



# Service specification

Primary care service – medical and nursing for  
prisons in England

2020



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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

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:

- exactly what should be provided, in what context
- how to go about providing it and
- how much of it to provide.

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

- areas of focus that – nationally – providers are expected to prioritise
- the outcomes that are expected from any provider, and examples of how evidence of their ability to deliver those outcomes may be demonstrated
- the freedom for regional commissioners to tailor the specification to their needs and the needs of any specific prison population.

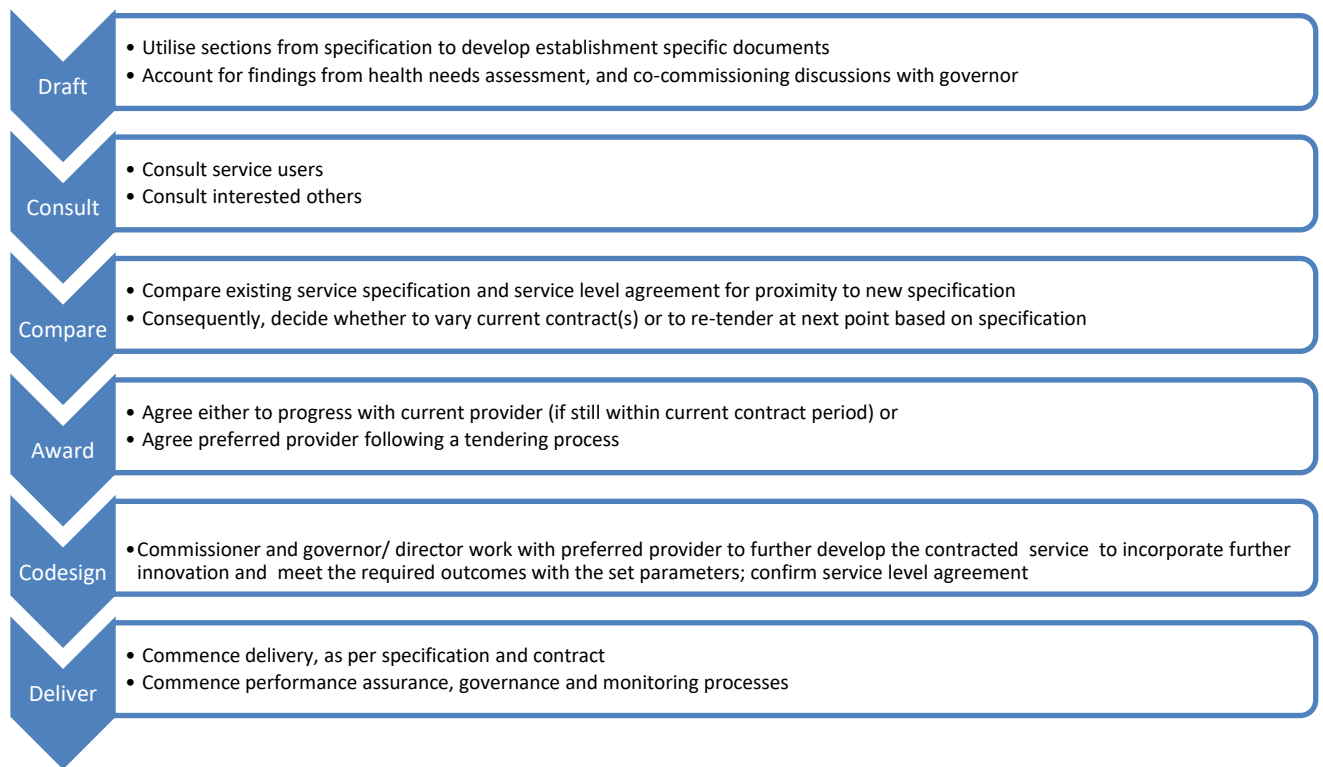
Where the following box is used, commissioners should insert local establishment/contract specific information or follow the instructions noted and delete the 'Note to local commissioners'.

## Note to local commissioners

Insert local additions required to suit the individual establishment.

- 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:

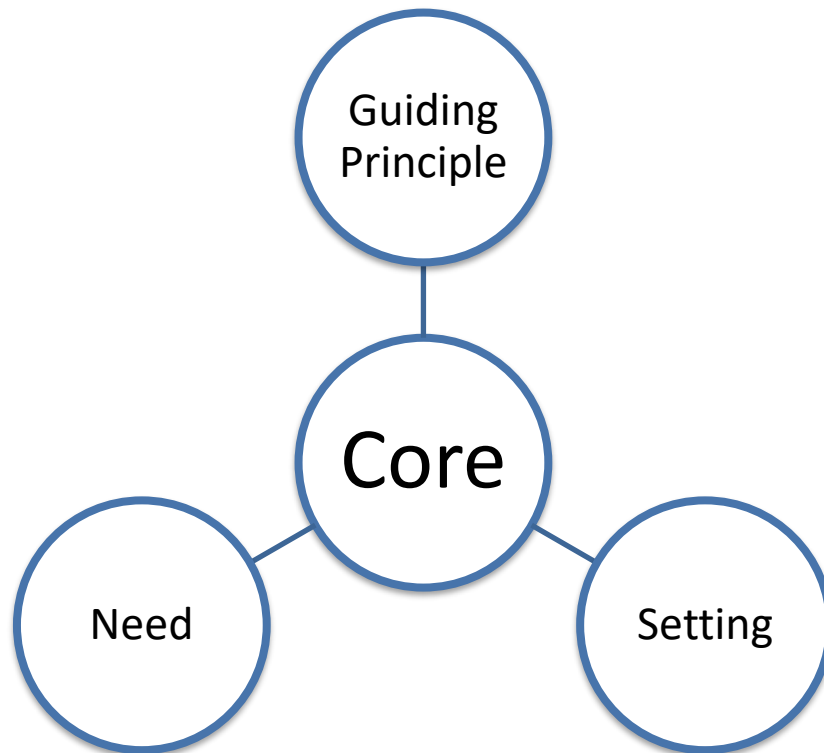


The specification also has an annex which is relevant to all health and justice specifications and is not service-specific. This annex forms part of the overall specification and ensures that providers within an establishment, and nationally, are working to the same standards.

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 primary care service specification is structured to enable the flexible use of the following concepts presented through four main considerations:



### National specification

- 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.
- An overarching **guiding principle**, that defines the basis upon which activities in the specification are delivered (i.e. safe, 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

- 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).

- 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 needs of the population*, as evidenced through needs assessment.

The updated specification and its implementation from 2019/20 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 primary care 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.

## **Primary care networks (PCNs)**

PCNs were introduced into local commissioning arrangements as part of the NHS Long Term Plan, published in January 2019. They are designed to enable GP practices to join networks with the net result of establishing fully integrated community-based healthcare delivery. They have a dedicated funding stream to support the employment of clinical pharmacists and social prescribing link workers (in the first instance) and in relation to these specifications offer a considered approach to anticipatory care and the potential to support personalised budgets for some of the patient co-hort. Elements of the PCN local to a prison establishment offers regional commissioners and providers of the services described within these

specification mechanisms to support the broader patient management innovations and continuity of care pre and post release that benefit improved patient outcomes.

### **3 Introduction**

The 2012 Health and Social Care Act mandates NHS England and NHS Improvement (NHSE/I) to commission health services across prisons and other places of prescribed detention. As such, this specification describes the required degree of primary care services that need to be delivered in these environments, ensuring that the principle of 'equivalence' is adhered to, enabling patients' access to physical and mental health care as required in line with services offered in the community, working towards agreed health outcomes and being supported to manage their ongoing health care needs.

This service specification outlines what should be included in a primary care service being offered to patient populations in secure and detained environments. It also includes guidance for the support that should be offered to individuals with learning disabilities and other vulnerabilities. The specification could, if required, be integrated with mental health and other health support provisions (as per the specific specifications detailing required provision for these areas).

There are numerous clinical guidelines and best practice documentation that describe clinical practice and processes to steer best practice in the delivery of physical healthcare for people in secure and detained environments. This document does not aim to replicate these guidelines but provide a description of the minimum service requirements for a prison primary care service. For specific clinical interventions, please refer to the appropriate clinical guidance.

People in secure and detained environments may require additional health and social care support generally. Whilst social care is not legally the responsibility of NHSE/I commissioning arrangements and therefore the detail for this lies outside the scope of this specification, there is a strong need to work collaboratively with local authorities' social care teams and other healthcare providers. This can entail a collaborative commissioning approach or the provider holding the social care contractual obligation through a separate contract.

Appropriate support must be provided to people in secure and detained environments with an identified or suspected learning disability or difficulty to enable them to cope better within the secure environment and ensure that their health needs are met. Specific guidance in relation to meeting the needs of this particular patient population will be published by NHSE/I separately and can be read in conjunction with this specification. The primary care service provider also has a role in providing general support and advising other agencies within a prison of their respective responsibilities to support patients in daily life.

For ease of reference, throughout this document the term 'learning disability', unless otherwise stated, encompasses individuals with learning disabilities (LDs), autism or other vulnerabilities.



A safe and secure prison system cannot be successfully delivered without effective primary care 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 physical and mental 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, prison reconfiguration and commissioning pathways, therefore elements of this specification may be subject to review in response to variations. NHSE/I 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 the population.

## **IT and HJIS**

All secure setting healthcare services will use the national IT solution provided by NHSE/I health and justice information system (HJIS) as the primary clinical record for the patient. This includes sub-contractors.

The provider will ensure there are standardised procedures and processes in place for the use of HJIS and that all clinicians and administrators receive thorough training in the correct use. Persons will be clearly identified as HJIS Superusers and the right level of training accessed to support this role throughout the prison healthcare service. The superuser will be able to assist the healthcare staff in accessing and using HJIS effectively.

## **4 Guiding principle**

The purpose of health care in prison is to provide an excellent, safe and effective service to all patients ensuring access to and the quality of services delivered is of an equivalent standard to that of the community. Services should meet the objectives and outcomes of national frameworks and priorities and are expected to develop and implement measures to monitor these outcomes.<sup>1</sup>

Services should operate from a position of 'Making Every Contact Count'. 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 health conditions and learning disabilities should be appropriate and address the wide range of other, often related mental and/

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<sup>1</sup> See section 5 and 7.6 of document for further details.

or substance dependency needs identified. It should have a public health perspective and focus on reducing harms 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 health promotion and supporting positive health and well-being. Where medication is indicated, its provision should be suitably safe 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 social care providers serving the prison and contacts 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.

### **Cross referencing commissioning responsibilities outside those of health and justice.**

There are a number of areas where the commissioning for delivering care must work in conjunction with the commissioning responsibilities of other areas within NHSE/I and where health and justice direct commissioning processes must be aligned. These include services commissioned by specialised commissioning to our patient population constituting services such as anti-libidinal medication, supporting patients with serious mental health needs which ultimately require secure hospital care, care and treatment of specific blood borne viruses (BBV) conditions such as HIV infection and the specialist treatment a transgender patient would require as well as supporting the social care requirements of a patient (this is not an exhaustive list).

This specification describes the requirement NHSE/I has to commission primary care services across the secure estate. This specification does not stand alone and should be considered in relation to other specifications and healthcare duties across the health and justice landscape including Public Health section 7a specifications.

## **5 Frameworks and priorities**

Healthcare for people in the CJS is influenced by a wide range of policy areas and developments. The provider will deliver a prison-based community care services model (hereafter referred to as healthcare services in prison) to meet the objectives and outcomes of the various frameworks and priorities and will be expected to develop and implement measures to monitor these outcomes. These include but are not limited to:

## NHS Outcomes Framework

The NHS Outcomes Framework sets out the framework and indicators used to hold NHSE/I and commissioned services to account for improvements in health outcomes. These are not prison specific but are organisationally relevant. The outcomes and indicators can be found here: <https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework>.

## Public Health England Strategic Plan: Better Outcomes by 2020

Public Health England's strategy sets out priorities for health, which can be found here:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/516985/PHE\\_Strategic\\_plan\\_2016.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/516985/PHE_Strategic_plan_2016.pdf).

## 6 NHS Long Term Plan

The NHS Long Term Plan (LTP) published in January 2019 sets out the vision for the NHS over the next decade. The entire document can be accessed here: <https://www.longtermplan.nhs.uk/>.

While the principles of the entire LTP apply to all health and justice commissioned services, there are five priorities related specifically to health in the justice system – in summary these are:

- **Additional investment in services for people experiencing a mental health crisis will make a real difference for people who need support and will help ease pressures on police services.** Adults, children and young people will receive health screening on entering prison and a follow-up appointment within seven days, or sooner as required. This will be supported by the full roll-out of the health and justice digital patient record information system across all adult prisons, immigration removal centres (IRCs) and secure training centres for children and young people. This will include the digital transfer of patient records before custody, in custody and on release.
- **Health and justice services are provided to some of the most vulnerable members of our society.** Many people within the justice system experience greater problems than the rest of the population but do not regularly access timely healthcare. The NHS is already working with partners across government to improve the wellbeing of people in prison, reduce inequalities and address health-related drivers of offending behaviours. A priority in services for this group of patients is improving continuity of care. The care after custody service, RECONNECT, starts working with people who meet the eligibility criteria before they leave prison and helps them to make the transition to community-based services that will provide the health and care support that they need. Over the next five years, RECONNECT will engage and support more people after custody per year.

- **Since 2017, five parts of England have been testing a new Community Service Treatment Requirement (CSTR) programme.** This enables courts to require people to participate in community treatment, instead of a custodial sentence. CSTR sites have provided community treatment for people who would otherwise have been sentenced inappropriately. We will build on this by expanding provision to more women offenders, short-term offenders, offenders with a learning disability and those with mental health and additional requirements.

## 7 Core service delivery

### 7.1 Service vision

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 primary care '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.

*NOTE: As the commissioner is contracting an integrated healthcare service this specification should be read in conjunction with the other specifications attached to this contract (especially substance misuse, medical and mental health) for the full service model to be fully understood.*

This service is commissioned as part of the overall prison health pathway and as such this model will ensure an integrated treatment system both within the prison and onwards into the community. The service will focus on delivering person-centred care within seamless and integrated clinical 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.

1. The NHS Standard Contract is mandated for use by clinical commissioning groups (CCGs) and NHSE/I when commissioning non-primary medical services NHS-funded healthcare services. Where primary medical services are being commissioned, the appropriate form of primary medical services contract must be used in accordance with the relevant regulations and directions.

2. In certain circumstances, commissioners may wish to commission a package of services including both primary and secondary care elements from a single provider. An example of this would be the commissioning of an integrated prisons healthcare service (for which the NHS Standard Contract must be used) and GP services (for which a general practice contract must be used). In those circumstances neither the NHS Standard Contract nor any form of primary medical services contract may lawfully be used on its own to commission that package of services. Various contractual structures may be used to deal with this. The use of Schedule 2L of the NHS Standard Contract offers a relatively simple solution, for use in appropriate circumstances.

3. If the package of services includes primary medical services and services for which the NHS Standard Contract is the mandated form of contract, commissioners may include provisions in Schedule 2L of the NHS Standard Contract to make the Contract compliant with the Alternative Provider Medical Services (APMS) Directions in relation to the provision of primary medical care services. In other words, to ensure that the contract is both an NHS Standard Contract and an APMS contract.

4. Schedule 2L is based very closely on NHSE/I model form of APMS Contract, which is available at: <https://www.england.nhs.uk/commissioning/gp-contract/>.

The service is to be made available to all people residing 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.

The service provider will establish and run a primary care service for the prison establishment, delivered to an equivalent standard and quality as services in the community. Primary care services should be delivered as part of an integrated healthcare service (as described within the full range of health and justice service specifications). The service provider must ensure that the workforce is able to provide high quality, safe, effective, caring, responsive and well-led care to patients and that 'the right staff in the right place at the right time' are available to achieve better outcomes, better patient and staff experiences and effective use of resources.

The provider will ensure staff capacity and capability is consistent with operational and strategic planning processes. The provider will ensure that the workforce is able to work flexibly and provide cover where required and appropriately manage shortfalls in staff cover. The provider is expected to have a workforce contingency plan in place.

The appropriate skill mix of healthcare staff in the prison will include the use of practitioners from a variety of disciplines e.g. GPs, nursing, paramedic, support workers and assistant/associate practitioners. The workforce must have the essential and relevant qualifications and competencies to carry out their roles and responsibilities and have access to regular clinical supervision.

The provider must ensure that there is a rolling training programme to ensure staff have access to mentorship skills training to maintain skills in supporting trainees and newly appointed staff.

The service must meet the prison's specific requirements for healthcare input as stated in Prison Service Instructions (PSIs) and Prison Service Orders (PSOs).

## 7.2 Days and hours of operation

Note to local commissioners

Local determination required but minimum offer must consist of service provision for 52 weeks per year. The provider will ensure that cover is provided for bank holidays.

## 7.3 Service availability

Note to local commissioners

Local determination required, but at a minimum must include:

- emergency referrals – within two hours when primary care services are on site
- urgent referrals – within one working day with protocols in place with out of hours (OOH) to manage any urgent cases that rise during the OOH period through CCG commissioned services or specialist services. Where 24/7 health cover is to be commissioned local management of this should be described
- the medical service must provide the patient population with the opportunity to book appointments more than 48 hours in advance, up to a period of six weeks in advance.
- an appointment system will be designed to meet the needs of the establishment's population
- where GPs are not on site there must be a system in place to access advice and/or a consultation with a GP.

## 7.4 Inclusion criteria

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.

## 7.5 Exclusion criteria

- Private procedures and practice - this is outside of the scope of this specification. If a patient wishes to obtain private treatment this can only be achieved if there is agreement with the healthcare provider, commissioner and prison operator. Any private work must occur outside of the agreed sessions detailed within this specification and the patient must bear all costs for treatment including security procedures to be implemented.
- Treatment of all establishment staff and visitors (unless in an emergency arising at the establishment).
- Exclusions in the management of minor injuries outside of the competence of staff includes injuries that require emergency hospital treatment and/or are outside of the competence of the onsite healthcare team at the time.

## 7.6 Equivalence

As required and described in the HSCA 2012 patients within secure settings should receive the same quality and access 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. The following definition of equivalence has been agreed by the national prison health partnership and signed off by the Department of Health and Social Care, the Ministry of Justice, HMPPS, NHS E/I and Public Health England<sup>2</sup>.

*Equivalence is the principle which informs the decisions of the National Prison Healthcare Board so that member agencies' statutory and strategic objectives and responsibilities to arrange services are met, with the aim of ensuring that people detained in prisons in England are afforded provision of and access to appropriate services or treatment (based on assessed population 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, in order to achieve equitable health outcomes and to reduce health inequalities between people in prison and in the wider community.*

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.<sup>3</sup>

Note to local commissioners
Local additions will be required to suit the individual establishment.

<sup>2</sup> [NPHB Equivalence of Care principle](#)

## 7.7 Setting

### Note to local commissioners

Within the ethos of collaborative 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.

Consider cultural issues that may present barriers to patients engaging with health care provision.

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.

## 7.8 Referral criteria and route

- Following referral, appropriate patients must be scheduled into clinic(s) through a robust triage process.
- An appropriate system for booking appointments must be utilised.
- It is expected that a receiving healthcare organisation (e.g. acute or mental health NHS trust/FT) must accept any reasonable referral and redirect referrals within the Trust where appropriate.
- There is an expectation that referrals are managed in line with NICE pathways

## 7.9 Demand management

The healthcare provider will proactively manage keeping waiting times to a minimum by:

- proactive management of demand and capacity and implementation of a flexible reactive appointment system that is responsive to need.
- accessible access to urgent care during contracted hours
- taking advantage of developments in technology to enhance access to care
- taking care closer to the patient where possible (e.g. use of wing-based facilities).



## 7.10 Access requirements

- First night reception - screening must take place on the day of arrival or within 24 hours of arrival for those transferred from another establishment.
- Healthcare to contact a patient's community GP to request a patient summary be sent securely to the healthcare department in the prison where applicable as soon after reception as possible.
- General health assessment and second stage screening to be completed within seven days of arrival at the prison to include BBV and other appropriate screening.
- Medical emergencies/urgent care – immediately (via Blue Light Ambulance services commissioned by CCGs).
- Urgent referrals - within 24 hours.
- Patient summaries to be sent securely to the patient's community GP on release where possible.
- Discharge plans for all patients – on release with follow-up in community if relevant.
- All patients on the Assessment, Care in Custody and Teamwork (ACCT) process – assessed within the six-hour timeframe.
- Healthcare staff attend ACCT reviews.
- All patients are examined by a healthcare practitioner during the 24 hours prior to discharge. (PSI 53/2010 Discharge).
- Systems are in place to enable the prison healthcare provider to support access targets including 18 weeks from referral to treatment (consultant led activity) and two weeks from referral to first outpatient appoint (cancer referrals).
- Ensure access to RECONNECT provision for those meeting the eligibility criteria is enabled prior to point of release from prison.
- Healthcare to identify patients due for release who do not have a community GP and to work with their Community Rehabilitation Company (CRC) /rehabilitation partner to ensure the patient is pre-registered with an appropriate community GP prior to release.

It is the responsibility of the healthcare provider to ensure all activities take place within the timescales specified by a suitably qualified member of staff, within available capacity and to prioritise accordingly

## 7.11 Clinical governance

Clinical governance arrangements and structures will be in place which facilitate continuous service improvement by the utilisation and analysis of key information sources such as: risk register, critical incidents, complaints, best practice and clinical audit, audit of Deaths in Prison Serious Incident reporting, Prisons and Probation Ombudsman (PPO) reports, Serious Case Reviews and Her Majesty's Inspectorate of Prisons (HMIP) action plans. Clinical governance concerns both clinical and non-clinical staff and acknowledges everyone's contribution to the patient's experience. Good integrated governance should combine and create consensus around the

concerns of clinical staff, prison staff and managers, patients and their families. Key to effective governance is the availability of information sources on which to base decisions.

The provider will use a variety of effective methods to ensure that a high-quality service is provided in accordance with standard NHS practice. These will include, but not be limited to the following:

- Patient engagement.
- Waiting time surveys.
- Clinical audit.
- Audit of prescribing and medicine usage.
- Activity information.

The provider will supply regular reports and relevant metrics/ performance data and any other reasonable additional information to enable the commissioners to monitor performance targets.

## **7.12 Safeguarding**

Details of expected safeguarding can be found in ***Appendix 4.***

## **7.13 Information governance**

Details of expected information governance, data protection, security and confidentiality can be found in ***Appendix 5.***

## **7.14 Information management and technology**

Details of expected information management and technology can be found in ***Appendix 6.***

## **7.15 Pharmacy and medicines optimisation**

Details of expected medicines management and optimisation can be found in ***Appendix 7.***

## **8 Reconfigured adult male estate**

The establishment types – reception, trainer, resettlement, open – will need to be considered when commissioning healthcare services in the reconfigured estate, as each will have different healthcare priorities. It should also be noted that most prisons will have a dual function (e.g. reception and resettlement), so the service will need to meet the needs of all patient populations within the establishment.

Local determination will be required based on the health needs assessment (HNA) for each establishment and the unique population of each site.

Below are general commissioning considerations for each type of prison function:

### **Reception**

- First night reception screening.
- Ensuring the identification of immediate health, risk and safety needs.
- Appropriate care for the first 10 days in custody and the transfer of health information to receiving prison where appropriate.
- Pathways across prison patient population and cluster may be needed to ensure continuous care.
- Appropriate screening, testing and treatment, e.g. BBVs and chlamydia.
- General health screening within seven days.

### **Trainer**

- Management of long-term conditions including health checks for over people over 35 years old.
- Referrals to secondary care.
- Public Health section 7a services.
- Appropriate links to social care.
- Appropriate screening, testing and treatment, e.g. BBVs.

### **Resettlement**

- Discharge planning to ensure continuity of care on release.
- Healthcare contribution to resettlement planning.
- Engagement with RECONNECT programme as per eligibility criteria.

## **9 Adult women's estates**

There is no reconfiguration strategy for the women's estate and as such women's prisons remain as they are with a mixed economy of patient management. The model for the women's estate includes young offender and older adult women and covers reception, resettlement, training, open and closed facilities. The women in these prisons will receive the general primary care services as outlined within this specification, with the specific gender related elements that should be taken into

account in meeting the health needs of this population as described in the gender specific element of this specification.

## **10 Health and justice objectives, outcomes and standards**

The service provider will work in partnership with commissioners and other stakeholders to contribute towards the following objectives and outcomes and will consider all opportunities to enhance the aims of the service.

### **10.1 National collected outcomes**

Each overarching objective has a few specified measures that will be nationally mandated and collected nationally for national assurance purposes. The guidance on the national indicators will come out annually via an information schedule which will be sent to providers by regional commissioners.

### **10.2 Regional collected measures**

All services should be commissioned to achieve the 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, the specification incorporates proposed regionally driven 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 in **Appendix 1**, there are examples of possible service outcome measures and ways in which providers 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 instead 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.

In **Appendix 2** there are considerations of outcomes for particular patient groups: older people in prison, women in prison, foreign national offenders and individuals with a learning disability or autism.

In **Appendix 3** there are **service standards**, which are the expected minimum service requirements for the prison primary care service.

## Appendix 1 – Objectives and outcomes for regional contract assurance

<b>Objective 1</b> <b>To improve the health and wellbeing of people in prison and reduce health inequalities</b> <b>National measures to be determined</b>	
<b>Outcomes</b>	<b>Examples of how this could be evidenced (<i>local determination required</i>)</b>
<p>PROMs: Patient Reported Outcome Measures</p> <p>Peer support/self-help services are available, and patients report that this is useful</p> <p>All patients are involved in, and have access to, their own care plans</p> <p>Patient views and feedback are regularly obtained, and their comments reflected in continuous service improvement</p>	<p>PROMs:</p> <p>Patient forum feedback sessions.</p> <p>Integrated care plan and evidence that the patient informs it</p> <p>Discharge summary shows evidence of integrated planning and improved outcomes and engagement</p>
<p>PREMs: Patient Reported Experience Measures</p> <p>I understand how to care for myself better than I did before I came to prison</p> <p>I make healthier choices now</p> <p>I feel the whole healthcare service listens to me and hears my concerns</p> <p>I feel that what matters to me is understood</p> <p>I receive great care</p>	<p>PREMs:</p> <p>Evidence of patient engagement (e.g. patient forums)</p> <p>Adapt the Friends and Family test</p> <p>Evidence of patient feedback mechanisms</p> <p>Patients inform the development of the service</p>
<p>CROMs: Clinically Reported Outcome Measures</p>	<p>CROMs:</p> <p>Implementation of the <i>Dying Well in Custody Charter</i></p>

<p>Pathways are in place for end of life care and life-limiting illness, including palliative care</p> <p>Long term conditions are managed through appropriate pathways and through a multi-disciplinary team approach, where appropriate</p> <p>Patients are appropriately referred to secondary care</p> <p>Providers utilise technology to support pathways to access secondary care</p> <p>Patients are prescribed safe and appropriate medications and interventions</p> <p>Staff skill mixes reflect the population need</p>	<p>Leads who work within a structured framework in place to measure outcomes of LTCs (e.g. asthma, diabetes, COPD) such as QOF or equivalent)</p> <p>In reach specialist services are in place for complex patients</p> <p>Use of QOF to support identification and management of LTCs within establishments, QOF outcomes needs to be agreed locally, depending on establishment and role, i.e. reception prison would be looking at identification and building of LTC register</p> <p>Evidence of referrals audit</p> <p>Use of telemedicine where appropriate</p> <p>Adherence to formulary in keeping with the national guidance<sup>4</sup></p> <p>Medicines reconciliations; in-possession medication risk assessments</p> <p>Skills mix is informed by health needs assessment</p> <p>NICE guidelines to be adhered to</p>
<p>PATOMs: Partnership Reported Outcome measures.</p> <p>Healthcare is delivered in a safe and confidential environment, and documented escalation processes are in place for staff to raise concerns</p> <p>The primary care team leads collaboration to deliver integrated care between all healthcare services within and outside the prison</p>	<p>PATOMs:</p> <p>Records kept of cancelled /late clinics, including secondary care and outpatient clinics due to prison regime issues and staff shortages</p> <p>Reports and discussion at Local Delivery Board of escalated issues</p> <p>Integrated care plans</p>

<sup>4</sup>Current National Pain Management Formulary Guidance appended to this document.

All Care Quality Commission (CQC) and relevant HMIP healthcare recommendations and findings are responded to and actioned

All PPO recommendations for healthcare are responded to and actioned

Multi-disciplinary working

Action plans are in place to implement recommendations



## Objective 2

**To reduce reoffending and support rehabilitation by addressing health-related drivers of offending behaviour**

**National measures to be determined**

<b>Outcomes</b>	<b>Examples of how this could be evidenced (<i>local determination required</i>)</b>
<p>PROMs:</p> <p>Patients are independently stable and confident to manage conditions with appropriate support</p> <p>Peer support and self-help services are available, and patients report this is useful</p> <p>Patients have access to programmes through social prescribing, (i.e. activities outside of normal out of cell opportunities for example, participating in 'walking well' schemes) to support improvements in health and wellbeing</p>	<p>PROMs:</p> <p>Engaging patients in personal responsibility activity for health</p> <p>Evidence of peer support services</p> <p>Social prescribing programmes are available and utilised.</p>
<p>PREMs:</p> <p>I understand my health condition and the impact it has on behaviour and daily living</p> <p>I understand what I need to do to live a healthy life</p> <p>I am supported to address my health needs which enables me to achieve my rehabilitation goals</p> <p>I am confident that my transgender needs are supported by my health provider</p> <p>My healthcare provider understands my personal goals and helps me achieve them through supporting my health needs</p>	<p>PREMs:</p> <p>Patient questionnaire</p> <p>Care plans demonstrate patient input on identifying goals and co-production</p>

<p>CROMs:</p> <p>Risks identified in the first night reception screens are managed</p> <p>Understanding the individual's rehabilitation goals and reflecting these in their care plan</p> <p>Wider health needs are identified within the first seven days of custody</p> <p>Services are accessible for all people in prison</p> <p>Health education is provided and tailored to the individual needs of the person</p> <p>Use of non-clinical therapies (i.e. social prescribing, purposeful activity) for mental health issues, where appropriate</p> <p>Healthcare to work with the prison to support risk management processes, including ACCT<sup>5</sup></p>	<p>CROMs:</p> <p>Evidence of agreement with prison re risk management from reception</p> <p>Evidence of care plan built from secondary reception screen</p> <p>Evidence of screening, testing and treatment planning pathways are in place, multi-disciplinary team working</p> <p>Availability of peer mentors, non-clinical programmes</p> <p>Health education/promotion strategy</p> <p>Evidence of structured PSI programmes in place</p> <p>Referrals to substance misuse team where appropriate</p>
<p>PATOMs:</p> <p>Supporting therapeutic regimes – such as trauma informed, Psychologically Informed Planned Environment (PIPES), Offender Personality Disorder (OPD) where they are offered in establishments as appropriate</p> <p>Clinicians are involved in the wider leadership of a healthy prison</p> <p>Consistent recovery focused support throughout the prison (whole prison approach)</p> <p>Wellbeing plan supported by a whole prison approach</p>	<p>PATOMs:</p> <p>Manage health providers inclusion in the planning and delivery of these initiatives</p> <p>Clinical representation at prison SMT meetings</p> <p>Evidence of recovery focussed discussions at LDB</p> <p>Referrals mechanisms to and joint working with gyms/education</p>

<sup>5</sup> The ACCT process is undergoing review and the acronym may change but the requirement for healthcare staff to engage and be engaged in the process of a system approach to supporting patients safety and care remains.

Asset based approach to healthy living including access to peer mentors, physical activity and education	
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**Objective 3**

**To support access to and continuity of healthcare through the prison estate, pre-custody and post-custody into the community**

**National measures to be determined**

<b>Outcomes</b>	<b>Examples of how this could be evidenced (<i>local determination required</i>)</b>
<p>PROMs:</p> <p>Information from community services is available on reception</p> <p>Patients are able to manage their conditions on release and know how to engage with community services</p> <p>Patients know how to engage with community healthcare services on release</p> <p>A partnership is in place with a local SARC (sexual assault referral centre) for people who report sexual trauma</p> <p>Sexual health, including non-recent sexual trauma is explored and incorporated into the care plan where appropriate.</p>	<p>PROMs:</p> <p>Systems for obtaining GP/community health records in timely manner</p> <p>Supply of minimum of seven days medication or FP10 prescriptions to maximise access to continuity of medication as appropriate and after risk assessment carried out (use of appropriate data collection tool)</p> <p>For discharges to the community a supply of seven days medication or FP10 prescription supplied, ensuring the risks associated with the individual, medicines to be prescribed and access to community services informs the clinical decision</p> <p>Health engagement in post-sentence planning and linking with case managers. Education about services on release</p>
<p>I am confident that my transgender healthcare needs are supported by my health provider</p>	<p>PREMs:</p> <p>Use of patient health passports used as memory aids for patients managing their continuity of care</p> <p>Attendance at discharge clinics</p>

	<p>Information on release</p> <p>Access to care plan on release</p>
<p>CROMs:</p> <p>Robust continuity of care arrangements are in place to support patients on release to the community</p> <p>Arrangements are in place to support continuity of care on transfer to another prison</p> <p>For those patients who meet the eligibility for RECONNECT interventions they will specifically be directed to community-based health provision</p> <p>Appropriate intermediate care service to support:</p> <ul style="list-style-type: none"> <li>• Reduction in unnecessary escorts and bed watches</li> <li>• Reduction in length of stay in acute trusts</li> <li>• Reduction in time from being declared medically fit for discharge back to custody</li> </ul> <p>Pre-release planning is considered early in the sentence</p>	<p>CROMs:</p> <p>Patients attend discharge clinics</p> <p>The transferring prison maintains clear care plans, medications are sent with patients, risks identified prior to transfer and shared</p> <p>Systems are agreed between prisons on transfer processes</p> <p>Intermediate care could include but is not limited to: Telemedicine/in-reach clinics; in-reach palliative care; on-site x-ray clinics; pathways in place with local acute trusts</p>
<p>PATOMs:</p> <p>Appropriate patient information flows across the patient pathway – including (but not limited to): Liaison and Diversion, CRC/probation, community healthcare providers, local authority, PERs</p> <p>Healthcare are linked to National Probation Service (NPS) and CRCs to input into discharge planning</p> <p>Information sharing agreements are in place locally to support appropriate sharing of patient information</p> <p>Regular multi-disciplinary teams for complex cases</p>	<p>PATOMs:</p> <p>Engagement across delivery arms to be captured through partnership measurement mechanism</p> <p>Pre-registration and regular and shared recording of healthcare contributions to discharge planning</p> <p>Localised integrated strategic partnership's (ISPs) in place with providers, commissioners, governors and other partners who work with healthcare providers</p>

## Appendix 2 – Considerations for specific patient groups

<b>Foreign national offenders (FNOs)</b>	
<b>National measures to be determined</b>	
<b>Outcomes</b>	<b>Examples of how this could be evidenced (<i>local determination required</i>)</b>
<p>PROMs:</p> <p>Patients can access healthcare and healthcare information in different languages</p> <p>Patients have an improved understanding of their healthcare conditions and know how to access healthcare in the community or in their country of origin</p> <p>Patients are discharged with sufficient quantities of essential medications</p> <p>Patients are made aware of their healthcare rights on discharge to the community and are supported to register with a GP</p> <p>Patients held under detention powers have had rule 34/35 assessments carried out within the required timescale where requested and required<sup>6</sup></p>	<p>PROMs:</p> <p>Translation services are available and utilised; healthcare and medicines leaflets are available in different languages</p> <p>Support access to information about healthcare in country of origin</p> <p>HJIP data; process for establishing legal restrictions of medicines being taken into other countries and acting on these for relevant patients</p> <p>Healthcare need to support a patient's understanding of this right and process.</p>
<p>PREMs:</p> <p>I am involved in a regular review in my health</p> <p>My medical confidentiality is protected but information is shared to keep me safe</p> <p>I can request and use health services and I know what is available</p> <p>I am supported to care for myself and maintain/improve my health and wellbeing</p>	<p>PREMs:</p> <p>Evidence of face to face clinical and medication reviews</p> <p>In-possession versus not in-possession medication proportion: this evidences independence in managing medicines</p>

<sup>6</sup> See guidance to FFLM quality standards on page 96.

<p>As a detained person in a prison setting, I understand my rights to request and receive a rule 34/35 assessment</p>	
<p><b>CROMs:</b></p> <p>Care is informed by histories of trauma and does not re-traumatise</p> <p>GPs or advanced nurse practitioners (ANPs) are trained to conduct 'Rule 35 equivalent'<sup>7</sup> assessments in the prison estate for foreign national offenders<sup>8</sup></p>	<p><b>CROMs:</b></p> <p>All staff have received trauma informed care training</p> <p>Pathways are in place to support patients undergoing deportation (methadone, medication, medical information etc)</p> <p>Pathways are in place for those needing a Rule 35 assessment to receive it and a cohort of staff working in FNO prisons receive Rule 35 assessment<sup>9</sup>training</p>
<p><b>PATOMs:</b></p> <p>Patients have access to Rule 21 assessments (prison estate R34/35 equivalent)</p> <p>Planning for release and resettlement – GP registration, NHS number</p> <p>Healthcare support to enable suitability assessment for transfer from prison to IRC for time served patients</p>	<p><b>PATOMs:</b></p> <p>Staff receive training on the Adults at Risk Policy and Rule 34/35 assessments</p> <p>Pathways are in place for patients transferred from an FNO prison to an IRC or to the community or country of origin</p> <p>Healthcare staff are involved in and contribute to basic case review as to suitability for transfer in relation to clinical needs and receiving establishment's ability to manage patient care.</p> <p>Prison healthcare to IRC healthcare case referral in relation to meds and pathways.</p>

<sup>7</sup> Rule 35 of the Detention Centre Rules requires the medical practitioner to report on any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention (rule 35(1)), on any detained person suspected of having suicidal intentions (rule 35(2)), and any detained person whom the doctor is concerned may have been the victim of torture (rule 35(3)).

<sup>8</sup> The second Shaw Review (2018) of the immigration removal estate identified the need to enable Rule 35 equivalent assessments to detainees held in the prison estate.

## Women in prison

### National measures to be determined

Outcomes	Examples of how this could be evidenced ( <i>local determination required</i> )
<p>PROMs:</p> <p>Reduced levels of self-harm</p> <p>All patients are treated with respect and dignity, especially following an incident of self-harm</p> <p>Sexual health, including historic sexual trauma is explored and incorporated into the care plan where appropriate</p>	<p>PROMs:</p> <p>Audit and benchmarking</p>
<p>PREMs:</p> <p>Healthcare understands what has happened to me</p> <p>I feel able to talk to healthcare</p> <p>I feel that healthcare is a safe environment</p> <p>My care plan recognises me as a carer and acknowledges my carer responsibilities</p> <p>I am confident that my transgender needs are supported by my health provider</p> <p>I feel understood and supported by healthcare when I self-harm</p>	<p>PREMs:</p> <p>Patient questionnaire</p>
<p>CROMs:</p> <p>All pregnant women should be placed on a peri-natal pathway with clear links to a community midwife service and peri-natal mental health services</p> <p>Women's mental health needs are reassessed and closely monitored</p> <p>Women's physical and mental health needs are assessed, and they are added to the pathway list triggering visits, support, referrals and practical items including</p>	<p>CROMs:</p> <p>Patients records reflect pathway status</p> <p>Specialist Perinatal (PN) and PN mental health maternity services are available within the establishment which are aligned to the primary care services supporting the pregnant and post-partum woman</p>

<p>maternity pads, breast pads, and medication  Screening services – breast and cervical cancer screening are offered to all eligible patients  Identification of pregnancies</p> <p>Women are provided with support for termination of pregnancies</p> <p>Healthcare provide a lead on post-care following pregnancy</p> <p>Healthcare providers support competency and skill mix that reflect a workforce that can manage gender specific health conditions</p>	<p>Women specialist clinical staff available</p>
<p>PATOMs:</p> <p>A trauma informed approach is employed in the women’s estate by healthcare, prison staff and other partner agencies</p> <p>All staff to receive trauma informed care training within three months of starting and refresher every two years</p> <p>A partnership is in place with a local SARC (sexual assault referral centre) for women who report recent sexual trauma</p>	<p>PATOMs:</p> <p>All staff in women’s prisons undertake trauma informed training</p> <p>Agreed clear pathway with local SARC</p>



## Care of populations over 50 years old

### National measures to be determined

Outcomes	Examples of how this could be evidenced ( <i>local determination required</i> )
<p>PROMs:</p> <p>Pathways are in place for end of life care, from diagnosis of a life-limiting illness</p> <p>Where appropriate, family and friends are involved in end of life care pathways</p> <p>An older person's health and wellbeing model is developed including appropriate diet, physical activity and social needs</p> <p>Patients have access to peer supporters/patient experts</p> <p>Patients are independently stable and confident to manage conditions with appropriate support</p>	<p>PROMs:</p> <p>Full implementation of the Dying Well in Custody Charter</p> <p>Family engagement strategy</p> <p>Older persons lead clinician and evidence of specific pathways</p> <p>Access to support for in-possession medication including monitored dosage systems; prompting about medicines taking by social care services</p>
<p>PREMs:</p> <p>The needs which I feel are most important are met</p> <p>I have hope for the future</p> <p>I am treated with respect, independent of what I may have done</p> <p>I receive safe and decent care from all staff</p>	<p>PREMs:</p> <p>Patient questionnaire</p>
<p>CROMs:</p> <p>Long term conditions are managed appropriately through pathways and/or in-reach services</p> <p>A multi-disciplinary approach is taken to address the needs of older patients</p> <p>Public health screenings are offered to all eligible patients (e.g. bowel cancer, Abdominal Aortic Aneurysm (AAA),</p>	<p>CROMs:</p> <p>Quality Outcomes Framework (QOF) Screening services and appropriately trained staff are in place</p> <p>NHS health checks are recorded on SystemOne</p>

<p>diabetic eye screening programme (DESP)) and pathways are in place for referral for treatment.</p> <p>NHS Health Checks are available for patients between 40-74</p> <p>Prescribing is safe and reviewed regularly to ensure it is still necessary</p> <p>Clinical skills in identifying and managing gender specific diseases of old age- and age-related conditions</p>	<p>Regular medication reviews to ensure meds optimisation Audit</p> <p>Clinical champions for specific conditions available</p>
<p>PATOMs:</p> <p>Multi-agency complex care plans are developed for patients with memory issues, dementia and capacity issues</p> <p>Advanced care planning and DNARs (Do Not Attempt Resuscitation) are in place for appropriate patients</p> <p>Reflective practice and continuous joint learning are embedded in everyday practice to keep patients safe and improve staff resilience</p> <p>Staff and other patients are supported following patient deaths</p> <p>Patients are supported in 'living well, ageing well, dying well'</p> <p>Health are able to input into Compassionate Release and Release on Temporary License applications.</p>	<p>PATOMs:</p> <p>Care plans are input on SystemOne and appropriate staff have access to these records.</p> <p>System in place for sharing this</p> <p>Multi-disciplinary team forums. Clinical governance meetings to include wider partnership.</p> <p>What systems are in place.</p>

**Patients with learning disabilities, autism, acquired brain injury (ABI) or other cognitive impairment or neuro-disabilities can fully access healthcare services and have their healthcare needs met<sup>10</sup>**

**National measures to be determined**

<b><u>Outcomes</u></b>	<b>Examples of how this could be evidenced</b> <i>(local determination required)</i>
<p><b>Patient Reported Outcome Measures</b> Individuals with learning disabilities, autism, ABI or other neuro-disabilities can fully access all types of healthcare services in prison</p> <p>Individuals are at the centre of their own care</p> <p>Individuals understand how healthcare can help, any health conditions/ treatments and how to take medications</p> <p>Individuals experience improvements in health conditions and feel supported to make healthy choices</p> <p>Individuals are able to fully communicate when using healthcare</p>	<p>Services have accessible appointment-booking systems Instructions and signage are accessible Services are ‘autism friendly environments’ The different types of healthcare available is made clear Assessments are fully accessible Specialist services (e.g. for neurodevelopmental disorders) are available via in-reach provision</p> <p>Individuals co-develop personal, accessible, care plans The views of the individual are heard as part of any case-conferences/multi-disciplinary meetings</p> <p>Reasonable adjustments are used as required Adapted versions of interventions are used Easy Read leaflets for health conditions are available Service provision is promoted via Easy Read Medication includes accessible labels and support</p> <p>Individuals are supported to adhere to any treatment plans and/or medication</p> <p>Staff practice clear and accessible communication Easy Read is used for written material when needed Speech and language expertise is available to advise as required</p>

<sup>10</sup> Please see accompanying guidance (at Guidance listing) concerning the implementation of this objective with regards to individuals with learning disabilities and autism.

<p><b>Patient Reported Experience Measures</b></p> <p><i>“Healthcare know about my condition, but I am still treated as an individual with my own needs, rather than someone with a disability.”</i></p> <p><i>“I trust staff to help me with my mental and physical health problems.”</i></p> <p><i>“Staff give me enough time to explain myself and make sure I understand everything. They are patient with me.”</i></p>	<p>These statements can be verified via patient feedback groups, forms and other forums to help develop the service</p> <p>(For more quotes about healthcare, please see the publication ‘Patients Voices.’<sup>11</sup>)</p>
<p><b>Clinical Reported Outcome Measures</b></p> <p>Services are able to identify individuals with possible learning disabilities, autism, ABI or other neuro-disabilities</p> <p>A nominated learning disability and autism healthcare champion (or existing learning disability nurse) promotes this agenda.</p> <p>All healthcare services have a joined-up approach regarding meeting the needs of these patients</p> <p>Services have access to expertise concerning individual cases and awareness training.</p>	<p>Services have access to credible screening tools (for use as required)</p> <p>The recommended additional responsibilities for this role are outlined in the accompanying guidance The champion is supported and enabled to fulfil this role</p> <p>There is a pathway of support and potential referrals.</p> <p>Staff are aware of the needs of these populations.</p> <p>The approach to individuals with learning disabilities, autism or both is informed by the accompanying guidance</p> <p>A learning disability practitioner or other relevant expert is employed/available</p>

<sup>11</sup> [www.prisonreformtrust.org.uk/Portals/0/Documents/No%20One%20Knows%20report-2.pdf](http://www.prisonreformtrust.org.uk/Portals/0/Documents/No%20One%20Knows%20report-2.pdf)

<p>The standard of healthcare provided is equal to that delivered in the community</p>	<p>Health action plans are offered to all individuals with a learning disability Annual health checks (including mental health) are offered to individuals with learning disabilities serving longer than a one-year sentence</p>
<p>Healthcare services work to address related health inequalities for these populations</p>	<p>Pro-active health checks/promotion take place Accessible public health campaigns are used</p>
<p>Individuals are medicated appropriately and supported to use any medication</p>	<p>Medicine use reviews take place and identify when support is required Accessible information and compliance aids are used to enable self-administration, when appropriate Decisions concerning whether/how to use anti-psychotic medication are informed by the NICE clinical guidance</p>
<p>All relevant guidance, standards and laws are adhered to</p>	<p>This is monitored via inspections and contract reviews Those regarding learning disabilities and autism are listed in the accompanying guidance</p>
<p>Essential information is recorded, kept and shared appropriately</p>	<p>A register of all patients with a learning disability, autism, ABI or other neuro-disabilities is kept (including those screening positive but not formally assessed) and formal diagnoses are recorded on all appropriate platforms This register is used to flag risk, vulnerability, safeguarding, etc Reasonable adjustments are recorded on SystmOne and SNOWMED and Summary Care Records Premature deaths of people with learning disabilities are reported to the regional Learning Disability Mortality Review Programme</p>

Partnership Reported Outcome Measures	
<p>Healthcare form part of a whole-prison approach to meeting the needs of individuals with learning disabilities, autism, ABI or other neuro-disabilities</p>	<p>Healthcare are part of a prison-wide information sharing agreement for appropriate information  Screening outcomes from education and prison reception are shared with healthcare (with consent)  Healthcare work closely with the prison psychology department and (where in place) or other relevant initiatives to coordinate any care delivered  Healthcare input into multi-disciplinary case conferences concerning individuals with behaviour that challenges or other related issues  Healthcare provide any required information to enable individuals to access specialist interventions  Healthcare refer individuals for the HMPPS programmes for men with learning disabilities or challenges</p>
<p>Healthcare work with prison safeguarding to help ensure vulnerable and at-risk individuals are kept safe</p>	<p>Healthcare services have an agreed approach with the safeguarding team to raise awareness of these populations, plan ways to keep them safe and to flag any specific concerns</p>
<p>Services are coordinated with external healthcare providers concerning an individual's care and support needs, including, with patient consent, supporting HMPPS to access families and gain their input concerning an individual's healthcare needs</p>	<p>Information is shared appropriately. External care providers (e.g. hospital appointments) are made aware of an individual's support needs and reasonable adjustments beforehand</p>
<p>Healthcare help to prepare individuals for resettlement and ensure continuity of care after leaving a prison</p>	<p>Healthcare input into resettlement plans to ensure an individual's care/support needs are considered  Services ensure any healthcare is continued and that individuals have a GP upon release  Individuals are supported to continue their medication upon leaving a prison  Individuals are made aware of their right to an annual health check from their GP</p>

Healthcare works with prison social care providers, the community learning disability team, local autism pathway, the forensic learning disability team/lead within the local transforming care partnership and any other relevant local services working with individuals with ABI or other neuro-disabilities

These services all feature in the pathways for these populations  
Clear referral routes are in place for these services  
Healthcare coordinate care plans regarding any individuals in receipt of social care

## Appendix 3 – Service standards

<b>General practitioner (GP) and advanced nurse practitioner (ANP) service</b>		
<b>No.</b>	<b>Standard</b>	<b>Type</b>
	The provider will deliver GP and ANP services which work collaboratively and in partnership with all prison healthcare professionals to deliver an integrated and patient-centred service	
	Providers should ensure that all those working within their secure services are equipped to deliver appropriate care. Where employees do not have a full range of competencies at the outset of their contract, the provider organisation should ensure that all team members have access to appropriate training and that this training is undertaken within a specified time frame.	
	GPs will support and mentor the ongoing development of nurses to achieve non-medical prescribing qualifications. GPs will be required to support nurse training and development and should be appropriately resourced to do so.	
	Provide and develop a community equivalent GP/ANP service to patients that meets the needs of the population in the specific prison types.	
	Provide medical input into the needs of patients with substance use and mental health needs.	
	Provide care and treatment that is consistent with national standards, e.g. QOF and NICE guidelines.	
	Develop effective interfaces with community and secondary care providers to ensure continuity of care.	
	Adhere to and implement the specified number of GP and ANP clinics that will be delivered across all prison establishments.	
	Meet the requirements for healthcare input as stated in relevant PSOs and PSIs.	
	Agree formal arrangements for the continued prescribing and monitoring of medicines prescribed and reviewed by specialist prescribers (e.g. mental health and hospital clinicians) in line with local and national arrangements.	
	Utilise the clinical IT systems including SystemOne, telehealth and Integrated Clinical Environment (ICE) pathology reporting to their full functionality to effectively and accurately record patient information.	
	Monitor and review patients with long-term conditions and/or under medication in accordance with an agreed personal care plan and in line with QOF, NICE guidance and other nationally accepted standards of best practice.	
	Provide assessment and management of minor injuries for patients who require medical attention but not a visit to A&E.	



	Provide minor surgery, in line with current directed enhanced services.	
	Support the ongoing care and monitoring of patients' resident in inpatient units in accordance with patient care plans.	
	Actively participate and input into the local health improvement plans.	
	Attend and actively participate in multi-disciplinary team reviews including ACCT reviews.	
	Visit each patient at least daily and more frequently if health needs require this to be the case. When located on the Separation and Care Unit or in cellular confinement/under mechanical restraint as specified in Prison Service Order 1600: Use of Force and Prison Service Order 1700: Segregation (or their replacements.)	
	Attend Death in Custody Inquests as requested by HM Coroner.	
	Assist with investigations into SUIs where required	
	Involvement in Multi-Agency Public Protection Arrangements (MAPPA) and safeguarding procedures.	
	Provide all relevant medical reports where a medical opinion relating to the patient's health is required e.g. parole reports.	
	Attend and actively participate in Prison Local Delivery Board.	
	Appropriate senior healthcare representation and participation in designated meetings such as Safer Custody and Security where medical input is required.	
	Participate in emergency planning for epidemics and pandemics.	
	Ensure notification of communicable diseases to Public Health England.	
	Health checks for over 40s.	
	Screening, testing and treatment.	
	<b>Prescribing and medicines management</b>	
	GPs and ANPs will comply with the local and National Prison Formulary.	
	GPs and ANPs will undertake timely and thorough risk assessments to ensure prescribed medication is safe and appropriate within a prison environment.	
	GPs and ANPs will use their discretion in prescribing using the prison healthcare exceptional case processes.	
	GPs and ANPs will provide medical input for the development of Patient Group Directions (PGDs) as required.	
	GPs and ANPs will work in conjunction with secondary and pharmacy services to ensure the seamless sign off of prescriptions within agreed timescales and to avoid delays in access to medication.	
	Utilise The Orange Book <a href="https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management">https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management</a>	

	GPs and ANPs will use SystmOne task templates to effectively request, record and document medicine reviews to ensure a complete audit trail. Details for the medication type and due date should be clear to enable the practitioner to sort requests by urgency and due dates.	
	GPs and non-medical prescribers will be the principal prescriber for shared health care for patients and the ongoing prescriber for treatment requirements along any clinical mental health care pathway.	
	<b>Palliative care</b>	
	GPs/ANPs must be able to appropriately support palliative care services and end of life care within the prisons and attend palliative care training as recommended by Macmillan and commissioners. This will include appropriate symptom control and pain relief, in line with the Gold Standards Framework and working to the Dying Well in Custody Charter guidelines.	
	In each prison with palliative care facilities, there will be a requirement for at least one GP to have undertaken recognised training and access ongoing appropriate supervision to maintain competencies.	
	Consultations for patients who have booked to see a GP/ANP, must commence within 15 minutes of the scheduled appointment time, unless there are exceptional circumstances. If there is a delay, the provider will ensure that the patient is informed.	

<b>GP and ANP workforce requirements</b>		
<b>No.</b>	<b>Standard</b>	<b>Type</b>
	<b>GP core competencies</b>	
	Have full GMC registration and discharge their professional responsibilities in line with professional standards, regulations and code of practice and conduct.	
	Are registered on NHSE/I Medical Performer's List.	
	Undertake a standard peer-led appraisal at least every two years to supplement their annual appraisal as a GP.	
	Be trained in trauma informed care.	
	Take part in GP revalidation, agree an annual personal development plan with their appraiser and undertake relevant CPD.	
	Have substance misuse qualification/training (Royal College of General Practitioners (RCGP) Part One) within the first year of this Agreement (please see section 3.9 substance misuse).	

	Utilise the RCGP Safer Prescribing in Prisons Document and The Green book <sup>12</sup> and the Orange Book <sup>13</sup> as appropriate in relation to the setting.	
	At least one GP in each of the establishments will hold RCGP level two for the management of substance misuse and work in that prison at least one session per week.	
	GPs have had experience in a community practice setting or have access to a GP mentor and link into GP professional networks. This ensures the principle of equivalent care. New GP recruits to receive robust induction, mentorship and ongoing training.	
	Have a right to work in the UK.	
	Have appropriate medical indemnity insurance.	
	Who are in process of attaining any accredited qualifications, have access to mentorship and support at all times.	
	Are competent in the 13 key areas derived from the core RCGP curriculum statement 'Being a GP', using RCGP's Workplace Based Assessment.	
	Follow and are competent in the 'RCGP Curriculum: Clinical Modules 3.10 Care of People with Mental Health Problems'.	
	Have the attitudes, skills, expertise and competencies as described in the RCGP Curriculum: Core Curriculum Statement.	
	Receive training and ongoing refresher training to ensure high level of competence in responding to medical emergencies and resuscitation.	
	Are competent in the use of SystemOne and functionalities to ensure that all clinical contacts are correctly recorded.	
	There will be a requirement for at least one GP per prison with palliative care facilities to have undertaken relevant accredited training and access ongoing appropriate supervision to maintain competence.	
	Utilise the RCGP Safer Prescribing in Prisons Document and The Orange Book. <a href="https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management">https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management</a>	
	Ensure their prison work is represented proportionally within their annual GP appraisal.	
	Work regular sessions within a community practice setting – the frequency of which is to be agreed with the Commissioners.	
	Have appropriate support to take the necessary study leave in order to develop the necessary skills and to keep up-to-date for working in secure environments e.g. RCGP Substance Misuse Certificate, STIF training, RCGP Secure Environment Group organised training days.	
	Security training.	
	Have and maintain appropriate security clearances.	

<sup>12</sup>[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/660902/Green\\_book\\_cover\\_and\\_contents.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/660902/Green_book_cover_and_contents.pdf)

<sup>13</sup> <https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management>

<b>ANP core competencies</b>	
	The provider must ensure that all ANPs have and demonstrate the core competencies as detailed in the RCGP General Practice Advanced Nurse Practitioner Competencies Framework (2015) and the RCN's 'Advanced nurse practitioners An RCN guide to advanced nursing practice, advanced nurse practitioners and programme accreditation'. All ANPs must hold a diploma or MSc in advanced practice with prescribing at level 7.
	All ANPs must be able to demonstrate they have achieved the competencies required to practice autonomously and are self-directed. Their practice should encompass direct clinical practice, education, research and management.
	Any nurses who are developing or undertaking training to become an ANP must be supported by an experienced and qualified mentor and have appropriate membership, regular supervision, an annual appraisal and ongoing continual clinical practice.
	All ANPs must be certified in or complete the RCGP certificate Level 1 and, as a minimum be working towards level 2 in the Management of Drug Use and the RCGP Certificate in the Management of Alcohol Problems and start the course within 12 months of commencement of the contract. All nurses should hold RCGP level 1.

Primary care nursing and administration service		
No.	Standard	Type
	Prison based nursing team will include registered and unregistered roles to ensure the patients are seen by the right person with the right skills.	
	All nurses and healthcare support workers (HCSWs) must possess the appropriate competencies and skills mix; including relevant and current qualifications in line with their specific role, which should be evidenced.	
	The workforce will be supported by a practice educator. The provider will appoint to this post in collaboration with an academic institution. The role of the practice educator will include the initial completion and annual review of training needs for the nursing and HCSW workforce.	
	<b>Leadership – this should sit outside any role specific sections and may not be a primary care clinician</b>	
	Each prison will have a <b>provider nurse manager (PNM)</b> . This post will be at a minimum Band 8a (or equivalent Grade) and can be a clinical or non-clinical employee. The <b>PNM</b> will be the registered CQC manager.	
	The PNM will take the lead and responsibility for: <ul style="list-style-type: none"> <li>• providing effective management support and professional leadership to staff</li> <li>• ensuring healthcare services are integrated.</li> <li>• attending the prison SMT meetings and linking with key prison strategic meetings</li> <li>• leading on reporting any issues/incidents through appropriate channels</li> <li>• ensuring patient engagement and consultation activities are undertaken</li> <li>• developing and delivering service improvement plans</li> <li>• participating in and supporting any inspections, audits, performance reviews and service reviews</li> <li>• coordinating services and care with all service leads, sharing operational issues across providers and ensuring their teams work together collaboratively.</li> </ul>	
	Each prison will have a clinical <b>lead nurse</b> . This lead is responsible for the day to day management and leadership of primary health care and coordinating care for those with long term conditions. During those times when the lead or equivalent is not present within the prison, a Band 6 or equivalent prison-based nurse must be on site during agreed healthcare hours.	
	The Band 7 or equivalent prison lead nurse will take responsibility for:	

	<ul style="list-style-type: none"> <li>• coordinating all nurse triage and nurse led clinics</li> <li>• improvement of the quality of patient care through the implementation of clinical governance activities</li> <li>• managing duty rotas and ensure adequate and appropriate staffing levels to fulfil service responsibilities</li> <li>• ensuring safe, responsible and clinically and professionally appropriate practice within the scope of nursing code of conduct</li> <li>• leading on infection control within their designated prison</li> <li>• providing clinical supervision to other nursing staff</li> <li>• providing expert nursing advice as appropriate to patients and to colleagues from other disciplines within the establishment</li> <li>• ensuring compliance and that the care plans are developed, maintained and monitored.</li> </ul>	
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<b>Reception / first night screening</b>		
	<p>All patients must undergo an initial health screen on receipt into the establishment by an appropriately qualified, competent registered nurse to identify any immediate health needs or risk - particularly in relation to issues such as suicide or self-harm, mental health, learning disability, continuity of essential medication, substance misuse (drugs and alcohol), infectious diseases and the needs of the older or younger adult and other specialist needs or protected characteristics. This will be completed in accordance with the requirements of PSI 52/2010.</p>	
	<p>Any patient who has an index offence of homicide will automatically be referred to the mental health team for assessment the same day.</p>	
	<p>It is expected that any patient identified at reception as either:</p> <ol style="list-style-type: none"> <li>I. already participating in a substance misuse treatment programme</li> <li>II. already under the care of mental health services.</li> </ol> <p>will be referred to the substance misuse / mental health service the same day.</p>	
	<p>Patient presenting at reception, or general health assessment stage, who are not currently on a substance misuse clinical programme but who identify an active substance misuse need will have to undertake a drugs test. Systems must be agreed with the substance misuse team to enable this to be undertaken in a timely fashion.</p>	
	<p>Systems must be in place to ensure that patients arriving at the establishment with medication are able to maintain access to this in line with their treatment regime. This should usually include completion of an in-possession risk assessment in line with the healthcare provider medicines management policies</p>	

	(see Section 8 below). Under no circumstances should patients be denied access to critical medication or be made to have an enforced break in their medication regime unless it would be unsafe to continue access.	
	Within one working day of reception the healthcare provider will initiate contact with external services used by the patient prior to their admission to prison e.g. GP and community mental health team (CMHT), where it is possible to verify patient engagement. Any patient entering the establishment directly from the community/court with an on-going medication requirement must have their prescription validated with the initiating prescriber. It is expected that patients transferring from another prison will have had this verification undertaken.	
	The health screening service must be available within the agreed hours of reception, although in cases where transfer or reception of patients for operational reasons falls outside these times, then every effort should be made to accommodate screening at that time. When a patient is identified as at risk of harm to self or others, the healthcare provider must inform and share information with the relevant agencies and take action in line with local safeguarding and risk management procedures.	
	An immediate healthcare plan must be written and put in place for any patient with urgent health concerns.	
	<b>Health assessment</b>	
	All patients must be offered a more in-depth health assessment which if accepted must be completed within 7 days of reception (in accordance with PSO 3050 and NG57). The healthcare provider will ensure systems are in place which actively encourage patients to accept this assessment. All reception screening information must be recorded on SystemOne in line with the National Clinical Template (SEAT)	
	The healthcare provider will advise the patient of the range of health services available within the establishment and will give information about: <ul style="list-style-type: none"> <li>• how healthcare services can be accessed</li> <li>• current waiting times</li> <li>• how to make a complaint or submit a compliment (internally and externally)</li> <li>• how to get involved in patient engagement activities.</li> </ul> Information must be provided in a format and language that the patient can understand.	
	The patient population are to be provided with information about the Health Trainer scheme ( <i>see the Health Promotion/Prevention Service Specification</i> ) and referred to see a health trainer made where indicated. This will compliment a process of self-referral to the health trainer programme and enable a proactive approach that targets new entrants into the establishment.	



	<p>The health assessment must be based on best practice and utilise recognised screening tools which include assessments for:</p> <ul style="list-style-type: none"> <li>• physical health problems including urine test and blood pressure</li> <li>• mental health problems</li> <li>• drug or alcohol abuse</li> <li>• risk of suicide and/or self-harm</li> <li>• learning disability/difficulties</li> <li>• ABI</li> <li>• opt out BBV screen.</li> </ul>	
	<p>A full assessment in accordance with SEAT templates is carried out with referrals and care pathways as per the outcomes of the assessment with ongoing monitoring covering:</p> <ul style="list-style-type: none"> <li>• reception health screen</li> <li>• secondary full health screen</li> <li>• in possession risk assessment</li> <li>• medicines reconciliation</li> <li>• release/transfer planning template</li> <li>• release transfer template.</li> </ul>	
	<p>The provider will ensure that patients have NHS equivalent access to a range of diagnostic services according to level of need within each prison.</p>	
	<b>Telehealth</b>	
	<p>The provider will ensure that in those prisons where telehealth equipment is available, it is used to its maximum potential. It will be used as a regional resource for healthcare services, and in order to minimise the requirement for patients to be taken to hospital under escort.</p>	
	<p>The equipment will also be used by staff for clinical supervision and training across establishments. Telehealth will also be used to facilitate inter-establishment consultations such as between a health provider in one prison and a client in another or other similar consultations. The commissioner is responsible for the procurement and maintenance of all telehealth equipment although can delegate this responsibility to the provider through the healthcare contract.</p>	
	<p>The provider must ensure that relevant staff receive training in the use of equipment and are competent and confident to use the equipment.</p>	
	<p>Telehealth can be used to supplement the management of highly specialised (e.g. gender dysphoria care) or specific long-term conditions. A HCSW or nurse must always be present with the patient to ensure patient confidentiality and clinical governance.</p>	
	<p>The provider will ensure that there are clear eligibility criteria and referral protocols in place, shared with all staff (GPs, nursing and administration). The provider must work with the</p>	



	telehealth provider and local providers to minimise adding delay/extra steps into the patient care pathway. In addition, the Provider will avoid duplication of appointments and diagnostic tests.	
	<b>Consent, assessments and care planning</b>	
	Information obtained at reception and general health assessment stages must be appropriately shared and health assessments effectively coordinated with other agencies so that patients are not repeatedly asked to provide the same information.	
	Information shared between healthcare and secure estate staff for health and welfare purposes must be limited to the minimum necessary and proportionate to the specific purpose. Healthcare and secure estate staff have a common purpose in the welfare of the individual.	
	Assessment of a person's capacity to consent must be made in accordance with the relevant legal principles and recorded in their health record.	
	Patients must understand and be fully involved in their health assessments.	
	<b>Triage</b>	
	Robust triage systems and referral pathways must be implemented to enable all healthcare applications / appointment requests to be screened on a daily basis and patients referred to the most appropriate healthcare service / professional, including mental health and substance misuse services. (including sub contracted services). These systems must be structured to support the achievement of national access targets.	
	For patients already under the care of a primary care clinician the practice of ensuring direct access, rather than resubmitting an application, is to be adopted.	
	<b>Planned care</b>	
	The service must provide specialist healthcare advice and treatment for a range of specific health conditions. The volume, location and range of nurse led services must be appropriate to the needs of the patient population as described in the health needs assessment.	
	All clinics must be provided to the equivalent same standards as those delivered within the community and in line with the requirements of the National Service Frameworks (NSFs) and published NICE guidelines. as appropriate for the secure environment. Appropriate clinician must operate regular review clinics with clear mechanisms to coordinate appropriate primary and secondary care referrals.	
	The healthcare provider is responsible for:	

	<ul style="list-style-type: none"> <li>ensuring HMPPS has provided the NHS appropriate clinical and cleaning facilities and they ensure that all required equipment is available to enable all clinics to take place</li> <li>ensuring effective follow up arrangements</li> <li>scheduling appropriate patients into clinics</li> <li>monitoring the time between receipt of request and appointment date.</li> </ul>	
	<p>Proactive management of demand and a flexible reactive appointment system according to patient need including:</p> <ul style="list-style-type: none"> <li>accessible urgent care during the contracted hours</li> <li>take advantage of developments in technology to enhance access to care.</li> </ul>	
	<b>Unplanned/emergency care</b>	
	<p>The aim of this service is to minimise the requirement for external escorts by ensuring that any interventions that can be safely delivered within the prison are done so. Exclusion criteria of the service include those whose injuries or illness(es) require medical or emergency intervention beyond the scope and practice of primary care nursing or general medical practice.</p>	
	<p>The provider will develop and implement protocols, specific to each prison, for responding to and managing situations in which a person's health quickly deteriorates, or in a health emergency such as accidents and self-harm or suicide.</p>	
	<p>The provider will work with the prison to ensure the effective triage and management of emergencies meet the requirements set out within Emergency Response in Custody (ERIC). This will include the use of a paramedic service where appropriate, which can be supported and supervised as required as part of the contract of delivery.</p>	
	<p>The provider will ensure that all registered nursing and medical staff are trained to manage acute clinical emergencies and that an annual training plan is developed within six months of the contract.</p>	
	<p>The service must offer:</p> <ul style="list-style-type: none"> <li>initial assessment and triage of minor injuries and illnesses using national based tools</li> <li>treatment for injuries and illnesses</li> <li>liaison with the prison service regarding unexplained injuries in accordance with PSO 2700.</li> </ul>	
	<p>Management of injuries, including self-harm and minor illnesses.</p>	
	<p>Exclusion criteria of the service include those whose injuries or illness(es) require medical or emergency intervention beyond the scope and practice of primary care nursing or general medical practice.</p>	

	Treatment time for minor injuries and illness(es) must be an appropriate response within the context of initial assessment/screening of the referral by a suitably qualified nurse or GP.	
	Risk assessments should be completed where there is potential significant exposure to blood and bodily fluids.	
	Appropriate details of assessment of injury/illness, as well as interventions outcomes (including referrals made or follow up arrangements) and outcomes must be documented in the patient's records.	
	<p>When a patient moves from the prison to hospital care, local processes must be developed with the receiving hospital and the healthcare provider must ensure the below are in place prior to the patient transfer:</p> <ul style="list-style-type: none"> <li>• Documented outcomes.</li> <li>• Information explicitly given regarding self-care including infection, prevention and control.</li> <li>• Any follow up or referral to other service including the GP.</li> </ul> <p>Once the patient returns to the prison from the hospital, the healthcare provider must arrange to see the patient within 24 hours of their return.</p>	
	<b>Responding to emergencies</b>	
	<p>The service will respond to requests for emergency clinical assistance for patients including:</p> <ul style="list-style-type: none"> <li>• accidents</li> <li>• self-harm and suicides</li> <li>• acute intoxication and medical emergencies</li> <li>• all other medical emergencies.</li> </ul>	
	Nursing support for coded calls will be provided in line with PSIs whilst healthcare staff are on site. Healthcare staff will be alerted through a coded call in accordance to local policy/protocol and as appropriate by telephone or radio call from other areas within the establishment.	
	The healthcare provider must ensure that this service is undertaken immediately and by a suitably qualified member of staff.	
	Healthcare staff must be trained and competent in managing non- fatal strangulation cases.	
	<p>Care options when responding to onsite emergencies include:</p> <ul style="list-style-type: none"> <li>• initial triage and assessment of whether more intensive treatment and care from external health services is required</li> <li>• co-ordinating with the prison to allow escort out to secondary care if clinically necessary</li> <li>• resuscitation including defibrillation where no DNAR in place</li> </ul>	

	<ul style="list-style-type: none"> <li>• support for the safer custody policies within the establishment in response to risk assessment and response to acts of self-harm</li> <li>• support for staff as a result of incident.</li> </ul>	
	Appropriate detailed patient records must be maintained, and all appropriate paperwork must be completed according to relevant PSOs/PSIs and healthcare records.	
	<b>Mental health</b>	
	<p>The foundation stage of the mental health Stepped Care Model is a whole prison approach to mental health promotion and primary prevention. As such the healthcare provider will provide:</p> <ul style="list-style-type: none"> <li>• mental health promotion and wellbeing activities in collaboration with the prison operator and mental health team</li> <li>• signposting and information provision</li> <li>• guided self help</li> <li>• referral of patients using an appropriate tool (e.g. Threshold Assessment Grid (TAG))</li> <li>• attendance at case conference meetings, as required.</li> </ul>	
	<b>People with learning disabilities, autism, neuro-disabilities or ABI<sup>14</sup></b>	
	The provider will ensure that a robust pathway is developed and implemented for the management of the health of people with learning disabilities, autism, neuro-disabilities or ABI.	
	Healthcare providers must ensure that the centre staff are made aware of an individual's presentation so that any social care support that might be required can be provided.	
	Providers may want to consider identifying a named learning disability and autism champion or dedicated nurse as part of the healthcare team.	
	The healthcare provider must ensure a suitable assessment of need is completed should someone with a known or suspected learning disability, autism, neuro-disability or ABI be detained.	
	The healthcare provider will liaise with the establishment who will make appropriate reasonable adjustments to enable individuals to have access to the full range of regime activities.	
	For people with learning disabilities, autism, neuro-disabilities or ABI, providers must consider:	

<sup>14</sup> Accompany guidance concerning the implementation of the relevant Objective for individuals with learning disabilities, autism or both is available. See page 96 for a list of all guidance documents.

	<ul style="list-style-type: none"> <li>• appropriate screening and assessment using an appropriate screening tool where available</li> <li>• producing a care plan should to ensure any health and care needs are met</li> <li>• ensure individuals have the appropriate reasonable adjustments to fully access healthcare services and interventions.</li> </ul>	
	<b>Suicide / self-harm</b>	
	Prisons have an established, multi-disciplinary approach to managing a patient at risk of suicide or self-harm, which is known as the ACCT process (Assessment, Care in Custody, and Teamwork). The ACCT process ensures that any patient who is causing concern or who needs to be kept safe receives immediate support, multi-disciplinary review and care planning. Please refer to PSI 64/2011 for more information and healthcare requirements.	
	<p>The desired outcomes of engaging someone in the ACCT process is:</p> <ul style="list-style-type: none"> <li>• reduction in the number of incidents of self-inflicted death and self-harm</li> <li>• vulnerable individuals are provided with positive care and support that gives them coping mechanisms other than self-harm.</li> </ul>	
	Where patients under ACCT are identified as requiring a health assessment by the primary care nursing team this must be undertaken within 24 hours.	
	Where a clinical causation has been identified through a clinical assessment as underpinning an individual's self-harming behaviour or ideation, and the patient has been placed under constant supervision, the healthcare provider will be responsible for funding this. The constant supervision may be undertaken by clinical staff or prison officers, but in all cases, staff must be appropriately trained, ensure there are therapeutic benefits to the constant supervision and have regular breaks.	
	<p>In the event of a Death in Custody:</p> <ul style="list-style-type: none"> <li>• healthcare staff should take appropriate action after a Death in Custody in accordance with PSO 2710</li> <li>• The provider director on call must be notified immediately</li> <li>• The commissioner should be advised no later than the next working day</li> <li>• Immediate initial review should be completed within 72 hours, the findings of which are shared with the commissioner</li> </ul>	

	<ul style="list-style-type: none"> <li>Quarterly action plan updates will be provided to the commissioner (and through them to the Prison Local Delivery Board) regarding how Death in Custody recommendations have been implemented to improve patient care and the care of detainees. An exception report is required where recommendations have not been implemented.</li> </ul>	
	<b>Older people</b>	
	The provider will ensure that a robust pathway is developed and implemented for the management of the health of older patients. This must follow the Department of Health document, A pathway of care for older offenders (DH, 2007a), which is based on the NSF for Older People (DH, 2001a), PSI 21/2001 and No problems – old and quiet (HMIP, 2004).	
	'Pathway of care for Older Offenders' DOH 2007 states that all older patients (classed as 50+) should have individual planned care whilst in prison followed by successful resettlement into the community to sustain optimum life.	
	The healthcare provider must ensure a suitable assessment of need is completed.	
	The healthcare provider will liaise with the prison and particularly the prison disability liaison officer, who will make appropriate adaptations to enable older patients or those with a disability to access the full range of regime activities.	
	The healthcare provider will hold a specific clinic for patients aged 50 and over to include: <ul style="list-style-type: none"> <li>medication reviews if required</li> <li>completion of a health and social care screen leading to an appropriate plan of care which includes ongoing review.</li> </ul>	
	<b>Palliative care</b>	
	When caring for terminally ill people in prison, the healthcare provider is expected to work with the prison governor and the Dying Well in Custody Charter (DWiCC).	
	Care plans must record the patient's wishes for ongoing care and end of life arrangements, along with any advance directives and directions for resuscitation.	
	There must be a clear process for the healthcare provider to liaise with the patient's legal representative to record the patient's wishes formally, which are then published to all relevant individuals involved in the patient's care.	
	Where a patient is no longer able to make these decisions for themselves, the legal framework under the Mental Health Capacity Act 2008 will be followed.	

	<b>Food refusers</b>	
	<p>The healthcare provider will work with the mental health team and the prison operator on the agreement of a protocol for the management of food refusers. This will include access criteria and pathways for prison and acute inpatient beds, communication and referral links with acute secondary care services and systems for the regular assessment of mental capacity. Members of the primary care team must be trained in relation to the Mental Capacity Act<sup>15</sup> and the use of Advanced Directives.</p>	
	<b>Escorts and bed watches</b>	
	<p>The escort and bed watch budget is managed differently and locally determined. Information regarding escort and bed watch activity and trends must be collated, on a minimum quarterly basis, and discussed as part of clinical governance meetings. Contracts would ordinarily allow for the providers to pay for maximum of two escort staff costs per patient.</p>	
	<p>An escort is the attendance of a patient at A&amp;E in an emergency or for an outpatient appointment or day case surgery / treatment, e.g. radiotherapy, dialysis and transfer of a patient to a secure mental health facility. Bed watch is where a patient is admitted to a hospital bed as an inpatient on a ward for ongoing care and/or clinical monitoring.<sup>16</sup></p>	
	<p>The healthcare provider will adopt a pro-active approach to working with the commissioner to develop innovative alternative solutions to external secondary care services. This would include the following:</p> <ul style="list-style-type: none"> <li>• Effective communication with A&amp;E regarding waiting times to be seen prior to transferring the patient to A&amp;E. For example, should a patient need to go to A&amp;E, this could be arranged on an appointment basis, i.e. if there is a four hour wait in A&amp;E, then three hours of this wait could be completed within the prison, thereby reducing the cost of escorts. The patient would first need to be assessed and triaged within prison healthcare by a clinician.</li> <li>• Arrangements with the local acute hospital to ensure that blood tests can be completed within the prison, e.g. to confirm overdoses. If further treatment is required, bloods are then sent over to the hospital for analysis with the results and further treatment advice (if required) then given via telephone. The patient is then transferred only if further treatment is required. Charcoal should</li> </ul>	

<sup>15</sup> Mental Capacity Act 2005  
[http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga\\_20050009\\_en.pdf](http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf)

<sup>16</sup> PSI Escort and Bedwatch PSI 58/2010



	<p>also be stocked in healthcare to enable administration to the patient in the event of an overdose.</p> <ul style="list-style-type: none"> <li>• Nurse practitioner posts, such as suturing.</li> <li>• Pre-operative and post-operative testing carried out within the prison where appropriate (on a case by case basis).</li> <li>• Consider implementing an 'intermediate care team' to go into the acute hospital to assess patients and facilitate early discharge back to the prison.</li> <li>• Follow up supported by GPs and ANPs working under the consultant's direction, on an agreed shared care management plan.</li> <li>• Effective channels of communication between Healthcare and the hospital.</li> </ul>	
	Proactive management of long-term conditions, including multi-disciplinary team working. Proactive promotion of service and healthcare facilities to secondary care providers and the wider community, to raise awareness of the level of skills and capabilities and also the security procedures required when treating patients.	
	Having a named contact in each secondary care setting with whom to deal with appointments and/or cancellations.	
	Actively scrutinising the number, reason and cost implications of cancellations.	
	Close collaboration with HMPPS to avoid repeated cancellations, e.g. transferred patients never get their appointment, avoid >3 times cancelled.	

<b>Public health</b>		
<b>No.</b>	<b>Standard</b>	<b>Type</b>
	All new receptions to prison establishments should be provided with an 'opt-out' offer for blood-borne virus (BBV) testing, covering Hepatitis B, Hepatitis C and HIV. After reception, detained individuals should be offered repeat screening for sexually transmitted infections (STIs) and BBVs every 12 months or whenever a clinician feels that the individual may have placed themselves at risk. Acceptance of the opt-out offer should be strongly encouraged, and assertively followed up in the case of refusal. After reception, detained individuals should be offered repeat testing every three to six months.	
	The provider will ensure that arrangements are in place to manage the treatment and care of patients with a long-term condition such as HIV.	



	The provider needs to carry out screening for TB at the point of reception, using recognised screening processes recommended by NICE and Public Health England.	
	The provider is required to support the delivery of the full range of public health programmes appropriate to the needs of the prison populations and will provide a localised service using nationally recognised values and behaviours with information flowing between local and national teams contributing to the key outcomes and improvement areas.	
	Where results received from screening indicate further intervention is required, this must be progressed without delay.	
	Diabetic Eye Screening programme (DESP): screening offered to all people aged 12 and over with diabetes. This is at least annual screening; individuals with identified eye disease may require more regular screening or referrals to the hospital eye service for treatment.	
	AAA programme: screening offered to all men who are 65. Men with aneurysm measuring over 3cm will require further screening or treatment dependant on size.	
	Bowel cancer screening programme: screening every two years for all men and women aged 60 to 69; in some areas the programme is being expanded to include people up to the aged of 75 years. The Faecal Immunochemical Test (FIT) test will be proactively sent to eligible patients.	
	Cervical cancer screening programme: screening from the age of 25 years every three to five years dependent on age and history of screening results.	
	Breast cancer screening programme: screening every three years between the ages of 50 and 70 years in females only. This can be extended passed the age of 70 years at the request of women. <sup>17</sup>	
	Antenatal and new-born programme (ANNB): inclusion of antenatal ultrasound screening; antenatal BBV; blood grouping screening; new-born bloodspot; new-born physical; and new-born hearing screening.	
	<b>Vaccination and immunisations</b>	
	All patients are made aware of, and fully understand, the benefits of vaccination.	
	All people in places of detention are offered vaccinations appropriate to their age and need in accordance with the national schedule/programme, specifically covering MMR, meningitis, Hepatitis B (see Sexual health/BBV service section), Hepatitis A, Td/IPV (Tetanus, Diphtheria and Polio) tuberculosis pneumococcal, completion of childhood vaccinations and flu vaccinations. Where evidence of	

<sup>17</sup> There is research currently in place which may lead to the age for breast cancer screening in women to be reduced to 47 years. Should this happen the age range for screening would have to be amended accordingly.

	previous vaccination (e.g. MMR) is not available, this should be offered.	
	An immunisation register is maintained.	
	Vaccination details are recorded in the individual's clinical record (including decline of offer). Data is submitted as per national requirements and uptake rates reviewed and reported to support high levels of compliance.	
	<b>Sexual and reproductive health</b>	
	All new receptions should have their sexual history taken as part of the general health assessment and screening process.	
	The provider is required to align the sexual and reproductive health and chlamydia screening needs of the patient population to the Public Health section 7a specification 29 requirements.	
	All new receptions to places of detention should be provided with an 'opt-out' offer of a test for HIV, Hepatitis B, Hepatitis C, syphilis, chlamydia and gonorrhoea.	
	The provider will work with the chlamydia screening programme in their local area and offer screening according to the needs of the prison populations. The regional sexual health/BBV service will offer assistance and advice when needed / available, though health and justice retain responsibility for ensuring that this is carried out.	
	Identify a named chlamydia lead in each prison to communicate with the local chlamydia screening service.	
	Display the relevant national and local sexual health and chlamydia screening materials.	
	Provide those testing for chlamydia with an information leaflet as part of the consent process.	
	The provider is required to investigate and/or manage patients with symptoms in line with the relevant standards (see: BASHH Standards for the Management of STIs (April 2019) and is responsible for ensuring timely onward referral for those people who they are not able to manage.	
	Be responsible for undertaking a satisfactory system of audit in line with the annual requirements to audit key performance indicators of the programme.	
	Provide information and advice about safer sex practices and, in line with local policies, ensure that condoms and lubricants are available.	
	Provide information about chlamydia and other sexual health promotion including the benefits of testing, specimen collection, management of results and access to free treatment.	
	Refer patients declaring symptoms suggestive of sexual ill health to the prison sexual health clinic.	
	Samples and forms should be collected for analysis in a timely manner, as defined by local operational guidance.	

	Mechanisms must be developed to identify under 25s who are appropriate for offering a chlamydia screen, including repeat offers for those already resident in the prisons.	
	The provider must take into account any request for: <ul style="list-style-type: none"> <li>• the continuation of community-commenced fertility treatment</li> <li>• the commencement of fertility treatment whilst in custody</li> <li>• gamete preservation for those who (for example) may become infertile through cancer treatment.</li> </ul>	
	<b>NHS Health Checks in Prisons Programme</b>	
	All eligible patients aged 35-74 who have not received an NHS Health Check in the last 12 months, will be invited to attend a one. This offer should be made to all those patients who have been sentenced to four years plus and therefore will remain in the secure estate for at least 12 months.	
	NHS Health Checks should be advertised across the establishment, and through different groups and roles, to encourage maximum uptake.	
	Ensure continuity of care from the prison community back to the wider community. Attend release planning multi-disciplinary planning meetings to ensure that secondary care service appointments are confirmed if needed.	
	Information on the checks should be available to the person in advance of their NHS Health Check if required.	
	The provider will ensure that patients presenting for an NHS Health Check are informed about the process of the service and given the opportunity to ask questions. Patients will be asked to agree to the assessment and the communication of results. The results will be communicated to the healthcare team by email. Patients will be asked to agree to the assessment and the communication of results to their GP.	
	The level of risk (high, moderate, low) will be communicated to the patient, and an individually tailored management programme, with appropriate advice, support and interventions depending on the level of risk identified will be agreed.	
	The provider will offer brief healthy lifestyle advice and support to all patients receiving the service to assist them with managing and / or reducing their risk.	
	Patients who are found to be at moderate risk will be offered, where appropriate, interventions such as stop smoking increased exercise or weight management.	
	Patients who are found to be at high risk will be offered, where appropriate, interventions such as stop smoking, exercise or weight management. All patients found to be at high risk will also be referred on to their GP for further investigation and management. In many cases these patients will require pharmacological.	

	interventions and / or an intensive lifestyle programme for impaired glucose tolerance/non-diabetic hyperglycaemia.	
	Where pre-existing disease is suspected or identified the patient will be referred to their GP.	
	The provider will actively involve the patient in agreeing what advice and/or interventions they will follow. Any decisions must be made in partnership with the patient and with their informed consent.	
	<b>Health promotion and prevention</b>	
	All healthcare services within the prisons must work in partnership with the prison to ensure that there is effective coordination a delivery of health promotion activities and interventions. <sup>18</sup>	
	<p>A prison specific health promotion and prevention plan will be developed within six months of the contract commencement. This will be owned and monitored by the Local Delivery Board.</p> <p>This will include but not be limited to the following:</p> <ul style="list-style-type: none"> <li>• Leading prison wide health promotion action group with development and monitoring of a health promotion action plan.</li> <li>• Delivery of health education, promotion and preventative care programmes.</li> <li>• Supporting patient self-care.</li> <li>• Prevention of re-infection (e.g. following successful treatment for Hepatitis C)</li> <li>• Auditing health education and preventative care and formulating an action plan to monitor areas for improving outcomes.</li> <li>• Liaising with voluntary sector organisations to support delivery of health promotion activities.</li> <li>• Training of healthcare peer mentors to support the delivery of consistent health improvement messages, programmes and interventions across the prison. This will include group and individual support.</li> </ul>	
	<b>Smoking cessation</b>	
	The provider will be required to deliver smoking cessation services in order to maintain a smoke free environment. This service must be delivered using a multi-disciplinary approach and will take into consideration age and gender specific needs. The provider will comply with national guidance in relation to smoking cessation. The provider will make available pharmacotherapies that meet the needs of patients.	

<sup>18</sup>People who have heart and kidney conditions that have already been identified are not eligible. Other exclusions apply and for full guidance available on: <https://www.healthcheck.nhs.uk/seecmsfile/?id=553>

## Discharge and release planning

No.	Standard	Type
	The provider must participate in the overall discharge planning for patients being released from the establishment and returning to the community, attending court or being transferred to another establishment.	
	The provider must ensure a robust procedure is in place to identify the patients who are due for release and do not have a current registered GP to attend a release planning appointment to identify the area as to which the patient will be released and to identify through pre-registration an appropriate GP practice.	
	Ensure continuity of care from the prison community back into the wider community, for all healthcare needs. This must include an extensive process of multi-disciplinary planning to enable an effective and functional hand over of the client to community health and criminal justice / supervision systems.	
	Work closely with the prison's relevant teams and staff (e.g. offender management, resettlement services) and CRCs to ensure that the health care element of the patient's discharge plan is included in the patients' resettlement plan where one is in place.	
	Establish a directory of information regarding local resources and foster a good understanding of the local patient care pathways to promote effective referrals.	
	The provider must ensure that appropriate community services are advised of: a patient's release; the care they have received whilst in prison; any ongoing care required; and any medicines administered prior to leaving the prison.	
	Where possible, patient summaries should be sent securely to the patient's community GP on release.	
	Provide advice to the patient on how to manage their healthcare needs on release, including provision of a discharge summary where required. This should include details of NHS 111 (PSO/3100 Continuity of Care).	
	Ensure medication needs are fully included in the discharge planning process. This is particularly important where the patient has a specific medication need (e.g. a specially prepared or difficult to purchase medicine). Patients should be provided with advice regarding local pharmacies. Where appropriate, patient consent should be obtained so that their medicines information can be sent directly to their community pharmacy.	
	Ensure patients have access to relevant and appropriate quantities of discharge medication or FP10s (once implemented). (PSI 53/2010).	
	Ensure that a patient is registered with a GP prior to release as a requirement, along with engaging with local RECONNECT /	

	prison discharge schemes and sharing information to support continuity of care.	
	Ensure the patient is aware of the date, time and place of any community healthcare appointments (PSI 53/2010).	
	Provide information and advice about the full range of contraceptive methods and offer to prescribe a contraceptive substance or appliance prior to discharge. Provide information and advice about how to obtain contraception and emergency contraception following discharge.	
	Where there is not 24 hour healthcare, ensure that the receiving prison is able to safely support the administration of patient specific medication.	
	<b>Joint care planning with other healthcare providers</b>	
	The healthcare provider must ensure that formal arrangements are in place for those with a dual diagnosis and/or complex needs and that the service offers a comprehensive, co-ordinated, and accurate approach to those needs. The healthcare service must ensure that all providers do so in a joined up, holistic manner, that is seamless to the end user.	
	Staff must work within local guidance for the management and disclosure of confidential information about service users, between different agencies and within multi-agency teams. As part of this, they should adhere to statutory and common law frameworks, allied to both government policy and best practice guidance, including, but not limited to the following: <ul style="list-style-type: none"> <li>• Information rights.</li> <li>• Data Protection Act.</li> <li>• Consent and confidentiality.</li> <li>• Using technology and information security.</li> <li>• Rights of access to information.</li> </ul>	
	To support joint working with other partnership services and organisations, when appropriate nursing staff must support and facilitate representatives visiting the prison to continue their supporting role.	

## Prison Service Instructions, Prison Service Orders and prison regime

No.	Standard	Type
	The healthcare service must provide healthcare advice through the formal and informal attendance at management meetings, forums and ad hoc requests.	
	The healthcare provider must fulfil all obligations and responsibilities applying to the application of Prison Service Orders and Instructions (PSOs and PSIs).	

	The healthcare provider must adhere to the requirements of the Mandela rules as they pertain to healthcare. <sup>19</sup>	
	Support and advice must be available to agencies and operational staff to support the health and wellbeing of patients within the context of local and national guidance for the management and disclosure of confidential information.	
	Input from healthcare must be provided in a number of prison operational forums, which include as examples (but not exhaustive list): <ul style="list-style-type: none"> <li>• Daily governors meetings and Senior Management Board/ team forums.</li> <li>• Safer custody/safer prisons meetings and patient reviews.</li> <li>• Public protection meetings.</li> <li>• Good order and discipline reviews.</li> <li>• Attendance at planned control and restraint interventions and incidents.</li> <li>• Preparation of specific reports as required i.e. Death in Custody reports, serious incident reports.</li> <li>• ACCT reviews.</li> <li>• Drugs strategy.</li> </ul>	
	To attend the segregation/care and separation unit to see all patients/detainees and complete a safety algorithm within two hours of the patient's admission (when the healthcare team are on duty).	
	Daily contact with patients/detainees held in segregation/care and separation unit.	
	As required provide constant supervision for patients at risk of harm to themselves where a clinical causation has been determined through a clinical assessment process.	
	When healthcare staff are on site, attend all planned use of force and where possible when unplanned use of force is used. Patients must be seen within 24 hours of force being used. (PSO 1600 Use of Force)	
	Completion of a range of prison health specific administrative activities, including writing medical reports on patients, answering solicitors' letters and complaints, OASYS reports, complete Patient Escort Record (PER) forms.	
	Provide follow up for patients with positive mandatory drug tests results.	
	Provide clinical screening prior to patients being transferred from the establishment.	
	Provide input on the cell share risk assessment on Reception.	

<sup>19</sup> The Mandela Rules revised 17<sup>th</sup> December 2015 outline a number of requirements for the delivery of Healthcare services (Rules 24-35) and Restrictions, discipline and sanctions (Rule 46: 1, 2 and 3)



## Management support and professional leadership

No.	Standard	Type
	The healthcare provider must deliver effective management support and professional leadership to staff. The healthcare manager has day to day operational responsibility for <b>all</b> healthcare services delivered within the establishment.	
	All healthcare staff must have access to appropriate clinical and professional management and supervision.	
	The healthcare provider must ensure that effective management and leadership are reflected in the roles of senior leaders of the service.	
	The healthcare provider must ensure the management, administration and smooth running of all healthcare services and healthcare centre.	
	Ensure all clinic rooms are properly equipped and equipment is fit for purpose and appropriately maintained in liaison with providers and in line with local protocol and statutory requirements. Any facility issues must be escalated to the establishment facilities manager in HMPPS.	
	Ensure working practice within the framework of local, national and best practice guidance on infection prevention control.	
	Ensure patients are informed about service available, waiting times etc in a suitable format.	
	Ensure patient engagement and consultation activities are undertaken.	



## Appendix 4 – Safeguarding

The provider must ensure they have up to date organisational safeguarding policies and procedures for children and adults and robust governance arrangements in place for safeguarding in line with the local authority and the prison's safeguarding policies and procedures. They must work with prison partners to ensure there are strong links between the establishments and local safeguarding boards.

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 multi-agency safeguarding processes.

The safeguarding policy must also detail: safeguarding responsibilities and accountabilities within the service; whistle blowing procedures; safe recruitment; safe working practices; induction and training; complaints procedures; confidentiality and information sharing.

Staff must have access to these policies and procedures at all times and practice in accordance with these policies.

There must be a named designated healthcare lead within each prison to champion the importance of safeguarding. These representatives must link in with the individual prison safeguarding managers and attend and contribute to any safeguarding case conferences/protection meetings within the prison and/or the relevant local authority.

There must be an effective system for identifying, recording, analysing and referring any safeguarding concerns, including potential neglect. Patterns and trends must be identified through governance arrangements including risk management systems, patient safety systems, complaints and human resources functions and referred appropriately according to multi-agency safeguarding procedures.

The provider must:

- review the effectiveness of its safeguarding policies, procedures and arrangements on an annual basis
- provide assurance through an annual safeguarding report to the Local Health Delivery Board and the commissioner
- implement robust quality assurance programmes to ensure that safeguarding systems and processes are working effectively
- consider and implement the recommendations of any Serious Case Review and devise an action plan to ensure that any learning is implemented and shared

- consider and implement the recommendations of any Serious Case Review and devise an action plan to ensure that any learning is implemented and shared.

All safeguarding concerns relating to a member of staff (including staff on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees) must be effectively investigated and referred appropriately according to local multi-agency safeguarding procedures. Disciplinary processes must be concluded irrespective of a person's resignation, and 'compromise agreements' must not be allowed in safeguarding cases.

### **Staff training**

All staff must undertake safeguarding training appropriate to their role and level of responsibility. All new staff must undertake safeguarding training during their induction. The training needs analysis and training plan will determine which groups of staff require further safeguarding training, how often and at what level for both safeguarding children and adults.

Safeguarding training should include how to recognise and respond to abuse, how to report concerns, the principles of the Mental Capacity Act and consent legislation.

All staff must be confident to report any suspicions of abusive practice, without fear that they will suffer as a result and are aware of their rights under the Public Interest Disclosure Act.

All staff must be aware of and fully comply with guidance in the documents:

- 'Working Together to Safeguard Children' (DfE, 2013)
- 'Safeguarding Adults: The Role of Health Service Practitioners' (DoH, 2011)
- PSI 15/2015 – Safeguarding.

### **Safeguarding vulnerable adults**

To promote the safety and protection of vulnerable adults, staff should:

- be aware that vulnerable adults may encounter abuse
- take reasonable steps to protect vulnerable adults
- identify vulnerable adults within the service
- report any concerns or risks to a vulnerable adult
- be alert to the risks that known abusers may pose to vulnerable adults
- ensure they are fully aware of the policy in relation to protecting vulnerable adults
- work in cooperation with all agencies involved in any investigation
- be aware of the referral procedures and refer as appropriate

Plans must be in place from any Serious Case Reviews that are on-going or completed and implementation is monitored with a robust process to share lessons learnt.

## **Safeguarding children**

The provider must ensure that policies and procedures include the safeguarding and promotion of the welfare of children of patients in their care and there is a process in place to report concerns, actual abuse or neglect of a child.

The provider will ensure that all staff:

- understand risk factors in relation to safeguarding children and recognise children in need of support and/or safeguarding
- recognise the needs of parents who may need extra help in bringing up their children and know where to refer for help
- recognise the risks of abuse to an unborn child
- contribute to child protection conferences, family group conferences and strategy discussions
- help ensure that children who have been abused and parents under stress (e.g. those who have mental health problems) have access to services to support them
- as part of generally safeguarding children and young people, provide on-going promotional and preventative support, through proactive work with parents and expectant parents
- are alert to the risks that individual abusers, or potential abusers may pose to children
- contribute to whatever actions are needed to safeguard and promote the child's welfare.

## **Prevent**

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 patients 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 states the health sector needs 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 detention centre director/establishment pathfinder lead.

## **Appendix 5 – Information governance, data protection, security and confidentiality**

The provider will ensure that they are fully compliant with the standards set out in the Data Security Protection Toolkit. This includes arrangements to ensure that personal identifiable information or information of a confidential nature is treated as such, including patients' records, and shall not be divulged to any unauthorised person. Evidence for the Data Security Protection Toolkit must be supplied and submitted as required by the predetermined submission dates to NHS Digital and submissions must be available for external audit.

The provider will ensure that relevant legislation concerning confidentiality, data protection and freedom of information are complied with, along with compliance with Caldicott principles.

The provider will ensure the co-ordination of IT, data collection and quality assurance process to allow for timely and comprehensive reporting to the commissioner on agreed service parameters, HJIPs and external health and social care needs assessments.

### **Compliance**

The provider will adhere to all appropriate governance and security for the IM&T systems and paper records to safeguard person identifiable information as determined by the commissioner and the prison establishments including appropriate security measures and access controls. This includes adherence to relevant PSO and PSIs.

The provider will demonstrate compliance with the Data Security Protection Toolkit Standards for prisons, working towards a minimum of 'satisfactory' compliance in all requirements and will co-operate fully with the commissioner in any submissions.

The provider will provide evidence of any registration under ISO.IEC 27002 -2005; ISO 27001 – 2005 and BS7799-2 or other appropriate information security standards.

### **Legislation and guidance**

The provider will adhere to all statutory obligations for the management of information and the operation of IM&T within the NHS, including, but not exclusively:

- Common law duty of confidence
- Code of Practice on Confidential Information 2014
- Confidentiality Guidance for Doctors GMC 2009
- Confidentiality and Disclosure of Information BMA 2008
- Code of Professional Conduct NMC 2004
- Caldicott Report 1997 and Caldicott 2
- Information – To Share or not to Share? The Information Governance Review 2013
- National Data Guardian for Health and Care Review of Data Security,

Consent and Opt-Outs 2016 Data Protection Act 1998 European Directive 1995/46C

- Access to Health Records Act 1990
- Freedom of Information Act 2000
- Environmental Information Regulations 2004
- European Directive 2003/4 EC
- Computer Misuse Act 1990
- Mental Capacity Act 2005 and Code of Practice 2007
- Human Rights Act 1998
- Health and Social Care Act 2015
- Health and Social Care Act 2008
- Health and Social Care Act 2001
- NHS Act 2006
- Crime and Disorder Act 1998
- Regulatory and Investigatory Powers Act 2000
- Records Management Code of Practice for Health and Social Care 2016
- Public Records Act 1958 <sup>[L]</sup><sub>SEP.</sub>

In addition to the statutory requirements the provider must meet prevailing national standards and follow appropriate NHS good practice guidelines for information governance and security, including, but not exclusively the following:

- Use of the Caldicott principles and guidelines
- Appointment of a Caldicott Guardian
- Policies on security and confidentiality of patient information
- Records Management Policies and procedures
- Achievement of the data accreditation requirements
- Governance arrangements in line with the NHS Information Governance Toolkit
- Risk and incident management system
- Encryption standards in line with guidance from NHS Digital (formerly Health and Social Care Information Centre)
- For the avoidance of doubt, obligations apply in respect of information held in all formats including electronically and manually.

### **Data protection**

The provider shall maintain the confidentiality of personal data entrusted to it in accordance with the provisions of the Data Protection Act 2018 (DPA), General Data Protection Regulation 2018 (GDPR) and any other relevant legislation.

The provider shall comply with the six principles of the Data Protection Act 2018 (the 2018 Act) and in particular the provider agrees to comply with the obligations placed on the commissioner by the data protection principles as set out in the 2018 Act, namely:

- To maintain technical and organisational security measures sufficient to comply at least with the obligations imposed on the commissioner.
- Only to process personal data for and on behalf of the commissioner, in accordance with the instructions of the commissioner and for the purpose of

performing the services in accordance with this Agreement and to ensure compliance with the 2018 Act.

- To allow the commissioner to audit the provider's compliance with the requirements of this Clause on reasonable notice and/or to provide the commissioner with evidence of its compliance with the obligations set out in this Clause. Both Parties agree to use all reasonable efforts to assist each other to comply with 2018Act. For the avoidance of doubt, this includes the provider providing the commissioner with reasonable assistance in complying with subject rights requests, (including rights to be forgotten, right to amend etc) served on the commissioner under Schedule 9 and 10 of the 2018 Act and the provider consulting with the commissioner prior to the disclosure by the provider of any personal data in relation to such requests. [SEP]The provider will be registered for Data Protection with the Information Commissioner for all appropriate categories of processing of personal data. There is a statutory obligation to protect person identifiable data against potential breach of confidence when processing or sharing with organisations outside of the United Kingdom. No information under this contract should be processed outside of the UK without the prior written consent of the commissioner.
- The provider should be a signatory to a local ISP developed by the local commissioner for all partnerships relevant to the establishment(s) concerned.

### **Clinical information systems**

To ensure the quality and safety of patient care, the IM&T systems must also support the following:

- Maintenance of individual electronic patient health records within an audit function to control access in line with Registration Authority guidance.
- Inter-communication or integration between clinical and administrative systems for use of patient demographics.
- Access to knowledge bases for healthcare, such as Map of Medicine, at the point of patient contact.
- Access to research papers, reviews, guidelines and protocols.
- Communication with patients, including seldom heard groups, such as service users with mental health problems, learning disability problems, hard of hearing and detainees to support the provision of quality care, including printed materials.
- Agreed arrangements and time scales for multi-agency audit of clinical record keeping including data quality.

### **Clinical records management**

The provider will at its own cost retain and maintain all the clinical records in accordance with:

- good practice
- the requirements of the contract (IM&T Schedule). The provider will at its own costs retain and maintain all the clinical records in chronological order and in a form that is capable of audit. Clinical records shall be retained and maintained in electronic form in accordance with the contract (IM&T schedule). The provider will ensure that all staff are trained and understand their responsibilities and legal obligations in relation to person identifiable

records. The provider will be expected to ensure that all records follow the principles of confidentiality and are in line with legislation and professional codes of practice. Clinical records will include as a minimum:

- A full account of the assessment.
  - Relevant information about the patient's condition at any time.
  - The measures taken to respond to the needs of the patient.
  - Evidence that the duty of care has been understood and honoured.
  - A record of arrangements for continuing care (care plan).
- recovery and discharge plans including integration with resettlement.

NHS standard contract SC23 requires:

- The Provider must create and maintain Service User Health Records as appropriate for all Service Users. The Provider must securely store, retain and destroy those records in accordance with Data Guidance, Information Governance Alliance Guidance and in any event in accordance with Data Protection Legislation.
- At a Commissioner's reasonable request, the Provider must promptly deliver to any third-party provider of healthcare or social care services nominated by that Commissioner a copy (or, at any time following the expiry or termination of this Contract, the original) of the Service User Health Record held by the Provider for any Service User for whom that Commissioner is responsible. Note this includes a request after termination/expiry of the contract.
- The Provider must give each Service User full and accurate information regarding their treatment and must evidence that in writing in the relevant Service User Health Record.

## Consent

The provider is expected to operate a patient consent policy, having regard to the Department of Health Reference Guide to Consent for Examination or Treatment<sup>20</sup>; Health Service Circular HSC 2001/023<sup>21</sup> and the Good Practice in Consent Implementation Guide – Consent for Examination or Treatment<sup>22</sup>, or to any amendment or reissue of them from time to time. Difficult situations can arise for healthcare professionals within prisons where concerns about an individual's capacity to consent are compounded by serious mental health issues and behaviour likely to result in self-harm. In such situations, the provider will have in place robust procedures in-line with the Mental Health Act Guidance 2007, which enables extremely careful handling, and which contains guidance provided by the appropriate

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<sup>20</sup>

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/138296/dh\\_103653\\_1\\_.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653_1_.pdf)

<sup>21</sup>

[https://webarchive.nationalarchives.gov.uk/20121105174045/http://www.dh.gov.uk/en/PublicationsAndStatistics/LettersAndCirculars/HealthServiceCirculars/DH\\_4003736](https://webarchive.nationalarchives.gov.uk/20121105174045/http://www.dh.gov.uk/en/PublicationsAndStatistics/LettersAndCirculars/HealthServiceCirculars/DH_4003736)

<sup>22</sup> [Good Practice in Consent Implementation Guide – Consent for Examination or Treatment](#)

department of health on seeking consent. All actions taken in these circumstances should be fully documented.

The provider will follow the requirements of and procedures within PSI 64/2011(updated) 'Management of patients at risk of harm to self, to others and from others (Safer Custody)' and will share relevant information appropriately with all those managing such patients.

### **General contractual confidentiality**

Subject always to the obligations of the Parties under statute or common law, in respect of Confidential Information it may receive from the other Party (the 'Discloser'), each Party (the 'Recipient') undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that the Recipient shall not be prevented from using any general knowledge, experience or skills which are in its possession prior to the commencement of this Agreement.

The provisions of this Clause shall not apply to any Confidential Information which is:

- in or enters the public domain other than by breach of this Agreement or other act or omission of the Recipient
- obtained from a third party who is lawfully authorised to disclose such information
- authorised for release by the prior written consent of the Discloser
- identified as no longer needing to be regarded as confidential in accordance with any relevant timescale relating to that class of information. [SEP]

Nothing in this Clause shall prevent the Recipient from disclosing Confidential Information where it is required to do so by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable law or, where the provider is the Recipient, to the provider's immediate or ultimate Holding Company provided that the provider procures that such Holding Company complies with this Clause as if any reference to the provider in this Clause were a reference to such Holding Company. [SEP] The Receiving Party shall indemnify the Disclosing Party and shall keep the Disclosing Party indemnified against Losses and Indirect Losses suffered or incurred by the Disclosing Party as a result of any breach of this clause. [SEP] The Parties acknowledge that damages would not be an adequate remedy for any breach of this clause 16 (Confidential Information) by the Receiving Party, and in addition to any right to damages the Disclosing Party shall be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this clause.

The provisions of this Clause shall continue following termination of this Agreement for any reason whatsoever and without limit in time.

### **Freedom of Information Act 2000 and Environmental Information Regulations 2004**

The commissioner is a public authority for the purposes of the regulation and guidance and cannot contract for services in a manner which prevents it complying with its obligations. The commissioner also recognises the special circumstances



and security issues arising from requests for information relating to offender establishments and would work with the Ministry of Justice where any conflict arises.

The provider will ensure that all applications for Freedom of Information will come through the commissioner or the respective Prison.

The provider will acknowledge the requirements of the Freedom of Information Act 2000 and the Environmental Information Regulations 2004 and shall assist and cooperate with the commissioner and/or the respective prison(s) (at their own expense) to enable them to comply with these information disclosure requests.

The provider will notify the commissioner and/or the governing governor receiving a request through Freedom of Information and shall where possible and appropriate:

- Transfer the request for information to the commissioner and/or the respective prison(s) as soon as possible after receipt and in any event within two working days of receiving a request for information.
- Provide the commissioner and/or the respective prison(s) with a copy of all information in its possession or power in the form that the commissioner and/or the respective prison(s) requires within five working days (or such other reasonable period as the commissioner may specify) of the commissioner requesting that information.
- Provide all necessary assistance as reasonably requested by the commissioner to enable the commissioner to respond to a request for information within the time for compliance as set out in the legislation and regulations. <sup>[1]</sup><sub>SEP</sub> If the provider determines that information (including confidential information must be disclosed), it shall liaise with the commissioner and the respective prison(s) before this is approved. <sup>[1]</sup><sub>SEP</sub> Public authorities who hold information (including the commissioner) shall be responsible for determining at its absolute discretion whether:
  - The information is exempt from disclosure under the Freedom of Information Act 2000 or is covered by an exception under Environmental Information Regulations 2004.
  - The information is to be disclosed in response to a request for information.

The provider will acknowledge that the commissioner and/or the respective prison(s) may, acting in accordance with the Department of Constitutional Affairs' Code of Practice on the Discharge of Functions of Public Authorities under Part 1 of the Freedom of Information Act 2000, be obliged under the Freedom of Information Act 2000 to disclose information without consulting with the provider, or following consultation with the provider and having taken their views into account. The Freedom of Information Act 2000 provides an exemption for information covered by the Environmental Information Regulations 2004 and information within that category will be considered under that guidance.

The provider will acknowledge that any lists or schedules provided by it outlining confidential information are of indicative value only and that the commissioner and/or the respective prison(s) may nevertheless be obliged to disclose confidential information.

## Appendix 6 – Information management and technology

The provider must have in place appropriate, secure and well managed IM&T systems, which properly support the efficient delivery of all healthcare services and which either includes or links with dental and mental health. These must comply with specific requirements and the underpinning standards and technical specifications. This includes the following services:

- Direct access IT links to pathology laboratories for the requesting and reporting of pathology results (such as ICE).
- National systems implementation – programme management support by planning the delivery of national clinical IT system (new or upgrades), implementation, training and business change for optimal use of IT to improve health and justice services.
- IT maintenance and local service desk - providing local service desk and technical support services to ensure continued availability of all hardware and software.
- Networking - enabling infrastructure through a local area network as required, connecting to HSCN.
- GMS Registration and GP2GP Transfers: The process by which a patient can register with the healthcare department at their place of detention, which then allows their entire community medical record to transfer across electronically from community to secure site (called GP2GP transfers). Completion date estimated 2021.
- Hardware management - ensuring all hardware is up-to-date and serviceable including the operation of replacement and disposal programmes.
- Registration Authority - administration of appropriate access to clinical systems.
- Clinical safety and assurance - to assure safe use and deployment of clinical systems (adherence to Information Standards Notices).

The provider shall deliver a level of service equivalent to that delivered by an NHS commissioning support unit (CSU) in line with the required outcomes as listed below:

### Required outcomes

Efficient and effective management of:

- the commissioner mandated system and national mandated IT systems
- internal networks E-mail services and systems
- external relations with the Health and Social Care Network
- NHSE/I patient and information directorate
- Any other service provider.

The provision of technical liaison with internet site host providers and telecommunications service providers:

- The efficient and effective acquisition and installation of all software and hardware, appropriate technical support day to day across all relevant healthcare centres.

- The continued maintenance of the current IT equipment and when required the deployment of software upgrades and training.
- Establish and maintain a regional wide IM&T disaster recovery policy and procedure, ensuring appropriate back-up systems are maintained on a daily basis.
- Manage all hardware to achieve optimal performance.
- Set up IT systems for all new recruits and provide an introductory overview of the data protection, information governance and NHS information standards.
- Manage the secure connection to the NHS net account in collaboration with the appropriate authorities.
- Ensure all staff (including sub-contractors) have an NHS net account which is used for all confidential communication.
- Deploy and maintain an agreed security access control system, ensuring that all new recruits are provided with appropriate training.
- Manage the decision-making, acquisition and implementation process for all new hardware and software.
- Manage the day to day technical relationship with any outside IT staff or contractors, telecommunication service providers, building management maintenance contractors and other facilities contractors, as required.
- Maintain an asset register of all hardware and ensure security tagging has been set up on all the hardware.
- Maintain a software license register.
- Upgrade and implement new IT system following technological advancement, ensuring implementation is within Health and Social Care Network guidelines and any in-house security systems.
- Support the development and establishment of internal management information and records management systems including document management, liaising with external consultants as required.
- The provider will ensure that home-based staff have access to relevant IT systems to ensure continuity of service.
- The provider must register details of their helpdesk with the commissioner for visibility and future planning of updates.
- The commissioner will guide the provider in obtaining access to NHS systems and services such as NHS Mail, HSCN, Spine services, clinical systems, but the provider will bear any charges for the use of these systems and services. The provider will be responsible for meeting any compliance requirements in setting up this access.
- The provider is expected to explore and innovate the use of technologies to improve health information.
- The IM&T systems that are part of the national provision include (not all the following are currently available in the prison IM&T environment):
  - **E-referral:** use of the Directly Bookable Service (DBS) for all patient referrals into secondary care.
  - **Health and Social Care Network (HSCN):** use of the national network for all external system connections to enable communication and facilitate the flow of patient information.

- **Summary Care Record (SCR) service:** use of the SCR to view recent medication and key safety information.
- **NHS Care Records Service (CRS):** use of CRS to ensure that all patient records are kept in the national compatible format and when available to communicate with the national spine services.
- **Electronic Transfer of Prescriptions (ETP):** use of the electronic prescribing service for supply, administration and recording of medications prescribed and transmission to the Prescription Pricing Division (PPD).
- **Patient Demographic Service (PDS):** use of the PDS to obtain and verify NHS numbers for patients and ensure their use in all clinical correspondence (both electronic and paper based).
- **NHSMail:** use of the NHSMail email service for all email communications concerning patient-identifiable information.
- **Calculating Quality Reporting System (CQRS):** use of CQRS to demonstrate performance against QOF achievement targets to support quality improvements in services provided to patients. Or Quality Management and Analysis System (**QMAS**): use of QMAS to demonstrate performance against QOF achievement targets to support quality improvements in services provided to patients.

### **Maintenance and support**

The provider will be responsible for ensuring that adequate and appropriate maintenance and support services and service level agreements are available and in place for all systems, infrastructure, hardware and software used in the delivery of the IM&T services, including but not limited to the following:

- Service/Helpdesk – provide the single access point for all ICT related issue and problem resolution.
- Desktop services – provide second level desktop services, including on-site support.
- Infrastructure services – provide third level support for network, server and infrastructure, including security.

The provider will also be responsible for obtaining, installing and maintaining software that is required to enable the core clinical systems to function and that is required for the provision of contracted services; this includes software updates, licencing and on-going training requirements.

Other healthcare providers subcontracted or otherwise authorised by the prison community care service provider or the commissioner (e.g. the dental and mental health service providers) may use the computers and network in order to provide services commissioned from the prison community care service provider with the consent of the commissioner, or services commissioned directly by the commissioner. This will be dependent on assurances being received from the prison community care services provider in respect of compliance with the contents of this document.

## **Management of clinical information**

All secure setting Healthcare services will use the national prison IT solution provided (HJIS) as the primary clinical record for the patient.

Adequate and appropriate information must be recorded onto the national IT solution to enable continuity of treatment and care. This will include assessment, diagnosis, treatment, prescriptions and any on-going healthcare needs, using nationally approved clinical templates where available.

All clinicians are expected to comply with good record keeping practice, as defined by their professional body and the provider must undertake regular record keeping audits, the results of which must be shared in writing with the commissioner, within agreed timescales. The provider must adhere to standard record keeping practices mandated by NHSE/I, including the use of standard templates where appropriate (national clinical templates are currently being developed).

Clinicians are permitted, in certain circumstances, to maintain their own patient records, (paper or electronic) supplementary to the primary patient clinical record, e.g. when making arrangements for continuity of care from alternative offices or where the ordering of patient apparatus is required off site. The provider must request written permission from the commissioner, in advance of all instances where additional clinical records will be used and assure all relevant policies regarding patient records are strictly adhered to. The provider will be required to demonstrate that any additional patient records are being transported and maintained securely, and in accordance with their policies and procedures. NHSE/I will not be liable for any losses or breaches occurring under these circumstances.

The provider must receive copies of, and approve, the protocols and policies that the clinician will be following in order to transport and maintain patient records safely. Patient records must not contain easily identifiable patient information and must not record any patient's offence.

Patient medical records will be available to all appropriate medical staff involved in the care of an individual within the boundaries of confidentiality. Information sharing protocols are to be agreed and signed off with the establishment operator.

Patients will be granted access to their medical records, upon request, in line with current NHS and prison service guidelines.

Patient medical records should not be destroyed under any circumstances and retention of records must comply with all current NHS guidance on the retention of records.

Paper patient medical records, where they exist, must not be removed from the establishment unless required by the courts or through an agreed archiving schedule.

Internet access will be available within the establishment to Healthcare Service Providers and sub-contractors. The provider is required to ensure all their employee's sub-contractors and other healthcare providers sign an 'internet access' agreement.

The provider will indemnify NHSE/I against any loss arising under the Data Protection Act 1998 caused by any action, authorised or unauthorised, taken by themselves, their employees, or sub-contractors.

All employees or sub-contractors involved in the delivery of services will be required to agree and sign a confidentiality statement should they require access to confidential personal and/or business information.

Please also refer to PSI25/2002 – The Protection and Use of Confidential Information in Prisons and Inter Agency Information Sharing.

### **Use of HJIS**

Effective use of SNOWMED +/- READ Codes will ensure the following:

- All tasks have a specific type and are managed effectively.
- A standard Read Code Formulary to be used regionally and locally.
- One overarching template linked to all other templates to indicate to clinicians and administrators the relevant templates to be completed. This process should be validated by the regional change control team.
- Adoption of national agreed clinical templates.
- Use of caseloads in place of waiting lists to minimise the potential of patients being deleted off waiting lists.
- Medicine use reviews carried out using a task template on HJIS.
- Processing and triaging all incoming correspondence ensuring there is an electronic audit trail.

### **General system characteristics**

The IM&T systems must in general support:

- management of all clinical services including ordering and receipt of pathology, radiology and other diagnostic procedure results and reports
- prescribing and where appropriate dispensing and medication administration
- maintenance of individual electronic patient health records
- inter-communication or integration between clinical and administrative systems for use of patient demographics
- access to research papers, reviews, guidelines and protocols
- communication with patients, including seldom heard groups to support the provision of quality care, including printed materials, telephone, text messaging, website, and email.

Clinical systems in addition to those specified by the health and justice programme may be used to provide contracted services with the written agreement of the commissioner.

Any such IM&T systems must comply with the following standards as appropriate to the services commissioned from the provider:

- NHS Terminology Service (NHS TS), NHS Classifications Service (NHS CS) and Healthcare Resource Groupings (HRG).
- new general medical services (nGMS) contract.

The provider's IM&T systems must be effective for referrals and bookings, including appointment booking, scheduling, tracking, management and the onward referral of patients for further specialised care provided by the NHS, independent sector or social care and must be compliant with e-referral requirements. This may require the provider to obtain, install and maintain systems other than the core clinical system and to enter into agreements with systems suppliers or their agents. These arrangements will be subject to approval by the commissioner and systems and services will need to comply with the requirements in this section.

The provider must comply with the NHS TS, NHS CS and HRG, including:

- Read Codes and migrate to SNOMED CT (UK Edition) when available.
- NHS Dictionary of Medicines and Devices.
- Office of Population Census and Surveys (OPCS) version 4.3.
- National Intervention Classification Service (NIC).
- International Classification of Disease (ICD) version 10.
- Healthcare Resource Groupings (HRG) version 4.

### **IM&T support and management**

The provider will be responsible for IM&T support and management which will include:

- backup of all data in a manner so that it can be retrieved easily and economically
- supply and regular updates of virus protection software for each server and workstation such that all data exchanged from or via the IM&T systems are subject to regular virus checking procedures
- prompt handling of system configuration changes required by the arrival, change and departure of staff including user account maintenance.

The provider shall provide the IM&T services to their users in accordance with, amongst other requirements:

- Good industry practice.
- All applicable laws (including, but not limited to, the Computer Misuse Act 1990, the Copyright Designs and Patents Act 1988, the Regulation of Investigatory Powers Act 2000, Data Protection legislation and the Freedom of Information Act 2000).
- Any reasonable policies or directions of the commissioner notified to the provider from time to time.
- The common law duty of confidence.
- Access to Health and Records Act 1990.
- Health and Social Care Act 2001.

The provider shall provide the commissioner with reasonable access to the premises from which the IM&T services are provided in order to carry out an IM&T audit.

An IM&T audit is any audit or inspection carried out so as to:

- ascertain that the information which has been provided to the commissioner or other bodies as required by this agreement in respect of IM&T services is accurate; and/or
- determine whether the provider has complied with its obligations in respect of IM&T services.

The provider shall comply with any audit recommendations arising from an IM&T Audit and establish an effective issue tracking process to ensure that recommendations are implemented in accordance with agreed timescales.

### **Intellectual property rights**

Any data relating to patients that is created by the provider as part of providing the service remains the intellectual property of the commissioner. The provider must provide access to this data:

- As part of regular performance reporting.
- By electronic link to the commissioners' data warehouse when this is implemented and in electronic form when requested in the meantime.
- As part of a handover to another provider at the end of the agreement term (see also section exit plan).

Patient information, system documentation, templates, standard reports and all other configured items will remain the property of the commissioner whether created by the provider or not.

This excludes financial data that is used by the supplier as part of their continuing operations.

### **Surveys**

The provider shall cooperate with the commissioner in respect of the intermittent collection of data or information for the purposes of sharing and spreading best practice through the NHS ('Surveys'). Such data collection may include but not be limited to:

- collecting information on subjective patient health outcomes
- collecting information to allow benchmarks to be developed against which to judge the productivity of primary medical care providers (and other NHS providers)
- distributing and collecting NHS standardised patient questionnaires
- administering such data collection through existing systems or by distribution and collection of questionnaires.

The commissioner shall own the intellectual property rights in any data, information or results collected as a result of surveys. The provider shall provide any information relating to the services or to patients that the commissioner reasonably requires in a form reasonably required by the commissioner from time to time.

### **Disaster recovery**

The provider must have an IM&T systems disaster recovery plan to ensure service continuity and prompt restoration of all IM&T systems in the event of major systems



disruption or disaster. There should be evidence of testing of this continuity plan at regular intervals throughout the life of the contract.

## Appendix 7 – Pharmacy and medicines optimisation

Pharmacy services and the optimisation of medicines within care pathways delivered by health and justice primary care providers are commissioned such that they:

- ensure patients get access to and a choice of the most effective treatments, and the outcomes that matter to them
- improve the quality (safety, clinical effectiveness, patient experience) of prescribing and medicines use
- make how we purchase and supply medicines more efficient, while ensuring the NHS retains its position as a world-leader in medicines
- provide clinical pharmacy services within health and justice services that deliver the services and pharmacy workforce expectations described in the Long Term Plan
- require continuity of care processes to be completed in line with national guidance in a timely manner.

### Pharmacy service and medicines outcomes

- Patients have prompt access to medication in accordance with clinical need via prescribing, pharmacy dispensing services, medicines packaging and access to pharmacy staff that aligns with services they would receive in community pharmacies.
- Systems enable the safe use and handling of medicines accessed by patients.
- A model of community pharmacy is provided with additional on-site clinical pharmacy services that support both patients and staff in optimising medicines. This includes arranging provision of a pharmaceutical supply service for the prison. For reception prisons this should be an on-site pharmacy. This cannot be successfully implemented without arrangements in place with HMPPS.
- Outcomes are underpinned by an on-site pharmacy workforce who are fully integrated into the healthcare team, provide services to patients that enable medicines optimisation and who are led by a senior pharmaceutical adviser or chief pharmacist.

### Prison medicines and pharmacy standards

The provider should consider this specification and deliver the service in line with the Royal Pharmaceutical Society's (RPS) Professional Standards for Optimising Medicines for people in Secure Environments<sup>23</sup>. This provides detailed information about medicines handling and optimisation in prisons and should be read alongside the RPS Safe and Secure Handling of Medicines 2018<sup>24</sup>, NICE guidance<sup>25</sup>, RCGP Safer Prescribing in Prisons 2019<sup>26</sup> and other national clinical guidelines, and GPhC

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<sup>23</sup> <https://www.rpharms.com/recognition/setting-professional-standards/optimising-medicines-in-secure-environments>

<sup>24</sup> <https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines>

<sup>25</sup> <https://www.nice.org.uk/guidance/ng5/evidence/full-guideline-6775454>

<sup>26</sup> <https://www.rcgp.org.uk/-/media/Files/Policy/2019/RCGP-safer-prescribing-in-prisons-guidance-jan-2019.ashx?la=en>

and NHSE/I standards for the provision of pharmacy services from a registered pharmacy.

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.

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

### **Prison pharmacy services and connecting with pharmacy services in integrated care systems and primary care networks**

The NHS Long Term Plan described the development of Integrated Care Systems (ICSs) and local Primary Care Networks (PCNs). In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. Within each ICS there will be local PCNs that serve between 30,000 and 50,000 people. The developments in pharmacy services within the ICS areas and PCNs within them include:

- clinical directors of pharmacy and medicines for each ICS
- clinical pharmacists within PCNs that can provide medication reviews and support for complex patients
- new services being delivered by community pharmacies such as medicines reconciliation- which could support released detainees who take high risk medicines or have complex medicines needs.

Collaboration and integration of the health and justice healthcare and pharmacy teams with pharmacy services in the new networks is essential. This is the case even if detained people are not being released into the local PCN. The reason for this is that providers can use their local PCN network to inform pharmacy leads in the community about the needs of people within the criminal justice pathway. This will develop blueprints to enable all PCNs to support all detained people and health and justice providers across England with continuity of and sustained outcomes from medicines.

To enable the access to pharmacy services within the ICS and PCN which a detained person is admitted from or released into, the provider will need to ensure that:

- the health and justice service provision and pharmacy team form part of ICS and PCN pharmacy networks within which the HJ site is located

- PCN pharmacy teams are used to support medicines reconciliation and information is shared to support safe medicines continuity for people admitted into custody
- there is collaboration with ICS clinical directors of pharmacy and medicines, community pharmacy network leads and local PCN pharmacists to agree pathways for referral of released detainees for clinical pharmacy services in the community.

### **Definitions**

The **provider** is the primary healthcare service provider who is responsible for the optimisation and safety of medicines use in the establishment.

The **pharmacy service provider** must provide a pharmaceutical supply services including:

- dispensing of individually named prescriptions issued at the prison
- supply of bulk stock of medicines via a wholesaler (if this stock is not procured directly by the provider) if the pharmacy service provider has a wholesale dealer licence and Home Office Controlled Drug supply licence.

**Pharmacy team:** This is the **on-site pharmacy team** delivering a medicines optimisation and governance service for the provider working within prisons.

### **Aims and objectives of the pharmacy service and medicines optimisation services**

The pharmacy and medicines optimisation service will be primarily concerned with patients and their safe and effective treatment with medicines, from prescribing, supporting delivery of medicines reconciliation, getting access to a legal/prompt supply, to giving it to the person and disposing of un-used/expired medicines. All services must comply with statutory requirements, prison rules and standing orders, prison service healthcare standards and professional and ethical codes/standards of practice.

The pharmacy service supplying, and dispensing medicines will be delivered by a pharmacy subcontracted by or delivered directly by the provider. This dispensing pharmacy will deliver a full pharmaceutical service to the prison providing all essential services as detailed under the national pharmacy contract, undertaking services that optimise medicine use, and offering pharmaceutical products, in usual packaging provided to community patients, information and advice to agreed consistent standards of quality within agreed budgets and defined areas. The pharmacy will comply with GPhC and professional standards whether the pharmacy is registered with the GPhC or not. Registration of the pharmacy with the GPhC may be required and should be confirmed by the provider.

Within the service provision, the provider will ensure pharmacy and medicines optimisation form a key part of the healthcare service. A senior pharmacist, directly commissioned or employed by the provider, leads on the pharmaceutical elements of prisons healthcare, including the provision of information and advice, medicines management and the development of integrated advanced and locally developed services for patients. Pharmacy technicians will be expected to be active in a multi-

disciplinary approach to delivering medicines optimisation including administering medications to patients and delivering locally developed services

In providing a full medicines optimisation service to patients, the provider will be responsible for the following:

- The provision of information and advice on medicine budgets and comparative costs, to ensure the rational and economic use of medicines.
- Establishing effective communication with patients and access to a pharmacist, either directly or through healthcare staff, concerning medicines optimisation, in particular by ensuring that those who have in-possession medication have sufficient understanding of how, when and why it is taken.
- Assuring all healthcare staff of the quality, safety and efficiency of pharmaceutical products, delivery systems and the medicines optimisation service as a whole.
- Delivering on-site support to the healthcare team and patients that is equivalent to the clinical pharmacy in GP practice service available in the community and described within the Long Term Plan.
- Contributing to and implementing actions arising from provider clinical governance and medicines management committees, regional NHS medicines management committee (RMOC) and health improvement plans.
- Liaising with the security department within the prisons on all aspects of security concerning pharmaceutical products.
- Working closely with the HMPPS to ensure the pharmacy service, equipment and stock is managed safely and securely and with consideration to wider regime constraints.
- Working with the pharmacy service provider to ensure the pharmaceutical supply service is meeting the needs of the provider and patients and is in line with the NHSE/I commissioned service and professional standards. Concerns that cannot be resolved locally should be escalated to the NHSE/I commissioner.

### **Service description**

Medicines optimisation services can be organised into two distinct areas of provision: medicines governance and services led by a pharmacy team, including clinical pharmacy services that integrate medicines safely into care pathways and services.

Providing healthcare in a custodial setting where the highest priorities are maintaining order, control and discipline has particular challenges with respect to supply, storage, administration and transfer of medicines. The CQC and related controls assurance and risk management standards which apply to NHSE/I 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 committee. The medicines management committee's advised membership is a lead pharmacist for the provider, healthcare managers, substance misuse representatives, non-medical prescribers, mental health providers, prison

GPs, a pharmacist from the external pharmacy service provider where this is different to the provider chief pharmacist and a prison staff lead.

The commissioner requires a service that provides the following:

- Sourcing of medicines stock either via a pharmacy (which has the required licenses) or via alternative pharmaceutical manufacturers or wholesalers.
- Accessing dispensed of medicines via a pharmacy directly provided by the provider or subcontracted. For reception/remand prisons this should be an on-site pharmacy. For other prison types, this is optional, usually retained if present, and must be agreed with the health and justice commissioner.
- A pharmacy supply service that delivers dispensed medicines within agreed timeframes and in packaging that is usually provided for dispensed medicines supplied to people living in their own homes in the community. This is because the health and justices' services are commissioned so that medicines are provided in the same way as people living independently (i.e. not in a hospital or care home). Any variation in routine packaging must be agreed with commissioner.
- Medicine optimisation services including as a minimum medicines reconciliation; medicines reviews; providing the pharmacist input for the development of PGDs; and delivering clinical pharmacist support that is equivalent to pharmacist roles being delivered in community GP practices.
- Monitoring stock control directly within the prisons.
- Monitoring Controlled Drug administration systems by healthcare and substance misuse providers.
- Analysing and reviewing prescribing against national prescribing indicators for cost and clinical effectiveness.
- Delivering training on the use of medicines and clinical effectiveness to those health professionals handling or administering medicines.
- Actioning and implementing drug and patient safety alerts and actions required by pharmacy or healthcare service regulators.
- Medicines governance: including development of a medicines governance framework underpinned by a medicines policy and procedures in line with RPS guidance and legislation.
- Nominating a medication safety officer (as described in national patient safety guidance) who provides a proactive role in managing medication safety.
- Routinely reporting medication safety incidents via the provider's organisational process AND sharing these incidents with the healthcare teams via the medicines management committee, the commissioner for contract monitoring AND entering relevant incidents onto the National Reporting and Learning System (NRLS) or any future national reporting process.
- Routinely undertaking clinical audits, benchmarking prescribing practice and developing an action plan to address where outcomes suggest use is not optimised.

### **Out of hours**

The provider is required to arrange and use a process for the dispensing of urgent medication from local pharmacies, or other urgent care or out of hours primary care services outside of core hours (including public holidays). This should be available

on request although pick up/delivery of the medicines will need to be arranged by the prison teams.

### **Sourcing of medicines**

The commissioner requires a service that includes the cost effective, legal sourcing and purchase of all required pharmaceuticals, and that ensures continuing patient treatment.

The provider will source stock medicines (including over-labelled stock for direct supply within the prisons) cost effectively either via the pharmacy service provider or elsewhere. This will include from the outset centrally procured vaccines via Immform and Payment by Results (PbR)/NHS Tariff excluded High Cost Drugs that will be sourced via NHSE/I in line with regional and national arrangements. The commissioner reserves the right to organise cost effective routes of any medicine and will advise the provider of the required supply chain for the affected medicines.

- Where a prescription for a pharmaceutical special is prescribed, the provider is expected to follow professional guidance including:
  - identifying whether a licensed alternative is available and suggest this to the prescriber
  - requesting that the pharmacy service provider shares the costs (ideally at least from three different sources/manufacturers) **in advance** to the prescriber or named healthcare lead.

All medicines including Controlled Drugs should be prescribed on an individual named patient basis. Supply from bulk stock should be reserved for the following:

- Initial supplies on admission until a named patient prescription can be dispensed.
  - Injectables that are directly administered to people where stock needs to be available for prompt use (e.g. immunisations/vaccinations).
  - Medicines for emergency administration.
  - Methadone, buprenorphine, where the number of people needing these medicines and storage requirements mean that individually named supplies would be at risk of administration error.
  - Where additional medicines for substance misuse (e.g. chlordiazepoxide, diazepam) are stored in Controlled Drug cupboards and a high number of people are prescribed them for example in a reception prison.
  - Over the counter general sale list (GSL) and pharmacy medicines that can be supplied un-labelled.
  - The commissioner requires stock items to be available which are consistent with the prison's individual usage.
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- The commissioner requires an agreed range of labelled pre-packed medication from a licensed provider to be available for use in an emergency for issue by the GP or healthcare staff against a prescription or for the supply of medicines using a PGD. However, the commissioner reserves the right to source these from an alternative provider should this be more cost effective.

- The provider shall liaise with the pharmacy service provider and agree an efficient and economic delivery service for both stock and dispensed prescriptions to the prisons, which ensures the availability of medicines required by patients within an agreed timescale that avoids delays in treatment or omitted doses. The commissioner will support the resolution of any issues arising from this agreement.

### **Dispensing and delivery of prescription medicines**

The commissioner requires the provision of a robust and cost-effective system for the transfer of signed prescriptions to the dispensing pharmacy, and their delivery to the healthcare department in the establishment within agreed timescales.

The provider may use their own initiative to devise the most appropriate systems to meet this requirement. The commissioner requires that any solution fully complies with the requirements of the commissioner and is not unduly burdensome. Orders, delivery notes and invoices are required and should conform to the requirements of regulatory and good practice standards. The commissioner therefore requires that the provider propose systems which are legally, professionally and financially compliant. The commissioner will retain the right to propose modifications and have the power to reject the proposals of the provider.

It will be the responsibility of the provider to consider whether the external dispensing pharmacy can remotely access the HJIS records for patients. This ensures that a comprehensive clinical check against dispensed prescriptions against all supplied medicines can be made for the benefit of patient care. In the absence of this, the provider must ensure that clinical pharmacy checks are undertaken that considers the interactions between all prescribed and supplied medicines and clinical markers that inform the safety of the prescribed medicine.

The commissioner requires the provider to work with the pharmacy service provider to have clear communication systems where the provider receives information via telephone as soon as possible after receipt of the prescription of any item that they are unable to dispense within two working days (within 24 hours for urgent medicines). Advice of delivery timescales should be shared with and recorded by the provider and followed up by the provider if the timescales are breached. Alternative medication should be agreed with the GP where the delay is considered potentially harmful to the patient.

The provider will be required to work/lead on initiatives such the on-going development of the prison formulary, prescribing practice, policies and procedures for handling of medicines by the healthcare team and pharmacy team. Where a national formulary for prisons exists (e.g. for pain) or national guidance for prescribing exists (e.g. Royal College of General Practitioners Secure Environments Group (RCGPSEG) Safer Prescribing in Prisons), the provider must use these in local care pathways and formularies.

The commissioner requires that prescriptions written in the prison by any prescriber is completed on SystemOne (HJIS) using the customised prison prescription form. FP10s are only used for urgent medicines and unplanned releases.



Medicines prescribed for a patient by an external prescriber (i.e. at an outpatient or in-patient hospital treatment episode) should be added to SystmOne in line with HJIS procedures and administered using the HJIS electronic administration system/e-medication chart.

The commissioner requires that all medication is dispensed in containers, which are in line with those provided to people in their own homes in the community, professional standards and suitable for use in the prison environment that meet the approval of the commissioner and the establishment security department. Monitored dose packs should be used for individually assessed patients only to support identified issues relating to self-administration of medicines.

Where the pharmacy service is subcontracted, the provider will have agreed remuneration and service fees for the pharmaceutical supply service from the subcontracted pharmacy service provider. The provider will share these costs with the commissioner as part of contract monitoring thus assuring the commissioner that the service is value for money.

Medicines are to be supplied/dispensed for a maximum of 28 days unless when specified by the prescriber. Prescriptions for greater than 28 days should be queried/confirmed with the prescriber before submission for dispensing unless they form part of a repeat dispensing batch

Medicines supplied or administered to a patient must be supplied safely in accordance with RPS and related professional standards and be recorded on the electronic medicines administration chart on SystmOne. This includes:

- the supply of supervised/directly observed by a registered healthcare professional
- the supply of Sch 2 and 3 Controlled Drugs and buprenorphine in the presence of a competent witness
- collaboration with HMPPS staff to ensure the level of supervision of medicines queues by officers is provided and is such that the risk of medicines diversion is minimised.

### **Control of stock**

The pharmacy service provider or wholesaler will retain ownership and risk of all stocks and dispensed medicines until such time as they are delivered to the prison.

The commissioner requires a service which provides advice on the type and quantities of medication to be held in stock so that minimum stock, consistent with the ability to provide a caring, responsive and cost-effective healthcare service, can be maintained. (i.e. to ensure availability and to reduce wastage). Stock requirements of the establishment should be reviewed on a regular basis to reflect any changes in prescribing trends and guidelines.

The commissioner requires monthly stock checks and a top up service to be carried out within each establishment, and a full detailed report to be provided.

The commissioner requires the maintenance of a safe, effective and secure storage system for medicines held in the prison, and to provide advice regarding storage to healthcare staff. Advice should take into consideration the constraints of the prison environment. Systems must meet current best practice and all applicable regulations (e.g. RPS Safe and secure handling of medicines 2018). Medication storage audits are to be carried out in the prison, using audit criteria to be agreed with the commissioner.

Items which are required for clinical emergencies, should be in clearly marked and kept in tamper-proof emergency boxes, at accessible sites. The provider should regularly check these boxes to ensure items are replaced after use or time expiry. All stock order lists require a countersignature by a prescriber.

The commissioner requires that appropriate arrangements are made for the secure storage and transportation of Controlled Drugs in accordance with relevant legislation and guidelines.

The commissioner requires that appropriate arrangements are made for the storage, daily monitoring of refrigerator temperatures and transportation of temperature sensitive medicines, and that procedures are put in place to validate and monitor storage and transportation systems. This includes ensuring procedures are in place and followed for refrigerators when temperature ranges fall outside those permitted.

The commissioner requires a system to be put in place to report any observed or identified incidences of poor practice with respect to, for example, prescribing, ordering and handling of medicines, with advice to be given on possible remedial action. The provider will retain a near miss log and report any Controlled Drug incidents to the accountable officer for the provider.

Towards the end of the contract there will be a requirement for the provider to decrease stock levels with an expectation that the incoming provider will purchase remaining stock at handover. Value of stock remaining may be assessed by independent valuation. A Wholesale Dealer Licence (WDL) is not required for this single transaction (i.e. the outgoing selling to the incoming provider) and the Home Office are able to provide a licence that permits this transaction for Controlled Drugs. This prevents the need to destroy Controlled Drugs and prevent stocks being decreased to levels that could result in delayed doses. The outgoing provider will need to apply to the Home Office at least three months before the contract changes to ensure permissions are in place for this transaction to occur.

### **Management of Controlled Drugs**

The commissioner requires a service whereby the management of Controlled Drugs fully complies with the Misuse of Drugs Act 1971, and any appropriate guidelines.

The commissioner requires Controlled Drug stocks to be checked within each prison in line with professional standards.

A registered doctor must have countersigned all orders (requisitions) for supplies of Controlled Drugs from wholesalers in line with Misuse of Drugs Regulations.

Any incidents, concerns or discrepancies related to Controlled Drugs must be brought to the immediate attention of the provider's Controlled Drug accountable/responsible officer, the health and justice commissioner and the NHSE/ Controlled Drug accountable officer.

### **Licence requirements**

Healthcare providers in prisons, no matter whether the prison is government or privately run, do not have Crown Immunity and therefore must hold the appropriate Home Office licence for each schedule of Controlled Drugs held. This includes NHS organisations providing healthcare within the prison.

In addition, following confirmation from the chief pharmaceutical officer, any supply of stock medicines on a commercial basis by a pharmacy service provider requires them to hold a Wholesale Dealers' Authorisation (WDA).

If stock supplies of Controlled Drugs in schedules 2-5 are made by the pharmacy service provider, then they also need to hold the corresponding Home Office Controlled Drug supply licence. Supplies of medication including Controlled Drugs that are made on a named patient basis do not require a WDA or the corresponding Home Office Controlled Drug licence.

### **Provision of drug/medical device alerts**

The provider will be responsible for ensuring that they are aware of all drug and medical device alerts issued by the Medicines and Healthcare Regulatory Agency, and that all necessary actions are carried out and documented for each of the establishment within the required timescale. The provider's pharmacist will ensure that each establishment has actioned this.

### **Policies and standing operating procedures**

These should be shared and agreed with healthcare teams. The commissioner requires a complete set of policies and operating procedures relating to the provider's medicines optimisation service and medicines policy to be in place at contract implementation and be part of a continuous review process. The commissioner may require copies of these at any time in support of, for example, clinical audits and inspections. Healthcare managers will advise the provider of any healthcare standing operating procedures that the provider must work to.

### **In-possession medication policy and assessment**

The provider is expected to lead on the development, revision and implementation (including audit) of the prison's in-possession medication policy as required by the healthcare teams and medicines management committee. The national health and justice in-possession risk assessment template should be used as part of this policy.

Implementation and assurance of the policy may include:

- leading on the development/revision of the policy and using the national clinical In-possession template
- ensuring that prescriptions are in line with this policy at the point of prescribing and dispensing and intervening if not

- that healthcare staff supply medicines in line with the IP status of the medicine
- auditing prescription and/or medicines administration records to identify whether the policy is being adhered to
- reporting on in-possession HJIP or equivalent as required by the commissioner.

### **Medicines reconciliation**

The provider will deliver medicines reconciliation within 72 hours of admission to prison in line with NICE guidance and RPS standards. The provider should use the national health and justice clinical medicines reconciliation template to record this.

### **Medication review**

The provider will liaise with the prison healthcare teams to identify those patients that would most benefit from a review of their medication with the aim of improving adherence. Patients are to be invited to a pharmacy led clinic for a medicines optimisation review which will be undertaken in accordance with the service expectations that currently exist for the NHS Structured Medication Review and other relevant primary care or community clinical pharmacy services. The provider will be expected to develop a template for recording these interventions, and this information will need to be entered in to the patient's records on SystemOne.

### **Development of Patient Group Directions**

The provider will be expected to identify where Patient Group Directions (PGDs) are needed and develop and authorise PGDs in line with NICE guidance and legal requirements.

### **Prescribing analysis**

The provider should produce reports or analyses of prescribed or dispensed medicines to allow monitoring of the use of medicines in the prison against the formulary or national guidelines (e.g. NHSE/I, NICE; NPSA) and to support financial governance.

### **Continuity of care**

The provider will work with the pharmacy service provider to ensure the timely dispensing and supply of medicines to patients on release or transfer in line with local policy on the minimum quantity of seven days' supply for such medicines. In the event that a medicine cannot be supplied on release FP10/FP10MDA prescription forms should be available for use and supply to the patient in line with professional standards for secure environments, so they can access the supply on release.

The provider will link in with local PCNs and clinical pharmacy services where people are admitted from and released to, in order to:

- support accurate medicines reconciliation on admission
- plan access to clinical pharmacy services and medicines reconciliation post-release based on local services available within PCNs, including community pharmacies.

### **Pharmaceutical waste**

Systems should be in place that minimises the waste of medicines where possible and in line with national standards. The provider is responsible for medicines waste disposal arrangements within the prison. A T28 exemption from the Environment Agency must be acquired by the provider to enable the denaturing of Controlled Drugs in line with requirements.

### **Pharmacy workforce**

The provider will be expected to provide pharmacist and pharmacy technicians within the establishment. Pharmacy assistants are optional based on local skill mix requirements. The chief pharmacist employed or commissioned by the provider oversees the pharmacy workforce and their roles.

The provider should employ or commission pharmacists to deliver clinical pharmacy services and pharmacy technicians who are based in or visit the IRC. The skill mix of staff, e.g. the recruitment of pharmacy technicians versus pharmacists and nursing staff, will be agreed by the provider.

- The role of the pharmacy technician can include the following:
    - Deliver a service that checks and organises the replacement of bulk stock.
    - Rotate stock cupboard to mitigate against expiry dates.
    - Dispose of out of date medication.
    - Flag where excessive stock is generated and take action to minimise its waste.
    - Ensure that stock is stored under appropriate conditions.
    - Review fridge temperature records and take appropriate action in the event that temperatures are not being appropriately maintained.
    - Provide information on drug alerts and recalls and ensure that they are actioned within specified timescales.
    - Reconcile stock against SystmOne ordering and alert the healthcare manager to any discrepancies.
    - Ensure that all stock order lists have been countersigned by a prescriber in line with Human Medicines Regulations and ordering of prescription only medicines (POMs) across different legal entities
- pharmacy technicians with demonstrated competence can also administer and supply non-IP and IP medication; deliver medicines reconciliation, smoking cessation services and medicines use reviews.

The provider will be expected to participate in hosting undergraduate placements, pre-registration and foundation pharmacists and pharmacy technicians as part of regional pharmacy workforce development programmes. This includes ensuring development of pharmacist and pharmacy technician tutors to support this and minimising the disruption of training of pre-registration trainees who are in post during a change in provider. The skills and functions of the pharmacy workforce should align with the clinical pharmacy and governance roles outlined in the RPS standards and NHS Long Term and People Plan.

### **Generic substitution**

Generic substitution policies which identify where generic substitution is not appropriate must be developed and agreed by the prison medicines management committees. The commissioner requires clinically equivalent generic products and reputable parallel imports to be supplied where they present the most economical option, when a proprietary brand is prescribed / ordered, except where a prescriber specifies that a proprietary brand must be supplied.

### **Pharmaceutical advice and formulary**

The provider will be responsible for securing pharmaceutical/medicines management advice for its employees and sub-contractors.

The provider will have responsibility for leading the development of a prison wide formulary. The formulary will:

- be based on relevant local primary care, mental health, substance misuse provider formularies or national guidance where available (e.g. NICE guidance, NHSE/I prison pain management formulary)
- reflect the health economics antibiotic formulary and strategy for reducing antimicrobial resistance for implementation within a secure setting
- be developed in collaboration with mental health and substance misuse teams, as well as secondary care services (e.g. via the area prescribing committee) so that it covers all aspects of the establishment's healthcare

### **Medicines governance and assurance**

The provider shall, in partnership with all the pharmaceutical services provided for them, participate, in the manner reasonably required by NHSE/I and secure settings, in an acceptable system of clinical governance.

For these purposes, a system of medicines governance and assurance must comprise of a minimum of the following components:

- A requirement that the pharmacist should undertake an approved establishment satisfaction survey annually, in an approved manner.
- Monitoring arrangements for drugs or appliances owed to establishments but which are out of stock.
- An approved complaints system which is acceptable to NHSE/I commissioners with a requirement that the lead pharmacist co-operates appropriately with the commissioner or provider and takes appropriate action following the outcome of any visits and meetings.
- A requirement that the pharmacy workforce co-operates appropriately with any reasonable inspection or review that the commissioner and prisons wish to undertake.
- Prescription monitoring and discussion of prescription issues with staff - to include a full 'clinical check', where this is not completed by the dispensing pharmacy team (i.e. for items supplied from stock) and liaison with clinicians where required. A record should be kept of all issues raised (i.e. interventions made) and any changes made as a result of discussions with clinicians. Prescription monitoring should be carried out on a regular basis, the frequency of which should be agreed with each individual prison according to their specific requirements.

- An assurance and risk management programme, which includes:
  - arrangements for ensuring that all stock is procured and handled legally and in an appropriate way
  - arrangements for ensuring that all equipment used in the provision of pharmaceutical services is maintained appropriately
  - a nominated and proactive medication safety officer and an approved incident reporting system, together with arrangements for analysing and responding to critical incidents. Incidents should be reported to the commissioner in line with local arrangements
  - never events and serious incidents: policy/process for management of including reporting arrangements and learning from, undertaking root cause analysis (RCAs) and developing/implementing/monitoring remedial action plans and identifying/responding to any trends identified
  - risk management: up to date risk management policy in place, detailing how they reduce and manage risk
  - audits of standard operating for all elements of the medicines pathway from prescribing, handling of received dispensed medicines, to supply, storage and waste management
  - assurance of appropriate waste disposal arrangements (in addition to those required in Section 2) for clinical and confidential waste associated with the establishment contract
  - the pharmacist's monitoring arrangements in respect of his compliance with the Health and Safety at Work Act 1974
  - arrangements for ensuring that appropriate advice is given by the pharmacy team in respect of medicines safety and handling to staff and patients.

### **Pharmacy service and medicines access innovations**

There are likely to be innovations in technology and workforce that provide opportunities for providers to review how pharmacy and medicines optimisation can be delivered to improve the safety, efficiency and patient experience. Any changes to the workforce or model by which the pharmacy service or medicines handling are delivered, will need to be agreed via local/regional contract monitoring and variation processes and with prison governor support. Regional commissioners will usually gain national support for any innovations new to the health and justice setting.

Examples include (but are not limited to):

- robotic/automated equipment for the dispensing of prescriptions in the on-site pharmacy or supply of medicines to patients
- changes to processes for dispensing medicines by the subcontracted pharmacy service provider that alters the packaging or other aspect of the delivered medicine that is not in line with the expected commissioned service as described in this specification.
- access to a pharmacist or pharmacy staff by patients using remote-access (tele-pharmacy)
- using new types of registered or non-registered health professionals in the medicines pathway.

## Guidance and reference documents

### Prisons

HMIP (2017) Expectations – Criteria for assessing the treatment of and conditions for men in prison [LINK](#)

<https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/02/Expectations-for-publication-FINAL.pdf>

NICE (2016) Guidance – Physical health of people in prison (NG57).[LINK](#)

<https://www.nice.org.uk/guidance/ng57>

NICE (2017) Quality Standard – Physical health of people in prison (QS156) [LINK](#)

<https://www.nice.org.uk/guidance/qs156>

World Health Organization (2014) Prisons and Health [LINK](#)

<http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2014/prisons-and-health>

MSO Smoking Cessation -[LINK](#)

<https://www.england.nhs.uk/wp-content/uploads/2017/08/smoke-free-mso-national.pdf>

National Aids Trust Guidance – Tackling Blood-Borne Viruses 2017 [LINK](#)

[https://www.nat.org.uk/sites/default/files/tackling\\_BBVS\\_in\\_prison2017.pdf](https://www.nat.org.uk/sites/default/files/tackling_BBVS_in_prison2017.pdf)

DHSC Detention Service Order- care and management of detainees refusing food or drink [LINK](#)

<https://www.gov.uk/government/publications/detainees-who-have-refused-to-eat-or-drink>

Quality Standards for Healthcare professionals working with victims of torture in detention Training [LINK](#)

[https://fflm.ac.uk/wp-content/uploads/2019/07/HWVT\\_QualityStandards\\_May19-ONLINE-FINAL.pdf](https://fflm.ac.uk/wp-content/uploads/2019/07/HWVT_QualityStandards_May19-ONLINE-FINAL.pdf)

NICE Guideline CG156. Fertility Problems: Assessment and treatment [LINK](#)

<https://www.nice.org.uk/guidance/cg156>

Equal Access, Equal Care: Guidance for prison healthcare staff treating patients with learning disabilities (NHS England, 2015) [LINK](#)

[www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/08/equal-access-equal-care-guidance-patients-ld.pdf](http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/08/equal-access-equal-care-guidance-patients-ld.pdf)



Mental capacity Act 2005 [LINK](#)

[http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga\\_20050009\\_en.pdf](http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf)

Mental Capacity Act Code of Practice (2007) [LINK](#)

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/497253/Mental-capacity-act-code-of-practice.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf)

Implementation guide and resource pack for Dementia [LINK](#)

<https://www.england.nhs.uk/wp-content/uploads/2018/01/implementation-guide-and-resource-pack-dementia-guide.pdf>

Best practice guidance to support the implementation of the learning disabilities and autism objective within the prison health primary care service specification (NHSE/I, 2019) [LINK](#)

<https://www.england.nhs.uk/commissioning/health-just/hj-resources/>

Dying well in custody charter [LINK](#)

<http://endoflifecareambitions.org.uk/wp-content/uploads/2018/06/Dying-Well-in-Custody-Self-Assessment-Tool-June-2018.pdf>

## **Older patients**

Public Health England (2017) Health and social care needs assessments of the older prison population. A guidance document [LINK](#)

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/662677/Health\\_and\\_social\\_care\\_needs\\_assessments\\_of\\_the\\_older\\_prison\\_population.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662677/Health_and_social_care_needs_assessments_of_the_older_prison_population.pdf)

## **Women in prison**

HMIP (2014) Expectations – Criteria for assessing the treatment of and conditions for women in prison [LINK](#)

[https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/02/final-womens-expectation\\_web-09-14-2.pdf](https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/02/final-womens-expectation_web-09-14-2.pdf)

Public Health England (2018) Women in prison: standards to improve health and wellbeing. [LINK](#)

<https://www.gov.uk/government/publications/women-in-prison-standards-to-improve-health-and-wellbeing>

Birth Charter for women in Prisons in England and Wales Birth Companions (2017) UHRA.Herts.ac.uk [LINK](#)

[https://uhra.herts.ac.uk/bitstream/handle/2299/19560/Birth\\_Companions\\_Birth\\_Charter\\_2016\\_7\\_.pdf?sequence=2&isAllowed=y](https://uhra.herts.ac.uk/bitstream/handle/2299/19560/Birth_Companions_Birth_Charter_2016_7_.pdf?sequence=2&isAllowed=y)

The Farmer Report: Lord Farmer 18 June 2019 Ministry of Justice  
The Importance of Strengthening Female Offenders' Family and other Relationships to Prevent Reoffending and Reduce Intergenerational Crime [LINK](#)

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/809467/farmer-review-women.PDF](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/809467/farmer-review-women.PDF)

### **Partnership Agreement documents**

<https://www.gov.uk/guidance/healthcare-for-offenders> LINK

National Partnership Agreement for Prison Healthcare in England 2018 to 2021 LINK

National Partnership Agreement: Commissioning delivery of Healthcare in Prisons 2015 - 2016 LINK

National Partnership Agreement: Joint extension letter 2016 LINK

National Partnership Agreement for Prison Healthcare in England: Workplan LINK

National Prison Healthcare Board Equivalence of Care principle LINK

NHSE/I hold similar agreements with co-commissioners of healthcare services in other secure settings, such as IRCs and the children and young people's secure estate. Further details of these agreements may be found on the NHSE/I Health and Justice webpages LINK