Public Health England

NHS

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 Secure Estate

NHS England and NHS Improvement

Promoting equality and addressing health inequalities are at the heart of NHS England and NHS Improvement 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 Secure Estate.

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Service Specification No.29 (SS29)

This is a service specification to accompany the 'NHS public health functions agreement 2019-20 (the '2019-20 agreement') published in December 2015.

This service specification is to be applied by NHS England and NHS Improvement in accordance with the 2019-20 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 2019-20 agreement was made between the Secretary of State and NHS England and NHS Improvement Board, unless otherwise specified. Any changes in other published documents or standards may have effect for the purposes of the

2019-20 agreement in accordance with the procedures described in Chapter 3 of the 2019 -20 agreement.

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

The 2019-20 agreement is available at www.gov.uk (search for 'commissioning public health').

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

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Chapter 1: Scope of Service Specification 29 (SS29)

Aim

This document describes the scope of public health programmes commissioned by NHS England and NHS Improvement for people in prison and other prescribed places of detention (PPDs), including the Children and Young People 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 120 prisons in England (and a further 4 in Wales) in use at this time. **Her Majesty's Prison and Probation Service (HMPPS)**[1] 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 a discrete arm of HMPPS. The Youth Custody Service is responsible for commissioning and delivering the CYPSE and the Home Office provides Immigration Removal Centre's (IRCs). There are approximately 85,000 people in prisons at any one time, 2,138 people in IRC's and around 926 children under the age of 18 years in the children's secure estate.

- Detailed data including weekly updates are available at

https://www.gov.uk/government/statistics/prison-population-figures-2015). NHS England and NHS Improvement assumed responsibility for commissioning healthcare in prisons in April 2013.

1.2 **Immigration Detention Estate:** The Home Office Immigration Enforcement Directorate (HOIE) commissions 7 Immigration Removal Centres in the UK (6 in England and one in Scotland) and two short term holding facilities one in England and one in Northern Ireland) 2. The UK detention estate can hold about 3,000 people. Of the 2,138 people in detention as at the end of March 2017, 250 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 (78% in Q4 2017) of people in immigration detention - leave detention within 29 days. In 2017 30% of detainees leaving detention were removed through enforcement and a further 7% left voluntarily. The remaining 63% 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-2018 In September 2014, NHS England and NHS Improvement received the commissioning responsibility for health

[1] For more information see https://www.gov.uk/government/organisations/her-majestys-prison-and-probation-service

provision across the IRC estate in England with the exception of Campsfield House in Oxfordshire which was subsequently transferred in April 2015. Campsfield House IRC closed in December 2018.

1.3 **The Children & Young People Secure Estate (CYPSE)** includes Young Offender Institutions under 18 (YOIs), Secure Training Centres (STCs) and Secure Children's Homes (SCHs)[2]. The Youth Custody Service (YCS)[3] commission's 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 Section 25 of the Children Act 1989 on welfare grounds into Secure Children's Homes.

More information on the population held is available at

https://assets.publishing.service.gov.uk/government/uploads/attachment_data/file/774866/youth-justice

and children accommodated in Secure Children's Homes

https://www.gov.uk/government/statistics/children-accommodated-in-secure-childrens-homes-31-march-2018

1.4 **NHS England and NHS Improvement** has responsibility for commissioning healthcare for both youth justice and welfare places in the whole of the CYPSE since April 2014.[4]

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

[3] For more information on YCS visit ?

[4] Oakhill STC is currently out of NHS England and NHS Improvemen operating regulations.

Chapter 2: Understanding and meeting health needs

2.1 Health inequalities

Individuals in prisons and other PPDs, compared with peers in the community, often experience significant health inequalities including higher rates of substance misuse (drugs, alcohol, misuse of medicines 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 long term conditions (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[5]. 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 health 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 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 may 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 21st century" 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 NHS Improvement 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 outcome, access, quality and service are equivalent.[6]

[5] Prison Reform Trust, 2006 Public health functions to be exercised by NHS England and NHS Improvement

[6] 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-

- **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 be 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 'under- served' 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 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 and NHS Improvement 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 and NHS Improvement, 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 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 and NHS Improvement 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 and NHS Improvement have also commissioned and published a summary

health/publications/2013/good-governance-for-prison-health-in-the-21st-century.-a-policy-brief-on-the-organization-of-prison-health-2013

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)

NHS England and NHS Improvement is responsible for the direct commissioning of health services in prisons, Immigration Removal Centres (IRCs), Sexual Assault Referral Centres (SARCs), Secure Children's Homes (SCHs), Secure Training Centres (STCs), and under-18 Young Offender Institutions (YOIs). The latter three form the Children and Young People Secure Estate (CYPSE). NHS England and NHS Improvement is committed to delivering consistent, high quality services in order to secure the best outcomes for people in secure settings. The core functions that underpin NHS England and NHS Improvement responsibility lie with the planning of services to meet national standards and local needs; securing of services with robust contracts that hold providers to account; and monitoring the quality of services with an outcome focus.

2014-15 saw the introduction of a new dataset in Health & Justice, The Health & Justice Indicators of Performance (HJIPs) for the adult prison estate. Following this, in 2016-17 the Health & Justice Children & Young People HJIPs (now renamed CYPIPs for clarity) were implemented. As well as the IRC HJIPs, SARCIPs and new Liaison & Diversion Indicators of Performance (LDIPs), these datasets collect information on the delivery and outcome requirements NHS England and NHS Improvement are required to commission as part of their organisational responsibilities. The National Business Intelligence contract aims to support commissioners through the provision of information, support and guidance to assist them in assurance of commissioned services. Indicators sit alongside the Health and Justice Commissioning Intentions 2017/18 document, which sets out for commissioners and health service providers the commissioning intentions for services commissioned by the Health and Justice host Sub Regional Teams, and outlines the ambition for improving the quality of health services and health outcomes for people in secure settings.

The CYPIPs provide an opportunity for the collection of vital high-level performance data from the clinical IT system in many secure settings. Some of the indicators rely on data collated via the Comprehensive Health Assessment Tool (CHAT). All providers in the CYPSE are already commissioned to deliver the CHAT.

The aim of collecting indicators of performance is to:

- Help inform the development of national and local policy on health service provision in the secure and detained estates.
- Support effective local commissioning and aiding commissioners with service improvement through the production of reliable data that can be used in the development of Health and Well-being Needs Assessments (HWBNAs).
- Act as a quality improvement and contract monitoring tool for health and well-being service providers in the sector.
- Aid in the assurance process for commissioners and their partners: proving that health service delivery in the secure and detained estates is fit for purpose, and that it is constantly evolving and improving.
- Provide supportive information that will feed in to local partnership boards.

- Support the Care Quality Commission (CQC), HM Inspector of Prisons (HMIP), Ofsted and all other auditors in their work.

2.5 Partnership Work

NHS England and NHS Improvement need 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 and NHS Improvement, 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 National Partnership Agreement for health and justice, as it relates to detained adults, is available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/767832/6.4289_MoJ_National_health_partnership_A4-L_v10_web.pdf

In relation to IRCs, the Partnership Agreement is available at:

https://www.england.nhs.uk/wp-content/uploads/2018/07/home-office-immigration-enforcement-partnership-agreement.pdf

In relation to children, the Children and Young people Secure Estate National Partnership Agreement 2018-2021 is available at:

https://www.england.nhs.uk/wp-content/uploads/2018/09/the-cyp-secure-estate-national-partnership-agreement.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 PPD setting should not exclude people from access to healthcare including screening and immunisation programmes, and should seek to achieve the same outcomes as community provision;

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, and taking account of the setting in which it is offered.

Public health programmes to be commissioned by NHS England and NHS Improvement 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 and NHS Improvement commissioned programmes must therefore take account both of the specific population and the specific secure setting.

Healthcare commissioned by NHS England and NHS Improvement 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 and NHS Improvement 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 and NHS Improvement - see section 2 above).

3.1 Healthcare standards for CYPSE

The 2013, Intercollegiate Healthcare Standards for Children and Young people in the Secure Estate are subject to a refresh and the refreshed standards will be published in Spring 2019.

'Healthcare Standards for Children and Young People in Secure Settings' available at: (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 settings (young offender institutions under 18, (YOIs) secure training centres (STCs) secure children's homes (SCHs).

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

The document is the standard against which NHS England and NHS Improvement should commission healthcare in the CYPSE and it informs the CYPIPs 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. However, 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 then SOS Andrew Selous on 29th 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 and NHS Improvement. Nationally around 80% of prisoners smoke compared with around 20% in the general population.[7] [8] [9] [10] Similar high rates of smoking have also been observed across the criminal justice system (CJS).[11] [12] [13] When high quality evidence based stop smoking services are provided, cessation rates in prisons are comparable as with those seen in community settings.[14] 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 likeliness of attempts at cessation. There is also a history of tobacco being used as a currency in prisons and

[7] Singleton N, Farrell M & Meltzer H. Substance Misuse among Prisoners in England and Wales. London: Office for National Statistics. 1999

[8] Lester C, Hamilton-Kirkwood L, Jones N. Health Indicators in a prison population: asking prisoners. Health Education Journal 2003;62:341-349

[9] 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.

[10] Public Health England (PHE). Survey of local prisons. Unpublished, 2014.

[11] 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.

[12] 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

[13] 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

[14] HSCIC Statistics on NHS Stop Smoking Services in England - April 2014 to March 2015 http://www.hscic.gov.uk/lifestyles

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: Ongoing cessation provision is offered though most take up relates to receptions into prison from the community (e.g. into Local and Reception prisons). This service provides access to smoking management services to address the high burden of nicotine dependency in this population. NHS England and NHS Improvement supports the optimization of 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 and nicotine dependence harm reduction 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 Service and Delivery guidance 2014.[15]

The roll out of the Smoke Free Prisons programme completed in April 2018, and now ongoing cessation provision is offered though most take up relates to receptions into prison from the community (e.g. into Local and Reception prisons).[16]

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 and NHS Improvement is responsible for commissioning substance misuse (drug and alcohol) services for individuals in custodial and detention settings. This does not, however, include those who are acutely ill (and in danger of death) as a part of alcohol withdrawal, who should be dealt with in adult acute care within the community.

Over 59,000 individuals receive structured treatment for drug or alcohol problems within English custodial settings each year (PHE NDTMS 2016-17) 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 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

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)

(Estimating the Crime Reduction Benefits of Drug Treatment and Recovery', NTA 2012 http://www.nta.nhs.uk/uploads/vfm2012.pdf)

[15] NCSCT Service and delivery guidance 2014 http://www.ncsct.co.uk/publication_service_and_delivery_guidance_2014.php

[16] CYPSE is smoke free.

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

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/)

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 and NHS Improvement 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

Services will be delivered against a National Service Specification[17] in line with current DH and NICE standards. Updated clinical guidance for the management of drug dependence was published in 2017. 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 https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

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

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

National Treatment Agency & Youth Justice Board (2012), Substance misuse interventions

[17] https://www.england.nhs.uk/publication/service-specification-integrated-substance-misuse-treatment-service-prisons-in-england/

within the Young People's Secure Estate: Guiding Principles http://www.nta.nhs.uk/uploads/secureestateguidelinesv1.2.pdf

Continuity of Care 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 Her Majesty's Prisons and Probation Service (HMPPS), Youth Justice Board and other agencies to provide service users with high-quality care.

The NHS England and NHS Improvement Long Term Plan[18] gives a commitment to the improvement of continuity of care for adults following custody, through the introduction of the RECONNECT service (testing 2019-20 and roll out from 2020).

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/

[18] https://www.longtermplan.nhs.uk/

- 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 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, (sentenced to 4 years plus) 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 incidents. The impact of a communicable disease on the populations in PPDs,19

[19] 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/

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.

In addition, all areas must take due cognisance of the WHO and NHS England and NHS Improvement ambition to eliminate Hepatitis C as a public health issue by 2030 and 2025 respectively. Effective diagnostic procedures within the secure and detained estate is central to the achievement of this aim and the throughput of affected patients to curative treatment.

Service Function: NHS England and NHS Improvement 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 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 2018-19, 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

documents/2014/90-90-90

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 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.

From 2019, it is planned that vaccination programmes in PPDs will include a pilot / phased implementation of Human Papilloma Virus vaccination in a selection of prisons, echoing the community pilot that has taken place to opportunistically vaccinate men who have sex with men (MSM). Prisons will offer this vaccination on an 'opt-out' basis; full roll out will be subject to future identification of funding for the programme, based on learning from early adopter areas.

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[20].

Service Function: NHS England and NHS Improvement 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.

[20] 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

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 custody and care 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 and NHS Improvement 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 and NHS Improvement 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 compliant 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

User guidance for all Indicators of Performance will be available for 2019/20 on the NHS England and NHS Improvement Health & Justice webpage within due course: https://www.england.nhs.uk/commissioning/health-just/. This will include:

- Health & Justice Indicators of Performance (HJIPs), Adult Prison Estate
- Immigration Removal Centre (IRC) HJIPs
- Children & Young People Indicators of Performance (CYPIPs), CYP Secure Estate
- Sexual Assault Referral Centre (SARC) Indicators of Performance
- Liaison & Diversion Indicators of Performance (LDIPs)