

Securing Excellence in
Commissioning
for Offender Health



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Introduction

Purpose of the document

1. From April 2013, the NHS Commissioning Board (NHS CB) will take up its full duties to ensure that the NHS delivers better outcomes for patients within its available resources and upholds and promotes the NHS Constitution. As a single national organisation, the NHS CB will be responsible for ensuring that services are commissioned in ways that support consistency not centralisation; consistency in ensuring high standards of quality across the country. The NHS CB will work through its national, regional and local area teams to discharge these responsibilities.
2. One of the NHS CB's responsibilities will be to commission directly health services or facilities for persons who are detained in prison or in other secure accommodation and for victims of sexual assault. This document sets out the operating model through which the NHS CB will secure the best possible health outcomes for prisoners, detainees, children and young people in secure settings. These outcomes should be equivalent standards of care to those in the wider community.
3. The operating model has been developed collaboratively with stakeholders across the NHS and Youth and Criminal Justice System, including key contributions from colleagues in the Department of Health, regional and local NHS offender health teams and National Offender Management Service and the Home Office. This document is the one of a series describing the commissioning arrangements of the NHS CB, which includes victims of sexual assault, primary care, specialised services, military health and those public health services commissioned by the NHS CB (i.e. screening, vaccinations, and child health for 0-5 year olds and public health for people in prisons).
4. Our ambition is to support commissioners in delivering a consistent, high quality approach to the delivery of services that secure the best outcomes for people in prisons and other secure settings. The NHS CB will use the framework to drive local improvements in quality and outcomes and reduce health inequalities.

Overview

5. Section 15 of the Health and Social Care Act 2012¹ gives the Secretary of State the power to require the NHS CB to commission certain services instead of CCGs. These include 'services or facilities for persons who are detained in a prison or in other accommodation of a prescribed description.' Regulations allow the NHS CB to assume these powers from April 2013.
6. In addition to prisons and Young Offender Institutions, the 'other accommodation' referred to in the Act includes the following:

¹ Health and Social Care Act 2012, <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

- (a) Secure children's homes;
 - (b) Secure training centres;
 - (c) Immigration removal centres;
 - (d) Police custody suites; and
 - (e) Courts
7. As set out in a Section 7a agreement with the Secretary of State, the NHS CB will also commission public health services for offenders (eg tobacco control) and Sexual Assault Services (SASs) which cater for the needs of victims of sexual assault. The reason for including SASs within the responsibilities of the NHS CB is the close alignment needed between the NHS and Police to deliver services, which address both the patient's health needs and forensic enquiry to support any criminal investigation. These services will be funded through a public health resource stream as opposed to the funding arrangements for prisons or in other accommodation of a prescribed description, but the NHS CB's commissioning model has been designed to ensure relevant integration of the commissioning of these services all of which will be commissioned by the same teams.
8. The NHS CB will be responsible for ensuring that services are commissioned in ways that support consistently high standards of quality across the country, promote the NHS Constitution and deliver the requirements of the Secretary of State's Mandate and the section 7a agreement with the NHS CB.
9. *Developing the NHS Commissioning Board (July 2011)*² sets out a number of features that will characterise the culture of the NHS CB. The proposals for commissioning care in prisons and other places of prescribed accommodation reflect these characteristics and key requirements:
- A clear **sense of purpose** focused on improving quality and outcomes
 - A commitment to putting **patients, clinicians and carers** at the heart of decision-making
 - An **energised and proactive** organisation, offering leadership and direction
 - A **focused and professional** organisation, easy to do business with
 - An **objective** culture, using evidence to inform the full range of its activities
 - A **flexible** organisation, promoting integration, working across boundaries and performing tasks at the right level, whether national or local
 - An organisation committed to **working in partnership** to achieve its goals, in particular by developing an effective and mutually supportive relationship with clinical commissioning groups
 - An **open and transparent** approach, sharing information freely wherever appropriate
 - An organisation with clear **accountability arrangements** and a grip on those things for which it will be held to account.

² 'Developing the NHS Commissioning Board', DH, 2011

- Consistent with the institution's needs for maintaining appropriate levels of security

Context of health in prisons and other accommodation of a prescribed description

10. Healthcare in some secure accommodation is currently commissioned by other government bodies; such as NOMS for some contracted prisons, the UK Borders Agency (Immigration Removal Centres), Youth Justice Board (Secure Training Centres) the Local Authority (welfare only secure children's homes) and Police Authorities (Police Custody Suites and Sexual Assault Referral Centres). There is an agreed direction of travel to migrate these commissioning responsibilities to the NHS and many pilot schemes are already in place where Primary Care Trusts (PCTs) in partnership with the National Offender Management Service (NOMS) are commissioning healthcare in these establishments, especially adult prisons. Regulations will allow the transfer of most of these responsibilities to the NHS CB as the responsible NHS commissioner from April 2013.
11. The secure estate in England can be summarised as follows:
 - a. **120 prisons** – The National Offender Management Service (NOMS) is responsible for commissioning and delivering of services in 120 prisons and Young Offender Institutions in England, both through the public sector prison service (HMPS) and contracted providers. The NHS is currently responsible for all health services in public sector prisons as well as some or all health services in contracted prisons, the scope of which may vary by the type of contracts held with prison operators for individual establishments by NOMS. From April 2013 the NHS CB must be satisfied that it is meeting its duty under the Health and Social Care Act to arrange medical services for prisoners irrespective of custodial providers and arrangements will be in place to affect this assurance for all prisons.
 - b. **16 Secure children's homes (SCHs)** – Seven of the 16 SCHs provide beds only for looked after children who are placed in secure accommodation under a secure accommodation order under s25 of the Children Act 1989, in order to protect them from injuring themselves or others, or from suffering harm through absconding. These children and young people have not committed an offence. Nine of the 16 SCHs have places commissioned by the Youth Justice Board for children and young people remanded or sentenced to custody. In addition, they provide places for looked after children placed under a secure accommodation order under Section 25 of the Children Act 1989. SCHs have younger, more vulnerable children placed with them, between the ages of 10 and 17.
 - c. **Four Secure training centres (STCs)** – For younger more vulnerable young offenders who are usually between the ages of 13 and 17.

- d. **12 Immigration removal centres (IRCs)** – Run by the UK Borders Agency, IRCs are used for temporary detention in situations where people have no legal right to be in the UK but have refused to leave voluntarily.
 - e. **Police custody suites** – Currently the responsibility of police forces, healthcare commissioning responsibility is undergoing voluntary transfer to the NHS. 33 of the 39 police forces are currently part of the pilot.
 - f. **Courts** – Liaison and Diversion Services, designed to identify and direct offenders with mental health problems away from the criminal justice system to mental health services
12. In addition to these services, Section 22 of the Health and Social Care Act 2012 inserts a new power in section 7a of the NHS Act 2006, to enable the Secretary of State to delegate the funding and commissioning of public health services to the NHS Commissioning Board by mutual agreement. Services for victims of sexual offences are included as part of the section 7a agreement, and NHS CB has decided to adopt commissioning model for these services as part of the general offender health arrangements because of the alignment with the criminal justice system.
13. The table below summarises the transition of new health commissioning responsibilities to the NHS and the indicative resources associated with each.

Accommodation	Current / Transitional Commissioner	Commissioning Responsibility from 2013/14	Approximate Resources 2012/2013
Prisons & Young Offender Institutions	NHS/NOMS	NHS	£470m
Secure Children's Homes	NHS	NHS	£1.4m
Secure Training Centres	Youth Justice Board	NHS	TBC
Immigration Removal Centres	UK Borders Agency	Mid-transition to NHS	£6m
Police Custody Suites	Individual police forces	Mid-transition to NHS	£66m
Courts (Liaison and Diversion Services)	DH Funded	NHS	£19.4m

14. It is key to the success of this framework that there should be a seamless transfer in provision of services, using *the same standards and quality of care that can be expected in the community*. This is a core principle that will underpin the NHS CB commissioning of these services. The Secretary of State's Mandate to the NHS CB, which sets out the Government's expectations of the NHS, contains the following reference to offender health³:

³ The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015
<https://www.wp.dh.gov.uk/publications/files/2012/11/mandate.pdf>

“The NHS and its public sector partners need to work together to help one another to achieve their objectives. This is a core part of what the NHS does and not an optional extra, whether it is working with local councils, schools, job centres, housing associations, universities, prisons, the police or criminal justice agencies such as Police and Crime Commissioners and Community Safety Partnerships. The NHS Commissioning Board’s **objective** is to make partnership a success. This includes, in particular, demonstrating progress against the Government’s priorities of:

- contributing to reducing violence, in particular by improving the way the NHS shares information about violent assaults with partners, and supports victims of crime;
- developing better healthcare services for offenders and people in the criminal justice system which are integrated between custody and the community, including through development of liaison and diversion services;

15. Adult Offenders and children and young people in secure settings typically have poorer health and health outcomes than the average population. For instance:

- 81% of adult prisoners said they had used illicit drugs at some point prior to entering prison, including almost two-thirds (64%) within the month before entering prison.⁴
- Rates of using heroin and crack cocaine were higher among women (44% and 49% respectively) compared to men (30% reported using both substances during the year before custody).⁵
- In a recent survey of prisoners released from custody, 12% of prisoners said they had a mental illness or depression as a long-standing illness and 20% reported needing help with an emotional or mental health problem. 17% of prisoners had been treated or counselled for an emotional or mental health problem in the year before custody. ⁶
- Female prisoners are more than three times as likely to self-harm as male prisoners.⁷
- Children and young people in contact with the youth justice system have high levels of vulnerability: over one quarter have been looked after children at some point.
- The proportion of children and young people in custody who have experienced serious child maltreatment is at least twice that in the population as a whole.
- Children and young people in the youth justice system are at least 3 times as likely to have mental health problems than their non-offending counterparts, and interaction with the YJS, particularly being in custody, can exacerbate their mental health problems.

⁴ *surveying prisoner crime reductions (SPCR) in the 2010 compendium of reoffending statistics and analysis, MOJ statistical bulletin* www.justice.gov.uk/publications/compendium-reoffending

⁵ *Steward 2008*

⁶ *(surveying prisoner crime reductions (SPCR) in the 2010 compendium of reoffending statistics and analysis, MOJ statistical bulletin* www.justice.gov.uk/publications/compendium-reoffending)

⁷ *Safety in Custody 2010, published 28 July 2011*

- The rates of smoking, drinking and use of illegal drugs are substantially higher among young offenders than among young people who do not offend.⁸
16. In April 2009, the former Home Office minister Lord Bradley published his Ministry of Justice commissioned report 'People with mental health problems or learning disabilities in the criminal justice system'.⁹ The report made 82 recommendations for change, to tackle the over-representation of people with mental health problems in prisons in England. There were recommendations to divert offenders with mental health problems from custodial settings, to reduce the waiting time for people who need to be transferred from prison to hospital for urgent mental health treatment and for the NHS to take on responsibility for providing health services in police stations. The report made recommendations for each stage of the 'offender pathway', ie:
- early intervention, arrest and prosecution;
 - the court process;
 - prison, community sentences and resettlement; and
 - delivering change through partnership.
17. The Government accepted nearly all of these recommendations in full or in principle and the Bradley Report is already shaping the development offender health services.

Sentences and re-offending rates

18. As well as improving the health of offenders, it is recognised that health services commissioned for offenders also have an important contribution to youth and criminal justice outcomes. For example, the Public Health Outcomes Framework (PHOF) includes a range of outcomes which contribute to both the wider determinants of health and justice outcomes such as reducing reoffending
19. The following facts and figures illustrate the complexity of delivering integrated and non-custodial settings. Improving continuity and integration of care and reducing fragmentation will be a major challenge for the NHS CB and its partners.

Custodial sentences

- In the 12 months to March 2011 101,975 offenders were sentenced to immediate custody, out of 1,349,540 sentenced.
- The latest figures show that 20,500 offenders in 2010 were given two or more custodial sentences on separate occasions. This compares with a figure of 18,800 in 2006.

⁸ Healthy Children, Safer Communities

⁹ The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system', DH, April 2009

- The average length of time children and young people spend in custody is 41 days if they are on remand and 111 days if they have been sentenced.

Community sentences

- In the 12 months to March 2011 the courts imposed over 188,000 community sentences (14% of all sentences).
- In 2010, the majority of offenders complied with their community orders and completed them within the required time. Two thirds of all community orders terminated in 2010 had run their full course or were terminated for good progress.
- The overwhelming majority of children and young people in contact with the Youth Justice System (YJS) remain in the community throughout that contact. There were 85,300 children and young people supervised by a youth offending team (YOT) in 2010/11 and 45,519 of these children were first-time entrants to the YJS. The majority of children and young people sentenced to custody will spend the second half of their sentence in the community.

Re-offending rates

- Offenders sentenced to one to two years in custody had lower re-offending rates than those given custodial sentences of less than 12 months – the difference in proven offending rates was 4.4 percentage points in 2008. These findings are not conclusive on whether the deterrent effect of longer custodial sentences is effective at reducing re-offending. Offenders receiving sentences of less than 12 months do not have access to offender management programmes and are not subject to supervision by the Probation Service upon release.
- Around 110,000 children and young people were cautioned, convicted or released from custody between July 2009 and June 2010. Just under 36,000 of them committed a re-offence. This gives a re-offending rate of 34.1 per cent which represents a rise of 1.5 percentage points compared to the previous 12 months and a rise of 0.4 percentage points since 2000.
- However, compared to 2000, the characteristics of children and young people committing offences in the year ending June 2010 meant that they were more likely to re-offend. After controlling for offender characteristics, the re-offending rate actually decreased by 2.0 percentage points.¹⁰

¹⁰ Source: <http://www.justice.gov.uk/statistics/reoffending/proven-re-offending>

Sexual assault services (SAS)

20. Baroness Stern's review (2010) into how rape complaints are handled by public authorities in England and Wales recommended that "the funding and commissioning of forensic medical services should be transferred from the police to the NHS. We also endorse the view of the taskforce led by Sir George Alberti that forensic physicians should be employed by the NHS, have better access to high quality training, be an integrated part of the new NHS clinical governance framework and commissioned in sufficient numbers to meet the needs of rape victims".
 21. Sexual assault affects large numbers of people, women and children in particular, and for women the figures are close to the incidence of stroke in women in the UK. The 2011-12 British Crime Survey notes that 53,665 sexual offences were recorded by the police in England and Wales. The majority of these (83%) were the most serious sexual crimes i.e. rape, sexual assault and sexual activity with children. At least 22%* (9,615) of the most serious sexual crimes are committed on children under 13 years old.
 22. SAS provide a 24/7, one-stop shop to support victims of sexual assault and rape. Their services include forensic medical examinations, medical care including emergency contraception, post exposure prophylaxis after sexual exposure, sexually transmitted infection (STI) tests and treatment and referral for psychological support including pre-court counselling. Children comprise approximately 30% of all sexual assault and rape cases presenting in SAS and are referred with vulnerable adults to local safeguarding services and support. Care and support of sexually abused children needs to be integrated with care pathways to local paediatric services and community mental health services.
 23. The key challenges and priority service areas include assuring that victims of sexual assault and rape have access to SAS across England that meet the NHS standards and in particular, that paediatric services are resilient and
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offer appropriate access to clinicians trained in both forensic examination and safeguarding.

24. The Commissioning of Sexual Assault Centres will be the direct responsibility of offender health commissioners within NHS CB area teams. These teams will work closely with the local public health leadership. The document *Securing Excellence for Victims of Sexual Assault* will provide further details of the governance and commissioning responsibilities.

Commissioning functions

25. The NHS CB will be responsible for planning, securing and monitoring an agreed set of services for:
- Prisons;
 - Young Offender Institutions (YOIs);
 - Immigration Removal Centres;
 - Secure Training Centres;
 - Secure Children’s Homes;
 - Police Custody Suites;
 - Court Liaison and Diversion Services; and
 - Sexual Assault Services
26. The functions which underpin this responsibility are:
- a. **Planning** – services must meet national standards and local ambitions to ensure that services meet the needs of the population. Key stakeholders are involved in the process including a range of health professionals who contribute to patient care;
 - b. **Securing services** – using relevant service specifications to procure new services or to achieve new standards , establishing robust contracts through which providers can be held to account for delivering high quality and outcomes for prisoners and detainees, and victims of sexual assault, that are characterised by continuity of care and integration of services.
 - c. **Monitoring** – assessing and challenging the quality of services with an ever increasing focus on the outcomes achieved rather than inputs and processes; and using this intelligence to design and commission continuously improving services for the future.

The new commissioning landscape

27. The following organisations have roles to play in the commissioning of health care for people in prison or in other secure accommodation;
- a. **Department of Health (DH)** – the DH is the lead organisation for policy development. It will continue to set out the Secretary of State’s

expectations and requirements of the NHS and reflect them in the annual mandate provided to the NHS CB, which will also set out the resources allocated by government to the NHS. The Secretary of State retains responsibility for public health services and will either discharge those or enter into agreements for these responsibilities to be discharged by Local Authorities and Public Health England or, by agreement, through the NHS CB.

- b. **The NHS Commissioning Board (NHS CB)** – The NHS CB will be responsible for the direct commissioning of health services for people who are in prison or in other accommodation of a prescribed description. It will also assume responsibility for commissioning some public health services as set out in a section 7a agreement with the Secretary of State, including public health services (which include substance misuse services) for prisons. Area teams may choose to devolve responsibility to existing local joint commissioning arrangements for substance misuse in communities where they are satisfied that this will deliver their required outcomes. This may support more joined up through the gate services and continuity of care.
- c. **Clinical commissioning groups (CCGs)** – CCGs will be responsible for commissioning health services for anyone who is engaged with the youth and criminal justice system but is not in detention. In relation to children and young people, CCGs are under a statutory duty (Crime and Disorder Act 1998) to co-operate in the provision of multi-agency Youth Offending Teams. CCGs will also be responsible for the commissioning of emergency care services for ‘every person present in its area’. This means that emergency services such as Accident and Emergency and ambulance services must be available to prisoners or other persons in other accommodation of a prescribed description in the CCG area. Offender health commissioners will support CCGs to develop appropriate services to ensure adequate provision of Section 136 facilities.
- d. **Local Authorities (LAs)** – LAs will be responsible for commissioning many of public health services including substance misuse for people in their area including those who are engaged with the youth and criminal justice system. Local authorities will also commission open access sexual health clinics and genito-urinary clinics, services which may be used by victims of rape or other sexual assaults who do not want to disclose what has happened to them.

Value and principles

- 28. The Secretary of State for Health at a joint event between the Ministry of Justice and Department of Health in March 2011 described the aims for offender health commissioning as follows;

“We need to do better...true justice for the most vulnerable is about pulling people into treatment, not pushing them away from the support they need. People should get the same quality of services in prison as they do in the community...we have to do more in early intervention, to support children and young people before they reach crisis point...we need diversion services to be a cornerstone of better care and support for offenders with mental health problems”

29. Ensuring high standards of patient care for commissioned services is one of the core values within the NHS Constitution and therefore places a requirement on all providers to strive to deliver high quality and safe care to patients. In addition, commissioners of health care have an important role in driving quality improvement and gaining assurance around the quality of care delivered by the provider organisations from whom they commission services.
30. The NHS CB is at the heart of an integrated system of organisations and services that are bound together by the value and principles of the NHS Constitution. The NHS CB is committed to joint working relationships with a wide range of organisations at a national and local level to ensure that there are continuous improvements in health and well-being.

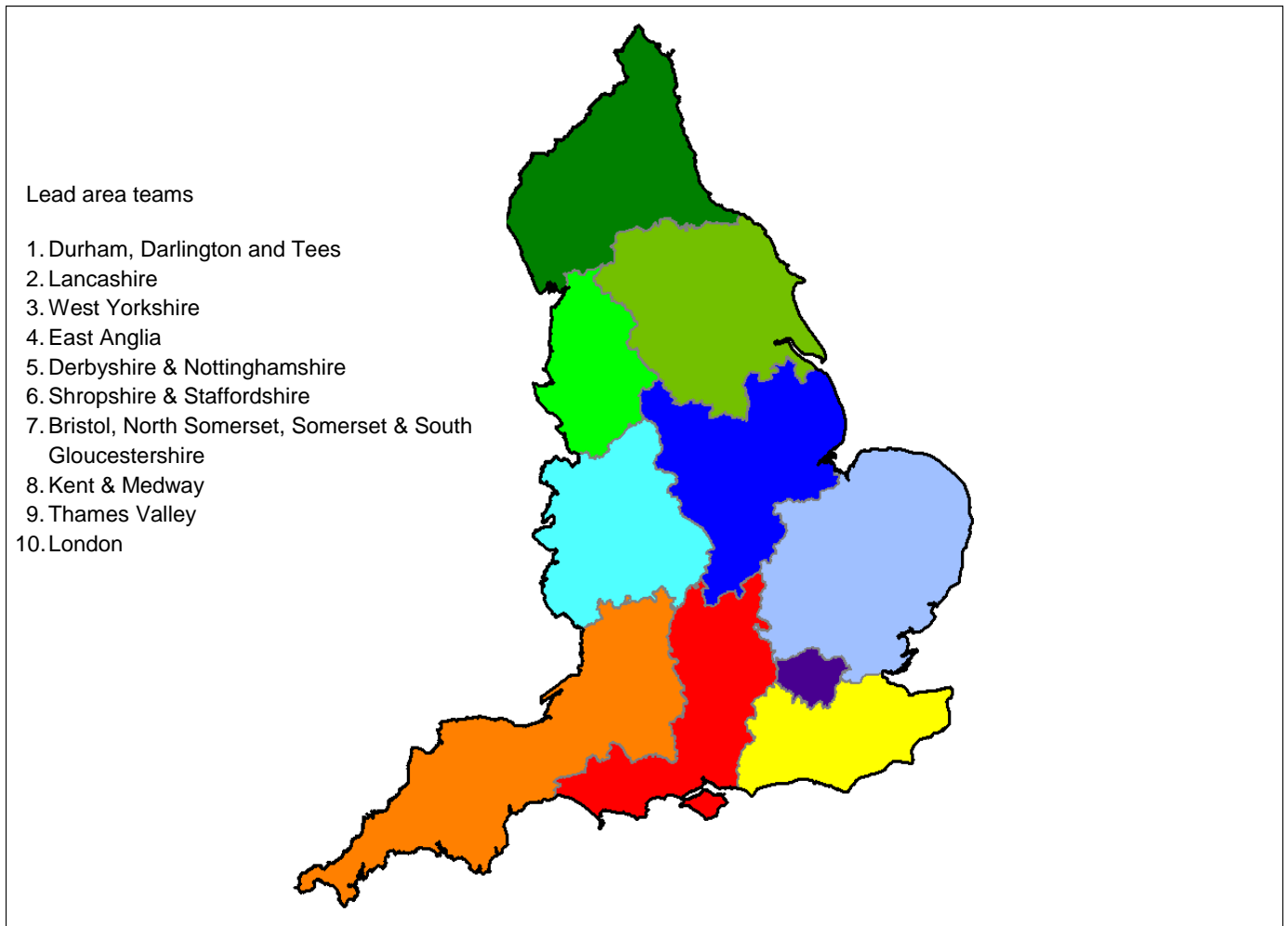
The integrated commissioning model

31. The NHS CB is structured with four regions and 27 area teams. Nine area teams and a regional team for London have been designated to build the expert capacity necessary to undertake the NHS CB's commissioning role, including commissioning of preventive and public health services as set out in the Section 7a agreement with the Secretary of State, in respect of persons detained in prison, or in other secure accommodation and the victims of sexual assault.
32. The institutions and police force areas each of the 10 offender health teams will cover are detailed in Appendix 1.
33. The funding the NHS CB receives for NHS care through the Mandate, and for public health services for prisoners, detainees, children and young people in secure settings and SAS through the Section 7a agreement, will be unified and directed through the NHS CB's structures to the nine area teams and the London region with responsibility for commissioning for prisons and detainees.
34. The nine area teams and the London region will enter into local agreements with other partners (in particular Local Authorities (LAs) and CCGs) to establish where appropriate pooled budgets and joint and co-commissioning arrangements with the youth and criminal justice system to maximise the efficient use of resources and concentrate expert commissioning (eg for substance misuse, mental health or children's services). They will also work

with CCGs and local authority DsPH to ensure effective integration and handover to local clinical public health services eg when people are discharged from secure to community settings. In addition, area teams may wish to secure additional support from local based expertise eg working with local specialist stop smoking services to complement training of staff working in secure settings.

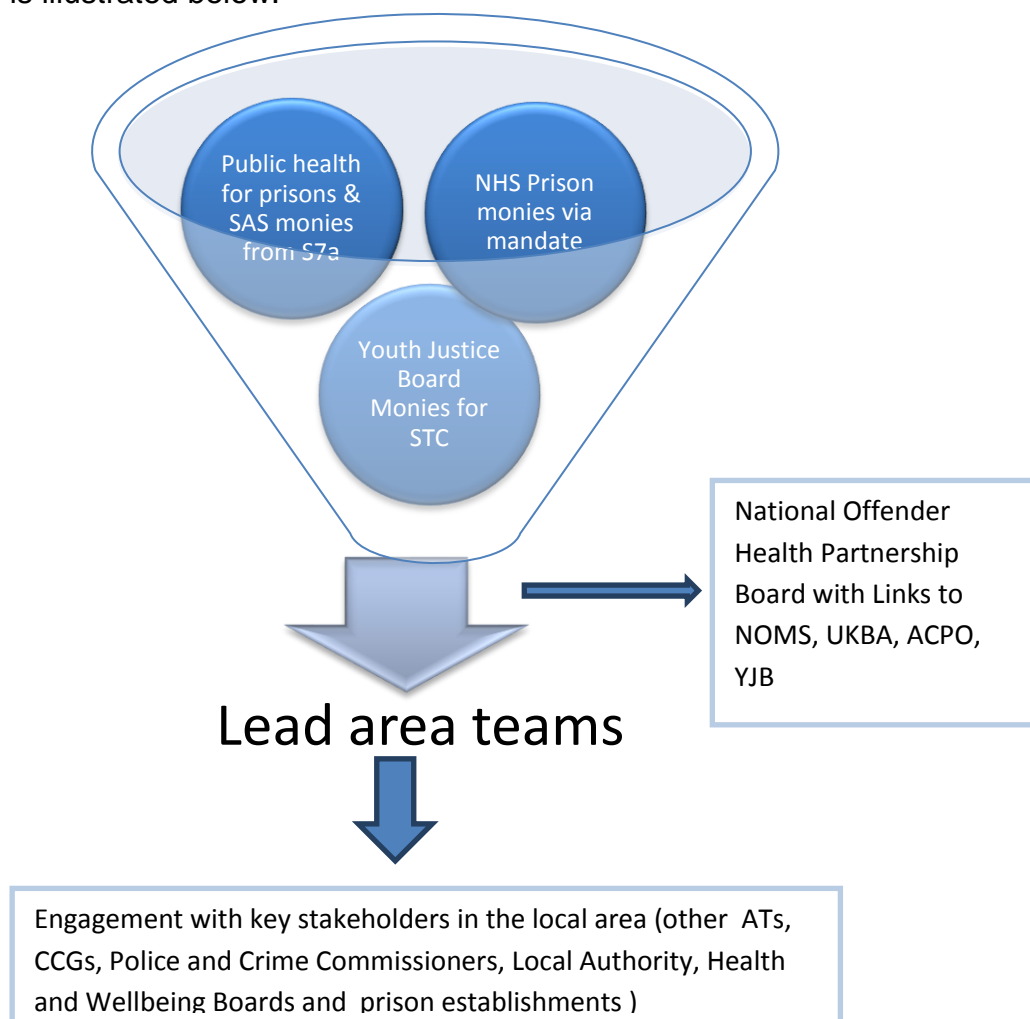
35. Appendix 1 details the prisons and other secure accommodation situated in each of the area teams, by region

Area of responsibility for lead local area teams for commissioning of offender health



36. Local Prison Partnership Boards and/or Health and Criminal Justice Boards, which bring together the interests of the NHS CB, CCGs, Prisons, the police, LAs, probation and the National Offender Management Service (NOMS). They are able to scrutinise and ensure the effective use of resources and foster continuity of care during transition from custody to community and can monitor and ensure equity of access for prisoners – as referenced in the Mandate provided by the Government to the NHS Commissioning Board. This will allow the alignment of Justice commissioning intentions with those of NHS CB offender health teams and local partnerships.

37. The process for partnership work with commissioners with expertise in child development and services appropriate for the health and well-being needs of children and young people in SCHs and STCs needs to be developed and embedded to ensure that safeguarding and other children's health and social care services meet with the Children's Health Outcomes Framework.
38. Health system reform presents an opportunity for health and criminal justice partners to work together more effectively. This opportunity is supported by inclusion of reducing re-offending rates and other related indicators in the Public Health Outcomes Framework and the requirements of the Mandate to the NHS CB. Partner agencies will be able to work together to develop outcomes aligned to local joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies (JHWBSs).
39. This system is illustrated below:



The operating model

40. The scope of health commissioning for prisoners, detainees and children and young people in secure settings transferring to the NHS CB will be set out in regulations. There are some tasks that are integral to discharging this responsibility.
41. The national responsibility for the commissioning of prisoners, detainees and children and young people in secure settings lies with the operations directorate of the NHS CB. A central national support team will provide the

framework to area teams to ensure commissioning consistency across the country. It will set the national strategic direction.

42. The NHS CB will inherit many and varied contractual forms and service level agreements which will have been locally negotiated. Initially, area teams will 'lift and shift' these local agreements, managing these locally negotiated contracts until such a time that all contracts are brought in line with the standard NHS Contract. The intention is that this should be achieved by 2015. It will also be important that area teams review the current contract content to ensure it is fit for purpose and consistent with the agreed national approach and Section 7a specifications.
43. The NHS CB will develop a single approach for agreeing what will be commissioned, to what standard within available resources. This will help reduce inequalities of access to services which prisoners and detainees currently experience across England.
44. New governance mechanisms will be put in place through which the NHS CB will discharge its responsibilities. These are currently being co-produced with partners, regions and area teams.
45. Individual funding requests for treatments not normally commissioned will be considered by the specialist commissioning teams that have responsibility for this function on behalf of all aspects of NHS CB direct commissioning.
46. Clause 13(3)(1C) of the Health & Social Care Act 2012 makes CCGs responsible for the provision of services or facilities for emergency care (ie emergency ambulances, A&E, walk-in and 111 services) 'for any person present in its area'. This is a legal responsibility that cannot be delegated to another body for particular groups of the local population. If a prisoner, child or young person in a secure setting needs emergency care services, CCGs are responsible. If, after accessing those emergency services, the patient is assessed as needing for instance an emergency operation or follow-up care, the NHS CB becomes responsible for this element of the care pathway.
47. With the exception of emergency care services described in paragraph 45, the NHS CB is responsible for commissioning all the healthcare needs for people in prison or other accommodation of a prescribed description (i.e. primary care, mental health services, public health services, other community health services and secondary care (physical and mental health)). For victims of sexual assault, people in court or in police custody, the scope of the NHS CB's commissioning responsibility extends only to the services commissioned within those environments, for instance, mental health liaison and diversion services for police custody and courts, and forensic examination and other health services provided in SARCs and police custody suites. It does not extend to secondary care referrals originating from these environments if the individual is no longer in secure accommodation.
48. To improve integrated care for offenders, there needs to be seamless service delivery and planning across pathways and across commissioners. This is particularly true for those prisoners who are moved frequently from prison to prison for security reasons. It is important for the NHS CB to engage at a

local level with CCGs and LAs as well as the prison service to manage the interface between services for patients and to manage the clinical service providers collectively. This will be the responsibility of all area teams and not just the responsibility of the 10 lead offender health teams.

49. There are a number of interdependencies still being considered as part of the overall design and future responsibilities of commissioning of services for people in prison or other secure settings and victims of sexual assault and some of these may not become the full responsibility of the NHS CB from April 2013.
50. The model needs to be flexible in its approach to respond to this and other emerging strategies.

Content of the framework

51. The new commissioning system aims to combine local knowledge with shared national values and behaviours with information flowing between local and national teams contributing to the key outcomes and improvement areas , namely:
 - a. **Reducing health inequalities;**
 - b. **Ensuring services are integrated; and**
 - c. **Reducing health risk factors.**
52. At a national level the NHS CB will work with key stakeholders to determine the outcomes expected of Offender Health Commissioning, and ensuring these are integrated with the NHS, Public Health, Children's, Social Care and Commissioning outcome frameworks,
53. To support this, the NHS CB will, over time, build a range of standard national operating procedures. These will be kept under review to ensure their continuing fitness for purpose within the context of the developing commissioning system.

Relationship to outcomes frameworks

54. The Public Health Outcomes Framework¹¹ and NHS Outcomes Framework¹² and the Children's Health Outcomes Framework include outcomes that are relevant to the provision of health services to Offenders and persons who are detained in other accommodation of a prescribed description and will form

¹¹ The Improving Outcomes and supporting transparency Part 1: A Public Health Outcomes Framework for England, 2013- 2016, <https://www.wp.dh.gov.uk/publications/files/2012/11/29-People-in-prison-specification->, <https://www.wp.dh.gov.uk/publications/files/2012/11/30-Sexual-Assault-Services-specification-121029.pdf>http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132559.pdf

¹² The NHS Outcomes Framework 2012/13

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf

part of the overall assurance to the NHS CB these include outcomes related to the :

- national immunisation programmes
- national routine screening programmes (non-cancer)
- national routine cancer screening programmes
- children's public health services from pregnancy to age 5 (for pregnant detainees)
- child health information systems
- public health services for people in prison and other places of detention
- sexual assault referral centers
- shared outcomes with youth and criminal justice including reducing reoffending and first time entrants to the youth and criminal justice system

Key principles

55. The NHS CB will usually manage contractual relationships within a consistent framework. However, in doing so it will also demonstrate enough flexibility to allow service developments and improvements to be locally responsive to meet the needs of individuals and local circumstances. All commissioning decisions will be based **on outcomes and value for money** and have regard to changing policy and nationally agreed commissioning guidance.
56. Commissioning should aim to **reduce inequalities in care provision** and show improvements against the wider factors that affect health and wellbeing and health inequalities. It will take account of the 2010 Equality Act and other relevant legislation.
57. Teams will work in one system and to one set of operating principles, but in ways that are sensitive to the local circumstances.

The NHS Outcomes Framework 2012/2013



Commissioning support service functions

58. The arrangements for commissioning support are set out in *Developing Commissioning Support; Towards Service Excellence (February 2012)*.
59. It is likely that the following functions will be purchased from commissioning support units (CSU).
 - Specialist Procurement support:
 - market analysis,
 - identifying best value providers to respond to service needs
 - lead on the tendering process up to the point of contract award.
 - Business intelligence support:
 - data collection and information analysis (Secondary care and contractual data)
 - data validation
 - database management
 - monitoring of achievement of key performance indicators and quantitative service standards
 - contract reporting and forecasting

The local/central relationship

60. The relationship between the local NHS CB team, local clinicians, the local authorities, prisons along with other accommodation of a prescribed description is central to the operating model. This will be a new way of working and will benefit from clinical support and expertise along with high quality management and systems.
61. The central NHS CB will provide the frameworks to ensure consistency in commissioning. This will draw on nationwide insight and intelligence and

reflect innovation, clinical knowledge and expertise and the NHS Constitution and Mandate.

62. A national framework will be developed that local teams can use for performance management, the management of local relationships and routine quality assurance and improvement.
63. The national team will lead on creating a framework for service level agreements with key stakeholders from the Home Office, NOMS, Youth Justice Board and local authorities including the use of premises for the delivery of healthcare where necessary.
64. The centre, regions and area teams need to work in a fully coordinated and integrated way to ensure the local activity informs the national strategy and vice versa. To improve outcomes, there must be a strong connection between design and delivery and this requires capacity and capability as well as strategic leadership.

Common operating procedures and principles

65. Offender health leads and other key stakeholders are working with the NHS CB central team to develop a series of common operating policies and principles to guide the work of area teams. These include policies on;
 - a. Secondary care commissioning;
 - b. The management of the commissioning interface of public health services with relevant stakeholders including Local Authorities, CCGs, children commissioners;
 - c. Standard policies for the delivery of the public health service specifications which are relevant to this cohort of patients;
 - d. Standard operating procedures for working with Prisons and Probation Ombudsman, Her Majesty's Inspectorate of Prisons, Independent Monitoring Board, Independent Police Complaints Commission and a national policy for death in custody reviews;
 - e. Work within the national IT programme to ensure standardised services and specifications; and
 - f. Standard models for delivery for learning & disability services.

Indicators

66. The set of indicators that reflect the performance and outcomes of on Offender Health includes:
 - a. NHS Outcomes Framework indicators that are clinically significant to the offender health population

- b. Public Health and Children's Outcomes Framework indicators that increase the life expectancy and reduce the inequalities of care for this community.
- c. NICE guidelines for Offender Health topics (in development). It is expected once this work has been completed that these will be incorporated into relevant national framework. The topics NICE are looking at are:
 - Guidance for those working in health, youth and criminal justice, education and social care sectors on the cost effectiveness of interventions for the prevention and early treatment of the mental health problems of offenders, taking account of the whole offender pathway
 - Guidance for those working in health, youth and criminal justice, education and social care sectors on the early intervention and management of young people who display sexually harmful behaviour
 - Joint clinical and public health guidelines for commissioners and service providers working in health and the youth and criminal justice sectors on ensuring people in prison, and, children and young people in a secure setting, have full and appropriate access to care known to be cost effective in preventing, diagnosing and managing physical health problems (both acute and chronic, infectious and non-infectious).
 - Joint clinical and public health guidelines for commissioners and service providers working in health and the youth and criminal justice sectors on an integrated model for addressing mental health in prison and in secure settings for children and young people.
 - Indicators that are not currently in any of the frameworks but are felt to be significant for this health community, that meet the overall aims of reducing inequalities
 - Indicators relevant for meeting the needs of children and young people.
- d. Intercollegiate Healthcare Standards for Children and Young People in Secure Settings. The Royal College of Paediatrics and Child Health, the Royal College of General Practitioners, the Royal College of Nursing, the Royal College of Psychiatrists and the Faculty of Public Health have worked together (funded by the Youth Justice Board) to agree draft standards, that will facilitate the development of high quality health services for children and young people (CYP) in secure settings. The standards are not listed in priority order but are designed to follow the pathway of a CYP through a secure setting.
 - Entry and Assessment
 - Care Planning
 - Universal Services
 - Physical Healthcare and Intervention

- Mental Healthcare and Intervention
- Substance Misuse Care and Intervention
- Transfer of Care
- Healthcare Environment and Facilities
- Planning and Monitoring
- Multiagency Working
- Staffing and Training

IT and data management

67. The Offender Health IT programme currently delivers a prison health care system. It is deployed as a 'closed' system which effectively means that there is no electronic sharing beyond or electronic data flow into or out of, prison healthcare. The system runs across the NHS N3 network but is not connected to the spine; additionally it has provided informatics implementation guidance to the 21 pathfinder Police Services who are working with local NHS commissioners to commission health care in Police custody, the UK Borders Agency regarding Immigration Removal Centres and the Department of Health Liaison and Diversion Working Group.
68. There are approximately 130,000 new receptions into custody per annum; on average 100 people leave a local prison each day to go to court or be released, 50 of those that go to court return to prison and there are 50 new receptions each day; on average a local prison transfers over 100 prisoners per month to another prison.
69. In order to support improved access to health care and to make contributions to reducing re offending it is critical that solutions are developed which enable health systems for this group to function as a pathway so that care and treatment at any point in the Youth and Criminal Justice system is integrated, effective and efficient. Enhanced clinical risk management, case management and the ability to transfer and share information at each stage are key outcomes which will support significantly improved outcomes.
70. This new work item supports the following strategic and policy objectives and is currently being developed in conjunction with NHS Connecting for Health.
- a) To provide NHS commissioned care to all 'prisons or other accommodation of a prescribed description' by 2015.
 - b) To reduce offending and the prison population, and the numbers of children and young people in secure settings by support for liaison and diversion at the first point of contact with the youth and criminal justice system, generally police custody
 - c) To continue to ensure equality of health care provision to prisoners as well as children and young people in a secure setting who have some of the most complex health care needs.

Tasks and functions

71. The table below set outs how commissioning tasks and functions might be allocated with the NHS CB.

Planning	Services to meet national standards and local ambitions
National Offender Health Team	<ul style="list-style-type: none"> • Develop commissioning policy • OH commissioning outcomes framework • OH healthcare budgets • Manage and engage with national departments and key national stakeholders • Develop National Policy
Local team	<ul style="list-style-type: none"> • Implement national policy and strategic vision • Ensure that OH is integrated into local joint strategic needs assessments • Engage and consult with key stakeholders, including CCGs, Health & Wellbeing Board, NOMs, Local Authorities, Probation & Police • Agree commissioning specifications and standards • Allocate finances to specific services and contracts • Undertake service reviews • Health & Wellbeing Assessments • Patient and public Consultation & involvement
Regional team	Will support and work with the national & local teams to develop policy and strategy.
Securing and procuring	Services through the contracting route to deliver the best quality and outcomes
National Offender Health Team	<ul style="list-style-type: none"> • Provides guidance on model of commissioning • Agree national performance frameworks with partners • Ensure that services meet national targets on quality and cost.
Local team	<ul style="list-style-type: none"> • Commissioning of appropriate quality services for the local setting • Development of local service specifications • Agree procurement approach and contractual agreements • Support providers in the delivery of services • Develop statements of readiness in the transfer of police custody suites and SAS
Regional team	<ul style="list-style-type: none"> • Approve the annual regional procurement plan • Provide regional guidance to area teams on contractual consistency
Monitoring	Monitoring, Assessing and where necessary challenging quality and outcomes, including arrangements for contract management
National Offender Health Team	<ul style="list-style-type: none"> • Engage with inspectorate and regulatory bodies • Manage national contingencies and risks • National performance monitoring (PHPQI,

	Substance misuse and the requirements of s7a etc)
Local team	<ul style="list-style-type: none"> • Risk management • Oversight of remedial action plans • Contract management (including contractual notices) • Advice providers on delivery, through service specification and contract variation • Carry out commissioning audits • Quality assure service delivery • Financial monitoring of budgets • Performance monitoring and management • Demand planning and activity monitoring
Regional team	<ul style="list-style-type: none"> • Ensure best practice is adopted across the commissioning board • Support the regional development of standard service specifications and tender templates

Next steps

72. In the coming months the NHS CB will provide more details about the operating arrangements including:
- a) Fully explore the interdependent relationships critical for the operating model and take any action to ensure they work effectively
 - b) Continue to work with stakeholders to identify risks and manage the transition
 - c) Test and operate standard operating models and, in the light of experience, where necessary make adjustments
 - d) Refine the scope and requirements for commissioning support services
 - e) Development of a communications plan for the NHS and other key stakeholders

Acknowledgements

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Appendix 1: Prisons and secure accommodation by NHS CB area teams

NHS North of England

Sub Region	Area teams (<i>lead AT highlighted</i>)	Prisons	Early Adopter Police Sites	IRCs STCs/SCHs
North West				
	Lancashire	Garth Kirkham Lancaster Farms Preston Wymott	Lancashire (1 st Wave)	
	Merseyside	Liverpool Altcourse Kennet	Merseyside	Red Bank SCH St Cath's SCH
	Cheshire, Warrington & Wirral	Styal Risley Thorn Cross	Cheshire (1 st Wave)	
	Greater Manchester	Hindley Forest Bank Buckley Hall Manchester	Greater Manchester (1 st Wave)	Pennine Hse IRC Barton Moss SCH
North East				
	Durham, Darlington & Tees	Deerbolt Durham Frankland Low Newton Holme House Kirklevington	Durham	Aycliffe SCH Hassockfield STC
	Cumbria, Northumberland & Tyne and Wear	Haverigg Northumberland	Cumbria Northumbria (1 st Wave)	Kyloe house SCH
Yorkshire & Humber				
	West Yorkshire	Wakefield New Hall Leeds Wealstun Wetherby	West Yorkshire (1 st Wave)	East Moor SCH
	North Yorkshire & The Humber	Everthorpe Full Sutton Wolds Hull Askham Grange Northallerton	North Yorkshire	
	South Yorks & Bassetlaw	Doncaster Lindholme Moorland Hatfield	South Yorkshire	Aldine House SCH

NHS Midlands and East

Sub region	Area teams (<i>lead AT highlighted</i>)	Prisons	Early Adopter Police Sites	IRCs STCs/SCHs
West Midlands				
	Arden, Herefordshire and Worcestershire	Hewell Grange Long Lartin	Warwickshire West Mercia	
	Birmingham & the Black Country	Birmingham	West Midlands (1 st Wave)	
	Shropshire & Staffordshire	Werrington Drake hall Swinfen Hall Brinsford Dovegate Featherstone Stafford Stoke Heath Oakwood	Staffordshire (1 st Wave) West Mercia	
East Midlands				
	Derbyshire & Nottinghamshire	Foston Hall Sudbury Nottingham Lowdam Grange Whatton Ranby	Nottinghamshire Derbyshire (1 st Wave)	Clayfields Hse SCH
	Leicestershire & Lincolnshire	Leicester Stocken Gartree Glen Parva Lincoln North sea Camp	Leicestershire	Morton Hall IRC Lincolnshire Secure Unit
East of England				
	Essex	Chelmsford	Essex	
	East Anglia	Littlehey Peterborough Whitemoor Highpoint South Highpoint North Hollisley Bay Warren Hill Blundeston Wayland Norwich Bure	Cambridgeshire Suffolk Norfolk	
	Hertfordshire & the South Midlands	Rye Hill Onley Woodhill Bedford The Mount	Northamptonshire Bedfordshire	Oakhill STC Yarls Wood IRC

NHS South

Sub Region	Area teams (<i>lead AT highlighted</i>)	Prisons	Early Adopter Police Sites	IRCs STCs/SCHs
South West				
	Bath, Gloucestershire, Swindon & Wiltshire	Erlstoke	Avon & Somerset	
	Bristol, North Somerset, Somerset & South Gloucestershire	Bristol Ashfiled Eastwood park Leyhill	Avon & Somerset	Vinney Green SCH
	Devon, Cornwall & Isle of Scilly	Channings Wood Dartmoor Exeter	Devon & Cornwall (1 st Wave)	
South East				
	Kent & Medway	Rochester Elmley Standford Hill Cookham Wood Blantyre House East Sutton Park Maidstone Swaleside	Kent (1 st Wave)	Dover IRC Medway STC
	Surrey & Sussex	Lewes Ford Bronzefield Coldingley Downview Highdown Send	Sussex	Tinsley IRC Brooke Hse IRC
South Central				
	Thames Valley	Reading Aylesbury Bullington Grendon/sprillhill Huntercombe	Thames Valley	Campsfield IRC
	Wessex	Winchester Isle of White Dorchester Guys Marsh Portland The Verne	Hampshire Dorset	Haslar IRC Swanwick Lodge SCH

NHS London

		Prisons	Early Adopter Police Sites	IRCs STCs/SCHs
London				
	North East London	Holloway Pentonville	The Metropolitan & City of London	
	South London	Belmarsh Isis Brixton Wandsworth Thameside	The Metropolitan & City of London	
	NW London	Wormwood Scrubs Feltham	The Metropolitan & City of London	Colnbrook IRC Harmondsworth IRC

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