



Commissioning healthcare in prisons

The results of joint work between the Healthcare Commission and Her Majesty's Inspectorate of Prisons in 2007/08

February 2009

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ISBN: 978-1-84562-213-8

Concordat gateway number: 152

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The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission's role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare.

The Healthcare Commission aims to:

- Safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.
- Promote the rights of everyone to have access to healthcare services and the opportunity to improve their health.
- Be independent, fair and open in our decision making, and consultative about our processes.

On 1 April 2009, the Care Quality Commission, the new independent regulator of health, mental health and adult social care, will take over the Healthcare Commission's work in England. Healthcare Inspectorate Wales will become responsible for carrying out our activities relating to Wales.

Her Majesty's Inspectorate of Prisons

Her Majesty's Inspectorate of Prisons for England and Wales (HMI Prisons) is an independent inspectorate which reports on conditions for and treatment of those in prison, young offender institutions and immigration removal centres.

HM Chief Inspector of Prisons is appointed from outside the Prison Service, for a term of five years. The Chief Inspector reports to the government on the treatment and conditions for prisoners in England and Wales and other matters.

The Prisons Inspectorate also has statutory responsibility to inspect all immigration removal centres and holding facilities and has been invited to regularly inspect the Military Corrective Training Centre in Colchester. In addition, HM Chief Inspector of Prisons is invited to inspect prisons in Northern Ireland, the Channel Islands, Isle of Man and some Commonwealth dependent territories.

Summary

For the second year, the quality of the provision of healthcare in prisons was variable. The assessment of needs for healthcare is paramount and comprehensive assessments for this group of patients have not always driven development and provision of healthcare services. The result of this is that the service delivered has not always best met the health needs of individual prisoners.

Although primary care trusts (PCTs) have emphasised the importance of an assessment of health needs to inform their priorities and strategies for commissioning services, the majority of PCTs did not have such an assessment, or had not completed it. Overall, there has been some improvement in the commissioning of healthcare in prisons, but further work is needed to ensure that specific areas, such as access to health services and the assessment of health needs, are addressed.

PCTs must ensure that prisoners' needs for healthcare are regularly assessed, agreed and signed off by PCTs' boards. They should also have processes to monitor these agreements.

There were links with the PCTs' overall structures of governance, with information about prisons being communicated to PCTs' boards and other governing committees.

Collecting information about healthcare in prisons was restricted by a lack of IT: the implementation of electronic records was at an early stage and some prisons used a system that was paper-based. PCTs need to adopt a more structured approach to resources, to clarify where

budgets for healthcare in prisons sit within PCTs, so that it is seen to be a priority.

Use of service level agreements (SLAs) in monitoring healthcare in prisons appeared to have increased since 2006/07, when just one PCT mentioned that data was required in their SLAs for health services for prisons. All PCTs confirmed they had SLAs in place.

There are other types of data that PCTs used to monitor prisons' performance including:

- Comparison with the Department of Health's *Standards for better health*.
- Indicators of national performance for prisons or other wider targets for PCTs, such as access to GPs and dental services.
- Monitoring contracts.

All PCTs appeared to have processes in place for managing serious untoward incidents (as was the case in 2006/07 for most PCTs), which informed their overall system for reporting incidents.

However, for the second year we found very limited evidence of clinical audit¹ of health services for prisons. This was mainly because PCTs found it difficult to gain access to clinical information due to the lack

¹ Clinical audit is the process formally introduced in 1993 into the United Kingdom's National Health Service (NHS), and is defined as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change".

of computerised records and data in prisons, with some prisons still using a system that is paper-based. Clinical audit is extremely important, as it is the best way for PCTs to find out where improvement in services is taking place and identify areas where improvement needs to be made.

Similarly, although some PCTs told us they collected national data, such as national service frameworks and information on quality relating to GPs, this was restricted in many cases by a lack of IT systems. We recorded that only two PCTs could demonstrate clinical audit activity being used to improve health services in prisons.

We found that PCTs that employ the staff in the prisons in their areas provided training that was said to be in line with that provided to all their other staff. This was less clear, however, for staff that are employed by the prison.

Similarly, PCTs gave us a mixed response about how they monitored training. For some PCTs, it was through reviews of performance and appraisals, while others kept databases or had no current system for monitoring in place.

Planning relating to the workforce did not appear to be well advanced. Some PCTs were taking this forward, while others said that it needed to be reviewed. Two PCTs told us that such planning would be done through the assessment of health needs.

PCTs identified assessments of health needs as being the main means of addressing the needs of black and minority

ethnic (BME) prisoners and monitoring the ethnicity of the people in prison. A small number of PCTs have employed, or were due to employ, community development workers to help with these assessments locally.

Some PCTs said that they used the National Institute for Mental Health in England's (NIMHE) BME strategy, although more said that they did not use the current strategy, despite being aware of it. As such, although PCTs' awareness of NIMHE's BME strategy has improved since 2006/07, the use of it is still limited.

Five PCTs said that complaints were reported to their prison partnership board, and five PCTs were unclear about how complaints were dealt with in their management systems.

Involving users of service has been challenging for PCTs. There appeared to have been some progress since 2006/07 when there was little evidence of the involvement of users by most PCTs interviewed.

Over half of the PCTs told us that they have some processes for transferring or releasing prisoners, or that these were currently being addressed. However, PCTs' arrangements seemed to vary widely, depending on the type of prison and the prisoners' circumstances. PCTs must continue to ensure that they have arrangements in place for the continuing care, transfer and release of prisoners and that compliance with these arrangements is routinely monitored.

PCTs rarely commissioned court diversion schemes², although in some cases such schemes were commissioned by other groups.

Summary of recommendations

PCTs should:

- Ensure that prisoners' needs for healthcare are regularly assessed, agreed and signed off by PCTs' boards.
- Clarify where the resources for healthcare in prisons sit within their overall budgets.
- Continue to measure performance within wider PCT targets, by using offender health indicators of performance, for example.
- Promote the development and implementation of electronic records to improve clinical audit.
- Provide their staff with specific training that addresses prisoners' needs for healthcare.
- Improve their strategies that ensure that prisoners receive equal access to healthcare, identifying the needs of black and minority ethnic groups more effectively.
- Regularly seek and record prisoners' feedback and complaints about healthcare services to improve their management systems.
- Ensure that their prisons are implementing drug treatment systems.
- Continue to ensure that they have arrangements for the transfer and release of prisoners and that compliance with these arrangements is routinely monitored.

The Healthcare Commission and its successor organisation, the Care Quality Commission, will monitor whether these recommendations are actioned by PCTs.

² Court diversion schemes divert offenders with mental health problems out of the criminal justice system and into appropriate health services.

Background

The Healthcare Commission and Her Majesty's Inspectorate of Prisons (HMIP) signed a memorandum of understanding in October 2005, setting out how we would cooperate and communicate our work on inspecting health services in prisons.

HMIP inspects the delivery of healthcare and the management of substance misuse within its overall programme of inspections, which occur regularly and on the basis of a risk assessment. All prisons will be inspected within a five-year rolling programme. The sample used in this report is based on HMIP's 2007/08 inspection programme. It inspects prisons by reference to a set of criteria known as 'expectations', which are linked to the *Standards for Better Health*.

Alongside each of the Inspectorate's announced prison inspections, the Healthcare Commission visits the PCT and conducts a structured interview regarding the arrangements for, and effectiveness of, the PCT's commissioning of healthcare services in prisons. PCTs' arrangements for the governance of their commissioning of health services and psychiatric services in prisons are also reviewed. This information is shared with the HMIP at the time of its inspection and is also used to inform the annual health check for PCTs in 2006/07. This information is fed into the screening process for cross-checking against trusts' declarations.

The questionnaire asked questions relating to: priorities for commissioning and delivering healthcare, budgets, governance arrangements, monitoring performance,

risk management, clinical audit and use of information, death in custody, staffing, training and development, fair access to healthcare and black and minority ethnic groups, complaints, involvement of users of services, controlled drugs and medicine management, arrangements for transfer and release, and court diversion schemes.

HMIP has carried out 35 inspections of prisons, with the Healthcare Commission carrying out 18 interviews at PCTs in 2007/08³ (see Appendix 1 for a list of PCTs where we carried out interviews and the prison that they commission healthcare for). We use the key findings from these interviews, and information provided to us from those PCTs not visited, in the healthcare section of the inspection report for a prison.

There are various ways that PCTs provide health services in prisons, with some delivering a mixture of services that they commission or provide directly, and others commissioning all of their services.

The main services that PCTs are responsible for commissioning include:

- General medical services (GPs)
- Dentistry
- Podiatry

³ We did fewer interviews than inspections in 2007/08 because we do not carry out interviews more than once in a financial year for those people who are responsible for commissioning prison health services for more than one PCT. Therefore if we have already interviewed someone about a prison in their area, we would not interview them again in relation to another prison, but request information from the relevant PCT.

- Nurse-led healthcare team (based in prisons)
- Mental health in-reach
- Optometry
- Pharmacy.

Some PCTs commission other specialist services based on the health needs of the people in their prisons, such as physiotherapy, sexual health and substance misuse.

On 1 January 2007 new regulations, as part of the programme, The Safer Management of Controlled Drugs, came into force that require PCTs to appoint an accountable officer. Since these regulations included healthcare in prisons, we have added questions to our structured interview to find out how PCTs have responded to this requirement.

Methodology

Our joint work covers a range of prisons, including local, high security, category B and C⁴, and open prisons, and groups of people, including young offenders.

Each time that HMIP makes an announced inspection, or a full unannounced inspection of a prison, an assessor from the Healthcare Commission visits the relevant PCT. The assessor interviews the person responsible for commissioning healthcare services for prisons to ensure that the PCT's arrangements are effective. This information is shared with HMIP at the time of their inspection.

We coded and entered the information we received from our structured interviews into software that allows the analysis of qualitative data and then analysed the results further. This is a themed analysis of textual information and as such the findings cannot be classed as significant, as they were not based on figures. The questions used related to the areas listed on page 8.

The main findings from this analysis and areas requiring further work are given below.

We have also used the information that we gathered from these interviews in the annual health check for PCTs in 2007/08 and

⁴ Category B prisons hold prisoners that do not need the very highest conditions of security, but for whom escape must be made very difficult. Category C prisons hold prisoners who cannot be trusted in open conditions, but who do not have the resources and will to make a determined escape attempt. (Prison service order 0900, *Categorisation and allocation*, HM Prison Service, 2000)

in the screening process for cross-checking trusts' declarations.

Our Prison Health Working Group, which has representatives from both the Healthcare Commission and HMIP, meets four times a year to ensure that our agreed programme of work is implemented.

The Commission and HMIP have worked together in this way since April 2006.

Findings, priorities and areas for action

Plans for delivering local services and plans for delivering healthcare in prisons

2006/07 was a period of mergers of PCTs, but in 2007/08 PCTs reported that their plans for delivering healthcare in prisons were in place and had been reviewed. However, they told us that healthcare in prisons was included less frequently in plans for delivering local services.

Thirteen out of 18 PCTs told us that prisons were not included in local area agreements and, in a number of cases, there was either no strategy for commissioning healthcare in prisons or the strategy needed updating.

Of the 18 PCTs, four had recent assessments of needs for healthcare and six had assessments in progress. A further two had assessments of needs for healthcare, although it was not stated when they were carried out. Two were planning an assessment, as they did not have an up-to-date one, and another three said that they needed an up-to-date assessment, but there were not currently clear plans in place to do this.

Assessment of needs for healthcare does not seem to have improved since 2006/07. PCTs have acknowledged this and, at the time of our interviews, were in the process of completing their assessments of needs for healthcare.

All PCTs were able to identify examples of initiatives to promote better health for prisoners – most commonly in relation to

stopping smoking, sexual health, substance misuse, healthy eating and exercise.

More PCTs said that prisons were included in emergency planning in 2007/08 than did in 2006/07, with 15 PCTs informing the Healthcare Commission that emergency planning was taking place.

Area for improvement

PCTs should:

- Ensure that prisoners' needs for healthcare are regularly assessed, agreed and signed off by PCTs' boards.

Budget

As in our findings relating to 2006/07, 10 PCTs noted they had ring-fenced money for healthcare in prisons, although for others the budget process was less clear. Budgets varied across all PCTs due to the type and size of their prison population.

All PCTs told us that their budget for prisons had remained the same, or had risen. As in 2006/07, PCTs appeared to have arrangements for monitoring their finances for healthcare in prisons, through the use of financial data and reports. Some PCTs told us that they had detailed financial information on monthly expenditure, which was reviewed every month between the PCT and the prison healthcare team.

Area for improvement

PCTs should:

- Adopt a more structured approach to resources, to clarify where budgets for healthcare in prisons sit within PCTs so that it is seen to be a priority.

Governance

Reflecting what we found in 2006/07, PCTs felt that they had good and effective relationships with the prisons in their area: we found evidence of regular meetings of partnership boards taking place across all PCTs.

There also appeared to be links with the PCTs' overall structures of governance, with information about prisons being communicated to PCTs' boards and other governing committees. Membership of the partnership boards often included the PCT's chief executive, associate director of commissioning, director of public health, governing governor, deputy governor, and head of prison healthcare.

Monitoring performance

Although the methods for monitoring the performance of prisons varied between PCTs, the most common method was for service level agreements (SLA) to include appropriate data on performance. Use of this method appears to have increased since 2006/07, when just one PCT mentioned that data was required in their SLAs for health services for prisons. All PCTs confirmed they had SLAs in place.

Other types of data that PCTs used to monitor prisons' performance included:

- Comparison with the Department of Health's *Standards for better health*.

- Indicators of national performance for prisons or other wider targets for PCTs, such as access to GPs and dental services.
- Monitoring contracts.

Area for improvement

PCTs should:

- Continue to use indicators of performance and wider targets for PCTs, such as offender health indicators of performance.

Risk management

All PCTs appear to have processes in place for managing serious untoward incidents (as was the case in 2006/07 for most PCTs), which inform their overall system for reporting incidents. Examples of serious untoward incidents are:

- Death of a person in custody.
- The wrong medicine being given to a patient, resulting in an adverse reaction.

Clinical audit and use of information

Clinical audit is extremely important as it is the best way to demonstrate improvement in services, and areas where improvement needs to be made. However, for the second year we found very limited evidence of clinical audits of health services for prisons.

This was mainly because PCTs found it difficult to gain access to clinical information due to the lack of computerised records and data in prisons, with some prisons still using a paper-based system.

Similarly, although some PCTs told us they collected national data, such as national service frameworks and information on quality relating to GPs' activity, this was restricted in many cases by a lack of IT systems. We recorded that only two PCTs could demonstrate clinical audit activity being used to improve healthcare services in prisons.

PCTs indicated to us that the use of information should improve, since prisons are beginning to implement electronic systems for managing information⁵.

The majority of PCTs said that they had arrangements and policies for data protection, although in two cases these were still being developed.

Area for improvement

PCTs should:

- Promote further the development and implementation of electronic records, in order to improve clinical audit and therefore improve information on standards of healthcare in prisons. It is only if this information is routinely

⁵ The Department of Health has commissioned NHS Connecting for Health to deliver the first national clinical IT system across the entire prison service estate. This programme of work will cover all public sector and contracted-out prisons across England, initially aiming to deploy TPP SystemOne Prison in November 2008.

collected, assessed and acted on that healthcare in prisons can improve.

Death in custody

All PCTs told us that they had processes to review all deaths of people in custody. As was the case in 2006/07, all PCTs understood their responsibilities and the procedure to be used. All PCTs interviewed could give examples of the process to follow. The Prisoners and Probation Ombudsman investigates all deaths of people in custody and reports them to the Coroner's Court.

Staffing, training and development

As in 2006/07, four of the PCTs reported difficulties in recruiting staff. This was particularly the case for nursing posts, although one PCT mentioned that they had improved the recruitment and retention of nurses.

We found that PCTs that employ the staff in the prisons in their areas provided training that was said to be in line with that provided to all their other staff. This was less clear, however, for staff that are employed by the prison.

Similarly, PCTs gave us a mixed response about how they monitored training. For half of the PCTs, it was through reviews of performance and appraisals, while others kept databases or had no current system for monitoring in place.

Planning relating to the workforce did not appear to be well advanced. Some PCTs were taking this forward, while others said that it needed to be reviewed. Two PCTs told us that such planning would be done through the assessment of health needs.

Areas for improvement

PCTs should:

- Analyse the development needs of staff that provide healthcare for the prison population, so that training relates specifically to those in prisons. The training and development of this group of staff is already an area that needs to improve, especially since PCTs struggle to recruit and retain them.
- PCTs should monitor these arrangements through their SLAs.

Fair access to healthcare and black and minority ethnic groups

PCTs aspired to ensure that those in prison receive the same access to healthcare as everyone else, and generally believed that they achieved or exceeded this, particularly in the case of primary care. However, half of the PCTs had no formal measurement of access to healthcare to establish whether this was true, representing little progress from the findings in 2006/07.

One PCT said that sometimes prisoners receive a reduced level of access to non-emergency hospital care, compared to other people, due to pressures on staff. Another PCT told us that it did not meet the targets on 48-hour access to hospital.

PCTs identified assessments of health needs as being the main means of addressing the needs of black and minority ethnic (BME) prisoners and monitoring the ethnicity of the people in prison. A small number of PCTs have employed, or were due to employ, community development workers to help with these assessments locally.

Only one PCT said that it recorded data on the ethnicity of prisoners in its IT system, and another said that information was collected from clinics.

Less than half of the PCTs said that they used the National Institute for Mental Health in England's (NIMHE) BME strategy⁶, although more said that they did not use the current strategy, despite being aware of it. As such, although PCTs' awareness of NIMHE's BME strategy has improved since 2006/07, the use of it is still limited.

Area for improvement

PCTs should:

- Ensure that prisoners receive equal access to healthcare and identify the needs of BME groups more effectively. More PCTs should use NIMHE's BME strategy and access their local BME strategies for the development of healthcare in prisons to make sure that all groups are included in the development of healthcare in prisons.

⁶ This programme aims to improve the mental healthcare of all BME people, including those of Irish or Mediterranean origin and eastern European migrants.

Complaints

Between April 2007 to March 2008, the Healthcare Commission received 109 complaints relating to prisons⁷, from 45 different prisons. Thirty-nine per cent of the requests for independent review that we received regarded complaints about prisoners' healthcare that were ineligible. This was because those requests fell outside the remit of the Healthcare Commission, as set out in the National Health Service (Complaints) Regulations 2004 (as amended).

Access to medication (22%) and general standard of healthcare (20%) were the most frequently raised issues during this reporting period. The majority of these complaints related to being denied access to pain relief.

The other most commonly raised issue among patients in prison was the general standard of healthcare they received, although complaints relating to this issue have declined slightly in comparison to 2006/07.

Interviewees were able to tell us how they made prisoners aware of the ways in which they could complain to the PCT. These were frequently through leaflets and the induction of prisoners. PCTs reported that they received only small numbers of complaints about healthcare in prisons. In 2006/07, some PCTs reported that they did

⁷ *Prison Healthcare Complaints: 2007/08*, Healthcare Commission Prison Complaints Special Interest Group, November 2008.

not see all the complaints about healthcare from prisons in their area.

Although five PCTs said that complaints were reported to their prison partnership board, six PCTs were unclear about how complaints were dealt with in their management systems and seven said that complaints were resolved locally.

One PCT highlighted a model of best practice, where issues were dealt with by healthcare staff at the first point of contact, before recording the information in its management systems.

Area for improvement

PCTs should:

- Ensure that complaints are regularly recorded as part of their management system and are acted upon.

Involvement of users

The majority of PCTs told us that the views of prisoners were captured through surveys of patients, providing some evidence of the involvement of users; this was often as part of an assessment of health needs. As such, there appears to have been some progress from 2006/07 when there was little evidence of the involvement of users by most PCTs interviewed.

Four PCTs explicitly stated that consulting users of services had been limited or challenging, as prisoners did not always feel able to contribute.

Area for improvement

PCTs should:

- Ensure that they have systems to involve users of services in their work relating to healthcare in prisons.

Controlled drugs and the management of medicine

All prisons included in this report have clear links to their PCTs' overall arrangements for controlled drugs and management of medicine. All PCTs said that relevant prisons were in the process of implementing an integrated drug treatment system and they were monitoring progress.

Area for improvement

PCTs should:

- Ensure that their prisons are implementing drug treatment systems.

Arrangements for transfer and release

PCTs are part of the process for preparing and supporting prisoners in their continuity of care during their transfer and release

from prison. It is important that prisoners have continued access to health services once they leave a prison. Over half of the PCTs told us that they have some processes for transferring or releasing prisoners, or that these were currently being addressed. However, PCTs' arrangements seemed to vary widely, depending on the type of prison and the prisoners' circumstances.

Area for improvement

PCTs should:

- Continue to ensure that they have arrangements for the transfer and release of prisoners and that compliance with these arrangements is routinely monitored.

Diversion schemes

For the second year, over half of PCTs that we asked did not directly commission court diversion schemes. Of these 18 PCTs, 13 said that they did not commission court diversion schemes (although three of these said there were court diversion schemes, but that they were not commissioned by the PCT). The remaining five PCTs said that there were court diversion schemes in place.

Conclusion

Overall the quality of commissioning healthcare in prisons has improved, although this varied across PCTs. Although PCTs were aware of the importance of the assessment of health needs, which can inform their priorities for commissioning services, the majority of PCTs did not have one, or had not completed an assessment. There has been some improvement in the commissioning of healthcare in prisons, but further work is needed to ensure that specific areas, such as access to health services and the assessment of health needs, are addressed.

There were links with the PCTs' overall structures of governance, with information about prisons being communicated to PCTs' boards and other governing committees. We found evidence that partnership boards and forums were used to discuss healthcare in prisons, which included issues around performance information, the management of risks to patients,

the monitoring of contracts, complaints and financial management. It is clear that collecting information about healthcare in prisons was restricted by a lack of IT and the implementation of electronic records was at an early stage. There was also very limited evidence of clinical audits of health services for prisons, due to the lack of computerised records and data in prisons, with some prisons still using a system that was paper-based.

There is some evidence of processes for transferring or releasing prisoners being addressed. However, PCTs' arrangements seemed to vary widely, depending on the type of prison and the prisoners' circumstances. PCTs rarely commissioned court diversion schemes, although in some cases such schemes were commissioned by other groups. This is an area to address in order to divert offenders with mental health problems out of the criminal justice system and into appropriate health services.

Appendix 1

Primary care trusts included in inspections of healthcare in prisons

Prison	Primary care trust
HMP Buckley Hall	Heywood, Middleton & Rochdale PCT
HMP New Hall – Rivendell Unit	Wakefield District PCT
HMP Lancaster Castle	North Lancashire PCT
HMP Lindholme	Doncaster PCT
HMP/YOI Gloucester	Gloucester PCT
HMP/YOI Eastwood Park	South Gloucestershire PCT
HMP/YOI Chelmsford	Mid Essex PCT
HMP The Verne	Dorset PCT
HMP Canterbury	Dorset PCT
HMY/YOI Drake Hall	South Staffordshire PCT
HMP/YOI Bullwood Hall	South East Sussex PCT
HMP Leeds	Leeds PCT
HMP Liverpool	Liverpool PCT
HMP Morton Hall	Lincolnshire Teaching PCT
HMP Lincoln	Lincolnshire Teaching PCT
HMP Full Sutton	East Riding PCT
HMP/YOI Feltham	Hounslow PCT
HMP Brockhill	Worcester PCT

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