# Physical Health of People in Prison

## Consultation on draft guideline - Stakeholder comments table

## 16/05/16 to 27/06/16

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| British Dental Association | Short | 4 | 4-19 | There is no mention of people receiving a specific dental health assessment on their reception into prison. However, unfortunately, we recognise that without significant financial support this is not possible in large, busy establishments. With local prisons having scores of new arrivals each day, often late into the evening after courts close and weekends, sometimes for just a couple of days' stay, this can be a resource intensive approach for very little tangible benefit to the prisoner. Often prisoners are highly stressed, disorientated or suffering detox at this point. This being the case, we would suggest signposting prisoners to dental services at first reception with a clearly identified opportunity for a dental assessment at a later point - depending on the local situation and population being served. | Thank you for your comment. Dentistry is not included within the scope of the guideline. |
| British Dental Association | Short | 7 | 2.8 | In terms of equipment and aids used, people should be asked whether they use dentures or braces. | Thank you for your comment. Dentistry is not included within the scope of the guideline. |
| British Dental Association | Short | 10-12 | General | The second-stage health assessment would be a better opportunity to explore dental issues; the dental assessment should be explicitly mentioned in the guideline. | Thank you for your comment. Dentistry is not included within the scope of the guideline. |
| British Dental Association | Short | 12 | 1-9 | Tailored health advice based on peoples' responses to second-stage health assessment questions should include clear advice on dental care, including cleaning, nutrition, ceasing activities harmful to oral health and the importance of regular visits to the | Thank you for your comment. Dentistry is not included within the scope of the guideline. Oral hygiene has been added to the list of health information that should be provided in the information on health promotion recommendation and states the |

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| | | | | dentist. The literacy and education levels of people in prison are lower than average, so it is important that any written information materials are simple, clear and contain illustrations. Prisoners should be given access to toothbrushes, toothpaste and mouthwash. Resources should focus on prevention, oral and general health education. | information should be provided in an appropriate format. |
| British Dental Association | Short | 17 | 14-18 | Information regarding dental benefits should be given when offering information about the benefits of a healthy diet and the healthier food options in prison. We disagree with the focus on obesity as the only negative outcome of an unhealthy diet. Better use of dental expertise in prison catering would also be useful as vast quantities of sugary options are available. | Thank you for your comment. Dentistry is not included within the scope of the guideline. Oral hygiene has been added to the list of health information that should be provided in the information on health promotion recommendation and states the information should be provided in an appropriate format. |
| British Dental Association | Short | 21 | 5-7 | If possible, the person's dental records should also be transferred to the prison healthcare team on the person's entry to prison, in addition to their medical records. It can be difficult to obtain these records, but it is important to obtain them if they exist. | Thank you for your comments. Dentistry is not included within the scope of the guideline. |
| British Dental Association | Short | 21 | 14-19 | There can be difficulties in transferring records between prisons in cases of transit between custodial settings; it is vital that the transfer of records is improved and passes smoothly. Note-sharing should be improving with the use of prison IT, but there is growing reluctance from dental teams outside prison to share radiographs. | Thank you. Recommendation 1.7.3 has been made on records transferring with the prisoner between custodial settings. |
| British Dental Association | Short | 21 | 21-28 | People should receive dental screening/a dental healthcare assessment before release from prison, in addition to as part of the second-stage health | Thank you for your comments. Dentistry is not included within the scope of the guideline. |

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| | | | | assessment and transit between custodial settings. Dental health is extremely important at the point of re-entry into the community, when people face the prospect of undergoing job interviews and wish to make a good impression. | |
| British Dental Association | Short | General | General | Without a clear focus of priority groups in prison, or significantly increased funding, resources will be wasted in assessing individuals who will not be able to access treatment. | Thank you for your comment. Priority groups were identified for special consideration during the scoping of the guideline. These include: people with disabilities, women, over 50 age group, those serving long and short term sentences and people with a history of substance misuse. The GDG considered any particular needs of these groups when drafting recommendations. The GDG recognise that implementing the recommendations will require operational changes, however they consider these achievable and support equivalence of healthcare in prisons with that provided in the wider NHS |
| British Infection Association | General | General | General | The BIA is content with this guideline. | Thank you. |
| Clinks | Short | General | General | Family members can be important advocates for people in prison with health and care needs, encouraging them to access health services, and may hold valuable intelligence about prisoners' existing and developing health needs. We therefore believe it is important that this guideline encourage health services in prison to seek consent to liaise with family members and involve them in care planning wherever possible. | Thank you for your comment. A sentence has been added to the guideline introduction to acknowledge that liaising with family/carers with consent may be appropriate.<br><br>In recommendation 1.7.9, family/carers have been added to the list of possible people to liaise with before release. |
| Clinks | Short | 4 | 4 | Reception into prison is a time of high anxiety, and prisoners may not feel confident disclosing detailed | Thank you for your comment. The GDG do not feel that this would be appropriate for the health |

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| | | | | information to health professionals at this point. Training peer representatives to assist with the health assessment can be valuable in helping to build trust with prisoners. We suggest adding:<br>**A healthcare professional (or trained healthcare assistant *or peer representative* under the supervision of a registered nurse)** … to this line. | assessment.<br><br>Recommendation 1.3.1 pertains to the role of peer representatives in promoting health and wellbeing: *Consider using peer support and mentoring to help promote a healthy lifestyle while in prison.* |
| Clinks | Short | 10 | 29 | It would be useful to also discuss consent to share information with family members during the second-stage health assessment. We suggest adding a further bullet to this list stating this. | Thank you for your comment. A sentence has been added to the guideline introduction to acknowledge that liaising with family/carers with consent may be appropriate. The GDG did not consider this to be an essential component of the second-stage health assessment. |
| Clinks | Short | 12 | 20 | The Care Act (2014) allows for prisoners to request an assessment for care support from the local authority in which the prison is located. Information should be given to prisoners on their rights under the Care Act and how to request an assessment if they feel they need support. | Thank you for your comment. Please see the following in the Recommendations and link to evidence section (5.8.1) of the full guideline: "The GDG noted that these should follow equivalent pathways to those in the community and should be in line with national health and social care guidance, such as the Social Care Act 2014." |
| Clinks | Short | 16 | 12 | Communication with family members is a vital part of communication and co-ordination of services. The Prison Reform Trust's 'Relative Justice' report (p32) makes the following recommendations around liaising with family members and confidentiality:<br>While recognising an adult's right not to give permission for information to be shared about them, or for information to be sought from family members, individuals in contact with criminal justice services should be made aware of the benefits of proportionate | Thank you for your comment. A sentence has been added to the guideline introduction to acknowledge that liaising with family/carers with consent may be appropriate. |

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| | | | | information sharing with named family members during their initial contact with health services.<br>Consent to share information should be 'fluid' – meaning that it should be reviewed at regular intervals and be open to amends, as needed.<br>A clear standard explanation should be developed describing why consent to share information is helpful, and when sharing information with family members or asking for information might be necessary; and this should be written in an accessible format such as easy read.<br><br>We suggest adding a further point to this section on communication and co-ordination, **1.2.7: Actively seek consent from prisoners to liaise with named family members about their healthcare, and follow an agreed plan for doing so.** The bullet points above could be included to give further advice on how to do this. | |
| Clinks | Short | 23 | 2 | Family members (or other carers) may need to be actively involved in providing care and support to prisoners after they are released, and need to be consulted and involved in developing their care plan. We suggest adding a further bullet point to this list for **family members and carers.** | Thank you for your comment. In recommendation 1.7.9, family/carers have been added to the list of possible people to liaise with before release as you suggest. |
| College of Mental Health Pharmacy | SHORT | 4 | 17 | Need to change "drug~" to "drug/illicit substances | Thank you we will make the suggested change. |
| College of Mental Health | SHORT | 4 | general | Add tobacco use /cigarette consumption – number | Thank you for your comment. The GDG felt that |

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| Pharmacy | | | | smoked per day | smoking status was not an urgent health issue for first week safety so is asked at the second-stage assessment rather than the first stage. Smoking status for immediate administrative issues (such as cell allocation) rather than health issues would be dealt with elsewhere in the prison reception process. |
| College of Mental Health Pharmacy | SHORT | 5 | 4 | Amend to prescribed medicines and over the counter …….such as creams or drops, inhalers, injections e.g. antipsychotics, recent or current courses of antibiotic therapy,<br><br>Add a comment about medications that are self-administered or that are being carried with the individual for self-administration in case of emergencies e.g. adrenaline for anaphylaxis/nut allergy or inhalers or GTN spray , insulin<br><br>Be extra vigilant for high risk medications that may have detriment if doses are omitted e.g. Lithium, Clozapine, insulin , methadone, opioids, or that may be affected by acute physical ill health e.g. anticoagulants, antiarrhythmic<br>These need follow up immediately | Thank you for your comment. 'Over the counter' has been added to the recommendation as suggested.<br><br>The high-risk medications are covered in Table 2 of recommendation 1.7.10-11. These include the drugs that you have listed. Adrenaline has also been added to this table. |
| College of Mental Health Pharmacy | SHORT | 6 | General | Amend to "Does the person have…allergies /sensitivities<br><br>Also add anaemia to the list | Thank you for your comment. It is not possible to cover every condition in the recommendation; however, an additional question about any other health concerns identifies those conditions not listed. |
| College of Mental Health Pharmacy | SHORT | 6 | General | Under additional questions for women | Thank you for your comment. The table contains a question on what medication is being taken. This |

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| | | | | Ask if she is currently on the contraceptive pill | would include contraceptive pills. |
| College of Mental Health Pharmacy | SHORT | 7 | general | Under 2.8 amend if they follow a particular diet e.g. due to intolerance or allergy or for religious or personal reasons | Thank you for your comment. As part of the health assessment dietary needs are focused on those for medical reasons only. |
| College of Mental Health Pharmacy | SHORT | 7 | General | Under past or future medical appointments ask if they attend any regular appointments for blood tests for monitoring drug therapy that they may be on e.g. immunosuppressants, clozapine, lithium therapy, antiepileptics | Thank you for this comment. These issues, as they relate to psychotropic drugs, will be dealt with in the specialist mental health assessment detailed in the Mental health of adults in contact with the criminal justice system guideline. |
| College of Mental Health Pharmacy | SHORT | 8 | General | 3.4 amend to say Prescription drugs to prescription and over the counter medication | Thank you for your comment. The Committee of the Mental health of adults in contact with the criminal justice system guideline agree and this recommendation has been amended. |
| College of Mental Health Pharmacy | SHORT | 8-9 | general | Under 4.2 amend from when they received it to say<br><br>When it was started and when the last dose was taken (in the case of some drugs such as clozapine or lithium or warfarin the time of the dose may be important)<br>If applicable, add details about healthcare professionals team that administers antipsychotic depots | Thank you for this comment. This change has been made to the recommendation. |
| College of Mental Health Pharmacy | SHORT | 10 | 5-9 | Add a comment to say<br><br>If necessary seek advice from a pharmacist<br><br>Add a link to the NPSA guidance for those drugs if | Thank you for your comment. This information is included in the NICE medicines optimisation guideline referred to in recommendation 1.1.8. |

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| | | | | omitted or delayed could cause harm (http://www.nrls.npsa.nhs.uk/alerts/?entryid45=66720) | |
| College of Mental Health Pharmacy | SHORT | 10 | 29 | Add pulse rate and temperature. | Thank you for your comment. This has been added to the recommendation. |
| College of Mental Health Pharmacy | SHORT | 15 | 12 | Add serious mental illness, diabetes, | Thank you for your comment. This list of examples of screening programmes is not intended to be exhaustive. |
| College of Mental Health Pharmacy | SHORT | 15 | 28 | Amend allergies/sensitivities | Thank you for your comment. The GDG feel that 'allergies' is the correct terminology in this case. |
| College of Mental Health Pharmacy | SHORT | 16 | 23 | Add another line to say counselling or psychological therapies such as CBT or counselling | Thank you for your comment. This recommendation lists the areas prioritised for an evidence review in this guideline. The Mental health in adults in contact with the criminal justice system guideline has included recommendations relating to the pathway through care of people with a mental health problem. |
| College of Mental Health Pharmacy | SHORT | 17 | General | However, ensure that appropriate mental health professional is involved for those drugs that have blood levels that may be affected by stopping smoking e.g. clozapine | Thank you for your comment. The first-stage health assessment includes a question on what drugs are being taken. If on-going management was needed, these people would be referred on. |
| College of Mental Health Pharmacy | SHORT | 18 | general | Add alcohol as another category | Thank you for your comment. As identified in the scope, this section is about "Identification of the most effective approaches regarding prescribing, dispensing and adherence to medicines in prisons to maximise adherence and good health outcomes and reduce inappropriate use." |
| College of Mental Health Pharmacy | SHORT | 18 | 9 | Be extra vigilant and ensure clear plans are in place for those that as a result of risk assessment cannot be carried but need to be administered in a timely manner e.g. adrenaline pen for anaphylaxis or | Thank you for your comment. This situation is covered by the recommendations on ensuring a local protocol is available for responding to health emergencies and ensuring that prison and healthcare |

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| | | | | inhalers for asthma/airways disease | staff are made aware of people who have underlying chronic conditions and allergies. |
| College of Mental Health Pharmacy | SHORT | 21 | 5 | If the medical information collected suggests that the person has mental illness, then contact any family or close friends for information about medication | Thank you for your comment. The guideline introduction has been amended to note that it may be appropriate to liaise with the person's family. |
| College of Mental Health Pharmacy | SHORT | `general | general | Need to include a clear statement about the need to complete annual health checks for certain groups of individuals ensuring that results are shared with usual health care provider and clear action is documented about actions to be taken as a result of the health screen e.g. annual screening in serious mental illness or diabetes | Thank you for your comment. This is covered by the following recommendation (1.1.31): "Offer people equivalent health checks to those offered in the community, for example:<br>• the NHS health check programme for people aged 40 and over<br>• learning disabilities Annual Health Check<br>• relevant NHS screening programmes, such as those for abdominal aortic aneurysm and bowel, breast and cervical cancer."<br><br>Further guidance on mental health will be covered by the accompanying guideline Mental health of adults in contact with the criminal justice system currently in development. |
| Department of Health | Short | 20<br><br>21 | General | Under Section 1.6, *Managing deteriorating health and medical emergencies,* we consider that there should be an explicit reference made to the February 2013 NOMS/MoJ guidance (*PSI 03/2013 Medical Emergency Response Codes).* This PSI outlines the medical symptoms in a prisoner but not behaviours such as drug misuse, for which a prison must always call out an emergency ambulance. This PSI is mandatory in all prisons in England, and it would be | Thank you for your comment. Managing deteriorating health only covers physical health issues as mental health is not included as part the scope of this guideline. Drug misuse is covered by the accompanying guideline mental health of adults in contact with the criminal justice system currently in development.<br><br>Also please see the following in the |

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| | | | | this guidance which should apply in emergency situations. | Recommendations and link to evidence section (10.4.1) of the full guideline: "*The GDG considered that particular elements of a structured response were critical in acting effectively in an emergency. These were ensuring that staff members are aware of how to access a prisoner's cell quickly during an emergency and communicating with the emergency services on how to access the prison, for example making sure there is a protocol for allowing paramedics or ambulance staff into the prison estate if necessary*" |
| Department of Health | Short | General | General | The NICE draft guideline pre-dates the PM's announcement on 8 February 2016, formally outlined in the Queen's Speech on 18 May 2016 about prison reform. However, there appears to be no mention of any Justice side role in commissioning. There is potentially a need for revision in the event of prison commissioning reform, although any reforms will not have been enacted before NICE's guidance is due to be published.<br><br>NICE should consider making reference to this Government policy somewhere in the Guideline. The Department of Health (DH) is happy to share the following top level lines about the reforms with NICE, which we have prepared for ministerial and senior official level briefing on these reforms for NICE to use.<br><br>Six reform prisons will pilot greater autonomy for governors, including financial and legal freedoms. If | Thank you for your comment. As noted any reforms will not have been enacted before publication of this guideline. The recommendations in this guideline set out the healthcare services that should be available for people in prison, but do not depend on what arrangements are in place regarding who is responsible for commissioning and organising the delivery of service provision in each context, which will vary between prisons. Therefore the recommendations could still be applied if different organisational patterns are trialled or adopted in future. However, as with all NICE guidance, this guideline will also be regularly reviewed after publication and updated in accordance with new evidence. |

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| | | | | successful, the reforms will be applied across the rest of the prison system in England from 2017, underpinned by new legislation in a Prisons Bill this Session.<br><br>Work is underway to consider and test co-commissioning of health services between governors and NHS England, with governors having a greater say in defining prison health services in their prison, and budgets. | |
| Department of Health | Short | 20 | 8 | We think that there should be recognition that individuals may be identified at first or second screen stage as having care or support needs which warrant an assessment from the local authority where the prison is situated.<br><br>DH suggests that the following additional wording is added to the end of the first sentence at line 8:<br><br>*"…or referral procedures for a care and support assessment."* | Thank you for your comment. We are unsure which area of the guideline is being referred to.<br><br>Any care or support needs would be identified and the first-stage of the reception assessment and the prison disability lead would refer for any further assessments required. |
| Department of Health | Short version | 21 | 22<br><br>17 | The reference to "multi-disciplinary teams" should include a specific reference to probation services, who will remain in contact with offenders when they return to the community. | Thank you for your comment. 'Probation staff' has been added to the definition of multidisciplinary team in the glossary. |
| Epilepsy Action | Short | General | General | Factors that are considered to be potential triggers for epileptic seizures may be heightened in a prison situation – for example: high levels of stress, restricted activity and possible drug abuse. These things must | Thank you for your comment. The recommendation on monitoring chronic conditions refers to the existing NICE guideline on epilepsies for their monitoring. |

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| | | | | be considered when developing guidelines for health professionals within the prison service. | |
| Epilepsy Action | Short | General | General | We would expect every member of prison staff that has first aid training to be fully competent in how to deal with an individual having a seizure. Where someone has disclosed their epilepsy we would deem it essential that prison staff with regular contact have specific training on awareness, understanding and how to care for an individual having a seizure. | Thank you for your comment. Within the recommendation for developing a protocol for responding to emergency situations one of the examples give is "essential training for front-line prison staff, including the first person likely to be on the scene in an emergency" |
| Epilepsy Action | Short | General | General | *NICE Guidelines: Epilepsies* state that healthcare professionals have a responsibility to educate others about epilepsy. Epilepsy Action believe this is an essential requirement within the prison population, should an individual prisoner disclose their epilepsy, if not before. | Thank you for your comment. This guideline hopes to highlight that NICE guidance, such as the Epilepsies guidance, is applicable to the prisons population |
| Epilepsy Action | Short | 5 | 2.1 | The first assessment should include a review of an individual's medication; how long their current supply will last and an appointment made with sufficient time to get a further prescription. It is essential that people with epilepsy take their medication regularly, without gaps in prescriptions, to maintain a steady level of the medicine in their blood. Not doing so can lead to an increased risk of seizure, which could lead to death. | Thank you for your comment. Recommendation 1.1.8 states that a medicines reconciliation should be carried out before the second-stage health assessment.<br><br>Anti-epileptic drugs are included in Table 2 as a critical medicine, that the person should be able to continue taking. |
| Epilepsy Action | Short | 5 | 2.1 | Medication consistency is essential for people with epilepsy. There are varying brands of certain types of AEDs available. For people with epilepsy, it is vital they have consistency of supply whenever they get a repeat prescription. It should be from the same manufacturer, and from the same country. This applies to generic versions, 'branded' generics and for | Thank you for your comment. This is beyond the scope of this guideline. However, epilepsy is one of the listed examples of NICE guidelines to follow in recommendation 1.5.1. |

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| | | | | brand leaders. For many people with epilepsy, switching version of AED has caused breakthrough seizures, worsening of their seizure control or worsening of side-effects. It is essential that guidance produced by the MHRA on AEDs is followed at all times. | |
| Epilepsy Action | Short | 6 | 2.4 | The assessment will ask if the prisoner has 'other physical health conditions' which includes epilepsy. Health professionals should be aware that often people with epilepsy may not wish to disclose their condition. They should therefore emphasise confidentiality and that nothing will be shared without the prisoner's permission. However, sharing with those who need to know will help to ensure the safety of the prisoner in the event of a seizure.<br><br>Epilepsy Action's Purple Poll undertaken in 2016 showed that 25% of people with epilepsy do not feel comfortable talking about their epilepsy with healthcare professionals. This figure rose to 40% for individuals who are not seizure free. | Thank you for your comment. Patient confidentiality and sharing of information has been addressed throughout the guideline and recommendations have been made on obtaining consent before requesting the person's medical record 1.1.6 and sharing information when necessary for the person's care 1.2.2. |
| Epilepsy Action | Short | 6 | 2.4 | Epilepsy Action believes making short notes for someone living with epilepsy is not sufficient. Epilepsy is an extremely complex condition and differs for each individual.<br><br>There is a lack of awareness and understanding of the condition; the different types of seizures, triggers for seizures, side-effects of medication (and someone's epilepsy), the impact of a seizure and the recovery | Thank you for your comment. As you note, the first-stage assessment is limited to a short amount of time. As well as making short notes, the recommendation is to 'Make appointments with relevant clinics or specialist nurses if specific needs have been identified'.<br><br>The second-stage health assessment begins with the recommendation to review the actions and outcomes |

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| | | | | period for each individual. Details of an individual's epilepsy must be recorded at the first assessment to ensure their safety and minimise risk. This cannot be achieved by making 'short notes'.<br><br>We recommend a specific set of questions that must be asked should a prisoner declare their epilepsy in the first assessment that will capture this information and ensure the individuals safety and minimise risk. These should include; typical seizure type, pattern, frequency, triggers, when medical help is required and recovery needs.<br><br>If this is not practical at the time of the first assessment, despite best efforts, an urgent appointment must be made with the relevant clinic or nurse. | from the first-stage health assessment.<br><br>In the section on monitoring chronic conditions, it is recommended to monitor people in accordance with the other NICE guidelines such as the NICE guideline on epilepsies. |
| Epilepsy Action | Short | 6 | 2.6 | Many anti-epileptic drugs have significant side-effects. These need to be considered when asked this question. | Thank you for your comment. Many medicines may result in physical side effects noted in the assessment. The action for the question highlighted is to refer to the GP. This will enable this to be identified versus other causes of the symptoms noted. |
| Epilepsy Action | Short | 7 | 2.8 | People with epilepsy may need certain things in place to ensure they remain safe. Depending on an individual's epilepsy, adjustments may need to be made or equipment supplied, for example considering an individual's cell and bunk allocation.<br><br>It is important that healthcare professionals consider | Thank you for your comment. This is covered under question 2.8 of the first-stage health assessment 'Ask the person if they need help to live independently', followed by the action "note any needs. Liaise with the prison disability lead in reception about:<br>• the location of the person's cell |

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| | | | | not only the seizure, but also the recovery period for an individual, which may cause someone to be unable to live independently, even for a short period of time. | • further disability assessments the prison may need to carry out" |
| Epilepsy Action | Short | 12 | 13 | Epilepsy Action believes that healthcare professionals should strongly encourage individuals who have disclosed their epilepsy to share this information with a peer. Telling a peer can mean that the risk to an individual's health or safety can be less. | Thank you for your comment. We hope that the following recommendation on risk sharing will reduce risks to health of people in prison in prison: 1.2.2 'Share information with other health and social care staff, offender supervisors and probation providers who are involved in the person's care in prison if necessary for the person's care.' |
| Epilepsy Action | Short | 15 | 26 | Communication between healthcare professionals and prison staff needs to be detailed and contain specific information about an individual's epilepsy.<br><br>Epilepsy Action believes there should be a clear and consistent list of questions that would essentially be an individual's care plan.(*NICE Guidelines: Epilepsies* state that "All children, young people and adults with epilepsy should have a comprehensive care plan) It would contain details of triggers, side-effects, types of seizures and how these present, as well as recovery periods. | Thank you for your comment. There are a number of recommendations in this guideline that support communication between staff over the care of individuals with complex health needs.<br><br>The NICE epilepsy guideline is cross-referred to under the section on monitoring chronic conditions. |
| Epilepsy Action | Short | 14 | 14 | To ensure continuity of care and to minimise the risk of seizure and therefore potentially death, an individual's comprehensive care plan should be provided during any transition between custodial settings. | Thank you for your comment. Recommendation 1.7.3 lists examples of what should be provided during transition between custodial settings. This list is not intended to be exhaustive. |
| Epilepsy Action | Short | 14 | 21 | To ensure continuity of care and to minimise risk of | Thank you for your comment. Recommendation 1.7.4 |

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| | | | | seizure and therefore potentially death, once a person has been confirmed as due for release from prison, an appointment should be made with a GP/Epilepsy specialist. | states that a multidisciplinary team, led by primary care, should conduct a pre-release health assessment for people with complex health needs. |
| Epilepsy Action | Short | 24 | 13 | Epilepsy Action believe that where a person is discharged or transferred from prison, the minimum number of days' prescribed medication given, should increase to 14 for individuals with epilepsy. | Thank you for your comment the recommendation states 'a minimum of 7 days' prescribed medicines', this would allow greater than 7 days' worth of medicines to be given in some cases. |
| Faculty of Dental Surgery | Short | 12 | 1.1.13 | We are concerned that there are missed opportunities to combine Oral Health promotion with General Health Promotion for the prison population.<br>We understand that Mental Health will be tackled by a separate Guideline but there is no mention of Oral Care being tackled by a separate guideline and yet it has been specifically excluded from this guideline on Physical Health. | Thank you for your comment. Dentistry is not included within the scope of the guideline. Very little evidence was identified on oral health and therefore no detailed recommendations could be made. Oral hygiene has been added to the list of health information that should be provided. |
| Faculty of Dental Surgery | Short | 12 | 1.1.14 | This section refers to Health Care advice and yet again, this is a missed opportunity to include information and advice on Oral care. | Thank you for your comment. No evidence was found to include this as part of the health assessment. Oral hygiene has been added to the list of health information that should be provided as part of health promotion. |
| Faculty of Dental Surgery | Short | 17 | 1.3.5 | This section promotes the benefits of a healthy diet and advises on healthier food options, as above, this could so easily include advice and information on dietary options which would enable the prisoners to choose healthier life styles both within the prison, and on their release, which could lead to reduced decay and periodontal problems.. | Thank you for your comment. Dentistry is not included within the scope of the guideline. Oral hygiene has been added to the list of health information that should be provided in the information on health promotion recommendation. |
| Faculty of Dental Surgery | Short | 22 | 1.7.6 | Transfer of records to other prisons should include | Thank you for your comment. Dental health was not |

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| | | | and 1.7.9 | information on oral status and needs, as well as medical information. This will enable a smooth transition and continuity of care. Similarly, advice can be given on accessing dental care on release, particularly if there are outstanding treatment needs or support required to enable prevention in the future. | included as part of this guideline. Oral hygiene has been added to the list of health information that should be provided as part of health promotion. |
| G4S Forensic and Medical Services (UK) Ltd | Short | General | General | There does not appear to be anything in the guidelines that help clinicians with refusal to co-operate, untruths and drug seeking or manipulative behaviour. | Thank you for your comment. Please see the qualitative review on what are the barriers and facilitators to health promotion in prison, which has captured this indirectly. No reviews were prioritised in this area as the guideline focuses on physical health. |
| G4S Forensic and Medical Services (UK) Ltd | Short | General | General | We support the principle described of record transfer between custodial establishments, which suggests that only one admission into custody may be required. However if we were to follow this it is likely to make us non-compliant with HJIPS which do not recognise such a a transfer. HJIPs require a new admission in each establishment with new screens etc. | Thank you for your comment.<br>The GDG recognise that HJIPs may need to be reviewed in the light of NICE guidance. The screen required in a post-transfer prison would also have the benefit of the previous, comprehensive clinical record and thus be shorter. |
| G4S Forensic and Medical Services (UK) Ltd | Short | 5 | 1 | Table 1; 1: Questions : record whether first time in prison | Thank you for your comment. The recommended health-assessment at reception should pick up most immediate health risks. Also, many prisoners are returning and therefore prison information systems will highlight that it is not their first time in prison. Other prison systems also pick up those who are entering prison for the first time as part of the induction process. |
| G4S Forensic and Medical Services (UK) Ltd | Short | 5 | 2.1 | Table 1; 2.1: And when did the medication/s commence | Thank you for your comment. The GDG do not agree that this information is essential to determine which medicines are currently being taken. |

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| G4S Forensic and Medical Services (UK) Ltd | Short | 5 | 2.1 | What happens if the GP wants community confirmation of medication or does not feel they are clinically appropriate but the patient disagrees | Thank you for your comment. The clinician is the person who takes the final decision on whether to prescribe. This guideline cross-refers to the NICE medicines adherence guideline, which covers a partnership approach to decision making about medicines. |
| G4S Forensic and Medical Services (UK) Ltd | Short | 6 | 2.4 | Include food sensitivities<br>Asthma<br>COPD | Thank you for your comment. Both asthma and COPD are now included in this list. Food sensitivities are only included if they are allergies. |
| G4S Forensic and Medical Services (UK) Ltd | Short | 6 | 2.7 | (i) the female should have an option of unknown in response to the question 'if she has reason to think she is pregnant'<br>(ii) the date of the LMP should be asked for all female patients | Thank you for your comment.<br><br>(i) The response states if there is reason to think the woman might be pregnant offered a test. This would include those women who were not certain.<br><br>(ii) The GDG consider the questions asked are adequate for the first reception assessment. |
| G4S Forensic and Medical Services (UK) Ltd | Short | 7 | 2.8 | Receipt of personal independent payment (PIP) or other social care allowances | Thank you for your comment. The GDG does not feel that this would be an appropriate question here as the focus of the first assessment is immediate healthcare needs on reception into prison. |
| G4S Forensic and Medical Services (UK) Ltd | Short | 8 | 3.2 | Ask about addiction to prescribed medication such as tramadol gabapentin/pregabalin in addition to benzodiazepines<br>Also Z drugs | Thank you we have amended the Mental health of adults in contact with the criminal justice system guideline to take into account misuse of prescribed medication |
| G4S Forensic and Medical Services (UK) Ltd | Short | 10 | 10 | Secondary screening within 7 days for all prisoners. This is currently offered but we find the uptake very low. For many prisoners it is clear from initial screening that they are fit and healthy, or will not co-operate once their priority has been addressed ie | Thank you for your comment. The recommendations describe the standard of care that the GDG believes should be provided in prisons settings. |

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| | | | | substance misuse | |
| G4S Forensic and Medical Services (UK) Ltd | Short | 14 | 13 | TB ?include in initial screening as refusal to attend may result in it not been detected. | Thank you for your comment. Recommendation 1.1.9 states that: *Healthcare professionals in prisons should ensure people coming into prison are screened for TB within 48 hours of arrival.* |
| G4S Forensic and Medical Services (UK) Ltd | Short | 19 | 19 | Important to specifically include Asthma – especially for YOIs and remand prisons | Thank you for your comment. A reference to the NICE quality standard on Asthma is given at the end of the highlighted list |
| G4S Forensic and Medical Services (UK) Ltd | Short | 21 | 5 | 1.7.2 – we agree but there needs to be a better understanding of sharing medical information – also the logistics of 'how' needs to be considered in the implementation. | Thank you for your comment. The GDG is made up of professionals who work within the prison environment and are fully aware of the challenges presented. The GDG understands that implementation may be a challenge, but believe that the recommendations are achievable. |
| G4S Forensic and Medical Services (UK) Ltd | Short | 22 | 1 | 1.7.6 – we should state the importance of accurate READ coding in SystmOne medical records (or its successor) | Thank you for your comment. The guideline recommendations do not specify certain software. |
| G4S Forensic and Medical Services (UK) Ltd | Short | 23 | 11 | Area: infections: TB treatment should be specifically mentioned. | Thank you for your comment. 'Anti-infectives' are listed as critical medicines in Table 2. |
| G4S Forensic and Medical Services (UK) Ltd | Short | 23 | 11 | Area: Epipen should be specifically mentioned | Thank you for your comment. "Adrenaline for allergic emergencies (patient held)" has been added to Table 2. |
| G4S Forensic and Medical Services (UK) Ltd | Short | 24 | 1 | 1.7.12: we feel consideration about anti-malarial prophylaxis for those being deported to high risk malaria areas. | Thank you for your comment. The list of examples is not intended to be exhaustive. The example that you suggest would be covered by this recommendation. |
| G4S Forensic and Medical Services (UK) Ltd | Full | General | General | We don't feel that the authors appreciate the practical reality of manipulative behaviours of some prisoners – especially in declaring epilepsy / fits (without evidence) because of the benefits it brings, such as accommodation. | Thank you for your comment. The GDG is made up of professionals who work within the prison environment and are fully aware of the challenges presented. Recommendations have been made to improve methods of assessment, record keeping and |

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| | | | | | transfer of records, which will provide more information about the patient to help health professionals in managing patients. |
| G4S Forensic and Medical Services (UK) Ltd | full | General | General | We don't feel that the authors appreciate the practical reality of manipulative behaviours of some prisoners – especially in declaring chronic pain in order to obtain tramadol / gapapentin / pregabalin / etc…<br>Many of this group are known to consult with a GP before admission with symptoms of significant pain in order to have these drugs prescribed to provide evidence of prescriptions on admission to prison. | Thank you for your comment. The GDG is made up of professionals who work within the prison environment and are fully aware of the challenges presented. Recommendations have been made to improve methods of assessment, record keeping and transfer of records, which will provide more information about the patient to help health professionals in managing patients. This guideline also makes cross-referrals to NICE guidelines on Medicines adherence and Medicines optimisation. |
| Her Majesty's Inspectorate of Prisons | Appendices | 6 | 4.2 a | The overall guideline covers NHS-commissioned care provided in prisons, young offender institutions and when people move from prison to another setting e.g. court. Improving health & wellbeing in prison, first reception and secondary health screen, coordination and communication between Health Professionals, Use of Medication; Urgent and emergency management in prison and continuity of healthcare on admission, transfer and release. We are concerned that with reform agenda and the potential changes to commissioning to increase Governor control that this may limits its usefulness in the future, arguably health provision in prison should be community equivalent regardless of who commissions it. We are also concerned that this suggests it is not applicable to private prisons where health services are | Thank you for your comment. This guideline was referred to NICE for development by NHS England and applies to all NHS commissioned care in the prison service. |

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| | | | | commissioned by NOMS, which could generate difference in care and non-equivalence with the community and other prisons. The commissioning stream should not determine whether NICE applies. | |
| Her Majesty's Inspectorate of Prisons | Short | 6 | 2.8 | The inclusion of a screening question regarding needing help to live independently is positive. The guideline advises the nurse/HCA completing the assessment record the prisoner's needs and liaise with prison disability lead. It appropriately stresses the need to ensure staff know that aids to independent living the prisoner came with should follow them to their accommodation and the nurse/HCA should liaise with the kitchen. It would be helpful to also advise that the nurse/HCA liaise with custodial staff to ensure an initial appropriate management plan including Personal Emergency Evacuation Plan is put in place as there may be a time delay until the disability liaison officer is available, if there is one and that the nurse/HCA may need to consider a referral for a social care assessment. | Thank you for your comment. It is not possible to cover every aspect of a management plan within the recommendation. The GDG think that this is implied by noting the needs of the person and organising any further disability assessments that may be needed. |
| Her Majesty's Inspectorate of Prisons | Full | 101 | 47-56 | On page 101 of full guideline when discussing reception screening the GDG noted that prisoners are not allowed to know when external hospital appointments are, if they are aware of these dates they will be changed (due to security issues) when entering prison. Security will decide if any original dates can be kept or if healthcare admin staff will re-arrange. We suggest the decision to rearrange should | Thank you for raising this error. We have amended the sentence in the LETR accordingly. |

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| | | | | be made in partnership with healthcare and security rather than security alone to ensure that clinical risk and security risks are both addressed. | |
| Her Majesty's Inspectorate of Prisons | Full | | | Secondary Screening - Non attendance at secondary screen is often high however in recommendations it suggests physical observations be done at that time. We wonder if observations should be done on primary screen as it may identify concerns that require more urgent follow up. | Thank you for your comment. The committee agree that non-attendance at secondary screening is often high, but note that this is an important assessment and aims with these recommendations to improve attendance. The time constraints of the first assessment mean that such observations cannot be fully conducted and are better placed in the second assessment. The intention of these recommendations is that the two stages form one health assessment. |
| Her Majesty's Inspectorate of Prisons | Full | | | **Recommendation 8** indicates the screen should happen within 7 days – HMI Prisons has previously advocated that it occur within 72 hours however Systm One (single shared electronic clinical record system) reduces risk by improving continuity of care and we accept that 7 days may be more achievable in establishments with high throughput, providing those on short sentences or with urgent issues are appropriately prioritised for review. | Thank you for your comment. The guideline recommends that the reception health assessment be split into two parts (as often occurs now). The first-stage immediate assessment (for first night safety) is followed by a more detailed health check within 7 days. The GDG note that this does not preclude conducting such assessments earlier than 7 days. |
| Her Majesty's Inspectorate of Prisons | Full | | | all prisoners are screened for TB within 48 hours of arrival. | Thank you for your comment. The recommendation on screening for TB from the NICE Tuberculosis guideline has been moved to follow the first assessment and the heading specifies the 48 hour time frame. |
| Her Majesty's Inspectorate of Prisons | Full | | | **Recommendation 25** states healthcare professionals in prison should ensure all prisoners are screened for | Thank you for your comment The recommendations on screening for TB from the NICE Tuberculosis |

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| | | | | TB within 48 hours of arrival. To meet this time frame and ensure prompt identification of TB it would be preferable to include some screening questions in the initial screen as otherwise it floats between the initial screen on arrival and secondary within 7 days, and active cases may be missed. | guideline have been moved, and are now placed between the first-stage and second-stage health assessments. |
| Her Majesty's Inspectorate of Prisons | Full | general | General | **Recommendation 26** Within 7 days for routine XRays may be a more realistic expectation for X Ray in prisons that have such facilities. | Thank you for your comment. This recommendation has been adopted from the NICE tuberculosis guideline. As stated within NG33 which has been in place since 2012. The GDG reviewed the recommendations and considered them to be achievable. |
| Her Majesty's Inspectorate of Prisons | Full | general | general | **Recommendation 32:** We are not sure that this is realistic or community equivalent and may be counterproductive. In large prisons this would result in each member of health staff having a large allocated caseload, most of whom have no significant health needs but the staff member could not be fully conversant with them all. A prisoner with routine needs could experience delays while waiting to access an allocated care coordinator. Generally in a GP practice a patient with routine needs would access whichever practitioner is available or be triaged by a duty practitioner and allocated to the most appropriate service. It would be more appropriate to recommend that prisons have an up-to-date register of patient with complex physical and social care needs, each of whom has an allocated care coordinator who is identified to the patient and prison staff. This would be achievable and ensure effective resource allocation. | Thank you for your comment.<br>This has been changed in line with your suggestion to: Ensure that people with complex health and social care needs have a lead care coordinator who is responsible for managing their care. Ensure that the person and all healthcare and prison staff know who this is." |

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| Her Majesty's Inspectorate of Prisons | Full | general | General | **Recommendation 33** - Overall positive re focus on communication and effective coordination included structured regular communication. However this could be strengthened to ensure a lead care coordinator is identified to ensure more cohesive management. HMP Stocken have been doing this very effectively. | Thank you for your comment. This is addressed by recommendation 1.2.3: *Ensure that people with complex health and social care needs have a lead care coordinator who is responsible for managing their care. Ensure that the person and all healthcare and prison staff know who this is."* |
| Her Majesty's Inspectorate of Prisons | Full | general | general | **Recommendation 40:** No recommendation made re nutrition made due to lack of evidence but the food choices in prison are often limited and do not always meet Department of Health guidelines on calorific and fruit and vegetable intake. We often report concern about portion size particularly in relation to breakfast packs in male prisons. It is important to educate prisoners about healthy eating but prisoners can only choose from what is offered to them. There is potential here to make a recommendation about people in prison having access to the appropriate calorific intake through a menu that has been created with dietician input to ensure easy access to at least 5 portions of fruit and vegetables a day and appropriate healthy options on menus and in the prison canteen as choice is often restricted. | Thank you for your comment. A recommendation has been made to offer information on the benefits of a healthier diet and healthier food options available. The GDG also considered the sections on diet within the NICE Obesity guideline to be relevant to a prison population and a link to this guidance has been made. It is not possible to add any further detail to these recommendations due to the lack of evidence available. |
| Her Majesty's Inspectorate of Prisons | Full | general | general | **Recommendation 42:** Easy access to barrier protection is an admirable and appropriate harm reduction goal that we have long advocated. However in a prison setting there may be risks in just being able to pick them up without recourse to confidential health advice and support. We are concerned that just having bowls of condoms out could create risks for vulnerable people. | Thank you for your comment. The recommendation in this guidance does not prescribe the method in which condoms should be made available, only that is should be discrete and without the need to ask. The GDG did consider the risks of this recommendation and regarded them as manageable when coupled with general sexual health advice, which the guidance also supports. |

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| Her Majesty's Inspectorate of Prisons | Full | general | general | **Recommendations 46 to 49** focus on supervised medication and having systems in place with prison staff to ensure administration is supervised to reduce diversion and ensure confidentiality which is commendable. It would be helpful to include in recommendations about the timing of supervised medication ensuring that appropriate therapeutic gaps are maintained as we often see the efficacy of supervised medication being drastically reduced by medication times that meet the needs of the regime and not the patient e.g. 0900, 1100 and 1600 or night sedation being given at 1630. | Thank you for your comment. The following sentences have been added to the Recommendations and link to evidence section 8.5.1: 'The GDG noted that the efficacy of supervised medication can sometime be drastically reduced by medication times that meet the needs of the regime and not the patient timing of supervised medication. The GDG agreed that medication timings for supervised medication should ensure that appropriate therapeutic timings are maintained.'<br><br>The following bullet point has also been added to recommendation 1.4.4: "Allow timings of medicines doses to align with the prescribed dose regime". |
| Her Majesty's Inspectorate of Prisons | Full | general | general | **Recommendation 46:** It would be helpful to specify a tool or specifically include the need to assess the person and the drug as currently this implies risk assessing the person is sufficient, however in prison the drug and access to secure in cell storage is also relevant. | Thank you for your comment. No evidence was found for in possession risk assessment tools and therefore it is not possible to recommend a particular tool. However, reference to the National Prescribing Centre risk assessment tool and NHS England's current work in this area has been made in the Recommendations and link to evidence section of the guideline (section 8.5.1).<br><br>Additional restrictions for specific medicines being held non-in possession is made according to local policies and agreements. |
| Her Majesty's | Full | general | general | **Recommendation 50:** Positive that review of In | No evidence was found for in possession review |

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| Inspectorate of Prisons | | | | Possession risk assessment is advised and all the identified triggers for review are pertinent, however it would be helpful to specify to review at least annually and sooner if circumstances change. | frequency. The recommendation includes a medication review at a point at which circumstances change and in possession can be reviewed. |
| Her Majesty's Inspectorate of Prisons | Full | general | General | **Recommendation 51** : only says consider providing secure storage it would be preferable to say provide secure storage particularly in shared cells – the GDG discussion recorded indicates that provision would be community equivalent. | Thank you for your comment. The following sentences have been added to the Recommendations and link to evidence section 8.5.1: "*The GDG agreed to recommend that prisons should consider the provision of secure storage for all prisoners and this should not be limited just to people in shared cells*" |
| Her Majesty's Inspectorate of Prisons | Full | general | general | **Recommendation 67** Completing the pre-release interview a month before release may increase the number seen but may create risk for some as additional issues may occur leading to duplication or things being missed. A week may be more reasonable for those with non complex needs, however it would be useful to specify at least a month prior to release for those with complex physical health or social care needs. The recommendation reads as though the care summary should be given at this point to the patient however it may be incomplete and it may be difficult for a prisoner to keep it confidential e.g. in a shared cell. It may be preferable to print it on the day prior to release and ensure it is given to them on release. | Thank you for your comment. The GDG have revised the recommendation to those with complex needs having a pre-release health assessment with the MDT.<br>The recommendation does not specify when the care summary should be given to the person prior to release. When and in what form it should be given should be determined locally. |
| Her Majesty's Inspectorate of Prisons | Full | general | general | **Recommendation 68**: discusses that if detainee expected to be in prison less than a month should plan pre-release during reception secondary screen, which is positive. It may be helpful to include that in | Thank you for your comment. We have added the pre-release plan to the second assessment recommendations if the person is to be released in less than 1 months' time. Recommendation 1.1.21 |

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| | | | | the secondary screen recommendations alongside discharge planning for those on remand to ensure it is not missed. | now reads "Plan a follow-up healthcare review at a suitable time based 5 on clinical judgement, taking into account the age of the person and 6 length of their sentence. For people who may be in prison for less 7 than 1 month see recommendation 1.7.5." |
| Her Majesty's Inspectorate of Prisons | Response to Q1 | general | general | Overall this is a comprehensive piece of work which pulls together best practice and should generate increased consistency across all areas covered. Prisons we inspect generally struggle most with:<br><br>Staffing – both for custody staff and across all aspects of the health team administrative, pharmacy, nursing staff, medical, substance misuse) which significantly impacts on prisoners ability to access health services and for health care teams to provide an effective service.<br><br>Unpredictable workload particularly in local prisons exacerbated by medical emergencies including the impact of New Psychoactive Substances which takes resources away from other activities.<br><br>Secondary Health Screens – due to staffing issues, lack of facilities, prisoners not prioritising the appointment the non attendance rate is often high. We advocate a separate secondary screen particularly in local prisons where people come in exhausted, confused and have a lot of information given to them and are asked a lot of questions. Separating out the secondary screen reduces the time in reception, | Thank you for your comment. The GDG recognises the issues and challenges for implementation you raise; these were considered and commented on within the Recommendations and link to evidence sections in the full guideline. See in particular sections 5.8.2 (second-stage health assessment), 8.5.1 (access to medicines), 10.4.1 (deteriorating health and emergency management) and 11.4.1 (continuity of healthcare).<br><br>The GDG recognises that implementing the recommendations will require operational changes, however it considers these achievable and necessary to support equivalence of healthcare in prisons to that provided in the wider NHS. A Quality Standard will be developed after the publication of the guideline to support the implementation of the recommendations and assist in achieving the standard set for prison healthcare.<br><br>Please note that the health assessment on reception applies to the first prison that receives a person, not to subsequent transfers between prisons, and so is |

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| | | | | increases the usefulness of the responses as they will have rested and gives another opportunity to assess them once they have been in prison a couple of days. However non-local prisons may struggle to implement a separate secondary screen due to resources and often combine them to maximise resource effectiveness and prisoner uptake. It may be worth considering if different types of prison can take a different risk based approach.<br><br>Officer supervision of medication queues - we believe this is important and essential to reduce opportunities for bullying and diversion however it will have cost implications and be difficult to implement depending on staffing levels in establishment and the duration of the medication administration session. It may also impact adversely on other aspects of the regime<br><br>Chronic Disease Management – many prisons struggle to recruit and retain staff who have the requisite skills and training to effectively complete chronic disease reviews, particularly within current grading structures. Embedding the NHS over 40 health check and effective chronic disease management that meets NICE guidance in prisons would significantly improve prisoners' health outcomes, but some areas may need increased funding to ensure it happens. It may be very useful to standardise templates and tools on the electronic clinical system alongside reducing the read codes to | not relevant for all types of prison. The GDG agrees that it is beneficial for the second-stage of the assessment to be separated from the first-stage, but for this to be conducted as soon as possible, and in any case within 7 days to maximise completion rates. |

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| | | | | increase consistency.<br><br>External hospital appointments – this is not included in this guideline but we increasingly observe prisoners experience delays which exceed national guidelines due to appointments being cancelled to accommodate emergencies or due to lack of escort staff. Delays in external appointments introduce inequality in healthcare for prisoners as they may not access services within the target timeframes expected for patients in the community. it would be useful to address that within the guideline as it is essential for effective care that prisoners have equivalent access to the community.<br><br>Continuity of health care can be difficult to implement when it is not clear where the prisoner will be released to or when prisoners are released suddenly. Many prisons struggle to set up effective release plans as a result. Joint planning for complex cases with offender managers and the Community Rehabilitation Companies (CRCs) is essential. | |
| Her Majesty's Inspectorate of Prisons | Response to Q2 | general | General | Please see above. | Please see our response to this comment. |
| Her Majesty's Inspectorate of Prisons | Response to Q3 | general | general | Training is central to ensuring some aspects of the guideline are achieved including chronic disease management and training in the electronic clinical record system for example using recall systems etc to make it work effectively. Some prison staff struggle to | Thank you for your comment. The GDG is made up of professionals who work within the prison environment and are fully aware of the challenges presented. The GDG agree staff may require training in order to implement the guidance and this would |

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| | | | | access relevant training, depending on the specialism and size of the provider organisation. Greater access to approved training including web based, face to face and practice based would be helpful.<br>Review of health related Prison Service Orders to ensure they adequately reflect current best practice and service specifications | need to be determined and organised locally. The recommendations are consistent with what can be delivered in prison settings. |
| LGBT Foundation | Appendices | general | General | Some of the points referenced within the Equality Impact Assessment which also have particular impact on prisoners who are trans*.<br><br>For example, the GDG make a recommendation that health checks are offered as frequently as they are in the community, including offering women breast and cervical screening. It is extremely important that trans people are offered screenings that are appropriate to their bodies. For instance, this might mean offering cervical screening to a trans man, and assuming that the individual is placed in a male estate this would not necessarily be considered as a health check to be offered to the whole prison population.<br><br>**Note that trans is an umbrella and inclusive term used to describe people whose gender identity differs in some way from that which they were assigned at birth; including non-binary people, cross dressers and those who partially or incompletely identify with their sex assigned at birth.* | Thank you for your comment. The following sentences have been added to the Recommendations and link to evidence section:<br><br>5.8.2 **"**The GDG discussed issues around people who identify as trans. The GDG agreed that health professionals would ensure that health checks are appropriate to people's bodies. For example, questions 'for women', such as whether they have ever had a cervical screening test or mammogram, might be appropriate to ask trans men to ensure they are appropriately screened." |

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| LGBT Foundation | Full | 14-16 | 2 | The assessments at reception should be conducted using language that is inclusive of lesbian, gay, bisexual and trans people (LGBT), to ensure that any specific needs of LGBT people are brought to light during this process.<br><br>As discussed above, staff should ensure that trans people have access to screenings and other health checks that are appropriate to their bodies. Equally, trans people who are on medications, whether prescribed or not, should be able to continue with their treatment. | Thank you for your comment. The following sentences have been added to the Recommendations and link to evidence section of the full guideline (5.8.2): **"***The GDG discussed issues around people who identify as trans. The GDG agreed that health professionals would ensure that health checks are appropriate to people's bodies. For example, questions 'for women', such as whether they have ever had a cervical screening test or mammogram, might be appropriate to ask trans men to ensure they are appropriately screened. The GDG also noted that healthcare professionals should use language that is inclusive of LGBT people.*"<br><br>References to gender in the recommendations have been edited to make the questions gender neutral where possible. |
| LGBT Foundation | Full | 21-22 | general | It should be made clear to staff delivering the Mental health first-stage assessment and second-stage assessments that for trans people, gender non-conformity should not be pathologised as standard as gender dysphoria.<br><br>Mental health problems can co-exist with gender dysphoria as distinct issues. However, not allowing a trans person to express their gender identity may cause them distress and further impact on their mental health; it is likely that untreated gender dysphoria too will aggravate other mental health issues unless they are address is parallel with the | Thank you for this comment.<br><br>The Guideline Committee were aware of the particular difficulties faced by transgender people in prison and the appropriate identification of mental health problems in this group. Therefore they decided to recommend that the choice of which CMHS scale is used should be determined by the gender that the individual identifies with. |

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| | | | | dysphoria. Competency around mental health and trans people is essential for staff completing these inductions.<br><br>LGBT people as a whole are far more likely to experience mental health problems; for example, 92% of LGB people in Greater Manchester said they had experienced a mental health problem, compared to 25% in the general population (LGBT Foundation, 2014). Equally, staff should feel able to work with all lesbian, gay, bisexual and trans people to ensure any mental health needs are met. | |
| LGBT Foundation | Full | 22 | 33 | The National LGB&T Partnership are welcoming of the recommendation offering interventions to increase HIV testing in Men who have Sex with Men (MSM).<br><br>It should also be made clear that in addition to being at high risk of HIV, MSM are at very high risk of other STIs such as syphilis and gonorrhoea. In 2014, MSM accounted for 81% of all syphilis cases in the UK and 52% of all gonorrhoea cases (PHE data, 2015). HIV prevention work with MSM should therefore be part of a wider programme that ensures MSM are having full STI screenings and given information around wider sexual health.<br><br>It is important that there is a sexual health offer for all LGBT people across all prison estates. Recent PHE | Thank you for your comment. The GDG has adapted the recommendation (1.1.24) to offer HIV tests to all prisoners: 'Offer all prisoners HIV testing when entering prison'.<br><br>The following has been added to the Recommendations and link to evidence section (5.8.4) of the full guideline: 'The GDG noted that LGBT people were often at high risk of STIs. ' |

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| | | | | data has shown that transwomen, alongside MSM, are equally the highest risks groups to acquiring HIV in the UK. HIV and wider STI screenings should therefore be offered to transwomen with equal importance. It is also likely that lesbian and bisexual (LB) women are a high risk group in regards to HIV and STI acquisition; in data from 2012 lesbian women who attended a GUM or sexual health clinic were over twice as likely to receive a diagnosis (PHE data, 2013). | |
| LGBT Foundation | Full | 26 | 17-18 | Trans people who are on medication, whether prescribed by a clinician or accessed via the internet, should not have their treatment interrupted as this can cause massively increased risk of self-harm and suicidality. Hormone treatment, once initiated, even if via the internet, can be undertaken by prison staff and may be continued under 'bridging' prescriptions where treatment is underway.<br><br>Medical staff should therefore be aware of and willing to support treatments such as hormone therapy. There is E-Learning training for GPs available on the Royal College of GP's website which is free to access: http://elearning.rcgp.org.uk/course/info.php?popup=0&id=169 | Thank you for your comment. This scenario would be covered by the question on prescribed medications in the first-stage health assessment and the recommendation on medicines reconciliation (1.1.8): "Carry out a medicines reconciliation (in line with NICE's guideline on medicines optimisation) before the second-stage health assessment. See also recommendations 1.4.1 and 1.7.10-11 for recommendations on risk assessments for in-possession medicines and ensuring continuity of medicine." |
| LGBT Foundation | Full | 59 | 3-25 | LGBT people are far more likely than the general population to self-harm and commit suicide than the | Thank you for this comment. We agree that the risk of self-harm and suicide are important issues but |

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| | | | | general population. Half of trans people have attempted suicide, and lesbian, gay and bisexual (LGB) people are twice as likely as the general population to commit suicide (LGBT, Building Health Partnerships, 2014). It is likely that this could be exacerbated in prison environments, so health professionals doing assessments at reception should be aware of, and address, this inequality. | think that the questions 19 and 20 in table 1 of the first-stage health assessment, apply equally to all people, including those who are LGBT. Training staff to be aware of these issues will be an important part of implementing this guideline |
| Nacro | general | General | General | We welcome the chance to respond to the draft NICE guidelines. Prison is an opportunity to for many individuals to benefit from health gains, contributing to their overall rehabilitation and resettlement once they leave custody. It can be an effective tool in getting an individual back on track and out of a chaotic lifestyle, improving their health and well being.<br><br>Nacro founded the **Offender Health Collaborative**, a partnership of three charities and two universities that was set up to support the development and delivery of the national Liaison and Diversion (L&D) Programme, we have a depth of knowledge around the importance of health provision in custodial settings. We would welcome the opportunity to contribute further to these guidelines. | Thank you |
| Nacro | Short | 4 | 4-13 | We would agree that the first stage health assessment should be undertaken before the individual is allocated to their cell as risk needs to be assessed as | Thank you for your comment. Reference to the PER has been added to the following recommendation: 1.1.2 "Ensure continuity of care for people |

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| | | | | a priority. As 1.1.2 states, this should cover self-harm and suicide and observations of anything that might lead the healthcare professional to believe the individual will be at risk, or at risk of harming others.<br><br>This section does not contain information on or consider how the healthcare professional will use any information passed on from court via the Prisoner Escort Record (PER). The PER contains important information on medication, physical health and indications as to whether the individual is at risk of self-harm and suicide and therefore needs to be considered in first stage health assessments. | transferring from one custodial setting to another (including court, the receiving prison or during escort periods) by, for example:<br>• accessing relevant information from the patient clinical record, prisoner escort record and cell sharing risk assessment<br>• checking medicines and any outstanding medical appointments""<br><br>This has also been added to the Recommendations and link to evidence section 11.4.1: "The GDG noted that information from the prisoner escort record (PER) should be accessed and consulted when people transfer from one custodial setting from another. The GDG also noted that the Cell Sharing Risk Assessments (CSRA) should be consulted for relevant information." |
| Nacro | Short | 8 | Table 1 | We would stress the importance of using physical observations as well as asking questions to the individual around mental health, and risk of self harm and suicide. Many individuals may not feel comfortable disclosing certain information especially on first arrival to prison. It's important that individuals are given sufficient time and know of a 'safe space' to disclose information, alongside the initial first stage assessment regarding any mental health conditions or concerns they may have.<br><br>1.1.3 refers to taking account communication needs or difficulties and it is worth considering a question | Thank you for your comment. The Committee of the Mental health of adults in contact with the criminal justice system guideline agrees and has put in an observational prompt into recommendation 1.1.15 to look at prisoner behaviour. We have also added an observational prompt into the self-harm and suicide queries during the first-stage assessment (Table 1, section 19).<br><br>Communication difficulties are important and this is dealt with in 1.1.3 and refers to relevant NICE guidelines |

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| | | | | around if the individual knows of any learning or communication difficulties they have and being aware that this may impair their ability to self-disclose. This should be noted in observations by the assessor, as someone who may suffer may not know, or know exactly what their specific difficulty is. It is also worth considering that the assessor may have to adapt the assessment if they are aware that there is ADHD, autism etc.<br><br>More generally, the stress experienced by going into custody, for those on remand as well as those having been sentenced, may impair how someone discloses any medical conditions, both physical e.g. drug use, and any mental health conditions.<br><br>It is also worth considering the identification of pre-existing trauma, which can often be below clinical mental health thresholds. This is particularly prevalent amongst gang-involved people. | Stress and of entering custody and pre-existing trauma are considered in the assessment section of the Mental health of adults in contact with the criminal justice system guideline (in development). |
| Nacro | Short | 9 | 3-8 | It is important that individuals are signposted to information on prison health services and feel comfortable in approaching staff to access these services. Ideally, materials with how to do so should be given to the individual to take away and refer to later on. Again, we would reiterate the importance of health-related observations, as disclosure by the individual of conditions, drug use etc. does not always happen. | Thank you for your comment. This is covered by recommendation 1.1.19 'Offer the person advice on… where to find health information that is accessible and understandable' |

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| Nacro | Short | 10 | 11-14 | We would support a second-stage health assessment soon after the first-stage assessment in order to act on outstanding issues quickly and to ensure the prisoner has another chance to disclose or discuss any health related issues. The time between a first and second stage health assessment should also depend on the outcome of the first stage assessment, e.g. concerns over a serious condition. | Thank you for your comment. 7 days is the maximum time period and it was based on the original evidence from Grubin (2002). |
| Nacro | Short | 12 | 13-20 | Providing advice on how to find information on health and GP appointments should be in the most accessible format to ensure take up is high. For many individuals, knowing where or how to talk to prison health services or GPs could prevent a number of long and short term health issues as well as help to minimise risk situations, for example self medication or harm to other individuals. | Thank you for your comment. This is covered in the following recommendations: '1.1.3 Take into account any communication needs or difficulties the person has (including reading and writing ability), and follow the principles in NICE's guideline on patient experience in adult NHS services.'<br><br>And 1.1.5: Give the person advice about how to contact prison health services and book GP appointments in the future. |
| Nacro | Short | 12 | 25-27 | Regular healthcare checks are extremely important, especially for older individuals and those with complex health issues. We would recommend annual checks for preventative purposes, where possible. | Thank you for your comment. There was no evidence identified for 1 year review. Therefore the GDG agreed this should be based on clinical judgement: 1.1.21 'Plan a follow-up healthcare review at a suitable time based on clinical judgement, taking into account the age of the person and length of their sentence.' |
| Nacro | Short | 15-16 | 13-29 & 1-12 | We would agree with and support each of the statements in this section. The key challenges for | Thank you for your comment. The recommendations in this guideline encourage information sharing |

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| | | | | effective co-ordination, case management and communication between healthcare professionals and other people involved in an indivdual's health and care include:<br>number and range of services involved in the care of someone with complex needs or multiple morbidities<br>lack of integration between services<br>absence of information sharing protocols<br>services having different aims and timescales.<br><br>To ensure that there is affective care an integrated person centred approach is needed. Therefore, we would have the following comments to strengthen this guidance:<br>1.2.2 – for this to be realised agencies need to develop an agreed treatment plan which has a shared vision and goals<br>1.2.3 – information sharing is a key element of multi-agency working but needs to be underpinned by a joint information sharing protocol supported by a multi-agency training programme so that all professionals understand their role and responsibilities in respect of requesting and sharing information<br>1.2.4 – whilst the sentiment behind this is correct, it needs to be recognised that multi-agency working is not always easy or straightforward. Rather, sufficient time needs to be freed up so that members can attend multi-agency meetings and reviews. We agree that primary care would be an appropriate vehicle to facilitate this multi-agency approach. | where appropriate and communication between multidisciplinary teams.<br><br>Thank you also for your suggestions. The GDG believe that this level of detail goes beyond the evidence available in this area.<br><br>Regarding family and carers, a sentence has been added to the guideline introduction to acknowledge that liaising with family/carers with consent may be appropriate.<br><br>In recommendation 1.7.9, family or carers have been added to the list of possible people to liaise with before release. |

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| | | | | This section requires a reference to including the individual and their family or carer in action planning, risk assessment, information gathering and informing sharing, and treatment reviews. Many 18 year olds have previously been looked after children and therefore children's services may also have relevant information to inform planning for some individuals. Communication and co-ordination should include the voice of the service user and their family or carer to ensure effective engagement with treatment plans. | |
| Nacro | Short | 16 | 15-16 | Peer support, when implemented and used correctly, can be an extremely effective way of promoting good health and lifestyle in prison in a safe space away from staff. We know that peer support, both in custody and the community, can be extremely beneficial, not only in offering advice and signposting but also on wider improvements in health and hygiene across the prison. The Irish Red Cross have developed a very successful scheme on this - insert web link. | Thank you for your comment. The GDG have made a recommendation to "1.3.1 Consider using peer support and mentoring to help promote a healthy lifestyle while in prison." As there was not enough evidence to support a stronger recommendation a research recommendation was also made by the GDG. |
| Nacro | Short | 16 | 17-23 | We would agree that tailored advice to each individual is extremely important in addressing individual prisoner needs. For example, older individuals in an ageing prison population who have mobility issues and be unable to access facilities. Undertaking a tailored approach means these barriers can be explored and best options found for each individual prisoner. | Thank you for your comment. The role of prison staff in health promotion is discussed in Section 7.6.3 Recommendations and link to evidence for the qualitative review on health promotion. |

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| | | | | Section 1.3 should emphasise the importance of wider prison staff being embedded in a culture of health promotion. Training and developing prison staff in health related observations, as well as knowing where to signpost an individual to appropriate healthcare services is extremely important. This should also include promoting healthy lifestyles on release and how they will continue this in their home environment. | |
| Nacro | Short | 18-19 | 6-28 & 1-14 | We would agree with and support each of the statements in this section. We would make the following comments:<br>1.4.1, 1.4.6 and 1.4.7 – we are fully supportive of individuals holding in-possession medication. We believe that this is more likely to lead to: better compliance; better self-management of any condition; better knowledge of and engagement with the treatment regime; and, better medicine literacy.<br>1.4.5 – we would like to see reference to including the individual prisoner with any risk assessment and review of in-possession medication | Thank you for your comment. We have added 'and the person' to Recommendation 1.4.5 accordingly. |
| Nacro | Short | 20 | 4-30 | 1.6.1 - the point around guidance on sharing information between prison staff and healthcare staff is extremely important and this is something we know often does not happen, or where it does, often lacks efficiency. Establishing a local protocol to ensure information is shared means more effective and responsive management of emergency situations and | Thank you for your comment. |

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| | | | | where an individual's health deteriorates quickly. The level of information sharing will differ from prison to prison, however establishing a robust and consistent process and training staff on this is key. | |
| Nacro | Short | 21 | 4-19 | The point around transferral of an individual's medical records is very important in gaining a clear picture of an individual's medical history and current situation. Continuity of care between custodial settings requires robust information sharing processes, with the prison healthcare team able to access relevant information in a timely manner, ready for when the individual arrives.<br><br>Smooth transfers of information from the youth secure estate and YOTS to adult settings also needs to be referenced. The Comprehensive Health Assessment Tool is a very detailed tool used in the youth justice system that would need to be transferred over in good time to ensure accurate assessments on arrival to adult prison.<br><br>As referenced in comments relating to 1.1.1, Prisoner Escort Records are essential tools in gathering background information and need to be passed on in a timely manner to staff receiving the individual. | Thank you for your comment.<br><br>The recommendations on continuity of care between custodial settings include youth secure estate and YOIs. The list of custodial settings is of examples and is not intended to be comprehensive. The following statement has been added to the section 11.4.1 Recommendations and link to evidence: 'The GDG noted that people could be transferred from Young Offenders Institutions or youth secure estate.'<br><br>Reference to Prisoner Escort Records has been added to recommendation 1.1.2 'Ensure continuity of care for people transferring from one custodial setting to another (including court, the receiving prison or during escort periods) by, for example:<br>• accessing relevant information from the patient clinical record, prisoner escort record and cell sharing risk assessment<br>• checking medicines and any outstanding medical appointments'. |
| Nacro | Short | 21 | 21-24 | We would argue that re-release health assessments should happen before 1 month of pre release, as soon as is possible. Ensuring the individuals health and care needs are met in the resettlement process is vital | Thank you for your comment. The current recommendations states that pre-release health assessments should happen at least 1 month before release. |

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| | | | | in continuity of care into the community. Like all other aspects of resettlement plans, health and care needs should be considered early to ensure a smooth transition into the community. Resettlement brokers/responsible officers in the prison, and through to the community should have access to any relevant information shared by the prison (with the consent of the individual). This information can help inform other areas of resettlement, for example suitable housing, employment etc.<br><br>It is also worth considering that many services or interventions in the community, for example substance misuse services, have long waiting lists and need to be considered well in advance. Provision in custody needs to link smoothly to the community, especially around preventing relapse. | The following statement has been added to the Recommendations and link to evidence section 11.4.1: 'The GDG noted that resettlement plans should be considered early to ensure a smooth transition into the community as many services in the community, for example substance misuse services, have long waiting lists and need to be considered well in advance.' |
| Nacro | Short | 22 | 22<br><br><br><br><br>24 | **1.7.8**<br>Linked to the comment above, it is important to ensure enough time to register the individual with a GP so this service can be accessed immediately upon release if needed and ensure smooth continuity of care. A process should be in place so that GPs can be passed all relevant medical information.<br><br>**1.7.9**<br>We fully support this point, as liaison with services providing care and support to individuals after they leave custody will need background and relevant | Thank you for your comment. The following has been added to the Linking Evidence to Recommendations section 11.4.1: "The GDG agreed that healthcare staff should encourage and assist people in prison to register with a GP in the community before release and that sufficient time should be given to enable this process to run smoothly" |

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| | | | | information to ensure continuity of care and take account of any events that happened while the individual was in prison.<br>This could also include community, VCS and support groups accessed on release. | |
| National AIDS Trust | Full | 16 | general | Currently testing for HIV is included in a second separate box called 'Other assessments'. However, NHS England, PHE and NOMS have introduced a policy of 'opt out' testing for BBVs in all prisons. This means an 'opt out' test should be offered to all prisoners during the reception assessment part two. It's important to note that the 'opt out' test should be offered to all prisoners, not just those that might currently be recommended a test under current NICE guidelines (which currently focus on men who have sex with men and black African communities, though are being revised).<br><br>For this reason NAT would like to see the text on 'other assessments' that relates to BBV testing integrated into the 'Reception assessment part two, within 7 days.' We would also like to see reference to the 'opt out' policy and the guidance that has been developed by PHE, NHS England and NOMs referenced within the guideline.<br><br>We would also highlight the importance of the phrase 'opt out' being used in reference to BBV testing. Currently the text mentions 'offer testing for hepatitis B | Thank you for your comment. The recommendations for hepatitis B, C and HIV have been moved to the second assessment section. The GDG agree that the recommendation for HIV testing should apply to all people in prison and have changed the wording to offer to all people, which is in line with the 'opt out policy'. |

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| | | | | and C and HIV.' The new policy has purposefully adopted an 'opt-out' approach following the success of 'opt-out' testing in antenatal care which has been shown to be far more effective than 'opt-in' testing. | |
| National AIDS Trust | Full | 18 | General | Algorithm 4 'Maintaining and promoting physical health in prison' refers to free and discreet access to condoms and dental dams, which we welcome. However, there is no reference to disinfecting tablets. These are meant to be provided to prisoners to assist with preventing the transmission of BBVs and yet we have been contacted by prisoners who have had difficulty accessing disinfecting tablets. It would be helpful if these could be included in the algorithm. | Thank you for your comment. The use of disinfecting tablets was not considered by this guideline and therefore we are unable to include this in the algorithm. However, drug misuse will be covered by the accompanying guideline mental health of adults in contact with the criminal justice system currently in development. |
| National AIDS Trust | Full | 18 | general | Algorithm 4 'Maintaining and promoting physical health in prison' mentions a number of chronic conditions but does not include HIV. This maybe because there are not NICE guidelines for HIV (a point that is referenced later in the document). However BHIVA guidelines are NICE accredited and so we would like to see HIV included here and reference to the BHIVA NICE accredited guidelines elsewhere in the guideline. | Thank you for your comment. HIV was not one of the prioritised chronic conditions identified for review by the GDG. However, reference to the BHIVA guideline is made in the Recommendations and link to evidence section of this chapter. |
| National AIDS Trust | Full | 19 | general | Algorithm 5 'Continuity of care on release or transfer'. We welcome the specific reference to HIV in relation to a medicinal review but would suggest that the minimum number of days medication is provided for on release is amended to be a month. Seven days | Thank you for your comment. Please note that the recommendation indicates that 7 days is the minimum number.<br><br>The GDG feel that a month of medicines is not |

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| | | | | medication, as currently stated, would not give somebody enough time to get an appointment with a new HIV clinic given all the other things they would be managing at this time of transition. | feasible for all medicines and is not equivalent with HIV medicines, which are provided via secondary care and not by the prison GP/pharmacy. Access to post-release HIV services forms part of release planning which would include access to medicines post-release. |
| National AIDS Trust | Full | 21 | 3 | There appears to be some text missing here. It says 'asking the person about:' | Thank you. This typo has now been corrected. |
| National AIDS Trust | Full | 21 | 5 | As mentioned above in relation to Algorithm 4, 'opt out' testing for BBVs should be included in the second stage health assessment in line with the NHS England, PHE and NOMS Partnership Agreement to roll out this policy by 2017 (see:<br>2015-2016 National Partnership Agreement, p21). | Thank you for your comment. Hepatitis B and C, and HIV have been added to the second-stage assessment |
| National AIDS Trust | Full | 22-23 | 19 – 43 & 1-8 | We would recommend that the text in relation to BBV testing is updated to be in line with the NHS England, PHE and NOMS policy of 'opt-out' testing in prisons. It is particularly important that the 'opt-out' nature of the testing is highlighted as this testing model has shown to be very effective in increasing uptake of testing. We would also underline that the 'opt-out' testing policy which is supposed to be implemented across the prison estate by 2017 is a universal offer for all prisoners and so HIV testing should not just be focused on men who have sex with men as in this current guideline. This would be a very difficult model to follow in a prison setting. Many prisoners will not feel able to be open about their sexual orientation in a | Thank you for your comment.<br><br>Recommendation 1.1.23 regarding vaccination is from existing NICE guidance on hepatitis B and C testing.<br><br>This recommendation states that prisoners should be offered hepatitis B vaccination. As a recommendation, this is not in conflict with NHS/PH/NOMS' 'opt-out' policy.<br><br>The GDG agree that the recommendation for HIV testing (1.1.24) should apply to all people coming into prison and have changed the recommendation to |

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| | | | | prison environment so many who are at high risk would not be offered testing using this approach. It also fails to take into account women and men who inject or have injected drugs and people from black African communities who are also at higher risk of HIV. We would note that the NICE guideline on testing that is currently referenced is being updated and reviewed and the scope widened from men who have sex with men to include other at risk groups, including people who inject drugs.<br><br>We would also like to see a greater focus in the text on signposting those who are given a positive test result to support services and for ongoing support for those already aware of their status. Psychological support is a key part of the care pathway for people living with HIV. NHS England's service specification for adults FO3 (https://www.england.nhs.uk/commissioning/spec-services/npc-crg/blood-and-infection-group-f/f03/) specifically mentions this:<br>"The provider is responsible for collaborating with other health, social care and third sector organisations as appropriate to help ensure the holistic needs of patients are met. In particular this is likely to include:<br>• Community services provided by third sector and other organisations. These services can provide important support on long-term condition management…." | offer to all people.<br><br>The importance of psychological support as part of care for people with HIV has been noted in the Evidence to recommendation section of the full guideline (section 5.8.4). |

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| | | | | We welcome the focus within the guideline on supporting equivalence of healthcare in prisons; if this to occur for people living with HIV, there needs to be a much greater focus on providing those with HIV with psychological support, particularly those diagnosed within a detention setting. | |
| National AIDS Trust | Full | 23 | 25 - 31 | We welcome the focus on screening for TB. We would however suggest the inclusion of a recommendation that those with confirmed TB are offered an HIV test in line with clinical guidelines. | Thank you for your comment. Please see the new recommendation (1.1.24) on HIV: 'Offer all people HIV testing when entering prison.' |
| National AIDS Trust | Full | 24 | 37 | We welcome the focus on sharing information if it is in the patient's best interest but would also like to see some content on remembering the importance of confidentiality as this is an issue which has been raised with us by prisoners living with HIV who have faced stigma and discrimination in a prison setting. | Thank you for your comment. The GDG agree that confidentiality is important and have revised the wording of the recommendation to state that information should be shared with those involved with the person's care when it is necessary for management of that person's care. The balance between maintaining confidentiality and sharing information when managing the person is discussed within the Recommendations and link to evidence section of the Coordination and communication chapter. |
| National AIDS Trust | Full | 24 | 13 | We would like to see some content on the provision of disinfecting tablets contained within this section on promoting health and well-being. All prisons are | Thank you for your comment. Promoting health was included in the scope but health protection was not.' 'We recognise the importance of the issue, and we |

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| | | | | meant to provide disinfecting tablets but we have been contacted by prisoners who are unable to access these. | will consider it for possible inclusion when the guideline is reviewed for update. |
| National AIDS Trust | Full | 26 | 56 | As noted above we would recommend that more than seven days medication is provided to prisoners on their release. Adherence to HIV medication is essential for its success and seven days does not seem sufficient time for someone to make and keep an appointment with an HIV clinician given all the other changes that will be going on in their life at that time. We would recommend a minimum of one month's supply. | Thank you for your comment the recommendation states 'an minimum of 7 days' prescribed medicines', this would allow greater than 7 days' worth of medicines to be given in some cases. |
| National AIDS Trust | Full | 27 | 60 | Under 'Monitoring chronic conditions' we would like to see HIV included as noted above and are concerned that it has not been included because there are not relevant NICE guidelines. We would note that the BHIVA guidelines are NICE accredited and ask for them to be included at 3.3.3. which lists related guidelines. | Thank you for your comment. HIV was not one of the prioritised chronic conditions identified for review by the GDG. Reference to the BHIVA guideline is made in the Recommendations and link to evidence section of this chapter. |
| National AIDS Trust | Full | 105 | general | We would suggest that the provision of disinfecting tablets is mentioned as part of the information provided to people who talk about current intravenous drug use. | Thank you for your comment. Promoting health was included in the scope but health protection was not.' 'We recognise the importance of the issue, and we will consider it for possible inclusion when the guideline is reviewed for update. |
| National AIDS Trust | Full | 116 | general | PHE, NHS England and NOMs developed background material and looked at research and prevalence as part of the development of the 'opt-out' BBV testing in prisons policy. This material does not seem to have been considered and we would suggest | Thank you for your comment. BBV testing was not reviewed as part of this guideline because NICE guidance is already available and has been incorporated. It is therefore not possible to include other research on this topic. |

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| | | | | it is included in this section and that the guideline is amended to reflect the new policy. | |
| National AIDS Trust | Full | 246 - 247 | 25 – 27 & 1-4 | NAT believe HIV must be added to the list of chronic conditions given the higher prevalence amongst the prison population than the community as a whole and the impact of poor management on individuals' health. We note that one reason for including conditions is to specifically mention those 'where poor management has a significant impact on health outcomes.' If managed well HIV is a long term condition and people doing well on treatment can expected to have a normal life expectancy. However access to treatment and good treatment adherence is essential and HIV must be one of the best examples of where poor management has a significant impact on health and can ultimately be fatal. We are concerned that HIV may not be included on the list because of the absence of NICE guidelines but would highlight that the BHIVA guidelines are NICE accredited and so should be considered in the same way. For this reason HIV should be added here and in the table on p275. | Thank you for your comment. HIV was not one of the prioritised chronic conditions identified for review by the GDG. However, the GDG agree HIV is a significant health issue and have amended recommendation 1.1.24 to include testing of all people coming into prison. Reference to the BHIVA guideline is made in the relevant Recommendations and link to evidence section (9.6) of the full guideline. |
| National AIDS Trust | Short | 8 | general | As noted the above, when people are asked about intravenous drug use, they should be provided with information about the availability in prisons of disinfecting tablets as prisons are obliged to provide these as a public health intervention. | Thank you for your comment. Promoting health was included in the scope but health protection was not.' 'We recognise the importance of the issue, and we will consider it for possible inclusion when the guideline is reviewed for update.<br>. |
| National AIDS Trust | Short | 10 | 29 | The section on BBV testing should be included within the second-stage health assessment in line with the | Thank you for your comment. The recommendations for hepatitis B, C and HIV have been moved to the |

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| | | | | 'opt-out' BBV policy being rolled out across the prison estate. The language must reflect the universal offer of the tests and that they are 'opt-out' as this will increase uptake. PHE, NHS England and NOMs can provided detailed background information on the evidence collected for the introduction of this programme. | second assessment section. By offering the tests the person would receive them unless they choose to opt out, therefore we consider the wording to be in line with the 'opt out 'policy. |
| National AIDS Trust | Short | 13-14 | 5-26 & 1-2 | As noted above this information should be included within the second-stage health assessment. It is essential that in the prison environment testing for HIV is not limited to men who identify as gay or bisexual as this will mean many people at risk of HIV are not offered testing (including people from black African communities and women and men who inject or have injected drugs). Individuals will be unlikely to identify as gay or bisexual in a prison environment and so the current recommendations are unlikely to be effective even with this group. As noted above the scope of the current NICE guidelines on HIV testing is being reviewed and widened. Given the higher prevalence of BBVs in the prison population, there should be a universal 'opt-out' testing offer to prisoners in line with PHE, NHS England and NOMS policy. Staff should be trained in how to do this. We would also like to see a greater emphasis on sign posting people to support if they have a positive test result in line with NHS England's service specification for HIV (F03) which underlines the importance of holistic support for people living with HIV (see comment 7 above). | Thank you for your comment. The recommendations on HIV (1.1.24 to 1.1.28) have been moved to the second assessment section. The GDG agree that recommendation 1.1.24 for HIV testing should apply to all people in prison and have changed the wording to offer to all people, which is in line with the 'opt out 'policy. Offering support to those with a positive test has been highlighted in the Recommendations and link to evidence section (5.8.4) of the full guideline. |
| National AIDS Trust | Short | 14 | 4 | The need to stress patient confidentiality when | Thank you for your comment. This issue has been |

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| | | | | discussing sexually transmitted infections should be underlined here. | identified in the qualitative barriers to health promotion review, please see the following sentence in the relevant Recommendations and link to evidence section of the full guideline (7.6.3): 'The GDG noted that lack of privacy or confidentiality in accessing health promotion services or activities was a barrier to health promotion, particularly with regards to sexual health. The GDG agreed that some health promotion information should be available in a discrete manner which enables the prisoner to access the information privately, for example information around sexual health may require discretion and sensitivity'. Please also see the reference to the patient experience guideline in the reception health assessment section, which addresses confidentiality issues: 'Take into account any communication needs or difficulties the person has (including reading and writing ability), and follow the principles in NICE's guideline on patient experience in adult NHS services.' |
| National AIDS Trust | Short | 14 | 28 | All those with confirmed TB should be offered an HIV test in line with clinical guidelines. | Thank you for your comment. Recommendation 1.1.24 states that all prisoners entering prison should be offered testing for HIV. |
| National Offender management Service | Short | 4 | General | It would be helpful to clarify if this section relates to first reception into custody only, or the prisoner's first arrival at subsequent prison(s) as part of the offender journey? These distinct events may merit separate consideration. | Thank you for your comment. The first-stage health assessment is for first reception into prison. This would currently be in a Category A or B prison where GPs would be present. The GDG has revised the table to clarify where the person should be referred to a GP, relevant clinic, or other health professional. |

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| | | | | | Recommendation 1.1.2 has been added to clarify the process for people transferring between custodial settings prisons where a GP would not be present. |
| National Offender management Service | SHORT | 7 | General | Independent Living – it would be helpful to put greater emphasis on the role of, and referrals to, social care services as part of an integrated approach | Thank you for your comment. Liaison with the prison disability lead is made as part of the reception assessment. Other recommendations include sharing information with social care staff involved with the person's care and social care needs and onward referral to social services as part of the pre-release action plan. |
| National Offender management Service | SHORT | 8 | 3.2 | Should this include anabolic steroids / performance and image enhancing drugs in assessment list for 'type and frequency of drug use'? | Thank you for this comment. We have added anabolic steroids to the list in question 14 of Table 1. |
| National Offender management Service | SHORT | 8 | 3 | Ought this to identify any engagement with psychosocial substance misuse services? | Thank you we have amended section 16 of Table 1 to reference community mental health services, alcohol or substance misuse services or learning disability services. |
| National Offender management Service | SHORT | 8 | 4 | To strengthen the focus on continuity of care, it would be helpful if more recognition could be made of the care pathway from police custody and court; in particular information available from NHS England (Health & Justice) commissioned Liaison & Diversion services to inform screening. | Thank you for these comments. The Mental health of adults in contact with the criminal justice system guideline has included recommendations relating to the pathway through care of people with a mental health problem. |
| National Offender management Service | SHORT | 5<br><br>9 | General | It would be helpful to have mention of tobacco use in the first stage assessment in light of implementation of smoke free prisons policy. Assessment would be helpful at both reception and secondary screen to | Thank you for your comment. The GDG felt that smoking status was not an urgent health issue for first week safety so is asked at the second-stage assessment rather than the first stage. Smoking |

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| | | | | support appropriate interventions. | status for immediate administrative issues (such as cell allocation) rather than health issues would be dealt with elsewhere in the prison. |
| National Offender management Service | SHORT | 5<br><br>9 | General | It would be helpful to have increased recognition that prisoners may be received at the prison on an existing pathway that requires continuity of care e.g. BBV, palliative care. | Thank you for your comment. The first-stage health assessment table for first reception into prison contains a section on past and future medical appointments.<br><br>Recommendation 1.1.2 has been added to reinforce that care should be continued for people transferring from custodial setting to another.<br><br>Recommendations have been made to carryout assessment or monitor people with diagnosed chronic conditions in line with existing NICE guidance. See recommendations 1.1.14 and 1.5.1. For other NICE guidance such as hepatitis B and C, HIV, TB and STIs relevant recommendations have been directly incorporated into the guideline.<br><br>Please note that end of life care is beyond the scope of this guideline. |
| National Offender management Service | SHORT | 10 | 1.1.8 | Secondary health screen within 7 days of the first reception screen is a considerably longer period than is currently typical. Should a prisoner's first reception screen be limited (e.g. by a prisoner's limited engagement on a late reception) this may present risks. | Thank you for your comment. 7 days is the maximum time period and it was based on the original evidence from Grubin (2002). |
| National Offender management Service | SHORT | 15 | 1.2 | There is an opportunity for references to integration with local authorities' duties in respect of social care in | Thank you for your comment. The environment in which health and social care is provided was |

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| | | | | prisons (and the community) to be strengthened throughout | carefully taken into account during guideline development |
| National Offender management Service | SHORT | 18 | 1.3.8 | Reference to access to condoms should refer to this being as part of a scheme locally agreed with the Governor. | The GDG agreed condoms should be made available without needing to ask and this should be applied nationally. |
| National Offender management Service | SHORT | 18 | 1.4.1 | The risk assessment may relate to the person or their circumstances (e.g. cell sharing/bullying); it would be helpful to clarify that it is not the person who necessarily 'fails' the risk assessment. | Thank you for your comment. In line with NICE language, the GDG agreed on the wording of 'does not pass the risk assessment' to avoid mention of failing. |
| National Offender management Service | SHORT | 12 | 1.13 | *Asking* prisoners about healthy lifestyle activities might also incorporate *sign-posting to, and encouraging involvement in,* such activities within the prison. | Thank you for your comment. This guideline makes recommendations on both encouraging exercise (1.3.3-1.3.4) and offering information about healthy diet (1.3.5). |
| National Offender management Service | SHORT | 22<br>23 | 1.79 | We would like to see stronger references to probation services (National Probation Service and Community Rehabilitation Companies) and the National Offender Management Services' Approved Premises estate. We (NOMS) can assist with additional wording in respect of integration with the justice pathway. | Thank you for your comment. These are referenced in the Recommendations (e.g. 1.2.2 and 1.7.9) and link to evidence sections (e.g. 6.6 and 11.4.1). |
| National Offender management Service | SHORT | 21<br>22 | 1.76 | It would be helpful to Include reference to post release licence conditions in respect of substance misuse, which can support engagement in the post custody substance misuse pathway. We (NOMS) can assist with additional wording. | Thank you for your comment. This is dealt with in the Mental health of adults in contact with the criminal justice system guideline (in development) in terms of transition from prison to mental health and substance misuse services. |
| National Offender management Service | SHORT | General | General | We would like to see reference to palliative and end of life care. | Thank you for your comment. Palliative and end of life care were not included in the scope, as existing NICE guidance is available and applicable to a prison population. |

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| | | | | | The NICE Care of the dying adult guideline (NG31) has been referred to in the Recommendations and link to evidence sections of the access to medicines and continuity of medicines chapters in relation to the management of medication at the end of life. It is also referred to within the monitoring of chronic conditions chapter. |
| National Offender management Service | SHORT | General | general | In light of learning from incidents, including investigations by the Prison Probation Ombudsman, the guidance has insufficient emphasis on the sharing of information with non-clinical staff. This is an area of persistent risk that might be addressed by (a) a requirement that healthcare staff advise each prisoner that information will routinely be shared with other (non-clinical) staff to prevent significant harm to self or others and (b) providing prisoners with the opportunity to consent to the wider sharing of information with custodial staff and partners agencies (e.g. social care provider, Community Rehabilitation Company) to promote their integrated care and management within prison and/or planning for transfer/release. It is also helpful to note the statement on information sharing from the Independent Advisory Panel on Deaths in Custody, which is referenced in the National Partnership Agreement between NOMS, NHS England and Public Health England; its main aim is to support the sharing of information from clinical to non-clinical staff. | Thank you for your comment. This guideline recommends the framework within which clinical and professional judgement should be made.<br><br>Recommendation 1.2.2 states: *Share information with other health and social care staff, offender supervisors and probation providers who are involved in the person's care in prison when necessary for the person's care.* |
| National Offender | SHORT | General | General | Continuity of care, and an integrated multi-disciplinary | Thank you for your comment. 'National Probation |

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| management Service | | | | approach particularly with probation and Through the Gate services should be given greater emphasis throughout the document. | Service and/or community rehabilitation company (CRC)' has now been added to the bullet point list in recommendation 1.7.9. 'Probation staff' has also been added to the examples in the glossary definition of multidisciplinary team. |
| National Offender management Service | SHORT | General | general | Consideration might be given to the introduction of the Health & Justice Information System, and appropriate references in this light. | Thank you for your comment. The GDG is aware of these developments; however these will not be completed before the guideline is published. References to these developments will be included when the guideline is updated. |
| NHS England | Short | 6 | 4 | Topic question 2.4 to include oral,or dental health problems eg toothache, broken teeth | Thank you for your comment. Dentistry is not included within the scope of the guideline. Very little evidence was identified on oral health and therefore no detailed recommendations could be made. Oral hygiene has been added to the list of health information that should be provided. |
| NHS England | Short | 7 | 1 | Topic question 2.8 - do they wear dentures | Thank you for your comment. Dentistry is not included within the scope of the guideline. |
| NHS England | Short | 7 | 1 | Topic question 2.9 have they seen a dentist in past 6 months and if so, what for?<br>Also - any outstanding dental appointments | Thank you for your comment. Dentistry is not included within the scope of the guideline. |
| NHS England | Short | 7 | 1 | Topic question 3.2 drug use - refer to dentist if using methadone | Thank you for your comment. The GDG feel that this would form part of the substance misuse care plan and is not needed as an action here. |
| NHS England | Short | 9 | 4 | 1.1.4 - How to contact prison dentist | Thank you for your comment. Dentistry is not included within the scope of the guideline. |

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| NHS England | Short | 10 | General | 1.1.8 - include oral health check /questions | Thank you for your comment. No evidence for oral health was identified in this area. Information regarding oral hygiene has been added in the health promotion recommendation. |
| NHS England | Short | 12 | General | 1.1.12 - include oral health advice | Thank you for your comment. No evidence was found to include this as part of the assessment. Oral hygiene has been added to the list of health information that should be provided as part of health promotion. |
| NHS England | Short | 12 | general | 1.1.14 - include dentists | Thank you for your comment. Dentistry is not included within the scope of this guideline. |
| NHS England | Short | 16 | General | 1.3.2 - include tooth brushing | Thank you for your comment. No evidence was found to include this as part of assessment. Oral hygiene has been added to the list of health information that should be provided as part of health promotion |
| NHS England | Short | 21 | general | 1.7 - discharge to dentist | Dental health was not included as part of this guideline. Oral hygiene has been added to the list of health information that should be provided as part of health promotion. |
| NHS England | Full | 22 | 31 | The suggestion of sending Hep B and Hep C test results to community based GPs could be a challenge for the healthcare provider as many prisoners will not have been historically registered with GPs.<br>Prisoners who have been registered are unlikely to want their community GP being aware that they are in or have been in prison.<br>Foreign national prisoners (where Hep B and C may be more prevalent) will not have been registered with a community GP. | Thank you for your comment. The GDG is aware of the difficulty that people not being registered with a community GP puts on sending information to community GPs. Therefore the GDG have amended the recommendation to giving the care summary to the person on release from prison rather than the GP (see recommendation 1.7.7. 'Give the person a copy of the care summary and post-release plan')<br><br>The following has been added on consent to the |

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| | | | | I am unsure how the proposal will work in practice? The current patient record system is a stand-alone/ autonomous system and does not 'talk' to GP systems to allow results to be shared.<br>The second generation system is more flexible however it would take time to implement. | Recommendations and link to evidence section 11.4.1: "*The GDG discussed the transfer of medical records from prison to the community, including issues regarding consent and confidentiality. The GDG noted that in the community when you move from one GP to another GP, you give tacit consent for your records to be moved to the new setting. The GDG agreed that this should also apply when registering with a GP on leaving prison.*"<br><br>The GDG noted the importance of improving communication and information sharing between health professionals in prison and in the community, in line with other sectors. The GDG noted that IT developments are likely to support this change. |
| NHS England | Full | 23 | 34 | Named Healthcare lead- The proposal of a named healthcare coordinator for each prisoner and awareness of all prison and healthcare staff regarding the link is an excellent idea in principle however could be a challenge in practice for healthcare and the prison.<br>Healthcare staff tend to be multidisciplinary, rotational and transitional.<br>I think the lead would have to be attributed to a post for all prisoners on a wing rather than specifically named persons.<br>The communication and awareness of all healthcare staff and prison staff regarding the link would have to be managed by a frequent and coordinated approach to communication, especially in prisons with a very | Thank you for your comment. Recommendation 1.2.3 has been amended so that only people with complex health needs have a lead care coordinator.<br><br>Recommendations 1.2.1 and 1.2.2 encourage communication and information sharing, where appropriate, for the care of all people in prison. |

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| | | | | high churn. | |
| NHS England | Full | 24 | 37 | Smoking- NRT from healthcare should only be offered to prisoners who want to quit and are signed up to motivational support.<br>Using NRT in isolation (away from abstinent-contingent treatment) contravenes NICE guidance. | Thank you for your comment. The recommendation (1.3.6) has been amended to make clearer support to stop smoking should be as part of a smoking cessation service which would comprise of a range of interventions including NRT. |
| NHS England | Full | 27 | 37 | Transfer- this section has stated the importance of medications, information transfer and FP10s.<br>It would be useful to add a bullet point around the transfer of personal healthcare items such as optical glasses and false teeth.<br>These items are rarely transferred with a prisoner, resulting in high costs - and the healthcare provider's time – for reassessments and reissuing. | Thank you for your comment. This recommendation lists key examples identified as key to person health. It is not intended to be an exhaustive list. |
| NHS England | Full | 23 | 11 | X-ray of all prisoners within 48 hours (excluding prisoners who have had chest X-rays in the past 6 months) would cause significant issues for the primary care team to arrange and schedule.<br>It is likely to have commissioning and financial impacts as X-ray sessions will usually be commissioned for a limited number of sessions once or twice per week, depending on the population size and need. | Thank you for your comment. This recommendation has been adopted from the NICE tuberculosis guideline As stated within NICE TB guideline NG33 which has been in place since 2012. The GDG reviewed the recommendations and considered them to be achievable. |
| NHS England | Full | 23 | 21 | Mobile X-ray- This could have significant cost implications for PHE and depending on the frequency of use would require a commissioning process. Mobile X-rays also require security clearance, the availability of a room in healthcare and radiation protection arrangements. | Thank you for your comment. The recommendation states to consider using a mobile x-ray. Further guidance on the use and commissioning of mobile x-ray is given in the tuberculosis guideline NG33. |

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| NHS England | Full | 26 | 3 | Lockable cupboards- The suggested lockable cupboards for the storage of in- possession medications would be very advantageous but could have significant cost implications for HMPS/ NOMS. For example Springhill prison is comprised of prefabricated buildings which could not safely and securely hold lockable cupboards on the walls and would require major infrastructure changes.<br>The cost of implementing lockable boxes in all cells across all establishments could be significant. | The GDG has noted that there would be a cost to providing lockable cupboards to those prisoners with in-possession medicine, but it did not seek to quantify the cost as this would vary considerably depending on the prison. It noted that cupboards are already provided in a minority of prisons. As a result the GDG made a recommendation for each prison to 'consider' providing storage, rather than a recommendation that storage must be provided.<br><br>However, the GDG did also note that secure storage is standard in hospitals, and that lockers can have additional non-healthcare related uses (for storing personal documents and valuables).<br><br>The GDG also noted that providing cupboards to store sensitive information/property by prisoners including medicines, especially in shared cells is a decency issue. |
| NHS England | Full | 23 | 34 | Healthcare champions/ peer supporters remain a key example of best practice across establishments and act a conduit between prisoners and Prison and healthcare staff.<br>The healthcare champion would support the coordination and communication of a named healthcare coordinator proposed in the guidance. | Thank you for your comment. The evidence in this area was found to be unclear and a research recommendation has been made. |
| NHS England | Short | 20 | 6 | Within this section, please include the scenario of somebody who is imminently dying, or in the last days to hours of life – this would represent 'rapidly deteriorating health' but because it may not be | Thank you for your comment. End of life care is outside the scope of this guideline as existing NICE guidance is available and applicable to a prison population. Care of the dying adult guideline (NG31) |

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| | | | | recognised as such, that should be explicitly stated as an example. | has been referred to in the Recommendations and link to evidence sections of the access to medicines (8.5.1) and continuity of medicines (8.5.2) chapters of the full guideline in relation to the management of medication at the end of life. It is also within the monitoring of chronic conditions section (9.6) of the full guideline. |
| NHS England | Short | 20 | 27 | This section also needs to include an explicit reference to somebody who is facing the end-stage of their chronic illness, and therefore likely to die within months. | Thank you for your comment. End of life care is outside the scope of this guideline as existing NICE guidance is available and applicable to a prison population.<br>Care of the dying adult guideline (NG31) has been referred to in the Recommendations and link to evidence sections of the access to medicines (8.5.1) and continuity of medicines (8.5.2) chapters of the full guideline in relation to the management of medication at the end of life. It is also within the monitoring of chronic conditions section (9.6) of the full guideline. |
| NHS England (second set of comments) | Short | 4 | 1.1.2 | Opening statement should emphasise the primacy of safety . | Thank you for your comment. A sentence has been added to the guideline introduction to reinforce this point. |
| NHS England (second set of comments) | Short | 5 | 1.1.3 | cross reference to equality and diversity/equality duty ( thinking about all protected characteristics ) | Thank you for your comment. The recommendation on communication needs (1.1.3) has been widened to include anyone who may have reading or writing difficulties. Literacy issues have been added to the NICE equality impact assessment carried out for all stages of NICE guideline development, as well as the guideline introduction. |
| NHS England (second set | Short | 5 | 1.1.3 | References to checking for consent and capacity ? | Thank you for your comment. This is covered by the |

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| of comments) | | | | | recommendation (1.1.3) and the reference to NICE's guideline on patient experience in adult NHS services which includes consent and capacity. |
| NHS England (second set of comments) | Short | 5 | 2.1 | Opportunity missed to reference a cross referencing with the PER form as need to check if patient has been given any medicines in police cells | Thank you for your comment. Reference to Prisoner Escort Records has been added to recommendation 1.1.2 "Ensure continuity of care for people transferring from one custodial setting to another (including court, the receiving prison or during escort periods) by, for example:<br>• accessing relevant information from the patient clinical record, prisoner escort record and cell sharing risk assessment<br>• checking medicines and any outstanding medical appointments". |
| NHS England (second set of comments) | Short | 5 | 2.2 | may benefit from stipulating injuries are assessed and recorded on a standard 'body map' | Thank you for your comment. This has now been specified in the action for '2.2 Physical injuries'. |
| NHS England (second set of comments) | Short | 5 | 2.3 | Questions re head injury . if these screen positive will there be automatic need to undertake the brain injury assessment | Thank you for this comment. We suggest consideration for referral for a specialist assessment, it may not always be necessary to refer for 'a brain injury ' assessment until closer questioning and assessment has determined the nature of the head injury. |
| NHS England (second set of comments) | Short | 6 | 2.7 | Consideration of perinatal mental health for individuals who test positive and also need to identify those who have recently had a baby who could have adjustment issues or postnatal depression (crossover with mental health prison guidelines) | Thank you for this comment. In the Mental health of adults in contact with the criminal justice system guideline we cross refer to other mental health guidelines including the Antenatal and postnatal mental health guideline. |
| NHS England (second set of comments) | Short | 7 | 2.8 | Could be prompt need for social care assessment in line with social care act. There may be an immediate need for aids and adaptations – e.g. wheelchair. | Thank you for your comment. Liaison with the prison disability lead is made as part of the reception assessment. Further assessment or referral may be |

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| | | | | Social care assessments to be conducted in line with requirements of CARE ACT | necessary at this point but not as part of reception assessment. |
| NHS England (second set of comments) | Short | 7 | 2.8 | Concern in request to catering if 'special diet' . CRG prison diets group and HMIP Findings report. Need for careful assessment of dietary need before request to catering made and some prisoners will report intolerances but there may not be documented evidence available.<br><br>Role of the health professional in informing prison catering departments . Clarity on NOMS position on this. Can place the health professional in role of advocating for special diets and may be a security or prison catering department and guideline issue | Thank you for your comment. We have clarified this recommendation to 'special medical diet'. |
| NHS England (second set of comments) | Short | 7 | 3.1 | Needs to be explicit about what screening tools are recommended AUDIT C, FAST Single alcohol questionnaire, also what dependence measures and monitoring we will be advocating SADQ, CIWA- AR. | Thank you for this comment. The screening for drugs and alcohol has been designed around the widely used Grubin questionnaire. The measures you refer to may be used as part of more specialist assessment. |
| NHS England (second set of comments) | Short | 7 | 3.2 | Need for guidance on assessment of drugs dependency. Physical and psychological dependency assessment and consistent screening. would we not expect assessment of smoking status and offer of early intervention and nicotine replacement form part of the first phase screen | Thank you for your comment. This guideline recommendations advice on smoking cessation and interventions in the section on promoting health.<br><br>The GDG felt that smoking status was not an urgent health issue for first week safety so is asked at the second-stage assessment rather than the first stage. Smoking status for immediate administrative issues (such as cell allocation) rather than health issues would be dealt with elsewhere in the prison reception process. |

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| NHS England (second set of comments) | Short | 8 | 4 | Need to be minded that the prison mental health guidelines are not yet published and the recommendations from this guideline group will need to dovetail with the recommendations for early assessment of mental health on first screen. | Thank you, both GDGs are working closely together to ensure constancy of approach across the guidelines. |
| NHS England (second set of comments) | Short | 9 | 1.1.4 | Following the first stage assessment. Encourage raising awareness of opportunities for self-care and management to be prominent as part of the orientation to prison healthcare services. Ensure prison health forms an integral part of a prisoners induction | Thank you for your comment. This is covered by this recommendation (1.1.18) in the second-stage of the reception health assessment:' Offer people tailored health advice based on their responses to the assessment questions.' |
| NHS England (second set of comments) | Short | 10 | 1.1.7 | If we are anticipating this all happening on day one; what are the implications for staff profiles and time to complete the full NHS England standard medicines reconciliation and in possession risk assessment on the initial first night screen | Thank you for your comment. The recommendation states that the medicines reconciliation should take place before the second-stage health assessment and not necessarily on day one.<br><br>The GDG recognise that this is an additional formal approach not currently implemented nationally. However we know (from the evidence within the NICE guideline on medicines optimisation) that a medicines reconciliation is a cost effective intervention that minimises risks and harm, which would result in additional interventions. The re-modelling of services to include it would therefore be worthwhile. We anticipate it will take time to implement in all prisons. |
| NHS England (second set of comments) | Short | 11 | 1.1.10 | Correctional mental health screen for men and correctional health screen for women is asked to be considered. This appears to be a US screening tool. What is the cross reference with the as yet to be | The recommendations here have been developed in collaboration with the Mental health of adults in contact with the criminal justice system guideline. |

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| | | | | published mental health guidelines?<br><br>https://www.ncjrs.gov/pdffiles1/nij/216152.pdf what about trauma informed and also perinatal mental health. What about the management of physical health in cases of mental health crisis and reference to approach and adjustments and additional risks that need to be managed | Issues in relation to trauma and perinatal mental health will be dealt with in the specialist assessments described in the Mental health of adults in contact with the criminal justice system guideline. |
| NHS England (second set of comments) | Short | 16 | 1.3 | There is evidence for placing greater emphasis on health promoting activity and intervention and access to this to realise improved patient outcomes than there is in the guidance . | Thank you for your comment. All studies meeting the criteria set out in the review protocols were included in the literature reviews. The list of excluded studies can be found in Appendix L. |
| NHS England (second set of comments) | Short | 15 | 1.2 | No specific reference to standardised approach to reporting and subsequent management of adults and children's safeguarding issues. Who to report to interface between prison and health policies and protocols for professionals who suspect or wish to report on a safeguarding issue in the prison . | Thank you for your comment. This is outside of the remit for this guideline, |
| NHS England (second set of comments) | Short | 20 | 1.6 | Managing deteriorating health conditions. There is no mention specifically of use of NEWS. This is a consistent evidence based approach to identifying and documenting deterioration It is being actively used in many healthcare settings already.<br><br>There is no reference to the importance of checking DNAR status and documenting this proactively in accordance with national standard | Thank you for your comment. Please see the following addition to the Recommendations and link to evidence section 10.4.1 in the full guideline: 'The GDG were aware of early warning systems, such as the National Early Warning Scores (NEWS)'. |
| NHS England (second set of comments) | Short | 21 | 1.7 | Continuity of care . Any evidence or comment on timeliness of receipt of information from own GP when received into prison. This needs to be as soon as | Thank you for your comment. This is information is covered in the NICE Medicines Optimisation guideline, which is cross-referred to in |

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| | | | | possible.<br><br>Importance of communication with GP on discharge highlighting specifically what medications have been reviewed and requesting that on receipt back into the GP practice in the community that an early review and alteration of the repeat prescriptions takes place to avoid a patient being put straight back on a reviewed medication. | recommendation 1.7.15. |
| NHS England (second set of comments) | Full | General | General | Surprised not to see references to differences in the approach and management of physical health based on age and lifecourse approach. For example older prisoners would need falls and frailty assessment – e.g. gait speed test on second phase assessment.<br><br>Dementia screen in the first phase screen . The dementia screen recommended by the Health and Justice CRG dementia exert group is GP COG. Also access to dementia friendly staff who have bene trained in dementia awareness.<br><br>Wondered about evidence of importance of care and compassion and mindedness to privacy and dignity which could be captured in section about assessing for escorts and also could not pick up any explicit references to care standards and expectations for the management of physical health and social care needs in segregation and CSUs | Thank you for your comment. Frailty has been added to the first-stage health assessment recommendations and reference has been made to NICE guideline NG21: Falls in older people for guidance on risk assessment.<br><br>The question that was searched, focused on identifying tools specific to the criminal justice system, that were effective in recognising psychiatric disorders. The GP COG is not specific to the criminal justice system and therefore the literature on this tool would not have been identified by our search. As we have not appraised the evidence on GP COG we are not able to include it in our recommendations. However the guideline does cross refer to the NICE guidance on Dementia.<br><br>Issues around consent and providing information to prison staff on a need to know basis and when in the interest of the prisoner is discussed in the recommendations and Recommendations and link to |

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| | | | | | evidence section of continuity of care chapter and in recommendation 1.7.2. Management of healthcare within specialist prison facilities which would require a different approach to that specified within this guideline are not covered.<br><br>Please refer to NICE guidance Home care: delivering personal care and practical support to older people living in their own homes (NG21). |
| NHS England (second set of comments) | Full | general | general | Express our disappointment that there is not more about oral health. It is disappointing enough that the choice was made to exclude dentistry. | Thank you for your comment. Dentistry is not included within the scope of the guideline. Very little evidence was identified on oral health and therefore no detailed recommendations could be made. Oral hygiene has been added to the list of health information that should be provided. |
| NHS England (second set of comments) | Full | general | general | To note the impact of being mainly a remand centre would have on the model/s of healthcare and service specifications/standards etc. | Thank you for your comment. The guideline is intended for use in all prison settings but particularly acknowledges the needs of remand prisoners, and hence focuses on assessment and safety issues.<br><br>The assessment part of the guideline is focused on first receptions that will include those on remand. Issues about longer term care are covered in the chronic disease management and health promotion sections. |
| NHS England (second set of comments) | Full | General | General | Would like a statement in the guidance that notes the need to test applicability in future transformed prisons as a result of the prison reforms agenda | Thank you for your comment. The recommendations in this guideline are based on the evidence looked at by the GDG.<br><br>After publication this guideline will be regularly |

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| | | | | | reviewed and updated in future based on new evidence. |
| NHS England (second set of comments) | Full | General | General | The current draft doesn't link well with the emphasis on assessment, intervention, treatment and recovery including through the gate in the new orange guidelines messages | Thank you for your comment. Drug misuse and dependence will be addressed by the accompanying guideline Mental health of adults in the criminal justices system, which is currently in development. |
| NHS England (second set of comments) | Full | General | General | These guidelines are landing in advance of the mental health guidelines in prisons which are a year behind and we also need to take into account the dual diagnosis new NICE guidelines and also the recently published serious mental health toolkit | Thank you for this comment – we agree but think that this is best dealt with through the development of a common pathway through the criminal justice system. |
| NHS England (second set of comments) | Full | General | General | The guidelines fail to include messages which stipulate the type of clinician to undertake the review and the length and detail of the primary and secondary screen that could look and feel radically different in a reformed prison ( or a remand prison) where there is a real opportunity to integrate the assets and strengths of the whole workforce to meet prisoner flow - not just health - to maximise the patient centred and needs led approach prisoners so value | Thank you for your comment. Recommendation 1.1.1 states that the first-stage health assessment should be conducted by a healthcare professional (or trained healthcare assistant under the supervision of a registered nurse).<br><br>Recommendation 1.1.13 states that the second-stage health assessment should be conducted by a health professional (for example a registered general nurse)<br><br>The recommendations list in detail what should be included in the assessment, what needs to be documented and when referral on to another health professional should be considered. The GDG developed the first-stage assessment based on what |

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| | | | | | is currently recommended by Grubin and is a short assessment focusing on the safety of the prisoner before allocation to a cell. The second-stage assessment would be longer, though the length would be determined by the needs of the individual. Detailed discussion is provided in section 5.8 of the full guideline. |
| NHS England (second set of comments) | Full | General | General | Attention to safe staffing, appropriate skills mix, good professional development and training are all essential. | Thank you for your comment. This has been covered in recommendation 1.6.1 outlining the protocol for responding to and managing emergency situations. Staffing levels and delivery of care by appropriately trained staff is very important and would need to be determined by the commissioners and providers of NHS services. |
| NHS England (second set of comments) | Full | General | General | The timings to the guidelines mean they are landing in advance of a test of applicability of the new prison reforms and the implications of commissioning and provision that will inevitably flow from this | Thank you for your comment. We have highlighted the shifting prison policy context within the introduction of the guideline. The remit of NICE guidance is to provide advice to the commissioners and providers of NHS care and therefore do not consider it will impact on the recommendations made within the guideline. |
| NHS England (second set of comments) | Full | General | General | The guidelines do not demonstrate the potential learning and new evidence emerging from the new models of care vanguards in terms of workforce and system and care redesign which are vital to understand and interface with as they represent the systems that prisoners come from and will be released to. In a whole pathway approach. | Thank you for your comment. Service delivery models and workforce systems are outside of the scope of this guideline. |
| NHS England (third set of | Short | General | General | Comments below are on `Assessing Healthcare' | Thank you for your comment. The recommendations |

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| comments) | | | | section. Accepting that this is the first consultation for this guidance, the guidance requires very many changes to be made to its current content before becoming the basis of national guidance and would benefit from incorporating more of the extensive lessons learned from deaths in custody over the last decade. | have been reconsidered and revised by the GDG, and quality assured by NICE in light of the comments received in the stakeholder consultation.<br><br>The GDG took into consideration reports by the Prisons and Probation Ombudsman regarding deaths in custody throughout the development of the guideline and have commented on these within the Recommendations and link to evidence sections for health assessment (5.8.1), monitoring of chronic conditions (9.6) and deteriorating health and emergency management (10.4.1). |
| NHS England (third set of comments) | Short | General | General | Section 1.1 ` Assessing Health' appears to draw much of its evidence base from Don Grubens 2002 work, and as such is very outdated and sets practice back to where it was 10 years ago. Many prisons have greatly improved first night reception screening over the last decade. An analysis of first night reception screening templates or calls for examples from Heads of Healthcare would demonstrate this. | Thank you for your comment. Only evidence on Grubin and CHAT was found in the published literature. The Evidence review follows NICE guideline methodology and therefore the sources you suggest could not be included |
| NHS England (third set of comments) | Short | General | General | Considering the time constraints available, and the anticipated introduction of the new HJIS electronic patient record from August 2016, the first night reception screening is much too lengthy, suggest looking at CHAT (Comprehensive Health Assessment Tool) from children and young people's estate and moving more to safety screen only for first night. Especially relevant for new remand centres being considered by MoJ, where there will be very high | Thank you for your comment. Evidence on both Grubin and CHAT was identified. However Grubin had a higher sensitivity and specificity than CHAT, therefore the GDG decided to recommend the Grubin assessment with some additional questions based on the consensus expert opinion of the group.<br><br>The GDG do not consider the assessment to be too lengthy and has focused on key questions in the |

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| | | | | numbers of high risk men coming in to the designated establishments and first night screening will need to be very focused on immediate safety. | assessment of safety prior to allocation to a cell. |
| NHS England (third set of comments) | Short | General | General | Not all prisons have G.Ps (General Practitioners) at reception. The guideline appears old fashioned in its reliance on GP's and doesn't embrace multi-disciplinary models of practice (Advanced Nurse Practitioners, Non-medical prescribers, para-medics etc.) | Thank you for your comment. The first-stage health assessment is for first reception into prison. This would currently be in a Category A or B prison where GPs would be present. The GDG have revised the table to clarify where the person should be referred to a GP, relevant clinic, or other health professional.<br><br>Recommendation 1.1.2 has been added to clarify the process for people transferring between custodial settings prisons where a GP would not be present. |
| NHS England (third set of comments) | Short | General | General | There is no reference at all to healthcare input in to CSRA (Cell Sharing Risk Assessments) or of need for healthcare staff to consult PER (Person Escort Record) – both of which have been identified as essential in previous lessons learned from Deaths in Custody. | Thank you for your comment. Reference to the PER has been added to the following recommendation:<br>1.1.2 "For people transferring from one custodial setting to another (including court, the receiving prison or during escort periods) ensure continuity of care by, for example:<br>• accessing relevant information from the patient record, prisoner escort record and cell sharing risk assessment<br>• checking medicines"<br><br>This has also been added to the Recommendations and link to evidence section 11.4.1: "The GDG noted that information from the prisoner escort record (PER) should be accessed and consulted when |

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| | | | | | people transfer from one custodial setting from another. The GDG also noted that the Cell Sharing Risk Assessments (CSRA) should be consulted for relevant information." |
| NHS England (third set of comments) | Short | 4 | 4 | This has implications for practicalities of screening assessment - need to define `under the supervision of' - is this immediate supervision (registered nurse present in reception with HCA) or can supervision be retrospective (e.g. qualified nurse checks through reception screening records within pre-defined period of time) | Thank you for your comment. This level of detail is not specified within the recommendation. Implementation of recommendations should be determined locally. |
| NHS England (third set of comments) | Short | 4 | 7 | `Screening to be done before individual allocated their cell ' this may be very difficult in some large remand prisons where they have large numbers of prisoners coming in at once and would result in prisoners waiting for unacceptable and lengthy periods in cramped holding cells, increasing anxiety and also risks of outbursts and altercations. In some prisons healthcare reception is situated next to, or on first night centres. This means prisoners can be allocated a cell on the first night centre where they can be readily observed and supported until reception screening completed. If reception screening identifies any issues, they can then be allocated a cell on a suitable location. | Thank you for your comment. There are differing local arrangements for people at reception into prison. However the health assessment should be completed before the person is allocated to their own cell. This recommendation is based on what should be possible in the prison setting. |
| NHS England (third set of comments) | Short | 5 | 2.1 | Not all prisons have GP present for 1st reception screening. Prescribed meds – if patient has prescribed medicines in their possession, correctly labelled, in their name, dispensed by pharmacist, confirmed by phone call to GP, no evidence of | Thank you for your comment. Recommendations have been made in the section on continuity of medicines, as well as the recommendation for a medicines reconciliation to take place before the second-stage health assessment, which involved |

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| | | | | tampering etc., these have already been legally prescribed for that individual and are their medicines - some prisons have developed processes for enabling such meds to be administered (or self- administered) to avoid unnecessary interruptions to medication regimes. procedures developed | checking the patient's own medicines. |
| NHS England (third set of comments) | Short | 5 | 2.2 | Implies all prisoners with injuries should be referred to GP – requires rewording as impractical. Need to include prompt / instruction on what to do if prisoner makes **first** disclosure of allegation of assault to healthcare professional. | Thank you for your comment. This referral to the GP has been removed from the action. |
| NHS England (third set of comments) | Short | 5 | 2.3 | Implies any prisoner who has ***ever*** lost consciousness should be referred to GP at reception. Could this be reconsidered and guidance for recent and historic head injuries differentiated otherwise will result in large numbers of prisoners being referred to GP. Historic injuries could be followed up at secondary screening. Disabilities Foundation Trust have recent research data on this from project undertaken at HMP Leeds. | Thank you for your comment. This recommendation has been moved to the second-stage health assessment and so no longer requires referral to the GP. |
| NHS England (third set of comments) | Short t | 7 | 2.8 | Prison disability lead will rarely be in reception – can wording be changed to reflect need to liaise with prison colleagues regarding any immediate needs and follow up with liaison with DLO and full assessment of need. | Thank you for your comment. The recommendation states that immediate needs should be met by prison staff. The reception staff, whether they are disability leads or not, have to deal with any immediate reception needs. People are referred for more thorough assessment of social care/disability needs as part of their induction. |
| NHS England (third set of comments) | Short | 7 | 2.9 | `Note any ongoing treatment the person needs and make appointments with relevant clinics, specialist | Thank you for your comment. The GDG agreed that this was important to address in first-stage health |

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| | | | | nurses, GP or other healthcare staff' – considering the time constraints of first night reception screening – especially in busy local prisons, would this not be better placed in secondary screening? | assessment, as on-going treatment may be required urgently. |
| NHS England (third set of comments) | Short | 7<br><br>8 | 3 | Alcohol and Drugs Use<br>Need to add in evidence based assessment tools e.g. COWS (Clinical Opiate Withdrawal Scale) CIWA –AR, (Alcohol Revised withdrawal scale), CIWA B (Benzodiazepine withdrawal scale) etc.<br>Urine drug screen – **need to take in to account whether any medications have been given in police custody** ( learning from DIC)<br>IV drug users – need to check history of DVT / Thrombosis and any previous or ongoing anti-coagulant therapy<br>Check calves for evidence of acute / chronic DVT | Thank you for these comments. We do not think it would be feasible to include these measures in an initial screening or secondary assessment. These will be reserved for use in a specialist assessment. |
| NHS England (third set of comments) | Short | 9 | 4 & 5 | **Mental Health & Self Harm & Suicide**<br>Given all that is known from PPO thematic reviews and lessons learned from DIC, this proposed section is really disappointing and misses a real opportunity to significantly improve reception screening and identification of vulnerable prisoners.<br>5.1 appears to suggest ACCT should only be opened if there are concerns in response to questions about self harm and suicide, when it is well established that prisoners who deny any thoughts of self harm or suicidal ideation but have a number of high risk factors are at extremely high risk. | Thank you for these comments. Please be re-assured that the Mental health of adults in contact with the criminal justice system guideline contains considerably more detail on the assessment of risk and the management of self-harm The NICE pathway for the criminal justice system will support an integrated approach to the management of self-harm |
| NHS England (third set of comments) | General | 10 | 27 | Women – requires questions about last menstrual period, pregnancy or potential pregnancy and need for | Thank you for your comment. This is covered in the additional question for women and the following |

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| | | | | emergency contraception where appropriate. | actions: "Ask the woman if she has reason to think she is pregnant or if she would like a pregnancy test?" |
| NHS England (third set of comments) | General | 10 | 28<br><br>29 | Many prisons have now implemented NEWS (National Early Warning Score). A full set of observations is useful to have as a baseline, as has been identified in DIC where individuals have become acutely unwell at a later date and there are no baseline observations for comparison, so change or deterioration has gone unnoticed. | Thank you for the information. We did not identify any evidence on NEWS and are unable to comment on the value of this tool. |
| NHS England (third set of comments) | General | 11 | 20 | CMHS – M / CMHS –W. Have not come across this tool before PHQ 9 and GAD much more frequently used. If the evidence suggests this is the best tool would need to raise awareness of this and support development of SystmOne templates | Thank you for this comment. |
| NHS England (third set of comments) | General | 15 | 9 | Doesn't PHE plan to reduce age for NHS Health Check Programme to 35 years and set criteria dependant on sentence length? – Does the proposed new criteria for eligibility need to be incorporated here? | Thank you for your comment. The reference to age in this recommendation has been removed, with just the link to the programme for clarity. |
| NHS England (third set of comments) | general | 15 | 12 | Should screening programmes include diabetic retinopathy screening for those with diabetes? | Thank you for your comment. NICE does recommend annual screening for retinopathy for type I [NG17] A recommendation for other assessments to be carried out according to other NICE guidance has been made in the guideline. |
| Northumberland, Tyne and Wear NHS FT | Full | 15 | General | Would the use of the AUDIT C be more helpful here rather than simply asking if they drink alcohol? | Thank you for your comment. The question regarding alcohol use was adapted from the Grubin assessment tool. The Mental Health GDG agreed to only review tools and cut-off points with acceptable sensitivity and specificity, which was determine by a |

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| | | | | | relatively conservative threshold of ≥0.70 for both values. In the absence of values for sensitivity and specificity, tools with AUC values ≥0.75 were considered to have acceptable performance. The AUDIT was among the tools that were excluded because of this. |
| Northumberland, Tyne and Wear NHS FT | Full | 16 | general | "if the person is not trained to perform an assessment of mental health problems, the person should be referred to an appropriate trained professional" How will the level of training required be determined? | Thank you for your comment. This is an implementation issue and will be for local services to determine. |
| Northumberland, Tyne and Wear NHS FT | Full | 17 | general | "medicines reconciliation completed" Our Trust provides specialist dual diagnosis psychiatry input into a number of prisons. This work has identified major problems in the appropriate prescribing at reception of psychotropic medications in prisoners with dual diagnosis. Given the high prevalence of comorbidity in prisons we would recommend advising primary care to seek advice early on whether to prescribe or not psychotropic medications on initial reception from a mental health professional, if they are unsure. In our experience it is common for medications to be either omitted or prescribed inappropriately in high risk prisoners with significant substance misuse and mental health problems. These issues should be resolved within 7 days of arrival in prison. If it is not addressed early the issue may continue unrecognized for months. | Thank you for your comment. Medicines reconciliation is only a part of the assessment/reception process and informs care and on-going prescribing. The recommendations regarding health assessment state that people who are taking medicine for mental health problems should be referred for further mental health assessment at the point of reception into prison (see Table 1, section 18). |
| Northumberland, Tyne and Wear NHS FT | Full | 19 | general | "Provide on release: a minimum of 7 days medicines or an FP10 Prescription" We would have concerns about safety of providing all medications on release to | Thank you for your comment. Please see the following in the Recommendations and link to evidence section (8.5.2) of the full guideline: "The |

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| | | | | a group of patients with high co-morbidity of mental health and substance misuse problems. There are REAL safety issues here to be considered especially in the first 1-2 weeks post release. We have had direct experience of these challenges whilst attempting to introduce FP10 prescriptions for substitute opioids on release. We would be happy to share our experience. | GDG also state that in current practice an FP10 prescription can be given instead of 7 days' supply. An FP10 prescription may be more appropriate for controlled drugs that need to be given under supervision post release."<br><br>"Based on a risk assessment" has been added to recommendation 1.7.13 to reflect these concerns.<br><br>The GDG note that current prison substance misuse guidelines and wider prison guidelines expect continuity of care with substance misuse medicines, and that this is current practice. |
| Northumberland, Tyne and Wear NHS FT | Full | 23 | 33 | "Ensure that every person has a named healthcare coordinator who is responsible for managing their care". This will be a challenge to implement especially in prisons were numerous different organizations are involved in providing different aspects of health care. | Thank you for your comment. Recommendation 1.2.3 has now been amended so that only people with complex health needs have a lead care coordinator. |
| Northumberland, Tyne and Wear NHS FT | Full | 22 | 15 | You have noted the lack of evidence for screening tools for mental health in the prison environment in your draft guidance. A screening tool linking mental health and substance misuse does not seem to have been considered. The prevalence of dual diagnosis is well recognized in this population. The importance of routinely assessing for both problems in one screening tool would surely be advantageous in this population. The Dual Diagnosis Screening Instrument has been well reviewed and would be a suitable | Thank you for this comment. The initial screening covers both mental health and substance misuse. This will help to identify those with dual diagnosis. The constraints of the assessment in initial assessment and secondary assessment preclude the use of a range of measures but they could be used in further specialist assessments. |

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| | | | | instrument to use. This is reviewed in the European Centre for Monitoring of Drugs and Drugs of Addiction (ECMDDA) in its recent publication on comorbidity available on the ECMDDA website.<br>We would welcome more mention of the need to address both problems concurrently in the guidelines given the extent and impact of these problems in this population. | |
| Northumberland, Tyne and Wear NHS FT | Full | general | General | We welcome the aspiration of equity of care in the prisons. However this will have significant practical implications for operational and clinical staff with the volume of assessments on a daily basis especially with the upcoming prison reforms. | Thank you for your comment. The GDG recognise that implementing the recommendations will require operational changes, however they consider these achievable and support equivalence of healthcare in prisons with that provided in the wider NHS. |
| Nottinghamshire Healthcare NHS FT | Short | 4 | 6 | It would be helpful to clarify 'First Reception into prison'. Is this the 1st screen undertaken at each reception or on the patients first reception into a prison (as opposed to a transfer) | Thank you for your comment. The first recommendation covers first reception into prison. The second recommendation has been added to clarify what should happen for people transferring between custodial settings. |
| Nottinghamshire Healthcare NHS FT | Short | 4 | 15 | 'Physical health' is very broad. Helpful to break this down – for example current active health concerns, past medical history, chronic diseases, medication. | Thank you for your comment. The bullet points in this recommendation are the headings from Table 1 to which they are signposting. These topics are broken down in Table 1 in more detail. |
| Nottinghamshire Healthcare NHS FT | Short | 4 | 19 | Suicide should include –we would suggest should include risk of and history of attempted suicide. | Thank you we will make the suggested change. |
| Nottinghamshire Healthcare NHS FT | Short | 5 | General | 'Ensure that the person is seen by the GP while they are in reception'<br>Our experience is that this is not workable. Most prisons do not have a GP in reception, or a GP on site during all of the hours of reception. Even if resourced | Thank you for your comment. The first-stage health assessment is for first reception into prison. This would currently be in a Category A or B prison where GPs would be present. |

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| | | | | via the commissioned service specification, recruiting this amount of GP resource is highly unlikely to be possible. | Recommendation 1.1.2 has been added to clarify the process for prisons where a GP would not be present. |
| Nottinghamshire Healthcare NHS FT | Short | 5 | General | 'Generate a medicine chart'<br>We believe that this should only be undertaken by a qualified prescriber. Non prescriber should not write medicine charts and would not have access rights to do this electronically where we work with SystmOne prescribing modules (and neither should they) A chart should not be generated by the reception nurse prior to reconciliation and issue of the correct prescription by a qualified prescriber | Thank you for your comment. This is now an automated process where "on-admission" medicines are populated on the electronic drug chart, available in all prisons. This allows continuity of legally prescribed medicines on admission, especially critical medicines. The person carrying out the health assessment is able to add medicines to a chart that have legally been prescribed elsewhere by a prescriber. |
| Nottinghamshire Healthcare NHS FT | Short | 5 | General | What about meds which are not prescribed – regular user of Over The Counter meds?<br>Where patients have they brought them in they require assessment for appropriateness for reuse in the prison or signposting to local arrangements via prison canteen. | Thank you for your comment. Over the counter medicines form part of the medicines reconciliation process (recommendation 1.1.8) and would not be considered critical medicines (see Table 2 of recommendation 1.7.10-11). Doses can be omitted pending the outcomes of the first-stage health assessment and medicines reconciliation. |
| Nottinghamshire Healthcare NHS FT | Short | 5 | General | 'Refer the person to the GP at reception.'<br>The expectation needs clarity. Are you saying complete the referral in reception, or for the GP to see them in reception. If latter above comments apply re no GPs in reception usually and not contracted to work all hours reception active. Recruitment pressures and financial resources likely to be a barrier to this. | Thank you for your comment. The first-stage health assessment is for first reception into prison. This would currently be in a Category A or B prison where GPs would be present.<br><br>Recommendation 1.1.2 has been added to clarify the process for prisons where a GP would not be present. |
| Nottinghamshire Healthcare NHS FT | Short | 5 | General | No mention of sensory assessment ie patients with hearing impairment / hearing loss /deaf or for patients | Thank you for your comment. The first stage health assessment contains the following questions: "2.5 |

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| | | 7 | | with impaired eye sight / deterioration / visual loss – may be indicative of progressive diabetic retinopathy | Are there any other physical health problems the person is aware of, that have not been reported?" And "2.6 Are there any other concerns about the person's physical health?"<br><br>For medicines, these issues are covered in the NICE guidance on medicines adherence and medicines optimisation cross-referred to within this guideline. |
| Nottinghamshire Healthcare NHS FT | Short | 5 | General | Requires referral to urgent mental health.<br>This is not appropriate within non remand establishments. Often nursing staff are not aware of the patient's index offence.<br>Inappropriate referral criteria to the Mental Health Team.<br>Not feasible for the patient to be seen by the GP in reception. | Thank you for your comment. The GDG feel that this should be a local decision on the health assessment triggered by this question. |
| Nottinghamshire Healthcare NHS FT | Short | 5 | General | Has the patient ever suffered a head injury or LOC – response Yes = refer to the GP at reception.<br>I would question the evidence of this. What is the value of booking up GP time and appointments with historical head injuries, long since resolved? This needs a clinically evidenced time parameter on it ie a head injury in the past week. Many prisoners have a history of head injury and this would generate resource pressures upon GPs. Also why is everything referred to GPs? Many teams have developed appropriate skill mix and employ highly skilled Advanced Nurse practitioners also. Throughout the guideline considerations should be given to widening | Thank you for your comment. The GDG were concerned about the poor identification of acquired cognitive impairment on the management of people in prison and so considered the identification of factors that could lead to it important.<br><br>The questions about head injury have now moved to the second-stage assessment and therefore no longer mandate referral to a GP. |

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| | | | | GP's to Appropriate Healthcare Professional or GP/ANP | |
| Nottinghamshire Healthcare NHS FT | Short | 6 | 2.7 | Where it asks for female prisoners if there is a risk of pregnancy, if they state no, we would suggest that the date for their last menstrual period is prompted and obtained (and therefore documented). | The GDG consider the questions asked are adequate for the first reception assessment. |
| Nottinghamshire Healthcare NHS FT | Short | 6 | 2.4 | First line (allergies, asthma, diabetes, epilepsy or fits – should this say history of fits?<br>Ventolin – this should say Salbutamol. Ventolin is a brand name | Thank you for your comment. A 'history of seizures' has been added to the list of health conditions.<br><br>The note mentioning Ventolin is an example of what someone in prison might say to the person conducting the health assessment. |
| Nottinghamshire Healthcare NHS FT | Short | 7 | General | The patient may be referred to the Substance Misuse Team and possibly the Substance Misuse GP rather than the primary care GP within our services. This would read better as 'GP or alternative suitable health care professional' | Thank you for your comment. We have amended question 13 in Table 1 as you suggest. |
| Nottinghamshire Healthcare NHS FT | Short | 7 | General | Line saying 'ask if they need a special medical diet' – we would advise this is checked to confirm diagnosis prior to advice to kitchens. In our experience it is not uncommon for false claims to be made re diets. | Thank you for your comment. Given a positive response to this question there is an action to confirm the need for a special medical diet. |
| Nottinghamshire Healthcare NHS FT | Short | 9 | 5<br><br>8 | Currently we do not have access to GP records on SystmOne. Also where GPs are not using S1 or the patient cannot recall their GP / or is unregistered there will be a delay in reconciling records. | Thank you for your comment. The GDG are aware of this. Our recommendations are aimed at improving this communication between prison and community GPs. |

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| Nottinghamshire Healthcare NHS FT | Short | 10 | 11<br><br>14 | To overcome failed second stage assessment due to high DNA rates and poor lack of officer support in many establishments, second stage health assessment is completed on the day of arrival following the first screen. We have significantly increased the quality of the screen and uptake of the send screen through this approach | Thank you for your comment. This guideline recommends that based on the evidence reviewed, the second-stage health assessment should be conducted within 7 days as a maximum. This does not preclude the second-stage health assessment being conducted on the same day as the first-stage. |
| Nottinghamshire Healthcare NHS FT | Short | 11 | General | Across the establishments we work in tools such as PHQ9 and GAD7 are used in conjunction with clinical judgment not the CMHS-M. | Thank you for this comment. We agree use of routine outcome measures such as the PHQ is good clinical practice and is covered in a number on NICE mental health guidelines. |
| Nottinghamshire Healthcare NHS FT | Short | 15 | 14<br><br>15 | We could not possibly allocate every patient to a care co-ordinator. We provide named nurses / coordinators to patients on our complex case registers (this includes unstable patient, older patients with complex conditions, palliative care patients etc) We would not have resources to offer this effectively. | Thank you for your comment. Recommendation 1.2.3 has now been amended so that only people with complex health needs have a lead care coordinator. |
| Nottinghamshire Healthcare NHS FT | Short | 13 | 8 | Should be 'persons' not prisoners | Thank you for your comment. This change has been made. |
| Nottinghamshire Healthcare NHS FT | Short | 15 | General | No mention of performing baseline physical observations such as temperature, pulse, bp, resp rate on admission. This is important as we need to ensure the patient is well and has no active infection (screening for sepsis and TB) | Thank you for your comment. The GDG agree that pulse, blood pressure and temperature should be included in the second-stage health assessment. This has been added to the recommendation.<br><br>Recommendation 1.1.9 states that: Healthcare professionals in prisons should ensure people coming into prison are screened for TB within 48 hours of arrival. |

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| Nottinghamshire Healthcare NHS FT | Short | 16 | general | No mention of what to do if no GP is present (as is the case in most establishments) and the patient does not have any medications with them and its 5pm on a Friday night | Thank you for your comment. In this recommendation, GP has been changed to "prescriber". |
| Nottinghamshire Healthcare NHS FT | Short | 17 | 16 | Prisoners complain about the limit of healthy food options – this is out of our control | Thank you for your comment. The GDG were of the opinion that a healthy option would always be available. This guideline recommends giving advice on healthy diet. |
| Nottinghamshire Healthcare NHS FT | Short | 18 | General | This is not appropriate due to the type of medication and level of risk. We have red and amber listed drugs not deemed suitable for IP status in all / some circumstances | Thank you for your comment. Additional medicines to be directed observed can be agreed upon locally based on local risks and policies. |
| Nottinghamshire Healthcare NHS FT | Short | 19 | 10<br><br>11 | The prison will not provide lockable cupboards due to the cost. If healthcare providers were expecting to do this this would require resourcing and would need to be agreed with the prisons. | Thank you for your comment. The GDG has noted that there would be a cost to providing lockable cupboards to those prisoners with in-possession medicine, but it did not seek to quantify the cost as this would vary considerably depending on the prison. It noted that cupboards are already provided in a minority of prisons.<br><br>As a result the GDG made a recommendation for each prison to 'consider' providing storage, rather than a recommendation that storage must be provided.<br><br>However, the GDG did also note that secure storage is standard in hospitals, and that lockers can have additional non-healthcare related uses (for storing personal documents and valuables). |

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| | | | | | The GDG also noted that providing cupboards to store sensitive information/property by prisoners including medicines, especially in shared cells is a decency issue. |
| Nottinghamshire Healthcare NHS FT | Short | 19 | 23 | Hypertension guideline requires ability to undertake 24 hour ambulatory BP. Not possible with all patients in this setting. IT facilities do not always support latest technology, there may be security and safety concerns. This section should acknowledge that local conditions within prisons may mean providers can only partially comply with guidelines to some recommendations but should identify this and mitigate against it where possible.<br>To aid continuity of carer as patients move establishments the guideline could recommend the use of recall systems (which transfer with the patient) | Thank you for your comment. The GDG discussed this point and agreed that this was possible, please see the following statement in the Recommendations and link to evidence section (9.6) of the full guideline: 'Areas were discussed such as glucose self-monitoring or continuous blood pressure monitoring and whether there were any security concerns, however it was considered that both are feasible and are currently achieved in prisons.' |
| Nottinghamshire Healthcare NHS FT | Short | 20 | general | First stage health assessment-this should be undertaken by a registered nurse and not a HCA as this is not a delegated 'task' it is an assessment. Additionally, if a prescription chart is to be generated, this cannot be undertaken by the HCA-as registered nurses we are responsible for delegating appropriate tasks to HCAs. | Thank you for your comment. The GDG was aware that first-stage assessments are currently sometimes conducted by nurses and sometimes by HCAs, and so investigated the cost-effectiveness of this difference in practice (see Appendix N). This health economic analysis found that under most scenarios investigated in would not be cost-effective for a nurse to conduct first-stage assessments instead of an HCA.<br><br>However, the GDG recognised that the results of this analysis were uncertain due to the lack of certainty in rates of health conditions in prisons and the proportion of health events that could be prevented |

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| | | | | | given high quality initial assessment, particularly the proportion of attempted suicides that may be preventable. The GDG also recognised that there are additional factors that needed to be taken into account alongside the economic analysis, notable the way healthcare staffing is organised in different prisons, and the proportion of prisoners who would need to see a more qualified healthcare professional for further assessment or to resolve medicine availability. As a result, the GDG agreed that who should carry out the first-stage assessment should be locally determined, but stipulated that healthcare assistants would need to be trained and under the supervision of a registered nurse as a minimum.<br><br>Regarding the prescription chart, this is now an automated process where "on-admission" medicines are populated on the electronic drug chart, available in all prisons. This allows continuity of legally prescribed medicines on admission, especially critical medicines. The person carrying out the health assessment is able to add medicines to a chart that have legally been prescribed elsewhere by a prescriber. |
| Nottinghamshire Healthcare NHS FT | Short | 21 | 14<br><br>15 | Information shared between prisons related to pre-existing significant healthcare problems needs to be further reviewed to ensure a more robust transfer procedure | Thank you for your comment. When a person transfers between prisons their medical record will be reviewed at the second-stage of the reception health assessment: 1.1.14 'Review the person's first- and second-stage health assessment records, medical history, GP and vaccination records and: |

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| | | | | | • refer the person to the GP or a relevant clinic if further assessment is needed. See for example NICE's guidelines on cardiovascular disease (recommendations on identifying people for full formal risk assessment ) or type 2 diabetes (the recommendation on risk assessment)<br>• arrange a follow-up appointment if needed.' |
| Nottinghamshire Healthcare NHS FT | Short | 21 | 14 | Not all patients will require a planned health care review as some are healthy and no interventions are required | Thank you for your comment. The date of review will be based on clinical judgement, for healthy people this may be a number of years. |
| Nottinghamshire Healthcare NHS FT | Short | 13 | 18 | Why are we not offering Hep A vaccines to men having sex with men?<br>This is a high risk group and it is recommended in the green book. | Thank you for your comment. There is currently there is no NICE guidance on hepatitis A. It is beyond the remit of this guideline to make new recommendations on hepatitis A. |
| Nottinghamshire Healthcare NHS FT | Short | 22 | 22<br><br>23 | Prisons healthcare have difficulty arranging GP on release – this needs looking at. Destination on discharge is not always known until the patient is at the gate eg when transferring to approved premises. Communication systems ie a standard transfer and discharge proforma to forward to requesting community services would be helpful | Thank you for your comment. The GDG is made up of professionals who work within the prison environment and are fully aware of the challenges presented. The GDG understands that implementation may be a challenge, but believe that the recommendations are achievable. Systems and procedures would need to be developed locally. |
| Nottinghamshire Healthcare NHS FT | Full | 23 | 25 | 'all prisoners screened within 48 hours of arrival for TB'<br><br>How are we going to do this within 48 hours? This is unrealistic and impracticable in most of our prisons. We can do a blood test, but not chest x-ray everyone. We need brief guidelines on what is expected with a realistic timeframe | Thank you for your comment. This recommendation has been adopted from the NICE tuberculosis guideline, as stated within NICE NG33, which has been in place since 2012. The GDG reviewed the recommendations and considered them to be achievable. |

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| Nottinghamshire Healthcare NHS FT | Short | 23 | 32 | every person in prison to have a named h/care coordinator'-<br>Unless they have a h/care need or LTC, this is not practicable due to staffing levels and patients not requiring a named person if they are healthy | Thank you for your comment. Recommendation 1.2.3 has now been amended so that only people with complex health needs have a lead care coordinator. |
| Nottinghamshire Healthcare NHS FT | Short | 25 | 5<br><br>9 | Does this need to include blood ketone testing kit | Thank you for your comment. The exact contents of the grab bag are not specified in this guideline. The definition of 'Grab bag' lists a number of examples and is not intended to be an exhaustive list. |
| Nottinghamshire Healthcare NHS FT | general | General | General | Prison to prison transfers-why is a new assessment required? No mention of ensuring all equipment and adequate supply of medications to be sent with the patient. Often patients are transferred on a Friday afternoon with no medications and it is very difficult to then obtain these medications as most establishments do not have on site pharmacies and stock medications are limited | Thank you for your comment. The first stage health assessment is on first reception into prison and this is stated in the recommendation 1.1.1. However the GDG agree that greater clarity is required for those transferring between prison and have added the following recommendation to the assessment section: *"For people transferring from one custodial setting to another (including court, the receiving prison or during escort periods) ensure continuity of care by, for example:*<br>*• accessing relevant information from the patient clinical record, prisoner escort record and cell sharing risk assessment*<br>*• checking medicines and any outstanding medical appointments"*<br><br>In the continuity of medicines section there is a recommendation stating that on discharge or transfer a minimum of 7 days medication or an FP10 should be given to the person. |
| Nottinghamshire | General | General | General | Use of NICE guidelines-there are other guidelines in | Thank you for your comment. We are only able to |

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| Healthcare NHS FT | | | | use such as BTS for Asthma. Guidelines are guidelines, and need to be adapted to each h/care | cross refer to published NICE guidance, but the committee are aware of other guidance, some of which are noted in the Recommendations and link to evidence sections of the guideline. |
| Nottinghamshire Healthcare NHS FT | general | General | General | No mention of access to services comparable with the community such as pulmonary and cardiac rehab, diabetes education programmes | Thank you for your comment. The introduction to the guideline states: *This guideline supports equivalence of healthcare in prisons, a principle whereby health services for people in prisons are provided to the same standard, quality and to the same specification as for patients in the wider NHS.*<br><br>Recommendation 1.1.14 recommends referral for further assessment, specifically mentioning CVD and type 2 diabetes as examples. |
| Nottinghamshire Healthcare NHS FT | Full | 14 | general | Would suggest that where it is noted to link with disability lead it also states for referral to Adult social Care Assessor, OT and Physio older persons rehab service where available | Thank you for your comment. Please see the following sentences that have been added to the Recommendations and link to evidence section (5.8.1) of the full guideline: "*The GDG, following Grubin, noted the actions that should be taken following a positive response. The GDG noted that these should follow equivalent pathways to those in the community and should be in line with national health and social care guidance, such as the Social Care Act 2014.*" |
| Nottinghamshire Healthcare NHS FT | Full | 16 | general | Query annual health checks age parameters/criteria as PHE have stated 35 years and 2 years of sentence or more for inclusion | Thank you for your comment. The recommendation states to offer equivalent health checks to those offered in the community and have removed the age range. The GDG did not think that there was sufficient evidence to recommend a healthcare |

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| | | | | | review at predetermined regular intervals but agreed that at the second stage of the health assessment the healthcare professional should use their clinical judgement to determine when a healthcare review should take place. |
| Nottinghamshire Healthcare NHS FT | Full | 18 | 2 | Section 2 : should social care needs be added for consideration? | Thank you for your comment. The GDG consider this to be implicit in the recommendation. |
| Nottinghamshire Healthcare NHS FT | Full | 21 | general | Would it also be useful to check Blood glucose? | Thank you for your comment. This list is 'as a minimum'. The points listed were considered a priority by the GDG. |
| Nottinghamshire Healthcare NHS FT | Full | 22 | 18 | Section 18: Hepatitis screening Opt out programme | Thank you for your comment. We believe the recommendations are in line with the opt-out policy. The wording states to offer the test therefore people would receive this unless they chose to opt out. |
| Nottinghamshire Healthcare NHS FT | Full | 23 | 25 | ? All prisoners or just those deemed at risk of TB. What are the parameters? | The recommendation states that this applies to all prisoners coming into prison. |
| Nottinghamshire Healthcare NHS FT | Full | 23 | 31 | ? 35 yrs + 2 year sentence | Thank you for your comment. The age stated for the NHS health check programme has been removed from the recommendation.<br>Recommendation 1.5.3 also states: *Consider more frequent monitoring for older people and people with chronic conditions (such as diabetes) who are serving longer prison sentences*. |
| Nottinghamshire Healthcare NHS FT | Full | 23 | 32 | Is this practical for every person in Prison or should it be just for those who are known to healthcare? | Thank you for your comment. This recommendation has been adopted from the NICE tuberculosis guideline as stated within NICE NG33, which has been in place since 2012. The GDG reviewed the |

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| | | | | | recommendations and considered them to be achievable |
| Nottinghamshire Healthcare NHS FT | Full | 23 | 34 | ? using the Prison system or should this state the Electronic Patient Record | Thank you for your comment. The recommendations in this guideline refer to the person's medical record. This is not restrictive and could be the electronic patient record if available. |
| Nottinghamshire Healthcare NHS FT | Full | 24 | 36 | electronic Patient record | Thank you for your comment. The recommendations in this guideline refer to the person's medical record. This is not restrictive and could be the electronic patient record if available. |
| Nottinghamshire Healthcare NHS FT | Full | 26 | 56 | What is the process for the transfer of CDs? | Thank you for your comment. Recommendation 1.7.13 states 'When a person is discharged or transferred from prison give them a minimum of 7 days' prescribed medicines or an FP10 prescription' includes controlled drugs as part of prescription. This has been clarified in the Recommendations and link to evidence section: "An FP10 prescription may be more appropriate for controlled drugs that need to be given under supervision post release." |
| Nottinghamshire Healthcare NHS FT | FULL | 26 | 59 | Should cancer be added to this list? | Thank you for your comment. This has been previously discussed by the GDG This list is of NICE guidelines that cover the monitoring of chronic conditions prioritised by the GDG as those commonly seen in prisons. The GDG acknowledge cancer is an important issue but it was not possible to consider all conditions covered by NICE guidance. |
| Nottinghamshire Healthcare NHS FT | Full | 27 | 62 | Clarity required for Out of Hours response and the sharing of information between Prison staff and Emergency services when Healthcare are not on site and there is no access to S1 records | Thank you for your comment. The recommendations on managing deteriorating health and health emergencies are to ensure that there is a protocol in place for health emergencies. |

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| Nottinghamshire Healthcare NHS FT | Full | 129 | 6.6 | Not sure if we can achieve this recommendation due to the high turnover and the frequent movement of Prisoners within establishments as well as the estate. There will always be a cohort of Prisoners who do not need to access healthcare during their sentence. | Thank you for your comment. Recommendation 1.2.3 has now been amended so that only people with complex health needs have a lead care coordinator. |
| Nottinghamshire Healthcare NHS FT | Short | General | General | We would advise assessing patients for safety priorities including tissue viability = pressure sore risk score on reception and falls risk. We use Purpose T within our reception reflecting the low prevalence of pressure sore risk. Patients at risk then receive a Braden Score assessment and SSKIN care plan with follow up arrangements.<br>We use a bespoke guide to action tool for falls risk within the prison environment. | Thank you for your comment. Frailty has been added as an example of the health related observations to be recorded in the first-stage assessment. It is not possible to specify every condition within the assessment questions. A general question is included about whether the person has any other health problems not previously reported which would assist in the identification of conditions not specifically asked about. |
| Optical Confederation | Full | 22 | 19 | We recognise why the draft focuses on the particular conditions that it does and also understand the decision to refer to "other health assessments" together in this section. However, we wanted to emphasise the importance of regular eye examinations, every 12-24 months depending on risk, exactly as is the case for the rest of the population. There are two main reasons:<br><br>A sight test can identify and enable the correction of refractive error. Undetected refractive error can contribute to delayed learning and literacy issues, which in turn can limit a person's ability to engage in a variety of social and economic activities. Recognising that there is some variation in the estimates due to different ways of assessing literacy and choice of | Thank you for your comment. Eye examinations were not prioritised by the GDG as an area for review. However, the areas included in the second-stage assessment are given as a minimum and could include other assessments if appropriate. A recommendation has been made to consider follow-up review based on clinical need taking the person's age and length of sentence into consideration. |

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| | | | | comparator group, it is commonly agreed that literacy among prisoners is poorer than that of the wider population outside prison. http://www.nrdc.org.uk/wp-content/uploads/2015/11/An-assessment-of-the-English-and-maths-skills-levels-of-prisoners-in-England1.pdf<br><br>An eye examination can also identify both eye disease (glaucoma, cataracts etc) and other pathology (tumours, high blood pressure etc). We suggest that older and long term prisoners in particular should be afforded eye examinations as part of the prison service's duty of care to them. | |
| Prison Reform Trust | Short | 4 | 16 -17 | When assessing alcohol and drug use, it is *misuse* that is the problem and the particular focus of a first stage assessment. This point might be better described as 'substance misuse'. | Thank you we will make the suggested change. |
| Prison Reform Trust | Short | 4 | 13-19 | This list should include 'any disability that might affect a person's ability to cope in prison'. For example, needs such as learning disability and autism are not clearly accounted for and these should certainly be a focus of the first stage assessment. | Thank you for your comment. This recommendation lists the key headings from the first-stage assessment table. This level of detail is found within the table itself. |
| Prison Reform Trust | Short | 5 | 1 | This guideline should be separated so it clearly acknowledges and separates communication needs that may be a result of a cognitive impairment with those that arise out of foreign language difficulties. Sensory impairment such as deafness should also be separately referenced. Also see comment 6 on this. | Thank you for your comment. This level of detail can be found in the NICE guideline on patient experience in adult NHS services, cross-referred to in recommendation 1.1.3. |

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| Prison Reform Trust | Short | 5 | 4 | There are regular references in the 'Actions' section of the table to GPs being present in reception. As far as we aware GPs are not constantly present in reception in many prisons and likely to be unable to cover this aspect of the delivery. If this is the case these actions will need to be rethought to account for this. | Thank you for your comment. The first-stage health assessment is for first reception into prison. This would currently be in a Category A or B prison where GPs would be present. The GDG has revised the table to clarify where the person should be referred to a GP, relevant clinic, or other health professional.<br><br>Recommendation 1.1.2 has been added to clarify the process for people transferring between custodial settings where a GP would not be present. |
| Prison Reform Trust | Short | 5 | 4 | Is it necessary to recount any head injury a person has ever had as oppose to those in recent medical history or those that still have effect them? This stage of the assessment is supposed to be focussing on urgent needs. | Thank you for your comment. We have amended the wording to a significant head injury. |
| Prison Reform Trust | Short | 6 | 4 | With reference to comment 3, awareness of learning disability and neurodevelopmental disorders should be gained right at the start of the assessment as it informs how the initial questions are asked and understood. Beginning the assessment without an understanding of these needs may result in that information being of little worth. | Thank you for your comment. Recommendation 1.1.3 states "Take into account any communication needs or difficulties the person has, and follow the principles in NICE's guideline on patient experience in adult NHS services." |
| Prison Reform Trust | Short | 7 | 4 | When assessing independent living needs it would be useful to ask if the person had any help when they were in the community such as from a carer or social worker. | Thank you for your comment. The GDG feel that this is covered by the first-stage assessment question, Table 1 section 8: *Does the person need help to live independently?*<br><br>The guidance on before release from prison (recommendation 1.7.9) recommends that social |

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| | | | | | services are contacted if necessary. |
| Prison Reform Trust | Short | 7 | 4 | Under actions, an explicit reference should be made to ensuring referrals are made (whether by health care or prison staff) to social services for an assessment under the Care Act, taking into account instructions in PSI 03/2016 Adult Social Care | Thank you for your comment. This information has been added to the Recommendations and link to evidence section 5.8.1 in the full guideline. |
| Prison Reform Trust | Short | 7 | 4 | We are uncertain if this is necessary during the first stage assessment, if there is to be a second stage assessment within 7 days | Thank you for your comment. This list was agreed upon by the GDG as being necessary for the first-stage assessment. |
| Prison Reform Trust | Short | 7 - 8 | 4 | There is a need for clearer distinction between non-prescribed drugs and prescription drugs that were not prescribed for that person/that dose. | Thank you for your comment. "Over the counter medicines" have been added to the prescribed medicines section in the first-stage health assessment table. |
| Prison Reform Trust | Short | 8 | 4 | Cannabis should be added to this list. | Thank you for your comment. The Committee of the Mental health of adults in contact with the criminal justice system guideline agree and this has been added. |
| Prison Reform Trust | Short | 8 | 4 | It should be sufficient here to refer to the prison mental health team rather than specifying the in-reach team. It is also unnecessary to qualify actions with 'if they have received care for mental health problems' - the question already assumes they have and there should be consideration anyway for those presenting with mental health needs who were not receiving support they needed prior to custody. | Thank you for your comment. The Committee of the Mental health of adults in contact with the criminal justice system guideline agree and this recommendation has been amended. |
| Prison Reform Trust | Short | 9 | 4 | Under actions, we prefer the wording '*immediate* mental health assessment rather than *'urgent'.* Urgent is more subjective and in a busy environment could still result in inappropriate delay. | Thank you but urgent and emergency are the terms now used in the NHS and applied consistently across NHS provided services. The use of other terms may therefore be confusing. |
| Prison Reform Trust | Short | 9 | 2 | This section should include an action to share | Thank you for your comment. This is covered in the |

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| | | | | information with prison staff that is relevant to their immediate care and wellbeing – for example if they have learning difficulties or need immediate social care referral and/or reasonable adjustments. Although communication is covered in a later section it is important to reinforce this as without this communication with prison staff the information gathered from these assessment will not influence the treatment they receive on the wings. | recommendations in the communication and coordination section 1.2.1–1.2.6. |
| Prison Reform Trust | Short | 10 | 10 | We welcome the idea of a second stage health assessment for every person in prison. This allows for the first stage assessment to focus on the immediate needs and safeguarding of the individual, and ensures that needs and actions identified are followed up on. It is also a chance to ensure things like continuity of appointments and medication are maintained following arrival in custody. | Thank you for your comment. |
| Prison Reform Trust | Short | 10 | General | The second stage assessment should include one of the validated learning disability screening tools in the second stage healthcare assessment at the very least. NHS England guidance on healthcare for people with learning disabilities in prison, 'Equal Access, Equal Care' would be a valuable reference for this. | Thank you for your comment. The review question did not include validated learning disability screening tools.<br><br>The following recommendation has been amended:<br>'1.1.31 Offer people equivalent health checks to those offered in the community, for example:<br>• the NHS health check programme<br>• learning disabilities Annual Health Check<br>• relevant NHS screening programmes, such as those for abdominal aortic aneurysm and bowel, breast and cervical cancer.' |
| Prison Reform Trust | Short | 10-12 | General | It is standard practice for people with learning | Thank you for your comment. The learning |

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| | | | | disabilities in the community to receive annual health checks. We suggest this is acknowledged and included under the second stage assessment section of the guidelines. | disabilities annual health check has been added to the recommendation listing examples of equivalent health checks to those offered in the community (1.1.31). |
| Prison Reform Trust | Short | 11 | 1-8 | Reinforcing the need to liaise with prison staff where needed would be beneficial here (e.g. about concerns relating to self harm/suicide, learning disabilities, autism, etc) | Thank you for your comment. We think that this is already covered in the communication section recommendation<br>1.2.2 "Share information with other health and social care staff, offender supervisors and probation providers who are involved in the person's care in prison when necessary for the person's care." |
| Prison Reform Trust | Short | 11 | 9 | Reference to 'mental health problems' here should be qualified and include learning disabilities, autism, ADHD, etc.<br><br>This screen should happen at the first stage assessment if there are any concerns raised or the health worker believes there is any possibility that a person has cognitive impairment. | Thank you for your comment. This is included as part of the Mental health of adults in contact with the criminal justice system guideline (in development), where it is clarified further.<br><br>The Mental health of adults in contact with the criminal justice system GDG agreed that this should happen as part of the second stage assessment. This is set out in the second stage assessment. |
| Prison Reform Trust | Short | 12 | 1 | We would like 'easy-read' format to be specified in this point. | Thank you for your comment. This is covered in the following recommendations: "1.1.3 Take into account any communication needs or difficulties the person has (including reading and writing ability), and follow the principles in NICE's guideline on patient experience in adult NHS services."<br><br>And 1.1.19: Offer the person advice, with supporting literature where appropriate, on:<br>• how to contact prison health services and book GP |

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| | | | | | appointments or other clinics for example, dental, optician, chiropodist.<br>• where to find health information that is accessible and understandable<br>• how to attend or get a referral to attend any health-promoting activities in the future<br>• medicines adherence |
| Prison Reform Trust | Short | 12 | 13 | We suggest phrasing this more actively such as 'tell the person' rather than 'offer the person'. Although this seems trivial, 'offering' advice is very passive and open to interpretation and could simply amount to having leaflets available. | Thank you for your comment. In the context of NICE guidelines, 'Offer' is a strong and active recommendation that takes into account patient choice. |
| Prison Reform Trust | Short | 12 | 21 | Details of what information has been shared with whom and for what reason should be included here | Thank you for your comment. Please see this following from the Recommendations and link to evidence section 6.6: 'information about high level risks (for example risk of self-harm, risk to others, deteriorating condition) should be shared with prison staff using their electronic record system, as supported by the evidence review key theme on information. The GDG noted the General Medical Council 200933 guidance on when to disclose information about serious communicable diseases, which states that with consent "you should make sure information is readily available to patients explaining that personal information about them will be shared within the healthcare team, including administrative and other staff who support the provision of care" and "if a patient refuses to allow you to inform someone outside the healthcare team of their infection status, you must respect their |

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| | | | | | wishes unless you consider that failure to disclose the information will put healthcare workers or other patients at risk of infection".' |
| Prison Reform Trust | Short | 12 | 25 | Planning a health care review should take into account other needs– as mentioned elsewhere a person with learning disabilities should get a health check annually so this should be taken into account. | Thank you for your comment. The GDG agreed that when health reassessments should take place should be based on clinical judgement: 1.1.21 'Plan a follow-up healthcare review at a suitable time based on clinical judgement, taking into account the age of the person and length of their sentence.'<br><br>The following has been added to the recommendation on health checks: 1.1.31 'Offer people equivalent health checks to those offered in the community, for example:<br>…<br>• learning disabilities annual health check' |
| Prison Reform Trust | Short | 13 | 19 | We are not clear if there is a reason why this only specifies men? We suggest this is amended to include women and specifically sex-workers that are more likely to be at risk. | Thank you for your comment. This recommendation has been changed to the following: "Offer all people HIV testing when entering prison" |
| Prison Reform Trust | Short | 15 | 6 | An annual health check for people with learning disabilities as is the standard in the community should be included in this section. | Thank you for your comment. This has been added to recommendation 1.1.31. |
| Prison Reform Trust | Short | 15 | 19 | We suggest removing the phrase 'complex' from this tendency. There is a tendency to interpret this as meaning only the most extreme cases when in actual fact this action should apply to all needs generally. | Thank you for your comment. Recommendation 1.2.2 states that the information necessary for the persons care should be shared between health staff for all people in prison. Recommendation 1.2.4 contains the word 'complex' because it pertains to sharing information with prison staff. This is necessary for people with complex needs due to risk. |

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| Prison Reform Trust | Short | 15 | 20 | The sharing of information needs to be more active – information shared via the prison record system may not be immediately seen by staff responsible for care during their first nights. Some direct and verbal sharing of information should be encouraged. | Thank you for your comment. This is covered in recommendation 1.2.2 'Share information with other health and social care staff, offender supervisors and probation providers who are involved in the person's care in prison when necessary for the person's care.' |
| Prison Reform Trust | Short | 15 | 23 - 29 | Autism should be added to this list | Thank you for your comment. This list of examples is not intended to be exhaustive. Learning disabilities are listed as an example. |
| Prison Reform Trust | Short | 16 | 2 | As with comment 26 above, we suggest removing the word 'complex' | Thank you for your comment. The GDG consider those with complex needs to be the population that should be targeted. |
| Prison Reform Trust | Short | 16 | 10 | Again, we suggest an emphasis on 'active' sharing of information and that prison staff should be included here. | Thank you for your comment. Recommendation 1.2.2 is an action that states: Share information with other health and social care staff, offender supervisors and probation providers who are involved in the person's care in prison when necessary for the person's care. |
| Prison Reform Trust | Short | 16 | 17 | We would like accessible information such as 'easy-read' format to be included in this point. | Thank you for your comment. This is covered in the following recommendation '1.1.3 Take into account any communication needs or difficulties the person has (including reading and writing ability), and follow the principles in NICE's guideline on patient experience in adult NHS services.' |
| Prison Reform Trust | Short | 16 | 25 | This section should include information about minimum rights to exercise and time in the open air whilst in the prison in accordance with the Prison Rules | Thank you for your comment. This is outside of the remit for this guideline, |
| Prison Reform Trust | Short | 17 | 19 | This section should include information on the drive to make prisons smoke free, and where the prison currently stands on this | Thank you for your comment. The introduction of smoke free prisons has been discussed in the Recommendations and link to evidence section |

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| | | | | | (7.6.1) of the full guideline. |
| Prison Reform Trust | Short | 18 | 22 | This section should include 'any change in social/legal status of the person' as this may change the risks involved. | Thank you for your comment, the highlighted list is not exhaustive and includes examples of when the risk assessment should be repeated |
| Prison Reform Trust | Short | 19 | 9 | This point should also include those transferred *from* a segregation unit back onto normal accommodation. | Thank you for your comment. This has been added to the recommendation. |
| Prison Reform Trust | Short | 20 | 1 | We strongly support the focus on monitoring for older people. Older people in prison are a growing population with associated health issues which need to be taken into account. Older people often report difficulty accessing health care and a fear for their wellbeing when unable to get urgent assistance for chronic health conditions. | Thank you for your comment. |
| Prison Reform Trust | Short | 20 | 4 - 30 | This is a major concern for people in prison with life threatening health conditions and reports of poor responses to emergencies. This has been repeatedly identified up by the Prisons and Probation Ombudsman (PPO). As well as having processes in place to ensure an appropriate response there should be regular reviews of these processes to ensure they are effective. | Thank you for your comment. The GDG agree and have recommended that a protocol is put in place. The following statement has been added to the relevant Recommendations and link to evidence section (10.4.1): "*The GDG noted that for all processes for managing deteriorating health and for emergency responses should be monitored and regularly reviewed to minimise harm*." |
| Prison Reform Trust | Short | 21 | 5 | There should be timelines to make sure medical records are transferred in a timely manner. People in prison often report delays to medication as a result of records not having been received from their GP in the community. | Thank you for your comment. The GDG agree that this may be an issue and this recommendation (1.7.1) states that record transfer should be arranged on the person's entry into prison. It is outside the remit of this guideline to mandate the actions of GPs in the community. |
| Prison Reform Trust | Short | 22 | 8 | This line should include eligible social care needs | Thank you for your comment. All relevant health and social care could be included here. The list is not intended to be exhaustive. |

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| Prison Reform Trust | Short | 22 | 13 | This list should include appointments with learning disability support services | Thank you for your comment. All relevant health and social care appointments could be included here. The list is not intended to be exhaustive. |
| Prison Reform Trust | Short | 22 | 22 | Suggest rephrase to '*Ensure* people who are being released from prison find and register with a community GP if they are not already registered with one'. People are often released without this support despite serious health issues and need for medication. This can be particularly problematic in areas where there is high demand and delays for GP appointments and can also delay access to health related benefits. | Thank you for your comment. The GDG felt that 'ensuring' this would not always be possible due to factors outside of the control of the prison staff and healthcare professionals. |
| Prison Reform Trust | Short | 24 | 19 | We are uncertain what is meant by reference to 'people moving from one care setting to another'. Should this not be moving between a care setting and prison, either when arriving or leaving? | Thank you for your comment. We have amended this recommendation to clarify that it is for people moving from prison to another care setting. |
| Prison Reform Trust | Short | 25 | 14 | Suggest rewording from 'experts' to 'appropriately experienced or qualified staff' | Thank you for your comment. This has been changed to 'professionals' in line with the NHS definition. |
| Prison Reform Trust | Short | General | General | At some point in the guidelines there should be reference to a clear process for prison staff to refer people they have concerns about. This process should be straightforward so as not to discourage referrals being made and the burden to justify the referral should not be on staff that are not medically trained. | Thank you for your comment. Guidance is given on referral for further assessment or to other professionals within the prison service throughout the guideline. For example, first and second assessment (section 1.1 ), managing medicines (section 1.4), managing deteriorating health and health emergencies (section 1.6), and continuity of care (section 1.7). The recommendations are directed at those delivering healthcare, but we have included other prison staff when appropriate to do so. |

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| Public Health England | general | General | General | **Who is responding:** PHE Health & Justice, consulting with other expert teams across our organisation, are leading the response to this document. We have close working relationships with other groups responding separately to this consultation including NHS England Health & Justice Clinical Reference Group and the RCGP Secure Environments Group. We also work closely with justice partners, including the National Offender Management Service and the Home Office. Therefore, our response includes reflections from our partners as well as our own. Further, we have significant experience in implementing health improvement, health promotion and health protection services in prisons in collaboration with our partners and understand fully the operation and policy context in which such programmes are being delivered currently and in the near future. Finally, as the UK Collaborating Centre to the WHO Health in Prisons Programme (WHO HIPP), we have a working knowledge of international evidence and practice in relation to the physical health of people in prisons and are currently working with the European Centre for Disease Surveillance and Control (ECDC) on a systematic review of evidence for health protection in prisons which is relevant to this consultation response. | Thank you |
| Public Health England | general | General | General | **Descriptor for population of interest:** we welcome the use of the phrase 'people in prison' rather than 'prisoner' in the title and throughout the document as | Thank you |

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| | | | | this puts the person first rather than the condition of being incarcerated, which for the majority of people will be for a relatively short period of time on any one admission. We encourage consistent use of this descriptor where possible throughout the final guidance and in subsequent briefings or publications issued by NICE. | |
| Public Health England | general | General | General | **In response to the consultation Question 1:** Many of the recommendations reflect current practice but implementation is contingent on strong cooperation between the prison regime and the healthcare providers within the prison as well as effective communication between community-based and prison-based healthcare systems and teams. Continuity of care on transition is a major challenge, between custodial settings or on moving from community to custody or on release from prison. Many transitions, such as transfer or release, are not known to healthcare services in advance- especially if people are transferred to court and subsequently released- therefore planning 'pre-release' health assessment is operationally difficult. There needs to be a stronger statement about planning for discharge to begin on reception. Further, that continuity of care is best supported by ensuring prisoners are appropriately registered with primary care providers during incarceration and on release. This will require some sophistication and change to current registration and this will be supported by new health informatics systems (Health & Justice Information Service or | Thank you for your comment. A recommendation (1.7.5) has been made for people who may be in prison for less than 1 month, to plan pre-release health assessments during the second-stage health assessment:<br>"For people who may be in prison for less than 1 month, plan pre-release health assessments during the second-stage health assessment (see recommendation 1.1.13 for details of this assessment)."<br><br>The GDG have also made recommendations (1.1.2) at the reception stage of prison for those transferring from one custodial setting to another. Relevant information from the patient clinical record, prisoner escort record and cell sharing risk assessment are transferred and checking whether medication is prescribed or any outstanding medical appointments need to be organised by the receiving facility:<br>"Ensure continuity of care for people transferring from one custodial setting to another (including court, the receiving prison or during escort periods) by, for example: |

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| | | | | HJIS) which are being deployed this summer by NHS England in partnership with HSCIC. However, continuity of care remains one of the most significant challenges and some of the recommendations in the guidance do not adequately account for this or consider the current and planned resources and supports sufficiently to mitigate this risk. | • accessing relevant information from the patient clinical record, prisoner escort record and cell sharing risk assessment<br>• checking medicines and any outstanding medical appointments<br><br>The GDG reviewed the continuity of care recommendations (1.7.1 – 1.7.11) and recognise that implementing the recommendations will require operational changes, however they consider these achievable and support equivalence of health and social care in prisons with that provided by the rest of the NHS. |
| Public Health England | general | general | general | **In response to consultation Question 2:** Many of the recommendations within the guidance would have significant costs implications. But the focus of the guidance is often on diagnostic tests, whether clinically or laboratory-based which although costly, is the least expensive part of the impact of the guidance. Rather, what will impact on costs significantly is the need to improve access to care, including treatments and therapeutic programmes. There is significant under-ascertainment of many infectious diseases (e.g. Hepatitis C, latent TB, and HIV) and chronic diseases (e.g. hypertension, hypercholesterolaemia) including mental health (e.g. depression) and learning disabilities among people in prisons. Improving case-finding and diagnosis of such needs will undoubtedly benefit the population but only if there are clear care pathways in place which include access to sometimes | Thank you for your comments. We agree that implementation of this guideline will require a 'whole prison approach', coordination between care providers and reallocation of funding to ensure that cost-effective preventative treatment is increased.<br><br>However, whilst better communication and coordination with prison staff are vital, the GDG does not agree that these guidelines will necessarily significantly increase prison costs. Healthy dietary options are already available, these guidelines encourage prisoners to take them up; whilst regarding exercise prisoners are encouraged to participate in more exercise (both using prison facilities and in their cells), there are no recommendations for prisons to increase their exercise facilities beyond that already standard for |

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| | | | | expensive treatments (e.g. direct acting antivirals for Hepatitis C infection). It is important to take appropriate account of the costs of such healthcare needs in assessing the total impact of the recommendations on costs of prison healthcare. Further, it is highly likely that identified health needs will not be fully managed by prison healthcare systems alone especially for chronic diseases, so the wider health system needs to be included in consideration. There is strong evidence that intervention and treatment for many of the health needs mentioned in the guidance is cost-saving and cost-effective but current healthcare budgets do not currently account for the likely increase in demand consequent to increased diagnosis. Finally, it is not healthcare alone which will bear the costs of increased case ascertainment- many of the interventions for chronic illnesses or pre-morbid conditions, will impact on the regime e.g. improved diet, better access to exercise, more time 'out of cell in purposeful activity' etc. Even supporting enhancements to current systems of reception and subsequent health assessments as well as ongoing access to healthcare will stress current levels of prison staffing. A 'whole prison' approach is required to implement the guidance as well as support the consequences of the guidance if it is to achieve the public health outcomes desired. | prisons. |
| Public Health England | general | general | general | **In response to consultation Question 3:** Some of the challenges inherent in the impact of the guidance | NICE guidance is based on a review of the published evidence and recommendations are made by the |

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| | | | | may supported through more cooperative working between prison governors and healthcare service providers and commissioners. The Prison Reform Programme recently announced in the Programme for Government (Queen's speech) in May could provide a structure around which such cooperation and collaboration can be built especially in consideration of how to support development of lifestyle modification including diet and exercise within a prison context but also in relation to how and what health services are commissioned https://www.gov.uk/government/news/biggest-shake-up-of-prison-system-announced-as-part-of-queens-speech . Wider health improvement programmes currently in implementation stage within prisons, led by PHE, including implementation of a BBV opt-out testing programme, implementation of smoke-free prisons, implementation of a Physical Healthchecks Programme for Prisons and improved access to screening programmes, supported by metrics collected by the Health & Justice Indicators of Performance (HJIPs), could provide a real structure around which to build implementation of this guidance. But the guidance also needs to take account of these programmes and it fails to do so. More information about PHE Health in Prisons Programme (including our National Partnership Agreements with NHS England and NOMS) is available at https://www.gov.uk/government/collections/public-health-in-prisons | committee that reflect the quality and strength of the available evidence. Reference has been made to prison policy and supporting documentation where appropriate within the Recommendations and link to evidence section of the guideline, PHE programmes currently being developed which will support implementation of the recommendations are to be welcomed. Following publication of the guideline quality standards will be developed to also support the implementation of the guideline. |

# Physical Health of People in Prison

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| Public Health England | general | General | General | The original scoping document outlined how the guidance would cover;<br>'Approaches (including interventions and methods of delivery) to improve health and wellbeing in prisons'. However, it has not succeeded in fulfilling this original scope.<br><br>This is an individually focused clinical guidance on 'clinical care' which focusses on individual clinical outcomes rather than population focused outcomes. It doesn't reference strategic and system leadership. Therefore it does not cover the wider context of the prison setting and prison regime and its impact on health except when considering factors which facilitate or are barriers to health promotion/health education, on which there was not strong enough evidence. In the criminal justice arena there is currently a strong emphasis on system leadership which encourages communication between organisations and sharing of information and co-commissioning. There was no acknowledgement to the importance of system leadership, especially relating to ensuring continuity of care and planning for discharge. Planning for discharge should be considered early on in the process.<br><br>The WHO advocate a 'healthy prisons' whole system approach which encourages the development of a health enabling environment, which can help to encourage prisoners to change their behaviour. This | Thank you for your comment.<br>The remit from NHS England was to develop a guideline on 'assessment, diagnosis, and management of physical health problems of people in prison' with the focus on individuals in prison rather than on the prison system. Service delivery is beyond the scope of this guidance as it was not highlighted as a priority area during the stakeholder consultation on the Scope.<br><br>The guideline considers the effectiveness of interventions in the physical healthcare of prisoners and focuses on clinical outcomes as outlined in the scope.<br><br>The GDG considers that communication and information sharing has been emphasised throughout the guideline and recommendations made to improve this at all stages of the person's time in prison and on release.<br><br>The GDG agrees planning for discharge needs to be done at an appropriate time and has included this as part of the second-stage health assessment for those serving short sentences. |

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| | | | | systematically involves the whole prison system including prison officers. However, there was no reference to this important aspect of improving prisoners' health.<br><br>This guideline seemed to focus on the initial assessment process rather than taking a broader view of the physical health of prisoners. There should be multiple opportunities for people in prison to engage with programmes, such as the Physical Healthcheck Programme which should be offered on entry but then reoffered at every opportunity to encourage a high uptake.<br><br>Recommendations need to include the acknowledgement that more NICE guidance is needed on delivering health and well-being using a whole prison approach and also that all general NICE guidance which is produced needs to consider prisoner populations and how NICE guidance will be implemented in a prison setting | |
| Public Health England | Short | General | General | There should be statement in the shorter document about people in prisons (and other places) having equal access to and outcomes from physical and mental healthcare as the general population, with NICE standards met where they exist for general population. | Thank you for your comment. The context section of this document states:<br><br>*This guideline supports equivalence of healthcare in prisons, a principle whereby health services for people in prisons are provided to the same standard, quality and specification as for patients in the wider NHS.* |
| Public Health England | Short | General | General | The guideline should include a section on co- | Thank you for your comment. Mental health is |

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| | | | | morbidities of physical health, mental health and substance misuse. | outside of the scope of this guideline as this is being covered by the accompanying guideline mental health in adults in contact with the criminal justice system currently in development. Both the physical and mental health guidelines have worked together to ensure a joined up approach and the two guidelines will be brought together on publication. |
| Public Health England | Full | General | General | Qualitative research has not been rated very highly according to the quality criteria and therefore not given much prominence. However, qualitative literature provides a rich source of insights and evidence into prisoner health. The methodology used in this review is robust but limited. It is strictly delineated as the guidelines are attempting to answer very specific questions. As a result, the findings are reported in 'silos' and lacks a 'whole prison approach'. Diet is a good example of this – what you eat in prison is **not** solely determined by your knowledge of healthy eating and what is available to eat. It's much more complex than that (particularly for women) but this really doesn't come across in the review. | Thank you for your comment. Qualitative reviews have been assessed according to the criteria set out in Table 6 of the Full Guideline. Themes identified in the qualitative reviews have been used to inform recommendations; this has been outlined in the Recommendations and link to evidence section. |
| Public Health England | General | General | General | There is no reference to recording of data and the monitoring of health outcomes as a result of the assessment. | Thank you for your comment. This is beyond the scope of this guideline. After publication of this guideline a NICE quality standard will be produced, to which this will be relevant. |
| Public Health England | General | General | General | An important aspect of producing guidelines is to evaluate whether they have been effective in changing both practice and outcomes. It is important to ensure evaluation is embedded in the process at an early stage. Evaluation including clinical audit has not | Thank you for your comment. Clinical audit is not part of NICE guidance, however quality standards will be developed after publication of the guideline. |

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| | | | | been specifically mentioned as a means of quality-assuring implementation of guidance. | |
| Public Health England | general | General | General | There is no reference in the guidelines to smoke free prisons programmes which has been in implementation since April 2016 in Wales and South West England and will be implemented fully across all adult prisons in England over the next two years. https://www.gov.uk/government/speeches/smoking-in-prisons | Thank you for your comment. The following has been added to the Recommendations and link to evidence section (7.6.1) of the full guideline: "The GDG also noted that smoke free prison programmes have been implementation since April 2016 in Wales and South West England and discussed that this may be implemented fully across all adult prisons in England over the next two years." |
| Public Health England | general | General | General | There is no reference in the document to infection control as part of wider health protection issues which impinge directly on the physical health of people in prisons- linking to wider NICE guidelines and/or national/international guidance on infection control in prison especially in relation to control of infectious diseases like measles, seasonal flu, TB or chickenpox, should be considered. PHE have produced national guidelines in this area which are found at https://www.gov.uk/government/collections/public-health-in-prisons#infection-control-in-prisons-and-secure-settings. | Thank you for your comment. Very little evidence was found for hygiene in general and nothing for preventing infection, in prisons in particular, however we have provided a link to NICE guidance on Infection control (CG139) which is aimed at healthcare workers delivering healthcare in primary and community settings. |
| Public Health England | Full | 14 | general | There is no reference to ascertaining or verifying vaccination history including Hepatitis B vaccination but also MMR, meningitis C or ACWY. However, in the full list of recommendations (pg. 22, line 25 Short) there is a recommendation to provide Hepatitis B vaccine as per Green Book Guidance. | Thank you for your comment. 'Vaccination records' has now been added to recommendation 1.1.14 accordingly. |

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| Public Health England | Full | 20 | 14 | Physical health reference does not specify assessment of vaccination history or vaccine requirements. Should include reference to Green Book and/or PHE guidance on vaccine requirements for people in prisons https://www.gov.uk/government/collections/public-health-in-prisons#infection-control-in-prisons-and-secure-settings | Thank you for your comment. 'Vaccination records' has now been added to recommendation 1.1.14 accordingly. |
| Public Health England | general | General | General | There is no reference to the consequences on physical health of overcrowding including risk of transmission of infectious diseases. | Thank you for your comment. Whilst we recognise overcrowding can have a detrimental effect on health, this was not an area where we found any evidence in the reviews conducted for the guideline and therefore has not been referred to. |
| Public Health England | general | General | General | There is no reference to the potential risks of a heatwave including impact on health in unsuitable and/or overcrowded accommodation. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/429384/Heatwave_Main_Plan_2015.pdf | Thank you for your comment. Whilst we recognise hot weather can have a detrimental effect on health, this was not an area where we found any evidence in the reviews conducted for the guideline and therefore has not been referred to. |
| Public Health England | Full | 24 | 35 | Sexual health- access to condoms/dental dams/water-based lubricants- current guidance in prisons enables access to condoms etc. but 'on application'- availability is through healthcare providers and provides an opportunity to engage with people about their sexual behaviour in prison including offer of STI screening as well as to talk about concerns about coercive sexual contact as well as consensual contact. There is no evidence that this is a significant barrier to use of condoms in English prisons and some support for argument that it has 'added value' | Thank you for your comment. Recommendation 1.3.8 states: *Ensure that people in prison have discreet access to condoms, dental dams and water-based lubricants without the need to ask for them.*<br><br>The evidence reviewed suggested that providing a condom dispenser increased the uptake of condoms, and increased the use of condoms when sex occurred within prison, compared to condoms being available on request or no readily available supply. |

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| | | | | as well as addressing security concerns of prison establishment.<br><br>There is only a passing reference in the guidance to NICE guidance on Reducing sexually transmitted disease and U18 conceptions https://www.nice.org.uk/guidance/ph3 in the reference section but not to its full advice nor to how such advice could or should be applied specifically in prisons. | The GDG noted that easy access to condoms is provided in other high-risk populations. This guideline is based on the principle of equivalence for NHS care. The GDG's consensus was that the prison population should be treated with equivalence and be able to access condoms discreetly.<br><br>Reference to PH3 has been made in the barriers and facilitators to health promotion Recommendations and link to evidence section in the full guideline. |
| Public Health England | Short | General | General | It is important to emphasise in the recommendations that the WHO state that the primary duty of healthcare staff is to protect and promote the health of prisoners and to ensure that they receive the best care possible. http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2014/prisons-and-health | Thank you for your comment. This reference has been incorporated into the introduction of this chapter. |
| Public Health England | Short | 14 | general | Answers to question 'is patient taking any prescribed medication' should include option 'not sure/not known/incomplete information' and subsequent management strategy as not all patients will have full knowledge or provide true representation or have full documentation of their prescribed mediation on first night reception. | Thank you for your comment. Omissions will be picked up by the medicines reconciliation (recommendation 1.1.8) and second-stage health assessment – where answers to the first-stage health assessment are reviewed. |
| Public Health England | Short | 4 | 1.1.1 | The assessment described is quite complex and requires a significant level of experience, knowledge and skill. PHE is concerned about a 'trained healthcare assistant under the supervision of a | Thank you for your comment. This recommendation was supported by the health economic analysis which found that a healthcare assistant conducting the health assessment would be more cost-effective |

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| | | | | registered nurse' undertaking this assessment. There is a risk that significant physical health problems will not be identified or fully understood if left to a healthcare assistant. | than a nurse.<br><br>However, due to the uncertainty around this analysis the GDG stipulated that the healthcare assistant would need to be trained and under the supervision of a registered nurse as a minimum. |
| Public Health England | Short | 6 | 2.7 | The Referral pathway appears to assume continuation with pregnancy. NICE need to consider that the woman may wish to terminate the pregnancy and so would need to add in a pregnancy options discussion. This could be from a reproductive or contraceptive health provider and would not be carried out by a midwife. GP could refuse to refer to termination services and so any conscientious objection by medical staff would need to be determined prior to referral. Timing of this referral is imperative as it would need to be in line with current abortion guidelines. | Thank you for your comment. The questions regarding pregnancy in the first-stage assessment have been amended accordingly. The first assessment is primarily concerned with safety, a second assessment is conducted that would address additional issues. |
| Public Health England | Full | 22 | 34 | Guidance on offer of HIV test only to MSM rather than to all prisoners as part of wider 'opt-out testing' for BBVs is flawed application of evidence to prison settings and populations. Firstly, the operational and ethical challenges of identifying MSM in a prison context, where homosexual behaviour is stigmatised and even an infarction of prison rules means that many men will not self-identify. Secondly, men who do not identify as homosexual but do have sex with other men in prison will not see this guidance as relevant to them. Thirdly, given the way in which the BBV test is administered, usually using a dried-blood spot kit, | Thank you for your comment. We believe the recommendations are in line with the opt out policy. The wording states to offer the test therefore people would receive this unless they chose to opt out.<br><br>The GDG agree that HIV testing should be offered to all people in prison and the recommendation has been amended. Support for people who have a positive test result has been noted in the Recommendations and link to evidence section of the guideline. |

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| | | | | which can test for HIV as well as HBV and HCV, it is operationally easier to provide opportunity to test for HIV to all prisoners and avoids need to self-declare any risk activities. This approach is evidence-based and has been found to significantly increase uptake of HIV testing in many settings including in antenatal clinics in the UK in the late 1990s. We strongly advise that the opt-out testing programme for all prisoners for all BBVs (HIV, HCV and HBV) is recommended rather than limiting offer of HIV test only to self-identified MSM.<br>https://www.gov.uk/government/collections/public-health-in-prisons#improving-testing-and-treatment-rates-for-bloodborne-viruses | |
| Public Health England | Short | 8 | 3.3 | If there is a recent history of injecting drug use the prisoner needs to be referred to SMS as they are at risk of continued IV use and at risk of contracting BBV. They also need to be referred for vaccinations. | Thank you we agree with your comments and will amend the guideline |
| Public Health England | Short | 9 | 5.1 | At the end of this section it would be useful to have a question regarding ability to read and write as this will have a significant impact if there are literacy issues. | Thank you for your comment. Reading and writing ability has now been added to the communication needs or difficulties in recommendation 1.1.3, as well as the guideline introduction. |
| Public Health England | Short | 10 | 1.1.18 | Second Stage Assessment: The process of identifying the patient's NHS number should be clearly part of the protocol (would suggest the process begins from the 2nd screening). The implications for continuity of care, research etc. would be hugely beneficial. | Thank you for your comment. This process has not been implemented into clinical practice yet, when the guideline is updated the process will be updated accordingly. |
| Public Health England | Short | 10 | 1.1.7 | This statement needs to be made clearer as it is currently ambiguous. Staff need to be clear what medicine reconciliation is and why it is important to | Thank you for your comment. A definition for medicines reconciliation has been added to the glossary. This corresponds directly to its meaning in |

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| | | | | review prisoner's history before continuing with medication. . | the NICE medicines optimisation guideline to which this recommendation refers. |
| Public Health England | Short | 10 | 1.1.8 | Undertaking a mental health assessment. In normal circumstances a mental health professional undertakes the mental health assessment. If mental health is included in this guideline PHE thinks it would be more appropriate to have a mental health practitioner to undertake the mental health assessment. The draft guideline says the mental health assessment was to be reviewed by a mental health guidelines group. Has this been completed prior to issuing this guidance and was this issue discussed? | Thank you for your comment. The recommendations about the mental health assessment were developed by the Mental health of adults in contact with the criminal justice system group. The initial assessment at reception to prison, and second stage assessment can both be done by a nurse or other healthcare professional and the recommendation actions include being referred onto a mental health professional based on certain results. |
| Public Health England | Short | 10 | 1.1.8 | Line 24 – This needs to be widened to include all screening rather than just mammogram and cervical screening. | Thank you for your comment. The recommendation states this should be included as a minimum and is not exhaustive. |
| Public Health England | Short | 11 | 1.1.9 | PHE would recommend the second stage assessment includes use of the Lester Tool (cardio vascular risk and intervention tool). This tool is being widely adopted to assess cardiovascular risk and NICE compliant interventions (NICE recently approved Lester). | Thank you for your comment. We have cross-referred to the NICE guidance on CVD and the recommendations within it identifying risk. |
| Public Health England | Short | 11 | 1.1.9 | Please add in after 'arrange a follow up appointment if needed and set up an appointment for an NHS physical health check if eligible'. This is very important to help encourage full uptake of the programme. | We consider this to be already covered in recommendation 1.1.31:<br>"Offer people equivalent health checks to those offered in the community, for example:<br>• the NHS health check programme<br>• learning disabilities Annual Health Check<br>• relevant NHS screening programmes, such as those for abdominal aortic aneurysm and bowel, |

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| | | | | | breast and cervical cancer." |
| Public Health England | Short | 13 | 1.1.18 | Please add 'all prisoners are offered BBV opt out testing'. It is very important that BBV opt out testing is offered in a systematic way. | Thank you for your comment. The GDG agree that the recommendation for HIV testing should apply to all people in prison and have changed the wording to offer to all people, which is in line with the 'opt out 'policy. |
| Public Health England | Short | 13 | 1.1.18 | Bullet point 3 – Please add – Hepatitis C should always include PCR confirmation before reporting to patients that they are positive. | Thank you for your comment. This recommendation is from NICE's already published guideline on hepatitis B and C testing. |
| Public Health England | Short | 13 | 1.1.18, | http://www.nat.org.uk/media/Files/Publications/Jan-2012-Hepatitis-C-and-HIV-co-infection.pdf<br>**All prisoners should be offered a HIV test as part of a comprehensive BBV screening approach**.<br>See embedded guidance re: HIV and Hep C and TB co-infections.<br>http://www.cdc.gov/tb/publications/factsheets/testing/hivscreening.htm<br>http://www.who.int/hiv/topics/tb/tbhiv_facts_2013/en/<br>and<br>http://www.bhiva.org/documents/guidelines/tb/hiv_954_online_final.pdf | Thank you for your comment. The GDG agree that the recommendation for HIV testing should apply to all people in prison and have changed the wording to offer to all people, which is in line with the 'opt out 'policy. |
| Public Health England | Short | 13 | 1.1.19 | Men who have sex with men do not always readily identify themselves for a range of reasons and there is increasing HIV amongst IVDU and PIED users http://www.nta.nhs.uk/uploads/providing-effective-services-for-people-who-use-image-and-performance-enhancing-drugs.pdf Choosing an opt out model of HIV testing in prisons could support the reduction of stigma and also protect the most vulnerable prisoners | Thank you for your comment. The GDG agree that the recommendation for HIV testing should apply to all people in prison and have changed the wording to offer to all people, which is in line with the 'opt out 'policy. |

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| | | | | as well as removing the requirement to identify sexuality. See evidence of increased HIV tests in maternity services following adoption of opt out model. Could significantly contribute to the reduction of undiagnosed HIV, currently approx. 25% of HIV+ population. | |
| Public Health England | Short | 13 | 1.1.21 | Essential to discuss the use of Post Exposure Prophylaxis (PEP) with all prisoners as part of health promotion discussion around safe sexual activity http://cks.nice.org.uk/hiv-infection-and-aids Also must be available as part of sexual health service offered to prisoners. | Thank you for your comment. Post-exposure prophylaxis was not included in the scope of this guideline. |
| Public Health England | Short | 14 | 1.1.23 | All prisoners must be offered a full sexual health screen including risk assessment https://www.nice.org.uk/guidance/ph3/chapter/1-Recommendations Current wording would suggest limited screening is required but offering to all prisoners could reduce stigma of testing and build good practice for continued good sexual health upon release. It would also reduce inequalities faced by the most vulnerable prisoners and omit the need for some prisoners to disclose their sexuality which can often increase their vulnerability in prisons. | Thank you for your comment. The recommendation is from the NICE guideline on sexually transmitted infections. This states all people are screened to identify those at high risk and those identified would receive further investigation. |
| Public Health England | Short | 14 | 1.1.25 | Screening in prisons is not happening systematically and cases of active TB are being missed. It is therefore very important to use this opportunity to refer to the NICE guidance requiring screening for TB within 48 hours of arrival **and also the PHE suggested risk assessment tool and pathways** included in the | Thank you for your comment. The guideline includes a number of recommendations from the NICE TB guidance that are applicable to prisons.<br><br>Thank you for the additional source, however, we are not able to refer to non-NICE guidance. |

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| | | | | PHE Management of TB in prisons Guidance for healthcare teams (pg.14 risk outbreaks of TB in prisons)<br>https://www.gov.uk/government/publications/managing-tuberculosis-tb-in-prisons | |
| Public Health England | Full | 23 | 9 | Need to specify what is meant by 'all prisoners should be screened for TB within 48hrs'- the current 'screening' is focussed entirely on active TB, specifically pulmonary TB, and is carried out using a symptom-based questionnaire and/or a CXR. However, recent updates to NICE guidance published in January 2016 suggest that people in prison should receive test for latent TB: Substance misuse services and prison health services should incorporate interferon‑gamma release assay testing with screening for hepatitis B and C, and HIV testing.<br>https://www.nice.org.uk/guidance/ng33/chapter/Recommendations | Thank you for your comment. This recommendation has been adopted from the NICE tuberculosis guideline (NG33). The GDG reviewed the recommendations and considered them to be clear and achievable. |
| Public Health England | Short | 14 | 1.1.23 | All prisoners aged 15-24 years of age must be offered a chlamydia test. | Thank you for your comment. The guideline recommends all people have access to equivalent health checks and screening programmes as those offered in the community, |
| Public Health England | Short | 15 | 1.2.2 | How is communication ensured and what are the confidentiality arrangements with regard to prisoners with complex health needs? Communicable diseases include HIV how is a prisoner's HIV status kept confidential? Concern that disclosure could place prisoners who are living with HIV at increased risk of vulnerability and this would make them reluctant to | Thank you for your comment. Please see the following in the Recommendations and link to evidence section (6.6) of the full guideline: 'The GDG agreed that it was important to support both healthcare and prison staff in understanding what information they are entitled to share with other professionals involved in their care, where |

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| | | | | disclose their status. This could lead to not receiving ARRT medication and also an increased onward transmission risk. | appropriate consent32 has been obtained or that is in the person's best interests in accordance with the Caldicott 2013 principles.' |
| Public Health England | Short | 15 | 1.1.31 | The NHS health check programme currently run in prisons will be changing to the NHS Physical Health Check for Prisoners Programme. The NHS Physical Health Check service will only be offered to those who;<br>Are aged between 35-74 years AND with a period of incarceration of 2 years or more, to reflect the high health risks associated with this population, who 1) have no previous diagnosis of CVD and 2) are not currently taking statins. These changes will take be made in August 2016. All references throughout the NICE guidance will need to be amended to take into account the different eligibility criteria. | Thank you for your comment. We have now removed the age from this reference. |
| Public Health England | Short | general | 1.3.3 | How long can people be out of cells and is it realistic to request that they achieve the PHE recommended physical activity levels of 150 minutes per week? How can prisoners be referred onto an exercise referral scheme? Do they exist in prisons? Very sedentary lifestyles due to incarceration would necessitate that this is a real need. | Thank you for your comment. The GDG discussed the applicability of the recommendations made in other NICE guidance on exercise and physical activity and this is described in the Recommendations and link to evidence section (7.6.1) of the Promoting health and wellbeing chapter of the full guideline. Although it would be challenging to provide this amount of time in open air, or as exercise classes, this would not preclude exercises that could be done in cells and a recommendation has been made to provide information on exercises that can be done within the cell. |
| Public Health England | Short | 17 | 1.3.5 | Would recommend that ALL food options in prisons are healthy making the healthy diet the default option | Thank you for your comment. The recommendation is regarding providing dietary information not about |

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| | | | | in prisons. | what should be provided. |
| Public Health England | Short | 17 | 1.3.7 | NICE PH3 to be embedded into the document https://www.nice.org.uk/guidance/ph3 | Thank you for your comment. We have added relevant recs and cross-refer to the STI guideline in the recommendations regarding HIV. |
| Public Health England | Short | 18 | 1.4 | Make sure staff are aware of the prison pain formulary and that this is followed, especially when medicine is at risk of misuse and diversion is prescribed. | Thank you for your comment. We are unable to directly refer to non-NICE guidance in the recommendations due to differences in process and standard of evidence. |
| Public Health England | Short | 21 | 1.7 | The section on continuity of healthcare is an important aspect of trying to ensure the prisoners are helped to register with a GP. It would be useful to also include a reference in this section to the use of the NHS number which can help aid the process of sharing information. Points 1.74 and 1.7.5 are essential. | Thank you for your comment. This process has not been implemented into clinical practice yet, when the guideline is updated the process will be updated accordingly. |
| Public Health England | Short | 22 | 1.7.6 | Bullet point four, please insert the word 'recovery' so it reads, 'substance misuse and recovery services'. | Thank you for your comment. We have made this change where appropriate in the guideline. |
| Public Health England | Short | 22 | 1.7.6 | Please insert bullet point – record of NHS physical health check | Thank you for your comment. The pre-release plan and care summary includes information the receiving service would need to know to ensure continuity of care, such as significant health events or on-going health or social care needs. |
| Public Health England | Short | 22 | 1.7.9 | Bullet point 3 -please insert the word 'recovery' so it reads, 'substance misuse and recovery services'. | Thank you for your comment. This change has been made. |
| Public Health England | Short | 24 | 1.7.12 | Please reword and change 'Consider carrying out a medicines review' to 'Carry out a medicines review'. (line 4) | Thank you for your comment. The wording of 'Consider' reflects the lack of evidence found in the literature review of this topic. |
| Public Health England | Short | 24 | 1.7.13 | Please insert the word 'always' so the line reads, | Thank you for your comment. We feel that the word |

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| | | | | 'when a person is discharged or transferred from prison ***always*** give them a minimum of 7 days prescribed medicine'. (line 13) | 'always' is redundant in this recommendation as the meaning is the same. |
| Public Health England | Short | 32 | 4 | The research question asked, ' What are the most effective tools to determine the health promotion needs of people in prison' should be widened to 'What are the most effective tools to change people's health related behaviour and to create a health enabling environment in prison'. Focussing just on health promotion is too narrow (see earlier point ) There is no mention of the research gap on the potential use of behavioural insights and social marketing. | Thank you for your comment. The GDG were only able to make research recommendations on areas where they had searched for existing evidence, this evidence search is described in the chapter on Promoting health and wellbeing. The potential use of behavioural insights and social marketing is beyond the scope of this guideline. |
| Public Health England | Short | 32 | 4 | There is a lack of evidence regarding the appropriate timing for health assessments (especially relating to health protection). This is a research gap which needs highlighting. | Thank you for your comment. We agree that there is a need for research in this area. This GDG made the following research recommendation (see research recommendations 1 in the Recommendations for research section): *When should subsequent health assessments be carried out in prison for people serving long-term sentences?* |
| Public Health England | Full | 18 | general | Does the person have any health promotion needs? The draft NICE guidance recognises the importance of the NHS partnership working to promote a whole prison approach to health promotion. However, the recommendations do not go far enough to help to develop a system wide approach to prevention and behavioural change. The guidance focusses on 'health promotion' offering face to face information about the benefits of exercise and healthy eating. We recognise these are an important aspect of improving health but the ability to change one's behaviour and to | Thank you for your comment. The strength of this recommendation reflects the limited evidence found in this literature review within a prison population. The guideline highlights and cross refers to other NICE guidance that provide more detailed health promotion recommendations on diet, exercise, smoking cessation and sexual health that the GDG considered to be relevant to a prison population. Service delivery models are outside of the scope of this guideline. |

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| | | | | develop a health enabling environment is essential if health promotion is to be successful. There is no point giving education and information on how to make lifestyle changes if the person cannot then have the opportunity to make these changes. More emphasis is needed on how lifestyle changes can be made in a prison setting. In a similar way to NICE guidance on obesity prevention guidance is needed on a whole systems prison approach, the involvement of the governor, provider, NHS commissioners to help develop the environment where prisoners are able to have adequate physical activity for weight management and access to a healthy diet. Including a recommendation would give help to enable this to happen. | We agree that governors, providers and NHS commissioners should work together to enable the implementation of existing NICE and PH guidance in these areas. |
| Public Health England | Full | 132 | 7.2 | The review question asked, 'What are the most clinically and cost-effective interventions that can be implemented to promote health and wellbeing in prisons?'. The literature review looked at five intervention areas;<br>Nutrition (food served, access to canteen, snack food)<br>Personal hygiene, self-care, oral health<br>Physical activity (including time in open air, mobilisation)<br>Sexual health (advice, access to barrier methods)<br>Smoking cessation (validated measures of cessation)<br>However this did not include health interventions relating to health protection, drugs and alcohol.<br>These are essential areas of relating to health and | Thank you for your comment. The scope of this guideline is the physical health needs of people in prison. There is an accompanying guideline on mental health of adults in contact with the criminal justice system (in development), which will provide guidance on substance misuse, and alcohol. |

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| | | | | well-being which are especially important in a prison setting which have been omitted from the review. | |
| Public Health England | Full | 190 | 7.6.1 | PHE supports the recommendation Promoting health and well-being and to offer people intervention and advice in line with NICE guidance on:<br>Physical activity: brief advice for adults in primary care<br>Physical activity: exercise referral schemes<br>Preventing excess weight gain<br>Obesity: identification, assessment and management<br><br>However, it would be better if this was phrased; '***ensure there are opportunities*** to offer people intervention and advice in line with NICE guidance' as currently services in this area within a prison setting are limited and need to be developed further to ensure equivalence of care with the community. The draft NICE guidance makes reference to NICE guidance in existence in the community but this guidance has not taken account the constraints of the prison environment. There needs to be consideration when developing any NICE guidance how this can be translated in a prison setting.<br><br>The review of evidence highlighted key points below but these need to be formulated into the guidelines and so clearer and more explicit. This would make it easier to then operationalise.<br>'The recommendations made in NG7 were deemed applicable to the prison population who do have access to additional sugary drinks and high fat snacks | Thank you for your comment. The provision of opportunities is the responsibility of the individual prison regime.<br><br>In the Recommendations and link to evidence section (7.6.1) of the full guideline, it is stated that: *The GDG considered the related NICE guidance to be applicable for the prison setting (with some considerations for setting and populations, for example the recommendations for children are not relevant and sensible interpretation should be applied for recommendations such as allowing access for bicycle rides) and the evidence review is relevant and appropriate.*<br><br>Little evidence was found on diet, therefore the GDG were unable to make detailed recommendations but have referred to the guidance provided in CG189 and NG7, which the GDG considered applicable for prisons. Full details of this are available in the nutrition section of the full guideline. |

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| | | | | via the canteen and often have choice of meals labelled as healthy options at meal times.<br>The evidence identified in NG7 supports an increase in drinking water, eating more fruit and vegetables and whole grains, and a reduction in total fat and sugary drink consumption.<br>The recommendations made in CG189 were discussed by the GDG and thought to be appropriate for a prison population as they focus on a balanced diet and avoid the use of very restricted calorie control diets. | |
| Rehabilitation for Addicted Prisoners Trust | Full | General | General | We think more can be said about the role that psychosocial substance misuse treatment can play in improving / promoting the physical health of prisoners. Substance misuse services are referred to in the guideline but we feel that due to the holistic nature of the psychosocial substance misuse programmes we (and other providers) deliver, more could be said about what is currently on offer and how this can help with communication between teams and reducing duplication of work for health service providers. We are happy to contribute the evidence base behind the health interventions delivered by RAPt to this guideline if deemed necessary. | Thank you for your comment. Substance misuse interventions will be covered in the Mental health of adults in contact with the criminal justice system guideline (in development). |
| Rehabilitation for Addicted Prisoners Trust | Full | 199 | General | Other considerations: RAPt have experience of implementing Health and Wellbeing Champions in prisons, peer supporters who motivate individuals to consider making changes to their health and wellbeing. We would be willing to submit our | Thank you for your suggestion. |

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| | | | | experiences to the NICE shared learning database. Contact hattie.moyes@rapt.org.uk | |
| Rehabilitation for Addicted Prisoners Trust | Full | 200 | general | Trade-off between clinical benefits and harms: RAPt have experience of implementing health-focused in-cell packs for prisoners, with information on how to access health promoting activities in prison. We have developed in-cell packs on smoking cessation and mindfulness (to reduce stress and feelings of anxiety). These in-cell packs are also translated into languages other than English so that prisoners who speak little English can also receive information about how to stop smoking and practice mindfulness. RAPt would be willing to submit our experiences of developing / introducing these in-cell packs to the NICE shared learning database. Contact hattie.moyes@rapt.org.uk | Thank you for your suggestion |
| Revolving Doors | Short | 8 | 1 3.2 | Ensure that questions about NPS are clear – e.g. synthetic cannabinoids often known to users and drug workers as 'spice', which has been identified as problematic in prisons. | Thank you for your comment. We have specified that the person should be asked about substance use in the first assessment. The person giving the assessment should use the listed examples as a starting point and should ask about any relevant 'designer' drugs that are popular at that moment. |
| Revolving Doors | Short | 8 | 1. 4.1 | There is considerable unmet mental health need among the offender population. Not having a diagnosis or prior contact with mental health services should not be taken as being indicative of low need or low risk. | Thank you we would agree with this comment, however it is still important to collect the information on past psychological treatment. And we think that the screening questions do address your concerns |
| Revolving Doors | Short | 9 | 1. 5.1 | There may be merit in adopting a standardised tool or structured checklist. | Thank you for your comment. Evidence was not searched for in this area, therefore we cannot recommend a standardised tool. |
| Revolving Doors | Short | 10 | 18 | There may be merit in using a standardised tool such | Thank you for your comment. The question regarding |

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| | | | | as AUDIT, which is increasingly used in criminal justice settings. | alcohol use was adapted from the Grubin assessment tool. The committee of the Mental health of adults in contact with the criminal justice system guideline agreed to only review tools and cut-off points with acceptable sensitivity and specificity, which was determine by a relatively conservative threshold of ≥0.70 for both values. In the absence of values for sensitivity and specificity, tools with AUC values ≥0.75 were considered to have acceptable performance. The AUDIT was among the tools that were excluded because of this. |
| Revolving Doors | Short | 10 | 18 | For screening prior to a more detailed assessment/onward referral a standardised tool such as DAST, which has been evaluated and has demonstrated excellent reliability and diagnostic validity in a variety of settings, may be of use. | The GDG considered the use of instruments such as the DAST in the initial screening but given that the question used in the initial screening were to be contained in the 'Grubin' format it would not be possible nor necessary to include the DAST or a similar measure. |
| Revolving Doors | Short | 10 | 18 | Ensure that questions about NPS are clear – e.g. synthetic cannabinoids often known to users and drug workers as 'spice', which has been identified as problematic in prisons. | Thank you for your comment. We have specified that the prisoner should be asked about substance use in the first assessment. The person undertaking the assessment should use the listed examples as a starting point and should ask about any relevant 'designer' drugs that are popular at that moment. |
| Revolving Doors | Short | 12 | 14 | Ensure that this advice includes substance misuse and mental health services. | Thank you for your comment. These topics will be addressed by the accompanying guideline Mental health of adults in the criminal justices system, which is currently in development. |
| Revolving Doors | Short | 16 | 14 | Consider evidence-based approaches to promoting mental wellbeing. | Thank you for your comment. This recommendation lists the areas prioritised for an evidence review in this guideline. The Mental health in adults in contact |

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| | | | | | with the criminal justice system guideline (in development) has included recommendations relating to the pathway through care of people with a mental health problem or substance misuse. |
| Revolving Doors | Short | 16 | 19 | Ensure that promotion of health and wellbeing includes harm minimisation from substance misuse. | Thank you for your comment. This recommendation lists the areas prioritised for an evidence review in this guideline. The Mental health in adults in contact with the criminal justice system guideline (in development) has included recommendations relating to the pathway through care of people with a mental health problem or substance misuse. |
| Royal College of General Practitioners | Short | General | General | Prisons are essentially unhealthy places and it is difficult to motivate prisoners unwillingly incarcerated.<br><br>It is important to treat them decently and with respect and to use rewards to motivate them and try to change behavioural patterns. Some prisoners are from deprived backgrounds and of low intelligence- they may need help in washing and in general hygiene.<br><br>A safe, clean environment with a healthy diet and access to exercise and work are part of that. The use of the gym as a privilege, some access to training e.g. Judo and team games can be used as rewards and motivations.<br><br>The problem of drug misuse in UK prisons is a particular barrier to the physical health of the community. | Thank you for your comment. Little evidence was found for hygiene and therefore unfortunately it was not possible to make any detailed recommendations on this. The importance of personal hygiene including oral hygiene has been commented on in the Recommendations and link to evidence section 7.6.3 of the full guideline.<br><br>Sexual health and the risk of sexually transmitted diseases are discussed within the guideline and a recommendation (1.3.8) on access to condoms and dental dams has been made. Recommendations from the hepatitis B & C, HIV and TB guidelines have been highlighted and incorporated into the guideline (see recommendations 1.1.23; 1.1.24 to 1.1.28; 1.1,9 to 1.1.12).<br><br>Dentistry is not included within the scope of the guideline and we are unable to provide guidance on |

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| | | | | The relationship with health staff is difficult, it is hard to build trust and the staff is seen as having first loyalty to the governor and not to the patient. People are moved often from prison to prison and this makes establishing trust and therapeutic relationships more difficult.<br><br>There needs to be acknowledgement of men with parasitic infestations and venereal disease and that sexual relationship willing or unwilling occurs with risk to both parities.<br><br>The question of screening for Hepatitis B, Syphilis and HIV is important- is such screening advised or compulsory in outbreak control and community protection and likewise administering essential vaccines.<br><br>Dentistry is important and for some prisoners the first time they have had access to dental treatment and instruction in oral hygiene.<br>(PS)<br><br>Overall this needs to be more of a narrative to take into account diverse presentation of the patients rather than a "tick box" exercise.<br><br>Does "refer to the GP at reception" imply this is the point a referral is made, or that they are expected to | this, however we have included oral hygiene within the recommendation on promoting hygiene.<br><br>The GDG have reviewed the recommendations that state referral to a GP and have amended these to make clearer if it should only be a GP or another health professional. |

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| | | | | be seen by the GP in reception?<br>(SEG) | |
| Royal College of General Practitioners | Short | 4 | 1.1.2 | The first stage health assessment is very good but too focussed on the remand situation where people are coming straight from the police station. It needs to be nuanced to accommodate the initial health screen on transfers between prisons, where the patients will be more stable and the emphases will be somewhat different. It also needs to take into account the situation in IRCs (Immigration removal centres).<br>It also needs to focus on "smoking" status of the person keeping in the mind the likely impact of proposed smoke free prisons.<br>(SEG) | Thank you for your comment. Recommendation 1.1.2 has been added to clarify the process when people have come from other custodial settings.<br><br>Immigration removal centres are beyond the scope of this guideline.<br><br>The GDG felt that smoking status was not an urgent health issue for first week safety so is asked at the second-stage assessment rather than the first stage. Smoking status for immediate administrative issues (such as cell allocation) rather than health issues would be dealt with elsewhere in the prison reception process. |
| Royal College of General Practitioners | Short | 5 | 1 | In the case of person being charged with murder or manslaughter and needing urgent mental health assessment by the prison mental health in-reach team and ensuring that the person is seen by the GP while they are in reception, is this only for the remand prisons or does this include other prisons as well? Needs to be specified here.<br>Also it needs to be taken into account if all such patients will be seen by the GP "in" reception owing to the resources available.<br>(SEG) | Thank you for your comment. The recommendation applies to those people on first reception into prison. This would currently be in a Category A or B prison. The GDG have amended the recommendation (Table 1, 'Prison sentence' section) to state refer the person for mental health assessment by the prison mental health in-reach team if necessary. |
| Royal College of General | Short | 5 | 2.2 | Concern is that the guidance refers to injuries within | Thank you for your comment. The assessment is |

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| Practitioners | | | | the "past few days" which would most likely relate to the individual's index offence.<br><br>Concerned that this may lead to defence solicitors requesting prison GPs to provide injury documentation, statements that may well result in the prison GP being asked to then give evidence in court. This would be of particular concern if there were discrepancies in the injuries documented by the prison GP when compared to any preceding documentation (such as by an FME in police custody over the previous few days), which could lead to difficult lines of questioning in court.<br><br>If we are going to encourage prison GPs to undertake injury documentation it may be beneficial to advise supportive training in this regard - clarity regarding abrasion, incision, laceration, ageing of bruises, etc, as these are areas that will certainly be tested in court.(SEG) | based on the reviewed evidence, which identified the Grubin health screen as the most accurate physical health assessment. This question is adopted from the Grubin health screen and is standard existing practice. The recording of injuries specified in the recommendations reflects current practice at the reception assessment. Referral to the GP is made only if the injury is very severe. Ensuring that personnel are adequately trained to perform this function would need to be determined locally. |
| Royal College of General Practitioners | Short | 5<br><br>6 | 2 | Screening questions on head injury – is there any particular reason why the figure of 20 minutes loss of consciousness has been chosen? The current wording would mean that a significant head injury several years ago with no ongoing problems would still trigger a GP assessment. There should be something about recent head injury included in the wording.<br>(SEG) | Thank you for your comment. The recommendation has been amended to specify that only significant head injury needs to be documented. The question about previous history of head injury has been moved to the second stage assessment. |

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| Royal College of General Practitioners | Short | 6 | 2.7 | Pregnancy questions– in the current wording, women would be referred to the GP and midwife merely for having reason to think she is pregnant. Surely a positive pregnancy test would be required in most cases, e.g. missed period etc.<br>(SEG) | Thank you for your comment. The questions regarding pregnancy in the first-stage assessment have been amended accordingly. If pregnancy is confirmed to refer to GP and midwife. |
| Royal College of General Practitioners | Short | 7 | 2.8 | Special equipment may need security exemption in some cases e.g. strips of aluminium in some splints especially with violent and Cat A prisoners.<br>(SEG) | Thank you for your comment. The following has been added to the Recommendations and link to evidence section (5.8.1): 'The GDG noted that equipment (for example strips of aluminium in splints) may need security exemption especially with violent and Cat A prisoners.' |
| Royal College of General Practitioners | Short | 7 | 2.8 | Special diet- could this be for clinically evidenced special diets only, as there are a lot of spurious claims for special diets. (SEG) | Thank you for your comment. We have clarified this recommendation to 'special medical diet'. |
| Royal College of General Practitioners | Short | 7 | 3 | Where is this figure of 15 units of alcohol daily, came from? Are we suggesting anyone drinking less than that and not showing withdrawal signs don't need to see reception GP?<br>(SEG) | Thank you for your comment. The figure of 15 units per day come from the NICE guidance – Alcohol-use disorders. |
| Royal College of General Practitioners | Short | 10 | 5<br><br>9 | 1.1.7: Could we have something about reliability of sources of information relating to patient medication e.g. electronic record, in-date prescriptions, sealed identified pharmacy supplied compliance aids versus patient claims, strips of tablets, unlabelled or out-of-date boxes. There needs to be accurate prescribing and a reduction in abuse of the usual suspects | Thank you for your comment. This information is included in the NICE medicines optimisation guideline referred to in recommendation 1.1.8. |

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| | | | | (pregabalin?)<br>(SEG) | |
| Royal College of General Practitioners | Short | 10 | 24 | The document suggests details of cervical and breast-screening status should be sought from women. There is no mention at this stage of other national screening programmes applicable to both men and women (notably bowel and abdominal aortic aneurism), which it is also important to ascertain at this stage.<br>(MB) | Thank you for your comment. The following recommendation (1.1.31) has been amended: "Offer people equivalent health checks to those offered in the community, for example:<br>• the NHS health check programme<br>• learning disabilities Annual Health Check<br>• relevant NHS screening programmes, such as those for abdominal aortic aneurysm and bowel, breast and cervical cancer." |
| Royal College of General Practitioners | Short | 13 | 1.1.18 | Rather than "offering" Hep B and C testing and Hep B vaccination should it not be a routine service that prisoners can "opt out" from if they so wish?<br>(SEG) | Thank you for your comment.<br>By offering the tests to the person they would receive these unless they choose to opt out. We believe the current wording is in line with policy. |
| Royal College of General Practitioners | Short | 14 | 14-16 | This sounds like the named nurse system used for in-patients. For a large capacity high turnover prison this could prove pointless. Could a named point of contact for Healthcare concerns/ complaints be an alternative? (Lead Nurse, lead GP?) We are running an essentially outpatient GP service for most patients.<br>(SEG) | Thank you for your comment. Recommendation 1.2.3 has now been amended so that only people with complex health needs have a lead care coordinator. |
| Royal College of General Practitioners | Short | 14 | 16-20 | 1.1.26 Why the urgency of within 48hr in asymptomatic patients? This will conflict with prison induction and detox clinics etc. Also will require three times weekly radiologist access (cost / benefit compared to a weekly session?) | Thank you for your comment. Based on the principle of equivalence of care, this recommendation is in line with current NICE guidance on Tuberculosis. |

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| | | | | (SEG) | |
| Royal College of General Practitioners | Short | 15 | 1.2.1 | Named healthcare coordinators– excellent idea but cannot see why *every person in prison* needs this, e.g. fit young man on no medication. Surely this should be for those with significant ongoing health issues and be determined by the team their issue comes under (e.g. ongoing mental health or substance misuse issues, or chronic physical health issues).<br>(SEG) | Thank you for your comment. Recommendation 1.2.3 has now been amended so that only people with complex health needs have a lead care coordinator. |
| Royal College of General Practitioners | Short | 15 | 19-29 | 1.2.3 Is any element of patient consent required or sought for information sharing?<br>(SEG) | Thank you for your comment. Please see the following in the Recommendations and link to evidence section 6.6: 'The GDG agreed that it was important to support both healthcare and prison staff in understanding what information they are entitled to share with other professionals involved in their care, where appropriate consent32 has been obtained or that is in the person's best interests in accordance with the Caldicott 2013 principles.' |
| Royal College of General Practitioners | Short | 16 | General | The health promotion section should include access to information about illicit drugs (including novel psychoactive substances) and alcohol, both whilst in prison and upon release. Avoidance whilst in prison is a particularly important health promotion message in the current climate of novel psychoactive substances, and the harm these are causing in prison.<br>(MB)<br>It is important to highlight that the prison routinely | Drug misuse is not included within the scope of this guideline as it is covered by the accompanying guideline on mental health in the criminal justice system. |

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| | | | | demands urine samples from prisoners to screen for drug misuse.<br>(PS) | |
| Royal College of General Practitioners | Short | 16 | 10 | 1.2.6: Who decides "best interests". Understand the desire to share all info as widely as possible but fear the legal basis for telling lots of people clinical information.<br>(SEG) | Thank you for your comment. This is based on clinical judgement. See the following in the Recommendations and link to evidence section 6.6: 'The GDG agreed that it was important to support both healthcare and prison staff in understanding what information they are entitled to share with other professionals involved in their care, where appropriate consent[32] has been obtained or that is in the person's best interests in accordance with the Caldicott 2013[14] principles.' |
| Royal College of General Practitioners | Short | 17 | 4 & 5 | 1.3.3: Could we have specialist advice on in-cell exercise and what is permitted by regulations on the yard? Do the PEI's have a Prison-Pilates programme we could appendix? Prisoners have differing access to exercise depending on whether they are on basic / standard or enhanced status. (SEG) | Thank you for your comment. No evidence was identified in this area. |
| Royal College of General Practitioners | Short | 17 | 19 | The document advocates the provision of information regarding smoking cessation. It is worth noting the context – many prisons are presently in transition to 'smoke free' status. This will have implications for the physical and mental state of newly incarcerated prisoners who may be in acute nicotine withdrawal. The document should consider some reference to early (on arrival) access to appropriate cessation productions, even (potentially) as part of the first | Thank you for your comment. The GDG is aware of this transition. The current recommendations were intended to be compatible with this. |

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| | | | | screen process.<br>(MB) | |
| Royal College of General Practitioners | Short | 17 | 26 | 1.3.7 & 1.3.8: Would recommending the existence of a local Post-exposure Prophylaxis Sexual Exposure (PEPSE) Policy for HIV be worthwhile here?<br>(SEG) | Thank you for your comment. The review on sexual health promotion was restricted to advice and access to barrier contraception. We are therefore unable to make recommendations regarding PEPSE policy.. |
| Royal College of General Practitioners | Short | 18 | 1.4.1 | In possession medicine – current wording states that all medicine should be in possession if the patient passes a risk assessment – this needs to take account of controlled drugs or highly tradable drugs that may be all supervised regardless of the patient's risk assessment.<br>(SEG) | Thank you for your comment. Controlled drugs are covered in recommendation 1.4.2 'Directly observe the administration of all schedule 2 and 3 medicines (also see NICE's guideline on controlled drugs) and medicines for tuberculosis (see NICE's guideline on tuberculosis)'<br><br>Additional medicines to be directed observed can be agreed upon locally based on local risks and policies. The Recommendations and link to evidence section (8.5.1) of this chapter of the full guideline states: "*The GDG noted that before people can have their medication in possession an individual risk assessment is undertaken to determine whether this is appropriate. This includes an assessment of their, ability to self-medicate, risk of suicide, self-harm and misuse and/or diversion*". |
| Royal College of General Practitioners | Short | 19 | 1.5 | Myocardial infarction is not a chronic condition but Ischaemic Heart Disease can be.<br>(SEG) | Thank you for your comment. The cross-referral to this guideline has been amended to make clear that this guideline is about secondary prevention of myocardial infarction. |

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| Royal College of General Practitioners | Short | 20 | General | The section regarding managing deteriorating health and emergencies should make stronger reference to the vital importance of structured documentation of clinical observations, escalation and handover according to a validated system. The guidelines should consider explicit recommendation of a validated system based on the National Early Warning Scores (NEWS) or similar, as this system provides structured recommendations for undertaking the clinical assessment, and ensures each person who has a set of observations has a de facto 'plan' on how to escalate. This is on the basis of learning from serious and untoward incidents.<br>(MB) | Thank you for your comment. Please see the following addition to the Recommendations and link to evidence section of the full guideline (10.4.1) 'The GDG was aware of early warning systems, such as the National Early Warning Scores (NEWS)'. |
| Royal College of General Practitioners | Short | 20 | General | The section regarding managing deteriorating health should make explicit reference to advance planning with external organisations who may be involved in the response to a health emergency, particularly the ambulance service. An explicit pre-planned response should be agreed between the ambulance service and the prison, including (where appropriate due to demand) site-specific escalation plans and shared understanding of the security and extrication issues that prisons present to the ambulance trust.<br>(MB) | Thank you for your comment. Please see the following in the Recommendations and link to evidence section of the full guideline (10.4.1): 'The GDG considered that particular elements of a structured response were critical in acting effectively in an emergency. These were ensuring that staff members are aware of how to access a prisoner's cell quickly during an emergency and communicating with the emergency services on how to access the prison, for example making sure there is a protocol for allowing paramedics or ambulance staff into the prison estate if necessary' |
| Royal College of General Practitioners | Short | 21 | 21-24 | 1.7.4: Might be an aspiration for sentenced prisoners but not remand, since date of release not known. Challenging in a core local with high turnover. | Thank you for your comment. This recommendation has been amended to only apply to people with complex needs. |

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| | | | | (SEG) | |
| Royal College of General Practitioners | Short | 21 | 1.7.4 | The idea of a multidisciplinary pre-release health assessment is good but it seems currently unrealistic to have a multidisciplinary assessment at least a month before release. That would have significant resource implications in order to implement.<br>(SEG) | Thank you for your comment, a clarification has been added to highlight that this recommendation only applies to people with complex needs. |
| Royal College of General Practitioners | Short | 23 | 2 | On the critical timeliness of medicine administration, is it worth specifying parenteral Vitamin C as an example, as this is going to be vanishingly rare? Would imagine that this would only be taking part in a hospital environment.<br>(SEG) | Thank you for your comment. The GDG discussed the inclusion of vitamins, and noted that Pabrinex is in prisons (parenteral vitamins B and C for rapid correction of severe depletion or malabsorption [e.g. in alcoholism, after acute infections, postoperatively, or in psychiatric states]), as supported by the NICE guidance on alcohol. |
| Royal College of Nursing | General | General | General | The Royal College of Nursing welcomes the opportunity to comment on this draft guidance. | Thank you |
| Royal College of Nursing | General | General | General | The draft guidance is comprehensive and we are very pleased to have had RCN members from clinical practice involved in the development of this work.<br><br>The challenge that is foremost in mind is that whilst these guidelines are entirely sensible and based upon good practice aspirations we also have a very limited workforce to deliver all that is proposed in a timely, safe and well documented manner. | Thank you for your comment. The GDG recognise that implementing the recommendations will require operational changes, however they consider these achievable and support equivalence of healthcare in prisons with that provided in the rest of the NHS |
| Royal College of Nursing | General | General | General | All of the headlines highlighted in the index fits with what we expect from good nursing practice. Nursing care is central to the achievement of these guidelines. | Thank you |

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| Royal College of Nursing | General | General | General | Attention to safe staffing, appropriate skills mix, good professional development and training are all essential. | Thank you |
| Royal College of Nursing | General | General | General | Good nursing practice currently exists already but in some areas high vacancy rates impede realisation of all the NICE guidelines and this must be addressed. | Thank you for your comment. The GDG recognise that implementing the recommendations will require operational changes, however they consider these achievable and support equivalence of healthcare in prisons with that provided in the rest of the NHS. |
| Royal College of Nursing | General | General | General | Health promotion is essential but often less well seen due to constraints on healthcare staff's time and high levels of medication administration. | Thank you for your comment. The GDG recognise that implementing the recommendations will require operational changes, however they consider these achievable and support equivalence of healthcare in prisons with that provided in the rest of the NHS. |
| Royal College of Nursing | General | General | General | Good healthcare administration and pharmacy support is essential to 'free up' the nursing care delivery so effective and safe primary care can be delivered in accordance with NICE guidelines. | Thank you for your comment. How resources and personnel are deployed would need to be determined by local commissioners. |
| Royal College of Nursing | General | General | General | Referrals to GPs are made on an all too frequent basis and perhaps do not take into account knowledge and expertise of other senior professionals.<br><br>We are concerned that this clashes with current Prison Service Orders but in the short time available there is no opportunity to do a full comparison on this.<br><br>It would be helpful to get some guidance around this. | Thank you for your comment. Referrals to GP are only found, where necessary, in the health assessment at reception recommendations of this guideline.<br><br>Throughout the rest of the guidance there are numerous referrals to healthcare staff, acknowledging that other healthcare professionals may be able to carry out these tasks. The committee does not believe the recommendations conflict with current PSOs. |
| Royal College of | Full | General | General | The RCP is grateful for the opportunity to respond to | Thank you. |

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| Physicians | | | | the above consultation. We have liaised with experts in acute medicine and would like to make the following comments. | |
| Royal College of Physicians | Full | General | General | Our experts believe that this is a comprehensive, well written, timely and highly important guideline, but would like to make the following suggestions:<br><br>The first medical assessment should be carried out by a GP (Not an HCA).<br>Drug testing, pregnancy testing, HIV and Hep B and C should be tested on all new prisoners.<br>All suspected TB cases should be isolated pending expert advice.<br>Nutritional status and BMI and Dental/oral health should also be assessed.<br>All staff to have basic life support training including using the automated defibrillator, checking blood sugar, giving IM naloxone to reverse opioid overdose | Thank you for your comment. Please see the following in the Recommendations and link to evidence section (5.8.1) of the full guideline: "*Original cost-effectiveness analysis was conducted to consider the cost-effectiveness of the reception assessment being conducted by a specified member of healthcare staff (a nurse compared to a healthcare assistant). This looked at whether the additional benefit of having the assessment conducted by a more highly trained member of staff (nurse) could be large enough to justify the extra cost of paying for the nurse's time instead of the healthcare assistant's time... the GDG agreed not to specify which members of healthcare staff should conduct the assessment, so long as they are trained and competent to do so, but to leave this decision to the healthcare service in each prison. Each service should consider the costs and benefits of deploying staff members for reception health assessment, compared to the other tasks they could be undertaking, bearing in mind the specific healthcare needs of the population that that prison is receiving.*"<br><br>Drug use should be identified in the first stage of the reception assessment, without the need to conduct tests. |

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| | | | | | The following recommendation on HIV has been added: "1.1.24 *Offer all prisoners HIV testing when entering prison.*"<br><br>Please see the following recommendations on hepatitis B and C "*1.1.23 Prison healthcare services (working with the NHS lead for hepatitis) should ensure that:*<br>*• all prisoners are offered a hepatitis B vaccination when entering prison (for the vaccination schedule, refer to the Green Book)*<br>*• all prisoners are offered access to confidential testing for hepatitis B and C when entering prison and during their detention.*"<br><br>With regard to TB, the guideline suggests to follow current NICE TB guidance (NG33).<br><br>The second-stage health assessment recommends that height and weight are recorded, from which BMI can be calculated.<br><br>Dentistry is not included within the scope of the guideline. However, oral health has been added to the recommendation on health promotion.<br><br>It would be expected that only appropriately qualified and trained healthcare staff would be delivering care to patients. Please see recommendation on |

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| | | | | | managing deteriorating health and health emergencies: "1.6.1 Ensure a local protocol is available for responding to and managing situations in which a person's health quickly deteriorates, or in a health emergency. This could include, for example: • essential training for front-line prison staff, including the first person likely to be on the scene in an emergency" |
| Royal College of Speech and language Therapists | Short | General | General | The RCSLT believe that from 31st July, 2016 it will be law for all health and social services (including any health/social services that are inputting into other services i.e. prisons) to provide accessible written and verbal information. It also states that any information about communication needs should be documented. Please see the standard summary - https://www.england.nhs.uk/wp-content/uploads/2015/07/access-info-upd-er-july-15.pdf | Thank you for your comment. The guideline recommends that communication needs are assessed at the point of entry into prison (recommendation 1.1.3) and that information is provided in an appropriate format (recommendation 1.3.2) reference has also been made to the Patient experience guideline (CG138) which provides detailed recommendations on information giving. |
| Royal College of Speech and language Therapists | Short | 6 | 2.4 | The RCSLT note the absence of asking about dysphagia (eating, drinking, swallowing difficulties), this is important as dysphagia could be a side effect of certain medications or a result of head injury. | Thank you for your comment. Section 2.3 of the first-stage health assessment includes physical disabilities under the examples of health conditions. |
| Royal College of Speech and language Therapists | Full | 100 | General | We would like to clarify that people with learning disabilities are not the only ones with communication needs. Also, many individuals in prison possess an IQ of 70-85; they do not have learning disabilities but experience some similar difficulties. | Thank you for your comment. The recommendation (1.1.3) and Recommendations and link to evidence section (5.8.1) of the full guideline have been amended to clarify that people with communication difficulties include those with limited reading and writing abilities. A cross reference has been made to the Patient Experience guideline CG138, which has |

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| | | | | | additional recommendations on enabling patients to actively participate in their care. |
| Royal College of Speech and language Therapists | Full | 104 | general | (Under 2.4) RCSLT suggest adding SLCN in this section. | Thank you for your comment. The recommendations state that referral should be made to specialist nurses or relevant clinics where appropriate. This would include speech and language therapy. |
| Royal College of Speech and language Therapists | Full | 132 | 17 | We would query whether the guideline committee considered the literacy needs of the population and the accessibility of health information? | The recommendation on assessing communication needs when the person enters prison has been amended to include consideration of ability to read and write. In addition, the guideline recommends providing health information in a variety of formats to address the address language and literacy needs.<br><br>The guideline introduction has been amended to note the literacy needs of people in prison. |
| Royal College of Speech and language Therapists | Full | 201 | 17 | (Under other considerations, starting with 'The GDG noted…') While this is a valid point the RCSLT believe it is not as simple as stating can/can't read. The average literacy age in the prison population is 11 and the average IQ is 85. | Thank you for your comment. We have amended this section in the Recommendations and link to evidence (5.8.1) of the full guideline and guideline introduction (Chapter 2 of the full guideline) to include those with low levels of literacy. The guideline has also makes reference to the Patient Experience guideline CG138 which includes recommendations on communication and information to enable the person to actively participate in their care. |
| Sophia Forum | Full | 14 | 1 | The question 'is the person taking any medication Yes/No does not facilitate determining whether someone **should** be taking medication but due to lifestyle factors of disengagement from care currently isn't.<br>Based on this The Sophia Forum would like to see a | Thank you for your comment. Please note the recommendation on medicines reconciliation: "*1.1.8 Carry out a medicines reconciliation (in line with NICE's guideline on medicines optimisation) before the second-stage health assessment*". See also recommendations 1.4.1 and 1.7.10-11 for |

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| | | | | sub question allowing this to be determined. | recommendations on risk assessments for in-possession medicines and ensuring continuity of medicine." |
| Sophia Forum | Full | 16 | GENERAL | Testing for BBV's is in a second separate box, under other assessments'. Due to current work being undertaken by NHS England, PHE and NOMS on Opt Out testing policy in prisons during the reception assessment part two. This recommends ALL prisoners be offered an opt out test, not just those under current NICE guidelines.<br>Based on the above, The Sophia Forum would like to see reference to the Opt out policy in this document and that testing for BBV is integrated into the reception assessment part two, within 7 days.<br>We also want to highlight the importance of Opt out' being used in reference to BBV testing, as adopted in the development of the policy 'opt out testing' for bbvs in prisons. | Thank you for your comment. The recommendations for hepatitis B and C and HIV have been moved to the second assessment section. The GDG agree that the recommendation for HIV testing should apply to all people in prison and have changed the wording to offer to all people, which is in line with the 'opt out policy'. |
| Sophia Forum | Full | 18 | GENERAL | Algorithm $ Maintaining and promoting physical health in prison' highlights a number of chronic conditions but has not included HIV. We are aware there are no NICE guidelines on HIV, but BHIVA guidelines are NICE accredited and referenced in care pathway so we feel it very important HIV is included here and to reference BHIVA NICE accredited guidelines throughout the guideline where relevant. | Thank you for your comment. HIV was not one of the prioritised chronic conditions identified for review by the GDG. Reference to the BHIVA guideline is made in the Recommendations and link to evidence section of the chapter. |
| Sophia Forum | Full | 21 | 3 | Incomplete question missing text | Thank you. This typo has now been corrected. |

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| Sophia Forum | Full | 21 | 9 | In relation to Algorithm 4, 'opt out' testing for BBV's should be included in the second stage health assessment in line with NHS England, PHE, and NOMS Partnership agreement to roll out this policy by 2017. Ref: 2015-2016 National Partnership agreement, p21) | Thank you for your comment. Hepatitis B, C and HIV have been added to the second-stage assessment. |
| Sophia Forum | full | 22<br><br>23 | 18<br><br>43 | We would ask the text in relation to BBV testing is updated to be in line with the NHS, PHE, NOMS policy of 'opt out' testing in prisons. We feel it particularly important that the 'opt out' model is highlighted as this particular model has proven effective in increasing uptake of testing in other settings.<br>We would also state here that the policy is due for full implementation by 2017 and is a universal offer for ALL prisoners and therefore HIV testing should not be limited to and solely focused on men who have sex with men. There are challenges to this model in the prison setting; it is known many prisoners will not be open about their sexual orientation.<br>By focusing solely on men who have sex with men, you are excluding women who inject or have injected drugs, female sex workers and people from BAME communities.<br>We would also like to see noted as standard practice signposting to support services including peer support for those given a positive result or who have known their status prior to detention and want some support whilst incarcerated. | We believe the recommendations are in line with the opt-out policy. The wording states to offer the test therefore people would receive this unless they chose to opt out.<br><br>The GDG agree that HIV testing should be offered to all people in prison and the recommendation (1.1.24) has been amended.<br>Support for people who have a positive test result has been noted in the Recommendations and link to evidence section (5.8.4) of the full guideline. |

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| Sophia Forum | full | 23 | 25<br><br>31 | We welcome a focus on screening for TB, we would recommend that those with confirmed TB are also offered an HIV test in line with clinical guidelines | Thank you for your comment. Please see the new recommendation on HIV: 'Offer all people HIV testing when entering prison.' (1.1.24) |
| Sophia Forum | full | 24 | 37 | We welcome the focus on sharing information if it is done in the patient's best interest, but we would like to see written examples of information deemed suitable for sharing, with informed consent from the patient involved and full explanation as to why this information is being shared. The impact of stigma and direct discrimination will have a very detrimental impact on the persons wellbeing. This is an ongoing concern for those i see incarcerated | Thank you for your comment. The GDG agree that confidentiality is important and have revised the wording of the recommendation (1.2.2) to state that information should be shared with those involved with the person's care when it is necessary for management of that person's care. The balance between maintaining confidentiality and sharing information in managing the person's care is discussed within the Recommendations and link to evidence section (6.6) of the Coordination and communication chapter of the full guideline. |
| Sophia Forum | Full | 26 | 52 | We welcome this focus on providing information /education. We would ask that it be given on an individual need basis and that face to face peer support be an option due to literacy barriers, but also from feedback from people in prison , nurses are poorly informed on HIV medicine and side effects, which will impact adherence. | Thank you for your comment. Recommendation 1.1.3 refers to NICE guidance on patient experience CG138. |
| Sophia Forum | Full | 26 | 53 | We welcome this recommendation that prisoners hold their medication on entering prison. we have concerns about how this can be effectively managed as the largest piece of feedback we receive from people entering prison or transferred to a different estate is their medication is taken from them and they then experience gaps in their anti-retroviral medication, causing great mental and emotional distress | Thank you for your comment. A recommendation (1.7.13) has been made for prisoners to be provided with a minimum of 7 days' supply of their medication or an FP10 prescription to ensure continuity of medication. The management of this would be determined locally but the GDG consider it to be achievable. |

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| Sophia Forum | full | 26 | 55 | We welcome this recommendation. We recommend it be carried out by a qualified nurse or specialist nurse informed about HIV or other BBV's. | Thank you for your comment. The guidance does not specify who, but anyone carrying out the medicines review would be expected to be appropriately qualified and trained. |
| Sophia Forum | full | 26 | 59 | Under 'monitoring chronic conditions' we would like to see HIV included as noted in previous text. We are concerned that It has been excluded due to there not being relevant NICE guidelines. We would like to reiterate that BHIVA guidelines are NICE accredited and ask for them to be included. | Thank you for your comment. HIV was not one of the prioritised chronic conditions identified for review by the GDG. Reference to the BHIVA guideline is made in the Recommendations and link to evidence section (9.6) of this chapter in the full guideline. |
| Sophia Forum | full | 27 | 60 | Under 'monitoring chronic conditions' the Sophia forum would like to see HIV included as noted above. We are concerned that it hasn't been included as there are not relevant NICE guidelines. We note that the BHIVA guidelines are NICE accredited and ask for them to be included at 3.3.3 which lists related guidelines.<br>A recent (live) situation where a positive patient was treated for encephalitis and hospitalised more than once as discharged too early from hospital, with Parkinson symptoms, incoherent yet entered back into the prison system, extreme concerns about management of chronic conditions/ co morbidities on long serving prisoners. | Thank you for your comment. HIV was not one of the prioritised chronic conditions identified for review by the GDG. Reference to the BHIVA guideline is made in the Recommendations and link to evidence section (9.6) of this chapter in the full guideline. |
| Sophia Forum | full | 27 | 62 | 'Managing deteriorating health and health emergencies' we welcome the recording of actions and observations taken by prison staff to hold accountable management of chronic conditions. We ask again that HIV be included in monitoring chronic conditions. | Thank you for your comment. HIV was not one of the prioritised chronic conditions identified for review by the GDG. Reference to the BHIVA guideline is made in the Recommendations and link to evidence section (9.6) of this chapter in the full guideline. |

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| Sophia Forum | full | 116 | GENERAL | NHS England, PHE and NOMS developed background material and looked at research and prevalence as part of the developing of the 'opt out' BBV testing in prisons policy. That material does not appear to have been considered and we would like to suggest it is included in this section and the guideline is amended to reflect the new policy | Thank you for your comment. BBV testing was not reviewed as part of this guideline because NICE guidance is already available and has been incorporated. It is therefore not possible to include other research on this topic. |
| Sophia Forum | full | 246<br><br>7 | 25<br><br>7 | The Sophia Forum strongly believes that HIV must be added to the list of chronic conditions, given the higher prevalence amongst the prison population than the community as a whole.<br>One reason for including conditions is linked to 'where poor management has a significant impact on health outcomes. If managed well HIV is a long term condition and people can be expected to have a normal life expectancy.<br>However access to treatment can vary in prisons and detention settings thus compromising consistent adherence and this can impact on a person's health in more than one way. We have concerns that HIV is not on the list due to the absence of NICE guidelines. We would like to raise here that BHIVA guidelines are NICE accredited and so should be considered in the same way. | Thank you for your comment. HIV was not one of the prioritised chronic conditions identified for review by the GDG. Reference to the BHIVA guideline is made in the Recommendations and link to evidence section (9.6) of the full guideline. |
| Spectrum CIC | Full | 28 | 31 | We undertook a prevalence study concerning non-communicable diseases and their risk factors amongst prisoners which we are in the process of submitting to the *British Journal of General Practice* (Hearty, Wright and Anthony, 2016). We undertook face-to-face questionnaires with 199 participants in one remand | Thank you for your comment. We are unable to include this study in the current guideline as it is beyond the cut-off point for inclusion. However, the guideline will be updated in accordance with the NICE update process in the coming years; if evidence reviews are conducted in this area this |

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| | | | | and one training prison. We cross-checked responses with participants' clinical records and as such believe we have made a significant contribution to the body of knowledge pertaining to the physical health of prisoners. Key findings were:<br>• Prevalence rates for non-communicable diseases amongst the sample were as follows; 4.6 % high blood pressure, 1% heart disease, 1% stroke, 0.5% cancer, 21.4% respiratory disease, 2% diabetes, 37.6% drug dependence, 14.2% alcohol dependence, 31% depression, 9.1% other mental health problem and 10.7% other physical health problem<br>• There is a high level of agreement between self-report and clinical records. Therefore, future needs assessments of physical health needs can rely upon clinical records for prevalence data rather than relying upon potentially costly survey methodology<br>• There was some poor agreement pertaining to a diagnosis of hypertension. Some participants stated they had "high blood pressure" based upon just one reading. We would therefore recommend that suspected hypertension be managed in accordance with NICE guidelines. Where this is not possible (e.g. concerns regarding appropriate use/misuse of, or loss of, ambulatory blood pressure monitoring kits in a secure environment), then a diagnosis should only be made following persistent raised blood pressure on at least three separate readings<br>• 81.9% of the sample smoked, and of these 63.8% wanted to stop smoking | study may be included in the update. |

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| | | | | • 45.7% of the sample were overweight and 9.5% were obese<br>• Whilst healthy food options are available in prison, our findings showed that those from BME backgrounds were significantly less likely than those from white backgrounds to eat fruit/vegetables once a day<br>• Those long tem unemployed prior to imprisonment, defined as unemployed for over 26 weeks, were significantly less likely to engage in physical exercise than the cohort that were either employed or short term unemployed<br>We would be willing to provide the full report upon request to help contribute to the sparse evidence base in support of this important guideline. | |
| Spectrum CIC | Full | 13 | General | Algorithm 1: needs accessible communication standard inserting | Thank you for your comment. The algorithm references the Patient experience guideline which provides detailed recommendations on methods of communication and information giving. |
| Spectrum CIC | Full | 14 | General | Algorithm 2: No safeguarding questions that might impact on health, domestic violence or any abuse that will inform a trauma based recovery plan - need to cross reference with mental health assessment. | Thank you for your comment. The focus of the reception assessment is on health issues and includes assessment and questions to ensure the safety of the person before allocation to a cell. This guideline includes recommendations on mental health assessment but not on on-going mental healthcare. This will be covered by the accompanying guideline mental health of adults in contact with the criminal justice system currently in development. |
| Spectrum CIC | Full | 14 | General | Re question about pregnancy staff wanting guidance | Thank you for your comment. Confidentiality would |

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| | | | | based on legislation about if a women says she is pregnant but doesn't want her pregnancy revealed | apply to any information held by clinicians, and information passed only when there is a clinical need to do so. |
| Spectrum CIC | Full | 14 | general | Also want to know what pathway to follow when patients disengage | Thank you for your comment. No evidence was prioritised in this area and therefore it is not possible to create a pathway for disengaged people in this guideline. |
| Spectrum CIC | Full | 14 | general | There could be a record of potential risks made either at first or second reception | Thank you for your comment. Please see the following recommendation in the first-stage health assessment "*1.1.7 Enter in the person's medical record:*<br>*• all answers to the reception health assessment questions*<br>*• health-related observations, including those about behaviour and mental state (including eye contact, body language, rapid, slow or strange speech, poor hygiene, strange thoughts)*<br>*• details of any action taken.*" and in the second-stage health assessment "*1.1.20 Enter in the person's medical record:*<br>*• all answers to the second-stage health assessment questions*<br>*• health-related observations*<br>*• details of any action taken.*" |
| Spectrum CIC | Full | general | general | Need to ask how they want to be involved in their health - co-production must be in there | Thank you for your comment. All NICE guidance states that people have the right to be involved in discussions and make informed decisions about their care. |
| Spectrum CIC | Full | general | general | Could do with robust pathway for chronic pain management which supports the chronic pain | Thank you for your comment. In this guideline chronic pain specifically was not prioritised for review |

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| | | | | management but also ensures we support the reduction of tradeable medications | and so we did not look for evidence on chronic pain management. However, the guidance on medication is applicable to pain medication. This guideline also makes cross-referrals to NICE guidelines on Medicines adherence and Medicines optimisation. |
| Spectrum CIC | Full | 18 | general | Algorithm 4: could promote the national early warning scores system | Thank you for your comment. No evidence was identified for national early warning scores, therefore we are unable to include this in the algorithm. |
| Spectrum CIC | Full | general | general | The guidance does not allow for the use of the different roles, it should say with oversight from registered professionals in some places - please can we consider the emerging divergent roles of ANPs, associate nurses', pharmacy practitioners etc. and future proof the document | Thank you for your comment. The range of healthcare staff delivering care within a prison setting has been added to the introduction of the guideline for clarification. |
| Spectrum CIC | Full | general | general | We also need more guidance about partner notification | The GDG have added family/carers to the list of people to be notified before the person is released from prison, if they will be providing any support or care to the person. |
| The Disabilities Trust | Short | General | General | The Disabilities Trust welcomes these guidelines, particularly the awareness of the need to assess prisoners for acquired or Traumatic Brain Injury (TBI). Prisoners presenting with TBI are more likely to have additional needs relating to their physical health and it is important that measures are in place from the beginning of the sentence to provide additional support and that staff are aware of the nature of needs that may arise from a history of brain injury.<br><br>A number of meta-analyses have found that there is a high prevalence of TBI in prisoners; our own research | Thank you we agree TBI or ACI (the term used in this guideline) is an important issue.<br><br>We have reviewed recent studies using the BISI (O'Sullivan, 2015 and Pitman et al, 2014) and neither proved data which would support the use of BISI as a screening instrument based on the criteria adopted for this guideline. |

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| | | | | has found that 47% of adult male prisoners screened on admission to prison reported a history of TBI. [The association between neuropsychological performance and self-reported traumatic brain injury in a sample of adult male prisoners in the UK, Pitman I, Haddlesey C, Ramos SD, Oddy M, Fortescue D. Neuropsychological Rehabilitation, 2014 Oct 29:1-17]<br><br>Prisoners with TBI are likely to have co-existing physical conditions, either caused by the TBI or due to the characteristics of the population most at risk of TBI (i.e. lower socio-economic groups, higher risk-taking behaviour, history of drug and alcohol abuse.) Prisoners with TBI are more likely to have had limited engagement with health services, including: prior to the TBI, at the time the injury was sustained and in the period following. There are therefore likely to be unaddressed physical health issues requiring targeted support during the time in prison to ensure more successful outcomes towards independent living following the release from prison. It is vital to ensure that physical health is not compromised further and that measures are put in place to enable prisoners with a history of brain injury to fully engage in opportunities offered within prison, including social, physical and educational activities.<br><br>The Disabilities Trust has developed a screening tool, the Brain Injury Screening Index (BISI) for use by all levels of professionals to identify people, including | |

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| | | | | offenders, who have a history of TBI. This has been piloted with prisoners in YOI Hindley, YOI Wetherby and HMP Leeds. The BISI is available to download for free: www.thedtgroup.org/bisi We suggest that the BISI be adopted as a standard part of the second-stage health assessment at the point of entry into prison when a brain injury has been identified. We have also highlighted the many ways that brain injuries may influence other aspects of physical health and suggest that prison staff are made aware of the many ways in which a brain injury may manifest. | |
| The Disabilities Trust | Short | 4 | 13 | All of these issues are likely to be influenced/exacerbated/induced by the presence of TBI and therefore it is vital that a history of brain injury is taken. | Thank you for your comment. There are questions regarding head injury in the second-stage health assessment. |
| The Disabilities Trust | Short | 5 | 2.3 | Suggest this refers to "brain Injury" rather than "head injury", and that if a positive response is recorded a referral is made to the GP and the GP/health professional/other professional uses the BISI during the second-stage health assessment. | Thank you but we think this is best left as a head injury as it would, in the view of the GDG, introduce more uncertainty if the term 'brain injury' were used.<br><br>We have reviewed recent studies using the BISI (O'Sullivan, 2015 and Pitman et al, 2014) and neither proved data which would support the use of BISI as a screening instrument based on the criteria adopted for this guideline |
| The Disabilities Trust | Short | 6 | 2.4 | Physical health issues likely to co-exist with TBI include problems with balance, sight/hearing loss, behaviour problems including aggression and poor executive functioning. The individual with a TBI may not recognise their own difficulties so there should be | Thank you for your comment. The symptoms of TBI should be identified during the assessment process and appropriate care should be taken by GP. |

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| | | | | opportunity for repeated assessment. | |
| The Disabilities Trust | Short | 7 | 2.8 | Given effect of TBI on balance and motor skills extra support may be needed with e.g. carrying trays, moving around the prison – likely to be more problematic in older prisons not designed for people with mobility issues. | Thank you for your comment. This is covered by recommendation 2.8 'Ask the person if they need help to live independently' |
| The Disabilities Trust | Short | 7 | 2.8 | Equipment may be required but not currently in use, particularly amongst younger prisoners with TBI – aids should be offered with sensitivity. | Thank you for your comment. This will be taken into consideration when the decision on the date of health reassessment is made. |
| The Disabilities Trust | Short | 7 | 2.8 | A special medical diet may be required – due to profile of people with TBI there may be a history of self-neglect and therefore dental problems. Equally, the TBI may result in difficulties with chewing or swallowing. | Thank you for your comment. This would be addressed in the question on medical dietary needs in the health assessment |
| The Disabilities Trust | Short | 7 | 2.9 | Profile of people with TBI suggests that they are less likely to engage on a regular and proactive basis with health services and therefore may be behind on regular appointments. Issues with executive functioning including decision-making and planning means they may have found it difficult to keep to appointments and there may be an element of self-neglect. | Thank you for your comment. |
| The Disabilities Trust | Short | 7 | 3 | Prisoners with TBI are likely to have a history of drug and alcohol abuse. This can be a cause of brain injury and may also affect progress towards recovery. | Thank you for your comment. |
| The Disabilities Trust | Short | 8 | 4 | Prisoners with TBI are more likely than prisoners without TBI to report anxiety and depression; these may not have been previously addressed by a mental health professional. | Thank you for this comment. The Mental health of adults in contact with the criminal justice system guideline has included specific mention of the needs of people with ACI. |
| The Disabilities Trust | Short | 9 | 3 | People with TBI may struggle to initiate interaction | Thank you for your comment. This will be taken into |

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| | | | | with health professionals even within the prison system and therefore measures should be put in place to ensure that they are prompted to engage in order to prevent deterioration in their health. | consideration when the decision on the date of health re-assessment is made. |
| The Disabilities Trust | Short | 10 | 1 | Abnormalities may indicate a history of TBI. | Thank you for your comment. The Mental Health of Adults in contact with the Criminal Justice System Guideline deals with this issue and makes further recommendations about acquired cognitive impairment. |
| The Disabilities Trust | Short | 10 | 10 | Where the initial health assessment indicated a history of brain injury, screening using the BISI should be conducted. If this produces a positive result the prisoner should be signposted to support services and a record should be placed on their health file. | Thank you for this comment. We have reviewed recent studies using the BISI (O'Sullivan, 2015 and Pitman et al , 2014) and neither proved data which would support the use of BISI as a screening instrument based on the criteria adopted for this guideline |
| The Disabilities Trust | Short | 11 | 12 | Note that presentation and behaviour suggesting a mental health problem may be due to TBI, i.e., a physical cause. | Thank you for your comment. The Mental health of adults in contact with the criminal justice system GDG agrees and this is the primary reason for having this as part of the assessment. |
| The Disabilities Trust | Short | 12 | 25 | This may need to be ongoing and more supportive than for a prisoner without TBI. | Thank you for your comment. This is covered in the following recommendation (1.1.3): "Take into account any communication needs or difficulties the person has (including reading and writing ability), and follow the principles in NICE's guideline on patient experience in adult NHS services." |
| The Disabilities Trust | Short | 15 | 19 | List should also include history of TBI. | Thank you for your comment. This is a list of examples and it not intended to be comprehensive. |
| The Disabilities Trust | Short | 22 | 19 | Additional support and structure including links to social care should be made before discharge of prisoners with TBI as they may struggle to self-initiate | Thank you for your comment. The recommendation has been updated as follows: 1.7.4 "Carry out a pre-release health assessment for people with complex |

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| | | | | ongoing support needed. | needs. This should be led by primary healthcare and involve multidisciplinary team members and the person. It should take place at least 1 month before the date the person is expected to be released." |
| The Disabilities Trust | Short | 22 | 24 | List should include brain injury; this should be treated as distinct from learning disabilities and mental health needs as although they may co-exist the support required is likely to be different. | Thank you for your comment. This would be included as part of any significant health events. |
| The Disabilities Trust | Short | 29 | 2 | Reference should be made to the Care Act 2014 which extends to the health and social care needs of people in prison. | Thank you for your comment. The Social Care Act is referred to in the Recommendations and link to evidence section (5.8.4) of the full guideline with regards to health checks for people with disability "The group also discussed the Annual Health Check Scheme for people with learning disabilities who need more support and who may otherwise have health conditions that go undetected, which is mandated by the Social Care Act 2014". |
| The Disabilities Trust | Short | 29 | 13 | This should also make reference to people with a TBI who may experience similar problems with processing new information. | Thank you for your comment. This is not an exhaustive list of conditions to include and therefore people with TBI would not be excluded. |
| Welsh Government | Short | 8 | 3.2 | Include anabolic steroids (or SIEDS – steroids and image enhancing drugs) in assessment list for 'type and frequency of drug use'. | Thank you for this comment. We have added anabolic steroids to the list in section 14 of Table 1. |
| Welsh Government | Short | 5<br><br>9 | General | There is no mention of tobacco use in the first stage assessment. Prisons in Wales are smoke-free therefore this needs to be assessed on admission and NRT should be available from reception. Continuity of patches or other appropriate NRT therapy should be enabled from first stage assessment. Brief intervention on smoke-free should be offered from first | The GDG felt that smoking status was not an urgent health issue for first week safety so is asked at the second-stage assessment rather than the first stage. Smoking status for immediate administrative issues (such as cell allocation) rather than health issues would be dealt with elsewhere in the prison. |

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| | | | | face-to-face contact. | |
| Welsh Government | Short | 10 | 17 | Questions about recent BBV screening/testing history should be included in the secondary health assessment | Thank you for your comment. Recommendations on HIV, hepatitis B and C have been moved to the second-stage health assessment. |
| Welsh Government | Short | 13 | 8 | The super-accelerated schedule should be recommended for hepatitis B vaccination delivery in prisons | Thank you for your comment. The recommendation given in the hepatitis B and C guideline (1.1.23) is for vaccination to be given on arrival into prison:<br>"Prison healthcare services (working with the NHS lead for hepatitis) should ensure that:<br>• all people are offered a hepatitis B vaccination when entering prison (for the vaccination schedule, refer to the Green Book)<br>• all people are offered access to confidential testing for hepatitis B and C when entering prison and during their detention.<br>• people who test for hepatitis B or C receive the results of the test, regardless of their location, when they become available.<br>• results from hepatitis B and C testing are provided to the person's community-based GP, if consent is given." |
| Welsh Government | Short | 13/14 | GENERAL | Prisons should ensure responsibility for contact tracing in relation to a new HIV diagnosis is made clear between the prison and any external sexual health service provider. | Thank you for your comment. This is covered by the inclusion of secondary and tertiary specialist services in recommendation 1.7.9: 'Before the person is released, liaise with services that will be providing care and support to them after they leave prison. This should include (as needed):<br>• primary care<br>• secondary and tertiary specialist services (for |

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| | | | | | example HIV, TB, oncology)<br>• mental health or learning disability services<br>• substance misuse services<br>• National Probation Service and/or community rehabilitation company (CRC)<br>• social services<br>• family/carers<br>• external agencies such as home care.' |
| Welsh Government | Short | 14 | 13 | References should be made to the latest NICE guidance on TB (NG33) which recommends routine IGRA screening for latent TB for all prisoners. How and when this offered, for instance as part of the BBV screen, should be made explicit in this guidance. | Thank you for your comment. It is not possible to include all the recommendations here but we have cross-referred to the NICE TB guideline which provides all the recommendations. |
| Welsh Government | Short | 15 | 9 | Wales does not use the over 40s NHS health check. Instead reference should be made to the over 50s "Add to your life" campaign: https://addtoyourlife.wales.nhs.uk/intro.cfm although this is web-based so prisoners would need staff assistance in order to access. | Thank you for your comment. NICE guidance is written as applicable to NHS England. Decisions on how our guidance applies in Wales are made by the devolved administration. |
| Welsh Government | Short | 17 | 19 | The guidance should recognise that prisons in Wales are now smoke-free. Stop smoking support should be given from the reception health assessment. | Thank you for your comment. NICE guidance is written as applicable to NHS England. Decisions on how our guidance applies in Wales are made by the devolved administration. |
| Welsh Government | Short | General | General | Palliative care is a growing issue for prisons and should be included within this guidance | Thank you for your comment. Palliative and end of life care were not included in the scope, as existing NICE guidance is available and applicable to a prison population.<br><br>The NICE Care of the dying adult guideline (NG31) has been referred to in the Recommendations and |

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| | | | | | link to evidence sections of the access to medicines and continuity of medicines chapters in relation to the management of medication at the end of life. It is also referred to within the monitoring of chronic conditions chapter |
| Welsh Government | Short | 5 | 4 | 2.4 Other physical health conditions<br>Does the person have any of the following: add Abdominal aortic aneurysm (AAA) | Thank you for your comment. The GDG feel that this would covered in the next question '*Are there any other physical health problems the person is aware of, that have not been reported*?' |
| Welsh Government | Short | 10 | 11 | Health professional should be aware of UK NSC age profile for screening programmes | Thank you for your comment. This is covered in the following recommendation (1.1.31): "Offer people equivalent health checks to those offered in the community, for example:<br>• the NHS health check programme<br>• learning disabilities Annual Health Check<br>• relevant NHS screening programmes, such as those for abdominal aortic aneurysm and bowel, breast and cervical cancer." |
| Welsh Government | Short | GENERAL | 17 | Add: known to have an AAA<br>Add to second stage health assessment:<br>Previous contact with screening programmes – are they on a screening surveillance programme | Thank you for your comment. This will be identified using patient records: "1.1.14 Review the person's first- and second-stage health assessment records, medical history and , GP and vaccination records and:<br>• refer the person to the GP or a relevant clinic if further assessment is needed. See for example NICE's guidelines on cardiovascular disease (recommendations on identifying people for full formal risk assessment ) or type 2 diabetes (the recommendation on risk assessment)<br>• arrange a follow-up appointment if needed." |

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| Welsh Government | Short | 11 | 1 | Review of first and second stage health assessment, medical history and GP records: add<br>Refer to relevant screening programme if eligible or on surveillance programme | Thank you for your comment. References to screening programmes are made in a separate section in the list of recommendations (section 'Other health checks and screening', recommendation 1.1.31). |
| Welsh Government | Short | 12 | 1 | 1.1.12: include information about UK NSC screening programmes, AAA, Bowel, Breast, Cervical & diabetic eye | Thank you for your comment, the highlighted list is not exhaustive. References to screening programmes are made in a separate section in the list of recommendations |
| Welsh Government | Short | 13 | 2 | Add and UK NSC screening programmes | Thank you for your comment, The highlighted list is not exhaustive. |
| Welsh Government | Short | 15 | 7 | Agree but reference to screening programmes could be integrated with the first and second stage health assessments as prisoners may have a condition already picked up by screening and requires monitoring. Could add eligibility criteria for individual screening programmes here | Thank you for your comment. At the second-stage of the assessment, GP records are reviewed which will include records of any screening programme undertaken. |
| Welsh Government | Short | 19 | 15 | Add known AAA | Thank you for your comment. There is currently no NICE guidance in this area.<br><br>The NICE guideline on abdominal aortic aneurysm is due for publication in 2018. |
| Welsh Government | Short | 22 | 1 | Include follow up appointments for screening programmes | Thank you for your comment. National screening and health checks would be arranged through the person's GP after release. |
| Welsh Government | Short | 23 | 2 | Add screening services to the list | Thank you for your comment. National screening and health checks would be arranged through the person's GP after release. |
| Welsh Government | Short | 24 | 19 | Add to discharge/transfer information: Where an individual is having investigations, treatment or | Thank you for your comment. This information should be covered in the care summary and post-release |

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| | | | | surveillance with a screening programme, the programme should be contacted on discharge or transfer to advise them of the individual's new address | action plan in recommendation 1.7.6. |
| Welsh Government | Full | 120 | General | Requires clarity regarding: names of Screening programmes e.g.<br>NHS abdominal aortic aneurysm (AAA) programme tends to be the English Programme, whereas the Welsh programme is Wales AAA Screening Programme. | Thank you for your comment. NICE guidance is developed for NHS services in England and the screening programmes referred to are those available in England. Decisions on how our guidance applies in Wales are made by the devolved administration. |
| Welsh Government | Full | 21 | 3 | Oral health has been excluded from this section. It should be included that during the second-stage health assessment, the person should be asked about any dental health issues – pain, toothache, bleeding, unusual lumps/swellings, any mouth ulcers that have been present for over two weeks. The person should be asked if they wish to be referred to the dental team. | Thank you for your comment. Dentistry is not included within the scope of the guideline, however, oral health in the context of self-care was not excluded. No evidence was identified in this area to make a recommendation from. |
| Welsh Government | Full | 21 | 14 | We feel dental health should be included as part of that list | Thank you for your comment. Dental management is outside the scope of this guideline. |
| Welsh Government | Full | 21 | 27 | Advice on how to contact the prison dental team should be mentioned | Thank you for your comment. Dental management is outside the scope of this guideline. |
| Welsh Government | Full | 24 | 27 | Dietary advice should also consider what is considered healthy in terms of dental health, and healthier food options to reduce sugar intake and frequency of intake. | Thank you for your comment. The evidence review identified a lack of evidence for nutrition, The following recommendation (1.3.5) was made by the committee: "Offer people information about:<br>• the benefits of a healthy diet<br>• healthier food options available in the prison.<br>See the section on diet in NICE's guideline on obesity: identification, assessment and |

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| | | | | | management", and the committee did not wish to make further recommendations. |
| Welsh Government | Full | 25 | 5 | The list should include oral hygiene and dental health | Thank you for your comment. Dentistry is not included within the scope of the guideline. Very little evidence was identified on oral health and therefore no detailed recommendations could be made. Oral hygiene has been added to the list of health information that should be provided. |