addressed.
49. The demands of the job and the skill levels needed will depend on the nature and size of the prison, and payment should reflect this. The job should be open to people from all backgrounds; recruitment and selection should follow NHS practice; and local NHS managers should be involved in the recruitment and selection process. Health care management may provide one possible career path for staff working in prison health care.
50. The NHS has expended a great deal of financial and staff resources in identifying management competencies and management development programmes. This work should be built upon when developing training for health care managers in prisons.
51. There are recognised awards for NHS management teams (for example, the Health Service Journal's Management awards). This approach, which recognises good practice, should be explored for prison health care management teams.
52. **We recommend that Training Services, working with NHS providers of management development programmes and the Prison Service, should design a pilot accredited management development programme for a cohort of up to 12 current health care team managers, based on the core competencies and person specification required, and delivered through a mix of residential, distance and learning set methods.**

53. **The estimated cost of this pilot programme is £50,000 and Training Services should be asked to seek ways of funding this from existing resources. Results should be evaluated by the Prison Service and, if successful, the programme could become a module of training and development available to health care staff.**
54. **Clear definitions of expectations and targets for the management of prison health care should be provided, and health care should be included in prisons' business plans following the guidelines being developed by the Policy Unit/Task Force.**
55. **We recommend that good practice should be recognised - for example, an award for the best health care team could be established as part of the annual Prison Service cycle of recognition and reward.**

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11. Nurse Leadership

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56. *'The Future Organisation of Prison Health Care'* states that nursing should be carried out under the direction of a registered nurse. This does not mean that all nursing duties must be conducted by registered nurses, but that all nursing should be led by a suitably qualified and competent registered nurse to enable appropriate supervision and quality standards to be maintained. For example, the issuing of medication may be delegated to suitably competent health care staff with the nurse retaining overall responsibility for the administration of medicines. Monitoring and auditing practice, reflective supervision and review all form a crucial part of effective delegation.
57. We believe that all health care staff should demonstrate that they have access to support and professional supervision either within the establishment or through arrangements with local NHS providers. The possibility of accessing support and supervision outside the prison should be explored, particularly in smaller establishments. (The term "professional supervision" is used here to mean the opportunity to review and reflect on practice and performance, critical incidents and achievements.)
58. The development of nursing leadership within the Prison Service should take place in conjunction with the nursing leadership programmes being developed to support the Department of Health's nursing strategy, *'Making a Difference'*. A 'Leading Lights' group, which includes representation from the Prison Service, has been established by the Chief Nursing Officer at the Department of Health to identify a range of approaches for developing nursing leadership in the NHS. These opportunities should be used to develop nursing leadership within the Prison Service in partnership with the NHS.
59. **We recommend that all staff working in a nursing capacity should have regular clinical supervision.**

12. Skill Mix

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60. The skill and grade mix of nursing and health care staff in prisons needs to be assessed. This should be based on the needs assessment work and the competencies identified to meet those needs, and the available staff. The current policy for 75% of nurses to be first level registered is no longer helpful. Within the NHS the percentage of first level registered nurses may vary from 100% in some instances to 50% in others. The Prison Service should move to a position where skill mix reflects the health needs of the prisoners which will be identified in the health needs assessments.
61. Staff recruited and trained to deliver a skilled service will be demotivated if they are given less skilled work to do and the best use will not be made of their time. The working party was told that considerable amounts of time could be spent by health care team members on escort duty, either of prisoners or of visiting health care staff, who have to be met at the gate and escorted to the health care centre. Alternative solutions should be sought to solve the problems presented by escort arrangements so that better use is made of skilled staff time.
62. It is likely to be difficult to recruit clinical staff for the foreseeable future. It will become more important for effective service delivery and recruitment and retention to make sure that clinical staff time is focussed on direct contact with prisoner patients, care and service planning. Arrangements for management and administration should involve clinicians but should, as far as possible, leave them free to work with patients. The high secure hospitals have undertaken significant work on skill mix issues which recognises the importance of administrative support for clinical staff as this releases them for more appropriate roles.
63. **We recommend that pilot projects look at ways of maximising the time spent by medical, nursing, therapy and other health professional staff in direct patient contact and on patient focused service and care.**

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13. Terms and Conditions

64. Health care officers, nurses, therapists and other staff working in prison health care each have different terms and conditions. The current Prison Service 'Pay and Grading' exercise excludes nurses who continue to be paid on Whitley terms and conditions. The overall annual and lifetime cost of employing health care officers, nurses and other health care staff should be made clear within the Prison Service.
65. Costs should be based amongst other things on earnings, pensions, overtime, sickness, absence and turnover costs. It might also be helpful to calculate the cost per hour of actual patient contact for each profession. It may then be possible to see ways of moving towards a common spine for pay and conditions. The current variation in terms and conditions creates problems which prevent the development of a cohesive prison nursing team.
66. A further issue of conflict is the opportunity for nurses to work and be paid for overtime. Health care officers are not paid overtime but have a system of time-off in lieu. In some establishments the use of regular overtime is counter to effective financial management or service delivery. Staff may become overtired, contributing to the cycle of sickness absence and low morale. The savings that could be realised from the reduction of overtime could be redirected to development and training.
67. The working party recognises that the use of overtime may be due to staff shortages which should now be eased with the reintroduction of health care officers.

14. Recruitment and Retention

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68. The recruitment of nurses into prison health care varies widely across England and Wales. Inner city prisons find it particularly difficult to recruit a suitable mix of registered nurses to meet their requirements. These problems are compounded by the delays in obtaining the security clearance needed before candidates can take up the offer of a post. All applicants to the Prison Service have to disclose any information which would be prejudicial to their appointment. This declaration should provide an opportunity for more flexibility in recruitment, enabling an immediate job offer to be made subject to the receipt of security clearance. Since a wide range of employment opportunities exists for nurses, we urge the Prison Service to provide security clearance within a month. If it does not find ways of addressing the delays experienced at present, the Prison Service runs the risk of losing suitable applicants to other employers.
69. Nurses and other clinical members of the health care team may have little or no experience of the prison setting. It is important that the recruitment process for nurses provides applicants with an opportunity to see the prison setting and includes a clear process for assessing aptitude for health care work in the prison setting.
70. Health care officers are recruited from prison officers and consequently have a good understanding of the prison setting although little knowledge, in many instances, of health care. Selection for health care officers should include a clear process for assessing aptitude for health care work and for making sure that applicants understand the implications of the move to health care, the training and development opportunities available and career prospects.
71. Greater use should be made of flexible approaches to staff employment and deployment. For example, part-time staff could be used for peak periods of activity, such as reception screening, or to provide a specialist service on a part-time basis. Steps should also be taken to attract and retain staff from black and ethnic minority communities to ensure that the health care workforce reflects the diversity of the community it serves.
72. **We recommend that the Policy Unit/Task Force work with Prison Service Training Services to:**
- **produce a competency based job description and person specification for all health care team members to be used for future recruitment.**
 - **develop a standard recruitment package for establishments.**

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- **ensure that job offers are made immediately following interview, subject to security clearance and health clearance.**
- **involve an NHS assessor in the recruitment of all members of the health care team.**
- **make sure that during recruitment it is made clear to all applicants that they are required to successfully complete assessed NVQ modules within a given period.**
- **make sure that where there is an urgent need to recruit health care officers, they are recruited explicitly in the light of this report and that advertisements and the recruitment literature make clear the need to comply with the new training requirements once they are in place.**
- **make sure that training plans and a competence-based portfolio approach to training is included at the beginning of all new inductions. The Task Force should support the development of annual training plans based on the assessment of need in 3-4 establishments. The aim would be to provide models for the rest of the service so that annual training plans are practical, relevant and reviewed. The local NHS should be included in the development of the training plans to encourage joint training.**
- **make sure that opportunities for job shares, dual/joint appointments and secondments between the local NHS and prisons are encouraged.**

15. Sickness

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73. The annual average sickness absence rate for all nursing grades is 18.7 days; for all female nursing grades it is 19.1 days and for all male nursing grades, 17.2 days. There is a very high proportion of long-term sickness (that is, in excess of 30 days). There are wide variations in sickness absence rates, from 0 to 68.6 days. The range also varies across prison areas; London South, Mersey and Manchester, and Mercia have the highest levels of sickness absence, and South Coast and North East the lowest. The establishments with the highest level of sickness absence are predominantly male local prisons.

Table 3 Nursing staff sickness absence rates 1998/9

Numbers of establishments within each length of sickness absence band:

	5 days or less	6-10 days	11-15 days	16-20 days	More than 20 days
Male staff	35	10	5	3	14
Female staff	39	11	18	11	24

Effective sickness management would benefit the whole health care team.

74. Sickness absence results in increased agency and overtime costs, compromised standards of care, and low staff morale which, in turn, leads to problems with recruitment and retention. Effective sickness management would benefit the whole health care team. Where sickness management is effective, the financial savings should be reinvested in the health care team through training and development, thereby breaking the cycle of low morale.
75. Recent surveys in the NHS show that nursing staff experience high stress levels. These high stress levels are reflected in the Prison Service in high rates of sickness absence and early retirement. NHS studies have shown that it is possible to reduce stress, sickness and absence through better management of staff time, changes in work patterns and better support for staff.
76. **We recommend that the Policy Unit/Task Force look at prisons where levels of stress, sickness and absence are high and compare the health care team management arrangements in these prisons with those in establishments with low levels of stress, sickness and absence. Examples of good sickness management practice should be identified and disseminated to other prisons. Sickness management practice should be subjected to performance management through the operational line.**

16. Buildings

77. In many places it is not possible, despite the best efforts of staff, to provide acceptable modern health care because of the limitations on the level of health care that can be provided in inappropriate buildings. In many older prisons, cell door design means there is no possibility of adequate observation or of patient/staff contact. We saw one establishment which had attempted to overcome some of these problems by replacing the regular cell door with a Perspex door so that even when patients needed to be isolated they could be adequately observed and spoken to – regular observation is often an important component of managing prisoners with mental health problems.
78. We were particularly concerned by the amount of time some prisoners with mental health problems spend in their cells, where they are isolated from staff and association with other prisoners, and where they are inadequately monitored and observed. The targets for “time out of cell” are not achieved in many health care settings and this denies patients, whose needs are often the greatest, the opportunity for purposeful activity, social contact, outdoor activity and exercise. This highlights the need for all newly built health care facilities to reflect health care trends in the wider NHS, and the known need for modernisation of many existing Victorian facilities.
79. The working party recognises that the Prison Health Task Force will be pushing forward work in this area, and as it does so the implications for service delivery will need consideration. We heard that some new buildings were unsuitable for modern health care. It is vital that early links are made between health care staff and those responsible for new buildings or the refurbishment of existing buildings so that health expertise informs decision making and design.
80. **We recommend that where new buildings and refurbishment are planned health care expertise from the NHS and Prison Service should be incorporated into the planning process.**

17. Health Care/Discipline Officer Dual Role and Health Care Team Membership

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81. We were frequently told that health care officers were not considered or did not consider themselves to be full members of the health care team because the Governor could require them to carry out duties outside the health care function. Although no recent examples of this were given, there may be a misunderstanding within parts of the Prison Service about the role of health care officers. It should be made clear that health care officers are full members of the health care team. We all accept that in exceptional circumstances health care officers might have to perform duties other than health care, but if this were to occur only in defined rare circumstances it would promote better team working.
82. **We recommend that Governors should make clear the circumstances in which they will call upon health care officers to perform duties outside the health care function and that where this happens it is recorded.**
83. We were told of confusion about identifying health care staff due to the wide range of uniforms worn by members of the health care team. One establishment identified this as a significant issue during the health needs assessment process. We consider it to be important for all members of the health care team to be readily identifiable and to have a corporate health care image.
84. **We recommend that all members of the health care team should be identifiable as members of the health care team. Consideration should be given to the acquisition of new uniforms for prison health care staff and the impact of this should be reviewed and evaluated.**

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18. Concerns about Secondary Mental Health Care in Prisons

85. In most circumstances individual nurses and health care officers provide care in extremely difficult circumstances within the scope of their knowledge and expertise. However, we are concerned about the practice of keeping disturbed prisoners with mental health problems alone in their cell for long periods of time. We are particularly concerned about the level of care provided at night. Many of these patients clearly need secondary level care, which prison health care does not and can not provide. In the NHS, seclusion is used only as a last resort under the direction of a consultant psychiatrist following strict protocols.
86. Management of prisoners with significant mental health problems should accord with the strict guidelines that pertain in the NHS and should involve either a consultant psychiatrist or a community mental health team. In our view, the local NHS secondary provider should manage these patients either in the prison or on NHS premises. If prisoners are sufficiently unwell to require a move to the health care centre because of their mental health condition, the level of care and staff expertise provided should be equivalent to that in an NHS in-patient mental health setting. Such equivalence does not exist at present because:
- staffing levels are too low;
 - sufficient expertise in mental health is not available;
 - the environment and buildings are unsuitable; and
 - levels of observation and treatment do not meet secondary needs.
87. We have referred elsewhere to the buildings in which prison health care is provided and the limitations they impose. Often ward accommodation is similarly unsuitable for the treatment of patients. The practice of having a single member of health care staff observing patients from a small closed locked area at the end of the ward, due to inadequate numbers of suitably trained staff, is clearly unsuitable and must be discontinued.
88. If a secondary mental health service is to continue to be provided within prisons, the Prison Service must make major changes to staffing, training, practice and accommodation.
89. **We recommend that standards for referral, treatment and discharge of patients with significant mental health care should be urgently addressed. Local NHS mental health services should take the lead in ensuring that levels of care for this group of patients in prison equates with current good practice within the NHS.**

19. Appropriate Delivery: Initial Assessment

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90. A number of prisons receive from the courts each day between 30 to 40 prisoners who have been either remanded, convicted and sentenced or who await details of their sentence. For example, in September 1999 at Pentonville there were 1468 receptions, 1414 releases to the courts, 89 transfers and 151 discharges. Within the number of reception prisoners there are 'new to this prison' arrivals who have been transferred from other prisons for a variety of reasons, but who will already have received a health care assessment. These movements can give rise to up to 60 new and 'new to this prison' arrivals a day at Pentonville. Although the contract with the security services which provide transport is supposed to deliver prisoners throughout the day, in practice nearly all deliveries of prisoners occur in the later afternoon, with the result that assessments are often rushed and run over normal working hours.
91. The fact that large numbers of prisoners arrive at once makes it difficult to respond appropriately. Reception is also a time of high anxiety for prisoners and there is often a high risk of self-harm, suicide, and a high prevalence of withdrawal and other health related problems in the days that follow. Ways of reducing this risk need to be sought. For example, methods to make best use of the information available on those prisoners likely to be at risk in first hours/days in prison should be found. This would ensure that the health care team is able to focus attention in the first few days on those prisoners with serious problems, where early intervention will be important.
92. Following the initial reception screening, prisoners should receive a comprehensive health check equivalent to a new patient check undertaken by a competent nurse in a GP practice. This should include a thorough mental health assessment. Nurses should then be in a position to refer to a medical officer if necessary or to a specialist nurse or community psychiatric nurse. The level of training required to undertake assessments might exceed that identified as of the core competency training for nurses in prison health care and should be secured through local training organisations.
93. Staff in the health care team conducting reception screening should be supported by validated health screening tools. Staff provision should be matched to the times when staff are most needed, thereby reducing overtime and, where possible, arranging the workload to match the time when staff are likely to be available.
94. The current Inmate Medical Records are not well maintained and do not always follow the prisoners on transfer. Comprehensive care plans based on individual needs assessments should also be developed for the prison setting.

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95. **We recommend that a pilot scheme looking at reception screening should be introduced and that a subsequent comprehensive health check should be devised and evaluated by the Policy Unit/Task Force.**
96. Current rules require all prisoners to have an assessment and be seen by a doctor within 24 hours. This is not in line with current NHS practice where first level screening, supported by appropriate validated tools, is increasingly done by nurses and health care team staff with appropriate training. Good screening instruments already exist for primary health care and mental health.
97. **We recommend that appropriate screening instruments and protocols should be used by non-medical health care team members for all 'new to service' prisoners requesting to see a doctor.**
98. **We also recommend that emphasis should be placed on building up a cumulative assessment and health record, which clearly identifies the key problems for which a care plan is then agreed.**
99. **In the interests of allowing information to follow the prisoner more easily, we recommend that the current Inmate Medical Record be re-designed to reflect changes in assessment practice so that a cumulative assessment and problem oriented health record is built up. The IMR should be in a format which is faxable (the current IMR is not).**
100. **The Prison Service should seek to maximise the benefits of modern technology and introduce information systems such as electronic prescribing, which is now standard practice in GP surgeries. The Policy Unit/Task Force should initiate some pilot projects based on information systems within General Practice and evaluate these before implementing them more widely.**
101. **We recommend that the development of core care plans and protocols should proceed, initially for remand reception and in-patients.**

20. Appropriate Range of Services and Skills for a Modern Health Care Service.

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102. Modern primary care includes services delivered by a range of health care staff, who also deliver community and home based services. It may be more appropriate in some prisons to deliver more care on the wings or in day hospital facilities.
103. **We recommend that there should be a systematic study to identify the best use of wing based care, which has much greater possibilities for involving all prison staff in health promotion and observation.**
104. Increasingly more specialist services are now provided within primary care: examples include asthma specialist nurse run clinics, mental health services, drugs and alcohol services and diabetes care. These services are linked to secondary hospital based services – specialist training for staff and workload specialisation build up expertise. There are a number of health conditions in the prison population which occur frequently enough to justify setting up such specialist services and appropriate training with links to the local NHS.
105. Similarly, an increasing number of secondary care health services are now available on an outpatient basis within the primary care centre. Given the high opportunity and staff costs of escorting prisoners to NHS hospital based outpatient appointments, identifying specialist services which could be brought into the prison would be worthwhile. Tele-medicine, which will soon be piloted at Belmarsh prison, might also reduce outpatient attendance at NHS hospitals.

21. Health Promotion.

106. There are examples of a range of health promotion activities within prisons targeted at the specific needs of the prison population, which include mental health, drugs and alcohol, AIDS, and smoking. Examples of such activities are given in the Health Promoting Prisons Awards reports of 1997 and 1998 and in 'Promoting Health'.²
107. As prison Governors develop a settings or 'healthy prisons' approach to health promotion and health improvement in line with advice from HMCIP, the role of the health care team, working in partnership with others, may be expanded. For example, the health care team manager may well act as a co-ordinator, ensuring that comprehensive and efficient health promotion programmes and activities are delivered, as well as providing strategic direction and policy making, in order to deliver the 'healthy prisons' approach. Health care staff may have competencies in a variety of health education topic areas (e.g. sexual health or smoking) and establishments should make full use of these skills.
108. **We recommend that staff should be appointed to carry out specific health promotion work and that these staff should be clearly integrated within the health care team. Their work should also form part of the team's plan to meet the assessed health needs of prisoners, and they should be trained to agreed competency levels.**
109. **We recommend that the health care team should co-operate with others to develop a settings or 'whole prison' approach to promoting health, including evidence based health education and health promotion, to address the wider determinants of prisoners' health, in line with recommendations from HMCIP.**
110. **We recommend that the health care team, in co-operation with all other services in the prison, should develop an annual plan for promoting health, organised through a Health Promotion Committee; and that the WHO Consensus Statement on Mental Health Promotion in Prisons should be adapted for implementation as part of the annual plan.**³

² *Promoting Health*, Good Practice Bulletin No.3, March 1998, HM Prison Service.

³ *Mental Health Promotion in Prisons*, WHO (Regional Office for Europe) Health in Prisons Project 1998, available at www.hipp-europe.org

22. Volunteering

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111. A range of national and local external organisations provides voluntary services in prisons, as well as community based services for released prisoners and for prisoners' families. Prisoners themselves also provide voluntary services through the 'listeners' programme. A list of the organisations providing services is included in the Prisoners' Information Book.
112. Voluntary services have an important role to play in the prison setting. Good voluntary services need well thought out agreements, induction, training and ongoing management involvement, so they are often expensive in terms of the time required from prison staff involved in setting them up. This cost is worthwhile where they are effective.
113. People in the community have access to a very wide range of self-help groups and voluntary organisations, and prisoners should be able to access similar services. The growth of health-related groups and self-help programmes, together with government support for the "patients as experts" approach, means that it is appropriate to look at what voluntary sector organisations, which are not currently involved in working with prisoners, might offer.
114. **We recommend that the Task Force should bring together all the main organisations currently providing voluntary services in prison and to ex-prisoners and families in the community.**
115. **We recommend that the Task Force should invite organisations that might potentially provide voluntary services to meet the needs of the prison population to a workshop. Voluntary organisations will be able to feed back on their experiences and make suggestions for the future.**

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23. Health Care Audit

116. There is clearly a strong role for a standard audit and quality framework to provide guidance on the service targets that should be achieved and to identify good levels of performance. The current audit has as its standard: 'to provide prisoners with access to the same range and quality of services as the general public receives from the National Health Service'. The information collected at present on 38 key audit measures provides a measure of process rather than outcome. The NHS is moving, wherever possible, to outcome measures and NHS organisations to share process and outcome measures. This should be encouraged within the Prison Service also.
117. **We recommend that performance indicators and the results of audit, including comparison with other broadly similar prisons, should be made available to the health care team and that the results should be used along with assessment of prisoners' needs in the health care team's annual planning.**
118. **We also recommend that where a health care team can show that it has a health outcome measure which is more appropriate than one of the current audit standards, agreement should be given for its use. This will ensure that innovation and new ways of delivering a good service are not held back because of audit standards that do not reflect new approaches to health care provision.**

24. Financial Implications

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Implementation of the NVQ

119. To deliver the training described in this report, it will be necessary to develop an infrastructure of assessment and verification to facilitate candidate progression towards the recommended NVQ and to assure the quality of the assessment process. Some of this infrastructure is already in place in prison establishments which have embarked on the introduction of NVQs in custodial care for health care officers. However, links need to be made with established assessment centres in the NHS.
120. The cost of training prison health care staff will vary from establishment to establishment depending on the size of the healthcare workforce and the previous experience of both the prison and its staff with NVQs. We expect a large number of staff to have already many of the competencies that will be included in the NVQ, but these will need to be verified before the NVQ can be awarded.
121. The approximate costs associated with the development of the NVQ have been identified in this report. To produce more accurate figures on the costs of implementing the recommendations made in this report, there needs to be an audit of current spending on training for health care staff. Such an audit will allow existing spending to be identified and then redirected to fund the implementation of our recommendations.
122. We estimate that it will cost between £350 – £500 a head for NVQ related training and qualification. Approximately 1600 staff will potentially require this training and the total cost is likely to be between £560,000 and £800,000. Other costs will include the training of assessors and the production of distance learning material. There will be an initial non-recurring cost for existing nursing staff to qualify for the new NVQ. Once this initial tranche of training has taken place there will be a continuing, but much smaller, commitment for new staff. The introduction of the NVQ needs to be phased, and we think that it would be practicable to train all current health care officers and nurses within a period of three years.

*there needs to be
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Training for Health Care Managers

123. There will also be costs associated with rolling out a programme of management training for all health care managers. Again, costs will be highest during the first two to three years of such a programme, tailing off once current staff have been trained. The costs of providing management training of the kind described in this report will be around £100,000 (e.g. based on the assumption that 100 staff will take up management training to

NVQ level 4 at approximately £1000 per person). To produce more accurate figures on the costs of implementing this recommendation, there needs to be an audit of the cost of existing management training for health care managers.

124. Further work is needed to establish the exact costs of this work and where efficiencies from within current resources might be achieved. Currently, resources are being spent on training in an ad hoc way and these resources need to be identified and refocused to achieve the outcomes outlined in this report.
125. **We recommend a review of the pattern of spending for prison health care training including the money spent by Training Services, establishments and the former Directorate of Health Care. This should identify ways in which resources may be redirected to meet, in part, the training requirements outlined in this report.**

25. Next Steps

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126. As agreed with Ministers, a draft of this report was made available to the Prison Health Policy Unit, Prison Service Training Services, Prison Service Personnel and other relevant units within the NHS Executive. Each of these parties was asked to respond to the document with a plan describing how they would implement each of the recommendations directed to them (the Joint Prison Service/NHS response is at Appendix 1). These responses were returned to us within 4 weeks.
127. In the meantime there is a need to provide training for health care officers who are being recruited now. **We recommend that establishments link with their local NHS providers in the first instance to find out what local training may be available which would help staff develop the competencies required by an NVQ in health care.** Many NHS Trusts run training for health care assistants which is suited to developing competencies at NVQ level 2 or 3. We suggest that, when considering such training, prisons should work closely with Trusts to ensure the training meets the needs of the prison establishment. It may be necessary to seek training from more than one Trust. For example, in Bedford, training is being accessed from the local acute Trust for general nursing skills and the Mental Health trust for mental health skills. Such training may subsequently be suitable for the NVQ in custodial health care once it has been developed, but it is vital that newly appointed health care officers are offered suitable training now, pending the development of the nationally accredited NVQ discussed in this report.

26. List of Recommendations

- I. **We recommend** that the Prison Service should commission a national occupational standards framework for prison nursing (para 15)
- II. **We recommend** that a cohort of 20 existing health care officers should contribute to the development of the occupational standards. All existing health care officers should then be offered the opportunity to achieve the qualification. Newly appointed health care officers and nurses should be required to achieve this qualification within their probationary year. In exceptional circumstances, this period may be extended by a further six months. £50,000 should be made available to support this work, a cost which could be met by re-focusing the current central training budget for health care (para 16).
- III. **We recommend** that the Prison Health Task Force/Policy Unit should commission a training and development framework to prepare staff for working in prison nursing services. In doing so consideration should be given to flexible approaches to providing training using distance learning and other similar models, so that the required standards are achieved within 1 year of appointment for people working full-time (para 26).
- IV. **We recommend** that all health care team staff should receive a nationally agreed induction-training module, delivered locally and completed within one month of appointment. This should be regularly updated and include the centrally agreed core 'Control and Restraint' ('C&R') techniques as part of the training for the therapeutic management of violence and aggression. To ensure that the therapeutic integrity of health care is maintained, this training should be organised in conjunction with the local mental health trust (para 27).
- V. **We recommend** the following model for nursing and health care officer training:
 - Existing and future nurses and health care officers should achieve competencies at the required level through completion of recognised training in custodial health care.
 - Health care officers should complete modules related to health care and nursing to complement the skills they have already acquired in custodial care.

- **Nurses should complete modules in custodial care and should also complete certain health care and nursing modules which are relevant to the prison health care environment but in which they may not have previously gained experience or qualifications (e.g. mental health).**
- **The nursing units should be accredited by professional nursing bodies to enable health care officers to gain credits towards nurse registration (para 28).**

VI. We recommend that, in addition to the model of training recommended for health care officers and nurses in section 4 of this document, training for discipline officers to become health care officers should include:

- **a mix of residential, on-the-job and distance learning, and workplace mentoring by a competent member of the health care team during the course and for the first six months following completion of the course;**
- **secondments to relevant local NHS services with specified learning objectives; and**
- **an appropriate module six months after completion of the course to consolidate learning and to evaluate whether there are additional training requirements (para 33).**

VII. We recommend that Governors should receive an annual update from the NHS about health care developments within the NHS. There should be a particular focus on current NHS policies, standards and frameworks and guidance about what Governors should expect from health care in prisons (para 46).

VIII. We recommend that the Prison Health Policy Unit and Task Force should establish a mechanism which would offer health care officers membership of a professional body. This should be in line with similar developments in the NHS to regulate the activity of health care support staff (para 47).

IX. We recommend that Training Services, working with NHS providers of management development programmes and the Prison Service, should design a pilot accredited management development programme for a cohort of up to 12 current health care team managers, based on the core competencies and person specification required, and delivered through a mix of residential, distance and learning set methods (para 52).

X. The estimated cost of this pilot programme is £50,000 and Training Services should be asked to seek ways of funding this from existing resources. Results should be evaluated by the Prison Service and, if successful, the programme could become a module of training and development available to health care staff (para 53).

Clear definitions of expectations and targets for the management of prison health care should be provided, and health care should be included in prisons' business plans following the guidelines being developed by the Policy Unit/Task Force (para 54).

- XI. We recommend that good practice should be recognised - for example, an award for the best health care team could be established as part of the annual Prison Service cycle of recognition and reward (para 55).**
- XII. We recommend that all staff working in a nursing capacity should have regular clinical supervision (para 59).**
- XIII. We recommend that pilot projects look at ways of maximising the time spent by medical, nursing, therapy and other health professional staff in direct patient contact and on patient focused service and care (para 63).**
- XIV. We recommend that the Policy Unit/Task Force work with Prison Service Training Services to:**
- **produce a competency based job description and person specification for all health care team members to be used for future recruitment.**
 - **develop a standard recruitment package for establishments.**
 - **ensure that job offers are made immediately following interview, subject to security clearance and health clearance.**
 - **involve an NHS assessor in the recruitment of all members of the health care team.**
 - **make sure that during recruitment it is made clear to all applicants that they are required to successfully complete assessed NVQ modules within a given period.**
 - **make sure that where there is an urgent need to recruit health care officers, they are recruited explicitly in the light of this report and that advertisements and the recruitment literature make clear the need to comply with the new training requirements once they are in place.**
 - **make sure that training plans and a competence-based portfolio approach to training is included at the beginning of all new inductions. The Task Force should support the development of annual training plans based on the assessment of need in 3-4 establishments. The aim would be to provide models for the rest of the service so that annual training plans are practical, relevant and reviewed. The local NHS should be included in the development of the training plans to encourage joint training.**
 - **make sure that opportunities for job shares, dual/joint appointments and secondments between the local NHS and prisons are encouraged (para 72).**

- XV. **We recommend** that the Policy Unit/Task Force look at prisons where levels of stress, sickness and absence are high and compare the health care team management arrangements in these prisons with those in establishments with low levels of stress, sickness and absence. Examples of good sickness management practice should be identified and disseminated to other prisons. Sickness management practice should be subjected to performance management through the operational line (para 76).
- XVI. **We recommend** that where new buildings and refurbishment are planned health care expertise from the NHS and Prison Service should be incorporated into the planning process (para 80).
- XVII. **We recommend** that Governors should make clear the circumstances in which they will call upon health care officers to perform duties outside the health care function and that where this happens it is recorded (para 82).
- XVIII. **We recommend** that all members of the health care team should be identifiable as members of the health care team. Consideration should be given to the acquisition of new uniforms for prison health care staff and the impact of this should be reviewed and evaluated (para 84).
- XIX. **We recommend** that standards for referral, treatment and discharge of patients with significant mental health care should be urgently addressed. Local NHS mental health services should take the lead in ensuring that levels of care for this group of patients in prison equates with current good practice within the NHS (para 89).
- XX. **We recommend** the introduction of a pilot scheme looking at reception screening and that a subsequent comprehensive health check should be devised and evaluated by the Policy Unit/Task Force (para 95).
- XXI. **We recommend** that appropriate screening instruments and protocols should be used by non-medical health care team members for all 'new to service' prisoners requesting to see a doctor (para 97).
- XXII. We also **recommend** that emphasis should be placed on building up a cumulative assessment and health record, which clearly identifies the key problems for which a care plan is then agreed (para 98).
- XXIII. In the interests of allowing information to follow the prisoner more easily, we **recommend** that the current Inmate Medical Record be re-designed to reflect changes in assessment practice so that a cumulative assessment and problem oriented health record is built up. The IMR should be in a format which is faxable (the current IMR is not) (para 99).

- XXIV. The Prison Service should seek to maximise the benefits of modern technology and introduce information systems such as electronic prescribing, which is now standard practice in GP surgeries. The Policy Unit/Task Force should initiate some pilot projects based on information systems within General Practice and evaluate these before implementing them more widely (para 100).**
- XXV. We recommend that the development of core care plans and protocols should proceed, initially for remand reception and in-patients (para 101).**
- XXVI. We recommend that there should be a systematic study to identify the best use of wing based care, which has much greater possibilities for involving all prison staff in health promotion and observation (para 103).**
- XXVII. We recommend that staff should be appointed to carry out specific health promotion work and that these staff should be clearly integrated within the health care team. Their work should also form part of the team's plan to meet the assessed health needs of prisoners, and they should be trained to agreed competency levels (para 108).**
- XXVIII. We recommend that the health care team should co-operate with others to develop a settings or 'whole prison' approach to promoting health, including evidence based health education and health promotion, to address the wider determinants of prisoners' health, in line with recommendations from HMCIP (para 109).**
- XXIX. We recommend that the health care team, in co-operation with all other services in the prison, should develop an annual plan for promoting health, organised through a Health Promotion Committee; and that the WHO Consensus Statement on Mental Health Promotion in Prisons should be adapted for implementation as part of the annual plan (para 110).**
- XXX. We recommend that the Task Force should bring together all the main organisations currently providing voluntary services in prison and to ex-prisoners and families in the community (para 114).**
- XXXI. We recommend that the Task Force should invite organisations that might potentially provide voluntary services to meet the needs of the prison population to a workshop. Voluntary organisations will be able to feed back on their experiences and make suggestions for the future (para 115).**
- XXXII. We recommend that performance indicators and the results of audit, including comparison with other broadly similar prisons, should be made available to the health care team and that the results should be used along with assessment of prisoners' needs in the health care team's annual planning (para 117).**

- XXXIII. We also recommend that where a health care team can show that it has a health outcome measure which is more appropriate than one of the current audit standards, agreement should be given for its use. This will ensure that innovation and new ways of delivering a good service are not held back because of audit standards that do not reflect new approaches to health care provision (para 118).**
- XXXIV. We recommend a review of the pattern of spending for prison health care training including the money spent by Training Services, establishments and the former Directorate of Health Care. This should identify ways in which resources may be redirected to meet, in part, the training requirements outlined in this report (para 125).**
- XXXV. We recommend that establishments link with their local NHS providers in the first instance to find out what local training may be available which would help staff develop the competencies required by an NVQ in health care. (para 127).**

Appendix A

PRISON SERVICE AND NHS EXECUTIVE RESPONSE

The Prison Health Policy Unit and Task Force **accept** the recommendations of the Working Group which set out the approach to training for nurses and health care officers. The model outlined in the two recommendations in Table 1 is accepted.

Table 2 which follows, shows how the Prison Health Task Force and Policy Unit will respond to the recommendations which fall into a number of areas, specifically, good practice, clinical governance, audit and performance management, mental health and a number of other policy issues.

Table 1

THE TRAINING MODEL proposed by the Working Group

We recommend the following model for nursing and health care officer training:

- Existing and future nurses and health care officers to achieve competence through completion of an NVQ in 'prison health care'
- Health care officers to complete modules related to health care and nursing in addition to the ones they should have already received in custodial care
- Nurses to complete modules in custodial care and also certain health care and nursing modules which are relevant to the prison health care environment but in which they may not have gained experience or qualifications previously e.g. mental health
- The nursing units to be accredited by professional nursing bodies to enable accreditation towards nurse registration for health care officers

We recommend that in addition to the model of training recommended for health care officers in section 7 of this document that training for discipline officers to become health care officers should include:

- a mix of residential and on-the-job and distance learning
- workplace mentoring by a competent member of the health care team during the course and for the first six months after completing the course
- secondments to the relevant local NHS services with specified learning objectives
- an appropriate module six months after completing the course to consolidate learning and evaluate whether there are additional training requirements

Table 2

Recommendation	Response	Next Steps	Time table
National Occupational Standards and training			
<p>Prison Service to commission the development of a national occupational standards framework for prison nursing.</p>	<p>Accepted</p>	<p>Agreed to commission with training services. Commissioning process with Custodial Care National Training Organisation (CCNTO) already underway. Steering group will be set up to guide the work. Funding agreed and available from central health care training budget held by training services.</p>	<p>Work to begin in September 2000. First draft of Occupational Standards available in January 2000.</p>
<p><i>Prison Health Policy Unit /Task Force (PHPU/TF) to commission the development of an NVQ , accreditation to which will prepare staff for working in the prison nursing services. This should consider flexible approaches to training using distance learning and other models to achieve standards within a year of appointment.</i></p>	<p>Accepted</p>	<p>This work is dependent on the development of occupational standards</p>	<p>The bulk of work should begin in Jan 2001. The NVQ would be available for implementation from Sept 2001. Where possible existing health care officers should be given priority for NVQ accreditation.</p>

Recommendation	Response	Next Steps	Time table
National Occupational Standards and training			
<p>A cohort of up to 20 existing health care officers should</p> <ul style="list-style-type: none"> a) Contribute to the development of occupational standards b) be assessed against them c) qualifications should be awarded accordingly. <p>£50k from the central training budget for health care 2000/01 should be allocated to fund this.</p>	<p>Accepted</p>	<ul style="list-style-type: none"> - Cohort to field test the occupational standards and assessment strategy. - The costs of the cohort are included in the 50k allocated to the development of occupational standards. 	<p>The nominations and selection for the cohort complete by January 2000.</p> <p>The cohort should begin field testing the NVQ in the first three months of 2001, and continue refining it until May 2001</p>
<p>There should be a review of the pattern of spending for prison health care, including training and of how resources can be redirected.</p>	<p>Accepted</p>	<p>PHPU/TF to look at existing spending on training for health care officers and nurses. This may include undertaking an audit of current spending.</p>	<p>Work beginning in September 2000. Complete by Jan 2001.</p>

Table 2 continued

Recommendation	Response	Next Steps	Time table
National Occupational Standards and training			
<p>A standard recruitment package to be used by establishments should be developed.</p> <p>Competency based core job description and person specification for all health care team members to be used for future recruitment. job offers should be made immediately following interview subject to security checks an assessor from the NHS should be involved in recruitment of all members of health team during recruitment it is made clear that staff are required to complete assessed NVQ modules within a specific time period.</p>	<p>Accepted</p>	<p>Contingent on the development of occupational standards and will also be with in the Prison Service Competencies.</p> <p>Produced jointly with Prison Service and NHS recruitment and training services.</p> <p>No major resource implications. This should fall out of the work at 1.</p>	<p>Work begins in Jan 2001. Package complete and available Sept 2001.</p>
<p>Development of a nationally agreed induction training module delivered locally and within one month of appointment.</p> <ul style="list-style-type: none"> – including core C+R techniques – training should be in conjunction with local mental health trust. <p>Training plans and a competence based portfolio approach to training should be included at the beginning of all new inductions.</p>	<p>Accepted</p>	<ul style="list-style-type: none"> – Contingent on the development of occupational standards. – Produced with Training Services. – No major resource implications to produce the induction module. Implementation may mean that prisons have to adapt existing induction arrangements. 	<p>Work begins in Jan 2001 when standards become available.</p> <p>Induction programme available for implementation from Sept 2001.</p>

Recommendation	Response	Next Steps	Time table
National Occupational Standards and training			
<p>Training services should design and pilot an accredited management development programme for a cohort of up to 12 health care team managers already in post. This should be:</p> <ul style="list-style-type: none"> – based on the core competencies and person specifications that will be agreed between PHPU/TF Training Services and the operational line – delivered through a mix of residential, distance and learning set methods. <p>Training services to redirect current spending to identify £50k to fund this cohort of health care managers.</p>	<p>Accepted – resources for cohort to be agreed with Training Services.</p>	<p>Need to look at programmes already available in health care management and if all the relevant skills are covered.</p>	<p>Health care manager nominations and selection for the cohort begin in Jan 2001, for courses beginning in September 2001.</p>

Table 2 continued

Recommendation	Response	Next Steps	Time table
Good Practice			
<p>Opportunities for job shares/joint appointments and secondments between local NHS and Prisons should be encouraged.</p>	<p>Accepted</p>	<p>Include in Prison Service guidance on recruitment to the field.</p> <p>Task Force to identify examples of good practice locally and make available to the field.</p> <p>Costs included in Task Force running costs.</p>	<p>Part of ongoing work of Task Force.</p>
<p>Prisons where sickness and absence are high should be compared with those that are not and good practice should be identified.</p>	<p>Accepted</p>	<p>Task Force working with Prison Service Personnel to encourage good practice and performance management of sickness absence</p>	<p>Part of ongoing work of Task Force</p>
<p>Recognition of good practice – e.g. an award for best health care team.</p>	<p>Accepted</p>	<p>The Prison Service is overhauling its performance and recognition systems and health care will continue to contribute to the systems.</p>	<p>Ongoing.</p>
<p>Pilot projects should look at ways of maximising medical, nursing, therapy and other health professional staff time spent in direct patient contact.</p>	<p>Under consideration</p>	<p>Task Force to consider.</p>	<p>Part of ongoing work of Task Force on Health Needs Assessments.</p> <p>Health Needs assessments completed by March 2001.</p>

Table 2 continued

Recommendation	Response	Next Steps	Time table
Clinical Governance			
We recommend that Policy Unit/Task Force should establish mechanism whereby health care officers could be offered membership of a professional body. This should be in line with similar developments in the NHS.	Accepted	PHPU and Task Force to consider the models being developed in the NHS and whether they should be introduced for health care officers.	Part of the ongoing work of the PHPU on workforce issues.
Governors should receive an annual update on health care by the NHS.	Task Force and Policy Unit to consider.	PHPU and Task Force to consider the practicalities of this.	Part of the ongoing work of the PHPU and Task Force.
All health care staff should have access to 'professional supervision' as in the NHS.	Accepted	PHPU will consider as part of work introducing continuing professional development to prison health care staff.	Part of the ongoing work of the PHPU and Task Force.
Audit and Performance Management			
Definitions of expectations and targets should be provided and health care included in the establishment business plans with guidelines developed by the PHPU/TF.	Accepted	Will form part of the Health Needs Assessment process and consequent Prison Health Plan, where each establishment will set out the programme for action. The PHPU will be monitoring progress in this work.	Health Needs Assessments and Prison Health Plans complete by March 2001.

Table 2 continued

Recommendation	Response	Next Steps	Time table
Audit and Performance Management			
Governors should make clear when they will call health care officers to work outside the health care function. A separate record should be kept of the times when this happens.	Policy Unit and Task Force to consider with the operational line.	Policy Unit and Task Force to investigate and discuss with operational line.	Any necessary action should be taken by September 2001.
The performance indicators and the results of audit, including comparison with other broadly similar prisons, be made available to the health care team and that the results should be used along with assessment of need in the health care team's annual planning..	Policy Unit and Task Force to consider.	Consideration will form part of the work the Prison Health Policy Unit are undertaking on performance monitoring.	Ongoing
Where a health care team has health outcome measures which are more appropriate than one of the current audit standards there should be agreement that it can be used in its place.	Accepted: Subject to PHPU review of performance monitoring generally.	Will form part of the review the Prison Health Policy Unit are undertaking on performance monitoring with standards audit.	Ongoing
Health Care Teams should have annual plans to reduce occupational deprivation and measure their outcomes.	Task Force and Policy Unit to consider.	Task Force and Policy Unit to consider how such issues might fit within Prison Health Plans.	Prison Health Plans produced before March 2001.

Recommendation	Response	Next Steps	Time table
Mental Health			
<p>Standards for referral, treatment and discharge of patients with significant mental health care needs be urgently addressed.</p> <p>Local NHS mental health services should take the lead in ensuring that levels of care meet NHS good practice.</p>	<p>Accepted.</p>	<p>This is being addressed by work which the Policy Unit and the Task Force are undertaking on Mental Health on good practice.</p> <p>In-reach of services would be the responsibility of the NHS; delivery of other services to the appropriate standards the responsibility of the Prison Service.</p>	<p>Ongoing.</p>
Other Policy Issues			
<p>All members of the health care team should be identifiable as such. Consideration should be given to new uniforms . The impact of this decision, should it be agreed, should be it be agreed, should be reviewed and evaluated.</p> <p>Pilot scheme looking at reception screening and subsequent comprehensive health check.</p>	<p>Prison Health Policy Unit and Task Force to consider.</p> <p>Accepted.</p>	<p>Prison Health Policy Unit to consider with operational line and finance colleagues. Proposal should be cost neutral.</p> <p>A pilot scheme looking at reception screening and developing a reception screening tool has been completed.</p> <p>Work is underway to see how this should best be introduced taking into account the likely knock on effects. .</p> <p>Work is underway to see how this should best be introduced taking into account the likely knock on effects. .</p>	<p>Ongoing.</p> <p>Work is underway to see how this should best be introduced taking into account the likely knock on effects.</p> <p>Already underway.</p>

Table 2 continued

Recommendation	Response	Next Steps	Time table
Other Policy Issues			
<p>Current IMR be re-designed to reflect changes in practice, with cumulative assessment and problem oriented health records, and that it should be in a format which can be faxed.</p> <ul style="list-style-type: none"> - In future the benefits of modern technology should be maximised e.g. electronic prescribing. - PHPU/TF should initiate pilots based on GP systems which could then be evaluated 	<p>Task Force and Policy Unit to consider</p>	<p>To be considered in work on an Information & Communications Strategy.</p>	<p>Ongoing.</p>
<p>The development of core care plans and protocols, with the first being for remand reception and in-patients.</p>	<p>Task Force and Policy Unit to consider.</p>	<p>Task Force and Policy Unit to consider as part of work on clinical governance and standards.</p>	<p>Ongoing.</p>
<p>There should be a study to identify the best use of wing based care, which has greater possibilities of involving all prison staff in health promotion and observation prison staff in health promotion and observation.</p>	<p>Task Force and Policy Unit to consider.</p>	<p>Task Force to consider as a focus for one of the needs assessments.</p>	<p>Ongoing.</p>
<p>Health promotion in the widest sense of mental health promotion through 'healthy prisons' approach should be based on the evidence that occupational deprivation reduces mental well-being, increases mental ill-health, and reduces untoward incidents and stress levels for prisoners and staff.</p>	<p>Accepted.</p>	<p>To be taken forward as part of joint work with the Kings Fund on health promotion.</p>	<p>Ongoing.</p>
<p>Where new buildings and refurbishment planned health care expertise from the NHS and prison health care must be involved in the process.</p>	<p>Accepted</p>	<p>This is already being taken forward in considerations of current building work for health care centres.</p>	<p>Already underway.</p>

Appendix B

Organisations Consulted

(Outside of Prison Service & NHSE Headquarters)

Broadmoor Hospital Director of Nursing
College of Occupational Therapists
Custodial Care National Training Organisation
English National Board
Health care officers, HMP Liverpool
Healthworks Care National Training Organisation
Her Majesty's Chief Inspector of Prisons (HMCIP)
HMP Bedford
HMP Belmarsh
HMP Bristol
HMP Brixton
HMP Cardiff
HMP Channings Wood
HMP Emley
HMP Exeter
HMP Highpoint
HMP Rochester
HMP Shrewsbury
HMP Swansea
HMP Whitemoor
HMP Winchester
HMP Wormwood Scrubs
HMYOI/RC Glen Parva
IPMS
National Assembly for Wales
NHS Executive Regional Office Prison Leads
NHSE Regional Office Directors of Nursing
Northern Ireland Prison Service Chief Nurse
Prison Governors Association
Prison Officers Association
Prison Service Area Managers
Royal College of Nursing
Royal Pharmaceutical Society
Sainsbury's Centre for Mental Health
UKCC (United Kingdom Central Council for Nursing, Midwifery and Health Visiting).
University of Central Lancashire
Welsh National Board
Chief Nursing Officer for Wales

Consultation responses received from:

Royal Pharmaceutical Society of Great Britain
Nursing advisor, Northern and Yorkshire Regional Office
HMCIP
Sainsbury's Centre for Mental Health
UKCC
HMP Belmarsh
HMP Exeter
College of Occupational Therapists

*Nursing in Prisons
Report by the Working
Group considering the
development of prison
nursing, with particular
reference to health care
officers*

Extensive comments were also received from the Prison Service Management Board, the Operational Policy Group in the Prison Service and the Nursing and Human Resources Directorates in the NHS Executive. These comments are incorporated in the summary below.

Summary of Responses

Comments on the Working Group's draft Report and Prison Service Response were varied. A common thread was support for the recommendations of the Working Group, which represented well the work of the group, and the emphasis on an 'integrated nursing workforce' which links well with current developments in nursing in the NHS.

There were suggestions that the model developed here should also be used for other staff, such as pharmacists and doctors who otherwise might miss out on such opportunities for CPD. It was also suggested that the model would allow 'nursing auxiliaries' to be brought into the service and trained under the NVQ.

The report was criticised for not taking into account the patient's perspective, and that it was not explicit enough about the fact that the NVQ proposed would provide a foundation for developing further expertise.

There were also specific questions about how the health care officers in the cohort would be selected and what would happen to those who either did not or could not complete the NVQ. It was suggested that the NVQ should allow for part-time or flexible study routes.

Prison Service/NHS Response to Consultation Responses

Many of the issues raised have been addressed in the Working Group's final report.

With regard to other professions, such as doctors and pharmacists, work is being taken forward separately by the Prison Health Policy Unit and Task Force and will take into account the recommendations of this report.

The Prison Health Policy Unit and Task Force will also consider the applicability the proposed model for training direct entrant 'nursing auxiliaries' prisons.

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nursing, with particular
reference to health care
officers*

Appendix C

Membership of Working Party Steering Group

Liz Haggard	Chair
Lindsay Bates	Nurse Adviser, Prison Health Policy Unit
Nick Wall	Governor, HMP Bristol
Andy Ransom	Health Care Principal Officer, HMP Brixton
Terry Hobin	Health Care Officer, HMP Liverpool
Dr. Roger Ralli	Principal Medical Officer, HMYOI/RC Glen Parva
Brian Caton	Prison Officers Association until Feb 2000
Pete Cartwright	Prison Officers Association from Feb 2000
Richard Bradshaw	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
Colin Beacock	Royal College of Nursing
Maggie Gairdner	Health Care Manager, HMP Highpoint

Appendix D

Working Party Reference Group

(Attendees 25 January 2000)

*Nursing in Prisons
Report by the Working
Group considering the
development of prison
nursing, with particular
reference to health care
officers*

Liz Haggard	Chair
Lindsay Bates	Prison Health Policy Unit
Paul Beard	Director of Nursing, Broadmoor Hospital
Nola Ishmael	NHS Executive
Steve Gannon	HMP Bedford
Mick Packman	HMP Rochester
Nick Wall	Governor, HMP Bristol
Julie Bunn	HMP Whitemoor
Liz Walsh	HMP Wormwood Scrubs
Sharon Scoton	HMYOI/RC Glen Parva
Dr Mary Piper	Prison Health Policy Unit
Sally Newton	Chief Nurse, Northern Ireland Prison Service
Amanda Ambler	Training Services, HM Prison Service
Steve Stanley	Standards Audit, HM Prison Service
Les Storey	University of Central Lancashire
Peter Nottage	Health Care Manager, HMP Shrewsbury
Mary Crawford	College of Occupational Therapists
Dave Wells	HMP Channings Wood
Ian Lock	Principal Pharmacist, HMP Wormwood Scrubs
Gill Williams	Royal Pharmaceutical Society
Eileen Nielson	Royal Pharmaceutical Society
Terry Hobin	HMP Liverpool
Dr Roger Ralli	HMYOI/RC Glean Parva
Anne Norman	HMP Winchester
Richard Bradshaw	UKCC

*Nursing in Prisons
Report by the Working
Group considering the
development of prison
nursing, with particular
reference to health care
officers*

Working Party Reference Group

(Attendees 23 February 2000)

Liz Haggard	Chair
Lindsay Bates	Prison Health Policy Unit
Jim Noak	Broadmoor Hospital
Steve Gannon	HMP Bedford
Mick Packman	HMP Rochester
Amanda Ambler	Training Services, HM Prison Service
Les Storey	University of Central Lancashire
Peter Nottage	Health Care Manager, HMP Shrewsbury
Mary Crawford	College of Occupational Therapists
Dave Wells	HMP Channings Wood
Terry Hobin	HMP Liverpool
Anne Norman	HMP Winchester
Richard Bradshaw	UKCC
Eileen Nelson	Royal Pharmaceutical Society
Ian Reynolds	HMP Swansea
Jeremy Bore	HMP Exeter
Hamza Aumeer	English National Board
Jan Picken	HMP Belmarsh
Keith Dixon	HMP Wormwood Scrubbs

Appendix E

Nursing Staff Statistics

*Nursing in Prisons
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development of prison
nursing, with particular
reference to health care
officers*

Number of Nurses on the UKCC register

1992	633,119
1993	641,749
1994	638,361
1995	642,951
1996	645,011

Source: Nurses Work: An analysis of the UK Nursing Labour Market (Butane, Succumb and Smith, Assignee Publishing, Hampshire, 1998)

HM Prison Service Nursing Staff*

Nurse Qualified Staff

RGN	816	EN (G)	100
RMN	399	EN (M)	34
RNMH	31	EN (MH)	13
REGISTERED MIDWIVES	12		

Health Care Officers

Health Care Principal Officer	49
Health Care Senior Officers	161
Health Care Officers	543
Health Care Officers with Nurse Registration	288 (37.4%)

*(approximate 1998/1999 figures).

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nursing, with particular
reference to health care
officers*

Appendix F

Other Key Documents Used

Nursing in Secure Environments, UKCC 1999

Fitness for Practice, UKCC 1999

Making a Difference, Department of Health 1999

Nursing Policy, HM Prison Service 1992

The Future Organisation of Prison Health Care,

Department of Health 1999

