NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Physical health of people in prisons

Output: Prioritised quality improvement areas for development.

Date of Quality Standards Advisory Committee meeting: 2 February 2017

Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for the physical health of people in prisons. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

1.2 Development source

The key development source referenced in this briefing paper is:

Physical health of people in prison NICE guideline 57 (2016).

Other development sources which may be used are:

Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes NICE guideline 5 (2015)

Obesity: identification, assessment and management NICE guideline CG189 (2014).

2 Overview

2.1 Focus of quality standard

This quality standard will cover assessing, diagnosing and managing physical health problems of adults aged 18 years and older in prisons or young offender institutes. It will not cover:

- people in immigration removal centres
- people in police custody
- NHS care provided for prisoners outside the prison service (for example in an acute hospital)
- end of life care
- dental management, other than self-care.

The initial assessment, diagnosis and management of mental health problems will be part of the scope of the upcoming quality standard on the mental health of people in prisons. This will be based on the NICE guideline on the mental health of adults in contact with the criminal justice system which is due to publish in March 2017.

2.2 Prison population

There are currently 118 prison establishments in England.[1] The prison population on 30 December 2016 was 84,857; 80,988 men and 3,869 women.[2]

There is a general underlying trend of an increasing number of people held in prison. The prison population of England & Wales rose by just over 90% between 1990 and 2015, an average rise of 3.6% per annum. At the end of March 2016, of the individuals in prison either sentenced, awaiting sentencing or on remand, 92% were adults, 5% were 18-20 year olds and around 0.6% were 15-17 year olds. Of those already sentenced, around 41% of prisoners were serving a determinate (fixed length of time) sentence of 4 years or more, 17% were serving indeterminate (no fixed length of time) sentences and around 25% were serving sentences ranging between 1-4 years. Offenders on recall and those serving sentences of less than one year in length each accounted for 9%.[3]

The prison population includes highly vulnerable groups such as:

- people with learning disabilities who find it difficult to understand the prison regime and what is happening to them
- older people and those serving longer sentences whose physical health often deteriorates or is exacerbated by previous lifestyle choices during imprisonment
- people serving short sentences, making it difficult for prison healthcare staff to achieve any sustainable change in their health
- people who have particular healthcare needs, such as:
    - physical disabilities
    - history of substance misuse
    - pregnant women.

2.3 Prison population and health

The prison population experiences a disproportionately higher burden of illness including infectious diseases, long term conditions and mental health problems. They

[1] Health and Justice, NHS England
[2] Prison population figures: 2016, population bulletin: weekly 30 December 2016, Ministry of Justice
[3] Prison Population Statistics briefing paper SN/SG/04334, House of Commons Library

may also have problems with substance misuse (drugs, alcohol and tobacco) but poorer access to treatment and prevention programmes.

Higher rates of hepatitis B and C, tuberculosis, HIV and sexually transmitted infections impact physical health. In managing the care of this patient population, a decade is generally added to their chronological age to address their physical presentation caused by poor diet, poverty, dependencies and lifestyles including homelessness and long-term unemployment.

77% of men serving a prison sentence and 82% of women serving a prison sentence smoke. 81% of those entering prison report they have taken drugs (40% report intravenous drug use within 28 days before custody). A high proportion of people in prison are dependent on over the counter medicines. There is also a high level of alcohol use and dependency.

74% of the prison population will be released within 12 months from the start of their sentence meaning it is important to ensure pathways of care in and out of the prison setting are well established and linked up.

The number of prisoners who are over the age of 50 was 12,577 (approximately 15%) in March 2016. Older prisoners have higher rates of long term conditions, social care needs and disability, and greater need for palliative care provision[4].

2.4 Prison population health management

In April 2013 NHS England became responsible for commissioning all health services for people in prison in England.[5]

In October 2013, Public Health England, NHS England and the National Offender Management Service published a National Partnership Agreement which set out the shared strategic intent and joint commitment to work together for the purposes of co-commissioning, enabling and delivery of healthcare services in adult prisons in England. This agreement included a commitment to introduce an opt-out blood-borne viruses (BBV) testing policy in prisons. This was rolled out though 'pathfinder prisons' and NHS England has indicated that by April 2016, 63% of prisons in England and Wales had implemented it.[6]

The implementation of Smoke Free Prisons began in September 2015, with a number of early adopter sites. Prisons in Wales have now moved to smoke free, as have four sites in the South West of England. The next group of 12 prisons are expected to be smoke free by March 2017.[7]

[4] Health and Justice commissioning intentions 2017/18, NHS England
[5] Health and Justice commissioning intentions 2017/18, NHS England
[6] Blood-borne viruses: reports on opt-out testing in prisons, Public Health England
[7] Health and Justice commissioning intentions 2017/18, NHS England

2.5 National outcome frameworks

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS outcomes framework 2016–17

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicators*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults ii Children and young people 1b Life expectancy at 75 i Males ii Females ***Improvement areas*** **Reducing premature mortality from the major causes of death** 1.1 Under 75 mortality rate from cardiovascular disease* 1.2 Under 75 mortality rate from respiratory disease* 1.3 Under 75 mortality rate from liver disease* 1.4 Under 75 mortality rate from cancer* i One- and ii Five-year survival from all cancers iii One- and iv Five-year survival from breast, lung and colorectal cancer *v One- and vi Five-year survival from cancers diagnosed at stage 1 & 2***
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicators*** 3a Emergency admissions for acute conditions that should not usually require hospital admission 3b Emergency readmissions within 30 days of discharge from hospital* ***Improvement areas*** **Improving dental health** *3.7 i Decaying teeth***
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 2 Public health outcomes framework for England, 2016–2019

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors which affect health and wellbeing and health inequalities ***Indicators*** 1.13 Levels of offending and re-offending
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.11 Diet 2.12 Excess weight in adults 2.13 Proportion of physically active and inactive adults 2.14 Smoking prevalence – adults (over 18s) 2.15 Drug and alcohol treatment completion and drug misuse deaths 2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison 2.18 Alcohol-related admissions to hospital 2.19 Cancer diagnosed at stage 1 and 2* 2.20 National screening programmes 2.23 Self-reported well-being
3 Health protection	***Objective*** The population's health is protected from major incidents and other threats, whilst reducing health inequalities ***Indicators*** 3.02 Chlamydia diagnoses (15–24 year olds) 3.03 Population vaccination coverage 3.05 Treatment completion for TB
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.03 Mortality rate from causes considered preventable** 4.04 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* 4.05 Under 75 mortality rate from cancer * 4.06 Under 75 mortality rate from liver disease* 4.07 Under 75 mortality rate from respiratory diseases* 4.08 Mortality rate from a range of specified communicable diseases, including influenza 4.12 Preventable sight loss

Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework

* Indicator is shared

** Indicator is complementary

3 Summary of suggestions

3.1 Responses

In total 9 stakeholders and 3 specialist committee members responded to the 2-week engagement exercise 06/12/2016 – 20/12/2016. Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 3 for further consideration by the Committee.

Full details of all the suggestions provided are given in appendix 4 for information.

Table 3 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Assessing health • First and second stage health assessments • Sexually transmitted infections (STIs), HIV and Hepatitis B and C • Health checks	NLGB&TP, SCM1, SCM2, PHE, G4S/RCN, RCGP
Promoting health and wellbeing • Health literacy • Physical activity and nutrition • Self management and service user involvement in services	G4S, G4S/RCN, PHE, SCM1, RCGP
Managing medication • Prescribing • Access to medicines and review	G4S/RCN, RCN, SCM1, SCM2
Release from prison • Registration with a GP • Continuity of medicines	SCM2, PHE
Communication and coordination • Lead care co-ordinator and MDT working • Sharing of information	SCM1, SCM2, SCM3, G4S
Additional areas • Use of security restraints • Holistic care for people with HIV • Quality Outcomes Framework (QOF) • Rehabilitation • In-reach services	G4S/RCN, SCM1, SCM3, SCM4
G4S, G4S Forensic & Medical Services (UK) Limited (Some identical comments from RCN – denoted above as G4S/RCN) NLGB&TP, National LGB&T Partnership PHE, Public Health England RCGP, Royal College of General Practitioners RCN, Royal College of Nursing SCM, Specialist Committee Member Responded but did not make comments: BASHH, British Association for Sexual Health & HIV	

BIA, British Infection Association
NHSE, NHS England
RPS, Royal Pharmaceutical Society

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 429 papers were identified for the physical health of people in prisons. In addition, 34 papers were suggested by stakeholders at topic engagement and 6 papers internally at project scoping.

Of these papers, 4 have been included in this report and are included in the current practice sections where relevant. Appendix 1 outlines the search process.

4 Suggested improvement areas

4.1 Assessing health

4.1.1 Summary of suggestions

First and second stage health assessments

A stakeholder commented that the two stage assessment, with an assessment on entering prison followed by a second stage assessment within 7 days, is key to delivering care. They stated there are variations in the initial assessment identifying critical health needs and these assessments taking place during the first 7 days in prison.

A stakeholder commented that carrying out a medicines reconciliation prior to the second stage health assessment will help to reduce the risk of deaths in custody particularly for people with mental health problems or receiving specialist medicines. They stated this practice is not embedded in prison medicines pathways with few prisons carrying out a formal medicines reconciliation. Two stakeholders also highlighted the importance of the skill level of the practitioner carrying out the assessments.

A stakeholder commented that screening for TB varies in prisons as does the response to the results.

A stakeholder commented that smoking, drugs and alcohol can be problematic for people in prison. In addition, sexual abuse of vulnerable people may also occur.

Sexually transmitted infections (STIs), HIV and Hepatitis B and C

A stakeholder commented that there are higher rates of STIs, including HIV, in prisons and that prisons are high-risk environments for transmission of HIV. The stakeholder stated that in prison this can disproportionately affect transgender people and gay, bisexual and other men who have sex with men. It would be inclusive to offer a full STI screening alongside HIV testing on entering prison.

A stakeholder commented that the Green book guidelines recommend hepatitis B vaccine for prisoners and this should be offered without confirming need for vaccination by testing in all eligible, consenting prisoners at or near reception.

A stakeholder commented that injecting drug use, which is higher in the prison population than the general population, is the main risk factor for the transmission of hepatitis C infection in England. Over 90% of new hepatitis C infections are thought to be acquired this way. They stated that people in prison should have access to the blood-borne virus opt-out testing for hepatitis B and C.

Health checks

A stakeholder commented that the health check programme systematically targets the top seven causes of premature mortality: high blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption. By identifying risks early, action can be taken to reduce and manage those risks, increasing the chances of maintaining or improving health. All national screening programmes should be provided routinely and are an effective way to detect abdominal aortic aneurysm, bowel, breast and cervical cancer.

A stakeholder commented that improvements in the care of patients with long-term conditions have been made but that recommended care is not delivered reliably to all patients, especially those with multiple long-term conditions.

4.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 4 to help inform the committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
First and second stage health assessments	**First-stage health assessment at reception into prison** NICE NG57 Recommendation 1.1.1, 1.1.4 **Following the first-stage health assessment** NICE NG57 Recommendation 1.1.8 **Medicines reconciliation** NICE NG5 recommendation 1.3.5 **Tuberculosis screening within 48 hours** NICE NG57 Recommendation 1.1.9 **Second-stage health assessment within 7 days** NICE NG57 Recommendation 1.1.13
Sexually transmitted infections (STIs), HIV and Hepatitis B and C	**First-stage health assessment at reception into prison** NICE NG57 Recommendation 1.1.4 (question 4 in first stage health assessment) **Hepatitis B and C** NICE NG57 Recommendation 1.1.23 **HIV** NICE NG57 Recommendation 1.1.24 **Sexually transmitted infections** NICE NG57 Recommendation 1.1.29

Health checks	**Other health checks and screening** NICE NG57 Recommendation 1.1.31

First-stage health assessment at reception into prison

NICE NG57– Recommendations 1.1.1, 1.1.4 (question 4 in first stage health assessment)

1.1.1 At first reception into prison, a healthcare professional (or trained healthcare assistant under the supervision of a registered nurse) should carry out a health assessment for every person. Do this before the person is allocated to their cell. As part of the assessment, identify:

- any issues that may affect the person's immediate health and safety before the second stage health assessment
- priority health needs to be addressed at the next clinical opportunity.

1.1.4 The first-stage health assessment should include the questions and actions in table 1[8]. It should cover:

- physical health
- alcohol use
- substance misuse
- mental health
- self-harm and suicide risk.

Table 1 Questions for first-stage health assessment

Does the person have any of the following:

- hepatitis B or C virus, HIV, other sexually transmitted infections

Following the first-stage health assessment

NICE NG57– Recommendation 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 for recommendations on risk assessments for in-possession medicines and ensuring continuity of medicine.

[8] See appendix 2 for the full table

NICE NG5 – Recommendation 1.3.5

Organisations should ensure that medicines reconciliation is carried out by a trained and competent health professional – ideally a pharmacist, pharmacy technician, nurse or doctor – with the necessary knowledge, skills and expertise including:

- effective communication skills
- technical knowledge of processes for managing medicines
- therapeutic knowledge of medicines use.

Tuberculosis screening within 48 hours

NICE NG57– Recommendation 1.1.9

Healthcare professionals in prisons should ensure people coming into prison are screened for TB within 48 hours of arrival.

Second-stage health assessment within 7 days

NICE NG57– Recommendation 1.1.13

A healthcare professional (for example, a registered general nurse) should carry out a second-stage health assessment for every person in prison. Do this within 7 days of the first-stage health assessment, and include as a minimum:

- reviewing the actions and outcomes from the first-stage health assessment
- asking the person about:
    - any previous misuse of alcohol, use of drugs or improper use of prescription medicine
    - if they have ever suffered a head injury or lost consciousness, and if so:
        - how many times this has happened
        - whether they have ever been unconscious for more than 20 minutes
        - whether they have any problems with their memory or concentration
    - smoking history
    - the date of their last sexual health screen
- any history of serious illness in their family (for example, heart disease, diabetes, epilepsy, cancer or chronic conditions)

- their expected release date, and if less than 1 month plan a pre-release health assessment: recommendation 1.7.5
- whether they have ever had a screening test (for example, a cervical screening test or mammogram)
- whether they have, or have had, any gynaecological problems
- measuring and recording the person's height, weight, pulse, blood pressure and temperature, and carrying out a urinalysis.

Hepatitis B and C

NICE NG57 – Recommendation 1.1.23

Prison healthcare services (working with the NHS lead for hepatitis) should ensure that:

- all people are offered a hepatitis B vaccination when entering prison (for the vaccination schedule, refer to the Green Book)
- all people are offered access to confidential testing for hepatitis B and C when entering prison and during their detention

HIV

NICE NG57– Recommendation 1.1.24

Offer all people HIV testing when entering prison.

Sexually transmitted infections (STIs)

NICE NG57– Recommendation 1.1.29

Identify people at high risk of STIs using their sexual history. Opportunities for risk assessment may arise during consultations on contraception, pregnancy or abortion, and when carrying out a cervical smear test or offering an STI test. Risk assessment could also be carried out during routine care or when a new patient registers.

Other health checks and screening

NICE NG57– Recommendation 1.1.31

Offer people equivalent health checks to those offered in the community, for example:

- the NHS health check programme

- learning disabilities annual health check
- relevant NHS screening programmes, such as those for abdominal aortic aneurysm and bowel, breast and cervical cancer.

4.1.3 Current UK practice

First and second stage health assessments

Unpublished data from NHS England was provided in confidence to the committee.

Sexually transmitted infections (STIs), HIV and Hepatitis B and C

Unpublished data from NHS England was provided in confidence to the committee.

The HIV Testing in England report[9] indicates that a blood borne virus (BBV) testing programme developed by Public Health England, NHS England and the National Offender Management Service is currently being rolled out across prisons and is expected to be fully implemented by March 2017. 60% of adult prisons in England were offering opt-out BBV testing to new receptions by April 2016.

Health checks

Unpublished data from NHS England was provided in confidence to the committee.

4.1.4 Resource impact

Implementing the above recommendations may require investment of resources to support early interventions and planned management of conditions. It is anticipated that this investment will be offset by savings from reduced emergency incidents and admissions, and by lower costs because fewer people will present with late stage conditions and infectious and communicable diseases. Overall, implementing these recommendations is not expected to have a significant resource impact.

[9] HIV testing in England: 2016 report Public Health England

4.2 Promoting health and wellbeing

4.2.1 Summary of suggestions

Health literacy

A stakeholder commented that the inability to access and interpret information stemming from a lack of basic literacy skills presents individuals in prisons with a fundamental challenge to take control of their own health. As a result, health literacy skills should be considered an integral part of the quality improvement process.

Physical activity and nutrition

A stakeholder commented that increasing physical activity can improve the physical and mental health and wellbeing of prisoners. Low physical activity is one of the top 10 causes of disease and disability in England and regular physical activity can help to prevent and manage over 20 chronic conditions and diseases. A stakeholder commented that there are limited opportunities to exercise whilst in prison.

A stakeholder commented that key factors affecting health and wellbeing are the increasing age of the prison population, the increased incidence of morbidity associated with excessive weight gain and reduced exercise availability. In addition, the provision of food is the responsibility of the prison service and a stakeholder commented there is little choice. A stakeholder noted that there is little nutritional or dietetic input in the prison setting and inconsistent provision of guidance across the prison estate about ‘medical diets’ and what these should consist of (e.g. nutrition for people with diabetes, coeliac disease or chronic kidney disease).

Self management and service user involvement in services

A stakeholder stated that supporting patients to be actively involved in their care and treatment can improve outcomes and experience, and potentially yield efficiency savings for the system through more personalised care that supports people to stay well and manage their own conditions better. They also highlighted the need for collaborative working between healthcare professionals and service users.

4.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 5 to help inform the committee’s discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Health literacy	**First-stage health assessment at reception into prison** NICE NG57 Recommendation 1.1.3
Physical activity and Nutrition	**Second-stage health assessment within 7 days** NICE NG57 Recommendation 1.1.19 **Exercise** NICE NG57 Recommendations 1.3.3 and 1.3.4 **Diet** NICE NG57 Recommendation 1.3.5 NICE CG189 Recommendations 1.7.3 and 1.7.11
Self management and service user involvement in services	No recommendations identified

First-stage health assessment at reception into prison

NICE NG57 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.

Second-stage health assessment within 7 days

NICE NG57 Recommendation 1.1.19

Offer the person advice, with supporting literature if appropriate, on:

- how to contact prison health services and book GP appointments or other clinics, for example, dental, optician, chiropodist, substance misuse and recovery services
- where to find health information that is accessible and understandable
- how to attend or get a referral to attend any health-promoting activities in the future (see recommendations 1.3.1 – 1.3.8)

Exercise

NICE NG57 Recommendations 1.3.3 and 1.3.4

1.3.3 Encourage people to be physically active. Offer them information about:

- the benefits of exercise
- what exercise facilities are provided, where they are and how they can use them, for example:
    - going to the gym
    - using the exercise yard
    - exercises that can be done in the cell.

1.3.4 Offer people information and advice in line with recommendations in the NICE guidelines on:

- physical activity: brief advice for adults in primary care
- physical activity: exercise referral schemes
- preventing excess weight gain obesity
- obesity: identification, assessment and management (section 1.6 on physical activity).

Diet

NICE NG57 Recommendation 1.3.5

Offer people information about:

- the benefits of a healthy diet
- healthier food options available in the prison.

See section 1.7 on dietary advice in NICE's guideline on obesity: identification, assessment and management.

NICE CG189 Recommendations 1.7.3 and 1.7.11

1.7.3 Encourage people to improve their diet even if they do not lose weight, because there can be other health benefits.

1.7.11 Encourage people to eat a balanced diet in the long term, consistent with other healthy eating advice.

4.2.3 Current UK practice

Health literacy

No current practice data has been identified for this area.

Physical activity and nutrition

The 2015-16 HM Inspectorate of Prisons annual report found that, of those who returned questionnaires, 32% of women in prison and 47% of men in prison went outside for exercise more than 3 times a week. 20% of women in prison and 30% of men in prison went to the gym 3 or more times a week.

The 2015-16 HM Inspectorate of Prisons annual report found that, of those who returned questionnaires, 28% of women in prison and 29% of men in prison felt the food in their prison was good/very good.[10]

A 2006 National Audit Office report found that prisoners were offered a variety of foods and different dietary requirements were catered for. At least one meal option labelled as healthy, was offered at lunch and in the evening.[11]

Self management and service user involvement in services

No current practice data has been identified for this area.

4.2.4 Resource impact

Implementing the above recommendations may require investment of resources to support early interventions and planned management of conditions. It is anticipated that this investment will be offset by savings from reduced emergency incidents and admissions, and by lower costs associated with late presentations of conditions and treatment of infectious and communicable diseases. Overall, implementing these recommendations is not expected to have a significant resource impact.

[10] Annual report 2015-16 HM Inspectorate of Prisons
[11] Serving time: prisoner diet and exercise, National Audit Office 2006

4.3 Managing medication

4.3.1 Summary of suggestions

Prescribing

A stakeholder stated that prescribing services for prisoners should be more consistent in relation to patient-focus, based on identified need and support self-care. The process should make better use of pharmacists' clinical and professional skills in the use and management of medicines.

Access to medicines and review

A stakeholder commented that managing medicine, including access to medicines and subsequent review, is important for the physical health of people in prison. Medications are either 'in-possession' (IP) or 'not in-possession' (NIP). There is variation between prisons in carrying out the risk assessments to decide whether to provide medication IP or NIP and when to change this status.

A stakeholder commented that prisoners should be responsible for administering and storing their own medicines, monitoring and administration devices but with a balance regarding those which could be 'tradeable'. In addition it is vital to have up-to-date records to support the prescribers and ensure that the correct medicines are given at the correct doses to the correct patient.

A stakeholder commented that critical medicines should be provided in a timely way. Omitted and delayed doses cause harm and increase anxiety for people coming into or being transferred between settings.

4.3.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 6 to help inform the committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Prescribing	None identified
Access to medicines and review	**Access to medicines** NICE NG57 Recommendations 1.4.1 – 1.4.5 **Continuity of medicines** NICE NG57 Recommendation 1.7.10

Access to medicines

NICE NG57 Recommendations 1.4.1 – 1.4.5

1.4.1 Carry out an individual risk assessment to determine if the person can hold their medicines in-possession. Allow people in prison to hold all medicine in-possession unless the person does not pass the risk assessment.

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).

1.4.3 Directly observe the administration of any medicine that is not in-possession.

1.4.4 Work with prison staff to ensure a system is in place to:

- supervise the administering of medicines not held in-possession to maximise adherence
- allow timings of medicines doses to align with the prescribed dose regime
- reduce diversion (passing medicines on to other people)
- protect confidentiality.

See the section on supporting adherence in NICE's guideline on medicines adherence.

1.4.5 Review and (if necessary) repeat a person's risk assessment for in-possession medicine if the person's circumstances change. Involve a multidisciplinary team if needed, including prison staff and the person. Examples of when the risk assessment should be repeated include:

- if carrying out a medicines review
- if a person is considered able to manage their own medicines after a period of having medicines not in-possession
- if there is a medicine safety incident, including evidence of self-harm
- if someone has raised security concerns (for example, about bullying, diversion or hoarding)
- if the person has not been taking their prescribed medicines
- if there is concern about the person's ability to self-medicate when following the Assessment Care in Custody and Teamwork care planning approach
- if the person is transferred to or from a segregation unit.

Continuity of medicines

NICE NG57 Recommendation 1.7.10

Ensure the person can keep taking their medicines after coming into prison.

4.3.3 Current UK practice

Prescribing

No current practice data has been identified for this area.

Access to medicines and review

Unpublished data from NHS England was provided in confidence to the committee.

4.3.4 Resource impact

It is anticipated that prison healthcare teams will be able to carry out medicines reconciliation within current funding arrangements. Services may need to be reorganised to ensure that appropriately skilled staff carry out the medicines reconciliation.

Implementing medicines reconciliation will reduce avoidable adverse drug events for people in prison. This will reduce the need for hospital attendances and the additional costs associated with moving people from prison. Reducing avoidable adverse drug events will bring down hospital attendances, including spending on prison escorts and bed watches. This is anticipated to save around £2.9 million per year when fully implemented. Reducing avoidable adverse drug events will bring down hospital attendances, saving £300,000 a year in England from 2017/18 onwards. Reduced attendances will also mean reduced spending on prison escorts and bed watch, saving £2,600,000 a year in England from 2017/18 onwards.

4.4 Release from prison

4.4.1 Summary of suggestions

Registration with a GP

A stakeholder commented that, for those people who were not registered with a GP prior to being in prison, registration with a GP before release can vary by prison. It is especially important for those on medication and those who have mental health or drug addictions to be registered with a GP.

Continuity of medicines

A stakeholder commented that on discharge or transfer from prison, people should be given a minimum of 7 days' prescribed medicines or an FP10 prescription to access continued doses of medicines. Failure to access the medicine can lead to harm or worsen clinical outcomes.

4.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 7 to help inform the committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Registration with a GP	**Before release from prison** NICE NG57 Recommendation 1.7.8
Continuity of medicines	**Continuity of medicines** NICE NG57 Recommendations 1.7.11, 1.7.14

Before release from prison

NICE NG57 Recommendations 1.7.8

Help people who are being released from prison to find and register with a community GP if they were not previously registered with one.

Continuity of medicines

NICE NG57 Recommendations 1.7.11, 1.7.14

1.7.11 Give critical medicines in a timely way to prevent harm from missed or delayed doses. Use the examples of critical medicines in table 2[12] in conjunction with clinical judgement and any safety alerts.

1.7.14 When a person is discharged or transferred from prison, give them a minimum of 7 days' prescribed medicines or an FP10 prescription, based on a risk assessment.

4.4.3 Current UK practice

Registration with a GP

No current practice data has been identified for this area.

Continuity of medicines

Unpublished data from NHS England was provided in confidence to the committee.

4.4.4 Resource impact

This area was considered not to have a significant resource impact (>£1m in England each year) in the resource impact assessment for NG57.

[12] See appendix 3 for full table

4.5 Communication and coordination

4.5.1 Summary of suggestions

Lead care co-ordinator and MDT working

A stakeholder commented that not all prisons have a clinical lead. The significance of having a clinical lead promotes leadership in establishments, accountability for the provision of healthcare and aids communication between prisons and community settings. This also enhances multi-disciplinary team working amongst the healthcare team and between the health, social care and custodial teams.

Sharing of information

A stakeholder commented that communication errors and omissions result in non-integrated care for people in prisons and duplication of consent or general information gathering. The Prisons and Probation Ombudsman's reports on deaths in custody[13] cite the need for improved communication that could have prevented the deaths.

A stakeholder commented that members of healthcare teams working in prisons need to understand when, where and how information should be shared, for example, with custodial staff, primary and secondary care or other bodies (eg social care services).

A stakeholder commented that medical screening should be transferred between establishments and another felt that communication is key to continuity of care. In a closed setting this needs to start at reception into prison through to beyond the gate and any pre-existing conditions or new diagnoses should receive equitable care.

4.5.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 8 to help inform the committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Lead care co-ordinator and MDT working	**Communication and coordination** NICE NG57 Recommendations 1.2.3 – 1.2.5

[13] Prisons and Probation Ombudsman

Sharing of information	**On entry into prison** NICE NG57 Recommendation 1.7.2 **Transit between custodial settings** NICE NG57 Recommendation 1.7.3 **Before release from prison** NICE NG57 Recommendations 1.7.4.

Communication and coordination

NICE NG57 Recommendations 1.2.3 – 1.2.5

1.2.3 Ensure that people with complex health and social care needs have a lead care coordinator responsible for managing their care. Ensure that the person and all healthcare and prison staff know who this is.

1.2.4 Share relevant information about people with complex needs with prison staff using prison record systems in line with legislation and national guidance. This should include information about any high-level risks, such as:

- risk of self-harm
- risk to others
- communicable diseases
- epilepsy
- diabetes
- allergies
- deteriorating health conditions
- learning disabilities.

1.2.5 Review people in prison with complex health and social care needs. Ensure that if a person is supported by a multidisciplinary team, the teams meet regularly to plan and coordinate ongoing management. These should be facilitated by primary care.

On entry into prison

NICE NG57 Recommendation 1.7.2

Primary and secondary care services should provide information from the person's medical records to the prison healthcare team that is:

- relevant

- in the person's best interests.

Transit between custodial settings

NICE NG57 Recommendation 1.7.3

Ensure continuity of care between custodial settings, including court, the receiving prison or during escort periods by, for example:

- providing access to relevant information from the patient record
- providing any medicines (including controlled drugs) – see also recommendations 1.7.10–1.7.16 on continuity of medicines
- issuing an FP10 prescription.

Before release from prison

NICE NG57 Recommendation 1.7.4
Carry out a pre-release health assessment for people with complex 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.

4.5.3 Current UK practice

Lead care co-ordinator and MDT working

No current practice data has been identified for this area.

Sharing of information

No current practice data has been identified for this area.

4.5.4 Resource impact

This area was considered not to have a significant resource impact (>£1m in England each year) in the resource impact assessment for NG57.

4.6 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the session on 2 February 2017.

Use of security restraints

A stakeholder commented that prisoners who are not deemed to be a high security risk remaining handcuffed whilst in a clinic environment in the community hinders their right to confidentiality, privacy and respect. They stated that it is mandated that officers use a chain when escorting prisoners to appointments.

This are is not within the scope of this quality standard as it relates to attendance at clinics in the community.

Holistic care for people with HIV

A stakeholder commented that there is evidence that peer support for those living with chronic conditions is a valuable resource. HIV is stigmatised which facilitates people not testing or engaging with health providers.

There is a strong focus on the medical management of HIV but not the wider determinants of health; in the case of those in prison, confidentiality (sharing cells) medicine reconciliation, side effects (weight gain) which can all affect effective adherence. Leaving prison with no fixed abode and poverty are also factors. There is inconsistency of peer led support throughout the prison estate.

This area is not specifically covered by the guideline however other areas within the briefing paper which are relevant to it, such as health assessments on entering prison, continuity of medicines and GP registration, will be discussed by the committee.

Quality Outcomes Framework (QOF)

A stakeholder commented that chronic conditions are managed by GPs in primary care in the community and many are measured against the QOF. By utilising the QOF scheme in the prison setting this would:

- promote continuity in the care of those coming into prison with a chronic condition as the GP working in prison would continue this work;

- promote continuity of care on release back to the community GP who would be able to see what care had been provided in the prison setting;

- provide an opportunity to assess the relative outcomes of the management of these chronic conditions in the prison setting.

This is not within the scope of the quality standards process.

Rehabilitation

A stakeholder commented that thought needs to be given to the range of organisations that could contribute to meeting a person's individual needs within a prison environment. Rehabilitation intervention is essential in helping to address the impact of physical, communication, psychosocial and emotional problems.

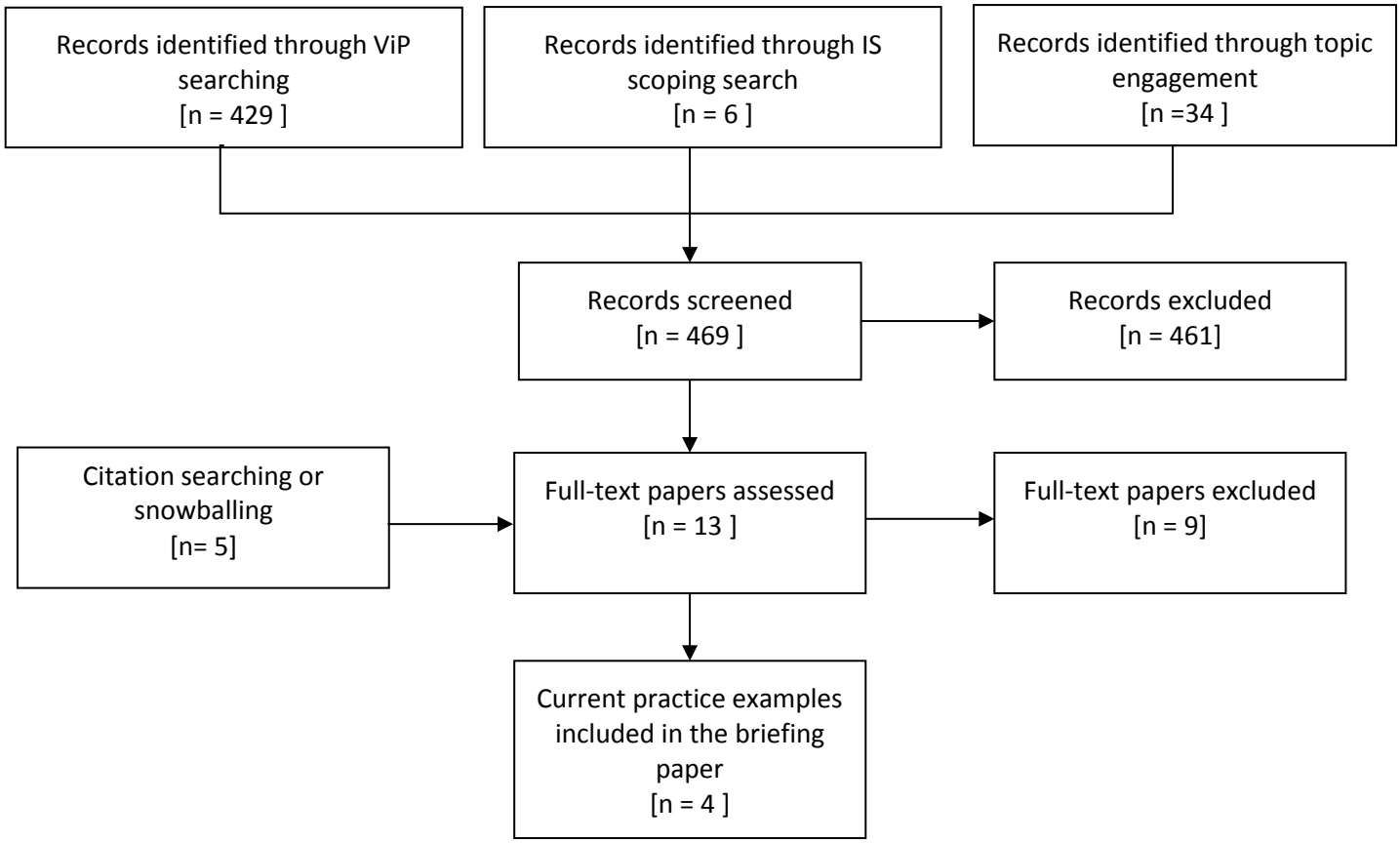
This area is not covered in the guideline in detail. However the health assessments on entering prison do address referrals for further review and assistance and these will be discussed. Rehabilitation which is provided outside the prison is not within the scope of this quality standard.

In-reach services

A stakeholder commented it would be helpful to promote in-reach services. This means that rather than people in prison having to attend hospitals and outpatient clinics, the services come into the prison.

The guideline includes a comment to refer people to in-reach mental health services, however it does not include recommendations on increasing the number of in-reach services.

Appendix 1: Review flowchart



Appendix 2: Recommendation 1.1.4 - Questions for first-stage health assessment

Table 1 Questions for first-stage health assessment

Topic questions	Actions
Prison sentence	
1. Has the person committed murder, manslaughter or another offence with a long sentence?	Yes: refer the person for mental health assessment by the prison mental health in-reach team if necessary. No: record no action needed.
Prescribed medicines	
2. Is the person taking any prescribed medicines (for example, insulin) or over-the-counter medicines (such as creams or drops)? If so: • what are they • what are they for • how do they take them?	Yes: document any current medicines being taken and generate a medicine chart. Refer the person to the prescriber for appropriate medicines to be prescribed, to ensure continuity of medicines. If medicines are being taken, ensure that the next dose has been provided (see recommendations 1.7.10 and 1.7.11). Let the person know that medicines reconciliation will take place before the second-stage health assessment. No: record no action needed.
Physical injuries	
3. Has the person received any physical injuries over the past few days, and if so: • what were they • how were they treated?	Yes: assess severity of injury, any treatment received and record any significant head, abdominal injuries or fractures. Document any bruises or lacerations observed on a body map. In very severe cases, or after GP assessment, the person may need to be transferred to an external hospital. Liaise with prison staff to transfer the person to the hospital emergency department by ambulance. If the person has made any allegations of assault, record negative observations as well (for example, 'no physical evidence of injury'). No: record no action needed.
Other health conditions	
4. Does the person have any of the following:	Ask about each condition listed.

• allergies, asthma, diabetes, epilepsy or history of seizures • chest pain, heart disease • chronic obstructive pulmonary disease • tuberculosis, sickle cell disease • hepatitis B or C virus, HIV, other sexually transmitted infections • learning disabilities • neurodevelopmental disorders • physical disabilities?	Yes: make short notes on any details of the person's condition or management. For example, 'Asthma – on Ventolin 1 puff daily'. Make appointments with relevant clinics or specialist nurses if specific needs have been identified. No: record no action needed.
5. Are there any other health problems the person is aware of that have not been reported?	Yes: record the details and check with the person that no other physical health complaint has been overlooked. No: record no action needed.
6. Are there any other concerns about the person's health?	Yes: make a note of any other concerns about physical health. This should include any health-related observations about the person's physical appearance (for example, weight, pallor, jaundice, gait or frailty). Refer the person to the GP or relevant clinic. No: note 'Nil'.
Additional questions for women	
7. Does the woman have reason to think she is pregnant, or would she like a pregnancy test?	If the woman is pregnant, refer to the GP and midwife. If there is reason to think the woman is pregnant, or would like a pregnancy test: provide a pregnancy test. Record the outcome. If positive, make an appointment for the woman to see the GP and midwife. No: record response.
Living arrangements, mobility and diet	
8. Does the person need help to live independently?	Yes: note any needs. Liaise with the prison disability lead in reception about: • the location of the person's cell • further disability assessments the prison may need to carry out. No: record response.
9. Do they use any equipment or aids (for example, walking stick, hearing aid, glasses, dentures, continence aids or stoma)?	Yes: remind prison staff that all special equipment and aids the person uses should follow them from reception to their cell. No: record response.

10. Do they need a special medical diet?	Yes: confirm the need for a special medical diet. Note the medical diet the person needs and send a request to catering. Refer to appropriate clinic for ongoing monitoring. No: record response.
Past or future medical appointments	
11. Has the person seen a doctor or other healthcare professional in the past few months? If so, what this was for?	Yes: note details of any recent medical contact. Arrange a contact letter to get further information from the person's doctor or specialist clinic. Note any ongoing treatment the person needs and make appointments with relevant clinics, specialist nurses, GP or other healthcare staff. No: record no action needed.
12. Does the person have any outstanding medical appointments? If so, who are they with, and when?	Yes: note future appointment dates. Ask healthcare administrative staff to manage these appointments or arrange for new dates and referral letters to be sent if the person's current hospital is out of the local area. No: record no action needed.
Alcohol and substance misuse	
13. Does the person drink alcohol, and if so: • how much do they normally drink? • how much did they drink in the week before coming into custody?	Urgently refer the person to the GP or an alternative suitable healthcare professional if: • they drink more than 15 units of alcohol daily or • they are showing signs of withdrawal or • they have been given medication for withdrawal in police or court cells. No: record response.
14. Has the person used street drugs in the last month? If so, how frequently? When did they last use: • heroin • methadone • benzodiazepines • amphetamine • cocaine or crack • novel psychoactive substances • cannabis • anabolic steroids • performance and image enhancing drugs?	Yes: refer the person to substance misuse services if there are concerns about their immediate clinical management and they need immediate support. Take into account whether: • they have taken drugs intravenously • they have a positive urine test for drugs • their answers suggest that they use drugs more than once a week • they have been given medication for withdrawal in police or court cells. If the person has used intravenous drugs, check them for injection sites. Refer them to substance misuse services if there are concerns about their immediate clinical

	management and they need immediate support. No: record response.
Problematic use of prescription medicines	
15. Has the person used prescription or over-the-counter medicines in the past month: • that were not prescribed or recommended for them or • for purposes or at doses that were not prescribed? • If so, what was the medicine and how did they use it (frequency and dose)?	Yes: refer the person to substance misuse services if there are concerns about their immediate clinical management and they need immediate support. No: record response.
Mental health	
16. Has the person ever seen a healthcare professional or service about a mental health problem (including a psychiatrist, GP, psychologist, counsellor, community mental health services, alcohol or substance misuse services or learning disability services)? If so, who did they see and what was the nature of the problem?	Yes: refer the person for a mental health assessment if they have previously seen a mental health professional in any service setting. No: record response.
17. Has the person ever been admitted to a psychiatric hospital, and if so: • when was their most recent discharge • what is the name of the hospital • what is the name of their consultant?	Yes: refer the person for a mental health assessment. No: record response.
18. Has the person ever been prescribed medicine for any mental health problems? If so: • what was the medicine • when did they receive it • when did they take the last dose • what is the current dose (if they are still taking it) • when did they stop taking it?	Yes: refer the person for a mental health assessment if they have taken medicine for mental health problems. No: record response
Self-harm and suicide risk	

19. Is the person: • feeling hopeless or • currently thinking about or planning to harm themselves or attempt suicide?	Yes: refer the person for an urgent mental health assessment. Open an Assessment, Care in Custody and Teamwork (ACCT) plan if: • there are serious concerns raised in response to questions about self-harm, including thoughts, intentions or plans, or observations (for example, the patient is very withdrawn or agitated) or • the person has a history of previous suicide attempts. Be aware and record details of the impact of the sentence on the person, changes in legal status and first imprisonment, and the nature of the offence (for example, murder, manslaughter, offence against the person and sexual offences). No: record response.
20. Has the person ever tried to harm themselves, and if so: • do they have a history of suicide attempts • was this inside or outside prison • when was the most recent incident • what was the most serious incident?	Yes: refer the person for a mental health assessment if they have ever tried to harm themselves. No: record response.

Appendix 3: Recommendation 1.7.11. Table 2 - Examples of critical medicines where timeliness of administration is crucial to prevent harm from missed and delayed doses

This table contains examples only and should be used in conjunction with clinical judgement. It is important to assess each person on an individual basis.

Area	**Medicines**
Cardiovascular system	Anticoagulants Nitrates
Respiratory system	Adrenoceptor agonists Antimuscarinic bronchodilators Adrenaline for allergic emergencies
Central nervous system	Anti-epileptic drugs Drugs used in psychoses and related disorders Drugs used in parkinsonism and related disorders Drugs used to treat substance misuse
Infections	As clinically indicated, such as anti-infectives or anti-retrovirals
Endocrine system	Corticosteroids Drugs used in diabetes
Obstetrics, gynaecology and urinary tract disorders	Emergency contraceptives
Malignant disease and immunosuppression	Drugs affecting the immune response Sex hormones and hormone antagonists in malignant disease – depot preparations
Nutrition and blood	Parenteral vitamins B and C
Eye	Corticosteroids and other anti-inflammatory preparations Local anaesthetics Mydriatics and cycloplegics Glaucoma treatment
Based on UKMi NPSA Rapid Response Report: Reducing harm from omitted and delayed medicines in hospital. Revised January 2016.	

Appendix 4: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		Assessing health			
1	SCM2	Key area for quality improvement 1 First stage health assessment followed by a second stage assessment within 7 days:	In the NICE guideline NG 57, there is clear recommendations about the content of both stages of assessment. Getting these consistent for the core suggestions in the guidance is key to delivering subsequent care for people.	The two-stage assessment is a key component for quality improvements as there are current variations in: • Whether people receive comprehensive assessments within their first 7 days in custody • Whether initial reception screening covers the scope of areas shown in the guidance- this leads to critical health needs not being actioned quickly enough (for example critical medicines; mental health needs). • Who carries out the first and second stage assessments- the guidance will enable a skill mix with supervision by a registered professional in stage one assessments. Current practice differs across prisons as to who delivers initial screening and the level of supervision/referral to registered professionals that can be accessed.	HMIP Expectations 2012- section 2 criterion 38. This includes a requirement for a two-stage approach to initial assessment. However this is interpreted in different ways which the NICE QS could improve.
2	PHE	1.1.1 A healthcare professional (or trained healthcare assistant under the supervision of a registered nurse) should carry out a health assessment for every person.	PHE strongly recommend that the person carrying out the reception assessment is a Registered nurse (RGN) or Registered mental health nurse (RMN). There is concern given the multiple complex needs of patients received into prison, the circumstances of their arrival, and the paucity of clinical information often available on reception, that the skills required to appropriately risk assess patients require a registered nurse conduct the initial assessment.	Research by Shaw et al has shown that 57% of detainees had mental health symptoms at reception and there have been problems with suicide risk assessment in particular distinguishing acute from long term risks. Research carried out by Birmingham et al showed that many prison healthcare staff lacked appropriate training for the reception assessment process. Recent rises in self-harm & suicide among people in prison and identification first few days as being particularly risky, highlight need for appropriate and rigorous risk assessment by qualified person at or near reception.	Shaw J, Baker D, Hunt IM, Moloney A, Appleby L. Suicide by prisoners. The British Journal of Psychiatry. 2004 Mar 1;184(3):263-7. Birmingham L, Gray J, Mason D, Grubin D. Mental illness at reception into prison. Criminal Behaviour and Mental Health. 2000 Jun 1;10(2):77-87.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
3	SCM2	Key area for quality improvement 3 Carry out a medicines reconciliation before the second-stage health assessment	In prison care, meds rec will help reduce the risks of deaths in custody where cessation of medicines on admissions is a known factor in PPO reports especially for people with mental illness whose medicines are not continued. There are also many cases where specialist medicines are not continued promptly as the usual screening processes don't identify these. A meds rec would pick these up as it guides the person completing it to ask about specialist medicines.	This is not really embedded in prison medicines pathways at all with only a handful of prisons carrying out a formal medicines reconciliation. It is a known quality inclusion for transfer of care into and out of hospitals and NICE MO guidance extends this to other sectors of care. Meds rec completion on transfer would identify previously missed adverse drug reactions, allergies and discrepancies' in what was being prescribed versus what is being taken. This may help reduce admissions to hospital from custody due to adverse drug reactions (currently 6% in the general population.).	NICE Medicines optimisation guidelines; RPS and CQC transfer of care guidelines SPS Medicines reconciliation resource The above all explain and recommend a formal medicines reconciliation on admission to a new care setting. Economic model in the Physical health in Prisons GDG- shows that meds rec is cost saving to the health economy. NHS England are producing a national meds rec template for all secure environments that will support embedding this into practice in a consistent and robust way.
4	SCM1	Key area for quality improvement 1 1.1.9 Healthcare professionals in prisons should ensure people coming into prison are screened for TB within 48 hours of arrival.	TB screening in prisons vary greatly from one establishment to another in terms of consistency of the screening and response to the results obtained. Prisons also vary greatly in their risk of receiving cases of suspected TB and LTBI.	As community prevalence increases, the relative incidence in prison will also rise disproportionately. The risk of a late diagnosis of TB in the prison setting is significant given the closed environment.	The rate of TB infection in the general UK population has been rising steadily. Prison and other detention setting populations are particularly vulnerable to TB infection, and both the National Institute for Health and Care Excellence (NIHCE) and the Chief Medical Officer (CMO) have highlighted the importance of prisons in TB control.14
5	National LGB&T Partnership	Key area for quality improvement 1: Ensuring all people are offered a full STI screening on entering prison	The limited research available on the UK prison population suggests that there are higher rates of STIs, including HIV, in prisons. The World Health Organisation in Europe recognised that prisons are extremely high-risk environments for transmission of HIV due to limited access to health care, frequency of unprotected sex and drug injection. It is also likely that	This is a key improvement area because in practice, fewer individuals attending sexual health services in prisons receive an HIV test than in other NHS sexual health services. This suggests that there needs to be a concerted effort to improve testing programmes in prison environments.	A UK study by David and Tang (2003) found high rates of STIs in a Young Offender Institute (YOI) in Reading, with people sharing a common past history of high risk behaviour with a significant number being intravenous drug users. The report recommended a need for immediate care, targeted sexual health information and STI prevention in YOIs in the UK.

[14] Guidance for PHE Centre Health Protection Teams on responding to TB incidents and outbreaks in prisons and other places of detention Second edition, July 2014

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			this disproportionately affects gay, bisexual and other men who have sex with men (MSM), as well as trans people, in prison populations. It is extremely positive that the Physical Health of People in Prison guidance recommends that all people are offered a HIV test on entering prison. In order to provide an STI screening the guidance differs, recommending that people at high risk of STIs are identified using their sexual history. A concern is that people are increasingly unlikely feel confident having open and honest conversations about their sexual history, particularly if that identifies themselves as a man who has sex with men, or as a woman who has sex with women, or as a trans person, due the continued sense of stigma and discrimination around these identities. A more inclusive step would be to offer a full STI screening alongside the HIV testing opportunity on entering prison.	Public Health England, NHS England and National Offender Management Service (NOMS) are in the process of collaboratively working together to introduce opt-out BBV testing in prisons. BBVs in this context are HIV, hepatitis B and hepatitis C. It is important that good practice is https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/560863/BBV_bulletin_October_2016.pdf https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365192/BBVs_Frequently_Asked_Questions.pdf	The Parliament Select Committee on HIV and AIDS in the UK (2011) suggested the need for robust HIV testing opportunities, including routine opt-out testing on entry into prison (see - http://www.publications.parliament.uk/pa/ld201012/ldselect/ldaids/188/18808.htm). Please see British Association for Sexual Health and HIV (BASHH) 'National guidance on commissioning sexual health and blood borne virus services in prisons 2011' (2011) at https://www.bashh.org/documents/3829.pdf
6	PHE	1.1.23 All people are offered a hepatitis B vaccination when entering prison and all people are offered access to confidential testing for hepatitis B and C when entering prison and during their detention	"Green book" guidelines have recommended hepatitis B vaccine (using the accelerated or hyper accelerated schedule) for prisoners and that this should be offered without 'confirming' need for vaccination by testing in all eligible, consenting prisoners at or near reception. Rates of injecting drug use among prisoners are higher than that of the general population. Injecting drug use is the main risk factor for the transmission of hepatitis C infection in England (over 90% of new hepatitis C infections are thought to be acquired via this route). However, prior to recent BBV opt-out programme implementation, only 4% of the prison population in England were offered testing	PHE have long advocated use of 0,7,21 day regimen for Hep B vaccine to be given on reception. Vaccine coverage had been higher in previous years in prison populations but has recently decreased (HJIPs). PHE, working with NHS England and NOMS, have since 2013, advocated testing for BBVs for all new prisoners at or near reception (if not known to be infected/immune and consenting). This is being implemented in a rolling programme guided by the experience of Data from NHS England show that as of April 2016, 63% of prisons in England have implemented the BBV opt-out testing policy. The programme objective	Public Health England, Hepatitis C in the UK, 2013 Report, 2014 https://www.gov.uk/government/publications/hepatitis-c-in-the-uk Blood-borne virus opt-out testing in Prisons: Preliminary Evaluation of Pathfinder Programme Phase 1 April-September 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/428942/BBV_pathfinder_evaluation_Phase_1_FINAL.PDF Public Health England. Opt-out blood-borne virus testing algorithm guidance notes, 2014. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/333059/

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			for Hepatitis C (PHPQIs, NHS England). Therefore it is vitally important that on reception detainees are offered a hepatitis B vaccination and also have access to BBV opt out testing.	had been to have opt-out testing available in all prisons in England by Q4 FY16-17 which means still a way off that target. Need to promote this practice strongly. Between April and September 2014, 21% of new receptions were tested for hepatitis C and HIV in nine out of the 11 pathfinder prisons that provided data. For hepatitis B, 8/11 prisons provided data showing 22% of new receptions being tested as part of the opt-out programme. BBV opt out testing needs to be offered systematically in every prison and having a standard would help to increase uptake rates.	Blood_borne_virus_testing_in_prisons_process_guidance_notes.pdf PHE has access to data from several different sources which measure and report on BBVs testing and diagnosis among people in prison: Health & Justice Indicators of Performance [NHS data asset], PHE Sentinel Surveillance of BBV testing (https://www.gov.uk/government/publications/sentinel-surveillance-of-blood-borne-virus-testing-in-england-2015), Genitourinary Medicine Clinic Activity Dataset [GUMCAD], National Drug Treatment Monitoring Service and data directly from reporting labs: https://www.ndtms.net/default.aspx). HJIP data show that in FY15-16, 10%, 12% and 25% of the prison population were tested for Hepatitis B, Hepatitis C and HIV resp.
7	PHE	(rec is 1.1.31) 1.31 Offer people equivalent health checks to those offered in the community, for example: • the NHS health check programme • learning disabilities annual health check • relevant NHS screening programmes,	The Physical Health Check in Prison Programme systematically targets the top seven causes of premature mortality (high blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption). By identifying risks early, individuals can then take action to reduce and manage those risks, increasing their chances of maintaining or improving their health. All national screening programmes should be provided as routine healthcare and are an effective way to prevent AAA, bowel, breast and cervical cancer, especially in this higher risk group.	An audit in 2014 showed that less that only 8% of prisons were providing people with a full NHS Health Check as they would be commissioned and delivered in the community. Almost half of the respondents reported that they were not providing NHS Health Checks (46%, 42 prisons). Among the remaining 50 prisons reporting provision of NHS Health Checks analysis has suggested that there is considerable variation in delivery. There is an issue with the delivery and quality of health checks currently being delivered in prisons. Having a standard would encourage better uptake and delivery of this important prevention programme. This is especially important	National Institute for Health and Care Excellence (2014) Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease www.nice.org.uk/Guidance/CG181 Uptake rates are monitored by the Health and Justice Indicators of Performance for screening and physical healthchecks in prison programme. Guidance and quality standards to be published in FY 17-18 by PHE.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		such as those for abdominal aortic aneurysm and bowel, breast and cervical cancer.		as people in prison suffer significant health inequalities and are most at risk from chronic diseases. PHE have identified problems with patients in prisons accessing cancer and non-cancer screening programmes in an equitable way to people in the community.	
8	G4S Forensic & Medical Services (UK) Limited / RCN (G4S Health Services (UK) Ltd)	Key area for quality improvement 3 Long-term conditions	Improvements in the care of patients with long-term conditions have been made over the years, but the evidence suggests that recommended care is not delivered reliably to all patients – especially those with multiple long-term conditions. There is significant scope for primary and community care providers to undertake more proactive preventive activities that can lead to earlier diagnosis and treatment and can prevent unscheduled hospital admissions. To make a real impact we believe we need to move from pockets of innovation and good practice to spreading and sustaining improvements across our services. Only if we implement all of these changes together we will generate an energy and a momentum that will get us to that tipping point where culture, behaviours, practice and performance shifts to deliver the consistency in the quality of performance outcomes we are looking for. With an ever-aging population we are attempting to: • Use our population data to accurately identify those at high risk • Target and deliver a proactive case/care management approach led by a LTC specialist nurse		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			• Introduce advanced/anticipatory care plans • Communicate and share data more effectively to deliver holistic rather than task-based care • Develop intermediate care alternatives to acute hospital care • Provide telehealth and telecare support • Imbed and improve our falls prevention pathway and services • Provide collaborative pharmaceutical care • Ensure timely access, flexible social care assessment and carer support Promote mental health and wellbeing		
9	RCGP	Smoking	Heavy smoking common and problems of passive exposure	Little motivation to give up smoking	
10	RCGP	Drugs and alcohol	Prisoners may brew alcohol and drugs are smuggled in-they provide an unofficial currency	Difficult to detect and control. Great efforts to stabilise addicts and wean them off drugs of addiction	
11	RCGP	Sex	Sexual abuse of vulnerable people Contempt and violence directed towards LGBT people	Long periods of “lock up, easy access to pornography, general disapprobation of conjugal visits	
		Promoting health and wellbeing			
12	G4S Forensic & Medical Services (UK) Limited	Key area for quality improvement 1 Health Literacy	The inability to access and interpret information stemming from a lack of basic skills presents individuals in prisons with a fundamental challenge to take control of their own health. As a result, health literacy skills should be considered an integral part of the quality improvement process. The team believe it is essential that literacy skills underpin our attempts to empower the prisoner population, reduce health inequalities, and reduce pressure on our services. Interestingly I note that the National Literacy Trust is working on a		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			shared public health agenda in conjunction with Middlesbrough Council, the James Cook Hospital, and numerous other partners, a local initiative and something that we could learn from and adapt for adults living in the prison environment. Weak health literacy skills are associated with riskier behaviour, poorer health, less self-management are synonymous with more visits to hospital and associated costs, a key issue at this time of austerity.		
13	PHE	1.3.3 / 1.3.4 Encourage people to be physically active. obesity: identification, assessment and management	Increasing physical activity has the potential to improve the physical and mental health and wellbeing of prisoners. Increasing physical activity will contribute to preventing chronic diseases. Low physical activity is one of the top 10 causes of disease and disability in England. Regular physical activity can help to prevent and manage over 20 chronic conditions and diseases. Physical activity can play a critical role across all elements of cancers; prevention, treatment, recovery and reducing the risk of recurrence. Encouraging people to be physically active can boost mental wellbeing Research shows that 29.5% of female prisoners in the UK are overweight or obese.	There is limited data on physical activity in prison Meeting the recommended Physical activity levels reduces the risk of CVD by 20-20%. The published literature on physical activity in prison is very limited. Research has shown that female prisoners in the UK were less likely to take part in sufficient physical activity compared with the female population of similar age in the community. The benefit of exercise are maintaining weight, but also helps with depression and mental health and well-being and helps to prevent chronic disease. In particular more interventions are needed as part of the care pathway for the physical health check programme.	Herbert K, Plugge E, Foster C, Doll H. Prevalence of risk factors for non-communicable diseases in prison populations worldwide: a systematic review. The Lancet. 2012 Jun 1;379(9830):1975-82. A Japanese study showed that blood pressure, blood lipids and BMI all improved when imprisoned women were obliged to undertake 30 min of moderate activity daily for 12 months. (Nara and Igarashi, 1998), Nara K, Igarashi M. Relationship of prison life style to blood pressure, serum lipids and obesity in women prisoners in Japan. Industrial health. 1998;36(1):1-7. Li J, Siegrist J. Physical activity and risk of cardiovascular disease - a meta-analysis of prospective cohort studies. Int J Environ Res Health. 2012;9(2):391-407. https://www.gov.uk/government/publications/health-matters-getting-every-adult-active-every-day/health-matters-getting-every-adult-active-every-day BHF. Making the case for physical activity. Evidence Briefing, 2013.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
14	SCM1	Key area for quality improvement 5 1.3.4 Offer people information and advice in line with recommendations in the NICE guidelines on: physical activity: brief advice for adults in primary care physical activity: exercise referral schemes preventing excess weight gain obesity: identification, assessment and management (section 1.6 on physical activity).	There a number of factors contributing to the relative importance of this: a). increasing age of prison population b). increased incidence of morbidity associated with excessive weight gain and reduced exercise availability c). the provision of food is the responsibility of the prison service rather than solely by patient choice	Currently, there is very little nutritional or dietetic input in the prison setting to either patients or the prisons preparing the food. There is very little consistency in the provision of guidance around the provision of 'medical diets' and what these should consist of across the prison estate (e.g. diabetes, coeliac, chronic kidney disease).	
15	RCGP	Diet	Obesity, balanced and healthier eating	Food is plentiful but "stodgy" with little choice. Food is not eaten communally for security reasons. Violence in dining rooms is a real problem	
16	RCGP	Exercise	Physical fitness, pleasure, competition	Limited facilities, limited time and problems of security, safety, and surveillance	
17	G4S Forensic & Medical Services (UK) Limited / RCN (G4S Health Services (UK) Ltd)	Key area for quality improvement 2 Self-management support better use of patient experience consider involving their patients in service development,	Evidence from the work completed with our health trainers tells us that supporting patients to be actively involved in their own care, treatment and support can improve outcomes and experience, and potentially yield efficiency savings for the system through more personalised care that supports people to stay well and manage their own conditions better. HMP Frankland healthcare department has made a commitment to become much		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		evaluation and **governance**	better at involving patients (and their buddies) by: • Where ever possible giving them the power to manage their own health and make informed decisions about their care and treatment; • Supporting them to become better informed about their health in a way that supports them improve their health and give them the best opportunity to lead the life that they want. We believe that person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and care. Care planned care that is coordinated and tailored to the needs of the individual, and sees us and associated professionals work collaboratively with people who use our services. The team is looking at a number of programmes which will support people to be more actively involved in their own health and care, as part of the drive towards a truly person-centred framework of delivery here in Frankland. Our work falls under three main areas: • Supporting self-management/self-care • Enabling people to make informed health decisions • Creating the conditions for person-centred care		
		Managing medication			
18	G4S Forensic & Medical Services (UK)	Key area for quality improvement 4	Not all GPs prescribe in line with standards of best practice. There is a need to standardise prescribing practice for certain		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	Limited / RCN (G4S Health Services (UK) Ltd)	Prescribing	treatments where there is clear evidence e.g. pain management or efficiencies – for example, in the prescription of low-cost statins. Prescribing services for prisoners should be; more consistent in relation to patient-focused, based on identified need, and support and promote self-care. The process needs to have more effective use of pharmacists' clinical and professional skills in the use and management of medicines, supported by extended roles for pharmacy technicians. The prescribing process needs to address the balance of what is rightly in possession and more appropriately not in possession, e.g. tradeable items, so that, wherever possible, prisoners are responsible for administering and storing their own medicines as well as associated monitoring and administration devices. • Developments in medicines management in the NHS, including repeat dispensing and medication review, should be better reflected in pharmacy services provided to prisoners. • All prisoners should have appropriate access to a pharmacist or pharmacy staff in addition to the GP, ANP or NMP. • In-possession medication should be the normal method of supplying non tradable medication in prisons.		
19	Royal College of Nursing	Key area for quality improvement 1 Medicines management in secure environment	There is good evidence that managing medicine including access to medicines and subsequent review is important for the physical health of people in the criminal justice system.	A recent stakeholder event involving Royal College of General Practitioners and SEG suggest that medicines management is a priority issue particularly around information sharing, workforce support to driving standards forward and providing clear clinical leadership were all important factors that	NICE Guidance: Physical health of people in prison (NG57) https://www.nice.org.uk/guidance/ng57/chapter/Recommendations#managing-medicines

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				would enable high quality care in improving physical health of people in the criminal justice system.	
20	SCM1	Key area for quality improvement 4 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 for recommendations on risk assessments for in-possession medicines and ensuring continuity of medicine.	Careful medicines management is an important aspect of the care provision in the prison setting. Medications are either 'in-possession' (IP) or 'not in-possession' (NIP). The risk assessments for the decision as to whether to provide medication in possession or not and also when to change this status remains variable across the prison estate. Furthermore, there are important differences between the community and prison settings regarding the safe use of medicines.	The provision of medication in prison is essentially a hybrid between community and hospital administration. People in prison can be administered their medication by a nurse from either a paper or electronic chart (NIP) but this usually from a dispensing room and hatch. Where medicines are IP, these may dispensed by a pharmacy service or alternatively by the nursing staff. In both cases, the physical process of prescribing is undertaken by the GPs (and in some cases Nurse Prescribers) working in prison. It is vital to have up-to-date records (see Key improvement area 3) to support the prescribers and ensure that the correct medicines are given at the correct doses to the correct patient.	
21	SCM2	Key area for quality improvement 4 Give critical medicines in a timely way to prevent harm from missed or delayed doses	We know that omitted and delayed doses causes harm and increases anxiety for people coming into or transferred between settings. PPO reports often cite omitted medicines as a factor that triggers self-harm/suicide.	The NICE GDG provides a list of critical medicines that, coupled with a formal meds rec and improved first stage assessment, will ensure safer and timely medicines continuity.	NICE physical health in prison GDG NICE Medicines optimisation guideline Patient safety alert on omitted and delayed doses.
		Release from prison			
22	PHE	1.7.8 To ensure continuity of care by helping people who are being released from	This is an important standard which will help to ensure continuity of care after release. This standard could be widened to also include the whole care pathway, to ensure medical information initially follows	Registration with a GP is currently not carried out systematically and can vary from prison to prison. It is especially important for those on medication and	Prison Service Order 3050. Continuity of healthcare for prisoners. Care quality Commission. Health and social care in prisons and young offender institutions, and health care immigration

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		prison to find and register with a community GP if they were not previously registered with one.	people into prison as well as is shared on release.	those who have mental health or drug addictions to be registered with a GP.	removal centres. Provider Handbook, 2015.
23	SCM2	Key area for quality improvement 5 When a person is discharged or transferred from prison, give them a minimum of 7 days' prescribed medicines or an FP10 prescription	This is important as people leaving a prison need to be able to access continued doses of medicines. Failure to access the medicine can lead to harm or worsen clinical outcomes.	There is a mechanism for all prisons to access FP10 prescription pads now so we have the tools to improve continuity of supply both with these and a supply of medicines where this is possible. Medicines continuity will improve through the gate care and maintain stability especially for mental health and substance misuse treatments. Currently we know that many prisons providers do not use FP10 forms for urgent medicines or unplanned releases. By including this topic as a QS, this will encourage commissioners and providers to prioritise this aspect of medicines continuity.	Provision of FP10 and FP10[MDA] prescription forms by HM Prison Service for released prisoners 2008. NHSBSA PPD web-site: http://www.nhsbsa.nhs.uk/PrescriptionServices/3994.aspx
		Communication and coordination			
24	SCM1	Additional developmental areas of emergent practice 1.2.3 Ensure that people with complex health and social care needs have a lead care coordinator responsible for managing their care. Ensure that the person and all healthcare and	Many prison healthcare teams have a 'clinical lead' but not all. The significance of having a clinical lead promotes leadership in establishments, accountability for the provision of healthcare in their team and aids communication between prisons and also community settings.	The presence of a clinical lead also enhances multi-disciplinary team working not only amongst the healthcare team but also between the health, social care and custodial teams.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		prison staff know who this is.			
25	SCM2	Key area for quality improvement 2 Communication and Co-ordination:	There is still a lack of MDT working especially between • mental health, substance misuse and physical health teams • healthcare and prison staff healthcare teams (including drug strategy and CRC teams) in prisons with community and hospital practitioners who need to continue care.	Communication errors/omissions have resulted in non-integrated care for people in prisons and duplication of consent or general information gathering. PPO reports on deaths in custody regularly cite the need for improved communication that could have prevented the deaths. A multidisciplinary approach is often needed as people in prison have multiple co-morbidities that results in complex health needs (e.g. several medicines)	NHS England is writing a briefing about the safety of MH medicines prescribing with RCGP SEG and RCPsych. This is because of current poor communication and partnership working that has been a factor in safe prescribing.
26	SCM1	Key area for quality improvement 3 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. 1.7.4 Carry out a pre-release health assessment for people with complex needs. This should be led by primary healthcare and involve multidisciplinary team members and	Supporting/Training members of healthcare teams working in prisons to fully understand when, where and how information should be shared to custodial staff, in-reaching services, primary and secondary care community health services or other relevant bodies (e.g. social care services, probation, courts and police) is vital for the continuity of care for people in prison. Continuity of care for people going into and being released from prison are critical points in the person's journey. Continuity of care also needs to be considered when people are being temporarily transferred to and from court or hospital as well as been transferred between one prison and another.	Current levels of understanding vary widely across the prison estate regarding the discussion around consent to share information. Understanding and agreement to share information from community services when requested by prison healthcare teams is also variable. In view of the impending changes to the current Prison Healthcare IT system, currently known as Offender Health IT, over to the new Health & Justice Information Service (HJIS), there will be a much increased flow of electronic patient records between community and prison primary healthcare teams. I am the Clinical Lead for HJIS and can elaborate on the technical aspects of what this entails and the progress of the contract negotiation.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		the person. It should take place at least 1 month before the date the person is expected to be released.			
27	SCM3	Key area for quality improvement 2 Continuity of healthcare (On entry to prison Transit between custodial settings Before release from prison. Continuity of medicines)	To ensure a person's care is continuous and of a high standard it is imperative there be excellent communication amongst all those involved in that person's treatment and care pathway. In a closed setting this needs to start at reception in to the prison right through to beyond the gate, any pre-existing conditions need to receive equitable care, as do those who receive a health-related diagnosis whilst incarcerated.	Positively UK report on HIV behind bars highlighted inconsistencies in clinical practice in medicine reconciliation on entering the prison estate and transferring between estates. Also poorer outcomes on HIV care for privately run prisons who opted out of having HIV specialist coming into the prison. NHS England recognise the essential need for improvement in continuity of care and have highlighted it as a strategic priority in their new H&J commissioning intentions 2017/18	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/428942/BBV_pathfinder_evaluation_Phase_1_FINAL.PDF http://positivelyuk.org/hiv-behind-bars/ concerns highlighted in this report about breaks in medication regime, putting patients at risk of viral non suppression. Medication not being transferred with the patient, inconsistencies in practice. http://positivelyuk.org/positive-change/ file:///C:/Users/Samsung/Downloads/6.%20PatientExperienceQSPatientInfo.pdf care for complex co morbidities and non HIV related issues, in line with national guidelines https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/10/hj-comms-intentions-17-18.pdf strategic context (4.1)- ensuring continuity of care, on reception and post release, by bridging the divide between healthcare services provided in justice, detained, and community settings.
28	G4S Forensic & Medical Services (UK) Limited	Key area for quality improvement 6. Transfer of Medical Screening between establishments	There appears to be a missed opportunity in guiding a process for transfer medical screening between establishments. The current process involves a great deal of staff time repeating the same questions in first and second screenings only for this to be replicated in the next prison, this will sometimes be within one week or two of the initial screen taking place and with little		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			chance of significant changes occurring in the patients' health. The guidance does elude to better information flow between our service and the community but this falls short of what could be achieved if all healthcare systems including those in Primary and secondary care, Mental Health and Social care services could and would actually interact with one another. The ideal guidance to improve standards and as such Health would have been aimed at a level that would have given consistency of screening across the whole service and we could avoid having each area or establishment building their own screening tools and moving forward with this theme a standard set of Templates for health delivery that would comply with standards and give consistency for monitoring.		
	Additional areas				
29	SCM3	Key area for quality improvement 3	The use of security restraints that hinders a patient right to confidentiality, privacy and respect.	Positively UK – HIV behind bars highlighted concerns about prison officers remaining present in consultations with the patient citing that they could not leave the room, there were notable inconsistencies in practice across the prison estate as more long serving officers said they would use the chain and others wouldn't. it is mandated that officers are to use a chain when escorting patients to appointments. The issue of prisoners remaining handcuffed whilst in a clinic environment in the community on release from prison for hospital appointment. Whilst there is an obvious security policy, if the patient is in a bed or a chair, then surely, they	http://positivelyuk.org/hiv-behind-bars/

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				cannot be handcuffed to the bed/chair if they are not deemed a high security risk. Evidence of example of a lady in stress induced psychosis handcuffed to a chair.	
30	SCM3	Key area for quality improvement 1 Holistic care pathway for people living with/diagnosed with HIV including psychosocial support	There is good evidence and a widening recognition of the valuable resource of peer support for those living with chronic conditions. HIV is highly stigmatised which facilitates people not testing or engaging with health providers. Even if engaged it can impact on a person's ability to adhere to medication depending on a wide range of circumstances. A person's mental health is automatically affected from point of diagnosis and support needs to available within the prison estate to support them	Public health England have developed their BBV Opt Out Policy for prisons, this is already showing an increase in diagnoses. Peer support has shown to help people become more knowledgeable around their condition and self-manage. It breaks down issues of trust between people perceived to be in roles of authority. There is a strong focus on the bio medical management of HIV. Not taking into consideration the wider determinants of health, in the case of those in prison, confidentiality (sharing cells) medicine reconciliation, side effects (weight gain) all facilitators to affect effective adherence. Leaving prison with no fixed abode, poverty are also factors. There is inconsistency of peer led support throughout the prison estate despite growing evidence of its effectiveness. Through the gate support is essential through Liaison and diversion programmes will further strengthen the care pathway for reintegration into the community.	http://www.nesta.org.uk/publications/supporting-self-management-guide-enabling-behaviour-change-health-and-wellbeing-using-person-and-community-centred-approaches http://positivelyuk.org/improving-well-being/ http://www.nesta.org.uk/sites/default/files/rtv-evidence-summaries.pdf https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/428942/BBV_pathfinder_evaluation_Phase_1_FINAL.PDF http://www.bhiva.org/documents/Guidelines/Monitoring/2016-BHIVA-Monitoring-Guidelines.pdf 5.13 screening for and managing mental health problems.5.15 Monitoring of patients in prisons http://www.nat.org.uk/Medialibrary/Files/Policy/2011/SocialCareSurveyJune2011FINAL.pdf http://positivelyuk.org/hiv-behind-bars/ file:///C:/Users/Samsung/Downloads/7.%20ServiceUserExperienceMHQSPatientInfo.pdf
31	SCM1	Key area for quality improvement 2 1.5.1 Monitor people with chronic	Chronic conditions are managed by GPs in primary care in the community and many are measured against the Quality and Outcomes Framework (QOF).	By utilising the QOF scheme in the prison setting this would a). promote continuity in the care of those coming into prison with a chronic condition (e.g. hypertension) as the GP	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		conditions in accordance with the following NICE guidelines:		working in prison would continue this work; b). promote continuity of care on release back to the community GP who would be able to see what care had been provided in the prison setting; c). provide an opportunity to assess the relative outcomes of the management of these chronic conditions in the prison setting;	
32	G4S Forensic & Medical Services (UK) Limited / RCN (G4S Health Services (UK) Ltd)	Key area for quality improvement 5 Rehabilitation	The breadth of rehabilitation means that careful thought needs to be given to the range of organisations that could contribute to meeting a person's individual needs within a prison environment. Rehabilitation intervention is essential in helping to address the impact of: • physical or movement problems – such as impaired motor control; loss of limbs; reduced balance, strength or cardiovascular fitness; fatigue, pain or stiffness sensory problems – such as impairment of vision or hearing; pain; loss of or altered sensation of touch or movement cognitive or behavioural problems – such as lapses in memory and attention; difficulties in organisation, planning and problem-solving • communication problems – such as difficulties in speaking, using language to communicate and fully understanding what is said or written • Psychosocial and emotional problems – such as the effects on the individual or buddy supporting a prisoner with a long-term condition. These can include stress, depression, loss of self-image and cognitive and behavioural issues medically unexplained symptoms –		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			where a holistic approach is needed to ensure the best possible support for both mental and physical wellbeing mental health conditions – such as anxiety and depression, obsessive/compulsive disorders, schizophrenia, eating disorders, post-traumatic stress disorder and dementia Although it is often attributed to the end of a treatment pathway, rehabilitation intervention can have significant impact as a preventative measure. For example: • exercise post-stroke has been shown to reduce the risk of further vascular event, advice and support directed towards smoking cessation, physical activity, obesity management, reduces the risk of adult cardiovascular disease. • it is well established that rehabilitation intervention reduces the risk of coronary heart disease and then reduces the risk of further events. I believe that if we were better at assessing patients an earlier stage in the pathway, pre rehabilitation intervention (such as prior to surgery) can improve functional outcomes, reduce length of hospital stay and enable timely return to work or occupation. • Both prevention and pre rehabilitation can be powerful tools for achieving a good outcome for individuals. They also reduce health inequalities, the cost of healthcare and give an increased return on our investment in rehabilitation.		
33	SCM4	In-reach services promotion	Promote inreach services ie rather than prisoners having to attend hospitals and outpatient clinics, the services come into the prison.		
		No comments			

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
34	British Association for Sexual Health & HIV (BASHH)		No comments.		
35	NHSE		Thank you for the opportunity to comment on the draft scope for the above Quality Standard. I wish to confirm that NHS England has no substantive comments to make regarding this consultation.		
36	Royal Pharmaceutical Society		We (the Royal Pharmaceutical Society) circulated the consultation to our specialist and partner groups when it was open - we will not be submitting any comments.		
36	British Infection Association		No comments.		