

# Specification 29 Section 7A Public Health Services for Children and Adults in Secure and Detained Settings in England

Public health services for people in prison or other places of detention, including those held in the Children & Young People's Secure Estate

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

# Specification 29 Section 7A Public Health Services for Children and Adults in Secure and Detained Settings in England

Public health services for people in Prisons or other Prescribed Places of Detention, including those held in the Children & Young People's Secure Estate.

Prepared by –

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## Service Specification No.29 (SS29)

This is a service specification to accompany the 'NHS public health functions agreement 2016-17 (the '2016-17 agreement') published in December 2015.

This service specification is to be applied by NHS England in accordance with the 2016-17 agreement. This service specification is not intended to replicate, duplicate or supersede any other legislative provisions that may apply.

Where a specification refers to any other published document or standard, it refers to the document or standard as it existed at the date when the 2016-17 agreement was made between the Secretary of State and NHS England Board, unless otherwise specified. Any changes in other published documents or standards may have effect for the purposes of the 2016-17 agreement in accordance with the procedures described in Chapter 3 of the 2016-17 agreement

Service specifications should be downloaded in order to ensure that commissioners and providers refer to the latest document that is in effect.

The 2016-17 agreement is available at [www.gov.uk](http://www.gov.uk) (search for 'commissioning public health').

All current service specifications are available at [www.england.nhs.uk](http://www.england.nhs.uk) (search for 'commissioning public health').

## Chapter 1: Scope of Service Specification 29 (SS29)

### Aim

This document describes the scope of public health programmes commissioned by NHS England for people in prison and other prescribed places of detention (PPDs), including the Children and Young People's Secure Estate (CYPSE), and Immigration Removal Centres (IRCs). Public health programmes in these settings aim to reduce health inequalities, support people in living healthier lives, and ensure the continuity of care in the community.

### Scope of PPDs:

**1.1. Adult prisons:** There are currently 113 prisons in England (and a further 4 in Wales) in use at this time. The **National Offender Management Service (NOMS)**<sup>1</sup> is responsible for commissioning and delivering adult offender services, in custody and in the community, in both England and Wales. The Agency is responsible for providing both custodial and community services directly through its delivery arms, the Public Sector Prison Service (HMPS) and National Probation Service (NPS). In addition, Her Majesty's Prison Service (HMPS) is also commissioned by the Youth Justice Board (YJB) to provide places for young people in Young Offender Institutions (YOIs), and the Home Office to provide Immigration Removal Centres (IRCs). There are approximately 85,000 people in prisons at any one time - detailed data including weekly updates are available at <https://www.gov.uk/government/statistics/prison-population-figures-2015>). NHS England assumed responsibility for commissioning healthcare in prisons in April 2013.

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<sup>1</sup> For more information see 'How NOMS Works' [www.gov.uk/government/publications/how-the-national-offender-management-service-works](http://www.gov.uk/government/publications/how-the-national-offender-management-service-works)

## **1.2. Immigration Detention Estate:** The Home Office Immigration Enforcement

Directorate (HOIE) commissions 10 Immigration Removal Centres in the UK (9 in England and one in Scotland) and two short term holding facilities one in England and one in Northern Ireland)<sup>2</sup>. The UK detention estate can hold about 3,500 people. Of the 3,483 people in detention as at the end of March 2015, 3,178 were male and 305 were women. The number of children in detention has been extremely low since 2011 following changes in legislation and policy. Most people detained under immigration powers spend only very short periods in detention. The majority (63%) of people in immigration detention - leave detention within 29 days. The overwhelming majority of detainees – 93% - leave detention within 4 months. In April 2014 to March 2015, 51% of detainees leaving detention were removed and 49% were granted Temporary Admission (TA) / Temporary Leave to Remain (TR), Leave to Enter (LTE) / Leave to Remain (LTR) or released on bail. More information on immigration detention statistics is available at <https://www.gov.uk/government/publications/immigration-statistics-april-to-june-2015/detention>. In September 2014, NHS England received the commissioning responsibility for health provision across the IRC estate in England with the exception of Campsfield House in Oxfordshire which was subsequently transferred in April 2015.

## **1.3. The Children & Young People's Secure Estate (CYPSE)** includes Young

Offender Institutions under 18 (YOIs), Secure Training Centres (STCs) and Secure

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<sup>2</sup> For more information on the IRC estate in the UK visit <https://www.gov.uk/immigration-removal-centre/overview>



## Public health functions to be exercised by NHS England

Children's Homes (SCHs). The Youth Justice Board (YJB)<sup>3</sup> commissions places in the CYPSE from a range of providers: YOIs are commissioned from NOMS, STCs are commissioned from private providers and the SCHs are commissioned by Local Authorities and the voluntary sector. The vast majority of children and young people in custody are held in YOIs, with STCs and SCHs used for children who are younger and deemed more vulnerable. More information on the population held in custody is available at <https://www.gov.uk/government/collections/youth-justice-statistics>. Local Authorities place children under The Children's Act 1989 welfare grounds into Secure Children's Homes.

More information on the population held is available at

<https://www.gov.uk/government/statistics/children-accommodated-in-secure-childrens-homes-31-march-2015>

**1.4.** NHS England has responsibility for commissioning healthcare for both youth justice and welfare places in the whole of the CYPSE since April 2014<sup>4</sup>.

**1.5. Police Custody Suites:** There is an ongoing programme to transfer police custodial healthcare commissioning to the NHS. At this time a decision is pending from Ministers. In the event of a positive outcome consideration will be given to what practical public health interventions can occur in police custody environment

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<sup>3</sup> For more information on the YJB, visit <https://www.gov.uk/government/organisations/youth-justice-board-for-england-and-wales/about>

<sup>4</sup> Oakhill STC is currently out of NHS England's operating regulations.

## Chapter 2: Understanding and meeting health needs

### 2.1 Health inequalities

People in prisons and other PPDs, compared with peers in the community, often experience significant health inequalities including higher rates of substance misuse (including drugs, alcohol and tobacco smoking); a higher burden of infectious diseases (including HIV/AIDS, other blood-borne viruses (BBVs), tuberculosis (TB) and sexually transmitted infection (STIs)); a higher burden of chronic illnesses (including epilepsy, asthma, coronary heart disease, musculo-skeletal problems); poorer mental health (including depression/anxiety & psychosis) and higher levels of learning disabilities. These health needs are often found as 'co-morbidities' and further compounded by a history of poorer access to treatment and prevention programmes, higher rates of homelessness, unemployment and a lack of basic level education<sup>5</sup>. More information on health needs of people in PPDs can be found in the annual report produced by PHE Health & Justice at <https://www.gov.uk/government/publications/prison-health-health-and-justice-annual-report> and in the document 'Balancing Act: Addressing health inequalities among people in contact with the criminal justice system' co-produced by PHE and Revolving Doors Agency at <http://www.revolving-doors.org.uk/documents/balancing-act/>.

Poor healthcare in prisons and other PPDs can exacerbate previous health issues and increase health inequalities. Such health inequalities are evident not only when in custody or detention but also continue to have an affect beyond the secure setting walls. Good prison healthcare can contribute to improving equality. People in prison and other PPDs often belong

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<sup>5</sup> Prison Reform Trust, 2006

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to and return to groups and networks in the community which contribute disproportionately to wider societal health and social inequalities. Prisons and other PPDs can and do impact positively on health care needs of people they manage but this effect is often contingent on being in custody or detention. A return to the community currently often results in ‘flipping’ previous health gains including access to health services especially preventive health services like screening and immunisation and chronic care.

### 2.2 Principle of Equivalence

The WHO Health in Prisons Programme (WHO HIPP) has published a document “Good governance for prison health in the 21<sup>st</sup> century<sup>6</sup>” which advocates for improvements in the quality of healthcare for people in prisons including the principle that “prison health services should work to at least the equivalent professional, ethical and technical standards to those applying to public health services in the community”. NHS England and its partners are committed to commissioning healthcare services for people in prisons and other PPDs which meet the following criteria:

- **Equivalence:** Healthcare services provided to people in prisons and other PPDs should be equivalent to that available to people in the wider community. This is not to say that care will be provided in exactly the same way in custodial or detention settings as in the community but that the fundamentals of access, quality and service are equivalent.

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<sup>6</sup> Good governance for prison health in the 21st century. A policy brief on the organization of prison health (2013). WHO, London 2013 <http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2013/good-governance-for-prison-health-in-the-21st-century.-a-policy-brief-on-the-organization-of-prison-health-2013>

- **Evidence-based care:** Care is commissioned and services provided according to needs, informed by rigorous health needs assessment approach, including collection and interpretation of data, and must be evidence-based;
- **Patient-focused:** People delivering care to people in prisons and PPDs are healthcare staff whose primary loyalty is to the health and well-being of their patients.
- **Quality:** Healthcare staff should be appropriately trained and accredited, participate in continuing professional development programmes, and work within a clear clinical governance structure.
- **Patient informed:** People in custody or detention should know their rights to healthcare, should have their voices heard in designing and delivering healthcare services, and should know how to complain if unhappy with the level of service they receive.
- **Partnership:** Working in partnership is essential. Where possible, healthcare programmes should be developed in 'co-production' with partner organisations bearing in mind the primary principle of patient-focused care.
- **Continuity of Care:** Care delivered in custodial or detention settings should take account of the need for continuity of care in the community and should support care pathways 'through the gate'.
- **Address health inequalities:** People in prison and other PPDs often belong to 'underserved' populations, who have poor access to healthcare prior to detention. Detention can and should be an opportunity to address previous unmet healthcare needs as well

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as contributing to addressing health inequalities in the wider community through ensuring ongoing access to health and social care on release.

### 2.3 Health Needs Assessment

NHS England should commission care for people in PPDs informed by a rigorous assessment of need identified through formal health needs assessments (HNAs). PHE have produced, in partnership with NHS England, NOMS and YJB, HOIE and police forces, a range of toolkits to assist formal assessment of health needs in various justice settings including adult prisons and police custody healthcare suites (<https://www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit>). Templates supporting the creation of Health and Wellbeing Needs Assessments (HWBNAs) for the Children's and Young People's Secure Estate (CYPSE) for ages 10-17 year olds are available on the Child and Maternal Health Intelligence Network (CHIMAT) website: <http://www.chimat.org.uk/yj/na/template>.

These toolkits also provide information on data sources, evidence-based guidelines and best practice. NHS England should only commission and publish health needs assessments which conform to these quality standards. PHE has developed a repository of quality-assured HNAs for justice settings <https://www.gov.uk/government/publications/health-needs-assessment-prison-examples>.

NHS England have also commissioned and published a summary document of HNAs for IRCs and short-term holding facilities <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/05/irc-hna-brand.pdf> which can be used to inform health service provision in the immigration detention estate.

## 2.4 Health & Justice Indicators of Performance (HJIPs)

Good quality data is the foundation stone of high-quality healthcare services, health needs assessment, effective commissioning and performance review. In 2007, Offender Health (OH) issued a set of Prison Health Performance Indicators (PHPIs)<sup>7</sup> to guide Strategic Health Authorities (SHAs), Primary Care Trusts (PCTs) and prisons in judging their own performance in delivering healthcare services to prisoners. In 2009, in line with measures being developed in the wider NHS, Offender Health redeveloped the PHPIs to become broader indicators of the quality of healthcare in prisons, as well as the performance of other contributing health and prison services. These were referred to as Prison Health Performance & Quality Indicators (PHPQIs)<sup>8</sup>. With the creation of NHS England and PHE in April 2013 and the dis-establishment of former organisations and their data collection and performance monitoring functions, to replace the previous Prison Health Performance and Quality Indicators (PHPQIs), a new set of **Health and Justice Indicators of Performance (HJIPs)** have been developed by NHS England, PHE, NOMS, YJB, DfE and HOIE. The first of these new datasets was developed for adult prisons and introduced in July 2014 (retroactive to April 2014). The HJIPs – see Annex A - are largely quantitative measures with most of the data used to populate them harvested from the health informatics system, SystemOne, which is available in prisons and IRCs.

HJIPs function to:

- Support effective commissioning of healthcare services

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[http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_079860](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079860)

<sup>8</sup> <https://www.gov.uk/government/publications/prison-health-performance-and-quality-indicator-report-and-guidance>

## Public health functions to be exercised by NHS England

- Enable national and local monitoring of the quality and performance of healthcare
- Provide a tool for providers to review their performance and identify areas that need improvement
- Provide data for local health needs assessments (HNAs)
- Support public health action, inform policy makers and provide information for inspectorates, e.g. Care Quality Commission (CQC), HM Inspector of Prisons (HMIP) & Office for Standards in Education, Children's Services and Skills (Ofsted)
- Provide quality standards for a range of health services which can guide both commissioner and healthcare providers.

Guidance notes for collection of HJIPs in adult prisons, IRCs and the CYPSE have been developed. From the 1st April 2015 providers of healthcare services in PPDs will be required to provide quantifiable data on a monthly basis to support the HJIP reporting. Where indicators are not quantifiable in nature, NHS England Health and Justice localities will audit these via their partnership boards. NHS England Sub Region Teams will take the lead on collecting this information in order for it to be reported via the Actuate system. The Actuate system is a business intelligence platform which has been used by Durham, Darlington and Tees Area Team for the past four years. The platform has been developed and will provide a desktop dashboard solution to all Region and Sub Region Team leads, and senior management within NHS England and key partners, to support the monitoring of the HJIPs. Reporting will be done on a monthly basis, allowing for trend analysis for the coming 12 months.

## 2.5 Partnership Work

NHS England must work in partnership with PHE and with justice and detention partners to commission services according to need for people in PPDs and appropriate to the setting in which services are provided. In 2015, National Partnership Agreements (NPAs) have been published by NHS England, PHE and different justice partners (depending on the specific setting of interest) which describe joint shared priorities for health improvement for the respective populations as well as agreed ways of working together and governance structures. The three current NPAs and the respective justice partners along with NHS England and PHE are:

- National Offender Management Service (NOMS)  
[http://www.justice.gov.uk/downloads/about/noms/work-with-partners/national\\_partnership\\_agreement\\_commissioning-delivery-healthcare-prisons2015.pdf](http://www.justice.gov.uk/downloads/about/noms/work-with-partners/national_partnership_agreement_commissioning-delivery-healthcare-prisons2015.pdf)
- Home Office Immigration Enforcement (HOIE)  
<http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/04/hoie-partnership-final.pdf>
- Youth Justice Board (YJB) <http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/04/yjb-phe-parts-agree.pdf>



## Chapter 3: Public Health Programmes in PPDs

All public health programmes in PPDs are informed by:

- a) **the principle of equivalence** especially that being in prison or other secure setting should not exclude people from access to healthcare including screening and immunisation programmes;
- b) **the need to tackle health inequalities**, especially in relation to 'care deficits' which people may experience due to lack of access to health services prior to detention;
- c) **evidence-based practice**, informed by a rigorous assessment of need and delivered in a way which is accessible and acceptable to the population concerned.

Public health programmes to be commissioned by NHS England in PPDs cover all aspects of public health including health protection, health promotion and healthcare public health. Some populations in detention settings have very specific needs due to both the population and the setting (e.g. substance misusers in prisons, foreign nationals in prisons and/or IRCs, and children with neuro disabilities and Child Sexual Exploitation in the CYPSE) whereas other needs are consistently seen across populations and across settings (e.g. high level of mental health needs, poor access to screening and immunisation programmes, and higher risk of infectious diseases especially TB and BBVs). NHS England commissioned programmes must therefore take account both of the specific population and the specific secure setting.

Healthcare commissioned by NHS England will in the main conform to NICE guidelines (where they exist and/or are relevant); national guidance/best practice guidance provided by Royal Colleges, expert bodies or organisations (where NICE guidance does not exist), and/or relevant international guidance where no national guidance exists. NHS England service specifications for providers will be informed by this guidance. Further information and

resources to inform commissioners and providers are available both in the HNA toolkits (published by PHE-see section 2 above) and the HJIPs (published by NHS England - see section 2 above).

### **3.1 Healthcare standards for CYPSE**

In 2013, the Department of Health and YJB supported the Royal College of Paediatrics and Child Health (RCPCH), in conjunction with the Royal College of General Practitioners, Royal College of Nursing, Royal College of Psychiatrists, Faculty of Forensic and Legal Medicine and Faculty of Public Health, to develop and publish new standards for the '**Healthcare of**

**Children and Young People in Secure Settings'** (<http://www.rcpch.ac.uk/cypss>). The

intercollegiate standards have been designed in order to help plan, deliver and quality assure the provision of children and young people's health services in secure settings. The standards apply to children and young people aged between 10-17 (inclusive) on both welfare and justice placements in secure centres (young offender institutions, secure children's homes, secure training centres and their equivalents).

These new standards take a pathway approach, following the young person's journey through a secure setting to aid multi-professional working. They support healthcare professionals, commissioners, service providers, regulators, managers and governors to ensure that young people in secure settings received the care they need to improve their health outcomes.

The standards cover Entry Assessment, Care Planning, Universal Health Services, Physical Health Care and Intervention, Mental Health and Neurodisabilities Care and Intervention, Substance Misuse Care and Intervention, Transfer and Continuity of Care, Healthcare

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Environment and Facilities, Planning and Monitoring, Multiagency Working and Staffing and Training.

The document is the standard against which NHS England should commission healthcare in the CYPSE and it informs the HJIPs for the CYPSE.

### 3.2 Healthcare Standards for Adult PPDs

There is no summative document similar to that for the CYPSE intercollegiate standards for the adult estate. But standards are available for healthcare services relevant to these settings, either developed specifically for patient care in PPDs or developed for the general population but applicable to PPDs. The following section provides information on standards for healthcare commissioners and providers relevant to adult PPDs. The list of public health programmes is not exhaustive and all programmes should be delivered according to need of specific populations in specific settings informed by a rigorous assessment of need (see Section 2- Health Needs Assessment).

#### 3.2.1 Smoking Cessation Services for Adults in PPDs

**Background:** The announcement made by the SOS Andrew Selous on 29<sup>th</sup> September 2015 of the intention to implement a smoke free prison estate in England and Wales is a significant driver behind the optimization of smoking cessation services across the estate for the NHS England. Nationally around 80% of prisoners smoke compared with around 20% in the general population<sup>9, 10, 11, 12</sup> Similar high rates of smoking have also been observed across the criminal

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<sup>9</sup> Singleton N, Farrell M & Meltzer H. Substance Misuse among Prisoners in England and Wales. London: Office for National Statistics. 1999

<sup>10</sup> Lester C, Hamilton-Kirkwood L, Jones N. Health Indicators in a prison population: asking prisoners. Health Education Journal 2003;62:341-349

<sup>11</sup> Plugge EH, Foster CE, Yudkin PL, Douglas N. Cardiovascular disease risk factors and women prisoners in the UK: the impact of imprisonment. Health Promotion International 2009;24:334-343.

justice system (CJS)<sup>13, 14, 15</sup> When high quality evidence based stop smoking services are provided, cessation rates in prisons are comparable as with those seen in community settings<sup>16</sup>. Offenders are more likely to be from a background of deprivation, display problematic drugs and alcohol use, and be diagnosed with a mental health problem (see Section 1). All these factors are associated with increased use of tobacco and decreased likelihood of attempts at cessation. There is also a history of tobacco being used as a currency in prisons and reports from prisoners that tobacco is an integral part of the prison routine. These are all contributing factors to the high rates of smoking observed in this population.

**Service Standard:** To provide access to smoking management services to address the high burden of smoking tobacco in this population. NHS England is now in a position to optimise service delivery so that across the board current need is met and to ensure that services are set up to meet future needs and any requirement for extended capacity. Doing this will require consideration of the different ways in which stop smoking services can be effectively delivered across the estate and may mean that healthcare is not the only point of access to pharmacotherapy or support. All services should be delivered in line with relevant NICE public health guidance and follow the NCSCT principles of commissioning and provision set out in the

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<sup>12</sup> Public Health England (PHE). Survey of local prisons. Unpublished, 2014.

<sup>13</sup> Payne-James JJ, Green PG, Green N, McLachlan GM, Munro MH, Moore TC. Healthcare issues of detainees in police custody in London, UK. *Journal of Forensic and Legal Medicine* 2010;17:11-17.

<sup>14</sup> Brooker C, Fox C, Barrett P, Syson-Nibbs L. A Health Needs Assessment of Offenders on Probation Caseloads in Nottinghamshire & Derbyshire: Report of a Pilot Study. Lincoln: CCAWI University of Lincoln, 2008. Available at: [http://eprints.lincoln.ac.uk/2534/1/Probation\\_HNA.pdf](http://eprints.lincoln.ac.uk/2534/1/Probation_HNA.pdf)

<sup>15</sup> MacLeod L, MacAskill S, Eadie D. Rapid literature review of smoking cessation and tobacco control issues across criminal justice system settings. Stirling: Institute for Social Marketing, 2010

<sup>16</sup> HSCIC Statistics on NHS Stop Smoking Services in England - April 2014 to March 2015  
<http://www.hscic.gov.uk/lifestyles>

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Service and Delivery guidance 2014<sup>17</sup>. The roll out of the implementation of the Smoke Free Prisons programme began in the open prisons from 1<sup>st</sup> October 2015 and at the same time all prisons across the closed estate had to identify smoke free wings for people who had health conditions which would be exacerbated through exposure to secondary smoke. In England there are 4 prisons in the South West, Exeter, Channing's Wood, Dartmoor and Erlestoke which will go live as early adopters of smoke free closed prisons from March 2016. The rest of the estate will follow incrementally as lessons are learned from the early adopter sites.

## **Public Health Outcomes Framework 2015-16 <http://www.phoutcomes.info/>**

- 2.14: Smoking prevalence – adult (over 18s)
- 2.03: Smoking status at time of delivery

### **3.2.2 Substance Misuse Services for Adults in PPDs**

#### **a) Drugs**

NHS England is responsible for commissioning substance misuse (drug and alcohol) services for individuals in custodial and detention settings (this will include police custody suites from next year - pending a ministerial announcement).

Approximately 60,000 individuals receive structured treatment for drug or alcohol problems within English custodial settings each year (PHE NDTMS 2013/14

<https://www.ndtms.net/default.aspx>)

81% of adult prisoners report using illicit drugs at some point prior to entering prison including almost two-thirds (64%) within the month before entering prison. Rates of heroin and crack

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<sup>17</sup> NCSCT Service and delivery guidance 2014

[http://www.ncsct.co.uk/publication\\_service\\_and\\_delivery\\_guidance\\_2014.php](http://www.ncsct.co.uk/publication_service_and_delivery_guidance_2014.php)

cocaine are 49% (female) and 44% (male). (Surveying Prisoner Crime Reduction (SPCR) NOMS 2013)

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf)

There is good evidence that effective drug treatment interventions can lead to improved outcomes in relation to drug related death, re-offending rates and the transmission of blood borne viruses. (The Patel report (2010): Reducing drug-related crime and rehabilitating offenders

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_119851](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119851))

(Estimating the Crime Reduction Benefits of Drug Treatment and Recovery', NTA 2012

<http://www.nta.nhs.uk/uploads/vfm2012.pdf>)

## **b) Alcohol**

Harmful, hazardous and dependent drinking are all relatively common problems among people entering prison. Of those prisoners who had drunk alcohol in the four weeks before custody, nearly half (46%) reported having some problems with their drinking, 39% felt that their drinking was out of control (sometimes, often or always) and 35% said that they would find it quite difficult, very difficult or impossible to stop drinking. (Surveying Prisoner Crime Reduction (SPCR) NOMS 2013)

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf)

There is good evidence that brief advice can help individuals to reduce harmful or hazardous levels of drinking. (Screening and Intervention Programme for Sensible drinking (SIPS)

<http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/>)

## Public health functions to be exercised by NHS England

People who are physically dependent on alcohol require more intensive forms of treatment. Alcohol problems are ameliorated by the combined effect of a breadth of psychological and social interventions. It is important therefore that health providers working in alliance with wider interventions programmes and reintegration services in prisons and beyond.

**Substance misuse service standards:** NHS England will commission specialist drug and alcohol provision for the therapeutic management and treatment of problematic and dependent use of either or both substances. The services will integrate with primary health care and secondary mental health care, for the delivery of treatment and the co-ordinated management of health and mental health associated with or exacerbated by alcohol or drug use. (DH 2009 A guide for the management of dual diagnosis in prisons)

[http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_097695](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097695)

Services will be delivered in line with current DH and NICE standards. Clinical guidance for the management of drug dependence is currently being reviewed and updated guidance is due to be published in 2016. Links to current guidance for adults and children and young people are indicated below.

### Adults

Dept. Health (2006) Clinical management of drug dependence in the adult prison setting

[http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_063064](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063064)

Dept. Health (2007) Drug misuse and dependence: UK guidelines on clinical management

[http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_104819](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104819)

### Children and young people

Dept. Health (2009) Guidance for the pharmacological management of substance misuse among young people in secure environments

[http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_106433](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_106433)

National Treatment Agency & Youth Justice Board (2012), Substance misuse interventions within the Young People's Secure Estate: Guiding Principles

<http://www.nta.nhs.uk/uploads/secureestateguidelinesv1.2.pdf>

### **Through the gate interventions**

The continuity of treatment and recovery support is central to good treatment outcomes.

Substance misuse teams are expected to:

- liaise pro-actively with community based treatment services or the substance misuse team from the transferring establishment and take account of existing assessment and care plan information
- contribute to resettlement plans in conjunction with Community Rehabilitation Companies (CRCs), National Probation service (NPS) and Youth Offending Team colleagues
- ensure that contingency arrangements are in place for individuals to access treatment in the event of unplanned or short notice release
- Within the bounds of all relevant legislation and Caldecott principles, services will work closely with the National Offender Management Service, Youth Justice Board and other agencies to provide service users with high-quality care.

### **Reporting Requirements**

To measure treatment outcome, full minimum data reporting is required to National Drug Treatment Monitoring System (NDTMS) and against the relevant Health and Justice Indicators of Performance (HJIP) measures.



## **Key service outcomes**

Recognising that periods of custody or detention for substance-dependent offenders can be relatively short, and the time of release is often the most testing episode, the principal outcome is as follows:

- Adults with a substance misuse treatment need, who successfully engage in community-based structured treatment following release from prison.

This will be based on the proportion of individuals in secure environments that engage in structured drug and alcohol treatment interventions who at the point of departure from that establishment have either:

- Successfully completed a treatment intervention in custody and did not represent to treatment (either in custody or the community) within 6 months of release; or
- Successfully engaged in community based drug and alcohol treatment interventions following release; or
- Where they were transferred to another prison, successfully engaged in structured drug and alcohol treatment interventions at the receiving establishment.

## **Public Health Outcomes Framework 2015-16 <http://www.phoutcomes.info/>**

- 2.15: Successful completion of drug treatment
- 2.16: people entering prison with substance dependence issues who are previously not known to community treatment
- 2.18: Alcohol-related admissions to hospital

### 3.2.3 Prevention of self-harm and self-inflicted deaths in custody.

**Background:** The high prevalence of mental health needs among people in prison and other PPDs is well recognised. There is an associated risk of self-harm and self-inflicted death in this population and data recently has shown an increasing level of both. Safety in custody statistics cover deaths, self-harm and assaults in prison custody in England and Wales and is reported at <https://www.gov.uk/government/collections/safety-in-custody-statistics>

The Independent Advisory Panel (IAP) on Deaths in Custody plays an important role in helping to shape government policy in this area through the provision of independent advice and expertise to the Ministerial Board on Deaths in Custody. The remit of the Council covers deaths which occur in prisons, YOIs, STCs or following police custody, immigration detention, the deaths of residents of approved premises and the deaths of those detained under the Mental Health Act (MHA) in hospital: <http://iapdeathsincustody.independent.gov.uk/about/>

**Service standard:** Health services in prison and other places of prescribed detention to work alongside other staff to reduce episodes of self-inflicted death and episodes of self-harm and improve their health and well-being as a whole.

**Reporting Requirements:** There are 21 HJIPs relating to mental health care and delivery and identification and management of people at risk of self-harm/suicide. These include measures regarding the Care Programme Approach (CPA) and information on the continuity and management of these between the community and detention.

**Public Health Outcomes Framework 2015-16** <http://www.phoutcomes.info/>

- 4.10: The number of people dying prematurely from suicide

### 3.2.4 Screening programmes (cancer and non-cancer)

**Background:** People in prisons and other PPDs are drawn from a population with a significantly raised risk of developing a range of chronic conditions for which national screening programmes are currently available. As the prison population ages the prevalence of these conditions increases. Social exclusion and disadvantage is common in the offender population and access to health care and screening services while living in the community tends to be poor. Prison, and other detained settings, therefore provides a valuable opportunity to offer screening to a population with significant unmet need.

People in PPDs are entitled to access all appropriate cancer and non-cancer screening programmes for their age, sex and other risks factors and all community-based screening programmes should include prison and other PPD populations.

Screening programmes vary in whether or not more than one test is required, on the screening interval and level of surveillance required. The key determinant of access to national screening programmes is GP registration to allow call/re-call systems to operate effectively and to ensure coverage of at-risk populations.

**Service Function:** All eligible people in prison and other prison and other places of prescribed detention should have access to all cancer and non-cancer screening programmes for which they are eligible. This should be facilitated by ensuring that all NHS patients in prisons or other PPDs have an NHS number and ideally are registered with a primary care service in custody and in the community on release.

**Eligible Populations:**

**Cancer screening programmes:**

Bowel: Men & Women 60 - 74 every two years. People 75+ can request it.

Breast: Women 50 – 70 every 3 years. 70 or over can self-refer.

Cervical: Women 15 – 49 every three years. 50 – 64 every 5 years.

### **Non-cancer screening programmes:**

- DES: annual screening offered to all people aged 12 and over with diabetes mellitus (excluding gestational diabetes) and have perception of light in at least one eye
- AAA: screening offered to all men in their 65th year, with over 65s self-referring; excluding those who have had previous surgery to repair an AAA.

### **Ante Natal and Newborn:**

Information on ante natal and newborns can be accessed at the following web site:  
<http://cpd.screening.nhs.uk/timeline>

### **Public Health Outcomes Framework 2015-16 <http://www.phoutcomes.info/>**

- 2.20: Cancer screening coverage
- 2.21: Access to non-cancer screening programmes

### **Physical Health Checks**

- All prisoners aged between 35 and 74, likely to be detained for more than two years, should be reviewed and offered routine tests to assess their risk of heart disease, stroke, kidney disease, type 2 diabetes and chronic kidney disease, as part of the NHS Health Check programme **or equivalent**.

### **Public Health Outcomes Framework 2015-16 <http://www.phoutcomes.info/>**

- 2.22: Take up of the NHS Health Check programme by those eligible

### **3.2.5. Communicable Disease Prevention, Detection, Surveillance and Control.**

**Background:** All the current National Partnership Agreements (see Section 2.5) include as common priority: to improve the pro-active detection, surveillance and management of infectious diseases in PPDs and improve capability to detect and respond to outbreaks and

## Public health functions to be exercised by NHS England

incidents. The impact of a communicable disease on the populations in PPDs<sup>18</sup>, including healthcare, custodial and care staff, is significant, not just affecting the healthcare management of disease but also affecting the operational integrity of the setting. Prevention of outbreaks is a key priority for prisons and other PPDs. Effective working relationships are required between healthcare commissioners, justice commissioners, welfare commissioners and health protection specialists at national and local level employed by PHE.

**Service Function:** NHS England commissioners must ensure that:

- a) all PPDs have a comprehensive written policy on communicable disease and infection control, including an outbreak plan, pandemic flu plan and immunisation policy, developed in partnership with the local Public Health England Health Protection Team (HPTs) and co-signed by health and justice commissioners as well as the Deputy Director for Health Protection locally;
- b) all PPDs notify local PHE HPTs of any reportable diseases in a timely manner to enable swift and coordinated public health action to prevent or control outbreaks of infectious diseases (A list of reportable diseases can be found at <https://www.gov.uk/government/collections/public-health-in-prisons>)
- c) patients have access to a comprehensive TB screening, diagnostic and treatment service and continuity of care on return to the community. Those prisons and PPDs with static digital X-ray machines (DXRs) should use them according to NICE guidelines and maximise the uptake of routine screening among high-risk new entrants (Identifying and managing

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<sup>18</sup> Powerful momentum is now building towards a new narrative on HIV treatment and a new, final, ambitious, but achievable target: By 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression. See <http://www.unaids.org/en/resources/documents/2014/90-90-90>

tuberculosis among hard-to-reach groups. NICE guidelines [PH37]

<https://www.nice.org.uk/guidance/ph37>);

d) all patients in prisons and IRCs are offered testing for BBVs on an 'opt-out programme' on a phased implementation programme to cover all prisons and YOIs in England by end 2016-17, and those found to be infected to be offered referral for assessment, care and/or treatment, with continuity of referral and care from custody to community

(<https://www.gov.uk/government/publications/blood-borne-virus-opt-out-testing-in-prisons-evaluation-of-pathfinder-programme>)

Information on health protection and infection control guidelines for prisons and other PPDs is available from PHE Health & Justice at <https://www.gov.uk/government/collections/public-health-in-prisons>

**Public Health Outcomes Framework** <http://www.phoutcomes.info/>

- 4.08: Mortality from Communicable Diseases;
- 3.05: TB incidence and treatment completion;
- 4.6. Mortality from liver disease

### **3.2.6 Vaccination preventable diseases**

**Background:** People in prison and other secure settings are a diverse population and differ by age, sex, ethnicity, country of origin and their experiences of health and disease. Primary prevention is an important public health principle and immunisation against infectious diseases is a cornerstone of good preventive practice. Many British-born people miss out on routine childhood immunisations and other required vaccines.

**Service Function:** All adults and children in PPDs should be have their needs and vaccination history investigated and then offered vaccinations appropriate to their age and need as defined in the UK immunisation policy as outlined in " Immunisation against infectious disease - 'The

## Public health functions to be exercised by NHS England

Green Book' <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>. There is a specific requirement to provide all new eligible and consenting adults and children in secure settings received into the establishment in the three months prior to the reference date.

## Public Health Outcomes Framework <http://www.phoutcomes.info/>

- 3.3: Population vaccination coverage

### 3.2.7 Sexual & Reproductive Health

**Background:** Addressing the sexual health of adults and children in secure settings supports the strategy for the prevention of the spread of communicable diseases in custody and detention, offering harm minimisation information and treatment. The national sexual health and HIV strategy published by DH in 2001 stated 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 identified prisoners<sup>19</sup>.

**Service Function:** NHS England should commission sexual health services such that all people in PPDs have a) access to condoms, dental dams and water-based lubricants; b) women have access to appropriate contraception according to their needs; c) have access to the social and life skills modules on sex and relationship education (SRE) or similar, d) have access to a genitourinary medicine (GUM) services (either provided externally or in house), and e) have access to the national chlamydia screening programme.

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<sup>19</sup> The national strategy for sexual health and HIV: (DH 2001)  
[http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publichealth/Healthimprovement/Sexualhealth/Sexualhealthgeneralinformation/DH\\_4002168](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publichealth/Healthimprovement/Sexualhealth/Sexualhealthgeneralinformation/DH_4002168)

**Public Health Outcomes Framework** <http://www.phoutcomes.info/>

- 3.4: People presenting with HIV at a late stage of infection
- 3.2: Chlamydia diagnoses (15-24 year olds)
- 2.04: under 18 yrs. conception rate



## Chapter 4 Patient and Public Participation

The views of service users, their parents/carers (including prison staff, fellow prisoners, detainees and children in the CYPSE) must be sought and taken into account in designing, planning, delivering and improving health care services prison and other places of prescribed detention. NHS England has a legal duty under section 13Q of the Health and Social Care Act 2012 to ensure that arrangements are made to secure that individuals to whom the services are or may be being provided are involved (whether by being consulted or provided the information in other ways) in the planning, development and delivery of services

<http://www.legislation.gov.uk/ukpga/2012/7/part/1/enacted>

The HJIPs dataset contains specific measures of user involvement to ensure patient populations are consulted, considered and informed in respect of planning, development and delivery of healthcare services in PPDs.

**Service Function:** NHS England must ensure that the opinions of service users are collected and actioned upon through formal forums, service user group, questionnaires or other appropriate means. All health needs assessments should include the views of patients and service users. Providers need to make available information on complaints and inform service users how to make a complaint and allow patients to express their concerns, criticisms of service protecting patient confidentiality appropriately and avoiding 'deductive disclosure'.

# Annex A – Health & Justice Indicators of Performance

Guidance on HJIPs can be found at the following web links:

1. Health and Justice Indicators of Performance (HJIP): Adult Secure Estate User Guide 2015/16
2. Health and Justice Indicators of Performance (HJIP): Immigration Removal Centres 2015/16
3. Health and Justice Indicators of Performance (HJIP): Children and Young Person's Secure Estate 2015/16