Quality First

Quality Assurance and Improvement Framework: Health and Justice and Sexual Assault Referral Centres

NHS England and NHS Improvement

Quality Assurance and Improvement Framework (QAIF): Health and Justice and Sexual Assault Referral Centres

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The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

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1 Executive summary

NHS England is responsible for the routine commissioning of health and justice services in its direct commissioning function.

Securing Excellence in Commissioning for Offender Health (2013) sets out the operating model with which NHS England will secure the best possible health outcomes for its patient population (including children and young people), with a view to ensuring those in secure settings are given access to the same quality and range of health care services the wider public receives from the NHS.

This Quality Assurance and Improvement Framework (QAIF) provides the basic infrastructure for quality assurance of health and justice services. It is designed to underpin the delivery of NHS England's responsibilities and duty in respect of quality, as stated in the Health and Social Care Act (2012) and is integrated with the wider NHS England quality assurance activities.

Quality is made up of three dimensions: clinical effectiveness, patient safety and patient experience and has a focus on four components:

1. Identification and implementation of standards for clinical effectiveness, patient safety and patient experience of care.
2. Monitoring, evaluating and reporting of performance against standards.
3. Action: to share good practice or address concerns.
4. Evidence of closure of concern and continuous improvement.

Health and justice providers are required to routinely report how well their service delivers against core service specification measures.

The QAIF captures and makes explicit the responsibilities of the commissioning organisation and stakeholders for quality assurance and describes the processes that will be used to commission high quality care in the secure and detained estate.

2 Purpose

Through the commissioning of services, NHS England's mission is to improve health and secure high-quality health care for the people of England, now and for future generations.

NHS England is fully committed to the continuous improvement and quality of services, including those we commission and those we do not commission directly but are provided to the population.

2.1 Health and Justice services – the current estate

NHS England is responsible for the routine commissioning of health and justice services as part of its direct commissioning function. The current estate includes:

- **Secure Training Centres (STCs) and Secure Children's Homes (SCHs)**

Offenders under 15 are normally held in SCHs, while those over 15 are held in STCs

or young offender institutions. There are three STCs in England, two of which hold women. Some secure children's homes hold children placed for both justice and welfare reasons, others hold children placed by Local Authorities under a secure welfare order for the protection of themselves and/or others (welfare placements) under section 25 of the Children Act, 1989 Young Offender Institutions (YOIs)

These are facilities designed for offenders from 15 – 21 years of age, but can accommodate those from age 15 and up to age 22. Young offenders are considered such until they reach their 21st birthday when they are transferred to an adult prison.

- **Youth Offending Teams (YOTs)**

These are statutory bodies that include representatives from health, education, police, probation, substance misuse and social services.

- **Liaison and Diversion Services (L&D)**

L&D services identify people who have mental health or substance misuse issues, learning disabilities or other vulnerabilities when they first encounter the criminal justice system as suspects, defendants or offenders.

L&D services can then support people through the early stages of the criminal system pathway, refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting.

L&D services aim to improve overall health outcomes for people and to support people in the reduction of re-offending. They also aim to identify vulnerabilities in people earlier on, which reduces the likelihood of people reaching a crisis-point and helps to ensure the right support can be put in place from the start.

- **Adult Prisons**

The range of services directly commissioned for prisons include primary care (GP) services, secondary care (hospital) services, public health including substance misuse services under a section 7a agreement with the Department of Health and Social Care (DHSC), dental services, ophthalmic services (eye care) and mental health services. Services not commissioned are emergency care, ambulance and out of hours services.

- **Independent (contracted) Prisons**

Independently run prisons are run under contracts which set out the standards that must be met, which in many respects mirror the Service Level Agreements (SLA) which apply to publicly run prisons.

Her Majesty's Prison & Probation Service (HMPPS) has responsibility for running prison services in England. It manages public sector prisons and the contracts for independent sector prisons. In independent prisons, there is a Director rather than a Governor.

In terms of healthcare services, commissioning arrangements are the responsibility of either NHS England or private companies such as G4S or Serco for instance with performance expectations and governance aligning with NHS standards.

A full list of private prisons in England, is attached at appendix 1. and more information about commissioned services within private prisons can be obtained by contacting the regional health and justice team.

- **Immigration Removal Centres (IRCs) and Residential Short Term Holding Facilities**

A key NHS England responsibility is to directly commission health services for persons who are detained in IRCs. IRCs are holding centres for foreign nationals awaiting decisions on their asylum claims or awaiting deportation following a failed application.

A residential short-term holding facility is a small detention facility with sleeping accommodation in which detainees may be legally held for a maximum of seven days. There is one facility at present situated in the North West (Manchester).

- **Public Health services for persons detained and in secure settings across England, including those held in the children and young people's secure estate.**

The public health functions agreement, section 7a, is an annual agreement between the Secretary of State for Health and Social Care and NHS England.

The section 7a agreement describes the services that will be commissioned by NHS England, which includes public health services for people in prison and other places of detention. This includes those held in the children and young people's secure estate and those using SARCS.

Public health programmes cover all aspects of public health, including health protection, health promotion and healthcare public health (HCPH), which is one of the core domains of specialist public health practice. HCPH is concerned with maximising the population benefits of healthcare and reducing inequalities whilst meeting the needs of individuals and groups. This is done by:

- Prioritising available resources
- Preventing disease
- Improving health related outcomes.

Some populations in detention settings have specific needs due to both the population and the setting. For example, substance misuse in prisons, foreign nationals in IRCs and/or prisons and child sexual exploitation (CSE) in the children and young people's secure estate. Other needs, including high levels of mental health needs, access to screening and immunisation programmes and increased risk of infectious diseases, such as tuberculosis and blood borne viruses (BBV), are consistently seen across settings and populations.

- **Sexual Assault Referral Centres (SARCs)**

SARCs provide services to those who have been the victim of rape or sexual assault regardless of whether they choose to report the offence to the police.

The delivery aim of SARCs is to provide service users with:

- Acute healthcare and support in age-appropriate settings
- Comprehensive forensic medical examinations
- Follow up services which address their medical, psychological, social and ongoing needs
- Direct access or referral to independent sexual violence advisors.

Through the QAIF, we will seek assurance about the quality of care provided by our commissioned services, including the infrastructure and governance framework within which we work.

We will make quality central to our commissioning, identifying the most impactful opportunities for change and continual improvement.

The NHS England health and justice and SARCs regional portfolios are attached at appendix 2.

2.2 NHS England's responsibilities in relation to equity and quality

The introduction of the QAIF is designed to support NHS England's statutory responsibilities with respect to the commissioning of quality health services for the health and justice sector. These responsibilities are:

- NHS England is under a statutory duty to 'exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals and in the outcomes, that are achieved from the provision of services' (Health and Social Care Act 2012).
- NHS England has duties in relation to equality and reducing health inequalities in access to service and outcomes (NHS England, 2014).
- NHS England is responsible for assuring the quality of the services it directly commissions and for oversight and assurance that clinical risks within those services are mitigated.

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of this document, we have given due regard to the need to:

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

2.3 Single definition of quality

The Health and Social Care Act 2012 sets out a single definition of quality based on Darzi (2008).

'The following three dimensions must be present to provide a high-quality service:

> ***Patient Safety*** *– quality care is care which is delivered to prevent all avoidable harm and risks to the individual's safety.*
>
> ***Clinical Effectiveness*** *– quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes.*

> ***Patient Experience*** *– quality care is care which looks to give the individual as positive an experience of and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect.'* (National Quality Board (NQB), 2013)

The Care Quality Commission's (CQC) single shared view of quality supports this definition. The CQC's assessment of quality has been developed around five questions asked about every service. The first four of these dimensions can be cross referenced to the definition described in Figure 1 (NQB, 2013):

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

The fifth question asked by the CQC (Is it well-led?), recognises the link between leadership and quality improvement.

3 The framework

3.1 Definition of quality assurance

In 2011, a Kings Fund publication defined quality assurance as the following:

- An assessment of quality of care by an external body often in terms of comparison against agreed threshold standards, to determine whether the quality of care is acceptable.
- A judgement which leads to further discussion as to whether and where 'corrective actions' are required to maintain or improve quality.
- Quality assurance also ensures these actions are implemented through monitoring and review of progress.

Considering the individual elements of this definition, it provides us with four overarching components for the QAIF:

1. Identification and implementation of standards for clinical effectiveness, patient safety and patient experience of care.
2. Monitoring, evaluating and reporting against standards.
3. Sharing good practice and addressing concerns.
4. Evidence of closure of concerns (that they have been dealt with) and continuous improvement (sustainability of any changes).

3.2 Core principles

We aim to ensure that the quality of care for patients and service users is not compromised by financial, management or other pressures of NHS England or those organisations from whom we commission services and those we do not commission directly, but provide services to our population.

NHS England, having direct commissioning responsibility for health and justice provision, will act as system leaders in delivering its statutory duty of assuring itself of the quality of the healthcare it commissions. In delivering this duty, NHS England regional teams will use the following principles to guide and inform all quality assurance activities and processes:

1. Our quality assurance processes should be equivalent to those expected from clinical commissioning groups (CCGs) and commissioning standards across the NHS, ensuring equity with equivalent services.
2. All quality assurance reporting and processes must be proportionate to the services commissioned and allow for local adaption and variation as required. This must be agreed by an NHS England registered senior nurse or a medic.
3. There must be an early warning mechanism and clear escalation process to mitigate and manage any concerns and failings in the quality of care.
4. All quality assurance processes must be transparent and support matrix working (a cross functional, non-hierarchical way of different individuals, teams and functions working together to accomplish a goal) and governance processes within NHS England at all levels.
5. Local quality assurance reporting and review must support integrated working with all partners within and out of health and justice, e.g. CQC, Her Majesty's Inspectorate of Prisons (HMIP), HealthWatch, Her Majesty's Prison and Probation Service **(**HMPPS), Department for Health and Social Care (DHSC), Youth Justice Coalition (YJC) , Office for Standards in Education (Ofsted), Independent Monitoring Board (IMB) Youth Justice service (YJS), Public Health England (PHE), Ministry of Justice (MOJ), LOA, Home Office *(please note that this is not an exhaustive list)*
6. Identification of external factors which impact on the delivery of NHS England's commissioned services and clear escalation processes to address these in a timely manner.
7. All quality assurance escalation, governance, action and reporting needs to be purposeful, proportionate, effective and avoid duplication.
8. Identification and recognition of good and innovative practice and supporting providers in continual learning and improvement with mechanisms in place for this locally, regionally and nationally.

4 Patient Safety

Patient safety is a key driver to use in reviewing and improving care. Three documents, Francis, Winterbourne and the National Advisory Group for the safety of patients in England, identify similar themes which can be summarised in five key principles:

1. Learning for improvement: Leaders and care providers should be supported to learn develop and act where there are safety concerns.
2. Listen and act: Patient experience should be considered, triangulated and acted upon.
3. Transparency: Openness and transparency is essential within healthcare.
4. Learning and development support: Staff experience is as important as patient experience. It is a strong indicator for quality of care.
5. A positive culture of values: A robust learning, development and safety culture improves quality of care. Organisations need to recruit and retain the best staff and ensure their development needs are met. Leaders should be developed at all levels to enable excellent outcomes to be achieved.

4.1 Serious incidents

Serious incidents in healthcare are adverse events where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is

so great, that a heightened level of response is justified.

Serious incidents include acts or omissions in care that result in:

- Unexpected or avoidable death
- Unexpected or avoidable injury resulting in serious harm – including where the injury required treatment to prevent death or serious harm
- Never events – incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services
- Incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

The Serious Incident Framework (SIF) lays out minimum standards and guidance to ensure serious incidents are identified correctly, investigated thoroughly and most importantly, learned from to prevent the likelihood of similar incidents happening again. An updated SIF planned for April 2019, places a focus on developing systems to support good investigations with less emphasis on checking individual serious incidents.

The needs of those affected should be the primary concern of those involved in the response to and the investigation of serious incidents. Patients, their families and victims' families must be involved and supported throughout the investigation process.

Providers are responsible for the safety of their patients and must ensure robust systems are in place for recognising, reporting, investigating and responding to serious incidents.

Commissioners are accountable for quality assuring the robustness of their providers' serious incident investigations and the development and implementation of effective actions by the provider, to prevent recurrence of similar incidents. Regional teams should ensure there are clear processes in place to support this.

4.2 Deaths in custody

NHS England health and justice regional commissioning teams have a duty to support the investigation into deaths that occur in NHS funded health and justice services where the Prison and Probation Ombudsman(PPO) has a remit to investigate. The PPO remit is to investigate the circumstances surrounding all deaths in the following:

- Prisoners and trainees (including those in YOIs and STCs).
- Residents on IRCs, short term holding facilities and persons under managed escort
- SCHs
- People in court premises or accommodation who are remanded into custody or who have been sentenced
- Residents of approved remises (including voluntary residents)

Under the terms of reference from the Home Secretary, the PPO's remit is to investigate all deaths in prisons, other secure settings, approved premises and court premises. A death shortly after release may also be investigated and require a clinical review; the decision to investigate or not is the discretion of the PPO. The PPO terms of reference can be found at https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2017/04/PPO-Terms-of-reference-2017.pdf

The PPO is appointed by the Secretary of State for Justice and is wholly independent. This includes independence from HMPPS, the National Probation Service for England and Wales and the community rehabilitation companies for England and Wales (probation), any individual Local Authority, the Home Office, the Youth Justice Service (YJS), providers of youth secure accommodation, DHSC, the Department of Education and NHS England.

This enables the PPO to execute fair and impartial investigations,

making recommendations for change where necessary, without fear or favour. The actual independence of the PPO from the authorities in remit is an absolute and necessary function of its role.

All deaths in custody must be reported and investigated, including natural causes and expected/end of life.

4.2.1 Reporting

NHS England recently developed a death in custody case management system with the aim of supporting a consistent and robust approach to assuring death in custody action plans and enabling local, regional and national learning is implemented.
The system is designed to support strategic work to address repeat recommendations and reduction of avoidable deaths in custody, identifying themes and trends to drive continuous improvements from learning. For specific cases, the system enables closer monitoring of action plans developed in response to recommendations and timelines for completion or implementation of actions.

Data held on the case management system also enables the production of quality, timely and consistent reports relating to deaths in custody and ad-hoc reports as and when necessary.

All deaths in custody must be reported onto the case management system.

4.2.2 Clinical reviews

The PPO investigation includes examining the clinical care relevant to each death. The Secretary of State for Health and Social Care has agreed that NHS England will take the lead responsibility for arranging an independent investigation into the clinical care provided, including whether referrals to secondary healthcare were made appropriately. The responsibility has been delegated to the NHS England regional health and justice commissioning teams. This investigation is known as a clinical review.

NHS England guidance to support provision of a clinical review investigation and guidelines for clinical reviewers can be found here: https://www.england.nhs.uk/publication/guidelines-for-the-provision-of-clinical-reviewers-to-support-health-and-justice-deaths-in-custody-investigations/

4.2.3 Preventing future deaths (PFD) - Regulation 28 reports:

All deaths in custody are subject to a Coroner's inquest under Article 2 EHRC, the Right to Life. The inquest will establish the following facts:

- Who died
- When they died
- Where they died
- How they died.

If any information is revealed as part of the Coroner's investigation, or during the course of the evidence heard at the inquest which gives rise to '*a concern that circumstances creating a risk that other deaths will occur, or will continue to exist in the future';* and if the Coroner is of the opinion that action needs to be taken, under paragraph seven of schedule 5 of the Coroner and Justice Act 2009, the Coroner has a duty to issue a report to a person,

organisation, local authority or government department of agency.

The Coroner's Preventing Future Deaths Regulation 28 Report will set out the concerns and request that action is taken. The person, body or organisation in receipt of this report then has 56 days to provide the Coroner with a response, to include details of actions taken and to reassure the Coroner that their concerns have been addressed to prevent future deaths.

NHS England receives and takes these reports very seriously and ensures a response is provided to the Coroner within the required timeframes. NHS England has produced guidance and healthcare providers and commissioners are required to comply with requests for input into responses to these reports and to act upon any learning identified. Coroner's PFD Regulation 28 Reports. The current document can be found here: https://nhsengland.sharepoint.com/TeamCentre/Medical/CP&O/QSU/qualitypolicy/coroners

Responses to reports, sent to NHS England, are produced with input from the relevant regional health and justice commissioning team and are signed off by the national medical director.

Providers and commissioners are required to comply with requests for input into responses to these reports and to act upon any learning from identified.

4.3 Article 2

Investigations into death and 'near death' incidents (usually following a life-threatening suicide attempt, incident of serious self-harm or assault) in prison, are part of the State's obligations under the European Convention on Human Rights (ECHR), in particular Article 2 ECHR – the right to life.

All deaths in prison custody are subject to an independent investigation by the PPO and a Coroner's inquest, which is held in public before a jury, processes that together will normally satisfy the State's investigative obligations under Article 2 ECHR.

In certain limited circumstances, an incident that has not resulted in a death can require such an Article 2 compliant investigation. In particular, the Courts have ruled that some 'near death' incidents in prisons are sufficiently serious to engage Article 2 ECHR and necessitate an Article 2 ECHR compliant investigation.

HMPPS commissions such investigations which examine the circumstances of the incident of serious self-harm or assault. These investigations will consider the care and treatment (including healthcare) provided to the patient and will identify if any lessons can be learned that might contribute to the safe and decent care of those held in prison custody.

NHS England health and justice teams, national and regional teams, have a duty to respond to any learning and recommendations made relating to their role in commissioning healthcare provision within the timescales provided.

A national process and guidelines document will be developed to outline the process and roles of NHS England central and regional teams in responding to these investigations.

4.4 Safeguarding

The Care Act (2014) sets out a clear legal framework for how the system should protect adults (18 years of age and over) at risk of abuse or neglect whilst the Working Together to Safeguard Children Statutory Framework provides statutory guidance relevant to safeguarding and promoting the welfare of children under the Children Act (2019, 2004). Service providers must be able to demonstrate compliance with the requirements and

principles of all relevant legislation, regulations and statutory circulars relating to safeguarding adults and children insofar as they are applicable to the services provided.

Abuse is any act, or failure to act, which results in a significant breach of a person's human rights, civil liberties, bodily integrity, dignity or general wellbeing, whether intended or Inadvertent and includes:

- Physical abuse (including female genital mutilation)
- Emotional or psychological abuse
- Sexual abuse (including child sexual exploitation)
- Financial or material abuse
- Institutional abuse
- Modern slavery
- Radicalisation.

Local Authority statutory adult safeguarding duties apply to all adults in all settings other than in prisons and approved premises where the prison governors and HMPPS respectively have responsibility. Senior representatives from prisons or HMPPS may sit on Safeguarding Adult Boards and they may ask for advice from local authorities when faced with a safeguarding issue which is challenging. The provider must clearly understand the processes within the prison for raising safeguarding concerns and how to escalate to HMPPS or other statutory body if required.

Provider safeguarding policies and procedures must give clear guidance on how to recognise and refer safeguarding concerns both within the establishment and, when necessary, outside of these structures. All policies and procedures must be consistent with and refer to safeguarding legislation, including reference to mental capacity and consent; national policy/guidance and local multiagency safeguarding processes. There must be a clear mechanism for ensuring this is clearly documented on Systm1 and a process for audit to ensure compliance. Systems must be in place to ensure all subcontractors and agency staff are compliant with these policies and procedures.

The duty to safeguard applies not only to prisoners, but also to staff and to any other individual when the provider has been made aware of the risk of potential harm or threat to that individual.

Service providers have a duty to ensure they are compliant with the statutory requirements for service delivery and recruitment.

Whilst the recommendations in The Lampard Review are focussed on acute NHS Trusts**,** point 9.5 states 'non-NHS hospital and care organisations should consider this report and implement any of our recommendations relevant to their services'. It is NHS England's expectation that all prime providers and their sub-contractors are compliant with these.

Prevent is part of the UK's Counter Terrorism Strategy, known as CONTEST. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity; this includes prisoners and staff. Radicalisation is a psychological process where vulnerable and/or susceptible individuals are groomed and become involved with criminal, terrorist activity.

In April 2015, the Prevent Statutory Duty, under Section 26 of the Counter-Terrorism and Security Act 2015, was made a statutory responsibility for the health sector. The Duty stated the health sector needed to demonstrate '*due regard to the need to prevent people from being drawn into terrorism*'. Within health, NHS trusts and foundation trusts are specifically mentioned in the Duty, however, Prevent is part of mainstream safeguarding and therefore all health staff must ensure vulnerable people are safeguarded. This is supported by the NHS Standard Contract (clause 32), which requires all NHS funded providers to demonstrate they comply with the requirements of the Prevent Duty. This includes ensuring there is a

named Prevent lead and there is access to quality training for staff in their organisation and embedded processes to identify and protect those who may be at risk of radicalisation. They must also have a clear process for escalating concerns regarding potential terrorist events to the police and/or prison governor/establishment pathfinder lead.

Accountability summary:

- All NHS funded services have a statutory duty to ensure they have taken the appropriate measures to safeguard adults and children.
- All NHS funded services must co-operate with the police and local authorities to improve the wellbeing of children.
- There is a responsibility for safeguarding which is discharged through commissioning arrangements:
    - Safeguarding requirements must be explicit within all contracts and monitored and managed.
    - Monitoring of training compliance.
    - Monitoring of responses to safeguarding issues.
- NHS England has a responsibility to ensure all providers and commissioners of services are clear about statutory requirements.
- A robust Training Needs Assessment must be completed for all aspects of safeguarding (including Prevent).
- All staff training within providers and commissioners must be compliant with:
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff
- Compliance with training and effectiveness of training must be proactively monitored and managed within NHS commissioned services and within NHS England.
- There must be effective monitoring and implementation of lessons learnt and recommendations from local and national cases of incidents in safeguarding adults and children.

5 Patient experience

Patient experience is a vital component of driving quality in that it improves both provider and commissioner understanding of the needs of patients and service users. Effective patient experience should be embedded in leadership, culture and operational processes, working together with patients, families, carers, staff and communities to hear their stories and understand what is important to them and ensuring we understand the needs of the people we serve.

There is a recognised association (Coulter and Ellins, 2006) between the engagement of patients in their own health, care and treatment and outcomes in relation to:

- Patients' recall of information
- Knowledge and confidence to manage the conditions they live with
- The likelihood of patients reporting a chosen treatment path was appropriate for them
- Patient reports of their experiences and also of their satisfaction with the care they received
- The use of health care resources, where engaged patients are much more likely to adhere treatment courses and to take part in monitoring and prevention, attending screening for instance.

Providers are required to have policies and processes in place for proactive engagement with patients to gather useful intelligence from their experiences and to share this with

commissioners in a report made annually.

5.1 Improving patient experience

NHS Improvement identifies the following indicators to assist in improving patient experience:

- Leadership: Demonstrating the attributes of compassionate leadership in everything you do.
- Organisational culture: An open and transparent organisational culture will impact positively on both staff and patients. Where there is a culture of staff groups displaying pride in their work and in being part of an organisation, it leads to a real commitment to learn from mistakes.
- Feedback: Effective collection (capacity and capability).
- Analysis and triangulation: Using quality intelligence and systems across all areas to understand feedback and triangulate it with other quality measures.
- Reporting: Using feedback effectively by learning from it and using it to drive continuous quality improvement (feedback loop/triangulation).

Figure1: Quality Dimensions

5.2 The duty to involve the public

Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), NHS England has a duty to involve the public in commissioning, under section 13Q. The duty to involve the public is a statutory requirement and more information can be found at: Duty to Involve

5.3 Public involvement in commissioning

Public involvement in commissioning and enabling people to voice their views, needs and wishes and to contribute to plans, proposals and decisions about services, ensures NHS England discharges its statutory duty to involve the public under 13Q (see appendix 3).

The NHS Constitution also enshrines public ownership of the NHS as a fundamental value.

> *'The*
> *belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill, and when we cannot fully recover, to stay as well as we can to the end of our lives.'*

The NHS is accountable to the public, communities and patients it serves and therefore subject to public scrutiny. Building on the NHS Constitution, the Five Year Forward View (FYFV) sets out a vision for growing public involvement.
NHS England has published a set of documents to strengthen patient and public participation in the services it is responsible for.

There is a framework for patient and public participation for each area of NHS England direct commissioning: these frameworks, including the one specifically for patient and public participation in health and justice commissioning can be found on NHS England's website at NHS England Patient and Public Participation Policy.

5.4 Complaints

All healthcare provided to prisoners and those in the detained estate is considered NHS care, therefore complaints about these services must be managed in accordance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 Providers are required to have a complaints policy in place which reflects these regulations.

> *'A complaint or concern is an expression of dissatisfaction about an act, omission or decision of the provider, either verbal or written, and whether justified or not, which requires a response.'* (NHS England Complaints Policy, 2017)

A healthcare complaint is classed as any expression of dissatisfaction about any NHS commissioned service in the detained estate in England or about the attitude, behaviour or conduct of healthcare staff working in those establishments. The definition of 'healthcare' includes any aspect of treatment or care provided by an NHS commissioned service. This can include:

- Issues with GP or dental appointments such as delays, waiting times, length of appointment or cancellations
- Prescribing issues such as errors, delays, refusal to prescribe
- Delays in obtaining referrals for secondary care or other services
- Medication issues such as errors, changes or reviews
- Staff behaviour or attitude
- Communication.

Healthcare complaints do not include medical escorts whose services are not commissioned by NHS England, nor does it include complaints relating to healthcare facilities (e.g. insufficient space in a waiting room or lack of privacy); these should be directed to the organisation responsible for site management.

Serious allegations about a member of healthcare staff, such as allegations of sexual assault, sexual abuse or violence, must be dealt with in line with existing NHS and internal processes for handling this type of incident. The police should be involved as appropriate. This type of issue should not be managed as a complaint under the 2009 regulations.

Should a complaint investigation identify serious professional misconduct issues, these must also be managed in line with NHS processes and the responsible professional body notified; the General Medical Council (GMC) or Nursing and Midwifery Council (NMC) for example.

If safeguarding issues are identified as part of a complaint, they must be handled in line with existing processes. Once any immediate risk has been dealt with, or a historical risk has been shared with the appropriate organisation or body, the complaint should be taken forward as appropriate.

An NHS complaint can continue to be managed pending the outcome of any criminal or other investigations unless instruction not to proceed is received (from an organisational legal team, coroner etc).

A complaint involving an allegation of serious misconduct against a member of staff will be led by the organisation responsible for that element of the complaint. In some instances, there will need to be a co-ordinated approach (for example a complaint about use of force by staff or a contractor, at the same time as a complaint about the conduct of a member of healthcare staff during or after the incident).

6 Clinical effectiveness

Clinical effectiveness is defined by the Department of Health (1996) as '*the application of best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes for care patients. The process involves a* framework for *informing, changing and monitoring practice'.*

NHS funded and commissioned healthcare in secure and detained environments should be based on credible evidence to ensure positive outcomes are provided across all services. Achieving the best outcomes requires provision of care that is safe and effective whilst also offering the best patient experience. All healthcare provision within NHS funded health and justice services must be commissioned and provided using a principle of equivalence, with the aim of ensuring that people detained in secure environments are afforded the same provision of, or access to, appropriate services or treatment (based on assessed need and in line with current national or evidence based guidelines) and that this is considered to be at least consistent in range and quality (availability, accessibility and acceptability) with that available to the wider community on order to achieve equitable health outcomes (https://www.rcgp.org.uk/about-us/news/2018/july/prison-health-is-public-health.aspx)

6.1 Health and justice commissioning

NHS England health and justice commissioners will commission high quality care which is focussed on:

- Positive patient outcomes
- Evidence based practice
- Research based practice
- Experience and competency-based practice.

Healthcare services commissioned should be based on credible evidence and available to all those who could benefit. The health and justice national team has developed a core set of service specifications, using current evidence base, NICE guidelines, and research to support
their regional teams in commissioning high quality healthcare that is consistently provided by the right team, in the appropriate place at the right time.

Health and justice regional commissioners will collate information from the following sources to verify that they are commissioning clinically effective care:

- Health and justice pressure reports
- Service specification compliance
- Service specific performance indicators:
    - Prison - health and justice indicators of performance (HJIPs)
    - IRC indicators of performance (IRCIPs)
    - L&D indicators of performance (LDIPS)
    - Children and young people indicators of performance (CYPIPs)
    - Sexual assault referral centres indicators of performance (SARCIPS)
- Quality schedules reports, including:
    - Appraisals
    - Audits
    - Outcome measures
    - Pathway development
    - Research and development
    - Innovation and initiatives
    - Policy updates.

6.2 Health and justice pressures reporting

The health and justice pressures reporting is qualitative assessment NHS England regional commissioners make, against a number of indicators, which can affect the delivery of quality healthcare services in the establishment.

Where required, recovery plans are developed by the healthcare providers and monitored by commissioners and NHS England works closely at regional and national level with HMPPS to share intelligence and work with them for resolution to issues directly under their control.

Pressure reporting is currently in place for prisons and IRCs. Children and young people's services pressure reporting is to be developed during 2019/20. The current indications for reporting against are:

- Which establishments are currently on an enhanced surveillance regime within the region's Quality Surveillance Group (QSG) process?
- Which establishments are causing you concern regarding enablement?
- Which establishments are causing you concern regarding psychoactive substance use.
- Which establishments are a cause for concern regarding self-inflicted deaths?
- Which establishments are not compliant with guidance on the levels of immunisation against communicable diseases, or are a cause for concern regarding outbreak controls?
- Which establishments are you concerned about, regarding the quality or availability of mental health and / or substance misuse services?

- What assistance (if any) do you require from the central team or national management to resolve any of these issues?

The health and justice pressures report provides assurance to national directors and national and regional direct commissioning governance structures, by gathering intelligence on a limited range of indicators which will enable NHS England to:

- Gain assurance where operational pressures on prison health care services are considered to be within normal tolerance and are capable of delivering safe, high quality healthcare through normal management
- By exception, identify where operational pressures are adversely affecting or have the potential to adversely affect the delivery of safe, high quality patient care
- Where pressures occur which breach normal tolerances, intervene to resolve problems and ensure healthcare delivery returns to normal.

6.3 Medicines optimisation and pharmacy services

Pharmacy services and medicines optimisation service are underpinned by the four principles of medicines optimisation and the five domains within the Royal Pharmaceutical Society's (RPS) Professional Standards for Optimising Medicines for people in Secure Environments (RPS Professional Standards). These standards apply to all residential secure environments for adults and children and young people. For the latter, this is also shown in the Healthcare Standards for children and young people in secure settings (refreshed 2018)

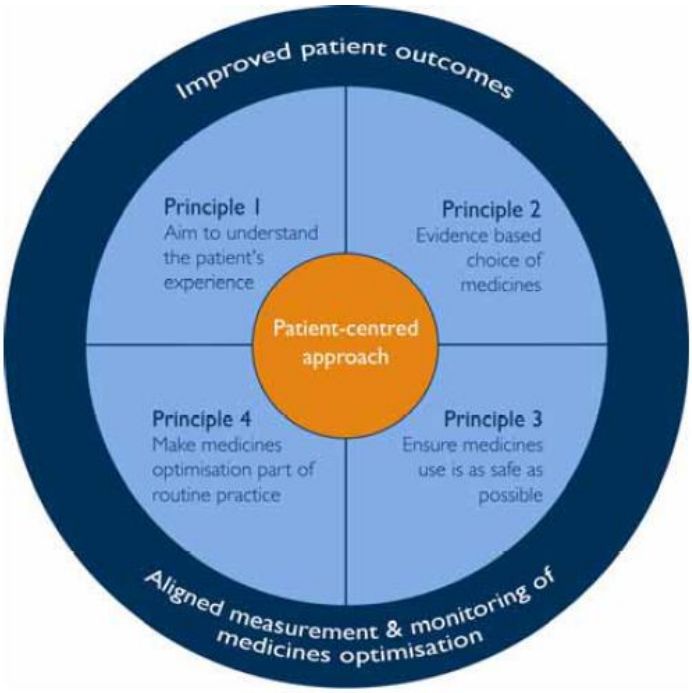


Figure 2: Principles of Medicines Optimisation

The domains in the RPS standards describe the standards needed within the detained person's time in custody, from admission to release or transfer:

- Domain 1: Arriving and meeting people's initial medicines needs
- Domain 2: Meeting people's medicine needs during their stay
- Domain 3: Continuing people's medicines on release and transfer
- Domain 4: Employing and training a competent workforce to underpin optimising people's medicines
- Domain 5: Maintaining a framework of safety and governance.

The national NHS England primary care service specification for health and justice forms the basis for the expectations about the delivery of medicines optimisation and pharmacy services. The service outcomes should be in line with the RPS's Professional Standards for Optimising Medicines for people in Secure Environments, The RPS Safe and Secure Handling of Medicines 2018, NICE guidance, The Royal College of General Practitioners (RCGP) Safer Prescribing in Prisons 2019 and other national clinical guidelines and General Pharmaceutical Council GPhC and NHS England standards for the provision of pharmacy services from a registered pharmacy.

In addition, there are specific medicines and pharmacy elements within the NHS England mental health and substance misuse national service specifications. These elements along with any guidance referenced in them require delivery by the provider.

Pharmacy services and medicines optimisation can be organised into three distinct areas of provision:

1. Medicines governance.
2. Essential and advanced services, including clinical pharmacy services.
3. Locally integrating medicines into care pathways and services.

In reception prisons, where people are admitted to the prison from the courts or the community, the provider must provide a dispensing pharmacy service within the prison. This provides access to medicines promptly and minimises wastage in reception prisons where turnover of prisoners is high. For other health and justice settings, the dispensing pharmacy service can be located outside the site, in the community via an external pharmacy service provider.

Providing healthcare in a custodial setting where the highest priorities are maintaining order, control and discipline has challenges with respect to supply, storage, administration and transfer of medicines. The CQC and related controls, assurance and risk management standards, which apply to NHS England will also apply to healthcare in secure settings. These and the RPS professional standards and medicines elements in all care pathways must be taken forward through the Prison's Management Committees. The Medicines Management Committees membership must include a chief pharmacist for the provider, healthcare managers, substance misuse representatives, mental health providers, prison GPs, pharmacist from the pharmacy service provider where this is different to the provider chief pharmacist and a prison staff lead.

The key elements within an effective pharmacy service that provides the following:

1. A dispensing pharmacy service that provides essential services as detailed under the National Pharmacy Contract, consistent to those available to patients in the community, whilst operating within the constraints of a custodial setting.

2. Sourcing of medicines including sourcing medicines stock on the proviso that the Medicines and Healthcare products Regulatory Agency (MHRA) and Home Office licences are in place.
3. Medicine optimisation services including as a minimum medicines reconciliation; medicines use reviews; providing the pharmacist input for the development of Patient Group Directions; delivering clinical pharmacist support that is equivalent to pharmacist roles being delivered in community GP practices.
4. Monitoring stock control directly within each prison or indirectly.
5. Monitoring controlled drug ordering, supply, transporting, prescribing and administration systems against regulatory and good practice expectations.
6. Engaging with the NHS England Accountable Officer and their local intelligence networks.
7. Analysing and reviewing prescribing against national prescribing indicators for cost and clinical effectiveness.
8. Delivering training on the use of medicines and clinical effectiveness to those health professionals handling or administering medicines.
9. Actioning and implementing drug and patient safety alerts.
10. Medicines governance: Including development of a medicines governance framework underpinned by a medicines policy and procedures in line with RPS guidance and legislation.
11. Nominating a Medication Safety Officer (as described in national patient safety guidance) who provides a proactive role in managing medication safety.
12. Routinely reporting medication safety incidents via the provider's organisational process and share these incidents with:

    - The healthcare teams
    - Commissioners as part of contract monitoring
    - Medicines Management Committee
    - Nationally by reporting them onto the National Reporting and Learning System (NRLS) or its replacement
    - The controlled drug Accountable Officers via occurrence reporting for controlled drug incidents.

In 2019, NHS England completed a national audit against the RPS standards (*report to be published in April 2019).* Each provider and health and justice site will have an action plan resulting from the audit which commissioners and quality leads can use to monitor service improvements that result in all the standards being met. In the event that the provider or commissioner wishes to re-audit against the standards, the audit tool is available here

Since 2018 there have been medicines management HJIPs which can be used to monitor the performance against key parts of the medicines pathway in health and justice. These are indicators for:

- In-possession medication assessment
- Medicines reconciliation
- Omitted and delayed doses
- Supply of medicines or FP10 prescriptions on release and transfer.

The tools above will assist NHS England commissioners and quality leads in assuring the commissioned services are delivering the safe and effective use of medicines in all health and justice settings.

6.4 Sexual assault services and medicines optimisation

In 2018, NHS England and the Faculty of Forensic and Legal Medicine collaborated with the clinical network and stakeholders for sexual assault referral centres to publish specific standards for medicines optimisation in sexual assault services.

6.5 Controlled drugs

Providers must have robust arrangements for the safe and secure use and handling of controlled drugs in line with national regulations and guidance, in particular the Safe Management and Use of Controlled Drugs in Prison Health in England

6.6 Standard operating procedures (SOPs)

Providers are expected to have SOPs in place to describe the processes of handling and managing medicines. These SOPs will be formally approved by the provider and reviewed at least every two years. SOPs will detail who is authorised to carry out each activity, be signed by staff using it, will indicate what training is necessary and what records will be kept.

7 NHS standard contract

7.1 Quality schedules

Quality schedules form part of the formal contracting process (a contract management tool) and act to focus providers and commissioners on the achievement of quality improvement and avoiding harm.

The quality schedules act as a trigger for quality improvement where there might be emerging concerns, directly related to national and local quality indicators (e.g. LDIPS, SARCIPS, HJIPS, QOF - *please note this is not an exhaustive list).* They ensure providers are learning from national reports, audits, complaints and incident investigations and that action is being taken on feedback to keep patients safe.

Providers are required to report against indicators on a period basis on aspects of the quality schedules and they form part of the routine quality and finance meetings held with providers.

For 2019/20 health and justice nursing and quality leads have developed a minimum reporting requirement for all health and justice service providers.

8 Workforce

8.1 Whistleblowing – Freedom to speak up (FTSU)

Whistleblowing is the term used when an employee shares information concerning wrongdoing. This is called ‘making a disclosure’ or ‘blowing the whistle’. The wrongdoing will typically (although not necessarily) be something they have witnessed at work.

In 2015, Sir Robert Francis published his report Freedom to Speak Up which was a review of whistleblowing within the NHS. In this report, Francis recommended that whistleblowing in primary care in particular be reviewed separately.

Primary care organisations and healthcare in health and justice settings are much smaller than hospital trusts and staff may feel unable or find it hard to raise concerns without being identified. The guidance issued following the review, guidance for primary care is intended to be used by primary care providers to review their policies and procedures for staff raising concerns about safety. The guidance sets out:

- Who can raise a concern
- The process for raising a concern
- How the concern will be investigated
- What will be done with the findings of the investigation.

Providers should ensure they have established whistleblowing policies and procedures in place and there are opportunities for staff to raise any concern they may have easily and early.

Managing concerns early reduces the risk of them escalating to bigger problems which risk impacting patients directly. Problems raised can include:

- poor clinical practice or other malpractice which may harm patients
- failure to safeguard patients
- maladministration of medications
- untrained or poorly trained staff
- lack of policies creating a risk of harm.

Key points:

- Providers should encourage NHS staff to raise any concern at the earliest opportunity.
- Providers should be proactive in preventing inappropriate behaviour such as bullying or harassment towards staff who raise a concern.
- Providers should review and update their local policies and procedures to ensure compliance with the FTSU guidance.
- Providers should name an individual, independent of the line management chain as a FTSU Guardian who can ensure policies are in place and that staff know who to contact if they have a concern.
- Providers should build on the work of being Open by adopting good practice published in FTSU.

8.1.1 Public Interest Disclosure Act (PIDA) 1988

The Public Interest Disclosure Act 1998 (PIDA) is the whistleblowing law that protects employees as it states employers should not victimise any employee who raises a concern internally or to a prescribed regulator.

The Act covers all workers including temporary agency staff, individuals on training courses and self-employed staff who are working for or supervised by the NHS.

The Act does not cover volunteers, although it is recommended as good practice that employers make volunteers aware of their local policy and procedures for raising concerns.

8.2 Workforce safeguards

NHS England recognises the continuing challenges in the supply and retention of workforce whilst continuing to provide safe and effective healthcare to patients and service users. Providers must use and build on good practice in effective staff deployment and workforce planning in order to meet these challenges.

8.2.1 Recruitment / staffing levels (Safer Staffing)

Safe staffing means having enough nursing staff with the right skills and knowledge, in the right place, at the right time to ensure patients' needs are met.

Providers have a duty to ensure staffing levels are adequate. Patients have a right to be cared for by appropriately qualified and experienced staff in safe environments. This right is enshrined within the NHS Constitution.

In England, demonstrating sufficient staffing is one of the six essential standards that CQC regulate

Short staffing compromises care both directly and indirectly. Recurrent short staffing results in increased staff stress and reduced staff wellbeing, leading to higher sickness absence (needing more agency/bank cover) and more staff leaving.
Regular reliance on non-substantive staff can impact on the quality and safety of services. Providers must recognise when they have high vacancy rates and potential shortfalls in staffing and ensure there is appropriate workforce planning and mechanisms in place to resolve this by way of recruitment.

9 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 healthcare providers.
The Duty of Candour helps achieve a transparent culture in healthcare provision; being open when errors are made and harm caused. If a reportable 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
- record what has happened and what action has been taken in writing for audit purposes in accordance with relevant guidance
- as soon as is practicable, but within 10 operational days, instigate and conduct a full investigation into the incident in accordance with relevant guidance
- as soon as is practicable, provide a step-by-step explanation of the events and circumstances which resulted in the incident to the relevant person
- complete the investigation within the relevant timescales identified for serious incidents.
-

10 Regulatory

The CQC is the independent regulator of health and adult social care in England. It is responsible for ensuring providers, covered by their regulation, meet the fundamental standards for quality and safety (CQC, 2015) and includes all NHS funded healthcare delivered within the secure and detained setting. It monitors, inspects and regulates services to make sure they meet the fundamental standards of quality and safety and publish what they find.

Healthcare services in secure and detained settings must register with the CQC in the same way as any other care service. There are some exemptions for services that are provided under arrangements with government departments.

The services CQC regulates and inspects range from health services that form part of the youth offending teams to prison healthcare. In delivering this duty, the CQC works in partnership with other inspectorates and uses different frameworks to inspect different types of services.

The CQC works with HMIP with a shared aim to protect and promote. HMIP's role is to ensure independent inspection of places of detention, report on conditions and treatment and promote positive outcomes for those detained and the public. Working jointly, they share a responsibility to ensure detainees are safeguarded against ill treatment and receive the same quality of care as the rest of the population.
The CQC and HMIP's joint regulation and inspection of health and social care cover the following:

- Prisons
- YOIs (prisons for young people aged 15 – 21 years)
- IRCs (holding centres for detainees awaiting decisions on their residency status or deportation following unsuccessful application).

More detail on how the CQC and HMIP deliver their joint inspection and regulatory role can be found in the How CQC regulates: Health and social care in prisons and young offender institutions and healthcare in immigration removal centres (provider handbook).
STCs are inspected once a year. This inspection is led by Ofsted and includes representatives of the CQC and HMIP Inspections of secure training centres provides full information on roles, inspection criteria and reporting information.

11 Governance

Governance will align with local arrangements, as defined by national quality oversight and governance documents and guidance. Currently for NHS England, this is the National Quality Board suite of documents, however, these may be superseded, replaced or updated within the next 12 months in line with emerging national governance processes.

Routine quality monitoring comprises:

- Quality assurance of clinical reviews
- Delivery against contract specification and quality schedule
- Partnership Board meeting reporting
- Pressures reporting
- Serious incidents
- Never events
- Leadership/workforce numbers

- Governance arrangements
- Local commissioner prison reports
- Safeguarding (including prevent).

Where quality concerns are identified, an enhanced quality assurance process, in line with national governance processes, is followed. This process may involve some or all of the following (this list is not exhaustive):

- Commencement of enhanced surveillance (ratified at QSG)
- Formal written communication to the provider
- Contract performance notices
- Deep dives
- Targeted and unannounced quality visits
- Agreement and monitoring of improvement plans and timelines
- Delegate a single point of contact from each organisation and align accountability
- Monitoring improvement and provision of update reports into QSG meetings
- Identify and implement additional support for provider if required.

Evidence should be obtained and assurance gained that concerns are resolved within the agreed timeframe. Where this is satisfied, the enhanced quality assurance process will be maintained until evidence of sustainability of improvements is delivered. Change of status back to routine surveillance will be ratified by QSG. Where it is not possible to obtain evidence and assurance of concerns being satisfactorily resolved, the following may be considered:

- Single item QSG or
- Risk summit.

If there are any safety concerns identified for a service user or risks that require urgent attention, a risk summit can be instigated immediately and at any point in the quality assurance process. An escalation flow chart is attached at. appendix 4.

Going forward, governance processes will be regularly reviewed in line with any organisational and quality system redesign.

12 Supporting documents and guidance

CQC Fundamental Standards
(https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers)

Defining and measuring the quality of general practice, Kings Fund, 2011
(https://www.kingsfund.org.uk/sites/default/files/Independent-inquiry-GP-3-defining-and-measuring-quality-general-practice-March-2011.pdf)

Duty of Candour 2016
(https://www.cqc.org.uk/sites/default/files/Duty-of-Candour-2016-CQC-joint-branded.pdf)

Equality Act, 2010
(https://www.legislation.gov.uk/ukpga/2010/15/contents)

Equality and Human Rights Commission: Article 2 (the right to life), 2018
(https://www.equalityhumanrights.com/en/human-rights-act/article-2-right-liife)

Freedom to Speak up, Francis, 2015
(https://www.england.nhs.uk/wp-content/uploads/2016/11/whistleblowing-guidance.pdf)

Guidelines for clinical reviewers, 2018
(https://www.england.nhs.uk/publication/guidelines-for-the-provision-of-clinical-reviewers-to-support-health-and-justice-deaths-in-custody-investigations/)

Health and Social Care Act, 2012
(http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted)

High Quality Care For All, Darzi, 2008
(https://webarchive.nationalarchives.gov.uk/20130105061315/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf)

Improving quality of care in general practice, The Kings Fund, 2011
(https://www.kingsfund.org.uk/sites/default/files/improving-quality-of-care-general-practice-independent-inquiry-report-kings-fund-march-2011_0.pdf)

Inspections of secure training centres, 2015
(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/698213/Inspections_secure_training_centres_framework_and_evaluation_schedule_from_1_September_2015.pdf)

Mental Capacity Act, 2005
(https://www.legislation.gov.uk/ukpga/2005/9/contents)

Mid Staffordshire Public Inquiry, Francis, 2013
(https://webarchive.nationalarchives.gov.uk/20150407084231/http://www.midstaffspublicinquiry.com/report)

National Health Service Act, 2006
(https://www.legislation.gov.uk/ukpga/2006/41/contents)

NHS Constitution, updated 2015
(https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england)
NHS England Accountability and Assurance Framework, Safeguarding, 2015
(https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-accountability-assurance-framework.pdf)

NHS England Area Team HM Prisons Medicines Standards, V2, 2014
(http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/07/NHS-England-Area-Team-2014-version-2-HM-Prisons-Medicines-Standards-Health-and-Justice-Commissioning.pdf)

NHS England - Board paper: responsibilities for quality, 2018
(https://www.england.nhs.uk/wp-content/uploads/2018/03/10-pb-28-03-2018-system-quality-v2.pdf)

NHS England - Documents to support participation
(https://www.england.nhs.uk/participation/resources/docs/)

NHS Executive. *Promoting clinical effectiveness: a framework for action in and through the NHS.* Leeds: Department of Health (DH), 1996.

NHS Standard Contract 2019/20
(https://www.england.nhs.uk/nhs-standard-contract/19-20/)

NICE Guidelines - Health and Justice
(https://www.nice.org.uk/search?q=health+and+justice+)

Patient-focused Interventions: A review of the Evidence, Coulter and Ellins, 2006
(https://www.health.org.uk/sites/default/files/PatientFocusedInterventions_ReviewOfTheEvidence.pdf)

Prevent Statutory Duty, 2015
(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance__England_Wales_V2-Interactive.pdf)

Prison Service Instruction 15/2014 - Serious self-harm/assaults
(https://www.justice.gov.uk/downloads/offenders/psipso/psi-2014/PSI-15-2014-Investigation-and-Learning-following-Incidents-of-Serious-Self-harm-and-Serious-Assaults-Revision-July2016.pdf)

Public Health Functions Agreement: Section 7a
(https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/09/public-hlth-comms-intent-2017-18.pdf)

Public Interest Disclosure Act 1998
(http://www.legislation.gov.uk/ukpga/1998/23/contents)

Quality in the new health system, National Quality Board, 2013
(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213304/Final-NQB-report-v4-160113.pdf)
CQC Provider Handbook - Health and social care in prisons and young offender institutions and health care in immigration removal centres
(https://www.cqc.org.uk/sites/default/files/20150729_provider_handbook_secure_settings_0.pdf)

Regulation 28 Coroners reports guidance
(https://nhsengland.sharepoint.com/TeamCentre/Medical/CP%26O/QSU/qualitypolicy/coroners)

Royal College of General Practitioners - Safer prescribing in prisons
(https://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/prison-health.aspx)

Royal Pharmaceutical Society - Professional standard for optimising medicines for people in secure settings
(https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/Optimising%20medicines%20in%20secure%20environments/Professional%20Standards%20Secure%20Environments-edition-2.pdf?ver=2017-05-18-112406-223)

Royal Pharmaceutical Society - Standards Audit Tool
(https://www.sps.nhs.uk/)

Securing Excellence in Commissioning for Offender Health, 2013
(https://www.england.nhs.uk/wp-content/uploads/2013/03/offender-commissioning.pdf)

Serious Incident Framework

(https://improvement.nhs.uk/resources/serious-incident-framework/)

Terms of reference - Prison and Probations Ombudsman, 2017
(https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2017/04/PPO-Terms-of-reference-2017.pdf)

The Berwick Report, 2013
(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf)

The Care Act, 2014
(http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted)

The Children Act, 1989
(https://www.legislation.gov.uk/ukpga/1989/41/section/25)

The coroner and justice act, 2009
(https://www.legislation.gov.uk/ukpga/2009/25/contents)

The Lampard Review, 2015
(https://www.gov.uk/government/publications/jimmy-savile-nhs-investigations-lessons-learned)

The Local Authority Social Services and National Health Service Complaints (England) Regulations, 2009
(http://www.legislation.gov.uk/uksi/2009/309/contents/made)

Winterbourne View: A time for change, 2014
(https://www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf)

Working together to safeguard children, 2018
(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722307/Working_Together_to_Safeguard_Children_Statutory_framework.pdf)

13 Appendices

13.1 Appendix 1 – Private (contracted) prisons

Contracted/Private Prison	Area
HMP Thameside	London
HMP Altcourse	North West
HMP Forest Bank	North West
HMP & YOI Doncaster	Yorkshire & The Humber
HMP Northumberland	Cumbria & North East
HMP Rye Hill	East Midlands
STC Oakhill	East Midlands
HMP Lowdham Grange	East Midlands
HMP Birmingham	West Midlands
HMP Oakwood	West Midlands
HMP Dovegate	West Midlands
HMP Bronzefield	South East
HMP Ashfield	South West
HMP Peterborough (Male)	East
HMP Peterborough (Female)	East

13.2 Appendix 2 – Health and justice and SARCs regional portfolios

North East and Yorkshire

Prisons	Immigration Removal Centres	Liaison & Diversion	Sexual Assault Referral Centres	Children & Young People
HMP & YOI Durham		Northumbria	SARC Teeside, Helen Britton House, Cleveland	Aycliffe SCH
HMP & YOI Deerbolt		Cleveland	The Royal Victoria Infirmary (Paediatric)	Kyloe House SCH
HMP Frankland		Durham	Reach Rhona Cross Suite & Ellis Fraser Centre	Wetherby YOI
HMP & YOI Low Newton		Humberside	The Meadows, Durham	Aldine SCH
HMP & YOI Holme House		West Yorkshire	The Bridgeway, Cumbria	
HMP & YOI Kirklevington Grange		South Yorkshire	Casa Suite, Humberside SARC (inc Paediatric)	
HMP Northumberland			The Hazlehurst Centre, Leeds	
HMP Wakefield			The Anlaby Suite, Hull Royal Infirmary	
HMP Leeds			The Acorn Unit, York Teaching Hospital	
HMP & YOI New Hall			Sheffield Children's Hospital	
HMP Wealstun			Hackenthorpe Lodge, Sheffield	
HMP Humber			North Yorkshire Paediatric SARC	
HMP Full Sutton			South Yorkshire Paediatric SARC	
HMP & YOI Hull			Bridge House, York	
HMP & YOI Askham Grange				
HMP & YOI Doncaster				
HMP Lindholme				
HMP & YOI Moorland				
HMP & YOI Hatfield				

North West

Prisons	Immigration Removal Centres	Liaison & Diversion	Sexual Assault Referral Centres	Children & Young People
HMP Haverigg	Pennine House Short Term Holding Facility	Cheshire	The Safe Centre Preston Hospital	Barton Moss SCH
HMP Lancaster Farm		Greater Manchester	St Mary's, Manchester	St Catherine's SCH
HMP Kirkham		Cumbria & Lancashire	Safe Place, Liverpool	
HMP & YOI Preston		Merseyside	Alder Hey SARC	
HMP Buckley Hall				
HMP Garth				
HMP & YOI Wymott				
HMP Liverpool				
HMP & YOI Hindley				
HMP Risley				
HMP & YOI Altcourse				
HMP & YOI Thorn Cross				
HMP & YOI Manchester				
HMP & YOI Styal				
HMP Forest Bank				

East of England

Prisons	Immigration Removal Centres	Liaison & Diversion	Sexual Assault Referral Centres	Children & Young People
HMP & YOI Peterborough	Yarlswood IRC	Cambridgeshire	The Emerald Centre, Bedfordshire	Oakhill Secure Training Centre
HMP Littlehey		Essex	The Ferns, Suffolk	Rainsbrook Secure Training Centre
HMP Whitemoor		Norfolk	The Elms, Huntingdon	Clare Lodge SCH
HMP Highpoint		Suffolk	Harbour Centre, Norwich	
HMP & YOI Hollesley Bay		Bedfordshire	Heart SARC, Hertfordshire	
HMP & YOI Warren Hill		Hertfordshire	Oakwood Place, Essex	
HMP Wayland				
HMP & YOI Norwich				
HMP Bure				

HMP Chelmsford				
HMP & YOI Woodhill				
HMP & YOI Bedford				
HMP The Mount				

Midlands

Prisons	Immigration Removal Centres	Liaison & Diversion	Sexual Assault Referral Centres	Children & Young People
HMP Hewell	Morton Hall IRC	Black Country	EMCYPAS	Werrington YOI
HMP Long Lartin		Warwickshire	Topaz Centre	Lincolnshire SCH
HMP Birmingham		Shropshire	Spring Lodge	Clayfields SCH
HMP & YOI Drake Hall		Worcestershire	Serenity	
HMP & YOI Swinfen Hall		Coventry	Millfield House	
HMP & YOI Brinsford		Herefordshire	Juniper Lodge	
HMP Dovegate		Staffordshire	The Glade	
HMP Featherstone		Birmingham & Solihull	The Blue-Sky Centre	
HMP Stafford		Northampton	Staffordshire & Stoke SARC	
HMP & YOI Stoke Heath		Leicestershire	Horizon	
HMP Oakwood		Lincolnshire	Birmingham Community Healthcare Trust	
HMP & YOI Foston Hall		Derbyshire		
HMP & YOI Sudbury		Nottinghamshire		
HMP & YOI Nottingham				
HMP Lowdham Grange				
HMP Whatton				
HMP Ranby				
HMP Leicester				
HMP Stocken				
HMP Gartree				
HMP Lincoln				
HMP North Sea Camp				
HMP Rye Hill				
HMP Onley				

London

Prisons	Immigration Removal Centres	Liaison & Diversion	Sexual Assault Referral Centres	Children & Young People
HMP YOI Belmarsh	Colnbrook IRC	One service delivered through a number of service providers:	Lighthouse (Child House)	Feltham YOI
HMP Brixton	Harmondsworth IRC	Barnet, Enfield & Haringey MH NHS Trust	The Haven, Whitechapel	
HMP YOI Isis		Together for Mental Health	The Haven, Paddington	
HMP YOI Pentonville		West London NHS Trust	The Haven, Camberwell	
HMP & YOI Thameside		SW London & St Georges MH Trust		
HMP & YOI Wormwood Scrubs		Oxleas NHS Foundation Trust		
		S London & Maudsley NHS Foundation Trust		
		Central & NW London NHS Foundation Trust		
		E London NHS Foundation Trust		
		NE London NHS Foundation Trust		

South West

Prisons	Immigration Removal Centres	Liaison & Diversion	Sexual Assault Referral Centres	Children & Young People
HMP Ashfield		Avon & Somerset	The Willow Centre, Devon & Cornwall	Vinney Green SCH
HMP & YOI Bristol		Gloucester	The Sanctuary, Swindon	Atkinson Unit SCH
HMP Erlestoke		Wiltshire	The Oak Centre, Exeter & Torbay	
HMP & YOI Eastwood Park		Devon & Cornwall	The Cove, Plymouth	
HMP Leyhill			The Bridge, Avon & Somerset	
HMP Channings Wood			Hope House, Gloucester	

HMP Dartmoor			The Shores, Dorset	
HMP & YOI Exeter				
HMP Guys Marsh				
HMP & YOI Portland				
HMP The Verne				

South East

Prisons	Immigration Removal Centres	Liaison & Diversion	Sexual Assault Referral Centres	Children & Young People
HMP & YOI Bullingdon	Gatwick:	Kent & Medway	The Solace, Slough	Cookham Wood YOI
HMP & YOI Bronzefield	Tinsley House IRC	Hampshire	The Solace, Bicester	Lansdowne SCH
HMP Coldingley	Brook House IRC	Thames Valley & Milton Keynes	The Treetops, Portsmouth	Beechfield SCH
HMP & YOI Downview		Sussex	The Solace Centre, Cobham	Swanwick Lodge SCH
HMP & YOI East Sutton Park		Surrey	The Saturn Centre, Sussex	Medway Secure Training Centre
HMP & YOI Elmley		Dorset	Pebble House, Brighton & Hove	
HMP Ford		Kent & Medway	Beech House, Maidstone	
HMP Huntercombe				
HMP Grendon/Springhill				
HMP & YOI Isle of White				
HMP & YOI High Down				
HMP & YOI Lewes				
HMP Maidstone				
HMP & YOI Rochester				
HMP & YOI Send				
HMP & YOI Stanford Hill				
HMP & YOI Winchester				
HMP Swaleside				
Aylesbury YOI				
HMP Blantyre House*				

*Temporarily closed

Our regional footprints

North East and Yorkshire
1. Cumbria and the North East
2. West Yorkshire and Harrogate
3. Humber, Coast and Vale
4. South Yorkshire and Bassetlaw

North West
5. Lancashire and South Cumbria
6. Greater Manchester
7. Cheshire and Merseyside

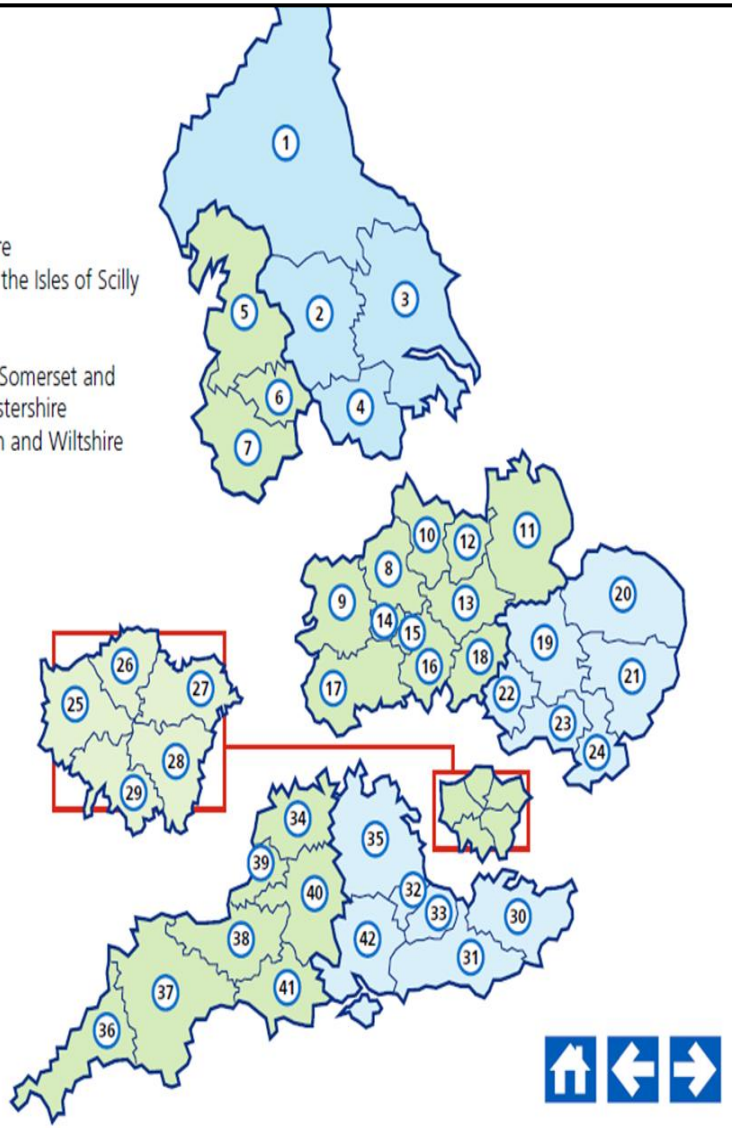
East of England
19. Cambridgeshire and Peterborough
20. Norfolk and Waveney
21. Suffolk and North East Essex
22. Bedfordshire, Luton and Milton Keynes
23. Hertfordshire and West Essex
24. Mid and South Essex

London
25. North West London
26. Central London
27. East London
28. South East London
29. South West London

Midlands
8. Staffordshire and Stoke on Trent
9. Shropshire and Telford and Wrekin
10. Derbyshire
11. Lincolnshire
12. Nottinghamshire
13. Leicester, Leicestershire and Rutland
14. The Black Country
15. Birmingham and Solihull
16. Coventry and Warwickshire
17. Herefordshire and Worcestershire
18. Northamptonshire

South East
30. Kent and Medway
31. Sussex and East Surrey
32. Frimley Health and Care
33. Surrey Heartlands
35. Buckinghamshire, Oxfordshire and Berkshire West
42. Hampshire and Isle of Wight

South West
34. Gloucestershire
36. Cornwall and the Isles of Scilly
37. Devon
38. Somerset
39. Bristol, North Somerset and South Gloucestershire
40. Bath, Swindon and Wiltshire
41. Dorset



13.3 Appendix 3 – 13Q duty to involve

Legal duties Section 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012

Section 13Q of the Act – Public involvement and consultation by NHS England

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by the Board [NHS England] in the exercise of its functions ('commissioning arrangements').

(2) The Board [NHS England] must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)

(a) in the planning of the commissioning arrangements by the Board [NHS England]

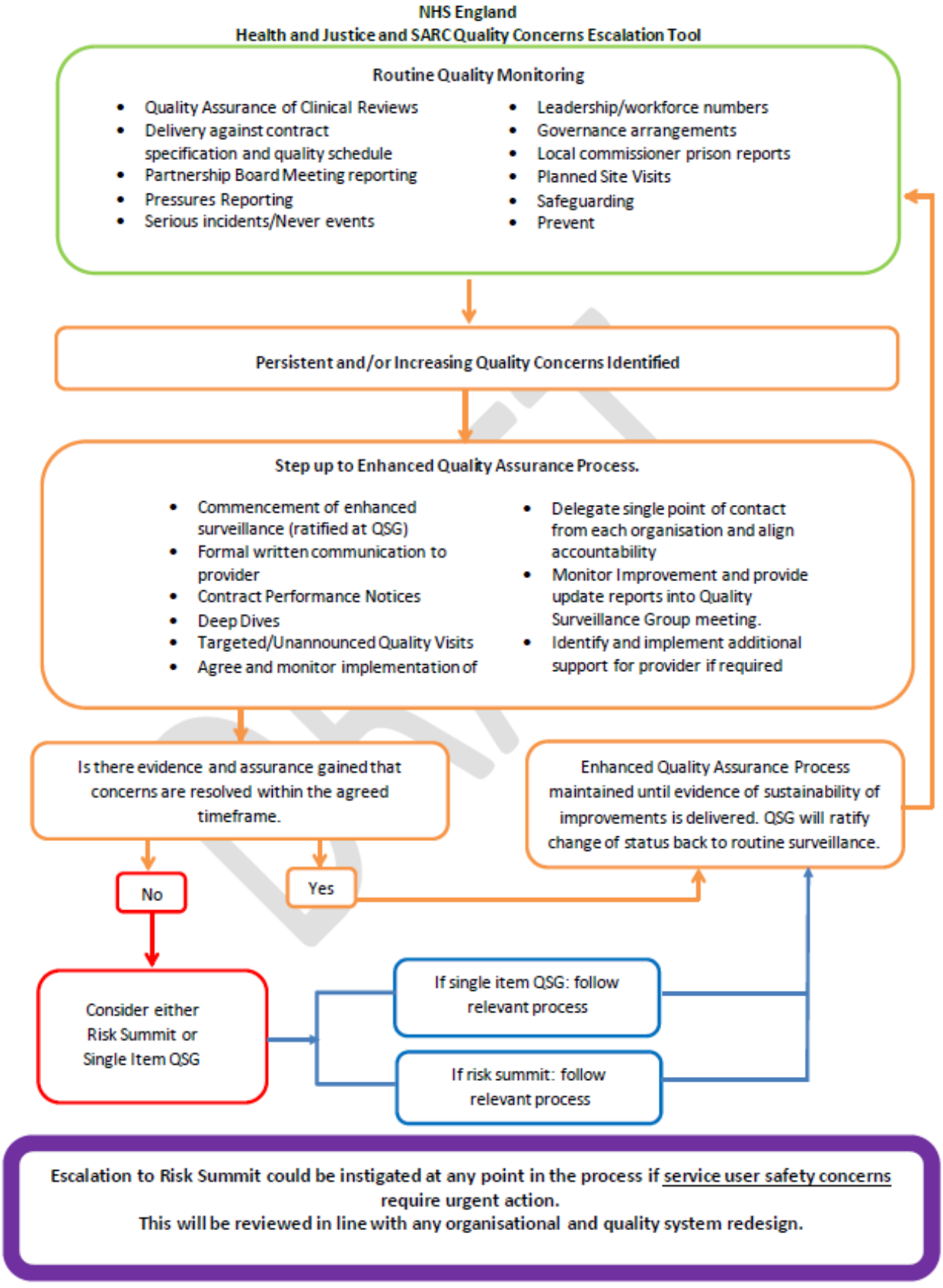
(b) in the development and consideration of proposals by the Board [NHS England] for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them; and

(c) in decisions of the Board [NHS England] affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

(3) The reference in subsection (2)(b) to the delivery of services is a reference to their delivery at the point when they are received by users.

(4) This section does not require the Board [NHS England] to make arrangements in relation to matters to which a trust special administrator's report or draft report under section 65F or 65I relates before the Secretary of State is satisfied as mentioned in section 65KB(1) or 65KD(1) or makes a decision under section 65KD(9) (as the case may be).

13.4 Appendix 4 – Quality escalation flow



14 Contributors

This document has been produced with input, advice and review from the following teams and individuals, with thanks.

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