

Service Specification

Integrated Mental Health Service For Prisons in England

FINAL v1

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Note to Local Commissioners

This section is for guidance to assist you and does not form part of the final specification. It should be removed prior to publishing.

1. How to use this document

1.1 This Service Specification represents something of a departure from earlier iterations of Health and Justice Service specifications. In previous specifications, the text has very much provided a clear steer as to:

- a. Exactly what should be provided, in what context
- b. How to go about providing it and
- c. How much of it to provide

What is presented in this document is a modular approach taking account of:

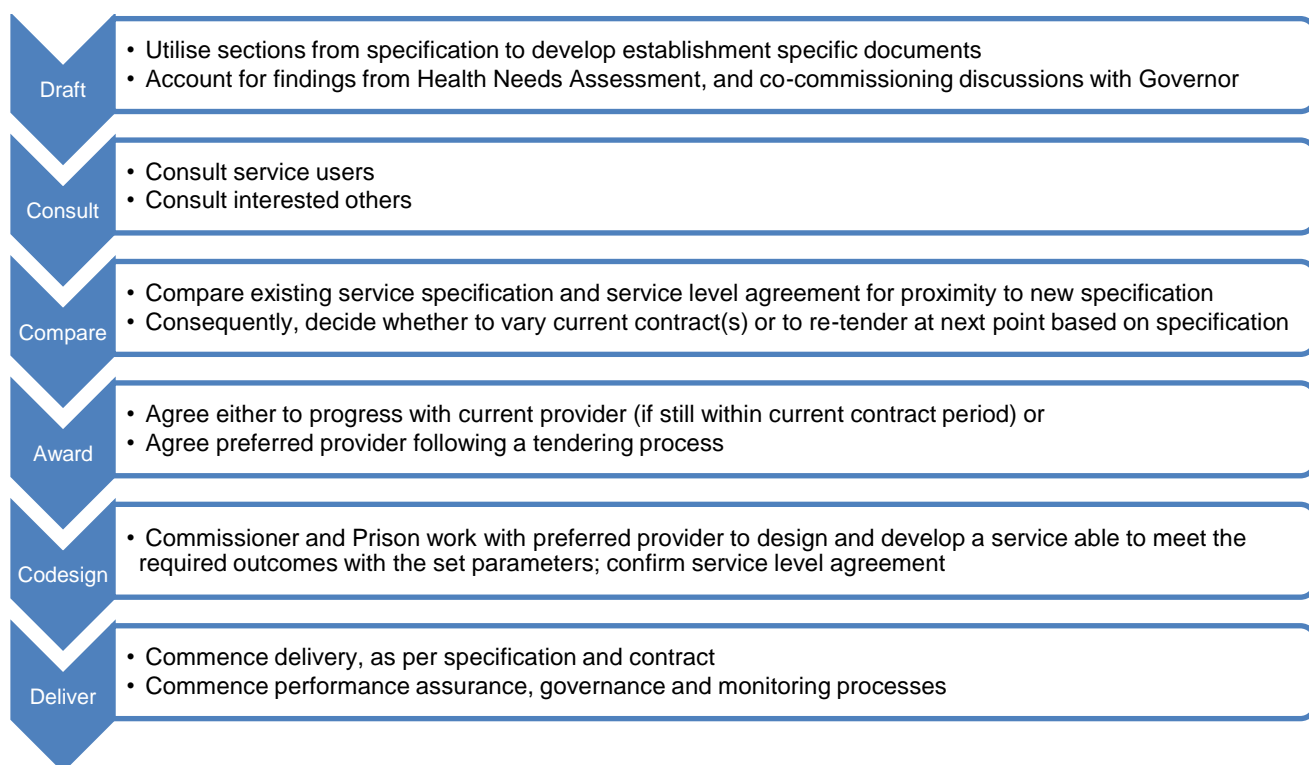
- a. Areas of focus that – nationally –providers are expected to prioritise
- b. The outcomes that are expected from any provider, and examples of how evidence of their ability to deliver those outcomes may be demonstrated
- c. The freedom for regional Commissioners to tailor the specification to their needs and the needs of any specific prison population.
 - Where the following box is used, commissioners should insert local establishment/contract specific information or follow the instructions noted and delete the “Note to Local Commissioners”

Note to Local Commissioners

Insert local additions required to suit the individual establishment

- d. The opportunity for providers to show their skill, experience and creativity in developing service models that will deliver the required outcomes.

The expectation is for the following process to take place:

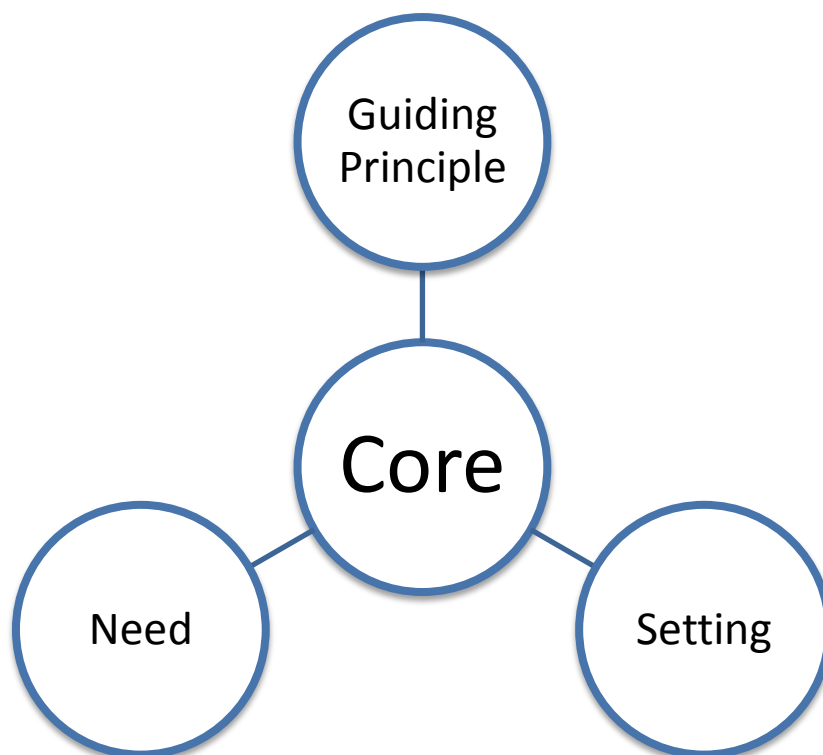


1.2 The specification also has an annex which is relevant to all Health and Justice Specifications and is not service-specific. This annex forms part of the overall specification and ensures that providers within an establishment, and Nationally, are working to the same standards.

1.3 As a part of the process of exploring the specification, co-design and agreements between parties, a number of documents will need to be in place (which will vary according to commissioner, provider, prison and regional / local approaches); further details of these will be included in other documents, such as the standard contract.

2. The Model

The Integrated Mental Health Service Specification is structured to enable the flexible use of the following concepts presented through four main considerations:



National specification:

- a. At its centre – a **core framework** that clearly outlines the required objectives, outcomes and standards of the service and the expected minimum levels of governance.
- b. An overarching **guiding principle**, that defines the basis upon which activities in the specification are delivered (i.e. safe, recovery focused, patient centred, integral peer approaches, and provided within a cohesive multi-disciplinary framework). The guiding principle element of the specification will also include signposting towards pre-existing reviews and recommendations (e.g. The Bradley Report 2009)

Localised elements of the specification:

- c. Full account of the **setting** within which delivery takes place should be taken, especially where this impacts on the type or duration of intervention that can be offered (e.g. Reception Prison, Training Prison, Resettlement Prison)

- d. A thorough examination of **need**, including (but not limited to) quantitative analysis, consultation and patient involvement. A comprehensive understanding of need is a cross-cutting issue across all elements of the specification. The flexibility offered by this specification places the emphasis on *an establishment based service designed around the establishment's needs*, as evidenced through needs assessment

The updated specification and its implementation from 2018/19 onwards provides an important opportunity to take into account

- the changing profile of people in prison, such as the aging population
- the different physical and mental health needs of women in custody, their social and family circumstances, and the forthcoming changes to the Women's Estate.
- service users, and their full and active involvement in the design and planning of services, service delivery, peer support and service evaluation
- the need for all parties to ensure all mental health services are commissioned and provided as services that are fit for purpose and take account of prison reforms.

It is proposed that the central Core Specification is the primary document – prefaced by the guiding principle statement – with guidance, signposting and links made to appendices/annexes/external sources to cover need, setting, and standards. These can then be utilised as appropriate by Commissioners and Providers in specifying the required service and evidencing delivery.

This model should ensure:

- Requirements are delivered, whilst allowing for local flexibility and personalisation.
- Existing standards (e.g. clinical guidelines) are not repeated or interpreted for the specification, instead they are signposted to.
- Rather than telling providers how they should be doing their job, Commissioners will be able to look for competence, creativity and innovation in evidencing ability to deliver the required outcomes. Once assured of the ability of the provider to deliver effectively against the 'must do' elements of the specification, Commissioner/Governor and provider can work in a process of co-design to develop a bespoke service tailored to the setting, focussed on achieving the desired outcomes.

3. Introduction

This service specification outlines what should be included in a trauma informed prison-based mental health service, providing support for individuals with learning disabilities and other vulnerabilities, that is integrated with wider health and other psychological and social support services. It includes desired objectives and outcomes concerning supporting people with mental health issues and guidance for providing support for prisoners with learning disabilities and other vulnerabilities.

There are numerous clinical guidelines and best practice documentation that describe clinical practice and processes. This document does not aim to replicate these guidelines, but to provide a description of the minimum service requirements for a prison mental health service. For specific clinical interventions please refer to the appropriate clinical guidance.

A 'mental health problem' is a term used to cover a range of emotional, psychological or psychiatric distress experienced by people. Mental health problems can affect anyone at any time and may be overcome with treatment.

A trauma informed service recognises that understanding and responding to the effects of trauma are key to improving resilience and mental wellbeing. Trauma informed care emphasises the physical, psychological and emotional safety of survivors and practitioners, and helps survivors rebuild a sense of control and empowerment through trust, transparency and collaboration.

People in prison may require additional health and social care support. Whilst social care is not the responsibility of the mental health service provider, there is a strong need to work collaboratively with Local Authorities social care teams and other healthcare providers. Appropriate support must be provided to prisoners with an identified or suspected learning disability in order to enable them to cope better within the secure environment and ensure that their health needs are met. The mental health service has a role in providing general support and advising other agencies within a prison of their respective responsibilities supporting prisoners to cope with daily life.

For ease of reference, throughout this document the term "Learning Disability", unless otherwise stated, will encompass individuals with learning disabilities, autism or other vulnerabilities.

All of the mental health and well-being outcomes outlined in this document apply to *all* people in custody, not just those with a diagnosed mental health condition.

A safe and secure prison system cannot be successfully delivered without effective mental health and learning disability services, in turn such services cannot be delivered without the full support and partnership of the prison regime and its staff. Both the physical environment within which a person lives and receives care and the service provided contribute towards general wellbeing within the prison.

This specification aims to build upon existing positive relationships between healthcare services, the prison services and patients and the vast body of work already successfully in place.

It is recognised that this is a significant time of change and transition in terms of NHS and Criminal Justice System (CJS) reforms and elements of this specification may change. NHS England and Her Majesty's Prison and Probation Service (HMPPS) commissioners will fully engage with the service provider during the initial service co-design period and then for the lifetime of the contract to ensure this specification remains relevant and meets the needs of those who need the service.

4. Guiding Principle

The purpose of health care in prison, including care for people with mental health problems and/or learning disabilities, is to provide an excellent, safe and effective service to all prisoners equivalent to that of the community. In line with implementing the "Five Year Forward View for Mental Health"¹, prison mental health services will provide timely access to evidence-based, person-centred care, which is focused on recovery and is integrated with primary care and other sectors.

Services should operate from a position of "Making Every Contact Count"². Wherever a patient presents to any health service, or via some other intervention, it is incumbent upon providers to meet immediate needs and bring appropriate provision to the patient, not 'send' the patient to another intervention.

Screening, assessment and treatment for mental health issues or learning disabilities should be in place as appropriate. This should address the wide range of other, often related health needs identified, such as substance misuse, physical health problems and any additional disabilities identified. The service should have a public health perspective and also focus on reducing harm and promoting recovery and rehabilitation.

Care should be person centred and delivered by professionals and allied staff who are suitably competent, well led, properly supervised and operating within a clear quality and clinical governance framework supporting safe and effective delivery.

Treatment and care plans should be regularly reviewed. There should be access to suitable psychosocial and clinical interventions, as well as a focus on mental health promotion and supporting positive mental health. Where medication is indicated, its provision should be suitably optimised, particularly in those with difficulties achieving stability and with clear shared care between prescribers.

Clinicians should be able to adapt evidence-based treatments from the wider community to the prison estate and regime, and be able to work with security staff and systems to reduce harm and to manage risk, particularly the risk of fatalities and self-inflicted harm as well as other risks to consider such as abuse and exploitation. They should also have established links with local social care providers serving the

¹ <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

² <https://www.england.nhs.uk/wp-content/uploads/2014/06/mecc-guid-booklet.pdf>

prison and contact with the Education provider for the establishment to ensure those with social care and/or communication needs receive a holistic package of care and support.

5. Core Service Delivery

5.1 Service Vision

The service provider will establish and run a recovery focused, trauma informed integrated mental health service. This service will provide psychologically informed, evidence based specialist support for all those assessed as requiring interventions to address mental health, personality disorder, and support for individuals with learning disabilities. The service will work closely with the substance misuse treatment provider and others where dual diagnosis is identified and with primary care and others where co-morbid physical or social care needs are present, and will utilise a “stepped care” model as appropriate.

Who is responsible for care?	What is the focus?	What do they do?
Step 5: Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT
Step 4: Mental health specialists, including crisis teams	Treatment-resistant, recurrent, atypical and psychotic depression, and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 3: Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 2: Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 1: GP, practice nurse	Recognition	Assessment

Figure 1 – Stepped Care Model

Note to Local Commissioners

(Delete as appropriate and include local governance arrangements)

This is as a part of a wider integrated model of commissioning, e.g. Prime Provider model, this document represents the mental health ‘module’ (inclusive of learning disabilities) of that wider commissioning activity and should be read in conjunction with the other related elements.

This is part of a “Lead Provider” model, where the service provider must work collaboratively and flexibly with the lead provider to deliver integrated services.

This service is a standalone service, however the provider must work collaboratively with other healthcare providers.

This service is commissioned as part of the overall Offender Health pathway within the prison and as such this model will ensure an integrated, recovery orientated treatment system both within the prison and onwards into the community. The service will focus on delivering person-centred care within seamless, integrated structured clinical and psychosocial interventions/services in prison and facilitating arrangements through the gate into the community to ensure effective continuity of care. Close joint working with other healthcare services, as well as other departments within the prison such as Education, Offender Management, and Physical Education, is imperative to the success of the delivery of this service.

The service is to be made available to all prisoners within the establishment. The provider must meet the unique needs of the establishment and take into account the needs of the population within that establishment.

Services should be familiar with the legal duties placed upon them by both the Equalities Act (2010) and the Health and Social Care Act (2012), as well as the Care Act (2014) and Mental Health Act (1983) and include such considerations into the overall approach taken and any plans made.

6. Health and Justice Objectives, Outcomes and Standards

The service provider will work in partnership with the Commissioners and other stakeholders to contribute towards the following Objectives and Outcomes and will consider all opportunities to enhance the aims of the service.

All services should be commissioned to achieve the three Objectives and their respective Outcomes. However how these are achieved will depend upon the service model provided within an establishment. Different establishments with differing functions will focus their service on achieving the most relevant outcomes for the need of the population. For example, this may mean that a local reception establishment will have a greater focus on screening and assessment and through the gate working, rather than long term treatment interventions. This will require local determination by Commissioners and providers on priorities based on the Health Needs Assessment and the current population.

To assist with the evaluation against the Objectives below, the Specification incorporates Outcomes that cover the following four domains:

- PROMs: Patient Reported Outcome Measures
- PREMs: Patient Reported Experience Measures
- CROMs: Clinical Reported Outcome Measures
- PATOMs: Partnership Reported Outcome Measures

In the table below there are examples of ways in which you can evidence that each of the Outcomes have been achieved. These examples are not exhaustive and should be locally agreed to fit the need of the establishment and patient population utilising data and information that is already in place in services. There is not an expectation that all these examples will be implemented, but are provided to assist in determining the type of evidence that may be available.

It is not anticipated that providers will report on each Outcome routinely, these simply provide a mechanism by which providers can evidence they are achieving the outcome measures to commissioners when appropriate, for example, this may be part of an audit cycle or a thematic contract review.

This is for local determination and should not create an additional reporting burden, but enable providers to demonstrate how their service meets the required Outcomes for the populations they serve.

Objective 1	
Improved mental health and emotional wellbeing	
Outcomes	Examples of how this could be evidenced (<i>local determination required</i>)
PROMs:	PROMs:

<p>Patient reported improvements in social, emotional and physical wellbeing</p> <p>Patients have access to peer support mentors and peer led groups available to all prisoners</p> <p>Patients report that, where appropriate, they are given the opportunity to involve family and friends in their care planning and treatment.</p> <p>Patients report continuity of medicines and partnership in decision-making about their treatment</p> <p>Patients report opportunities to comment on their experiences of using the service, and user comments are responded to appropriately.</p> <p>Patient is involved in planning their own care.</p>	<p>Improvements on outcome measuring tools e.g. STAR</p> <p>Peer mentor availability; patient led groups are delivered</p> <p>Active engagement of family and friends</p> <p>Minutes from councils or service user involvement meetings</p> <p>Patient surveys; focus groups</p> <p>Care plan in place which supports their involvement</p>
<p>PREMs: <i>"I expect that all my mental and physical health and my care needs are known by everyone supporting me when I am in prison. I do not have to keep telling my story."</i></p> <p><i>"I feel that staff in all the different health services are trying to help me get better. I feel they work with me in a caring way."</i></p> <p><i>"I am given information on the treatments they can use to help me. They also explain the ways treatments might help me and any possible problems."</i></p>	<p>PREMs: Patient councils and surveys</p> <p>Patient feedback</p> <p>Recorded in clinical records</p>
<p>CROMs: Reduction in the number of Mental Health related self-harm incidents and self-inflicted deaths in custody</p> <p>Appropriate management of patients following self-harm incidents or attempted suicide</p> <p>The mental health service achieves improvements in health status and prevent or decrease morbidity and disability associated with mental and physical health</p> <p>A robust mental health risk assessment is carried out on all new referrals to enable priority to be assessed</p> <p>Regular review of care and care plans is carried out which includes clear treatment goals and rationale for actions taken</p>	<p>CROMs: Recorded number of individuals involved in mental health related self-harm incidents and self-inflicted deaths</p> <p>HMPPS data</p> <p>Multi-agency action plans</p> <p>An improvement in Health of Nation Outcome Scale (HONOS score) GAD 7 – IAPT, CORE, PHQ9 Warwick-Edinburgh Mental Well-being Scale (WEMWbs)</p>

<p>Effective and safe prescribing is underpinned by an evidence-based formulary that takes account of the diversion and illicit use of specific mental health medicines</p> <p>The issue of confidentiality (and its limitations) and consent to share information are explained to the patient at the first assessment, both verbally and in writing</p> <p>Staff have an understanding of issues concerning mental capacity, i.e. to give consent, etc.</p> <p>Waiting times or issues accessing interventions are monitored and work is in place to reduce such instances.</p>	<p>Mental health risk assessments completed</p> <p>Mental health medicines formulary in place and evidence of</p> <p>Mental health clinical reviews completed/robust records of care plans</p> <p>implementation</p>
<p>PATOMs: Mental Health service provider contributes to the reduction of self-inflicted deaths in custody</p> <p>Wider prison staff (including officers, Education staff and gym staff) are involved in improving the mental health and wellbeing of people in prison</p> <p>Information is shared appropriately between Criminal Justice System and Health. A shared understanding across the health provider and the prison with regard to the purpose of the service</p> <p>There is evidence of all healthcare, substance misuse, mental health teams and prison operational staff all sharing responsibility in the provision of treatments, as appropriate.</p> <p>Clinic availability is appropriate to the establishment regime to enable patients to attend appointments with healthcare.</p> <p>Healthcare managers are on the prison senior management team/meetings to ensure key messages and information sharing with heads of departments and joined up approaches to promote wellbeing.</p> <p>Ensure that healthcare is linked in with any prison led wellbeing work for prisoners and with Offender Management in Custody work and Safer Custody work.</p>	<p>PATOMs: Health improvement plan</p> <p>Evidence of involvement of prison staff (including officers, Education staff and gym staff)</p> <p>An information sharing agreement is in place. There is appropriate attendance at Care Programme Approach (CPA)</p> <p>A partnership agreement is in place with all relevant agencies / partnership meetings take place. Number of prisoners subject to CPA Proportion of ACCTs managed jointly at all reviews</p> <p>Shared care protocols in place for medicines.</p> <p>Meeting minutes</p>

	Health improvement plan
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Objective 2	
The rehabilitation of prisoners and a reduction in reoffending through the improvement of mental health and contribution to sentence planning where appropriate.	
Outcomes	Examples of how this could be evidenced (<i>local determination required</i>)
<p>PROMs: Patients' mental health shows improvement enabling them to take part in rehabilitation programmes.</p> <p>Patients receive treatment that is responsive to their needs and appropriate.</p> <p>Patients' treatments continue when they are discharged into the community.</p> <p>Patients are able to self-administer their medicines and know how to access support and information about their medicines</p>	<p>PROMs: Involvement in rehabilitative programmes and activities.</p> <p>Number of prisoners receiving a variety of treatments GP summaries Number of prisoners under CPA</p> <p>Patient surveys, patient-led groups, patient reported access to pharmacy team</p>
<p>PREMs:</p> <p><i>"I am involved in decisions about my care. I feel able to talk my about my treatment with the staff treating me."</i></p> <p><i>"I can easily obtain the information I need and can understand it. This includes information about therapies and other programmes in prison."</i></p>	<p>PREMs: Patient involvement</p>
<p>CROMs: Where appropriate, the Mental Health Team will participate in the ACCT process as part of a multi-disciplinary team</p> <p>The Mental Health team will fully participate in mental health multi-disciplinary training provided for all prison staff</p> <p>The mental health team review in-possession medication risk assessments to achieve a goal of self-administration of medicines as mental health improves</p> <p>The extent to which a patient correctly takes their mental health medicines is monitored by the team.</p>	<p>CROMs: Documented attendance at ACCT meetings</p> <p>Documented attendance on multi-disciplinary training</p> <p>Documented in-possession risk review</p> <p>Proportion of people on In Possession mental health medicines</p>

<p>There are clear triggers for a clinical review being required when a patient is not taking their medicines correctly.</p>	<p>Protocols for identification of and referral due to omitted doses or failure to collect medicines.</p> <p>Omitted doses audits</p>
<p>PATOMs: The mental health service and prison staff support a whole prison approach to positive mental health and wellbeing</p> <p>Those accessing support services reflects the demographic makeup of the patient population and need (e.g. ethnicity, disability, religion, sexual orientation). Processes are in place to support this.</p> <p>Healthcare contribute to general reducing reoffending targets set by the prison and work in partnership, where appropriate, on reducing reoffending programmes.</p> <p>A formal referral process is in place with social services that ensures appropriate referrals are made should social care assessments be required to support prisoners with support needs</p>	<p>PATOMs:</p> <p>Health improvement plans</p> <p>Needs Assessment and equality monitoring</p> <p>Documented attendance at ACCT meetings</p> <p>MH team inclusion in medicines management committees</p>

Objective 3	
Improved continuity of care through the gate and within the prison system	
Outcomes	Examples of how this could be evidenced (<i>local determination required</i>)
<p>PROMs: Patients are aware of and engaged with their local community mental health services, learning disability services and/or any other required care services upon release or discharge</p> <p>Patients have a robust discharge plan to enable continuity of care in the community</p>	<p>PROMs: Discharge plan 14 day follow-up</p> <p>Discharge plan</p>
<p>PREMs: <i>"I am involved in my planning my care, my support and how I will get better."</i></p> <p><i>"I know what my medicines are for and how to take them... I know how to get them in prison and when I have left prison."</i></p> <p><i>"I have helped to make healthcare better for other people leaving prison... I told staff what works and what does not work."</i></p> <p><i>"I know which team and service will support me when I leave prison and I know how to contact them."</i></p> <p><i>"I know how to make a complaint about the service"</i></p>	<p>PREMs: Care plans signed and agreed by service users</p> <p>"You said we did", health councils</p> <p>CQC inspections</p> <p>Care and resettlement plans in place and shared with others in advance.</p>
<p>CROMs: A range of comprehensive care pathways, policies and procedures are available and implemented in collaboration with patients and /or their advocates.</p> <p>A reduction in the need for patient transfers to mental health hospitals.</p> <p>Therapeutic drug monitoring and outcomes from prescribed mental health medicines are assessed and recorded with changes to medicines actioned.</p> <p>Systems are in place to avoid omission of mental</p>	<p>CROMs: Schedule of clinics, group work, key work sessions and clinical policies.</p> <p>Transforming Care review of transfers for learning disabilities.</p> <p>Clinical audit</p>

health medicines on admission, during custody and at release or transfer	HJIPs; local audit
MH team inclusion in medicines management committees	Medicines HJIPs
Pharmacy team involvement in MDT/case reviews	
PATOMs: Services are delivered in partnership with both the Prison Operator, primary care and substance misuse healthcare teams The Mental health team shares appropriate details about an individual's condition and capacity with partners, such as Offender Managers	PATOMs: Training plan and evidence of staff development There are written policies in place for liaison and joint working with substance misuse services and primary care in cases of co-morbidity.

6.1 Standards

The following standards are taken from the Royal College of Psychiatrists' Quality Network for Prison Mental Health Services **Standards for Prison Mental Health Services – Third Edition (2017)**. Any future version of the Standards will replace the current 2017 edition.

Note to Local Commissioners

(Delete as appropriate)

Providers are expected to be a member of the Quality Network for Prison Mental Health Services (QNPMHS) and participate in peer review of delivery against standards.

Providers are expected to work to the Standards even if they are not a member of QNPMHS

The Quality Network for Prison Mental Health Services (QNPMHS) was established in 2015 to promote quality improvement in the field of prison mental health. The standards act as a framework by which to assess the quality of prison mental health services via a process of self and peer review. The standards are revised on a regular basis to take into account new developments within the field. These standards set out “what good looks like” for a prison Mental Health Service and are the standards against which services must be provided.

The original publication can be found at: www.qnpmhs.co.uk

Note to Local Commissioners

(Delete as appropriate)

Establishments that have a 24 hour mental health facility should also work to the standards embedded within Appendix 1

All criteria are rated as Type 1, 2 or 3

Type 1: Essential standards. Failure to meet these would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence based care and treatment.

Type 2: Expected standards that all services should meet.

Type 3: Desirable standards that high performing services should meet.

It is recognised that due to circumstances outside of the control of the healthcare service provider, occasionally standards may not be able to be achieved. These should be documented and exception reported against.

Admission and Assessment

No.	Standard	Type
1	As part of the formal prisoner induction process, all prisoners undergo health screening that incorporates a mental health assessment.	1
2	The secondary care mental health assessment is carried out by a mental health professional.	1
3	The role of the team in the screening process is clearly defined and in agreement with the prison establishment.	1
4	There is a clear and consistent process for prison staff to refer prisoners directly to the mental health team.	1
5 (C1.4)	A clinical member of staff is available to discuss emergency referrals during working hours.	1
6	Urgent assessments are undertaken by the team within 48 hours and routine assessments within 5 working days. <i>Guidance: The term 'urgent' refers to an individual in a mental health crisis, or with rapidly escalating needs or presentation, and/or at risk of immediate harm to self or others.</i>	1
7	The mental health assessment uses a standardised format, which includes a relevant previous history, an assessment of mental health, intellectual and developmental disabilities, substance misuse, psychosocial factors, risk to self and others. <i>Guidance: Standard mental health assessment tools are used and they are compliant with NICE guidelines.</i>	1

8 (C3.4)	The assessing professional can access notes about the patient (past and current) from primary care, secondary care and other relevant services (NICE guideline 66, 2017). <i>Guidance: Notes should be accessed for all patients known to mental health services and where notes are available, including how up to date the information is and how it was gathered.</i>	3
9 (C4.6)	The team discusses the purpose and outcome of the risk assessment with each patient and a management plan is formulated jointly.	1
10 (C5.1)	All patients have a diagnosis and a clinical formulation. <i>Guidance: The formulation includes presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation should be devised.</i>	1
11 (C17.5)	When talking to patients, health professionals communicate clearly, avoiding the use of jargon so that people understand them.	1
12 (C17.2)	Information is provided to patients. <i>Guidance: Information can be provided in languages other than English and in formats that are easy to use for people with sight/hearing/cognitive difficulties or learning disabilities. For example; audio and video materials, using symbols and pictures, using plain English, communication passports and signers. Information is culturally relevant.</i>	1
13 (C1.3)	Clear information is made available, in paper and/or electronic format, to patients and healthcare practitioners on: <ul style="list-style-type: none"> • A simple description of the service and its purpose; • Clear referral criteria; • How to make a referral, including self-referral if the service allows; • Clear clinical pathways describing access and discharge; • Main interventions and treatments available; • Contact details for service, including emergency and out of hours details. 	1
14 (C3.3)	Patients are given verbal and/or written information on: <ul style="list-style-type: none"> • Their rights regarding consent to care and treatment; • How to access advocacy services; • How to access a second opinion; • How to access interpreting services; • How to raise concerns, complaints and compliments; • How to access their own health records. 	3
Case Management and Treatment		
15	Patients are managed under the Stepped Care Model for People with Common Mental Health Disorders (NICE guidelines 41, 2011).	2
16 (C8.1.6)	Patients are offered written and verbal information about their mental illness. <i>Guidance: Verbal information could be provided in a 1:1 meeting with a staff member, a ward round or in a psycho-education group.</i>	1
17 (C7.3)	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews. <i>Guidance: Referrals that are urgent or that do not require discussion can be allocated before the meeting.</i>	1

18 (C7.4)	<p>Every patient has a written care plan, reflecting their individual needs. <i>Guidance: This clearly outlines:</i></p> <ul style="list-style-type: none"> • <i>Agreed intervention strategies for physical and mental health;</i> • <i>Measurable goals and outcomes;</i> • <i>Strategies for self-management;</i> • <i>Any advance directives or stated wishes that the patient has made;</i> • <i>Crisis and contingency plans;</i> • <i>Review dates and discharge framework.</i> 	1
19 (C7.5)	The practitioner develops the care plan collaboratively with the patient.	1
20 (C7.2)	The team reviews and updates care plans according to clinical need or at a minimum frequency that complies with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.	1
21	Where applicable, patients are encouraged and supported to be fully involved in their CPA meeting, or equivalent.	1
22	Patients discuss, negotiate and agree with their care coordinator on who should be invited to their CPA meeting, or equivalent, and a joint decision made on what happens if people are unable to attend.	1
23	Patients will be shown a copy of the final draft report after the CPA meeting, or equivalent, and will have the opportunity to add their views at this stage.	1
24	The team has a policy on inter-agency working across criminal justice, social care, physical healthcare and the third sector within limits of patient consent, confidentiality and risk management.	2
25	There are written policies in place for liaison and joint working with substance misuse services and primary care in cases of co-morbidity in accordance with NICE guidelines 57 (2016) and 66 (2017). <i>Guidance: This can be an individual policy or included as part of a wider operational policy.</i>	2
26	There are contracted agreements for joint working with primary care to ensure high standards of physical healthcare and mental healthcare for patients with co-morbid physical and mental health problems.	2
27	The team works collaboratively with other health care providers and the prison to manage self-harm and suicidal ideation in accordance with NICE guidelines 16 (2004), 133 (2011), 57 (2016), and 66 (2017).	1
28	The team actively participates with the Assessment, Care in Custody and Teamwork (ACCT) process in managing the risk of self-harm and suicide. <i>Guidance: The mental health team attends or contributes to all ACCT reviews for prisoners under their care. They are involved in decisions about location, observations and risk.</i>	1
29 (C8.1.1)	Patients are offered evidence based pharmacological and psychological interventions and any exceptions are documented in the case notes. <i>Guidance: The number, type and frequency of psychological interventions offered are informed by the evidence base.</i>	1
30 (C8.2.1)	When medication is prescribed, specific treatment targets are set for the patient, the risks and benefits are reviewed, a timescale for response is set and patient consent is recorded.	1

31 (C9.2.1)	<p>Patients who are prescribed mood stabilisers, antipsychotics or stimulants for ADHD are reviewed at the start of treatment (baseline), at 3 months and then annually unless a physical health abnormality arises. The clinician monitors the following information about the patient:</p> <ul style="list-style-type: none"> • A personal/family history (at baseline and annual review); • Lifestyle review (at every review); • Weight (at every review); • Waist circumference (at baseline and annual review); • Blood pressure (at every review); • Fasting plasma glucose/HbA1c (glycated haemoglobin) (at every review); • Lipid profile (at every review). 	1
32 (C6.2)	The team pro-actively follows up patients who have not attended an appointment/assessment or who are difficult to engage.	1
33 (C9.1.5)	<p>The service has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes:</p> <ul style="list-style-type: none"> • Assessment; • Care and treatment (particularly relating to prescribing psychotropic medication); • Referral to a specialist perinatal team/unit unless there is a specific reason not to do so. 	1

Referral, Discharge and Transfer

34	There is an agreed policy that identifies the role of the team in initiating, facilitating and managing referrals to outside hospitals.	1
35	The process for referral and transfer of patients under Part 3 of the Mental Health Act follows the Good Practice Procedure Guide (DH, April 2011).	1
36	<p>When a patient is transferred to another prison, the mental health team provides a comprehensive handover to the receiving prison's mental team before the transfer takes place.</p> <p><i>Guidance: Where a transfer is not known, the handover is provided to the receiving team within one working day of the individual's reception to the establishment.</i></p>	1
37	<p>The care co-ordinator or equivalent is involved in discharge/transfer planning.</p> <p><i>Guidance: Planning occurs ahead of the individual's discharge/transfer and the timescale for this depends on the individual patient's presentation and identified needs.</i></p>	1
38	An identified key worker and/or responsible clinician from the receiving service are invited to discharge/release planning CPA meetings.	1
39	Referrals to community mental health services are made for those patients who require continued care and follow-up support following release.	2
40	On discharge from the team, patient information is provided to the receiving primary care or mental healthcare service.	1
41	<p>The team carries out a follow-up interview with the patient and/or the new care co-ordinator/service provider within 14 days of release/transfer from prison.</p> <p><i>Guidance: This includes communication in person, by telephone, email or in writing.</i></p>	2

Patient Experience

42	The patient is involved in decisions about their care, treatment and discharge/release planning.	1
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43 (C14.1)	Patients are given the opportunity to feed back about their experiences of using the service, and their feedback has been used to improve the service. <i>Guidance: This might include patient surveys or focus groups.</i>	1
44 (C16.1)	Patients are treated with compassion, dignity and respect. <i>Guidance: This includes respect of a patient's race, age, sex, gender reassignment, marital status, sexual orientation, maternity, disability and social background.</i>	1
45 (C16.2)	Patients feel listened to and understood by staff members.	2
46 (C17.3)	The service has access to interpreters.	1
47 (C18.1)	Confidentiality and its limits are explained to the patient at the first assessment, both verbally and in writing.	1
48 (C18.3)	The patient's consent to the sharing of clinical information outside the team is recorded. If this is not obtained the reasons for this are recorded.	1
Patient Safety		
49	The patient is given information on the intervention being offered and the risks and benefits are discussed with them. This is recorded in clinical records.	1
50 (C13.1)	Capacity assessments are performed in accordance with current legislation and codes of practice.	1
51 (C8.2.5)	The safe use of high risk medication is audited at a service level, at least annually. <i>Guidance: This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines and stimulants for ADHD.</i>	1
52	The team proactively follows up with patients who fail to collect or take their medication.	1
53	A system is in place for recording non-compliance with medication. <i>Guidance: Guidance is available to the team on the management of medication and how to deal with non-compliance.</i>	1
54	Compliance with medication is recorded as part of the patient's care plan and this is reviewed on a monthly basis, or more frequently where required.	1
55 (C10.2)	Staff members follow inter-agency protocols for the safeguarding of vulnerable adults and young people. This includes escalating concerns if an inadequate response is received to a safeguarding referral.	1
56	The team understands and engages in prison service policies on food refusal and mental capacity assessments.	2
57	The team understands and engages in prison service policies on reporting incidents according to the Mercury Intelligence System (MIS).	2
58	There is a joint working policy between the prison, primary care, substance misuse services and the mental health team on the control and management of substance misuse and substances.	2
59	The team understands and engages in prison service policies on Multi-agency Public Protection Arrangements (MAPPA).	2
60	The team supports the prison establishment in the provision of mental health awareness training for prison staff in accordance with NICE guidelines 66 (2017). <i>Guidance: This could include: The direct involvement of the team in delivering training sessions; or the team has input into the development of training content and learning materials.</i>	2

Environment		
61	The prison and healthcare regimes ensure that patients are able to attend appointments with the team at the scheduled appointment time.	2
62	There are designated rooms for the team to run clinics and one-to-one sessions.	2
63	There are designated rooms for the team to run group sessions.	2
64	All interview rooms are situated close to staffed areas, have an emergency call system, an internal inspection window and the exit is unimpeded.	2
65 (C19.3)	Clinical rooms are private and conversations cannot be easily over-heard.	1
66	The team has dedicated spaces and meeting rooms for confidential working.	1
67	There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information, e.g. information about services/conditions/treatment, patient records, clinical outcome and service performance measurements.	1
Workforce Capacity and Capability		
68	The multi-disciplinary team consists of or has access to staff from a number of different professional backgrounds that enables them to deliver a full range of treatments/therapies appropriate to the patient population.	1
69	The team has access to specialists relevant to the needs of the patient group. This may include: child and adolescent mental health, intellectual disabilities (ID), autistic spectrum disorder (ASD), neuropsychiatric disorders and cognitive impairment.	2
70	There is a clearly identified clinical lead for the team. <i>Guidance: The clinical lead has overall responsibility for the clinical requirements of the service.</i>	1
71 (C22.4)	There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify gaps in the team and to develop a balanced workforce which meets the needs of the service.	2
72	There are written arrangements and processes in place which ensure that the prison healthcare team can access specialist mental health advice out of hours.	2
73	Capacity management plans are in place to ensure continuity of service in the event of leave or sickness. <i>Guidance: This is a written document that describes the measures the service will take to manage sudden increases in demand.</i>	1
74	There are clear written protocols outlining prescribing responsibilities between psychiatrists, GPs and nurse prescribers. <i>Guidance: Clinicians refer to 'Safer Prescribing in Prisons: Guidance for Clinicians' (RCGP, 2011).</i>	2
75	There is a minimum of monthly multi-disciplinary team clinical meetings, which are recorded with written minutes.	1
Workforce Training, CPD and Support		
76 (C25.1)	The team actively supports staff health and well-being. <i>Guidance: For example; providing access to support services, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.</i>	1

77	All permanent staff within the team receive a full local prison induction within 28 days of commencing employment and before being issued with keys. <i>Guidance: This includes: key security, prison awareness, the Assessment, Care in Custody and Teamwork (ACCT) process and personal protection, or equivalent.</i>	1
78	All staff who use SystmOne are fully trained and are competent in its use.	1
79 (C23.2)	Staff members receive an induction programme specific to the service, which covers: The purpose of the service; The team's clinical approach; The roles and responsibilities of staff members; Care pathways with other services. <i>Guidance: This induction should be over and above the mandatory Trust or organisation-wide induction programme.</i>	1
80 (C10.1)	The team receives training consistent with their roles on risk assessment and risk management. This is refreshed in accordance with local guidelines. This training includes, but is not limited to training on: <ul style="list-style-type: none"> • Safeguarding vulnerable adults and children; • Assessing and managing suicide risk and self-harm; • Prevention and management of aggression and violence. 	1
81 (C26.3)	Staff receive training consistent with their role and in line with their professional body. This is recorded in their personal development plan and is refreshed in accordance with local guidelines.	1
82 (C24.1)	All staff members receive an annual appraisal and personal development planning or equivalent. <i>Guidance: This contains clear objectives and identifies development needs.</i>	1
83	All staff within the team receive Continuing Professional Development (CPD) in line with their personal development plan and revalidation requirements.	1
84 (C24.2)	All clinical staff members receive individual clinical supervision at least monthly or as otherwise specified by their professional body. <i>Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications. The activity should offer the supervisee an opportunity to reflect upon their practice and to think about how their knowledge and skills may be developed to improve care.</i>	1
85 (C24.6)	All staff members receive monthly line management supervision. <i>Guidance: Supervision forms a part of individual performance management and discusses organisational, professional and personal objectives.</i>	2
86 (C25.3)	Staff members have access to reflective practice groups.	2
Governance		
87	A representative of the team is part of the prison clinical governance and quality processes.	1
88	Patients are involved in the governance and development of the team. <i>Guidance: This includes representation from a patient or a patient representative in governance meetings and/or direct consultation with the patient group on areas of development.</i>	2
89 (C27.4)	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy to use.	2
90 (C27.1)	The team attends local business meetings that are held at least monthly. <i>Guidance: Business meetings address strategic matters and the general management of the service, e.g. audit processes, quality and governance systems, finance, and performance.</i>	2

91 (C6.3)	Data on missed appointments are reviewed at least annually. This is done at a service level to identify where engagement difficulties may exist. <i>Guidance: This should include monitoring a patient's failure to attend the initial appointment after referral and early disengagement from the service.</i>	2
92 (C27.2)	In conjunction with partner agencies, the team reviews its progress against its own local plan/strategy, which includes objectives and deadlines in line with the organisation's strategy.	3
93 (C29.3)	When staff undertake audits they; <ul style="list-style-type: none"> • Agree and implement action plans in response to audit reports; • Disseminate information (audit findings, action plan); • Complete the audit cycle. 	2
94 (C30.1)	Staff members can quickly and effectively report incidents. Managers encourage staff members to do this and staff members receive guidance on how to do this.	1
95 (C30.3)	Team members and patients who are affected by a healthcare related serious incident are offered a debrief and post incident support.	1
96 (C30.4)	Lessons learned from incidents are shared with the team and disseminated to the wider organisation. <i>Guidance: This includes audit findings and action planning information.</i>	1
97 (C30.5)	Key clinical/service measures and reports are shared between the team and the organisation's board, e.g. findings from serious incident investigations, examples of innovative practice.	2
98 (C20.7)	Staff members feel able to raise any concerns they may have about standards of care. <i>Guidance: Staff members should follow their Trust or local policy.</i>	1
99	The team engages in service relevant research and academic activity.	3

6.2 Learning Disabilities and other vulnerabilities

Average estimates and research findings regarding the number of adults with learning disabilities in the prison population are between 1–10%, depending on various factors including the type of prison and the research methods used.

The number of adults with autism or Asperger's Syndrome in the adult prison population is unknown. 1% of the general population have an autistic spectrum condition and this percentage is thought to be slightly higher in the criminal justice system. People with learning disabilities are more likely to experience certain physical and mental health conditions and are less likely or able to access healthcare services³. People with other vulnerabilities such as autism, ADHD or acquired brain injury, may also experience associated health problems and have difficulty communicating their situation or symptoms.

In 2015, *'Equal Access, Equal Care; Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities'*⁴ was published, outlining the changes and standards for prison healthcare settings to ensure prison healthcare services are on par with services delivered to people with LD in the community.

Members of the mental health team need to have a comprehensive understanding of learning disabilities and other vulnerabilities.

The mental health team will take a leading role regarding learning disabilities. This is to involve:

- helping prison and healthcare staff to identify possible learning disabilities
- implementing pathways to enable patients with learning disabilities to be referred, where appropriate, to local or regional services
- ensuring the service has access to learning disability expertise to advise and have input into planning and support, as required
- liaising with social care regarding any prisoners who require a social care assessment and ensure that any outcome of such an assessment is embedded within the prisoner's support plan
- raising awareness of learning disability across the prison
- working with the establishment operator and other healthcare services to manage specific prisoners with learning disabilities, whose behaviour is causing considerable disruption or concern. This includes contributing to case conferences.

The mental health team will also work with the primary care team in the development of learning disability registers that will enable an annual health check and health action plan to be completed.

Individuals identified with a learning disability will be given a comprehensive physical and mental health assessment using an appropriate tool which healthcare staff are

³ [The health Equality Framework \(2013\)](http://www.ndti.org.uk/uploads/files/The_Health_Equality_Framework.pdf)
www.ndti.org.uk/uploads/files/The_Health_Equality_Framework.pdf

⁴ <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/08/equal-access-equal-care-guidance-patients-ld.pdf>

fully trained to use and which the prisoner is able to fully comprehend and take part in.

Appropriate support must be provided to prisoners with an identified or suspected learning disability in order to enable them to cope better within the secure environment and ensure that their health needs are met.

Patients identified with a suspected or confirmed learning disability must be clearly identified on a central prison healthcare database and appropriate information shared with the establishment operator and other healthcare and prison services.

All detained patients with a learning disability should be able to access all relevant information via clear communication, including accessible, easy to read information that meets their specific needs, including Easy Read health literature.

6.3 Care Planning and Care Programme Approach

The Provider will ensure that there are systems in place to ensure all patients who require a care plan have one in place, documented on SystemOne or equivalent, for all patients on case load and that patients receive a copy of their care plan.

All patients will have the Health of the Nation Outcome Scale For users of Secure and Forensic Services (HoNOS) – secure care outcome monitoring tool – completed at the beginning of their treatment episode and thereafter every 12 weeks up to discharge. Routine enquiry into sexual abuse and violence should form part of any CPA process in line with Department of Health guidance Refocusing the Care Programme Approach (March 2008),

Joint care planning with other healthcare services within the prison and community health teams should be undertaken as required. The Provider will enable appropriate attendance at multidisciplinary case conferences, both inside and outside the prison, to ensure good levels of communication are in place and that services work together in an integrated way in order to meet individual patient's requirements.

The Care Programme Approach (CPA) should be used for those with complex mental health needs. Care Programme Approach (CPA) is a way in which services are assessed, planned, coordinated and reviewed for someone with Mental Health or Learning Disability problems or a range of complex needs. Recovery and outcome focussed multidisciplinary treatment and intervention with the Care Programme Approach (CPA) should form the cornerstone of the delivery of an effective care pathway. CPA meetings must be held at least six monthly.

The Provider will provide a transfer and remission to and from Mental Health hospital navigator function to coordinate patient care and ensure smooth pathways into and out of prison.

6.4 Medicine Optimisation

Medicines optimisation within mental health services follows the principles described in professional guidance (*RPS Professional Standards for optimising medicines for people in secure environments Feb 2017*)⁵. Expectations about the standards for optimising medicines in secure environments that are described in professional guidance (*RPS Professional Standards for optimising medicines for people in secure environments Feb 2017*) apply to mental health medicines. The standards form the foundation from which the mental health service provider will optimise medicines for patients in their care.

The mental health service provider will need to work in partnership with the primary healthcare and pharmacy service providers who lead on the overall medicines policies and procedures in the prison. The partnership should result in an integrated approach that from the patient's perspective is seamless, responsive to their medicines needs and collaborative.

There are specific elements within delivery of the mental health service where the optimisation of mental health medicines requires focus:

1. The mental health team use the prison clinical IT system for prescribing and documenting key outcomes from medicines in line with processes led by the healthcare provider and professional best practice
2. Selection of mental health medicines is based on clinical evidence and national guidance, including guidance published specifically about prisons (*NHS England Health and Justice mental health services: Safer Prescribing of mental health medicines Sept 2017*⁶; *RCGPSEG: Safer Prescribing in Prisons 2011*⁷) with effective use of local formularies.
3. Mental health staff proactively review the patient's capacity to have mental health medicines in their possession in line with the healthcare provider led in-possession policy and assessment tools.
4. The mental health service provider agrees shared care arrangements for initiating, reviewing, monitoring and repeating mental health medicines in partnership with the healthcare provider. These arrangements follow best practice described in national guidance (*NHS England Health and Justice mental health services: Safer Prescribing of mental health medicines Sept 2017*).
5. The mental health service provider works in partnership with the pharmacy service provider and pharmacy team to ensure an effective medicines supply pathway for mental health medicines and to enable patients to access pharmacy team support for mental health medicines.
6. Clinical pharmacy services are accessed by the mental health service provider either via the pharmacy service provider for the prison or via directly employed pharmacy staff
7. Mental health prescribers actively collaborate with other prescribers where mental health medicines are co-prescribed with other medicines so co-morbidities are managed effectively.

⁵ <https://www.rpharms.com/resources/professional-standards/optimising-medicines-in-secure-environments>

⁶ <https://www.england.nhs.uk/commissioning/health-just/health-justice-crg/>

⁷ <http://www.rcgp.org.uk/clinical-and-research/a-to-z-clinical-resources/prison-health.aspx>

8. The mental health team attend, contribute to the outputs from and implement agreed actions arising from the prison medicines management committee (MMC)
9. The mental health provider works in partnership with the MMC in monitoring prescribing, clinical audit and patient safety incidents relating to mental health medicines.
10. Mechanisms are in place that ensure mental health medicines are:
 - Reconciled promptly and continued safely on admission into the prison
 - Reviewed in line with clinical guidance and based on individual patient need
 - Monitored for adverse effects, positive clinical outcomes and adherence
 - Agreed in partnership with the patient with provision of information for the patient that supports the patient's understanding of expected benefits and actions the patient should take if they have concerns about the medicines.
 - Continued when the patient is released from prison via a supply of the medicines or arrangements for prompt access post-release via a community prescription with information shared with receiving clinicians about the mental health medicines regimen
11. The mental health service provides additional support and information about medicines in a suitable format for people with learning disabilities or physical disability in partnership with the pharmacy service provider.
12. Mental health medicines will usually be dispensed, supplied and administered to the patient by healthcare staff unless a specialist medicine needs to be administered by specialists. Where this is not the case, clear partnership agreements exist that describe the responsibilities of mental health and healthcare staff in managing the medicines pathway.
13. The mental health service provider will work collaboratively with the healthcare team to ensure timing of doses of mental health medicines is appropriate.
14. The mental health team use the prison clinical IT system for prescribing and documenting key outcomes from episodes of care.

6.5 Service Availability

1. Services must be provided for 52 weeks per year.
2. Services must be provided during and outside of the core day with cover at weekends and evenings, including operating at lunchtimes, according to identified need.
3. Services should be provided on a 7-day week basis according to need at the establishment(s) and be appropriate to the prison regime. This may be achieved through provision of on-call crisis response through to booked clinic sessions.
4. Where appropriate consideration should be given to 24/7 services in line with the "core 24 mental health" approach

6.6 Inclusion Criteria

1. The service is open to all patients according to clinical need. Patients will not be excluded if they have a personality disorder, learning disability or substance misuse issue;

2. In carrying out the Services the Provider will be “exercising public functions” for the purposes of section 149(2) of the Equality Act 2010. As such, the Service Provider must pay due regard to the Public Sector Equality Duty under section 149(1) of that Act and to deliver the Services accordingly. The Equality Act 2010 relates to service users and employees.

6.7 Equivalence and Parity of Esteem

Patients within secure settings should receive the same level of healthcare as those people in the community – both in terms of the range of interventions available to them which meet their needs, and the quality and standards of those interventions.

Parity of esteem is the principle by which mental health must be given equal priority to physical health. It was enshrined in law by the Health and Social Care Act 2012.

Taking into account the substantial health inequalities likely to be faced by most, if not all, patients within secure settings, it is imperative that any provision is not only equitable to community provision, but that it takes bold and innovative steps to improve the health of the most vulnerable and reduce health inequalities . As such it would be imperative that services provide:

- Access to crisis intervention and crisis prevention for those at high risk of self-harm and suicide where such behaviours relate to poor emotional wellbeing and/or minor psychiatric morbidity
- Psychological interventions for minor psychiatric morbidity
- Clinical and recovery focussed psychosocial interventions for severe mental illness
- Support and clinical, including psychological, interventions to those with poor emotional well-being as a result of personality disorders or substance misuse
- Access to dementia services
- Support and treatment to those with Learning Disabilities
- Access to specialist advice for eating disorders, perinatal psychiatry and for transgender people (where required).

Note to Local Commissioners
Local additions will be required to suit the individual establishment

6.8 Co Morbidity and Dual Diagnosis

Service users with co-morbid mental health and substance use, or physical health issues often have multiple and complex needs, which require a comprehensive, coordinated, seamless, multi-agency response. The Service Provider must:

- Contribute to the development of clear pathways and joint assessments with mental health, substance misuse and primary care services to ensure high levels of joint working for those identified with a multiple needs
- Ensure mental health advice and support is provided to substance misuse agencies that are responsible for co-ordinating care delivery for service users with substance dependency.
- Contribute to the development of a mental health and substance misuse comorbidity protocol for prisons and comply with the protocol once agreed.
- Operate from a position of “No Wrong Door”; wherever a service user presents – to substance misuse services, mental health services, primary care or via some other intervention, it is incumbent upon providers to meet immediate needs and bring appropriate provision to the client, not ‘send’ the client to another intervention; there should be no ‘hand offs’
- Should be able to evidence jointly run group interventions, and co-attendance at Complex Care Meetings
- Ensure substance misuse issues are assessed and care delivery is coordinated or managed for service users with common mental health and substance misuse problems – often through joint care planning
- Be aware of emerging drug use trends and respond appropriately, for example Novel Psychoactive Substances (NPS)

Note to Local Commissioners
Local additions will be required to suit the individual establishment

7. Setting

Note to Local Commissioners

Within the ethos of co-commissioning between Health Commissioners and Prison Governors, and maintaining the flexibility of this specification to be adapted to local need, this section is where you would consider and iterate the specific needs of the setting within which the service is to be provided.

The impact of the different settings should help providers to consider their service model and the needs to be met through their service offer in collaboration with other services provided in the prison and subsequently help commissioners and providers with co-designing the service.

Considerations of setting should also include the appropriateness of the estate to facilitate effective treatment and recovery interventions, such as a healthcare setting which actively promotes recovery, safe and appropriate dispensing facilities, and whether recovery wings and therapeutic communities could enhance the model of delivery.

Please insert local setting requirements here. E.g. establishment role (Reception, Training, Resettlement), size, healthcare facilities and prison regime.

8. Documentation, guidance and resources

A number of sources of guidance and review have recommended multiple options for service outcomes and developments moving forwards, including;

- “Health Outcomes in Prisons In England: a rapid Review” (October 2016)⁸
- NHS Outcomes Framework Domains and Indicators⁹
- Health and Justice Outcomes detailed in the Patel Report¹⁰
- NHS England strategic direction for health services in the justice system 2016-2020¹¹
- Supporting recovery in mental health services: Quality and Outcomes
- Mental Health Outcomes in the community – The Five Year Forward View for Mental Health¹²
- The Bradley Report (2009)
- NICE guidelines on coexisting severe mental illness and substance misuse

⁸ <https://www.gov.uk/government/publications/health-outcomes-in-prisons-in-england-a-rapid-review>

⁹ <https://www.gov.uk/government/publications/nhs-outcomes-framework-2016-to-2017>

¹⁰ <https://www.gov.uk/government/publications/the-patel-report-reducing-drug-related-crime-and-rehabilitating-offenders>

¹¹ <https://www.england.nhs.uk/commissioning/health-just/#justice>

¹² <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

- NICE guidelines on physical health of people in prison and related Quality Standard (2017)
- NICE guidelines on mental health of adults in contact with the criminal justice system (2017)
- NICE guidance: Autistic Spectrum Disorder in adults: diagnosis and management (2012).
- NHS England and NOMS, 'Working with Offenders with Personality Disorder: Practitioners Guidance' (2015)
- All current relevant Prison Service Instructions (PSIs) and Prison Service Orders (PSOs) and good practice guidance
- Department of Health Transfer and Remission Best Practice Guidance (2011)
- NAO report Mental Health in Prisons (2017)
- Standards for Prison Mental Health Services, Quality Network for Prison Mental Health Services Edition 2 September 2016
- RPS Professional standards for optimising medicines in secure environments Feb 2017
- NHS England 2017 Health and Justice Mental Health Services: Safer use of mental health medicines
- Equal Access, Equal Care: Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities (2015)¹³
- Valuing People: A new strategy for people with learning disabilities in the 21st Century (Government White Paper, 2001)¹⁴
- Learning disabilities: challenging behaviour. Quality standard [QS101] (2015)
- Various guidance for the NHS England Transforming Care agenda for people with learning disabilities.¹⁵
- The Autism Strategy (Cross Government Strategy, 2014)¹⁶
- Adult Autism Strategy, Statutory Guidance for services (2015)¹⁷
- RCPSYCH Perinatal mental health services: Recommendations for the provision of services for childbearing women (2015)
- NICE Quality Standards: Personality disorders: borderline and antisocial
- NHS National Institute for Mental Health in England Personality disorder: No longer a diagnosis of exclusion. Policy implementation guidance for the development of services for people with personality disorder
- RCPSYCH Improving in-patient Mental Health services for Black and minority ethnic patients
- MIND Mental health crisis care: commissioning excellence for Black and minority ethnic groups A briefing for Clinical Commissioning Groups (2013)
- RCPSYCH Caring for Women with Mental Health Problems Standards and Competency Framework for Specialist Maternal Mental Health Midwives
- RCPSYCH Good practice guidelines for the assessment and treatment of adults with gender dysphoria

¹³ <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/08/equal-access-equal-care-guidance-patients-ld.pdf>

¹⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/250877/5086.pdf

¹⁵ <https://www.england.nhs.uk/learning-disabilities/care/>

¹⁶ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/299866/Autism_Strategy.pdf

¹⁷ <https://www.gov.uk/government/publications/adult-autism-strategy-statutory-guidance>

- Psychological Therapies, Annual report on the use of IAPT services - England - 2014/15
- Stepped Care Model for People with Common Mental Health Disorders (NICE guidelines 41, 2011).
- Self-harm in over 8s: short-term management and prevention of recurrence – Clinical guideline [CG16] Published date: July 2004
- RCPSYCH Perinatal mental health services: Recommendations for the provision of services for childbearing women (2015)
- Royal College of Nursing – various guidance documents¹⁸
- This list is not exhaustive

¹⁸ <https://www.rcn.org.uk/clinical-topics/dementia/professional-resources>
<https://www.rcn.org.uk/publications>
<https://www.rcn.org.uk/professional-development/learning-zone>
<https://www.rcn.org.uk/library>
<https://www.rcn.org.uk/library/subject-guides/mental-health-nursing>
<https://www.rcn.org.uk/clinical-topics/mental-health/physical-health-in-mental-illness>
<https://www.rcn.org.uk/library/subject-guides/learning-disability-nursing>

9. Appendix 1 – Standards for 24 Hour Mental Health Care in Prisons

Admission and Assessment		
No.	Standard	Type
i1	<p>There is an agreed operational policy which includes the following areas:</p> <ul style="list-style-type: none"> • admission and discharge criteria; • admission decision making, including out of hours; • leadership of the unit, including clinical and discipline; • the clinical model of the service, including therapeutic activities and prescription/administration of medicines; • the process by which other prisons may refer to the unit when it operates as a regional resource; • the process for liaising with families; • follow-up arrangements. 	1
i2	<p>Patients have a comprehensive assessment which is started within 4 hours and completed within 48 working hours. This involves the multi-disciplinary team and includes the patient. An immediate care plan is completed which includes:</p> <ul style="list-style-type: none"> • mental health and medication; • physical health needs; • risk assessment, including risk of suicide. 	1
i3	<p>The purpose of the admission is explained to the patient and an assessment of their capacity to consent to admission, care and treatment is completed within 24 hours of admission.</p>	1
Case Management and Treatment		
i4	<p>Managers and practitioners have agreed weekly clinical review meetings that comply with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.</p>	1
i5	<p>Activities are provided seven days a week. <i>Guidance: This can include occupational therapy, art/creative therapies, non-therapeutic activities and in cell activities.</i></p>	1
i6	<p>Each patient receives a pre-arranged one-hour session at least once a week with their key worker (or equivalent) to discuss progress, care plans and concerns.</p>	2

i7	Clinical outcome measurement data is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible.	1
Referral, Discharge and Transfer		
i8	Discharge planning begins at the first review and outcomes for discharge are agreed.	1
i9	There are protocols agreed with the prison to enable patients to access accident and emergency services.	1
Patient Experience		
i10	Every patient is engaged in active conversation at least twice a day by a staff member. <i>Guidance: This is an opportunity for patients to discuss any issues or difficulties they are experiencing.</i>	1
i11	There is a weekly minuted community meeting that is attended by patients and staff members. <i>Guidance: This is an opportunity for patients to share experiences, to highlight issues on the unit and to review the quality and provision of activities with staff members. The meeting should be facilitated by a professional who has an understanding of group dynamics.</i>	3
Patient Safety		
i12	Risk assessments and management plans are updated according to clinical need or at a minimum frequency that complies with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.	1
i13	Patients are able to access safe outdoor space every day and should be encouraged and supported to do so.	1
i14	Patients have their medications reviewed at least weekly. Medication reviews include: <ul style="list-style-type: none"> • assessment of therapeutic response; • safety; • side effects, with a clear care plan to manage them when they occur; • adherence to medication regime. <i>Guidance: Side effect monitoring tools can be used to support reviews.</i>	1

i15	The team keeps medications in a secure place, in line with the organisation's medicine management policy.	1
i16	There is a clear policy agreed with the prison concerning the management of violence and aggression within the unit. This includes: <ul style="list-style-type: none"> the roles of discipline staff and healthcare staff; the use of restraint; reviews following episodes of restraint in the unit; audits of restraint. 	1
i17	There is a clear policy regarding the use of rapid tranquilisation within the unit, which includes the issue of consent.	1
Environment		
i18	An audit of environmental risk, including ligature risks, is conducted annually and a risk management strategy is agreed with the prison. <i>Guidance: Any problems are recorded and reported to prison senior management personnel.</i>	1
i19	Emergency medical resuscitation equipment (crash bag), as required by Trust/organisation guidelines, is available within 3 minutes and is maintained and checked weekly and after each use.	1
Workforce Capacity and Capability		
i20	The team has access to a specialist pharmacist and/or pharmacy technician to support their prescription of medication.	2
i21	There are agreed minimum staffing levels that include at least one qualified nurse present on all shifts.	1
i22	The unit is staffed by permanent staff members, and bank and agency staff members are used only in exceptional circumstances, e.g. in response to additional clinical need. <i>Guidance: The use of agency staff is monitored on a monthly basis. An overdependence on bank and agency staff members results in action being taken.</i>	2
i23	Arrangements are in place to ensure that a doctor is available at all times to attend the unit, including out of hours.	1

Governance

i24	The operation of the unit is explicitly included in the commissioning specification from NHS England.	2
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10. Appendix 2 – Standard Annex to Health and Justice Specifications

1 Context

This Standard Annex for Health and Justice Service Specifications contains essential and standard protocols that sit behind all the prison healthcare specifications commissioned by Health and Justice, and supports the delivery of a seamless and coordinated integrated care pathway across the adult prison estate.

Current NHS England developments should be considered within the context of the 'NHS Five Year Forward View'¹⁹, Five Year Forward View for Mental Health (FYFVMH)²⁰ and the 'NHS England strategic direction for health services in the justice system 2016-2020'²¹ ('Care not custody, Care in Custody, Care after custody'). These set the intention and direction for commissioning and provision.

The Health and Justice Service Specifications allow for significant localisation and flexibility in line with the establishment Health Needs Assessment, which should be regularly reviewed and provide the basis for service design, commissioning and delivery of an effective and integrated suite of interventions.

The Commissioners reserve the right to review the contents and detail of the service specifications on an annual basis to take into account any changes in national policy, funding and changes in the local population mental health needs.

2 Health Promotion

The Five Year Forward View for Mental Health (FYFVMH) recommends that the Ministry of Justice, Home Office, Department of Health, NHS England and PHE should work together to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed.

In line with the FYFVMH Providers should:

- work in partnership with local stakeholders and voluntary organisations
- co-produce with clinicians, experts-by-experience and carers
- consider physical health needs
- plan for effective transitions between services, including into the community
- enable integration of services within the prison and in the community
- draw on the best evidence, quality standards and NICE guidelines
- make use of financial incentives to improve quality
- emphasise early intervention, choice and personalisation and recovery

¹⁹ <https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/5yfv-exec-sum/>

²⁰ <https://www.england.nhs.uk/wp-content/.../Mental-Health-Taskforce-FYFV-final.pdf>

²¹ <https://www.england.nhs.uk/commissioning/health-just/#justice>

- ensure services are provided with humanity, dignity and respect.
- ensure that Mental Health awareness training is cascaded to all staff (including prison)

To provide an adequate and suitably safe service, it is crucial to integrate reception screening, initial assessment, and the initiation of interventions at entry, and with systems for through care, aftercare, and risk management planning that support release and integration back in to the community. Exactly how these three elements are organised may vary but services need to plan for, and contribute when appropriate to, all these elements to ensure 'equivalent' and proper care. It is important that services do not focus unduly only on the initial period of need but on the opportunities and the risks that will face a patient with mental health issues across this whole pathway, including immediately after release.

3 Reducing harm and reducing deaths in custody

Any death within the prison system is a tragedy not just for the individual but their family, friends and those within the prison estate charged with looking after their safety, health and wellbeing. It is incumbent upon every person who comes into contact with people in prison – whether they see them as patients, prisoners or just people, to ensure that the contact between the individual and the system/service is meaningful, makes a difference and considers their individual needs. Any indication of self-harm, harm by others or suicidal ideation should be considered, assessed, discussed with colleagues/escalated and where appropriate an intervention put in place. Where incidents of harm – or death – occur, procedures should be in place to robustly carry out an establishment-level review of the incident, in addition to any external (e.g. Prison & Probation Ombudsman) review. The incidents must be reported in line with the Serious Incidents Framework and internal governance procedures.

Any service model should include provision for involvement in prison suicide prevention programmes including multi agency mental health training and the Assessment, Care in Custody & Treatment (ACCT) process to safeguard patients at risk and with an appropriate access to 7 day crisis management provision, including external (community-based) 24/7 out-of-hours mental health provision. Services should be evidence based, clinically and therapeutically led, trauma informed and appropriate for the population.

Any service model should prioritise interventions specifically aimed at reducing deaths in custody, reducing and preventing self-harm and ensuring that interventions are sufficient to prevent suicide. The Provider should be able to clearly articulate what these interventions are, and how effective they are in addressing and reducing incidents of harm or death.

The service provider will work in partnership with HMPPS to deliver safer custody plans for the establishment.

4 Reducing Reoffending

The potential for effective healthcare interventions – especially mental health interventions, treatment and recovery – to be a positive mediator of change in criminal behaviour is frequently underestimated. Assisting the individual to consider their offending behaviour in the context of the changes they are seeking to achieve through treatment access, facilitating the continuation of behaviour change through effective care co-ordination, and improved continuity of care from secure settings to community services and from the establishment to other secure settings. It should be noted that this is a shared responsibility in line with the whole prison approach and requires collaboration between healthcare staff, prison staff and offenders, which would also consider support to access wider social interventions for example access to employment and training to improve the outcomes for offenders upon release.

5 Clinical Governance (Quality)

Clinical governance is an established system in the NHS and the independent healthcare sector to deliver and demonstrate that quality and safety of its services are of a high standard that is continually improving.

NHS England Health and Justice Commissioning is committed to improving the quality of clinical interventions through a systematic approach. The Service Provider, Service and individual clinicians have to take account of both formal and informal clinical governance structures.

The Service Provider and Service should abide by local and national arrangements for clinical governance. Managers of services will ensure quality through appropriate clinical governance arrangements and report to Commissioners on governance as required below:

- a) The Service Provider must ensure attendance and contribution at quality boards/clinical governance meetings within the prison establishment.
- b) The Service Provider must follow the Health and Justice Commissioning Serious and Untoward incidents processes, and the NHS SI framework, including controlled drug incident processes.
- c) Consideration should be given to patient representatives attending and contributing to local and service level meetings and committees.

6 Vigilance and responsiveness

Multiple stakeholders including the health service provider, prison staff, security, and service users all need to be engaged in monitoring and responding to need. Prospective providers of services should be able to evidence how they continually monitor individual and establishment health needs.

A range of services to deal with emerging need should be clearly communicated to target populations and escalated in discussions with commissioners. This should be

part of a range of approaches that include prevention activities, education and strategies to maintain the skill levels of staff.

7 Discreet provision and integrated systems

Whilst this treatment service is a standalone system the service must take account of the following principles:

- An ability to creatively meet the multiple needs that clients present with in a cohesive, patient-centred and holistic way including physical needs, reducing reoffending, managing trauma and loss and maintaining their emotional and mental wellbeing.
- The planning, coordination and delivery of care is patient-centred and should not unnecessarily result in multiple assessments, care plans and reviews that can be more effectively managed through a single, multi-faceted and multi-disciplinary process

As a principle, greater integration between healthcare services, the prison service, between prison establishments, and community health services can help to ensure that any person who has multiple health, care and social needs is seen holistically as a person, rather than a collection of disparate needs and conditions.

8 Entries and Exits

From the moment of entry, induction needs to inform service users of the treatment and support pathways available, and how to refer themselves or any other offender to services. Providers must also manage patient expectations around patient waiting times and have open lines of communications via patient engagement forums as well as face to face.

Where exits are from the criminal justice system, rather than from treatment itself (e.g. transfer from custody to community or secure hospital care) an extensive process of multidisciplinary planning should be instituted in good time to enable an effective and functional handover of the client for effective care continuity via community mental health services and criminal justice/supervision systems. This planning should be started as early as possible, and ideally should be regularly revisited as a part of care planning. Discharge planning should include crisis de-escalation and management plans.

Delivery models should be able to describe a full range of activities both pre- and post-release to ensure that an individual's safety and recovery is maintained, and that adequate resources are in place to ensure effective transfer/integration to community mental health services, and other forms of community assistance (e.g. Peer Support).

9 Information Sharing and Record Keeping

Clinicians are required to keep appropriate, comprehensive and contemporaneous Inmate Medical Records utilising the healthcare clinical IT system in line with information governance and data protection legislation. Clinicians are required to share information where relevant and appropriate (in-line with information governance expectations) to ensure patient safeguarding.

The patient's consent to the sharing of clinical information outside the team is recorded. If this is not obtained the reasons for this must be recorded in the patient record. If information is going to be shared without patient consent then the reasons also need to be recorded. Data can only be shared against the patient's wishes if: there is a legal requirement (e.g. a Court Order or statutory requirement; or an overriding public interest (e.g. to protect another person from serious harm); or another legal reason. Patient consent is not required if it is proposed to share data in an anonymised form.

Protocols should be in place to enable effective sharing of information for safety, continuity of care and reducing reoffending. These protocols should cover information which needs to be shared both within the establishment, between HMPPS staff and Healthcare, for example, and outside of the establishment – such as with the release area Community Rehabilitation Company (CRC), community services and HMPPS community-based teams (e.g. Probation) and social care, where necessary.

The Provider must ensure full, accurate and timely reporting of activity through SystemOne (or any successors thereof). They should record key clinical codes and flag any key vulnerabilities on the front page of a prisoners file.

All assets registered to the prison and NHS England will remain for the use of the successful provider, they will remain the property of NHS England/HMPPS.

The Service Provider must comply with any Prison Information Sharing Agreement and UK data protection legislation as well as PSO 9015; Information Assurance. The Service Provider must also comply with the Common Law duty of confidentiality and the Human Rights Act 1998.

Information collected and recorded by the Service Provider (or sub-contractors) in regard to service users who attend and/or engage with treatment will be made available anonymously to members of the Commissioners or other persons appointed by the Commissioners on request in line with Information Sharing Agreements.

The Commissioners (or its appointed persons) will make anonymous any data and information gained as a result of this access. Any information obtained is for the sole purpose of informing the continued development and improvement of the Commissioners commissioned services.

There must be representation from Mental Health Service Manager and/or service delivery manager at security committee meetings and a reciprocal arrangement with Medicine Management Meetings, where the sharing of information should be facilitated. Data can only be shared if there is a legal requirement (e.g. a Court Order

or statutory requirement; or an overriding public interest (e.g. to protect another person from serious harm); or another legal reason.

The provider must provide each service user with a copy of the data use policy.

Attention should also be given to the Consensus Statement on Information Sharing and Suicide Prevention.²²

10 Compassion

Compassion is an important concept in healthcare, and care should be delivered in a culturally competent manner, taking into account the values, culture, and health beliefs of the individual. Services should have a focus on working with people rather than doing 'to' them, and aim to develop a patient centred service which is responsive to people and their needs, rather than being process-driven. Competent compassion encapsulates the 'therapeutic relationship' that is one of the most important factors in successful treatment outcomes.

11 Duty of Candour

The Duty of Candour is a legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm

Duty of Candour aims to help patients receive accurate and truthful information from health providers.

The duty of candour helps to achieve a wholly transparent culture in health provision – being open when errors are made and harm caused.

If a reportable serious incident occurs or is suspected to have occurred the provider must:

- Provide the service user and any other relevant person all necessary support and information in relation to the incident.
- Report the incident in accordance with local policies.
- Verbally notify the relevant person that the incident has occurred as soon as is practicable, but within 10 days including:
 - An apology if appropriate
 - All the facts the provider knows about the case
 - Offer the option of an additional written notification
- Recorded in writing for audit purposes in accordance with the guidance.
- As soon as is practicable, but within 10 operational days, instigate and conduct a full investigation into the incident in accordance with National Patient Safety Agency (NPSA) incident investigation tools and guidance.

22

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf

- As soon as is practicable, a step by step explanation of the events and circumstances which resulted in the incident should be given to the relevant person.
- Complete investigation within the relevant timescales identified for the serious incidents.
- Whistle blowing requirements

12 Prison Healthcare Services Coordination

Service users may present with other healthcare needs which require support from prison healthcare services. Often this will need a coordinated response between mental healthcare services and physical healthcare services. The Service Provider must:

- Contribute to the development of clear pathways with healthcare services to improve levels of joint working for those identified with other healthcare needs
- Contribute to the development and implementation of a joint working protocol with prison healthcare services
- Work flexibly to ensure that clients' interests are foremost, including GP prescribing primary care drug on an exceptional basis and clear shared care between GP and mental health prescribers when initiating, reviewing and monitoring mental health medicines. Local policies must be developed to support this and records kept of incidences when this has occurred.

13 Links with Community Services

The Service Provider must develop strong links and clear referral pathways to ensure continuity of care for service users being transferred between custodial settings to community and vice versa. This should include: local community Mental Health providers, Substance Misuse services, General Practitioners, Local Authorities, Liaison and Diversion services, voluntary organisations, community Learning Disability teams, and Community and Social Enterprise organisations that provide mental health and recovery support services.

The Service Provider must develop robust plans and mechanisms for continuity of care for clients on their release from custody to whichever region or local authority they are returning to. The plans should form part of an overarching recovery, treatment and/or care plan, which is discussed with the service user and community providers at the earliest opportunity.

The release plan must include contact details of their local mental health treatment provider in case of unexpected or early release. Links should be made with other appropriate services such as Community Rehabilitation Companies.

14 Partnership Working

The Service Provider must work in partnership with the full range of health or social care organisations in the community, where the patient originates and in the local authority area that the prison is located to support service users and/or their families to achieve the Service Outcomes.

Partnership working requires the Provider to work collaboratively with all departments throughout the establishment and should include their arrangements for partnership working with Security Departments, Safer Custody Teams, Offender Management Units etc.

The Service Provider should liaise and work collaboratively with all commissioned services working within the prison, including but not limited to:

- Primary Healthcare services
- Sexual Health In-Reach Services
- Integrated Clinical Assessment & Treatment Service (ICATS)
- Dental and Oral Health Services
- GP services
- Podiatry Services
- Occupational Therapy Services
- Substance Misuse Services
- Opticians
- Pharmacy Services
- Social care services (if agreed a role within the prison)
- Local adult social services
- Statutory Advocacy Provision (IMCA and Care Act)
- Any other Specialised Services

Representatives from the Service Provider must attend relevant establishment and /or partnership meetings to improve the effectiveness of the service and to facilitate the smooth running of the prison.

The Service Provider will be required to work in close collaboration with any persons appointed by the Commissioners to undertake an evaluation of the Service.

The Service Provider must ensure all health and social care professionals involved in the service user's care or associated care are kept fully informed of their progress.

15 Sub-contracting arrangements

Any sub-contracting arrangements made by the Service Provider must be agreed in advance, explicitly in writing by the Commissioners.

The Service Provider must ensure the effectiveness and efficiency of health service delivery in the prisons and will remain accountable as Prime Provider for all services whether provided directly or sub-contracted to other providers.

The Service Provider must ensure that any sub-contractors have the necessary registrations and licenses needed to provide regulated interventions.

Sub-contracting arrangements must have embedded termination clauses which allow the subcontract to be terminated with minimal delay.

16 Capacity or service delivery issues

The Service will be required to meet the staffing requirements (including the appropriate use of agency staff) and deliver to capacity. Recruitment and retention strategy should be developed and implemented for robust management of staffing.

The Service Provider will alert commissioners to any capacity or service delivery issues in a timely and appropriate way.

The Service Provider must inform the Commissioners of any urgent issues that arise and will work with the Commissioners to agree and implement solutions as necessary.

Note to Local Commissioners

Local additions will be required to suit the individual establishment

17 Serious Incident Definition

NHS England has a Serious Incident (SI) Framework which sets out the definition of an SI. In brief, Serious Incidents requiring investigation are:

- Unexpected or avoidable death of one or more service users or staff or visitors
- Serious harm to one or more service users or staff, visitors or members of the public where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm.
- A scenario that prevents or threatens to prevent the Service Provider's ability to continue to deliver services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure
- Allegations of abuse
- Adverse media coverage or public concern about the organisation
- Serious incidents involving controlled drugs
- Breach of information security
- Breach of Prison service professional standards

18 Serious Incident Reporting

The Service Provider must comply with the requirements of the Commissioners and Prison Service for Serious Incident management using the relevant reporting

mechanism. The provider should ensure they are applying learning from incidents; using Human Factors in Patient safety and patient safety is informed by a recognised framework for improving patient safety.

The Service Provider must attend the Commissioner's Serious Incident meetings as required. The outcome of Serious Incident investigations should inform agency improvement programmes if they are highlighted and evidence of these improvements should be provided to the Commissioners and Prison establishment.

The Provider must comply with the arrangements for notification of deaths and other incidents in accordance with CQC regulations and guidance where applicable, and to any other regulatory or supervisory body, any office or agency of the Crown or any other appropriate regulatory or official body in connection with Serious Incidents, or in relation to the prevention of Serious Incidents in accordance with good practice and the law.

The parties must comply with their respective obligations in relation to deaths and other incidents under the NPSA reporting and learning from Serious Incident guidance and local standard operating models for reporting.

The NPSA investigation tools should be used, including but not exclusively the incident decision tree and root cause analysis.

19 Safeguarding and PREVENT

The Care Act (2014) sets out a clear legal framework for how the system should protect adults at risk of abuse or neglect. The Service Provider must comply with the requirements of The Care Act (2014) and associated regulations and guidance provided by the Independent Safeguarding Authority (ISA) and the local Safeguarding Board Guidelines. The Service Provider has a duty to ensure that referrals are made to the Disclosure and Barring Service (DBS) whenever necessary, in line with DBS guidance.

The Provider must ensure they have up to date organisational safeguarding policies and procedures for children and adults and robust governance arrangements in are in place for safeguarding in line with the Local Authority and the prison's safeguarding policies and procedures. They must have strong links with local Safeguarding Boards and any safeguarding issue must be managed through these policies and brought to the attention of the Local Authority Designated Officer (LADO).

Safeguarding policies and procedures must give clear guidance on how to recognise and refer safeguarding concerns both within the prison and when necessary outside of these structures. All policies and procedures should be consistent with and make reference to safeguarding legislation, including in relation to mental capacity and consent, national policy/guidance and local multiagency safeguarding processes.

All organisations providing health funded services are required, through the national contract, to adhere to the requirements of the PREVENT strategy. This includes the training of all relevant front line staff in the responsibilities of PREVENT as well as

introducing and embedding processes to identify and protect those who may be at risk of radicalisation as well as escalating concerns regarding potential terrorist events to the Police. If a PREVENT referral is received, all health organisations are required to provide information on the individual named in the alert as well as information on family members. This information will then be considered against the information provided by other agencies to determine if there is a potential concern that should be addressed.

20 Family, Friends and Carers

The Service Provider will work in partnership with local carer's agencies to ensure family, friends and carers access the range of support available. The service will include a family liaison role which will enhance community services to enable prisoners to maintain, develop and build upon family relationships.

Note to Local Commissioners

Local additions will be required to suit the individual establishment

21 Lived Experience

NHS England is committed to strengthening the voice and involvement of those with lived experience. This is and should be reflected through planning, commissioning and delivery of services, and through the integral use of peer systems in supporting specialist delivery (with appropriate support, training and reward for those peers engaged in the delivery of interventions).

The Service Provider must ensure appropriate and effective service user involvement in line with the Commissioners HMP Service User Involvement (SUIT) Strategy and principles of Duty to Involve. The Service Provider must comply fully with Section 242 of the NHS Act (2006) and Section 11 of the Health & Social Care Act (2012).

Where appropriate service user involvement representatives are expected to be supported to attend key forums that contribute towards the planning, delivery and evaluation of service provision and the Commissioner's Service User Focus Groups meetings held quarterly in each establishment, as well as service user and carer consultation events.

22 Service User feedback and complaints

The Service Provider will seek the views of service users, their families and carers to help ensure that services are effective and responsive to the changing patterns of need.

The Service Provider will seek and review levels of service user satisfaction with the overall aim of service and quality development assurance; this will be demonstrated through performance management reviews at which the Provider will inform and

evidence to the commissioners any changes made to the provision as a direct result of Service User involvement.

23 Workforce Development

The provider must be able to demonstrate how it intends to deliver a workforce that is competent and continually involved in professional development. Training needs to reflect that the workforce is multidisciplinary and to consider the training needs of the wider prison environment. It should include training to enhance recognition of trauma and its effects, as well as more routine developmental aspects.

This development should address the need for:

- Greater integration and take account of new care models
- Recruitment and retention
- Systems leadership and management
- Workforce planning , learning and development
- Improving staff mental health awareness, wellbeing and resilience
- Quality and safety of patients
- Equality and diversity training
- SystemOne training

This development should enable:

- A workforce that is capable and confident in providing physical and mental healthcare, as well as supporting wellbeing across the whole prison population
- A service committed to improving health outcomes
- Services crafted so that they are equipped to address mental and physical health conditions at the same time

Staff should receive training consistent with their role and in line with their professional body.

Regard must be given to the Health and Justice Competency Framework.

Annual skills audit should take place to ensure the correct staffing requirements and enable the development of a balanced workforce that meets the needs of the population.

Services may wish to consider ensuring the additional skills and knowledge-base required to meet the needs of people with learning disabilities by employing a learning disability nurse or dual-qualified mental health and learning disability nurse. Prisons where such nurses are in post have reported a significant impact upon things such as reducing challenging behaviour and improvements in general awareness for all staff.