

NOMS National Offender
Management Service
Working together to reduce re-offending



DH Department
of Health

A large, abstract graphic consisting of flowing, wavy lines in various shades of blue, creating a sense of movement and depth. It occupies the upper half of the page.

2007/08
Prison Health
Performance Indicators
Guidance
Booklet

Purpose of this document

The aim of this booklet is to provide guidance for individuals and organisations completing the 2007 / 8 prison health performance indicators.

The indicators have been designed after a comprehensive programme of review and consultation and although **Non Mandatory**, have been identified as offering significant benefit to contributors, service users and service providers. A number of SHA's have indicated their intention to use these indicators as key information sources in reviewing prison and PCT performance.

Each indicator contains a rationale as to its inclusion, academic and policy references and a suggestion as

to what information may be collected to evidence the indicator. Much of the evidence specified also fulfils the requirements of other data collection processes (eg HCC, HMIP). It must be stressed that, apart from indicators requiring a numeric response, the supporting evidence in this document is suggested. Contributors are encouraged to specify additional or substitute evidence, which would, upon scrutiny fulfil the requirements of the indicator.

This booklet should be used alongside the 2007 prison indicator collection tool (excel sheet) and the process / timescale map.

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PART 1 – Performance Indicators

Area: - Safety

1.1 Patient Safety

Green Indicator

There is a formal system in place, which protects patients through identifying and learning from all patient safety incidents and other reportable incidents, AND improvements are made in practice based upon local and national experience and information derived from the analysis of such incidents.

Rationale

Healthcare Organisations protect patients through the use of systems that identify and learn from all patient safety incident and other reportable incidents. By seeking to identify the root cause and likelihood of repetition the potential to avoid incidents in the future and improve standards is increased. Such a system protects patients and staff.

Suggested Supporting Evidence

Evidence of collection and actioning of patient safety incidents, including deaths in custody reports. This would include samples of recent report forms, action notes and record of audit of action (including minutes of safety meetings). In addition there should be evidence of communication with the staff groups and evidence of practice or process change as a result indicating pre and post change arrangements.

Literature and Reference

- Building a safer NHS for Patients: implementing an organisation with a memory (DH 2001)
- Nice Guidelines: The interventional procedures programme (Health Service Circular 2003/011)
- The Health Act 2006 Code of Practice for the prevention and control of Health Care Associated Infections (DH 2006)
- PSO 3810 - Health and Safety Arrangements for consultation with staff (Guidance note 03/2006)
- PSO 3801 – Health and Safety Policy Statement
- PSO 1301 – Death in custody
- PSO 2710 – Death in custody
- PSI 36/1998 – Investigating a death in custody

Amber Indicator

There is a formal system in place, which protects patients through identifying all patient safety incidents and other reportable incidents; HOWEVER, there is no system to ensure that improvements are made in practice based upon local and national experience and information derived from the analysis of incidents.

Red Indicator

There is NO formal system in place, which protects patients through identifying and learning from all patient safety incidents and other reportable incidents.

PART 1 – Performance Indicators

Area: - Safety

1.2 Medicines Management

Green Indicator

Prisons Medicine Management, including sections on medicines handling/risk and in-possession practice forms a distinct element in the Local Delivery Plans and Infrastructure of the PCT.

Rationale

The indicator links the key recommendations in “A Pharmacy Service for Prisoners” June 2003¹. The remaining recommendations slot into place within one or more of these elements. The suggestions for evidence are based on the DH guidance + evidence included in a recent regional assessment on performance against the DH recommendations

Inclusion of Prison Medicines Management in PCT Local Delivery Plans forms the building block for an effective infrastructure for the commissioning, monitoring and delivery of medicines management services in prisons. Specifically mentioned in the DH document (recommendation 19) effective delivery of the PCT Plan is likely to be via a prison-focussed medicines management committee which is linked to the medicines management committees within the PCT.

Suggested Supporting Evidence

- Completion and regular review of an overall risk assessment/audit for medicines handling (prescribing and supply processes).
- A formal incident reporting mechanism from prisons into the PCT reporting systems that incorporates and encourages the reporting of medication-related incidents.
- Formal process for considering the risks and incidents identified resulting in changes to minimise these risks.
- Risks identified from the above should be included in the PCT Risk register.
- In-Possession Policy ratified by the PCT and Prison via Medicines Management Committee and Prison Health Partnership Board
- In-Possession Risk Assessment Tool in-use by the prison (usually at reception or at a specified time post-reception). The tool should be reviewed regularly at specified intervals and any incidents relating to the use of the tool (e.g. security or clinical) should be included in the incident reporting processes in Medicines Handling and Risk (above).
- Access to Over the Counter medicines via the items on the mandatory list developed by Prison Health November 2005

Literature and Reference

The DH guidance¹ forms the basis for the indicator. However, the principle of this guidance was to provide as far as possible, the medicines management services to prisoners that are available in the community and the wider NHS. This not only includes the services available in community pharmacies, but also those in health centres, GP practices, and hospitals where medicines are available.

Related Policy documents that are relevant to improving medicines management services in its broadest sense include:

- “Choosing Health through Pharmacy” DH April 2005
- “A Vision for Pharmacy in the New NHS” DH July 20003
- Implementation of NICE Guidelines and Technology Appraisals in prisons
- “Implementing the New Community Pharmacy Contract: Info for PCTs” DH April 2005 (Draft)
- “Quality and Outcomes Framework” DH (nGMS contract) updated January 2006: Clinical and medication-related outcomes should apply to prisoners.
- “A Self Care Challenge: A Strategy for Pharmacists in England” RPSGB March 2006
- “Clinical Management of Drug Dependence in the Adult Prison Setting” DH December 2006.
- Medicine Matters “A Guide to the mechanisms of the prescribing, supply and administration of medicines” DH July 2006
- “Building a Safer NHS for Patients: Improving medication safety” DH January 2004.
- “Medicines Management: A resource to support implementation of the wider aspects of medicines management for the National Service Frameworks for Diabetes, Renal Services and Long-Term Conditions” DH July 2004.

Amber Indicator

Prisons Medicine Management, including sections on medicines handling/risk and in-possession practice CURRENTLY DOES NOT form a distinct element in the Local Delivery Plans and Infrastructure of the PCT, but action is being taken to address this.

Red Indicator

Prisons Medicine Management, including sections on medicines handling/risk and in-possession practice CURRENTLY DOES NOT form a distinct element in the Local Delivery Plans and Infrastructure of the PCT, ACTION IS NOT BEING TAKEN to address this.

PART 1 – Performance Indicators

Area: - Clinical and Cost Effectiveness

1.3 Personal Development Plans

Green Indicator

Each staff member has an up to date personal development plan, which is reviewed on a regular basis, no less than every six months, this personal development plan contains specific reference to the training needs of the individual and the organisation.

Rationale

In order to continue to deliver high quality care, staff should be equipped with the appropriate skill set and knowledge for the roles they fulfil. The organisation will obtain optimum benefit from the staff resource if there is a tailoring of the knowledge and skills to the service purpose.

Suggested Supporting Evidence

On (or immediately after) the identified reference date, the designated audit person should access all staff records. Where staff are not directly employed by the organisation conducting the audit prior arrangements should be made with their employing authority and audit responsibility delegated to them. Evidence of a personal development plan should be sought, the plan, or a review note, should be dated at least six months prior to the reference date. There should be specific reference to the individuals training needs, which have direct relevance to the organisation.

Literature and Reference

- Personal Learning Plans- Doctors Working in Prisons,
- clinical appraisal for doctors employed in prisons – PSI 29/2003
- Clinical Supervision in Prison
- Nursing-getting started (DH.)
- Knowledge and Skills Framework
- Skills for Health (DH 2007) (http://www.dh.gov.uk/en/Policyandguidance/Humanresourcesandtraining/Modernisingworkforceplanninghome/CareGroupWorkforceTeams/DH_4064895)
- PSI 09/2003 Abolition of Mandatory Training
- Changing Workforce Programme (DH 2007) (http://www.modern.nhs.uk/scripts/default.asp?site_id=15)
- The HR in the NHS Plan: A Prison Health Workforce Perspective and Briefing (dh 2005)

The core and specific dimensions in the NHS Knowledge and Skills Framework are: -

Core Dimensions:

1. Communication
2. Personal and People Development
3. Health, Safety and Security
4. Service Improvement
5. Quality
6. Equality and Diversity

The following advice was developed by NHS staff at Staff Survey workshops, run by NHS Employers (<http://www.nhsemployers.org/practice/practice-1307.cfm>)

- Link the appraisal timetable to the organisations annual planning cycle and make sure the process is reviewed at board level
- Consider mandatory training for both parties involved in the appraisal process, with regular refresher training - this should include guidance on what is a 'well constructed' appraisal
- Spot check appraisal documents and audit personal development plans to ensure the agreed approach is being applied consistently
- If your trust's score is low, consider carrying out 'discovery interviews' with staff to get more information on the problems which can then be considered as part of the appraisal process
- Establish a directory of training opportunities mapped to the core areas of the Key Skills Framework, and ensure it is accessible to all staff to help inform appraisal discussions
- Limit the maximum number of staff that managers have to appraise - ideally a maximum of 12 staff for one manager, depending on the level
- Ensure that the appraisal is a continuous process through regular one-to-ones with direct reports

Amber Indicator

Each staff member has an up to date personal development plan which is reviewed on a regular basis, no less than every six months, this personal development plan DOES NOT contain specific reference to the training needs of the individual and the organisation.

Red Indicator

Each staff member DOES NOT have an up to date personal development plan.

PART 1 – Performance Indicators

Area: - Clinical and Cost Effectiveness

1.4 Chronic Disease and Long Term conditions care

Green Indicator

PCT commissioned services in Prison (including commissioned social care services) are working towards the delivery of chronic disease care being at the same standard of process and outcomes as is required by the National Service Frameworks for: Diabetes, CHD and Long Term Conditions, Mental Health etc, a formal approach has been developed and is being implemented.

Rationale

Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes. NICE technology assessments and the National Service Frameworks provide a good practice base from which deliver equivalence of service for all NHS users, including prisoners. This indicators seeks to assure commissioners of services that work is in progress to ensure that services delivered within prisons are at an equal standard to those delivered within the wider community.

Suggested Supporting Evidence

On, or soon after the reference date the audit individual should be able to access a formal action plan (document) outlining the activities, resources and timescales necessary to deliver chronic disease care to the standards required by the National Service Frameworks. This plan may be a generic PCT document, or a part of the wider PCT delivery plan, but it should contain distinct reference to the health care of offenders.

Evidence of implementation may include: minutes of implementation meetings, evidence of task completion, evidence of plan review and reformulation.

Literature and Reference

- NSFs on Diabetes, CHD & Long Term Conditions,
- NICE guidelines on COPD, Chronic Heart Failure, Epilepsy, Dyspepsia, Hypertension, Types 1 & 2 Diabetes, MS, Mgt. Of post MI in primary care, TB and Parkinsons Disease.
- Quality and Outcomes Framework - Guidance -(Aug 04)
- Standards for better health D2

Amber Indicator

PCT commissioned services in Prison (including commissioned social care services) are working towards the delivery of chronic disease care being at the same standard of process and outcomes as is required by the National Service Frameworks for: Diabetes, CHD and Long Term Conditions, Mental Health etc,, a formal approach has been developed BUT HAS YET TO BE implemented.

Red Indicator

PCT commissioned services in Prison (including commissioned social care services) are working towards the delivery of chronic disease care being at the same standard of process and outcomes as is required by the National Service Frameworks for: Diabetes, CHD and Long Term Conditions, Mental Health etc, NO formal approach has been developed.

PART 1 – Performance Indicators

Area: - Clinical and Cost Effectiveness

1.5 Continuity of Case Management (Including prisoner transfers)

Green Indicator

In the previous year where there have been incidents of patient complaint or formal investigation of which the findings identify a continuity of care failure, an action plan has been developed and remedial action taken to prevent reoccurrence.

Rationale

Patients in prison often have many complex and varied health and social care needs requiring a co-ordinated approach to support from a number of disparate agencies. A large number of individual agencies may be involved with a patient at any one time. The regularity of patient movement across the prison estate and the necessary security restrictions placed upon certain individuals means that at times, continuity of treatment or assessment programmes is disrupted. This indicator aims to illustrate this disruption and evidence that action is being taken to reduce both the incidence and impact.

Suggested Supporting Evidence

For the first data collection period, only incidents within the previous three months are collected (and thereafter the previous year). The organisation should evidence that all patient complaints have been reviewed and incidents whereby a disruption to a treatment plan or assessment has been recorded have a written action plan associated. This may be in the form of a formal report, correspondence with the patient or minutes of meetings. In addition, where recommendations have been made in these documents, or an undertaking of action has been specified, evidence should be produced to show that this has taken place.

Literature and Reference

- PSO 3050-Continuity of Healthcare for Prisoners,
- PSO 6200-Transfers,
- PSO 6400-Discharges
- PSO 2710 – Follow up to death in custody
- Promoting Continuity of Care for People with Severe Mental Illness whose needs span primary, secondary and social care - Department of Health Research findings register (ReFeR)
- Maternity Matters: Choice, access and continuity of care in a safe service (DH 2007)
- Prisoners' access to PALS (Patient Advice and Liaison Services) and ICAS (Independent Complaints Advocacy Service) (DH 2005)
- PSI 14/2005 Handling complaints about prison healthcare

Amber Indicator

In the previous year where there have been incidents of patient complaint or formal investigation of which the findings identify a continuity of care failure, an action plan has been developed BUT NO remedial action HAS BEEN taken to prevent reoccurrence.

Red Indicator

In the previous year where there have been incidents of patient complaint or formal investigation of which the findings identify a continuity of care failure, an action plan has NOT been developed AND NO remedial action HAS BEEN taken to prevent reoccurrence.

PART 1 – Performance Indicators

Area: - Clinical and Cost Effectiveness

1.6a Discharge Planning

Green Indicator

Health and social care arrangements post discharge form a distinct part of a wider discharge and resettlement plan focussing upon the wider support needs of the offender including health care input to dedicated plans such as final (prior to discharge) ACCT case reviews.

Rationale

A key element of reducing re offending is the effective co-ordination and continuity of services upon discharge from prison. The most effective discharge planning addresses the 7 pathways to reduce re offending, these are: Accommodation, education, health, drugs, finance, children and families and finally, attitudes thinking and behaviour. This indicator addresses the contribution that health and social care arrangements make in the wider plan.

Suggested Supporting Evidence

For the three months prior to the reference date, a sample of at least 30 per cent of discharge plans (or transfer plans in cases where establishments do not discharge into the community) should be reviewed to evidence they contain reference to health and social care arrangements. Where no specific arrangements are identified, a discharge plan from health care should be sought.

Literature and Reference

- Social Exclusion Unit Report 2002 - Reducing re-offending by ex-prisoners,
- PSO 2300 – resettlement
- PSO 6400 – discharge
- Managing Variation in Patient Discharge – NHS Institute for innovation and improvement (<http://www.nodelaysachiever.nhs.uk/CaseStudies/CaseStudyItems/CSJB08Managing+variation+in+patient+discharge.htm>)
- End-to-end offender management – NOMS (<http://noms.homeoffice.gov.uk/managing-offenders/end-to-end/>)
- Standards for better Health , Fifth Domain, D11

Amber Indicator

Health and social care arrangements post discharge ARE INCLUDED IN SEPARATE discharge and resettlement plans focussing upon the wider support needs of the offender including health care input to dedicated plans such as final (prior to discharge) ACCT case reviews.

Red Indicator

Health and social care arrangements post discharge ARE NOT INCLUDED IN ANY discharge and resettlement plans focussing upon the wider support needs of the offender including health care input to dedicated plans such as final (prior to discharge) ACCT case reviews.

PART 1 – Performance Indicators

Area: - Clinical and Cost Effectiveness

1.6b Discharge Planning – Chronic Disease Management - Collected Quarterly

Green Indicator

All prisoners suffering from chronic diseases receive a discharge plan and primary care advice that contains direct reference to their condition.

Rationale

A key element of reducing re offending is the effective co-ordination and continuity of services upon discharge from prison. The most effective discharge planning addresses the 7 pathways to reduce re offending, these are: Accommodation, education, health, drugs, finance, children and families and finally, attitudes thinking and behaviour. The National Offender Management Service has a requirement to collect information specifically relating to those individuals suffering from chronic diseases.

Suggested Supporting Evidence

For the three months prior to the reference date, the records of all patients suffering from Chronic Diseases (defined as diseases which have one or more of the following characteristics: they are permanent, leave residual disability, are caused by nonreversible pathological alteration, require special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation, or care) who have been discharged are to be checked for the presence of a discharge plan and evidence that they have had primary care advice.

Literature and Reference

- Social Exclusion Unit Report 2002 - Reducing re-offending by ex-prisoners,
- PSO 2300 – resettlement
- PSO 6400 – discharge
- Managing Variation in Patient Discharge – NHS Institute for innovation and improvement (<http://www.nodelaysachiever.nhs.uk/CaseStudies/CaseStudyItems/CSJB08Managing+variation+in+patient+discharge.htm>)
- End-to-end offender management – NOMS (<http://noms.homeoffice.gov.uk/managing-offenders/end-to-end/>)
- Standards for better Health , Fifth Domain, D11

Amber Indicator

75% of prisoners suffering from chronic diseases receive a discharge plan and primary care advice that contains direct reference to their condition

Red Indicator

Less than 75% of prisoners suffering from chronic diseases receive a discharge plan and primary care advice that contains direct reference to their condition

PART 1 – Performance Indicators

Area: - Governance

1.7 Clinical Governance

Green Indicator

There are joint (between the prison and the PCT) clinical governance arrangements in place, which facilitate continuous service improvement by analysis of, key information sources such as: critical incidents, complaints, best practice and clinical audit, audit of Death in Custody and HMIP Action plans. There is evidence of communication of these improvements across the organisation.

Rationale

Clinical governance may be defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Clinical governance concerns both clinical and non-clinical staff, and acknowledges everyone's contribution to the patient's experience. Good integrated governance, for example, combines and creates consensus around the concerns of clinical staff, security staff and managers. Key to effective governance is the availability of information sources on which to base decisions. It is assumed throughout this indicator that the PCT will have clinical governance arrangements. This indicator measures the availability of reference material to support the clinical governance process.

Suggested Supporting Evidence

The clinical governance arrangements and policies should identify reference materials. With reference to these arrangements auditors should identify the access routes to the information and the ease in which it may be accessed. Readily available means that information is at hand and up to date. Should a protracted search (whether electronically or through admin processes) then this should be deemed not readily available. If the identified sources cannot be found, they should be marked as 'do not exist'.

Literature and Reference

- PSO 3100 Clinical Governance,
- PSO 7035 Research Ethics Panel
- NHS Clinical Governance Support Team - <http://www.cgsupport.nhs.uk/>
- Clinical Governance Responsibilities and Lead Roles in Primary Care Trusts: (NHS _ Aug 2006)
- Integrated Governance Handbook – 2006 (DH)
- PSO 1301 – Death in custody
- PSO 2710 – Death in custody
- PSI 36/1998 – Investigating a death in custody

Amber Indicator

There are joint (with the PCT) clinical governance arrangements in place, which facilitate continuous service improvement by analysis of, key information sources such as: critical incidents, complaints, best practice and clinical audit, audit of Death in Custody and HMIP Action plans. **HOWEVER ALL KEY INFORMATION SOURCES ARE NOT READILY AVAILABLE.** There is evidence of communication of these improvements across the organisation.

Red Indicator

There are joint (with the PCT) clinical governance arrangements in place, which facilitate continuous service improvement by analysis of, key information sources such as: critical incidents, complaints, best practice and clinical audit, audit of Death in Custody and HMIP Action plans. **HOWEVER ALL KEY INFORMATION SOURCES DO NOT EXIST.** There is evidence of communication of these improvements across the organisation.

PART 1 – Performance Indicators

Area: - Governance

1.8 Corporate Governance

Green Indicator

Partnership arrangements are sufficiently robust to ensure joint decision making, effective management of resources, effective information sharing, audit and service development. The arrangements ensure compliance with the joint aims and objectives of the parties.

Rationale

Since April 2006 full devolution of commissioning responsibility for healthcare to those Primary Care Trusts which host prisons been in operation . These PCTs are expected to work closely with their prisons to discharge this commissioning responsibility in a way that meets both the health and custodial needs of prisoners. There is a responsibility for the PCT and the Prison to have in place formal arrangements to ensure that service provision fulfills all the tenants of good governance. The national partnership arrangement states that "Prison/ PCT partnerships will be expected to target investment and improvement on priorities identified in local Health Needs Assessments and local planning processes". Other providers of services may be included in this partnership, eg the local Mental Health Service Provider. This indicator measures the robustness of these partnerships.

Suggested Supporting Evidence

Written partnership agreements which demonstrate transparency of all relevant financial, performance and strategic planning information and documentation between the parties. Evidence of regular partnership meetings and correspondence, with the majority of all partner members.

Literature and Reference

- National partnership agreement on the transfer of responsibility for prison health from the Home Office to the Department of Health _ (DH 2003)
- National partnership agreement between the Department of Health and the Home Office for the accountability and commissioning of health services for prisoners in public sector prisons in England (DH – 2007)

Amber Indicator

Partnership arrangements are sufficiently robust to ensure joint decision making, effective management of resources, effective information sharing, audit and service development. HOWEVER full engagement of all parties has not been achieved.

Red Indicator

Partnership arrangements are insufficient and do not adequately support joint decision-making, effective management of resources, effective information sharing, audit and service development.

PART 1 – Performance Indicators

Area: - Governance

1.9 Information Governance

Green Indicator

Health care units have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required, AND policies relating to effective information sharing, AND systems are in place to ensure that appropriate consent is obtained from prisoners in relation to the use of their confidential information, AND staff receive regular training in the appropriate management of patient information.

Rationale

The effective management of records and information is a fundamental component of safe, secure and effective health care delivery. In recent years, the majority of negative service audit reports and critical incident feedback relates to poor information governance. The transfer of responsibility to PCT's has provided the opportunity for health care units to address many of their information governance shortfalls. Human rights, data protection and mental capacity legislation set the foundations of how information governance is to be managed.

Suggested Supporting Evidence

The following documents should be accessible:

- Health records policy
- Information sharing policy (amended for local use)
- Patient information consent form
- Patient Information consent policy

An individual should be assigned responsibility for records management and a random selection of staff training records should demonstrate training in the management of confidential information.

Literature and Reference

- Confidentiality: NHS Code of Practice (DH 2003)
- Data Protection Act 1998
- Freedom of Information Act 2000
- Mental Capacity Act 2005
- The protection and use of confidential health information in prisons and inter-agency information sharing – PSI 25/2002

- PSO 9010-IT security,
- PSOs 9020 & 9020a,
- PSO 2520 Prison and Probation Ombudsman
- Standards for better health, C9, C13
- Safe and Secure (www.ohcsportal.co.uk)
- DH Information Governance Toolkit (<https://www.igt.connectingforhealth.nhs.uk/>)
- DH Knowledge Base (<https://www.igt.connectingforhealth.nhs.uk/KnowledgeBaseList.aspx?tk=2550471799&Inv=5&cb=16%3a16%3a16>)
- Good practice in consent: achieving the NHS plan commitment to patient centred consent practice (HSC 2001/023)
- Seeking Consent: Working with People in Prison (DH 2002) (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008751)
- PSI 38/2002 – Guidelines to consent to medical treatment

Amber Indicator

Health care units have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required, AND policies relating to effective information sharing, THERE ARE NO systems are in place to ensure that appropriate consent is obtained from prisoners in relation to the use of their confidential information, AND staff DO NOT receive regular training in the appropriate management of patient information.

Red Indicator

Health care units have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required, THERE ARE NO policies relating to effective information sharing, AND NO systems are in place to ensure that appropriate consent is obtained from prisoners in relation to the use of their confidential information, AND staff DO NOT receive regular training in the appropriate management of patient information.

PART 1 – Performance Indicators

Area: - Governance

1.10 Work Force

Green Indicator

A Joint Workforce Plan is in place, which is coherent with the Local Strategic Service Plan and the Joint Delivery Plans of the Prison Health Partnership Board. This plan is based upon up to date demand assessment, review of recruitment and retention, current workforce reviews. and includes optimising opportunities for joint training across organisational boundaries.

Rationale

As the staff groups delivering health care to prisoners come from a variety of organisations and professional backgrounds a joint approach to planning and training various aspects of this resource is recommended. Recruitment and retention have often been problematic within prison health. Modernising the way staff work and the roles they undertake will help to achieve optimum workforce capability.

Suggested Supporting Evidence

A current, written joint workforce plan is available, or the workforce plan forms a distinct part of a wider multi agency strategic document. Specific mention within the plan should be made of how the partners aim to maximise joint training opportunities.

Literature and Reference

- Mental Health services - Workforce Design (NHS pub.),
- Healthcare staff skills toolkit (prison health pub.)
- Modernising workforce planning (DH) (<http://www.dh.gov.uk/en/Policyandguidance/Humanresourcesandtraining/Modernisingworkforceplanninghome/index.htm>)
- A workforce response to local delivery plans: A challenge for NHS Boards (DH 2005)
- Changing Workforce Programme (http://www.modern.nhs.uk/scripts/default.asp?site_id=15)
- Workforce Planning FAQ (DH 2007) (http://www.dh.gov.uk/en/Policyandguidance/Humanresourcesandtraining/Modernisingworkforceplanninghome/CareGroupWorkforceTeams/DH_4053852)
- Workforce Improvement Themes (NHS Modernisation agency - 2007) (<http://www.wise.nhs.uk/cmsWISE/Workforce+Themes/Into.htm>)

Amber Indicator

A Joint Workforce Plan is in place, which is coherent with the Local Strategic Service Plan and the Joint Delivery Plans of the Prison Health Partnership Board. This plan is based upon up to date demand assessment, review of recruitment and retention, current workforce reviews but DOES NOT include optimising opportunities for joint training across organisational boundaries.

Red Indicator

A Joint Workforce Plan is NOT in place.

PART 1 – Performance Indicators

Area: - Accessible and Responsive Care

1.11 Supporting Diversity

Green Indicator

The planning and delivery of health care within the prison, makes direct reference to the needs of the diverse prison population, with specific reference to ethnicity, learning disability, gender, age, sexuality, physical disability, diet, consent to treatment, religious requirements, language and dignity. Health Care Staff receive additional training and awareness of the requirements of BME prisoners and people with disabilities.

Rationale

In order to provide a service which is both equitable and sensitive to individuals requirements reference to the diversity of the population served by health care providers within prisons needs to be made. Not only do services need to be planned to take account of an individuals requirements, but to provide a high standard of personalised care and service, staff need to have an understanding of the distinct needs, preferences and choices of the populations they serve.

“The NHS of the 21st century must be responsive to the needs of different groups and individuals within society, and challenge discrimination on the grounds of age, gender, ethnicity, religion, disability and sexuality. The NHS will treat patients as individuals, with respect for their dignity. Patients and citizens will have a greater say in the NHS, and the provision of services will be centred on patients’ needs.’

Extract from the NHS Plan

Suggested Supporting Evidence

There is available baseline evidence to illustrate the diversity of the local prison population. Plans for service development have separate sections relating to how the initiative will address the requirements of the diverse population. The range of literature available to patients is accessible in formats appropriate to the population. The design of the facilities allows access to people with physical disabilities or there are plans in place to provide people with physical disabilities access to health care facilities appropriate to their needs. Staff records contain reference to recent (within the last 18 months) diversity training.

Literature and Reference

- Improving Mental Health services for BME communities in England (NHS pub.)
- PSO 4630 Immigration & Foreign Nationals.
- PSO 2800. Disability Discrimination Act (1995)
- Disability Discrimination Act 2005
- Standards for Better Health – Fourth Domain – Patient Focus
- Race relations Act 1976
- Human Rights Act 1998
- Sex Discrimination Act 1975
- PSI 14/1999 Prisoners with Disability, Management
- Implementing race equality in prisons, a shared agenda for change (HMPS CRE 2003)
- The NHS Plan (DH 2000)
- Mental Health and Social Exclusion (ODPM 2004)
- Breaking the cycle of social exclusion
- Disability Strategy (HMPS 2004) http://www.hmprisonerservice.gov.uk/assets/documents/10000510Disability_Strategy_Document.doc

Amber Indicator

The planning and delivery of health care within the prison, DOES NOT OVERTLY makes direct reference to the needs of the diverse prison population, with specific reference to ethnicity, learning disability, age, gender, sexuality, physical disability, diet, consent to treatment, religious requirements, language and dignity. Health Care Staff receive additional training and awareness of the requirements of BME prisoners and people with disabilities. There is evidence that arrangements are in place to address this.

Red Indicator

The planning and delivery of health care within the prison, DOES NOT OVERTLY makes direct reference to the needs of the diverse prison population, with specific reference to ethnicity, learning disability, age, gender, sexuality, physical disability, diet, consent to treatment, religious requirements, language and dignity. Health Care Staff receive additional training and awareness of the requirements of BME prisoners and people with disabilities. There are no plans to address this.

PART 1 – Performance Indicators

Area: - Accessible and Responsive Care

1.12 Service User Involvement

Green Indicator

The views of service users, their carers (including prison staff) and others are sought and taken into account in designing, planning, delivering and improving health care services. Formal procedures are in place to ensure involvement and such involvement is documented accordingly.

Rationale

Section 11 of the Health and Social Care Act 2001 places a duty on NHS trusts, Primary Care Trusts and Strategic Health Authorities - to make arrangements to involve and consult patients and the public in service planning and operation, and in the development of proposals for changes.

This is a statutory duty, which means consulting and involving:

- not just when a major change is proposed, but in ongoing service planning
- not just in the consideration of a proposal, but in the development of that proposal; and
- in decisions about general service delivery, not just major changes.

Patients feel involved in their care when they are treated as equal partners, listened to and properly informed. Privacy and time for discussion are both required to achieve this. Benefits include greater confidence, reduction in anxiety, greater understanding of personal needs, improved trust, better relationships with professionals and positive health effects. (Health in Partnership programme)

Suggested Supporting Evidence

Patient user groups exist within the health care unit. There is evidence of formal patient feedback procedures (feedback or treatment evaluation forms). Multi disciplinary service improvement groups exist.

Literature and Reference

- PSO 2510 -Prisoner request and complaints procedures,
- Access to PALS and ICAS for prisoners (DH 2005, letter gateway 5557.).
- Standards for better health - C17 – 5th Domain
- Strengthening Accountability, patient and public involvement in policy guidance – Section 11 of the Health and Social Care Act 2001(DH 003)
- Building on the best: Choice , responsiveness and equity in the NHS (DH 2003)
- Getting over the wall – How the NHS is improving patient experience (DH 2004)

Amber Indicator

The views of service users, their carers (including prison staff) and others are sought and taken into account in designing, planning, delivering and improving health care services. THERE ARE NO formal procedures in place to ensure involvement and such involvement is documented accordingly. Arrangements are in place to address this.

Red Indicator

The views of service users, their carers (including prison staff) and others are sought and taken into account in designing, planning, delivering and improving health care services. THERE ARE NO formal procedures in place to ensure involvement, such involvement is documented accordingly, AND NO arrangements are in place to address this.

PART 1 – Performance Indicators

Area: - Accessible and Responsive Care

1.13 Health Needs Assessment

Green Indicator

A baseline Health and Social Care Needs Assessment has been completed. There is evidence that this has been reviewed and amended within the last 12 months, as appropriate to the establishment. It DOES include all the following: information relating to the incidence of chronic illnesses, severe and enduring mental illness, outcomes of screening programme, prisoner demographic profile, health service activity in prison and referrals to NHS. It ALSO contains agreed annual health priorities, which are published in the local prison health delivery plan and signed off by the prison governor and the chief executive of the local PCT.

Rationale

Prisoners present diverse health problems. When they seek formal health care, the prison health care service is normally their first point of contact. Demand for health care often appears to outstrip the capacity of services. The Health Care Needs Assessment deals with this problem by differentiating between needs and demands for health care services. The aims of a health care needs assessment are to gather information to plan, negotiate, change services for the better, to improve health in other ways, and to build a picture of current services, i.e. a baseline. (University of Birmingham 2000)

This indicator aims to ensure that Health Needs Assessments are kept up to date and with the rapidly changing prison population, are as relevant and contemporary as possible. The indicator also stresses the collaborative role all partners have in ensuring that the assessment takes into account the wide range of services

Suggested Supporting Evidence

A baseline Health Needs Assessment document, containing sections relating to incidence of chronic illness, severe and enduring mental illness, outcomes of screening programmes, prisoner demographic profile, health service activity in prison and referrals to NHS. Dated iterations of the document, identifying which sections have been amended within the last 12 months. Reference within the document to the local prison health delivery plan, priorities and evidence of sign off from the Governor and the CEO of the local PCT.

Literature and Reference

- Guidance - Healthcare in Prisons- a health care needs assessment, (University of Birmingham 2000)
- Guidance on developing prison health needs assessments and health improvement plans,
- (1) Toolkit for health care needs assessments in prison (University of Birmingham 2000)
- Standards for better health.

Amber indicator

A baseline Health and Social Care Needs Assessment has been completed. There is evidence that this has been reviewed and amended within the last 12 months, as appropriate to the establishment. It DOES NOT include all the following: information relating to the incidence of chronic illnesses, outcomes of screening programme, severe and enduring mental illness, prisoner demographic profile, health service activity in prison and referrals to NHS. OR IT DOES NOT contain agreed annual health priorities which are published in the local prison health delivery plan and signed off by the prison governor and the chief executive of the local/ PCT.

Red indicator

A baseline Health and Social Care Needs Assessment has been completed. There is evidence that this has been reviewed and amended within the last 12 months, as appropriate to the establishment. It DOES NOT include all the following: information relating to the incidence of chronic illnesses, outcomes of screening programme, severe and enduring mental illness, prisoner demographic profile, health service activity in prison and referrals to NHS. AND IT DOES NOT also contain agreed annual health priorities which are published in the local prison health delivery plan and signed off by the prison governor and the chief executive of the local/ PCT.

PART 1 – Performance Indicators

Area: - Accessible and Responsive Care

1.14 Comprehensive Range of Services - Collected Quarterly

Green Indicator

The complete range and capacity of services, which have been identified as necessary within the Health Needs assessment and through service user involvement, are provided to the prisoner population.

Rationale

The aims of a health care needs assessment are to gather information to plan, negotiate, change services for the better. This indicator requires evidence that, once needs are identified then services are provided to address those needs. This indicator also illustrates that a degree of planning has gone into the provision or facilitation of access to the service.

Suggested Supporting Evidence

A comprehensive health needs assessment exists which identifies required access to services to meet needs of the population. Service availability is then measured against this requirement. The service may not be provided by the health care unit, but the health care unit or prison will facilitate the patient accessing that service.

Literature and Reference

- PSO 3550-Clinical Services for substance misusers
- NICE guidance on pre-operative tests, dental recall, skin disorders and wounds and head injuries,
- Developing & Modernising Primary Care in Prisons (DH 2002.),
- Strategy for modernising dental services in Prisons in England (DH.)
- A Pharmacy service for prisoners (prison health pub.)
- Prison Health Services, an introduction for managers: (NLH 2006)
- Changing the outlook, - a strategy for modernising mental health services in prison (DH 2001)
- Guidance on developing local prison health delivery plans (DH 2003)

Amber Indicator

A LIMITED range and capacity of services, which have been identified as necessary within the Health Needs assessment and through service user involvement, are provided to the prisoner population.

Red Indicator

The range and quantity of services provided by the establishment ARE DETERMINED LOCALLY with NO DIRECT REFERENCE to the Health Needs Assessment.

PART 1 – Performance Indicators

Area: - Accessible and Responsive Care

1.15 Access and Waiting Times – Collected Quarterly

Green Indicator

Access and waiting times for outpatient first appointment following written referrals of prisoners are equivalent to those experienced by the local population and fall within the specified targets within the NHS, Specifically 13 weeks for General Outpatients appointments, 2 weeks for urgent cancer appointments

Rationale

Standards for better health core standard 18 states that 'healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably. Prisoners are members of the population and as such are entitled to the same level of service access to the general population. Difficulties do arise due to the significant amount of movement around the estate prisoners are often subject to. Such movement should not have a detrimental effect upon their access to services and subsequent waiting times.

Suggested Supporting Evidence

Evidence that waiting times for first appointment are within the 13 week and 2 week targets. Waiting times should be cross referenced against the published waiting times. Where waiting times fall outside of the 13 weeks and 2 week targets evidence of a written plan to address this breach should be in place..

Literature and Reference

- Standards for Better Health , 5th domain, C18
- Waiting times for cancer: progress, lessons learned and next steps (DH 2006)
- Achieving the two-week standard. Questions and answers how to help you with issues arising from the two-week wait standard (DH 2002)
- England Summary: Outpatient first appointment data: (<http://www.performance.doh.gov.uk/waitingtimes/index.htm>)

Amber Indicator

Where access and waiting times for outpatient first appointment following written referrals of prisoners fall outside the specified targets within the NHS, Specifically 13 weeks for General Outpatients appointments and 2 weeks for urgent cancer appointments, a plan is in place with the local PCT to address this shortfall.

Red Indicator

Where access and waiting times for outpatient first appointment following written referrals of prisoners falls outside the specified targets within the NHS, Specifically 13 weeks for General Outpatients appointments and 2 weeks for urgent cancer appointments, no specific plan is in place with the local PCT to address this shortfall.

PART 1 – Performance Indicators

Area: - Accessible and Responsive Care

1.16 Prison Dentistry

Green Indicator

Access times for Emergency Dental Treatment are at least equivalent to those experienced within the local population

Rationale

Individuals in prison, either on remand awaiting trial or in receipt of a custodial sentence, have been shown to have poorer health, including oral health, than the general population. Many prisoners enter prison with extensive and long-standing oral neglect. Substance misuse and smoking also pose a particular challenge to dental health. Methadone contributes to higher levels of tooth decay and gum disease and smoking is a risk factor in mouth cancer. Prisoners with substance misuse problems are likely to report toothache very soon after entering prison, as the pain is no longer inhibited by the analgesic properties of the drugs they had previously been taking.

Suggested Supporting Evidence

Numerator

In the three months prior to the reference date, the number of individuals assessed as requiring emergency dental treatment whose access to treatment falls outside of the 24 hour recommended time period, determined by the difference between the date of request and the date of treatment.

Denominator

In the three months prior to the reference date, the number of individuals assessed as requiring emergency dental treatment.

Literature and Reference

- Reforming prison dental services in England – a guide to good practice (OPM 2005)
- Strategy for modernising dental services for prisoners in England (DH 2003)
- Evaluation for the Impact of the National Strategy for Improving Prison Dental Services in England (PHRN 2006)

Amber Indicator

Access times for Emergency Dental Treatment are greater than those experienced within the local population and the Prison is actively working with the PCT to improve those times.

Red Indicator

Access times for Emergency Dental Treatment are greater than those experienced within the local population and the Prison BUT THERE IS NO active plan to improve this access.

PART 1 – Performance Indicators

Area: - Accessible and Responsive Care

1.17a Substance Misuse Activities - IDTS fully funded establishments

Green Indicator

The prison provides a range of clinical and 28 day psycho- social interventions, which address the needs of prisoners who substance misuse. These include All of the following: 1. Opiate substitution programme ,2. First night prescribing for drug and alcohol problems (where applicable). ,3. opiate stabilisation programme, 4. Advice and information prior to discharge, 5. Pre discharge risk assessment.

Rationale

Drug treatment involves a range of interventions both clinical such as detoxification or substitute prescribing, and psychosocial, such as groupwork and face to face therapy. The Integrated Drug Treatment System seeks to bring together into one system the planning and delivery of all interventions so that they work together in the most effective and economic way, are experienced by the prisoner as one plan of treatment, and ensure uninterrupted continuity with community treatment at both the start and finish of custody. This approach has been shown to offer significant benefit for prisoners and the 5 areas highlighted in the indicator are integral components of this approach. Demarcating IDTS fully, partially and non funded establishments provides information as to the range of interventions offered to people who misuse substances.

Suggested Supporting Evidence

Number of range of interventions available to individuals who substance misuse.

Literature and Reference

- IDTS clinical and psychological intervention guidelines. (DH 2006)
- Integrated Drug Treatment System for Prisons (IDTS) Budget – 2006/07 (DH 2006)
- IDTS Frequently asked questions (NTA 2007) (http://www.nta.nhs.uk/areas/criminal_justice/docs/idts_faqs_april_07.doc)
- Models of Care for the treatment of drug misusers (NTA 2002)
- Types of treatment (NTA 2007) (http://www.nta.nhs.uk/about_treatment/Types_of_treatment.aspx)
- IDTS statement of readiness.
- PSO 3601-Mandatory Drug Testing,
- PSO 3605-mdt samples,
- PSO 3620-Voluntary Drug Testing,
- PSO 3550 Clinical Services for Substance Mis users,
- PSO 3625-testing of external drug workers,
- PSO 3630-CARATs
- PSI/2005 Drug Treatment and Self Harm

Amber Indicator

The prison provides a range of clinical and 28 day psycho- social interventions, which address the needs of prisoners who substance misuse. These include AT LEAST THREE of the following: 1. Opiate substitution programme ,2. First night prescribing for drug and alcohol problems (where applicable). ,3. opiate stabilisation programme, 4. Advice and information prior to discharge, 5. Pre discharge risk assessment.

Red Indicator

The prison provides a range of clinical and 28 day psycho- social interventions, which address the needs of prisoners who substance misuse. These include LESS THAN THREE of the following: 1. Opiate substitution programme, 2. First night prescribing for drug and alcohol problems (where applicable). , 3. opiate stabilisation programme, 4. Advice and information prior to discharge, 5. Pre discharge risk assessment.

PART 1 – Performance Indicators

Area: - Accessible and Responsive Care

1.17b Substance Misuse Activities – IDTS partially funded establishments

Green Indicator

The prison provides a range of clinical and psycho-social interventions, which address the needs of prisoners who substance misuse. These include All of the following: 1. Opiate substitution programme, 2. First night prescribing for drug and alcohol problems (where applicable), 3. opiate stabilisation programme, 4. Advice and information prior to discharge, 5. Pre discharge risk assessment.

Rationale

Drug treatment involves a range of interventions both clinical such as detoxification or substitute prescribing, and psychosocial, such as groupwork and face to face therapy. The Integrated Drug Treatment System seeks to bring together into one system the planning and delivery of all interventions so that they work together in the most effective and economic way, are experienced by the prisoner as one plan of treatment, and ensure uninterrupted continuity with community treatment at both the start and finish of custody. This approach has been shown to offer significant benefit for prisoners and the 5 areas highlighted in the indicator are integral components of this approach. Demarcating IDTS fully, partially and non funded establishments provides information as to the range of interventions offered to people who misuse substances.

Suggested Supporting Evidence

Number of range of interventions available to individuals who substance misuse.

Literature and Reference

- IDTS clinical and psychological intervention guidelines. (DH 2006)
- Integrated Drug Treatment System for Prisons (IDTS) Budget – 2006/07 (DH 2006)
- IDTS Frequently asked questions (NTA 2007) (http://www.nta.nhs.uk/areas/criminal_justice/docs/idts_faqs_april_07.doc)
- Models of Care for the treatment of drug misusers (NTA 2002)
- Types of treatment (NTA 2007) (http://www.nta.nhs.uk/about_treatment/Types_of_treatment.aspx)
- IDTS statement of readiness.
- PSO 3601-Mandatory Drug Testing,
- PSO 3605-mdt samples,
- PSO 3620-Voluntary Drug Testing,
- PSO 3550 Clinical Services for Substance Mis users,
- PSO 3625-testing of external drug workers,
- PSO 3630-CARATs
- PSI/2005 Drug Treatment and Self Harm

Amber Indicator

The prison provides a range of clinical and psycho-social interventions, which address the needs of prisoners who substance misuse. These include AT LEAST THREE of the following: 1. Opiate substitution programme, 2. First night prescribing for drug and alcohol problems (where applicable), 3. opiate stabilisation programme, 4. Advice and information prior to discharge, 5. Pre discharge risk assessment.

Red Indicator

The prison provides a range of clinical and psycho-social interventions, which address the needs of prisoners who substance misuse. These include LESS THAN THREE of the following: 1. Opiate substitution programme, 2. First night prescribing for drug and alcohol problems (where applicable), 3. opiate stabilisation programme, 4. Advice and information prior to discharge, 5. Pre discharge risk assessment.

PART 1 – Performance Indicators

Area: - Accessible and Responsive Care

1.17c Substance Misuse Activities – Non IDTS funded establishments

Green Indicator

The prison provides a range of clinical and psycho-social interventions, which address the needs of prisoners who substance misuse. These include All of the following: 1. Opiate substitution programme, 2. First night prescribing for drug and alcohol problems (where applicable), 3. opiate stabilisation programme, 4. Advice and information prior to discharge, 5. Pre discharge risk assessment.

Rationale

Drug treatment involves a range of interventions both clinical such as detoxification or substitute prescribing, and psychosocial, such as groupwork and face to face therapy. The Integrated Drug Treatment System seeks to bring together into one system the planning and delivery of all interventions so that they work together in the most effective and economic way, are experienced by the prisoner as one plan of treatment, and ensure uninterrupted continuity with community treatment at both the start and finish of custody. This approach has been shown to offer significant benefit for prisoners and the 5 areas highlighted in the indicator are integral components of this approach. Demarcating IDTS fully, partially and non funded establishments provides information as to the range of interventions offered to people who misuse substances.

Suggested Supporting Evidence

Number of range of interventions available to individuals who substance misuse.

Literature and Reference

- IDTS clinical and psychological intervention guidelines. (DH 2006)
- Integrated Drug Treatment System for Prisons (IDTS) Budget – 2006/07 (DH 2006)
- IDTS Frequently asked questions (NTA 2007) (http://www.nta.nhs.uk/areas/criminal_justice/docs/idts_faqs_april_07.doc)
- Models of Care for the treatment of drug misusers (NTA 2002)
- Types of treatment (NTA 2007) (http://www.nta.nhs.uk/about_treatment/Types_of_treatment.aspx)
- IDTS statement of readiness.
- PSO 3601-Mandatory Drug Testing,
- PSO 3605-mdt samples,
- PSO 3620-Voluntary Drug Testing,
- PSO 3550 Clinical Services for Substance Mis users,
- PSO 3625-testing of external drug workers,
- PSO 3630-CARATs
- PSI/2005 Drug Treatment and Self Harm

Amber Indicator

The prison provides a range of clinical and psycho-social interventions, which address the needs of prisoners who substance misuse. These include AT LEAST THREE of the following: 1. Opiate substitution programme, 2. First night prescribing for drug and alcohol problems (where applicable), 3. opiate stabilisation programme, 4. Advice and information prior to discharge, 5. Pre discharge risk assessment.

Red Indicator

The prison provides a range of clinical and psycho-social interventions, which address the needs of prisoners who substance misuse. These include LESS THAN THREE of the following: 1. Opiate substitution programme, 2. First night prescribing for drug and alcohol problems (where applicable), 3. opiate stabilisation programme, 4. Advice and information prior to discharge, 5. Pre discharge risk assessment.

PART 1 – Performance Indicators

Area: - Accessible and Responsive Care

1.18 General Health Assessment

Green Indicator

Following First Reception, all prisoners are offered a General Health Assessment health screen and this has a 100% take up.

Rationale

Studies indicate that on entering the prison system, prisoners have complex health needs and their health status is generally poorer than a comparable non prisoner population. A large proportion (up to 50%) of prisoners are not registered with a General Practitioner or have not accessed one. The general health assessment screen offers an ideal opportunity to assess these individuals and provide treatment for previously untreated conditions. The screen also supports the placement of the individual within the establishment and provides information allowing effective planning and targeting of future services.

Suggested Supporting Evidence

Percentage of prisoners who take up the offer of general health assessment as a proportion of total receptions.

Numerator

Number of prisoners receiving general health assessment in the three months prior to the reference date.

Denominator

Number of first receptions into prison in the three months prior to the reference date

Data Source: LIDS,/NOMIS, Clinical recording

Literature and Reference

- PSO 2700 – suicide and self harm prevention
- Reception screening and mental health needs assessment in a male remand prison (Grubin et al 2003)
- ACCT Plan (Assessment, Care in Custody and Teamwork) 2007
- Healthcare Screening – Zahid Mubarek Investigation (<http://www.zahidmubarekinquiry.org.uk/article.asp?c=516&aid=3740>)

Amber Indicator

Following First Reception all prisoners are offered a General Health Assessment health screen and has a TAKE UP RATE OF BETWEEN 90 and 100%

Red indicator

Following First Reception all prisoners are offered a General Health Assessment health screen and has a take up rate of LESS THAN 90%

PART 1 – Performance Indicators

Area: - Accessible and Responsive Care

1.19 Secondary Health Screen – Prison Transfers

Green Indicator

All prisoners being transferred between establishments, have a health transfer screen completed on the day of reception.

Rationale

To aid continuity of care and reduce the number of health transfer errors (medication access, follow up appointments, medical record transfer), it is important that all prisoners transferred between establishments have a health transfer screen. The extent and complexity of this screen is driven by clinical need.

Suggested Supporting Evidence

Number of health transfer screens, taking place on the day of reception as a percentage of all transfers into the establishment.

Numerator

Number of health transfer screens for a three month period prior to the reference day, by individual day, delivered on the same day of reception.

Denominator

Number of receive transfers, by individual day, for the three month period prior to the reference date.

Data Source: LIDS / NOMiS, Clinical Recording

Literature and Reference

- PSI 8/2004 – transfer and allocation of life sentenced prisoners
- PSI 26/2006 – instructions for the transfer and allocation of life sentenced prisoners
- SO1H – Transfer of Prisoners
- PSO 2700 – suicide and self harm prevention
- Healthcare Screening – Zahid Mubarek Investigation (<http://www.zahidmubarekinquiry.org.uk/article.asp?c=516&aid=3740>)

Amber Indicator

90% of prisoners being transferred between establishments, have a health transfer screen completed on the day of reception.

Red Indicator

LESS THAN 90% of prisoners being transferred between establishments, have a health transfer screen completed on the day of reception.

PART 1 – Performance Indicators

Area: - Accessible and Responsive Care

1.20a Age Bounded Services (YOI Only)

Green Indicator

There are clear arrangements and support to facilitate young people through age bounded services.

Rationale

There is a marked distinction between the regimes of the juvenile and adult estate. Transfer between the estates due to a prisoners increase in age is often a difficult transition. Such a transition can lead to both emotional distress for prisoners and organisational complexity for the services. Where a patient is receiving treatment from external health and social care sources, there may also be an additional to transfer to adult services. A smooth emotional and organisational transition to the adult estate enables the prisoner to settle quickly, reduces stress and subsequent disruption and ensures continuity of care.

Suggested Supporting Evidence

A written policy relating to the transfer of prisoners should be available. There should be evidence of a transfer plan, indicating the range of agencies who should be contacted to ensure continuity. There should be evidence of contact with the receiving prison. There should be reference within the patient record of both discussions with the patient prior to transfer and contact with outside agencies currently providing support services. Evidence of case conferences prior to transfer would indicate collaboration with other agencies. Evidence of contact with families and carers.

Literature and Reference

- Every Child Matters, (HMSO 2003) (<http://www.everychildmatters.gov.uk/>)
- Youth Justice the next steps – companion to every child matters (Home Office 2003)
- National Service Framework for children, young people and maternity services (DH 2003)
- PSO 3050 – continuity of healthcare for prisoners
- PSO 4960 – Young people serving longer sentences for serious offences.
- Female Health Needs in Young Offender Institutions (B292) (YJB 2006) (<http://www.yjb.gov.uk/Publications/Scripts/prodView.asp?idproduct=322&eP=>)
- A Health Needs Assessment for Young Women in Young Offender Institutions (D83) (YJB 2006) (<http://www.yjb.gov.uk/Publications/Scripts/prodView.asp?idproduct=321&eP=>)
- Health, Education and Substance Misuse Services (Full Report) (D47) (YJB 2004)
- Key Elements of Effective Practice - Mental Health (B126) (YJB 2003) (<http://www.yjb.gov.uk/Publications/Scripts/prodView.asp?idproduct=138&eP=>)
- Key Elements of Effective Practice - Substance Misuse (B127) (YJB 2003)

Amber Indicator

There are clear arrangements and support to facilitate young people through age bounded services, BUT ACCESS TO THIS SUPPORT IS LIMITED

Red indicator

There are NO clear arrangements and support to facilitate young people through age bounded services.

PART 1 – Performance Indicators

Area: - Accessible and Responsive Care

1.20b Services for Older Adults (NOT YOI Estate)

Green Indicator

Planning and delivery of services to the prison population makes specific reference to the distinct requirements of the Older Adult Population, with direct reference to the National Service Framework for Older People.

Rationale

The NHS and Prison Service are working in partnership to ensure that prisoners have access to the same range and level of health services as the general public. At any point in time 700 people in prison are aged over 60. They have a wide range of health and social care needs, both while in prison and on release. Over 1,000 people aged over 60 leave prison every year. It is important that there is good liaison between prison healthcare staff and their colleagues in health and social care organisations in the community to ensure that prisoners who are being released are assessed for and receive services which meet their continuing health and social care needs.

Suggested Supporting Evidence

Health care delivery plans are consistent with the requirements of the National service framework and there should be evidence within the plans of reference to:

- rooting out age discrimination
- providing person-centred care
- promoting older people's health and independence
- fitting services around people's needs.

In addition, it should cover elements of care not addressed in other National Service frameworks such as:

- strokes
- falls, and
- mental health problems associated with older age

Literature and Reference

- National service framework for older people (DH 2001) (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066)
- Dignity in Care (DH 2006) (<http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Socialcare/Dignityincare/index.htm>)
- Securing better mental health for older adults (DH 2005) (http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Olderpeopleservices/Browsable/DH_4113714)
- Managing Older Prisoners at HMP Wymott (HMPS – Prison Service Journal) (<http://www.hmprisonservice.gov.uk/resourcecentre/prisonservicejournal/index.asp?id=3836,3124,11,3148,0,0>)
- PSI 21/2001 – National Service Framework for Older People

Amber Indicator

Planning and delivery of services to the prison population makes specific reference to the distinct requirements of the Older Adult Population, this is done in a less informal manner with no direct reference to the National Service Framework for Older People.

Red Indicator

Planning and delivery of services to the prison population DOES NOT make specific reference to the distinct requirements of the Older Adult Population.

PART 1 – Performance Indicators

Area: - Mental Health

1.21 Section 117

Green Indicator

All prisoners returning to prison from any other Mental Health facility following treatment under the Mental Health Act (including section 3, 47, 48) are accompanied by a 117 aftercare programme.

Rationale

Section 117 give the statutory authorities a duty to made arrangements for a person's continuing support and care. It applies to people who have been detained under Section 3, Section 37, Section 47, and Section 48. Aftercare should be planned with the patient, their family and carers, as well as professionals, looking at both health and social care needs. 117 ensures continuity of care. The type of aftercare required will depend on the circumstances of the individual and health. Section 117 gives a considerable discretion to health and local authorities as to the nature of the services that can be provided.

Suggested Supporting Evidence

Numerator

Number of patients in the previous three months prior to the reference date returning to prison following treatment under the mental health act with an active 117 care programme.

Denominator

Number of patients in the previous three months prior to the reference date returning to prison following treatment under the mental health act.

Literature and Reference

- Mental Health Act 1983
- Aftercare under section 117 of the Mental Health Act - Mind information (<http://www.mind.org.uk/Information/Legal/s117.htm#def>)
- Mental Health Act Code of Practice (HMSO 1999) (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4074961.pdf)
- PSI 03/2006 - transfer of prisoners to and from hospital under sections 47 and 48 of the Mental Health Act 1983
- Changing the outlook: a strategy for developing and modernising mental health services in prisons (DH 2001) (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009699)
- Offender mental health care pathway (DH 2005) (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4102231)

Amber Indicator

75% of all prisoners returning to prison from any other Mental Health facility following treatment under the Mental Health Act (including section 3, 47, 48) are accompanied by a 117 aftercare programme.

Red Indicator

Less than 75% of all prisoners returning to prison from any other Mental Health facility following treatment under the Mental Health Act (including section 3, 47, 48) are accompanied by a 117 aftercare programme.

PART 1 – Performance Indicators

Area: - Mental Health

1.22 Care Programme Approach – Collected Quarterly

Green Indicator

All service users with a Severe Mental Illness are subject to the CPA

Rationale

The function of the CPA and the role of the care co-ordinator are central to this. They are, or should be, the “glue” that holds it all together.

However, this has often not been the case, and sometimes the opposite occurs and the CPA is ‘suspended’ when something else happens – for example the person is admitted to hospital or to prison. This not only produces disjointed care, it also generates more paperwork and undermines the confidence of the service user in the system, and can cause distress and frustration when the same questions are asked repeatedly in different settings by different people.

Continuity of care is essential when the care setting changes, and is often identified as having been lacking when untoward incidents have occurred. The care co-ordinator has a key role in keeping the ‘story’ together across the care pathway, and the care plan should be the key reference document irrespective of where care is being delivered, added to and amended by the care co-ordinator as dictated by the care needs in each setting.

(Reviewing the CPA 2007)

Suggested Supporting Evidence

Numerator

Number of service users with a severe mental illness known to health care during the 3 months prior to the reference date with a CPA care plan.

Denominator

Number of service users with a severe mental illness known to health care during the 3 months prior to the reference date.

Literature and Reference

- Audit pack for monitoring CPA(DH 1996),
- Effective care co-ordination in mental health services: modernising the care programme approach - A policy booklet (DH 1999) (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009221)
- NSF for Mental Health, (DH 2000)
- Reviewing the Care Programme Approach 2006: A consultation document (DH 2006) (http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_063354)
- Changing the outlook: a strategy for developing and modernising mental health services in prisons (DH 2001) (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009699)
- Offender mental health care pathway (DH 2005) (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4102231)

Amber Indicator

75% of service users with a Severe Mental Illness are subject to the CPA

Red Indicator

LESS THAN 75% of service users with a Severe Mental Illness are subject to the CPA

PART 1 – Performance Indicators

Area: - Mental Health

1.23 Suicide and Self Harm

Green Indicator

All prisoners subject to ACCT who have had their referrals assessed by a qualified ACCT assessor and deemed to be requiring a health assessment or intervention are seen within 24 hours.

Rationale

ACCT is the replacement for the old F2052SH system and is designed to be more flexible. The plan encourages staff to work together to provide individual care to prisoners in distress, to help defuse a potentially suicidal crisis or to help individuals with long-term needs (such as those with a pattern of repetitive self-injury) to better manage and reduce their distress. Prisoners are fully involved in the ACCT process. They first have an interview with a trained Assessor, from which an individual Care Plan is drawn up. This indicator ensures that where a health assessment or intervention is identified within the care plan, this is expedited within an acceptable time period.

Suggested Supporting Evidence

Numerator

Number of ACCT referral group who have a record of being seen within 24 hours of the referral date / time identified within the ACCT documentation.

Denominator

Number of prisoners within a three month period who have been referred for health assessment or intervention as a direct result of ACCT assessment.

Literature and Reference

- Nice Guidelines on Self Harm (NICE 2004 / 031) (para 1.6.2)
- National Suicide Prevention Strategy for England (DH 2002), http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009474
- NSF for Mental Health (DH 1999) (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598)
- PSO 2700-Suicide & self-harm prevention,
- NICE guidance on depression and self-harm, (NICE 2004 / 050)
- The ACCT Approach

Amber Indicator

75% of prisoners subject to ACCT who have had their referrals assessed by a qualified ACCT assessor and deemed to be requiring a health assessment or intervention are seen within 24 hours.

Red Indicator

LESS THAN 75% of prisoners subject to ACCT who have had their referrals assessed by a qualified ACCT assessor and deemed to be requiring a health assessment or intervention are seen within 24 hours.

PART 1 – Performance Indicators

Area: - Mental Health

1.24 Access to specialist mental health services

Green Indicator

The prison has access, on a needs led basis, to all of the following specialist mental health services: Dual Diagnosis, Personality Disorder Services (adult prisons only), Women's Mental Health Service (Female Estate Only) Child and Adolescent Mental Health Services (YOI estate only), Early Intervention in Psychosis, Crisis Resolution Home Treatment, Learning Disability Services and Brief / Structured Psychotherapeutic Interventions.

Rationale

Surveys have shown that as many as 90% of prisoners have a diagnosable mental illness, substance abuse problem or, often, both. Among young offenders and juveniles that figure is even higher, 95%. It has also been shown that mental illness can contribute to re offending and problems of social exclusion. Every prison working with its local PCT should look critically at the mental health needs of its inmates, and consider how far existing provision meets those needs. This indicator identifies a range of specialist mental health services which, if all were to be accessible to the patient (dependent upon need) would contribute significantly to a person's recovery.

Suggested Supporting Evidence

The health care unit should be able to identify clear access and referral pathways for each of the indicated services appropriate to the client group they support.

Literature and Reference

- NSF for Mental Health, (DH 1999)
- PSO 2400-Democratic Therapeutic Communities,
- NICE guidance on Bipolar disorders, Eating Disorders, OCD, PTSD & Schizophrenia, (www.nice.org.uk)
- Personality disorder: no longer a diagnosis of exclusion - policy implementation guidance for the development of services for people with personality disorder (DH 2003)
- Mental Health Policy Implementation Guide (DH 2001.)
- Changing the outlook: a strategy for developing and modernising mental health services in prisons (DH 2001)
- Organising and Delivering Psychological Therapies (DH 2004)
- Treatment choice in psychological therapies and counselling: Evidence based clinical practice guideline (DH 2001)
- Womens Mental Health Strategy (DH 2004)

Amber Indicator

The prison has access, on a needs led basis, to at LEAST THREE of the following specialist mental health services: Dual Diagnosis, Personality Disorder Services (adult prisons only), Women's Mental Health Service (Female Estate Only) Child and Adolescent Mental Health Services (YOI estate only), Early Intervention in Psychosis, Crisis Resolution Home Treatment, Learning Disability Services and Brief / Structured Psychotherapeutic Interventions.

Red Indicator

The prison has access, on a needs led basis, to LESS THAN THREE of the following specialist mental health services: Dual Diagnosis, Personality Disorder Services (adult prisons only), Women's Mental Health Service (Female Estate Only) Child and Adolescent Mental Health Services (YOI estate only), Early Intervention in Psychosis., Crisis Resolution Home Treatment, Learning Disability Services and Brief / Structured Psychotherapeutic Interventions..

PART 1 – Performance Indicators

Area: - Mental Health

1.25 Primary Care Mental Health

Green Indicator

A primary Mental Health service triages referrals to Secondary Mental Health services and offers a full range of primary mental health psychotherapeutic interventions to all suitable service users in partnership with GP and primary healthcare, including access to Child and Adolescent Mental Health Services and Services to older adults were applicable.

Rationale

The assessment and delivery of appropriate and effective mental health care is a complex undertaking. There is ample evidence that individuals in custody are one of the most acute and challenging client groups for mental health practitioners. The ability of a service to direct clients to primary mental health practitioners provides significant opportunity for enhanced recovery and positive outcomes. The concept of equivalence of access to healthcare, is measured here with a particular emphasis on access to mental health care. This indicator also stresses the central role the GP plays in this access and provision and recognises the support necessary for primary care practitioners to provide a comprehensive service.

Suggested Supporting Evidence

A formal triage system should be evident, offering access to a full range of primary mental health psychotherapeutic interventions. There should be evidence of joint planning of service provision between GP's and primary healthcare services.

Literature and Reference

- Fast-forwarding primary care mental health (DH 2007) http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Mentalhealth/DH_4001917
- NSF for Mental Health (DH 1999) (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598)
- Health Promoting Prisons: A Shared Approach PSI 24/2002 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006230
- NICE guidance - Mental health and behavioural conditions <http://guidance.nice.org.uk/topic/behavioural>
- Mental Health Primary Care in Prison (WHO) <http://www.prisonmentalhealth.org/>
- Changing the outlook: a strategy for developing and modernising mental health services in prisons (DH 2001) (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009699)
- Offender mental health care pathway (DH 2005) (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4102231)
- Effective Practice INSET Tutor Pack: Mental Health (B151) (YJB) <http://www.yjb.gov.uk/Publications/Scripts/prodList.asp?idCategory=15&menu=item&eP=>
- Mental Health Needs and Provision (Full Report) (D69) (YJB) <http://www.yjb.gov.uk/Publications/Scripts/prodView.asp?idproduct=256&eP=>

Amber Indicator

A primary Mental Health service triages referrals to Secondary Mental Health services but CANNOT PROVIDE a full range of primary mental health psychotherapeutic interventions to all suitable service users in partnership with GP and primary healthcare, including access to Child and Adolescent Mental Health Services and Services to older adults were applicable.

Red Indicator

Primary Mental Health Care is provided ONLY by a General Practitioner

PART 1 – Performance Indicators

Area: - Public Health

1.26 Vaccination / Immunisation Policy

Green Indicator

As a matter of policy and practice all prisoners are offered vaccinations appropriate to their age and need, specifically covering: MMR, Meningitis, Hepatitis B, Hepatitis A, Tetanus, Tuberculosis and Pneumococcal vaccination

Rationale

According to the National Aids Trusts (NAT): Prisoners are some of the most vulnerable people in the UK to BBV infection. Why?

- Because there is evidence of higher rates of BBVs amongst those received into the prison system.
- Because the sharing of injecting equipment for drug use poses a very high risk of BBV transmission – a high proportion of injecting drug users (IDUs) will be incarcerated at some point, often more than once.
- Because there is some evidence that people who offend are at greater risk of BBV exposure due to heightened sexual risk taking. Because prisons are an environment where risk practices (sharing injecting equipment, unprotected sex and tattooing) may continue to take place.

In addition to this the prison environment itself offers an ideal opportunity for virus's, bacteria and other pathogens to spread by contact due to the often close proximity living conditions. There is evidence that up to 50% of first time receptions to prison are not registered to a GP and it is unlikely that they have had a full course of childhood vaccination and immunization. This indicator supports the development of formalized systems and policies covering a range of vaccinations and immunizations.

Suggested Supporting Evidence

Evidence of a written vaccination policy, evidence that the policy is adhered to (random sample of patient casenotes of receptions within the three months prior to the reference date).

Literature and Reference

- Immunisation against Infectious Disease (DH 1996) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4072984.pdf
- Infection Inside: The prison Infection diseases quarterly: http://www.hpa.org.uk/infections/topics_az/prisons/files/Infection_Inside_Vol3May_%202007.pdf
- Understanding the barriers to the uptake by prisoners of opportunities for testing for Hepatitis C viral infection: (Khaw et al Jan 2006, University of Newcastle) <http://www.ncl.ac.uk/lhs/assets/pdfs/>

[hcvprisonsreport2006.pdf](#)

- Reports and Publications – Prison Infection Prevention Team : http://www.hpa.org.uk/infections/topics_az/prisons/reports.htm
- www.immunisation.nhs.uk
- Tackling BBV's in Prison Framework: <http://www.nat.org.uk/document/255>
- Pneumococcal Vaccination : (HPA 2007) http://www.hpa.org.uk/infections/topics_az/pneumococcal/vaccine/vaccine.htm
- Clinical diagnosis and management of tuberculosis, and measures for its prevention and control : (NICE 2006) <http://www.nice.org.uk/CG033>
- Control and prevention of tuberculosis in the United Kingdom: Code of Practice 2000. Joint Tuberculosis Committee of the British Thoracic Society. Thorax 2000. Vol. 55,11: 887-901 <http://thorax.bmj.com/cgi/reprint/55/11/887>
- Hepatitis A (HPA 2007) http://www.hpa.org.uk/infections/topics_az/hepatitis_a/menu.htm
- Tetanus (NHS 2007) <http://www.immunisation.org.uk/article.php?id=191>
- Hepatitis B - General Information (HPA 2007) http://www.hpa.org.uk/infections/topics_az/hepatitis_b/gen_info.htm
- MMR the Facts: (NHS 2007) <http://www.mmrthefacts.nhs.uk/library/>
- Meningitis (HPA 2007) http://www.hpa.org.uk/infections/topics_az/meningo/menu3.htm
- Guidelines - Hepatitis C (HPA 2007) http://www.hpa.org.uk/infections/topics_az/hepatitis_c/guidelines.htm
- Shooting Up - Infections among injecting drug users in the United Kingdom 2005, An update: October 2006 (HPA 2006) http://www.hpa.org.uk/infections/topics_az/injectingdrugusers/shooting_up.htm

Amber Indicator

A policy IS UNDER DEVELOPMENT to ensure that all prisoners are offered vaccinations appropriate to their age and need, specifically covering: MMR, Meningitis, Hepatitis B, Hepatitis A, Tetanus, Tuberculosis and Pneumococcal vaccination

Red Indicator

NO policy exists NOR IS ONE UNDER DEVELOPMENT to ensure that all prisoners are offered vaccinations appropriate to their age and need, specifically covering: MMR, Meningitis, Hepatitis B, Hepatitis A, Tetanus, Tuberculosis and Pneumococcal vaccination.

PART 1 – Performance Indicators

Area: - Public Health

1.27 Vaccination

Green Indicator

All new receptions to prison where there is no verifiable evidence of previous vaccination are offered Hep B vaccine or where there is evidence of a started course it is continued AND there is an uptake greater than 80%.

Rationale

The failure to clear hepatitis B infection after six months leads to the chronic carrier state. Many people who become chronic carriers have no symptoms and are unaware that they are infected. These individuals will remain infectious and will be at risk of developing cirrhosis and primary liver cancer.

The proportion of Intravenous Drug Users (IDU) reporting uptake of hepatitis B vaccination has increased markedly in recent years, with the prison vaccination programmes being a major factor in this increase. However, the transmission of hepatitis B continues among IDUs. Therefore there is a need to continue with the vaccination programme, monitor and attempt to increase the uptake.

The high numbers of prisoners within the estate has necessitated in some cases, frequent establishment moves. This indicator seeks to ensure that, where individuals have commenced a course of vaccination, it is continued.

Suggested Supporting Evidence

Numerator

Number of new receptions to prison in the three months prior to the reference date, where there is no evidence of previous vaccination or where there is evidence of a started course who accept and are given the Hepatitis B vaccine.

Denominator

Number of new receptions to prison in the three months prior to the reference date, where there is no evidence of previous vaccination or where there is evidence of a started course.

Literature and Reference

- Hepatitis B - General Information (HPA 2007) http://www.hpa.org.uk/infections/topics_az/hepatitis_b/gen_info.htm
- Infection Inside: The prison Infection diseases quarterly: http://www.hpa.org.uk/infections/topics_az/prisons/files/Infection_Inside_Vol3May_%202007.pdf
- Immunisation against Infectious Disease (DH 1996) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4072984.pdf
- Reports and Publications – Prison Infection Prevention Team : http://www.hpa.org.uk/infections/topics_az/prisons/reports.htm
- Shooting Up - Infections among injecting drug users in the United Kingdom 2005, An update: October 2006 (HPA 2006) http://www.hpa.org.uk/infections/topics_az/injectingdrugusers/shooting_up.htm
- Prison Infection Control Guidelines (Essex HPU 2007) <http://www.hpa.org.uk/essex/publications/PrisonJan07.pdf>

Amber Indicator

All new receptions to prison where there is no verifiable evidence of previous vaccination are offered Hep B vaccine or where there is evidence of a started course it is continued AND there is an uptake of between 50% and less than 80%.

Red Indicator

All new receptions to prison where there is no verifiable evidence of previous vaccination are offered Hep B vaccine or where there is evidence of a started course it is continued AND there is an uptake of less than 50%.

PART 1 – Performance Indicators

Area: - Public Health

1.28 Health Promotion Action Groups

Green Indicator

Health promotion action groups exist within the partnership and have appropriate stakeholder membership of the local health community, Within the local delivery plan there is a health promotion strategy which specifically addresses and there is evidence of activity within and benefit from, all the following areas: (a) Mental Health Promotion and Well being, (b) Smoking Cessation / Reduction, (c) Healthy eating and nutrition, (d) Healthy lifestyles including relationships, (e) drug and other substance misuse

Rationale

The Prison Service in partnership with the NHS has a responsibility to ensure that prisoners have access to health services that are broadly equivalent to those the general public receives from the NHS. This means that prisons should already provide health education, patient education, prevention and other health promotion interventions to meet within that general context. (PSO 3200). This indicator highlights 5 key areas of focus for the health promotion action groups and requests evidence that activity takes place and benefits are derived from that activity.

Suggested Supporting Evidence

That the Health Promotion Action group exists and that membership is drawn from, the local health community including healthcare, catering, physical education, general education, substance misuse services, chaplaincy and mental health services. A strategy exists which has direct reference to all 5 of the specified areas with action plans, notes of evaluation presented to HPAG meetings. Benefits may be measured through the collection of formal patient feedback, completion of smoking cessation programme, increase in demand for healthy food options, reduction in referrals for stress and anxiety support from mental health teams, increase in take up of CARAT and drug treatment programmes, reduction in referrals for sleep disorders and general feedback from prison staff.

Literature and Reference

- NSFs for Cancer, Mental Health & CHD, http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/DH_4070951
- PSO 3200- Health Promotion,
- PSO 3801 Health & Safety Policy Statement,
- Mental Health Promotion in Prisons (WHO 1998) <http://www.euro.who.int/document/E64328.pdf>
- Health Promoting Prisons: A Shared Approach PSI 24/2002 <http://www.dh.gov>

[uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006230](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006230)

- Choosing Health (DH 2004) <http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Modernisation/Choosinghealth/index.htm>
- A to Z of Substance Misuse Guidance & Publications <http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Substancemisuse/AtoZofSubstanceMisuseGuidancePublications/index.htm>
- Guidance on developing prison health needs assessments and health improvement plans (DH 2002) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006651
- Acquitted: Best practice guidance for developing smoking cessation services in prisons (DH 2003) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005383
- Stop Smoking support in HM Prisons: the impact of nicotine replacement therapy - executive summary and best practice checklist , by Susan Macaskill and Paul Hayton (2006) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4134515

Amber Indicator

Health promotion action groups exist within the partnership and have appropriate stakeholder membership of the local health community, Within the local delivery plan there is a health promotion strategy which specifically addresses and there is evidence of activity within and benefit from, THREE OR FOUR of the following areas: (a) Mental Health Promotion and Well being, (b) Smoking Cessation / Reduction, (c) Healthy eating and nutrition, (d) Healthy lifestyles including relationships, (e) Drug and other substance misuse

Red Indicator

Health promotion action groups exist within the partnership and have appropriate stakeholder membership of the local health community, Within the local delivery plan there is a health promotion strategy which specifically addresses and there is evidence of activity within and benefit from, LESS THAN THREE of the following areas: (a) Mental Health Promotion and Well being, (b) Smoking Cessation / Reduction, (c) Healthy eating and nutrition, (d) Healthy lifestyles including relationships, (e) drug and other substance misuse

PART 1 – Performance Indicators

Area: - Public Health

1.29 Sexual Health

Green Indicator

The Sexual Health of Prisoners is supported by All of the following. That prisoners:

1. Are aware of means of accessing condoms in prisons.
2. Access the social and life skills modules on sex and relationship education (SRE) or similar.
3. Have access to a Genito Urinary Medicine (GUM) service in prison.
4. Have access to a chlamydia screening programme.
5. Have access to barrier protection and lubricants.

Rationale

Addressing the sexual health of prisoners supports the Prison Service's strategy for preventing the spread of communicable diseases in prison, offering harm minimisation information and treatment of substance misusers. A clear link between sexual ill health, poverty and social exclusion is identified, as is the unequal impact of HIV on gay men and certain ethnic minorities.

Genital chlamydia trachomatis is the commonest sexually transmitted infection (STI) in England. Genital chlamydial infection is an important reproductive health problem. 10-30% of infected women develop pelvic inflammatory disease (PID). A significant proportion of cases, particularly amongst women, are asymptomatic and so, are liable to remain undetected, putting women at risk of developing PID.

The national strategy states that some groups need targeted sexual health information and HIV/STI prevention because they are at higher risk, are particularly vulnerable or have particular access requirements, within this group they identify prisoners.

Suggested Supporting Evidence

Evidence that ALL the identified services are available to prisoners in the establishment either on site or via referral mechanisms. It should be possible to demonstrate that all 5 areas can be accessed.

Literature and Reference

- Better prevention, better services, better sexual health - The national strategy for sexual health and HIV: (DH 2001) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003133
- Choosing Health: Making healthy choices easier (DH 2004) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550
- Competencies for providing more specialised sexually transmitted infection services within primary

care - Assessment Toolkit (DH 2006) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139358

- Effective Sexual Health Promotion Toolkit (DH 2002) http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Sexualhealth/Sexualhealthgeneralinformation/DH_4002168
- House of commons Hansard debates for 24th May 1994 : <http://www.publications.parliament.uk/pa/cm199394/cmhansrd/1994-05-24/Writtens-2.html>
- The National Chlamydia Screening Programme (NCSP). (DH 2007) http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Sexualhealth/Sexualhealthgeneralinformation/DH_4084098
- 10 high impact changes for genitourinary medicine 48 hour access (DH 2006) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074104
- The National Chlamydia Screening Programme (NCSP). (DH 2007) http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Sexualhealth/Sexualhealthgeneralinformation/DH_4084098
- Chlamydia (Chlamydia trachomatis) (HPA 2007) http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/sti-chlamydia/default.htm

Amber indicator

The Sexual Health of Prisoners is supported by AT LEAST THREE of the following. That prisoners:

1. Are aware of means of accessing condoms in prisons.
2. Access the social and life skills modules on sex and relationship education (SRE) or similar.
3. Have access to a Genito Urinary Medicine (GUM) service in prison.
4. Have access to a chlamydia screening programme.
5. Have access to barrier protection and lubricants.

Red Indicator

The Sexual Health of Prisoners is supported by AT LEAST TWO of the following. That prisoners:

1. Are aware of means of accessing condoms in prisons.
2. Access the social and life skills modules on sex and relationship education (SRE) or similar
3. Have access to a Genito Urinary Medicine (GUM) service in prison.
4. Have access to a chlamydia screening programme.
5. Have access to barrier protection and lubricants

PART 1 – Performance Indicators

Area: - Public Health

1.30 Communicable Disease Control

Green Indicator

The Prison has a comprehensive written policy on communicable disease control, including an outbreak plan and pandemic flu plan, developed in partnership with the Local Health Protection Unit (and other prisons in the HPU's area) and signed off by the Prison Governing Governor, Chief Executive of the PCT and the lead CDDC for prisons in their region. The Prison has an Infection Control LINK NURSE who has specific responsibility / training in infection control. The Prison link Nurse attends meetings with the local HPU six monthly.

Rationale

The impact of a communicable disease upon the population of an establishment, including the staff is significant, encompassing not just the health care management of the disease but also affecting the operational integrity of the prison. It is important that a co-ordinated plan is developed between all significant parties concerned with senior manager support. Prevention of outbreaks is seen as a key priority for prisons and prison healthcare necessitating effective liaison between the prison and the local Health Protection Unit. This indicator reviews the development and operation of outbreak plans, with a specific focus on pandemic flu plans, it requires the prison to work in partnership with key stakeholders.

Suggested Supporting Evidence

It should be possible to identify a specific, comprehensive policy relating to communicable disease control. The policy should contain an outbreak plan and have specific reference to procedures in relation to pandemic flu. Signatures of the current Governing Governor, PCT Chief Executive and the lead CDDC for prisons in the region should be evident. It must be possible to identify a named Infection control link nurse for the prison and there should be evidence of attendance at six monthly HPU meetings.

Literature and Reference

- All Health Protection Units (HPA 2007) http://www.hpa.org.uk/lars_hp.us.htm
- Reports and Publications – Prison Infection Prevention Team : http://www.hpa.org.uk/infections/topics_az/prisons/reports.htm
- Pandemic Influenza (HPA 2007) http://www.hpa.org.uk/infections/topics_az/influenza/pandemic/default.htm
- Infection control in the community study (HPA 2002) <http://www.hpa.org.uk/hpa/publications/ICICreport.pdf>
- Prison Infection Control Guidelines (Essex HPU 2007) <http://www.hpa.org.uk/essex/publications/PrisonJan07.pdf>
- Major Outbreak plan – Example (Essex HPU 2005) <http://www.hpa.org.uk/essex/publications/Major%20outbreak%20Plan%20-%20Web%20Page.pdf>
- OUTBREAK OF ISONIAZID RESISTANT MYCOBACTERIUM TUBERCULOSIS IN NORTH LONDON 1999 – 2004 (HPA 2004) http://www.hpa.org.uk/london/pubs_pdf/iso_res%20sum_rep_final.pdf

Amber Indicator

The Prison has a comprehensive written policy on communicable disease control, THIS DOES NOT include an outbreak plan OR pandemic flu plan, developed in partnership with the Local Health Protection Unit (and other prisons in the HPU's area) and signed off by the Prison Governing Governor, Chief Executive of the PCT and the lead CDDC for prisons in their region. The Prison has an Infection Control link nurse who has specific responsibility / training in infection control. The Prison link Nurse attends meetings with the local HPU six monthly.

Red Indicator

The Prison has a comprehensive written policy on communicable disease control, THIS DOES NOT include an outbreak plan OR pandemic flu plan, developed in partnership with the Local Health Protection Unit (and other prisons in the HPU's area) and signed off by the Prison Governing Governor, Chief Executive of the PCT and the lead CDDC for prisons in their region. The Prison DOES NOT have an Infection Control link nurse who has specific responsibility / training in infection control. The Prison link Nurse attends meetings with the local HPU six monthly.

PART 1 – Performance Indicators

Area: - Public Health

1.31 Exercise

Green Indicator

All prisoners are offered the opportunity to engage in a range of physical exercise programmes appropriate to their health needs. These programmes have been developed and operated in consultation with the health care unit and contain a range of interventions which are tailored to support the , cardio vascular, respiratory, physical rehabilitation, weight reduction and mental health well being of prisoners.

Rationale

NICE fully endorses the importance of physical activity as a means of promoting good health and preventing disease, and the consequent need to develop comprehensive, multi-sectoral strategies (including innovative approaches) to promote physical activity as part of daily life. NICE also acknowledges that physical activity has a range of benefits beyond direct health outcomes, such as contributing to community cohesion and addressing the needs of vulnerable groups and communities.

It is often difficult within prison to freely engage in a range of suitable physical activities which promote health and well being. Working alongside prison colleagues, health care staff would be able to promote recovery and health related activities appropriate to the individuals health needs.

Suggested Supporting Evidence

On the reference date a sample of patients records should be reviewed. Reference to their requirements and access to exercise should be evident. There should be evidence of jointly arranged and managed programmes within the prison aimed at enhancing patients well being and recovery through exercise.

Literature and Reference

- PSO 4250-physical education,
- PSO 4275-Time in the open air,
- Physical activity (Nice 2006) <http://guidance.nice.org.uk/PHI2>
- Choosing Health (DH 2004) <http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Modernisation/Choosinghealth/index.htm>

Amber Indicator

All prisoners are offered the opportunity to engage in a range of physical exercise programmes appropriate to their health needs. These programmes have been developed with reference to the wider health needs of prisoners but NOT in consultation with the health care unit, however they do contain a range of interventions which are tailored to support the , cardio vascular, respiratory, physical rehabilitation, weight reduction and mental health well being needs of prisoners.

Red Indicator

All prisoners are offered the opportunity to engage in a range of physical exercise programmes. These programmes have NOT been developed with reference to the wider health needs of prisoners and consist mainly of generic Gym sessions.

PART 2 – Mental Health Numeric Indicators

All collected Quarterly

2.1 Initial Assessment

Total number of prisoners in the last quarter who received an initial psychiatric assessment to which the in-house Psychiatrist who is contracted to work in the prison agreed that the Mental Health Act criteria were met for transfer.

2.2 Second Assessment

Total number of prisoners who received a second psychiatric assessment by a provider organisations Psychiatrist in the last quarter.

2.3 Second Assessment – suitability of provider facility

Total number of prisoners who received a second psychiatric assessment by a provider organisations Psychiatrist in the last quarter and were not assessed as suitable for transfer because the provider facility was not assessed as suitable and the patient needs re-referring to a more suitable provider facility.

2.4 Second Assessment – not suitable for transfer

Total number of prisoners who received a second psychiatric assessment by a provider organisations Psychiatrist in the last quarter and were assessed as not suitable for transfer because transfer was deemed clinically inappropriate under the mental health act.

Of this group;

- How many had a personality disorder?
- How many people's condition had improved over time due to engagement with mental health services?

2.5 Second Assessment waiting times

Number at the end of the last quarter awaiting a second psychiatric assessment by a provider organisations Psychiatrist with a view to transfer for:

- Less than 2 weeks
- 2 weeks
- 4 weeks
- 6 weeks
- 8 weeks
- 12 weeks
- 20 weeks

2.6 Second Assessment – assessed, accepted but not suitable

Number at the end of the last quarter awaiting a second psychiatric assessment by a provider organisations Psychiatrist with a view to transfer how many have already been assessed by a provider and deemed not suitable for transfer.

2.7 Transfer wait

Total number of prisoners at the end of the quarter awaiting transfer from date of acceptance for transfer to a mental health in-patient facility which is:

- Less than 2 weeks
- 2 weeks
- 4 weeks
- 6 weeks
- 8 weeks
- 12 weeks
- 20 weeks

2.8 Transfer management in segregation

At the end of the quarter, of the number waiting transfer after transfer has been agreed, how many are managed in Segregation?

2.9 Mental Health Act transfers waiting times

Total number of mental health transfers under each of the following sections at the end of the last quarter;

- Section 47 (sentenced)
- Section 48 (un sentenced)
- Sections 36, 37, 38



For further details

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