NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Physical health of people in prisons

Date of quality standards advisory committee post-consultation meeting:
1 June 2017

2 Introduction

The draft quality standard for the physical health of people in prisons was made available on the NICE website for a 4-week public consultation period between 11 April and 9 May 2017. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 24 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

4. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Stakeholders were also invited to respond to the following statement specific questions:

1. For draft quality statement 3: For purposes of quality improvement, should measurement of performance against this statement focus on the second-stage health assessment? Please give reasons for your answer.

2. For draft quality statement 4: Should this statement focus on a specific subpopulation of people in prison who have complex health and social care needs? If so, what should this population be?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Quality standard covers the key areas and was well received.
- The main focus of the statements is the first few days of being in prison however at this time new entrants may not be fully engaged.
- Quality standard should distinguish between types of prison establishments.
- Pharmacy technicians are not mentioned in the quality standard.
- Pregnancy is not mentioned in the quality standard.

Consultation comments on data collection (general)

- It was felt that local systems and structures are in place for data collection.

Consultation comments on resource impact (general)

- Prison service funding cuts may make these quality statements difficult to achieve.
- Many prison healthcare departments are understaffed. Access to and availability of healthcare varies across prisons and not all prisons offer 24 hour nursing, on-call doctors or other healthcare.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

People entering prison have a medicines reconciliation carried out before their second-stage health assessment.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Agreement that medicines reconciliation should be completed before the second-stage health assessment, within 7 days.
- All medication should be prescribed and given within 12 - 24 hours, or with appropriate urgency as some drugs need to be given sooner.
- People with hepatitis C virus (HCV) receiving direct-acting antiviral treatment, should have medicines reconciliation via in-reach or virtual support from the local operational delivery network responsible for implementing the HCV service.
- A medication review would reflect both process and outcome measures better than a medicines reconciliation.
- Include delivery of timely clinical care to ensure omitted doses are kept to a safe and acceptable/agreed minimum.
- Often people arrive at the end of the day and in some prisons there can be less than 24 hours between the first and second assessment.
- In young offenders' institutes, the comprehensive health assessment tool (CHAT) process is used with the second assessment taking place within 24 - 72 hours. Formal medicines reconciliation may be done after assessment but within 72 hours. Suggestion to therefore measure a timescale instead.
- The reference in the rationale to critical medication should include people with HIV receiving multiple medicines to treat age-related comorbidities.
- Add an outcome measure for people being treated in primary care, not just hospital admissions, because of adverse medication events.
- Include pharmacy staff in audience descriptors.

- The definition of second-stage health assessment should start with general medical history, not focus on drugs and alcohol. It should also say ‘any evidence of previous diagnosis or any history in their family’.
- The definition of medicines reconciliation could be improved.
- For people with learning disabilities it may be important to speak with family or support workers.
- Gender issues need to be considered.

Consultation comments on data collection

Stakeholders made the following comments in relation to consultation question 2:

- Data could theoretically be recorded on the existing healthcare IT system (SystmOne) or other prison systems, however they do not current capture these specifics.
- Potential data collection difficulties are consistency of data collection, entry and local interpretation.

Consultation comments on resource impact

Stakeholders made the following comments in relation to consultation question 3:

- Not all prisons are currently in a position to do this partly due to resource issues.
- This will not be consistently achievable due to time constraints and pharmacy resource.
- Current provision and working arrangements may not be able to fully comply with this due to resources and IT.

5.2 Draft statement 2

People entering prison have a second-stage health assessment within 7 days.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Agreement that the assessment should take place within 7 days or sooner if clinically prioritised.
- Assessment should not take place until at least 5 days after entering prison.
- If people are going through detox on entry to prison the assessment should be after 10 or more days so they are able to engage.
- Statement should make it clear that it refers to transfer and first reception.
- Statement does not allow for patient choice, the assessment should be offered.
- A validated screening tool and consideration of mental health issues should be included in the assessment. It is positive to see lifestyle issues are included.
- It is possible to meet this quality standard without achieving the desired outcome of diagnosing chronic disease as it focusses on a measurable process.
- Chronic diseases are usually diagnosed over time. Making a diagnosis and providing information requires a suitably trained health professional.
- Maintaining a healthy weight, which impacts on numerous other health conditions, is difficult and access to support and appropriate services is essential.
- Suggestions to add to the rationale that weight management, administration of vaccinations and reviewing vaccine requirements are included in the assessment.
- Change the denominator in the process measure as a prison admission would not take more than 7 days.
- People with learning disabilities may not understand the importance of this assessment and require encouragement to attend. The measure should require the provider to show the efforts taken to encourage full take-up.
- Additional outcomes include: information given on identified health problems, referral rates to appropriate services (e.g. weight management), vaccination requirements identified and vaccinations offered and accepted.
- Include obesity in the ‘diagnosis of chronic disease’ outcome measure.

- No reference to elderly care, identifying those suffering cognitive decline or at increased risk of falls.
- Access to services for health problems is an issue for people who are obese.
- For people with learning disabilities it may be important to check with family members or support staff for full information about their health and any relevant family history of health problems.

Consultation comments on data collection

Stakeholders made the following comments in relation to consultation question 2:

- Generally systems are already in place for this.
- This should be evidenced in the QOF register. QOF is used in prisons in the same way as the community but does not have the same payments.

Consultation comments on resource impact

Stakeholders made the following comments in relation to consultation question 3:

- Local prisons are resourced to do this but some struggle, for example, due to lack of health staff and lack of prison staff to escort prisoners to appointments.
- Quality standard doesn't differentiate between different types of establishment and not all non-local prisons (eg open prisons) are resourced for this.
- Moving resources to a separate second assessment may result in other services not being provided such as NHS health screens.
- Some prison GPs have to target higher risk groups due to resources rather than offering the assessment to all people in prison.

5.3 Draft statement 3

People entering prison are offered blood-borne virus (BBV) testing and assessment for risk of sexually transmitted infections.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Support for this statement.
- Statement should be clear that people transferring between establishments are included.
- People receiving a high number of short sentences would be tested frequently, sometimes within a time frame where there is no clinical benefit.
- It is possible to meet this standard without achieving the clinical outcome of identifying, referring and treating BBVs in a timely way.
- Prisons operate an opt-out BBV screening policy so the statement is confusing.
- The testing should be optional not compulsory.
- BBV testing should be offered every six months to all prisoners as standard.
- BBV testing should be covered separately from sexually transmitted infections. The statement implies those with BBVs will have acquired them sexually.
- Include healthcare professionals providing educational material to people in prison about the risk factors associated with BBVs.
- Offering sexual health testing to all prisoners would be a less discriminatory approach for this vulnerable population.
- Change BBV definition as viral haemorraghic fevers are not common BBVs in UK prisons.
- Change the denominator to the number of people who are in prison for 7 days or more.
- Additional measures include: staff training enabling positive and consistent service delivery, appropriate referral at the point of opt-out testing being offered and referrals to specialist care for people diagnosed with a BBV.

Consultation comments on data collection

Stakeholders made the following comments in relation to consultation question 2:

- Generally systems are already in place for this.
- This is already being measured and monitored through the Health and Justice Indicators of Performance.

Consultation comments on resource impact

Stakeholders made the following comments in relation to consultation question 3:

- Generally resources are in place to achieve this as offering the services has a negligible resource cost. However many establishments will struggle to provide the services in a timely manner due to lack of health staff and lack of prison staff to escort people to appointments.

Consultation question 4

For purposes of quality improvement, should measurement of performance against this statement focus on the second-stage health assessment? Please give reasons for your answer.

Stakeholders made the following comments in relation to consultation question 4:

- This should take place at the second stage assessment.
- BBV testing should be offered upon entry to prison and one suggested offering again during the second-stage assessment if initially refused.
- Unsure that focusing on the second screen will be sufficient.
- Measures of performance should include efforts made by the provider to achieve outcomes.

5.4 Draft statement 4

People in prison who have complex health and social care needs have a lead care coordinator.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- General agreement with the statement.
- People with severe support needs already have additional support in place.
- The statement should explicitly reference ‘assessed social care needs’.
- Expand the statement to include having a care plan in place with input and regular updates from a multidisciplinary team.
- Most prisons identify significant conditions such as palliative care or social care needs but are less effective at identifying complex needs.
- There is a disability liaison officer in each prison who manages complex needs.
- Good management of health and social care needs will increase the number of people registered with a GP at discharge and with a care plan on transfer or discharge.
- Need to define ‘complex health and social care needs’ as there is variation in how this is perceived and managed.
- The outcome ‘unplanned hospital admissions of people in prison’ is too narrowly focussed.
- The audience descriptors should state that healthcare professionals in the prison service are also responsible for managing low level social care needs.
- Definition of health and social care needs should include people with autism.
- Clarification of the staff groups in the definition of lead care coordinator is needed as it is not clear if the focus is on health or social care teams or custodial teams.
- The measures for the statement note that commissioners may wish to focus on ‘prisoners with specific needs such as those with alcohol or drug addiction’ but this may skew activity and outcome.

- Professionals should consider the health effects of conditions such as mental ill health, learning disabilities and substance misuse, and how these can be affected by non-health support needs, for example, literacy levels.

Consultation comments on data collection

Stakeholders made the following comments in relation to consultation question 2:

- This may be difficult currently where the complexity is the combination of conditions. A clear definition would assist.
- This is a measurable statement.

Consultation comments on resource impact

Stakeholders made the following comments in relation to consultation question 3:

- This is an achievable quality statement.

Consultation question 5

Should this statement focus on a specific subpopulation of people in prison who have complex health and social care needs? If so, what should this population be?

Stakeholders made the following comments in relation to consultation question 5:

- People with learning disabilities or autism, many of whom will also have mental and physical health conditions.
- Sub-populations with an increased likelihood of deterioration of physical and mental health needs, such as people in segregation units or older people.
- People with HCV.
- People who are actively injecting drugs.
- All people with identified complex health or social care needs should be included.
- Young offender institutes would define complex health needs more specific to their population. Social care relates more to the adult population.
- It would be better to define complexity by focussing on people who are being treated by more than one prison health sub-team or require significant input.

- Focus on the needs of people in prison on a case-by-case basis from the second-stage health assessment.
- Health, care and social support needs in prisons are high therefore using standard criteria to identify a sub-population would be problematic.
- Focusing on a specific subpopulation may not produce more beneficial outcomes.

5.5 Draft statement 5

People being transferred or discharged from prison are given a minimum of 7 days' prescribed medicines or an FP10 prescription.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- General support for this statement and reference to homelessness and sheltered accommodation was welcomed.
- Statement may need to include reference to community prescribing.
- Concern that 7 days may be insufficient to ensure that individuals with HCV can receive their medications as they are prescribed by a consultant.
- Consider where and when a person will next be able to get medication prescribed, it can be difficult to get a GP appointment for some time.
- People may be released to temporary/homeless facilities or may not have a fixed address, which would prevent registration with a GP.
- Support people to set up community appointments and tailor the take home medication to that, particularly for those with complex health needs or who will not understand how to engage with their local health organisations.
- Measures should include evidence of continuity of care plans upon transfer to another facility or release, including active referral to the corresponding GP, local drug and alcohol services, and community pharmacy where relevant.
- Issuing FP10s for those with substance misuse problems may be dangerous.
- Not all types of medication will be permitted in other prisons on transfer.

Consultation comments on data collection

Stakeholders made the following comments in relation to consultation question 2:

- Local structures exist in certain areas for the metrics and objectives to be achieved. Provision for them can be achieved in those areas currently lacking.
- Generally systems are already in place for this.
- This is a measurable standard.

Consultation comments on resource impact

Stakeholders made the following comments in relation to consultation question 3:

- Generally resources are in place for planned discharges. Sudden discharges from court or from the prison on bail can be problematic particularly in prisons that rely on the use of stock medication.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Robust pathways for people diagnosed with a BBV.
- ‘In-reach’ treatment provision for people who are diagnosed with hepatitis C and commencement of treatment within eight weeks.
- Provision of take home naloxone kits and referral to drug counselling services on transfer or discharge.
- First-stage health assessments.
- Promoting health and wellbeing.
- TB screening.
- Continuity of healthcare.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement No	Comments[1]
1	Prison Governors Association	General comments	Whilst welcoming this involvement, it became clear when reading through the attachment that a lot of the standard is based around clinical \ medical standards which are already in place and that the performance outcomes appeared to be owed by commissioners and providers – At this point prison governors are neither. This is due to change in the near future when Prison Health moves from its current arrangements, to one where NHS England and individual Prison Governors co-commission health services within their establishments. We believe anything that supports an improvement in outcomes for those in our care is a positive thing, but we have some reservations that the complexities of the prison population may skew or mask performance outcomes – We note that this standard focuses much attention on early days and '7' day assessments, then subsequent secondary assessments – The 7 day entry period is generally the time when our new entrants are perhaps at their least engage – Whilst we really do support the desired outcome, it feels like we could be asking too much of our new entrants to be fully engaged in health promotions and screening as well as coming to terms with being imprisoned. We would have liked to have seen more connection to mental health and drug dependency \ detox and support within the 7 day period – We note that this is mentioned elsewhere, but these factors are barriers we have found to getting new entrants to engage in our custodial processes , especially within the first 7 – 14 days stabilisation period. We also note that there does not appear to be any distinction made between the types of establishments which operate, notably male \ female – Having worked in both types there are significant challenges faced within a female prison not normally or acutely felt within a male. We also take note that there is no reference to pregnancy related matters.
2	Prison Governors association	General comments	Could this not extend to Police Custody? Detainees can spend some time in police / court cells prior to prison. Could some reference be made to a standard level of information sharing between other NHS providers - On occasion getting detailed and timely updates from acute hospitals back to a prison can hinder care
3	RCGP	General comments	• The guidelines should be generally well received though Prison Services are subject to so many service cuts due to funding cuts that it may make it difficult to achieve these objectives. The quality standards will need funding and prison support to enable their implantation. • There is a need for a universal template across the prison/secure estate which incorporates the NICE guidance

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Stakeholder	Statement No	Comments[1]
4	Royal College of Physicians and Surgeons of Glasgow	General comments	The College is very supportive of improving Health Care for anyone in custody or in prison. It is the College view that health care should be of the same standard as for the general population using the National Health Service throughout the United Kingdom. Equally while primarily directed to England and Wales, there are implications for Scotland and Northern Ireland. This guidance is a start to this process.
5	Royal College of Physicians and Surgeons of Glasgow	General comments	Our reviewer noted that readers of this standard by its very nature may not be the normal NICEguidance readership. It is suggested the content from p. 21 under the heading 'About this quality standard' in the first page is put earlier to gently introduce those who are unfamiliar with the very technical terminology of the NICE like 'quality statement' and 'measure' to ensure that the content and sub-content of each quality statement easier to follow.
6	Royal Pharmaceutical Society (RPS) on behalf of Secure Environment Pharmacists Group (SEPG)	General comments	There is no mention of pharmacy technicians at all and only one for pharmacists relating to the FP10s.
7	Foundation for People with Learning Disabilities (part of the Mental Health Foundation)	Question 1	We welcome the focus on improving continuity of care from community into custody and out again, for example through the proposals in statements 1, 4 and 5. Ensuring that people have (and take) the correct medicines is particularly important for prisoners who may be used to relying on others for prompts about their medication regimes (such as people with learning disabilities).
8	Leeds Community Healthcare	Question 1	**Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement? Yes. CHAT (Comprehensive Health Assessment Tool) process in YOI does already ensure that a lot of these standards are met ie 1, 2 and 3
9	Leeds Community Healthcare	Question 2 1 2 3 4 5	**Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? Will need to work out the read code on S1 Yes Yes Yes as long as there is a clear definition of complex health needs Yes
10	AbbVie UK Ltd.	Question 6	AbbVie is aware of innovative approaches to healthcare within this setting that could be supported, reinforced and expanded. One such pilot study is taking place in Barlinnie prison in Scotland whereby Waverley Care are testing the feasibility and benefits of connecting a link worker to an individual within prison, before their release, to also support their treatment and care after release within the community. This approach to provide a "constant" in the pathway between prison and community should be closely considered for wider adoption.

ID	Stakeholder	Statement No	Comments[1]
11	British Infection Association	Statement 1	We support a medicines reconciliation occurring prior to the second-stage health assessment but the health assessment is required within 7 days and the standard risks setting that as an acceptable time frame. This statement needs to include a requirement for all medication to be prescribed and given within 24 hours (ideally 12 hours) of arrival in prison at a minimum. The healthcare professional in charge of this assessment could be a pharmacist rather than a nurse or doctor.
12	British Infection Association	Statement 1	This list seems at a glance to suggest that the most important condition to assess is drug and alcohol abuse. Whilst this is important to assess the list should commence with a medical history in general and not presume these to be the most important conditions in every prisoner. The first and most important item on such a list should be acute or current medical conditions and the next past medical problems.
13	Foundation for People with Learning Disabilities (part of the Mental Health Foundation)	Statement 1	What the quality statement means for different audiences: we would just want to remind healthcare staff that for someone with learning disabilities it may be important to check with the person's family or support workers what medication they have been taking and any special considerations with regard to methods of administration
14	The Hepatitis C Coalition and The Hepatitis C Trust	Statement 1	The Hepatitis C Coalition supports the requirement for people entering prison to have a medicines reconciliation carried out before their second-stage health assessment and believes that it is essential to ensure that the physical wellbeing of those under regular medication or a prescribed course such as antiviral treatment for hepatitis C is maintained. Gaps in such medication can have an impact on the efficacy of the treatment and hence the elimination of the virus in an individual.
15	Her Majesty's Inspectorate of Prisons	Statement 1	**Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement? **Quality Statement 1 says *People entering prison have a medicines reconciliation carried out before their second-stage health assessment.*** NICE has recommended that the second-stage health assessment be completed within 7 days. It is absolutely desirable that a medicines reconciliation be completed as soon as possible and within a maximum of 7 days, but it will not be consistently appropriate or achievable to sequence it so that the medicines reconciliation always precedes the secondary assessment. In very busy locals this could be logistically impossible when added in with all the other practicalities that impact on appointments including volume of appointments, regime restrictions, room and staff availability, prisoner's physical wellbeing e.g. during stabilisation period of drug and alcohol withdrawals and court appearances. Other staff would include pharmacy technicians, pharmacists and competent "super HCA's" and the indicators are quantitative not qualitative – i.e. for assurance need to know % achieved and were appropriate sources of information used – nothing gained by achieving 100% but of poor quality.
16	Her Majesty's Inspectorate of Prisons	Statement 1	**Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? **Quality statement 1** - We are not confident from our inspections that all prisons are currently in a position to do this partly due to systems including SystmOne not yet being set up for this. Regarding data source it may be useful if medicines reconciliation post arrival is included within the data reported to NHS England within performance reporting.

ID	Stakeholder	Statement No	Comments[1]
17	Her Majesty's Inspectorate of Prisons	Statement 1	**Question 3 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.** **Quality Statement 1** We are not confident from our inspections that all prisons are currently in a position to do this partly due to systems including SystmOne not yet being set up for this, but also resource issues.
18	Leeds Community Healthcare	Statement 1	**Question 3** Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment. Medicines reconciliation before the 2nd stage physical health assessment. In the youth estate the CHAT assessment process is used with the standard of completing the 2nd stage within 72 hours. It is often completed within 24 hours so the pharmacy techs may not do the formal medicines reconciliation until after this but within 72 hours. Therefore it may be best to set a timescale rather than after 2nd health assessment. Also definition of medicines reconciliation could be improved Would need to factor in mitigations for not achieving this standard due to release or transfer with no notice
19	MSD Ltd	Statement 1	In order to support the health reconciliation goals detailed in statements 1 and 2, MSD would advocate a review of the prison estate (as a whole and as individual facilities) in order to ascertain whether or not appropriate and adequate clinical rooms are in place for assessment and treatment activities- and where they are not, looking to establish appropriate service contracts or other arrangements with NHS facilities outside the prison.
20	MSD Ltd	Statement 1	MSD welcome the focus on medicines reconciliation in this quality standard, and believe a comprehensive and consistent approach in this regard must be applied both for incoming prisoners who are new to the prison system and individuals transferring from other prisons. The reference to antiretroviral (ARV) treatment as critical medication is hugely important, but MSD would also suggest expanding this statement to account for the increasing number of ageing people living with HIV who may be receiving multiple medicines to treat age-related comorbidities. Looking specifically at individuals infected with hepatitis C virus (HCV) and receiving direct-acting antiviral (DAA) treatment at time of entry into prison, medicines reconciliation should be facilitated via in-reach or virtual support from the local operational delivery network (ODN) responsible for implementing the HCV service specification. Adequate psychosocial support should also be factored in.
21	NHS England North West Health and Justice	Statement 1	This may be difficult to measure as more often the patents arrives at the end of the court day and outside normal hours – therefore this makes it difficult to review the medications in detail, as there would not always be a doctor or pharmacist available at this time. Quite often there is less than 24 hours between 1st and 2nd screen. Additionally the structure should state evidence of people entering **the** prison, as on transfer each prison healthcare should use the transfer in process to review and medications and in possession risk assessment as this is likely to change in each prison dependent on the security regime. Second stage assessment This should read : **any evidence of previous diagnosis or** any history in their family
22	Obesity Group of the British Dietetic Association	Statement 1	We agree that medicine reconciliation should be carried out before the second stage health assessment which according to statement 2 will be before 7 days.

ID	Stakeholder	Statement No	Comments[1]
23	Prison Governors Association	Statement 1	Is there an enforcible NHS standard to external providers to provide detailed patient records? We do not have any issues with this, we fully understand the rationale and how this will be measured. I would have concern that the current provision and working arrangements may not be able to fully comply with this, be it down to resources or other process restrictions (IT?) Has any consideration been given to any gender considerations and how this may impact on this standard?
24	Prison Reform Trust	Statement 1	We support measures which address the continuity problems some people have with medication on arrival at prison. It should be clear that medicines reconciliation should occur with appropriate urgency, given the target for a second-stage health assessment is within 7 days as this could be too long in some cases.
25	Public Health England	Statement 1	Medicines reconciliation is only one aspect of medicines management for people in prison. Review of prescribed medicines should include both continuity of appropriate medicines to meet needs but also review of prescribed medications to take account of current clinical need and to reflect situation of incarceration e.g. a person dependent on an opioid substitution therapy (OST) programme in the community may be prescribed buprenorphine but this may be less appropriate to prison settings due to risk of diversion and therefore a switch to another opiate substitute e.g. methadone, may be justified. Further, assessment of previously prescribed medications could identify problematic drug interactions, adverse effects or high pill burden, all of which could be addressed by the reviewing clinician supported by a pharmacist. Finally, this could also enable additional support to improve adherence especially relevant for TB and human immunodeficiency virus (HIV) treatment but also for management of diabetes, epilepsy, asthma and other chronic illnesses.
26	Public Health England	Statement 1	Unplanned hospital admissions of people in prison because of adverse medication events is a rather high level outcome measure when more commonly people may be treated in primary care because of adverse events, including drug interactions, side effects or missed doses of medicine. Another outcome measure is required to reflect this.
27	RCGP	Statement 1	• This statement focuses on a process that can be measured. While this is fundamental to delivery of good care, it does not cover the required outcome, which is delivery of timely clinical care to ensure omitted doses are kept to a safe and acceptable/agreed minimum. • It would be possible to deliver this standard and not deliver safe clinical care (ie ensure patients have continuity of prescribing and medication review). • A medication review is fundamental to delivery of good care and would reflect both process and outcome better than just a medicines reconciliation
28	Royal college of physicians	Statement 1	We are happy with this apart from one important detail in Quality Statement 1. Medicines reconciliation should take place in the first 12 hours (not within 7days) of arrival at prison. Drugs such as insulin, methadone, heparin, antihypertensives, must not be omitted for any longer than this.
29	Royal College of Physicians and Surgeons of Glasgow	Statement 1	• **Standard 1 – Medicines reconciliation prior to second stage health assessment** • This standard is essential for effective health care in prison. The goal of this standard is to undertake a medicines reconciliation before the second stage health assessment. Our expert reviewer notes the denominator and numerator suggestions could be improved. The denominator “the number of prison

ID	Stakeholder	Statement No	Comments[1]
			admissions where second stage health assessments take place should be more appropriately be “the number of prison admissions”. The numerator should be “the number of medicine reconciliations undertaken prior to second stage health assessment”. Data collection is suggested to be local in health records. Can we assume this will allow easy electronic access to the data for the numerator and denominator? If this standard is going to form a Key Performance Indicator access to data should be “real-time” and accurate. Our second expert reviewer notes the critical part is “if the systems and structures were available”. Almost by definition, if these were available it would be possible to collect the data for the quality measures – the question almost becomes “If everything was set up to work, would it work?”. The area of significant uncertainty and difficulty is around the systems and structures. Across the areas outlined, there is a requirement that the data collection should ensure the ability to count these items. In some of the Quality Statements, these require connections to be made by professionals e.g. QS1 – an “adverse effect” being identified as related to “medicines reconciliation”. At that point, these connections need described and systematically stored in the local prison/hospital database. This explicit identification is required for return for central analysis of the combined national database. This requires structured awareness-raising and training to avoid low-quality data gathering. The risks I see present are in consistency of data collection, entry and interpretation locally, before data is received by the central database. Additionally, the range of points of identification of data and its entry into the database (hospitals, prisons) increases the possibility of variation in interpretation of the definition of what is being collected. That said, depending on training and systems in place, this may have no greater effect on the data than in analogous systems in healthcare.
30	Royal Pharmaceutical Society (RPS) on behalf of Secure Environment Pharmacists Group (SEPG)	Statement 1	In practice I’m not sure all of our sites do the first and second screen separately due to issues with getting patients to come back for their secondary screen so we might have to manage it a little differently to ensure that any issues are actioned following the meds rec if there isn’t a 2nd screen arranged. Could it say ‘appropriately trained’ pharmacy technicians or similar? Lack of any pharmacy staff being mentioned on page 5 with regards to medicines reconciliation. With the evidence behind the benefits of meds reconciliation being undertaken by pharmacy staff, why NICE have omitted to mention pharmacy staff here. Positive experience and service set-up at Berwyn with regards to meds reconciliation process involving pharmacy techs performing a joint face to face reception role with the registered nurses. Then concurrently pharmacists remotely joint reviewing the patient’s history alongside our GPs for good prescribing following much needed medicines optimisation is going well.
31	Royal Pharmaceutical Society (RPS) on behalf of Secure Environment Pharmacists Group (SEPG)	Statement 1	Concerned that Quality standard 1 implies that a Stage 2/Level 2 medicines reconciliation should take place at reception (First night in custody). Assumption is that the majority of prisons have nurses and GPs in receptions rather than pharmacy staff. As you’ve already stated, pharmacy staff are best placed to provide Level 2 medicines reconciliation. Level 2 medicines reconciliation will be a challenge at reception due to time constraints. Secondly, there is likely to be a lack of pharmacy resource to provide this.

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			Level 1 is more realistic as this is likely to highlight any critical medicines for prescribing, however " identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated" does not seem achievable unless pharmacy resource is put into reception areas and the prison will allow enough time per prisoner to process in reception. More specific to HMP Wandsworth which will become a remand prison from August 2017, it is highly unlikely that the healthcare department will achieve QS1 for the reasons stated above.
32	Women in Prison	Statement 1	We fully agree that women entering prison should have a medicines reconciliation carried out before their second-stage health assessment and we can see no reason why medicines reconciliation could not be standard procedure. This could easily be recorded on the existing healthcare IT system (Systm1) or other prison systems. Many of the women we work with tell us that they used to be on medication prior to entering prison but that all their medication was stopped on entry into prison. Once in prison, women face long waiting lists to see a doctor to be revaluated. In a hospital setting, medicines reconciliation and dosage is monitored on a daily basis. In prison, however, this process is much slower and can take weeks or even months. Waiting lists to see a doctor are also significantly longer than in the community. In cases involving mental health, women often have to be assessed by a psychiatrist before being prescribed medication, rather than this being prescribed directly by the prison GP. This process significantly delays any medicines reconciliation even further. The current lack of medicines reconciliation, including of anti-depressants, and long waiting lists to see a doctor in prison put many women at risk. Where women do continue being prescribed medication on entry to prison, the dosage might change. Healthcare staff in prison sometimes feel that women are overly medicated in the community, perhaps because community GPs are not used to working with this client group and feel ill-equipped to manage demands and expectations. For women, this change of dosage can be difficult to navigate. This is particularly the case for women on short sentences where women might have their dosage of medication changed on entry to prison and subsequently being release back into the community soon thereafter, with yet further change to their dosage. Another point to note here is that where women bring packets of medication into prison, unless these have fully intact labels then these will be removed from the woman for security reasons. For some women, short-term medication ends up carrying on in the long-term due to a lack of regular assessments in prison. We agree it would be a good idea for people in prison to have an accurate list of medicines they should be taking, prepared by their healthcare professional. This should be the case also on release from prison where it would be helpful for women to have their discharge notes from the healthcare in prison.

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			One potential problem with this quality statement, applicable to all statements, is the reliance on staff resources for carrying out tasks and recording outcomes. Under-staffing is endemic in prisons, including in healthcare and especially in mental health; all of these quality statements are contingent on adequate staffing levels. Access to and availability of healthcare varies across prisons and not all prisons offer 24 hour nursing, on-call doctors or other healthcare. Not only is this in contravention of guidelines stating that prison healthcare should be comparable to community care, but it is also leaves prison staff to deal with medical emergencies, hence adding a significant strain on untrained staff and putting women at risk. Prison staff are forced to make decisions and act on any potential emergencies and ring for an ambulance if deemed appropriate, a costly option if unnecessary and a dangerously time-consuming option if a genuine emergency. Although non-medical prison staff should be offered training on first aid and first response this, of course, is no substitute for 24 hour presence by medical staff. Furthermore, in relation to staff shortage and medication, where 24 hour medical care is not offered, medicine distribution has to fit around staff working hours. This results in drowsiness-inducing medication such as anti-depressants, which should be taken before bedtime, being given to women in the afternoon. As a result, some women are tempted not to take their medication, others end up feeling drowsy in the afternoon and having sleep patterns disrupted.
33	Foundation for People with Learning Disabilities (part of the Mental Health Foundation)	Statement 2	We welcome the focus on a second stage health assessment and the inclusion of a reference to accessible information. People with learning disabilities who have been in prison tell us that they do not always want to tell anyone during the reception process that they have a disability, or difficulty understanding what is happening, and may be too shocked to talk about it. By the time of the second stage assessment they may have settled sufficiently to talk more openly about any difficulties they are experiencing. However, they may not understand the importance of this opportunity and may require encouragement to attend (positive reaching out). We therefore think that the quantitative measure should be accompanied by a requirement for the provider to say what measures they have taken to encourage full take-up.
34	Foundation for People with Learning Disabilities (part of the Mental Health Foundation)	Statement 2	Explanation of the second stage health assessment: as with Statement 1, for people with learning disabilities it is often important to check with family members or support staff for full information about the person's health and any relevant family history of health problems. We note that the summary here of questions to cover does not include exploring whether the person may have learning disabilities, autism or learning difficulties. This was mentioned in the guideline, but we remain concerned that the suggestion is to ask the person directly and to ask about any contact with learning disability services. As noted above, people do not always wish to declare this – and indeed may not understand themselves whether they have a disability. We remain of the view that a validated screening tool should be used as part of the second stage health assessment.
35	The Hepatitis C Coalition and The Hepatitis C Trust	Statement 2	The Hepatitis C Coalition supports the requirement that people entering prison have a second-stage health assessment within seven days, but proposes that the second-stage health assessment should not take place until five days after entry into prison. When someone first arrives in prison, they are often more concerned about specific issues such as acclimatising and adjusting to their sentence, rather than their general physical health (with the exception of those with substance misuse dependency). The second-stage health assessment is therefore more appropriately placed between five and seven days after entry, when people are better able to engage in decisions about their health.

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36	Her Majesty's Inspectorate of Prisons	Statement 2	**Quality Statement 2** ***People entering prison have a second-stage health assessment within 7 days***. The wording of this quality standard is not clear as to whether it is only applicable to local prisons receiving people directly from the community, although this is made clear later in the section on page 8. It would be helpful to make it clear in the standard that it refers to transfer and first reception if that is the intention, although we have highlighted concerns below about the achievability of separate assessments in all establishments. This statement does not allow for patient choice – should the wording focus on being offered a second stage assessment as not all people (prisoners) will engage. Our previous expectation was that this assessment would occur within 72 hours. We have altered our expectation to reflect NICE guidance but there does need to be some mechanisms for clinical prioritisation.
37	Her Majesty's Inspectorate of Prisons	Statement 2	**Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? **Quality statement 2 –** Generally systems are already in place for this.
38	Her Majesty's Inspectorate of Prisons	Statement 2	**Question 3 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.** **Quality statement 2 –** Generally our observation is that local prisons are theoretically resourced to provide this service but some struggle particularly for many reasons including lack of health staff, lack of prison staff to escort prisoners to appointments, lack of space, regime restrictions inhibiting access and some prisoners do not want to engage with this assessment. However the guidance and standard do not differentiate between different types of establishment and not all have nonlocals are resourced for this. We have generally taken the position that it is desirable to also complete a separate second screen in all establishments as it facilitates a further check up a few days after arrival, however resources within many nonlocal prisons particularly open prisons are much less. On transfer it may be acceptable that the secondary screen is combined with the first screen as the prisoner will have stabilised in the receiving prison and will be transferred during the core day. Moving their resources to a separate second screen may result in other services not being provided such as NHS Health screens.
39	NHS England North West Health and Justice	Statement 2	Process Denominator – The number of prison admissions which last for more than 7 days – Doesn't make sense! Why would a prison admission last for more than 7 days? Second stage health assessment – This should read: **any evidence of previous diagnosis or** any history in their family. This should be evidenced in the QOF register. There is no reference to elderly care and the identification of those suffering cognitive decline or at increased risk of falls. I note from the briefing paper that it states that QOF is not used in prisons. In fact it is used in the same way that it is used in the community, it just doesn't attract payment in the same way as the community GMS contract. Additionally, in the community, this process is managed predominately by practice nurses and nurse practitioners. This is also in place in the prisons. The prisoner clinical record contains electronic QOF, and QOF alerts and recall are set up in the same way as the GP clinical records. This is a major omission to not have this in this quality standard.

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40	Obesity Group of the British Dietetic Association	Statement 2	We agree that the second stage health assessment should take place within 7 days to ensure that health needs are identified and a proactive approach to health is taken.
41	Obesity Group of the British Dietetic Association	Statement 2	In our view weight management should also be included here.
42	Obesity Group of the British Dietetic Association	Statement 2	Information and support are both essential, as is referral to appropriate services. However we are unsure to what extent appropriate services and support are actually available to those in prisons especially with regard to complex behaviours such as physical activity and diet. Those in prison have limited food choices and rely on what is available to them, and are limited in access to opportunities for physical activity. Maintaining a healthy weight, which impacts on numerous other health conditions, is therefore possibly more difficult and access to support and appropriate services is essential for this population.
43	Obesity Group of the British Dietetic Association	Statement 2	Outcomes also include information given on identified health problems, referral rates to appropriate services for identified health needs (e.g. weight management).
44	Obesity Group of the British Dietetic Association	Statement 2	Diagnosis of chronic disease should also include obesity.
45	Obesity Group of the British Dietetic Association	Statement 2	In our view access to appropriate services for identified health problems is also an issue of equality for this vulnerable population.
46	Prison Governors Association	Statement 2	We fully understand the rationale behind this standard - We would have concern that this assessment and standard does not contain reference o mental health issues - Whilst we are aware that this standard does not cover mental health, from an experienced prison manager the majority of early health issues are either masked or overtaken by mental issues. It may be that a 7 day window may be detrimental to the quality of information disclosed by the patients - This is certainly something the prison experiences with those entering custody during their early days, making our assessments difficult, if not having a blanket extension of the within 7 days, would an inclusions of extending this window in cases where mental health, detoxing and or other nationalisation issues are a factor?
47	Public Health England	Statement 2	Rationale should include 'opportunity to administer vaccinations and/or review vaccine requirements'. This should include administration of second dose of Hepatitis B vaccine on 0,7,21 regimen (as per Green Book advice) as well as to require other vaccine requirements including seasonal flu, Measles, Mumps and Rubella (MMR), human papilloma virus (HPV), Men ACWY, Varicella or other appropriate vaccine relevant to patient/population requirements. Outcomes should also be amended to reflect this requirement of the quality standard to include vaccination outcome e.g. vaccination requirements identified and appropriate vaccines offered/accepted.
48	RCGP	Statement 2	• This statement focuses on a process that can be measured. A healthcare assistant or nurse who is not trained to a level to be able to make a diagnosis or diagnostic decisions often delivers the second stage health assessment

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			• It would be possible to meet this quality standard (ie carry out the process) without achieving the desired outcome (b) of diagnosing chronic disease. • Chronic diseases are usually diagnosed over a period of time eg hypertension requires several readings and then assessment of other cardiac risk factors (requiring blood tests). • Making a diagnosis and delivery of diagnosis and its implications requires a suitably trained health professional.
49	RCGP	Statement 2	• Staff roles at the first screen and the second screen: It is important that the person completing the first screen and second screen communicates skillfully with a GP or other senior clinical colleague regarding issues of clinical importance in a timely way. • With the secondary screen GPs are having to target higher risk groups due to resources rather than offering to all people in prison. • Many prisons have problems with patients being escorted to healthcare due to lack of 'runners' (officers) this is out of the GPs control and has significant impacts on the healthcare deliver. Healthcare is not in the prisons performance indicators so there is no incentive for them to prioritise.
50	Royal College of Physicians and Surgeons of Glasgow	Statement 2	This standard is essential for effective health care in prison. It is very positive to see that lifestyle issues (diet, exercise, smoking etc) are part of the assessment. Our first reviewer notes the denominator and numerator are appropriate. Data collection is suggested to be local in health records. Can we assume this will allow easy electronic access to the data for the numerator and denominator? If this standard is going to form a Key Performance Indicator access to data should be swift and accurate. Institutions should be able to monitor in real time as possible.
51	Women in Prison	Statement 2	We fully agree with a second-stage health assessment as a more in-depth follow-up from the initial screening upon entering prison. A more in-depth assessment is beneficial not just to women's physical health but also their mental health and is an opportunity to explore options for healthier lifestyles and self-care. Currently, not all women undergo a second assessment in prison, resulting in old and/or incorrect details on medical records. A lack of assessment means staff then go on to make decisions based on these potentially out-of-date records. For women on short sentences there is not always time to have a second-stage assessment before release. It might in some cases be problematic to have assessments with women within 7 days if they are going through detox on entry to prison. In the case of alcohol detox, at least 10 days need to elapse. Many women will be on a methadone script and should have a reasonably managed and gradual process of detoxing. However, if women are experiencing discomfort, it might be better to wait a few days until they are more able to engage in a meaningful way in a health assessment. The second-stage health assessment provides an opportunity to look into patient history of illness or existing health conditions, routine screenings such as cervical cancer and to carry out overall health checks such as weight and blood pressure. It is also an excellent opportunity to discuss and explore patients' history of smoking, drinking and using drugs as well as their interests in

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			healthy eating, weight gain/loss, exercise, giving up smoking and other ways for women to take more control of and responsibility for their health. Many women in the criminal justice system lead chaotic lives in the community and face multiple challenges and therefore health is not always a priority. Despite the trauma of entering prison, admission into custody can be a chance to focus on health and well-being. However, it is important that this effort to take control of health is continued throughout a woman's sentence through ongoing health promotion and opportunities for lifestyle changes such as exercise and healthy eating in prison. Unfortunately, opportunities to exercise in prison can be limited, depending on a woman's individual situation. Attending the gym has to fit into the wider prison regime and cannot generally take place in the morning or evenings to fit around work or education, appointments or visits. With sequencing in certain prisons, exercising will not be regarded as a priority by the prison and will be secondary to education or training. Unless working as a gym orderly, women are unlikely to have the opportunity to attend the gym several times per week. In addition, technically, in-cell exercising is not allowed in prisons due to health and safety regulations. It might be a good idea to offer more flexibility in terms of exercising in prisons and make exercising more or a cornerstone of the prison regime, similar to the daily 30 minutes outdoors "exercise". Certain prisons are trying to offer opportunities to attend the gym in the evenings, an initiative that should be replicated across all prisons. Likewise, it is quite difficult to eat healthily in prisons as the food on offer is low in fresh vegetables, fruits and whole grains but high in white bread, pasta, potatoes and other carbohydrates. There are opportunities for women to buy certain healthy products on the canteen. However, this requires women to buy food from their limited personal spends account. Not all women are able to get work in prison and therefore do not have any money to spend on additional food while others prioritise spending their prison wages on phone credit, stamps, toiletries or clothing. It would be of significant benefit to prisoner health if the prison food were made healthier and we believe this should be subject to review in the same way school dinners have over recent years. We believe it is fully possible to put in place second stage health assessments as well as opportunities for exercising and healthier eating. However, this requires not only cooperation by healthcare staff but also a government investment in staffing levels and a willingness by prison governors to make changes to existing regimes.
52	AbbVie UK Ltd.	Statement 3	AbbVie UK welcomes the intention to develop and implement a NICE quality standard covering the physical health of people in prisons. Of particular importance is the recognition of the need to address Blood Borne Viruses (BBVs) within the prison setting. Effectively implementing testing, diagnosis and care pathways within this setting will play a significant role in supporting the UK in eliminating hepatitis C as a public health concern by 2030. Hepatitis C is highly prevalent in prisons and in other detained populations. A recent study among Scottish prisoners found the rate of hepatitis C to be almost 20% - the picture is likely to be similar in England. Around half of people who inject drugs (PWIDs) are thought to have the virus and around a third of offenders in prisons have injected drugs. In October 2013 Public Health England (PHE), NHS England and the National Offender Management Service (NOMS) agreed to introduce opt-out testing for hepatitis B, hepatitis C and HIV across the prison estate by 2016/17. Testing rates have

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			improved, from 5.3% in 2010/11 to 11.5% in 2015/16 , but the figures remain low and while this proposed quality statement is an important additional step AbbVie believes these efforts would be improved by specific and ambitious testing targets.
53	AbbVie UK Ltd.	Statement 3	• Statement 3 reads: People entering prison are offered blood-borne virus testing and assessment for risk of sexually transmitted infections. AbbVie supports this draft statement and feels it would be further strengthened by an ambition to implement opt-out testing in all prisons combined with a specific and appropriately ambitious target of individuals actually undertaking the test. It will also be enhanced by the requirement of quality measures to ensure every establishment has a robust and validated BBV care and treatment pathway in place. • BBV testing should be offered upon entry to prison and also again during second stage assessment if initially refused or not conducted to ensure as wide uptake and benefit as possible. • • BBV testing should be offered every six months to all prisoners as standard. This will ensure provision for those individuals serving longer sentences who may not have been offered a test before and also recognises that an individual may not always have the same levels of receptiveness to testing whilst in prison or upon entry to prison and is therefore provided further opportunities to engage. It may also be useful for NICE to consider including within this Quality Statement the need for healthcare professionals to ensure educational material has been provided to prisoners that outlines the risk factors associated with BBVs. • • The quality standard should include a metric to measure and encourage the referral into specialist care of all those individuals for whom a positive diagnosis of a BBV is found. • The provision of prison services and laboratory testing of BBVs are procured on a tender basis and providers may therefore change. As such, disruption and variation of services may occur. The quality standard should therefore make clear the minimum standard and requirements of testing to ensure all services apply a similar approach.
54	British Infection Association	Statement 3	Blood-borne virus testing should be covered separately from sexually transmitted infections as the implication of the title is that those with blood-borne viruses will have acquired them sexually. This is a common misconception and the wording of this document should be sensitive to the fact.
55	British Infection Association	Statement 3	Although risk-assessment may detect an increase in risk for a particular prisoner a less discriminatory approach to this vulnerable population would be to offer sexual health testing to all prisoners and then during a consultation ask about particular risk factors if relevant. Universal screening reduces the stigma associated with testing.
56	British Infection Association	Statement 3	This section is factually incorrect and needs editing. Viral haemorraghic fevers are not common blood-borne viruses in UK prisons.
57	The Hepatitis C Coalition and The Hepatitis C Trust	Statement 3	The Hepatitis C Coalition supports the provision of blood-borne virus (BBV) testing for those entering prison. A 2012 study from Scotland estimated hepatitis C prevalence among prisoners to be almost 20%; a rate that we can expect to be similar in English prisons. Indeed, one study showed that hepatitis C antibodies were present in an estimated 31% of prisoners who inject drugs in

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			England and Wales. The exceptionally high prevalence of hepatitis C within prisons makes it an ideal setting to diagnose many of those living with an undiagnosed infection of the virus. While testing rates have increased from 5.3% in 2010-11 to 11.5% in 2015-16, significant opportunities are still being missed to test and diagnose prisoners with hepatitis C, and testing provision in prisons across the country remains highly variable, with the availability of testing often being dependent on the personal commitment of prison governors. In October 2013 Public Health England (PHE), the National Offender Management Service (NOMS) and NHS England (supported by organisations such as The Hepatitis C Trust and the National Aids Trust) agreed to implement opt-out BBV testing in each prison in England by 2016-17. However, as the figures above show, testing rates are still too low. It is therefore essential that prison and prison healthcare staff are aware of their responsibility to offer BBV tests on an opt-out basis. As well as conducting BBV testing upon entry to prison, The Hepatitis C Coalition proposes that BBV tests are offered to people in prison at regular intervals, in order to increase the chances of diagnosing those who had previously refused a test or contracted a BBV since they were last tested. A 2013 audit of hepatitis C services in English prisons found that 81% had training on BBVs for healthcare staff, 48% had training for prison officers, and 57% had training for drug workers. However, there is clearly a significant distinction between training being available and training being delivered. Indeed, a report from The Hepatitis C Coalition in 2016 found that prison healthcare staff were overwhelmingly of the belief that additional training for healthcare and wider prison staff was required in order to ensure the smooth implementation of BBV opt-out testing, as well as the effective provision of in-reach treatment. This could be achieved, for example, by requiring BBV training to be a compulsory component of all prison staff's personal development plans. This would help to ensure that prison staff are offering BBV testing in an appropriate manner (which is more likely to increase uptake) and confident in carrying out BBV testing. The Hepatitis C Coalition also proposes that the quality standard is used to encourage prisons to undertake hepatitis C and BBV awareness-raising activities among the prison population, principally focused upon embedding peer support within the prison. People in prison are at high risk of contracting hepatitis C, with 60% of those entering prison having used drugs prior to their incarceration. Prison therefore offers the opportunity to deliver key messages around prevention and treatment opportunities to this at-risk group. Peer support is a particularly effective means of delivering messaging around hepatitis C to people in prison, as well as to support those who have been diagnosed through treatment.
58	The Hepatitis C Coalition and Hepatitis C Trust	Statement 3	While Quality Statement 3 requires that prisoners be offered BBV testing, The Hepatitis C Coalition would also like to see a requirement that prisoners diagnosed with hepatitis C are offered treatment at the first opportunity. The Data Source for Outcome a) notes that: "The NHS England health and justice indicators of performance contain data on people diagnosed with hepatitis B or C being referred to a specialised service and receiving treatment within 18 weeks."
59	The Hepatitis C Coalition	Statement 3	An increase in portable fibroscanners would greatly help with this. It reduces the need for prison inmates to have to arrange to leave the prison for testing and treating, which can result in a prisoner's treatment being slowed down. New antiviral medicines

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			for hepatitis C will cure the disease in most cases within an eight week treatment plan, but delays can make it more likelihood that the inmate will be released before completing treatment.
60	Her Majesty's Inspectorate of Prisons	Statement 3	**Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement? **Quality statement 3:** ***People entering prison are offered blood-borne virus testing and assessment for risk of sexually transmitted infections***. As above the standard needs to be clear that those transferring between establishments are also included. It is important that people entering or transferring between establishments are offered testing, but the offer is not sufficient if there is a lack of competent personnel to provide it in a timely manner within an appropriate environment. We would prefer that this standard focused more on the latter than just the offer.
61	Her Majesty's Inspectorate of Prisons	Statement 3	**Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? **Quality statement 3 –** Generally systems are already in place for this.
62	Her Majesty's Inspectorate of Prisons	Statement 3	**Question 3 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.** **Quality statement 3 –** Generally resources are in place to achieve this standard as offering the services has a negligible resource cost. However many establishments will struggle to provide the services in a timely manner for the same reasons as statement 2 above.
63	Her Majesty's Inspectorate of Prisons	Statement 3	**Question 4 For draft quality statement 3: For purposes of quality improvement, should measurement of performance against this statement focus on the second-stage health assessment? Please give reasons for your answer.** Often the offer of blood borne virus and sexual health screening will be made within the second screen, but not exclusively particularly if risks are identified within the primary screen or within the assessments for substance misuse treatment. We are not sure that focusing on the second screen will be sufficient, particularly if the standard changes its focus away from the offer.
64	Leeds Community Healthcare	Statement 3	**Question 4** For draft quality statement 3: For purposes of quality improvement, should measurement of performance against this statement focus on the second-stage health assessment? Please give reasons for your answer. Yes because this (CHAT 2) is the more in depth physical health assessment, there is more time and the young person is more settled. Any screening tests would take place at CHAT 2
65	MSD Ltd	Statement 3	MSD fully support the reference to blood-borne virus (BBV) testing in the prison environment, which highlights the importance of testing for and treating serious infections in a vulnerable population. The Public Health England guidance on opt-out BBV testing in prisons (accessible via the hyperlink below) could be vital to ensure a consistent approach to testing is implemented across the country; therefore MSD would propose that measurement of this standard captures adherence to this guidance. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/333059/Blood_borne_virus_testing_in_prisons_process_guidance_notes.pdf MSD would also recommend that the following factors are taken into consideration: • Clear linkage to care pathway for patients subsequently diagnosed with a BBV (ability to access DAA treatment via local ODN, whether through in-reach or virtual service delivery)

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			• Provision of advice about treatment and prevention; advice on risk avoidance and contraception for prisoners who test negative for BBV or sexually transmitted infections (STIs) • Provision of adequate psychosocial support for all prisoners undergoing BBV and STI testing • Sharing of past test results as prisoners are transferred between prisons and upon release into the community The data source for quality statement 3 is described as “local data collection.” As the success of this quality statement will rely heavily on accurate and timely delivery of testing by prison staff, MSD would recommend also factoring in demonstration of adequate training and support that enables positive and consistent service delivery, and appropriate referral of prisoners at the point of opt-out being offered.
66	NHS England North West Health and Justice	Statement 3	Rationale – BBV testing should be routine and as per national guidance we Opt out should be in place since 2016. Therefore the wording in this section is confusing – offering opt out screening is Opt in. Suggested wording : BBV screening should be performed routinely when people enter and transfer prisons. Healthcare professionals – Routinely perform BBV screening on all people entering and transfer prisons. This section heavily focusses on sexual health / infections. Needs to include offering of support to patienst who have been diagnosed with BBV. Also anyone previously diagnosed – need follow and referral into appropriate specialist services. Question for consultation Yes this should be a performance measure – in the north west we have added it to quality monitoring of all our providers.
67	Prison Governors Association	Statement 3	Could this be extended to include screening for all drugs ? We fully understand the reason for this element, our thoughts would be that the people most at risk would possibly be the most reluctant to undergo this test at the point of entry in to custody ? This may skew the outcomes as we could foresee a number of new entrants refusing to undertake this test during their early days in custody. Whilst not part of this standard is there any reason why the testing for illicit drugs is not being included?
68	Prison Governors Association	Statement 3	We think any measures of performance should take account of the effort and commitment shown by the provider in achieving outcomes - It is difficult to see how improvement can be used as a measure given the very complex and chaotic lives some of the service users have prior to custody - Consideration of the length of time users spend in custody and their personal commitment to engage should also be factored in - Sadly a large number of our service users have 'opted' out and have not engaged in a whole range of processes - On occasion, however well meaning and right, we sometimes feel the expectations on treatment and engagement are too high.
69	Obesity Group of the British Dietetic Association	Statement 3	In our view it makes sense to measure whether testing has been offered at the second stage health assessment as a pragmatic measure. However it would be ideal if testing was done on entry to prison to identify high risk individuals as soon as possible (for their own sakes and those of other prisoners and staff).
70	Public Health England	Statement 3	Public Health England (PHE) welcomes the inclusion of this statement of offering blood borne virus (BBV) testing and assessment of sexually transmitted infections. This will not be difficult to measure as it is already being measured and monitored through the Health & Justice Indicators of Performance (HJIPs). The measurement of performance should focus on the second stage as the guidelines advices that the screening should ideally take place within 72 hours and no more than 7 days.

ID	Stakeholder	Statement No	Comments[1]
71	RCGP	Statement 3	• This statement focuses on a process that can be measured. For prisoners who receive a high number of short sentences, this can result in them being tested frequently and sometimes within a time frame where there maybe no more clinical benefit (ie less than three months from the previous test) . • It is possible to achieve this standard without achieving the clinical outcome of identifying, relaying appropriate clinical information to the patient, referring (where required) and treating any BBVs identified in a timely way through an appropriate clinical pathway.
72	Royal College of Physicians and Surgeons of Glasgow	Statement 3	This standard is welcomed and individuals need to be encouraged to have such screening. Presumably Blood Borne Virus screening takes place at the second stage health assessment. Should the denominator therefore be the number of people with who are in prison for 7 days or more? Our reviewer considered measurement of quality of performance in relation to statement 3 should focus more on the second-stage health assessment than the first. The rationale is that at the first stage health assessment, the risk of the inmate having a sexually transmitted infection has already been undertaken, and any specialist support and/or treatment (if required) is prescribed. Thus, focusing on performance at the second-health assessment may allow for a better assessment of whether the relevant course of action and referrals to specialist care that are being prescribed at the first health-assessment are being followed through at the second health assessment, and that they are producing the intended outcomes.
73	Women in Prison	Statement 3	We fully endorse offering optional blood borne virus testing when people enter prison in order to facilitate support and treatment. We see no reason why this testing cannot form part of the initial health screening and information be collated by healthcare staff on existing systems. We insist, however, that this testing is optional, not compulsory. Women we work with have told us that they have had blood tests without knowing what they are for which is clearly not acceptable. As with other quality statements, staffing resources might be an issue. However, there are already examples of good practice across the estate with certain prisons having Hepatitis C clinics and specialist nurses in place. We would like to see this as a standard feature of prison healthcare. We also fully support voluntary assessments of a person's risk of sexually transmitted infections to enable testing and treatment. As with other assessments of women prisoners, full disclosure and honesty is much more likely with female healthcare professionals and any physical examinations of women prisoners should be undertaken by female staff only. Not only is this a general point in relation to women but it is particularly important in prison settings given the heightened vulnerability of women prisoners. As a group, women prisoners face disproportionate levels of violence and abuse, including sexual violence. The majority of women in prison have experiences of domestic and/or sexual abuse; it is therefore important that healthcare and other staff are mindful about this fact when speaking to women about their sexual health and sexual history. For women prisoners, sexual health can also be linked to involvement in prostitution, hence adding an additional layer of complexity. We agree that these discussions should take place during the second-stage health assessment as the lapse of time since entry to prison should enable women to be in a better place mentally to speak about and reflect on their lifestyle.

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74	Foundation for People with Learning Disabilities (part of the Mental Health Foundation)	Statement 4	We very much welcome the proposal for a lead care co-ordinator. NHS England (London) has funded learning disability co-ordinator posts for each prison. A recent audit (report being finalised) found that such posts were beginning to make a difference to the identification of people with learning disabilities and to the co-ordination of their care – both within the prison (across both healthcare and the prison regime) and in planning for release.
75	Foundation for People with Learning Disabilities (part of the Mental Health Foundation)	Statement 4	We believe strongly that this statement should focus on people with learning disabilities or autism as an absolute minimum. The case has been made in both project reports (such as the prison Reform Trust's 'No One Knows' project) and inspection report (Criminal Justice Joint Inspectorate). As noted above, some practical evidence of benefit is beginning to emerge. There is an argument for including anyone with neurodevelopmental disabilities.
76	The Hepatitis C Coalition	Statement 4	Prisons should have clear and established pathways for an individual diagnosed with a BBV into treatment and care within the prison.
77	The Hepatitis C Coalition	Statement 4	The Hepatitis C Coalition supports the provision of a lead care coordinator for people in prison who have complex health and social care needs. As noted in the 'Definition of terms used in this quality statement', both BBVs and substance misuse are examples of a complex health and social care need. With many hepatitis C patients acquiring the infection through injecting drug use, people with the virus are undoubtedly a group that can be said to have complex health and social care needs. As such, hepatitis C patients are a group that would benefit from the provision of a lead care coordinator, who would be able to help patients to access treatment and, where necessary, support dealing with other complex needs.
78	The Hepatitis C Trust	Statement 4	The Hepatitis C Trust supports the provision of a lead care coordinator for people in prison who have complex health and social care needs. As noted in the 'Definition of terms used in this quality statement', both BBVs and substance misuse are examples of a complex health and social care need. With many hepatitis C patients acquiring the infection through injecting drug use, people with the virus are undoubtedly a group that can be said to have complex health and social care needs. The Hepatitis C Trust believes in adopting a syndemic approach to understanding hepatitis C. Such an approach recognises the presence of two or more states that negatively interact with each other, such as hepatitis C, substance misuse, homelessness and mental health issues. These states, as well as the social, environmental and economic contexts in which they occur, negatively affect each other and heighten the vulnerability and inequity faced by the individual. As such, hepatitis C patients are a group that would benefit from the provision of a lead care coordinator, who would be able to help patients to access treatment and, where necessary, support dealing with other complex needs.
79	Her Majesty's Inspectorate of Prisons	Statement 4	**Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement? **Quality Statement 4** - ***People in prison who have complex health and social care needs have a lead care coordinator*.** This is a key and appropriate area to focus on, although it may be helpful to define complex health and social care needs as we observe significant variation in how this is perceived and managed.

ID	Stakeholder	Statement No	Comments[1]
80	Her Majesty's Inspectorate of Prisons	Statement 4	**Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? **Quality Statement 4 –** This may be difficult currently where the complexity is the combination of conditions. On page 15 the last paragraph suggests that for measurement purposes, service providers and commissioners may wish to focus on prisoners with specific needs such as those with alcohol or drug dependency or diversity characteristic. In our view the real challenge and "complexity" is where a person has more than one condition and is being cared for across different teams, which can contribute to incoherent care and competing priorities such as receiving Opiate Substitution Treatment, having chronic pain and being on complex polypharmacy and mental health issues. A clear definition and read code would assist. We commended HMP Stocken in our last inspection in its clear identification and management of those with complex needs including the allocation of a lead care coordinator.
81	Her Majesty's Inspectorate of Prisons	Statement 4	**Question 3 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.** **Quality Statement 4 –** Most prisons we inspect can identify those with life long conditions, mental health problems, substance misuse needs, palliative care and end of life and social care needs. However they are often less effective at coherently identifying those with complex needs, partly because primary care, mental health, substance use and social care function largely separately and there is insufficient clarity as to when a significant health problem becomes a complex one. Additionally many prisons struggle with recruitment and retention of staff and this often impacts on the proactive management of life long conditions. We observe that the weakness in many prisons is systems and coherent partnership working. A clear national definition of complex needs and guidance on effective care coordination is necessary.
82	Her Majesty's Inspectorate of Prisons	Statement 4	**1. Question 5 For draft quality statement 4: Should this statement focus on a specific subpopulation of people in prison who have complex health and social care needs? If so, what should this population be?** As stated above rather than focusing on a specific subpopulation it would be desirable to define complexity with a focus on those that are being treated by more than one of the prison health subteams (primary care, mental health, substance misuse or social care) on an ongoing basis or require significant input or monitoring such as in receipt of dialysis, cancer treatment, end of life care, unstable/brittle diabetes/COPD, experiencing a severe mental health crisis such as psychosis or under CPA.
83	Leeds Community Healthcare	Statement 4	**Question 5** For draft quality statement 4: Should this statement focus on a specific subpopulation of people in prison who have complex health and social care needs? If so, what should this population be? Yes. We would need to define complex health needs specific to the younger population – possibly long term conditions. Social care relates more to the adult population.
84	MSD Ltd	Statement 4	For statement 4, MSD suggest giving consideration to prisoners that are actively injecting drugs. Individuals in this cohort often have comorbidities such as mental health issues, and have a relatively high prevalence of HCV particularly in the prison setting. Management of these individuals' complex health needs requires a multidisciplinary approach that also considers ongoing support if the prisoner transfers to another facility and especially upon release, as these individuals often have temporary and unsecure living arrangements outside the prison environment.
85	NHS England North West	Statement 4	Quality measures – data source – Should also include service providers to focus on those with complex needs such as older prisoners etc

ID	Stakeholder	Statement No	Comments[1]
	Health and Justice		Healthcare professionals – the prison service have a responsibility for the management of low level social care needs also. There is a disability liaison officer in each prison who manages complex needs. This section should also read assessed social care needs – otherwise all people with mobility needs etc would be referred to the healthcare unit to manage, this is already causing issues with the blocking of in patient beds in the prisons. Question for consultation – this should read assessed social care needs
86	Obesity Group of the British Dietetic Association	Statement 4	We agree that a lead care coordinator should be identified for those with complex needs. This is particularly important for those in transition e.g. between different prisons, or leaving prison, and needs to include handover to local health services for those leaving prison.
87	Obesity Group of the British Dietetic Association	Statement 4	No, in our view all those with identified complex health and/or social care needs should be included.
88	Prison Governors Association	Statement 4	We feel that this would be achievable and understand the rationale behind this.
89	Prison Reform Trust	Statement 4	This statement rightly identifies a range of prisoners likely to have complex health and social care needs (page 17). Prisoners with autism should be added to this list. The statement should focus on the specific subpopulation of people with learning disabilities, many of whom will also have mental and physical health conditions. A cross reference to prisoners with assessed social care needs should be made, including both eligible and non-eligible social care needs.
90	Prison Reform Trust	Statement 4	This statement could also refer to subpopulations in which an increased likelihood of deterioration of physical and mental health needs would benefit from regular contact from healthcare services, such as older people in prison and all persons detained in segregation units.
91	Public Health England	Statement 4	Need further clarification on staff groups within scope of definition of 'lead care coordinator'. Given remit is to "manage a person's care, particularly when they have complex health and social care needs", it is not entirely clear if focus on health or social care teams or custodial teams- requires clarification. Suggested focus on "prisoners with specific needs such as those with alcohol or drug" is not helpful and may skew both activity and outcome. No reflection of local authority responsibility for social care for those in prison but this is an important dataset to describe element of numerator.
92	Public Health England	Statement 4	Too narrowly focused: Unplanned hospital admissions of people in prison. Good management of health & social care needs should drive up the number of people registered with a general practitioner at discharge (compared to reception- evidenced by National Health Service number); drive up numbers with planned care plan on transfer or discharge, and perhaps address wider determinants like housing, employment, access to welfare payments etc. on discharge.
93	Revolving doors agency	Statement 4	As highlighted in our recent publication Rebalancing Act (available at: http://www.revolving-doors.org.uk/file/2050/download?token=m-t2NRKC) highlights, levels of health, care and social support needs in prisons are high and the prevalence widespread. This would make introducing standard criteria to identify a particular sub-population problematic. For Revolving Doors Agency's population of interest, a common experience is where multiple sub-threshold problems (such as from among the seven conditions identified in the draft) combine to have a significant and adverse effect on the individual.

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			We would hope that the final quality standard will provide guidance to providers to be mindful of cumulative and combinative health effects of conditions such as mental ill health, learning disability/borderline learning disability, substance misuse and so on. The standard should also be clear about how these health problems can be compounded by non-health support needs such as low literacy, low educational attainment and, upon release, negative or harmful social networks and, on resettlement, distance from the labour market, lack of pro-social networks and housing problems.
94	RCGP	Statement 4	• This is a measurable standard. • An additional standard that might ensure good quality care would be 'People in prison who have complex health and social care needs have a care plan in place that is developed and has input and regular updates from a multidisciplinary team.
95	Royal College of Physicians and Surgeons of Glasgow	Statement 4	This standard is welcomed provided that it is providing a lead coordinator it is not to the detriment of others with lesser but still important needs. Our reviewer felt it is difficult to judge whether focusing on a specific subpopulation would produce more beneficial outcomes. This could be problematic for the following reasons. The recommendation with respect to this statement is that prisoners for whom multidisciplinary care and support is essential must have a lead coordinator to ensure that a wide variety of needs are met, some of which will apply to larger portions of the prison population, such as alcohol and drug addiction and sexually transmitted diseases, that cut across a wide pool of individuals. Then there are health needs that are more specific to smaller portions of the prison population, including individuals with very specific requirements. The latter might include specific physical and mental health requirements and behavioural problems. It is possible that focusing on just one subpopulation would be to the exclusion, and possibly detriment, of the individuals that could be classified under other groups which fall outside the focus of the target group. All individuals to whom this statement applies face greater risks with respect to their health and wellbeing if they do not receive a multidisciplinary care plan that is sensitive to, and can accommodate, all the health and social care requirements they need. As such, it would be difficult to determine who should be the focus of the statement, and who should not. Thus, to uphold the standard as stated in the document of treating the prisoner as an individual, ensuring their wellbeing and continuity of medical care, this statement would be more effective if it focused on the needs of prisoners on a case-by-case basis at least from the time of the second health assessment, if not the first, instead of isolated subpopulations.
96	Women in Prison	Statement 4	We always advocate for a multi-agency approach and coordination of support services available to women prisoners, given the overall complexity and multiple needs of this client group. Arguably, almost all women in prison have complex health and social care needs, especially if we include mental health and substance misuse in this definition. While the role of a lead care coordinator would be helpful to ensure communication with multidisciplinary teams and help ensure care and support for those with multiple needs, we have concerns that this is unrealistic in practice. Due to lack of healthcare resources and staff shortages, it is clearly unrealistic for all women prisoners to have a designated lead care coordinator. This means there would need to be more specific criteria to qualify for such support, the details of which would need to be refined in order to be realistic in practice. Arguably, those women who have particularly severe support needs

ID	Stakeholder	Statement No	Comments[1]
			already have some form of additional support in place, for example from Adult Social Care or from Mental Health In-reach. We fear that a Lead care coordinator would simply add an additional level of bureaucracy to service provision. Any care coordination inevitably requires multi-agency meetings and admin tasks, time that is already in short supply for many professionals. Arguably, the money set aside for this role would be better allocated to increase healthcare staff posts, especially across the mental health teams.
97	AbbVie UK Ltd.	Statement 5	• Statement 5 relates to the transfer or discharge of an individual from prison. In particular reference to homelessness and sheltered accommodation is made which is welcome and recognises the often complex housing arrangements for an individual upon release from prison and the vulnerability this causes. • AbbVie believes local structures do exist in certain areas for the above metrics and objectives to be achieved and that the provision for them can be achieved in those areas currently lacking. However, it is clear that a mandate from government regarding the importance of effective diagnosis, treatment and care within the prison setting of BBVs is required. • In the case of hepatitis C NHS England must ensure Operational Delivery Networks are adequately funded to be able to provide the necessary in-reach services to prisons and the necessary support for individuals upon release back into the community to commence, maintain or complete treatment and achieve Sustained Virological Cure.
98	Her Majesty's Inspectorate of Prisons	Statement 5	**Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement? **Quality Statement 5** ***People being transferred or discharged from prison are given a minimum of 7 days' prescribed medicines or an FP10 prescription.*** It is positive to focus on release and the minimum of 7 days is appropriate, but it may need to include reference to community prescribing being set up as occurs for opiate substitution treatment. Currently in most cases those on opiate substitution treatment will have community prescribing or an assessment appointment set up. It would be helpful to specify that the standard includes other controlled drugs, as we regularly see instances where prisoners receiving tramadol or other non OST controlled drugs do not have appropriate continuity of prescribing arrangements in place. It is helpful that the standard suggests a risk assessment is carried out to consider whether a prescription or FP10 should be used. However there is a wider consideration about the individual understanding how to access community services and being able to do so. Many prisoners have easier access to some health services than in the community, although the choice of providers is much less. Many people will routinely wait more than 7 days to obtain a routine GP appointment. There may need to be a greater focus on supporting prisoners to set up community appointments to support continuity of care and tailor the take home medication to that, This will be particularly important for those with complex health needs or who have been in prison for a long time and will not understand how to engage effectively in their local health structures. It should be noted that some medicines would not be dispensed or an FP10 provided i.e. substance misuse treatments and some hospital only medicines– in these cases arrangements would be made to transfer care and the supply made via the new provider - so the standard needs to embrace other appropriate arrangements being made.
99	Her Majesty's Inspectorate of Prisons	Statement 5	**Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? **Quality Statement 5 –** Generally systems are already in place for this.

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100	Her Majesty's Inspectorate of Prisons	Statement 5	**Question 3 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.** **Quality Statement 5 –** Generally resources are in place for planned discharges. Sudden discharges from court or from the prison on bail can be much more problematic particularly in prisons that rely on the use of stock medication.
101	MSD Ltd	Statement 5	MSD is concerned that from a linkage to care perspective, 7 days may be insufficient to ensure that individuals with HCV can receive their prescriptions as DAA medications need to be prescribed by a consultant. In many cases patients may be released to temporary/homeless facilities or may not have a fixed address, which would also prevent registration with a GP. MSD would recommend that any measurement of statement 5 captures evidence of clear continuity of care plans for prisoners upon transfer to another facility or release, including active referral to the corresponding GP, local drug and alcohol services, and community pharmacy where relevant.
102	Napp Pharmaceuticals Limited	Statement 5	Q1.Does this draft quality standard accurately reflect the key areas for quality improvement? Please see our comments above and suggestion for an additional Quality Statement.
103	NHS England North West Health and Justice	Statement 5	No comments
104	Prison Governors Association	Statement 5	We fully support this - Has any consideration been given to the types of medication and whether they would be allowed at other sites? Some establishment have restrictions in place as to the types of medication they will allow (I dont know why)
105	Prison Reform Trust	Statement 5	We strongly support this statement and practice. Cases where this does not happen can have disastrous consequences for individual rehabilitation, leading to deterioration of wellbeing as well as being a potential trigger for a quick return to prison. Consideration should always be given to where and when a person will next be able to get medication prescribed – in some areas it can be difficult to get a GP appointment for a matter of weeks.
106	Public Health England	Statement 5	PHE welcomes this statement that people transferred or discharged from prison are given a minimum of 7 days' prescribed medicines or FP10 prescription. We don't believe this should apply to any subpopulation as most of the people leaving custody will have multiple complex needs and/or will have difficulty accessing healthcare on immediate release
107	RCGP	Statement 5	• This is a measurable standard. There would need to be clear guidance on the prescription of Controlled Drugs
108	Royal College of Physicians and Surgeons of Glasgow	Statement 5	The FP10 prescription should cover controlled drugs such as methodone? It will be essential for 7 days access to controlled drugs but not appropriate to leave with 7 days supply of such products. It would be helpful if wider health and social care needs were stated at discharge and that a clear support system and plan with health and Social Service liaison was in place before discharge.
109	Royal Pharmaceutical	Statement 5	HJIP data picks up transfers and discharges with 7 days of medicines however it is not explicit what this HJIP or QS actually refers to i.e.

ID	Stakeholder	Statement No	Comments[1]
	Society (RPS) on behalf of Secure Environment Pharmacists Group (SEPG)		1. Number of TTOs prescribed/or those released with in-possession medicines already prescribed 2. Those released/transferred with a supply dispensed from pharmacy 3. Those released/transferred with an actual physical supply of medication Depending on whether 1,2, or 3 – data collection could range from simple to requiring regular audits. Issuing FP10s for those with substance misuse problems may be dangerous. Giving an unstable person 7 days' supply of methadone/chlordiazepoxide or an FP10 for the same with no monitoring system in place may be unsafe. Some may require supervised methadone/buprenorphine consumption however this needs to be pre-arranged with community pharmacies and will not take place on a Friday afternoon.
110	Women in Prison	Statement 5	We fully agree that women should be discharged with a 7-day supply of medication (where applicable). In theory, this is already the case. However, far too often women are released without any medication at all or with the wrong medication. This is particularly concerning where women are released from prison without correct medication on a Friday afternoon, without any possibility of visiting a GP until the following week. Transfer of medical records can also take a very long time due to the usage of different systems. We would suggest that women leaving prisons have healthcare exit appointments in advance of discharge rather than on the same morning as is often the case. As suggested in the draft guidelines, the second stage health assessment should include looking at release dates to plan pre-release health assessments, where release is imminent. However, for women on longer sentences, there must be another mechanism in place for flagging up release dates in order to arrange pre-release health assessments. It can be difficult to plan ahead for releases in prison as women are sometime released relatively suddenly on Home Detention Curfews or after parole hearings. However, more forward planning would enable healthcare staff to prescribe accurate medication, supply women with medical notes and ensure transfer to a GP in the community. Far too many women leave prison without having a named GP in the community, not knowing how to register with a GP and without the required forms of ID. There are, however, schemes in certain prisons to rectify this, for example, a project commissioned by Public Health England taking place in HMP Downview to set women up with a GP before leaving prison.
111	AbbVie and The Hepatitis C Coalition	Additional areas	The intention to develop and implement a NICE quality standard covering the physical health of people in prisons is welcome. Of particular importance is the recognition of the need to address Blood Borne Viruses (BBVs) within the prison setting. Effectively implementing testing, diagnosis and care pathways within this setting will play a significant role in supporting the UK in eliminating hepatitis C as a public health concern by 2030. However, the quality standard should include a focus on ensuring there are robust pathways in place for those individuals who are diagnosed with a BBV and are then discharged either before commencing treatment or after treatment has commenced. Individuals must be referred to a named healthcare professional so that any treatment and care needs can be maintained upon release. If this is not done the true benefit of an opt-out BBV approach will not be realised and the system will simply be diagnosing individuals with potentially life threatening conditions and then not adequately caring for them. Innovative community based support programmes, particularly those run by third sector organisations and providers, will be particularly relevant in this regard as will in-reach health services. In the case of hepatitis C, the Operational Delivery Networks have a vital role to play in ensuring joined-up and coherent patient pathways are in place across their geography between prisons and the community.

ID	Stakeholder	Statement No	Comments[1]
			The quality standard should include a metric to measure and encourage the referral into specialist care of all those individuals for whom a positive diagnosis of a BBV is found. The provision of prison services and laboratory testing of BBVs are procured on a tender basis and providers may therefore change. As such, disruption and variation of services may occur. The quality standard should therefore make clear the minimum standard and requirements of testing to ensure all services apply a similar approach.
112	The Hepatitis C Coalition and The hepatitis C Trust	Additional areas	The Hepatitis C Coalition supports the requirement for people being transferred or discharged from prison to receive a minimum of seven days' prescribed medicines or an F10 prescription. Where a person being discharged from prison has been diagnosed with hepatitis C while in prison, but not started treatment, The Hepatitis C Coalition proposes a requirement that an onward referral be made to treatment services in the community, in order to ensure that patients remain engaged in the care pathway. It is important to stress that even a 24 hour gap in HCV anti-viral therapy can impact on treatment outcome and that all measures should be taken to avoid any interruption of treatment. There should also be clear pathways in place for those many prisoners in remand who may get diagnosed within prison but released before any treatment commences. Ensuring they are mapped properly into care upon liberation is important to ensure it's not a missed diagnosis opportunity. Given the lack of decent in-reach services in most prisons a lot of the individuals testing positive within prison aren't able to actually access treatment when in prison, making referral into care following their release even more important.
113	The Hepatitis C Coalition and The Hepatitis C Trust	Additional areas	The Hepatitis C Coalition proposes an additional Quality Statement that requires prisons to ensure that 'in-reach' treatment provision is available for all prisoners who are diagnosed with hepatitis C, and for the patient to be receiving treatment within eight weeks. People can be initiated into hepatitis C treatment very quickly, with eight weeks a realistic length of time in which to do so. We would also suggest that a minimum target of opt-out testing should be imposed on all prisons.
114	IOM Prison Healthcare Department	Additional areas	(Ensure the person can keep taking their medicines after coming into prison 1.7.10) Ordinarily, this would be the case; however, many drugs prone to abuse are discontinued in prison and alternatives prescribed (as per RCGP Safer Prescribing in Prison guidelines 2011) to prevent bullying and diversion of medication. I think the standard needs to reflect this.
115	Napp Pharmaceuticals Limited	Additional areas	***People being transferred or discharged from prison are given a minimum of 7 days' prescribed medicines or an FP10 prescription*.** We agree that this an important arrangement in order to continue care for those people leaving prison and that there should be measures in place. We feel that an opportunity has been missed to minimise the number of deaths from opioid overdose. Risk of an overdose increases more than seven fold in the first fortnight following release and one in every 200 prisoners with a previous history of heroin injecting will die of a heroin overdose within the first 4 weeks following release from prison. Farrell and Marsden (2008) state that of 442 deaths recorded in 48,771 prisoners on release, 59% were drug related. Singleton et al (2003) suggest that there is an excess mortality ratio related to time from release and this is at its highest in weeks 0-1 and 1-2 from release.

ID	Stakeholder	Statement No	Comments[1]
			We believe that there is sufficient evidence to support the inclusion of Take Home Naloxone (THN) as a specific measure. This preventative medicine could be given to all prisoners who are known to have abused opioids whilst in prison. There is a particularly high rate of drug overdose deaths (mostly involving heroin or other opioids) amongst heroin using prisoners following release from prison. This may need to be covered in a separate Quality Statement.For example we would suggest a new QS could read: **NEW Quality Statement 6** ***People being transferred or discharged from prison with a history of opioid abuse are given a Take Home Naloxone (THN) kit and referred to drug counselling services***. Singleton N, Farrell M and Meltzer H. Int Rev Psych 2003;15:150-152. Farrell M and Marsden J. Addiction 2008;103:251-255.
116	Public Health England	Additional areas	There is no specific standard on the first-stage health assessment at reception into prison - this is a significant omission as a) the quality of this assessment is a key determinant of both immediate health (and social care) needs as well as of subsequent patient management; b) 'first night' assessment includes review of risk of suicide and risk of self-harm, and c) first night assessment includes assessment of immediate needs for management of pain, drug dependence and nicotine-dependence as well as other prescribed medication. First stage assessment should include offer of Hepatitis B vaccine and/or ascertainment of need as well as provide opportunity to sign-post patients to health services in prisons. The lack of a quality standard to support NICE guidance around nature and content of assessment; when it is conducted and by whom (include statements on qualifications/grade of staff) could undermine impact of other aspects of physical (and mental) health.
117	Public Health England	Additional areas	There is no quality statement relating to 1.3 of the NICE guidance on the Physical health of people in prison – Promoting Health and Well Being. This is a very important element of prevention of ill health in a vulnerable population group. If a quality statement is not included it will not be focussed on for delivery and audit. There needs to be an additional quality statement, 'People in prison are given lifestyle advice to improve their health and offered the opportunity to partake in physical exercise'. This offer of advice can be recorded on system one and the outcome monitored.
118	Public Health England	Additional areas	A quality statement needs to be included relating to tuberculosis (TB) screening. 'People in entering prison are screened for TB within 48 hours'. Current evidence from large outbreaks shows that this is not routinely happening and the financial and ethical cost of large contact tracing exercises is extensive. It is important this is specifically included as this will focus providers on the delivery of screening.
119	Public Health England	Additional areas	There is no quality statement regarding the section 1.7 of the guidance- Continuity of healthcare. There needs to be a quality statement, 'People leaving prison who have complex health needs have to have a pre- release health assessment and post release action plan'. Continuity of care is best supported by ensuring prisoners are appropriately registered with primary care providers and referred to, if required, to specialist care, during incarceration and on release. A quality standard is needed as there is large variation on this element of care and it is very important in reducing the risk of suicide on release but also for those who with substance misuse problems and for those need continuation of care and review for a long term condition. The audience for this standard should also include those responsible for the care of people as they leave prison i.e. within the community e.g. Clinical Commissioning Groups. The Community Rehabilitation Companies and Probation Service also have a role in delivering this standard. Support to deliver this standard needs to link to standard 4. There is community dividend/ return on investment consideration – appropriate ongoing support reduces the demand on expensive emergency care

ID	Stakeholder	Statement No	Comments[1]
120	Department of Health	No comments	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
121	NHS England	No comments	We can confirm that there are no comments to be made on behalf of NHS England.
122	RCN	No comments	This is to inform you that the Royal College of nursing has no comments to submit to inform on the Physical health of people in prison quality standard consultation

Registered stakeholders who submitted comments at consultation

- AbbVie UK Ltd
- British Dietetic Association Obesity Group
- British Infection Association
- Department of Health
- Foundation for People with Learning Disabilities (part of the Mental Health Foundation)
- The Hepatitis C Coalition
- The Hepatitis C Trust
- Her Majesty's Inspectorate of Prisons
- Isle of Man (IOM) Prison Healthcare Department
- Leeds Community Healthcare
- MSD Ltd
- Napp Pharmaceuticals Limited
- NHS England
- NHS England North West Health and Justice

- Prison Governors Association
- Prison Reform Trust
- Public Health England
- Revolving Doors Agency
- Royal College of General Practitioners (RCGP)
- Royal College of Nursing
- Royal College of Physicians
- Royal College of Physicians and Surgeons of Glasgow
- Royal Pharmaceutical Society (RPS) on behalf of Secure Environment Pharmacists Group (SEPG)
- Women in Prison