



HOME OFFICE

PATIENT OR PRISONER?

This Discussion Paper was prepared and published by Her Majesty's Inspectorate of Prisons for Her Majesty's Chief Inspector of Prisons, Sir David Ramsbotham. The terms of reference were -

“To consider health care arrangements in Prison Service establishments in England and Wales with a view to ensuring that prisoners are given access to the same quality and range of health care services as the general public receives from the National Health Service”

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HER MAJESTY'S CHIEF INSPECTOR OF PRISONS
is required to inspect, or to arrange for the inspection of,
prisons in England and Wales and to report on them
to the Secretary of State,
in particular on the treatment of prisoners
and on conditions within prisons.

It is also the duty of the Chief Inspector of Prisons
to report to the Secretary of State on specific matters
as required, and to submit an annual report
to be laid before Parliament.

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by HM Chief Inspector of Prisons, Sir David Ramsbotham

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FOREWORD

by Sir David Ramsbotham

Her Majesty's Chief Inspector of Prisons for England and Wales

HER MAJESTY'S INSPECTORATE OF PRISONS has for many years studied all aspects of the medical care provided for prisoners within establishments, including access to outside treatment. Any overview of Prison Service health care arrangements will show that, while much care and effort have been applied to the creation of a medical service separate from the National Health Service and the application of policies that begin to reflect current standards in the community at large, there are a number of major deficiencies and problems in actual delivery that need to be addressed. Copies of the chapters describing health care in the last two Inspectorate Annual Reports are attached to support this contention.

Firstly it has to be said that, although many health care staff in prisons can demonstrate an ever wider range of qualifications and flexibility in their work and working practices, the overall service provided, across the spectrum of establishments, does not match up to National Health standards, or satisfy the provisions of the Patients' Charter. As the Prison Service has acknowledged in successive Corporate and Business Plans and begun to do something about, there is particularly a shortage of health care managers with National Health experience. The standard of inpatient care requires improvement. There is particularly urgent need for increased provision for the care of those with mental health problems, who make up a larger proportion of the prison population than they would of any other group in the community. What is more, prison can exacerbate mental health problems, which has a long term impact on the individual concerned and the community into which he or she may be released.

The range of problems faced by medical staff in establishments differs from those occurring in the rest of the community only in degree. There is less responsibility for care of the elderly, but, at the other end of the age scale, there are an increasing number of young offenders with drug addiction and other substance abuse problems, as well as the general health problems that their life style creates. All these are making an increasing demand on increasingly scarce resources.

The purpose of this discussion paper, therefore, is to draw attention to these issues at the time of the appointment of a new Prison Service Director of Health Care, in the hope that it will lead to action to ensure better provision of health care in prisons. It concludes that, as has been recommended but never implemented in the past, the National Health Service should assume responsibility for the delivery of all health care, by the introduction of a purchaser/provider relationship that acknowledges the full and peculiar needs of the Prison Service. This means that certain NHS Trusts will be asked to assume certain responsibilities, and to ensure that adequate provision for Prison Service needs is included in all resource allocation. Only in this way can consistency of delivery to everyone in the community, in or out of prison, be ensured. NHS standards apply before and after custodial sentences, so why not during?

I have discussed these proposals with the Prison Service. Dr Mike Longfield, Acting Director of Health Care, has presented comments which have been included at the end of this discussion paper.

I hope that the paper will soon lead to full, frank and meaningful discussions between all concerned in the National Health and Prison Services. It recognises that time will be needed to ensure that all relevant implications have been established and taken into account. We believe that all concerned can only benefit from taking part in the discussion process, the aim of which must be to ensure the delivery of urgently required, genuine and lasting improvements, as soon as possible. We in the Inspectorate look forward to contributing to that process.

Chapter 1

CURRENT ISSUES

INTRODUCTION

PRISONERS ARE ENTITLED to the same level of health care as that provided in society at large. Those who are sick, addicted, mentally ill or disabled should be treated, counselled, and nursed to the same standards demanded within the National Health Service. Failure to do so could not only damage the patient but also put society at risk.

It is not the purpose of this paper to describe the existing health care system in the Prison Service, which devotes a great deal of care and time to ensuring that prisoners are provided with many levels of medical care. Nor have we, for example, explored how the role of

Prison Service psychologists, and other such specialists, who contribute to the overall health of the prisoner and the establishment, would fit into the options discussed in this document.

One of the most persistent dilemmas concerns the question of whether inmates requiring medical attention are patients or prisoners. It is encouraging that the Prison Service Health Care Standards refer to prisoners as patients throughout. The need for security and discipline can cut across the perception of individuals as patients. This problem remains, to some extent, unresolved in the Prison Service, but has been squarely faced within the

psychiatric services for the mentally disordered offender. There will always be tension over this issue, because health care providers will clearly demand that those requiring its services are recognised as patients. How else can prisoners voluntarily accept the care that they so often desperately require?

STANDARDS

More needs to be done to deliver the Prison Service's own health care standards and ensure proper audit systems are in place; patients in prison are not provided with a charter.

It is not sufficient just to lay down standards; these should be supported by resources, audits and evaluation. The present administration has done a great deal, for example, introducing nine detailed health care standards since 1994 and requiring governors to plan to achieve them within set timescales. But there is still much to be done, in the areas of inpatient care and addiction treatment.

The provision of health care within the Prison Service should be supported by a patients' charter. This should lay down the relationship between patients and medical staff; and the duty of care to which they are entitled. There should be greater clarification of differences between the responsibilities of medical staff

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and the day to day working of the establishment. Medical staffs should be given more support within establishments.

The present structure for nurses is confused and divisive. All should hold a professionally recognised nursing qualification and form a single identifiable group with an appropriate status and career structure.

At present, a patient, presenting him or herself for medical attention, is faced by nursing staff with a variety of uniforms, grades and qualifications within the same establishment. Some are in Prison Officer uniform, with or without a nursing qualification. Others are in different uniforms, probably with nursing qualifications. Their supervisors will also have a different range of backgrounds with differing qualifications. Nurses should have a set of recognised qualifications with a single recognisable uniform. They should have a proper career structure with promotion based on first level qualifications.

The Prison Service has acknowledged that the current situation should not continue. Its Nursing Policy Review is considering movement towards a nursing-led service; closer matching of service to needs; a 24-hour therapeutic regime; and suitably qualified health care managers.

Most doctors are not psychiatrically qualified, and have received no recognised training in

assessment and treatment of mentally disordered offenders or addicts. As a result they are often expected to undertake inappropriate duties. The Prison Service has sought to address this by introducing diploma level training in addictive behaviour, through St George's Hospital, London, and a specialist examination in prison medicine formulated by the three Royal Medical Colleges. Because doctors working in prisons belong to an independent medical service they are isolated from their peers in the National Health Service and suffer comparatively low status.

Despite considerable investment by the Prison Service in training for doctors and prison health care staff, some of those directly employed by the Prison Service have become isolated, with little training and limited support in management of their areas.

Nursing staff require far more expertise in the handling of the mentally-ill, depressed and suicidal patient. Some improvements have been made, for example, the multi-disciplinary approach to take care of those at risk of suicide, set out in the Prison Service training package *Caring for the Suicidal in Custody*. However, the whole question of training and research needs to be addressed.

The public must feel safe in the knowledge that the mentally disordered offender is given proper assessment, treatment and help.

The many mentally disordered offenders who fall outside the 1983 Mental Health Act, and are thus cared for within establishments, are not adequately provided for. Their assessment and daily care needs to be markedly improved, which will assist establishments in dealing with their often bizarre and disruptive behaviour. One example would be to expedite plans for further Grendon-style therapeutic communities.

Given that all establishments will have a number of mentally disordered inmates, they must be enabled to provide proper psychiatric consultant supervision. At present this is not systematically provided.

The various population groups in establishments present their own problems and require specific differential policies.

The health care needs of women, especially those who are pregnant, are not adequately catered for in prison. Juveniles, as they are quickly maturing, need close attention to their problems, especially those who are weak or inadequate.

The matters raised here, and other issues of concern, are discussed in more detail in the Health Care chapter of the Inspectorate's annual reports of 1993/4 and 1994/5. A copy of each of the relevant chapters is at Appendices 4 and 5.

INTERNAL REFORMS

Health care provided by the prison medical service does not match that provided by the National Health Service.

Continuing pressure has been brought to bear, from within the Prison Service, to enhance the delivery of health care. Undoubtedly standards have improved, and there has been an increase in the number of qualified staff. Better physical facilities have been provided. Set against this, while it is true that resources have grown, so too has the size of the problem presented by prisoners. For example, it is now well established that the bulk of prisoners are involved with drugs, with many addicted. A significant number are mentally ill. In short, the pace of change within the Prison Service is dictated by the scale of the presented medical problems, and it is rapidly falling behind that in the NHS.

Very few establishments have trained health care managers with a good understanding of how health care should be provided, managed and linked to the NHS.

Given the issues facing prison medical services (discussed in the preceding text) and the growing need to meet the challenge of pressing medical change, separate Prison Service provision, or local arrangements between

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individual prison Governors and NHS trusts, cannot provide NHS standards.

Only a small, although increasing, number of health care managers have undertaken a relevant certificate or diploma in management studies, to assist the delivery of efficient and effective health care services.

All prisoners requiring health care must be seen as patients and given the same care as provided in the community.

There is still a desperate need to provide proper psychiatric services to the many mentally disordered offenders in prisons. This will require new units for day care centres, and the ability to provide nursing services 24 hours each day - even allowing for inpatient cells to be opened at night for nursing care. The demands of public health require that prisons do not allow inmates to deteriorate through drug addiction. Prisoners should be released into society having been properly educated, supported by the knowledge that the National Health Service will, and can, continue to provide the same level of service.

STAFFING

Prison health care staff are independent of, and isolated from, the National Health Service. Nurses experience difficulty in maintaining the level of skills necessary for re-registration. The

constant flow of new ideas, training and development within the National Health Service passes them by. Some ideas are picked up, examined and presented as policy from Prison Service headquarters. Other advances stem from local initiatives.

A number of prison nurses are active in a special interest group sponsored by the Royal College of Nursing, and many avail themselves of education and training funding devoted to enabling statutory re-registration. However,

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others are isolated from developments and contacts in the National Health Service and this may be detrimental to standards of practice.

Prison Service doctors, nurses and health care personnel need the same professional opportunities for development and experience as all qualified staff. They must experience, participate in and influence change.

This can only be achieved if medical and nursing staff in prisons belong to the mainstream providers of health care. The resulting constant interchange will allow the latest developments to spread and enable personal development.

Chapter 2

A NEW DIRECTION

THERE IS A REQUIREMENT for health needs analyses to be carried out by establishments. These analyses should provide the foundation for drawing up policies, which not only examine how health is seen and determined but integrated into the whole establishment and linked into the National Health Service.

Much work needs to be done in this area. There must be acceptance, by all establishments, that health should be integrated into all aspects of an establishment's work. This can be done by producing a health plan based upon the needs of staff and prisoners.

The conditions in which people live are vital in providing the healthy environment they require.

Assessment of these conditions, and their effects, should be part of any strategy developed for the health care of those who live and work in establishments. Particular attention should be paid to the care given to staff (alongside occupational health care), especially those who are unexpectedly taken ill or injured while at work .

Health care must not be seen solely as the responsibility of medical staff or a medical service. It includes the part each person plays in maintaining a healthy environment. The way in which stress affecting staff is identified and dealt with, is as important as the aid given to the addict. Confidence, integrated policies, a safe place of work and care for all is necessary for staff and prisoners.

Health for the individual is part of the overall quality of life and health for everyone. Every penal establishment is a small part of the wider local community, which should be seen as an organic whole. Health standards affect all who work and live within the establishment. Staff, prisoners, visitors and contractors all contribute to the overall well being of each other.

WHY THE NHS?

It is no longer sensible to maintain a health care service for prisoners separate from the National Health Service. There is an immediate need for the Home Office and the Department of Health, together with the Prison Service and the National Health Service to agree a timetable for the NHS to assume responsibility for the commissioning and provision of health care and health promotion in prisons.

The National Health Service is a high-quality, cost-effective service, defining the nation's standards for public health care. Setting these standards, assessing the nation's needs for health care and ensuring sufficient funding and the availability of properly qualified staff to meet these needs, is a very difficult and often highly

prisons and in the wider community. Only by the NHS accepting responsibility for health care in prisons can two essentials - equality and continuity of care - be ensured.

PURCHASING AND PROVIDING HEALTH CARE AND HEALTH PROMOTION

Since the introduction of the division of responsibility for the purchasing and the provision of NHS health care, Health Authorities have been responsible for the assessment of need of their local populations. They have among their staff people with specialist skills able to perform these complex needs assessments and to publish local health plans addressing all aspects of the needs of the community for health care and health promotion. Appendix 2 is a brief extract from the plan for Liverpool city showing the width of issues that need to be considered. Health authorities then must reach agreements with providers of health care, whether in the NHS or the independent sector, to meet the identified needs of the populations for whom they are responsible.

Since the Efficiency Scrutiny of the Prison Medical Service in 1991, the Prison Service has been committed to a similar purchaser/provider split in relation to health care. The Directorate of Health Care Standards require all establishments to conduct an assessment of need every three years. Conducting these need

no need for two parallel systems and, indeed, serious potential disadvantages from having two systems. For instance, when two services compete to recruit from the same limited pool of doctors and nurses, the smaller service is likely to lose out.

The Health Care Service for Prisoners has tried to guard against becoming isolated, and being seen as a 'poor relation' when contrasted with the NHS, yet this has been the inevitable result of independence. The time has come for this reality to be accepted and action to be taken to ensure there is equality of health care for all, whether prisoner or free.

Prisoners were members of the wider community before their reception into prison and their health care then was the responsibility of the NHS; the vast majority will return to that community and to the NHS on their release. It is illogical that, during the time that they are prisoners, their health care is provided through separate channels. It is also necessary to recognise the interdependence of health care in prisons and wider health care.

A prisoner's health and health care before offending has impact on what happens in prison, both to the individual prisoner and more widely. A prisoner's health care in prison can,

assessments and providing the services to meet the needs, however, remains the responsibility of the governor of individual establishments, guided by the Directorate's Health Care Standards and assisted by the Health Care Advisers. Yet the vast majority of the experience in both needs assessment and contract setting remains with the NHS. New arrangements in the Prison Service should make use of these skills and the most effective way to achieve this would be by treating the prison population as if, for health purposes, it was part of the wider population.

As for the rest of publicly purchased health care, providers might come from the NHS or from the independent sector though their relative size makes it likely that the NHS would be the major provider.

The main benefits from the NHS commissioning and, to a large extent providing, prison health care would be:

- continuity in planning between the NHS and the Prison Service
- public health issues examined and linked to wider issues local to the prison
- common standards between the two services

- continuity of health care between prison and the wider community
- health care staff trained to work in either prison or the NHS
- a common system of audit and evaluation
- a common commitment to evidence-based practice
- a common commitment to setting and improving standards as, for example, in the Patients' Charter.

But these changes cannot just happen - there needs to be time for discussion, for consultation and for examination of the ways in which this change could be made.

The Home Office, the Department of Health, the Prison Service and the National Health Service should agree and establish systems to purchase, deliver and monitor the provision of health care in prisons

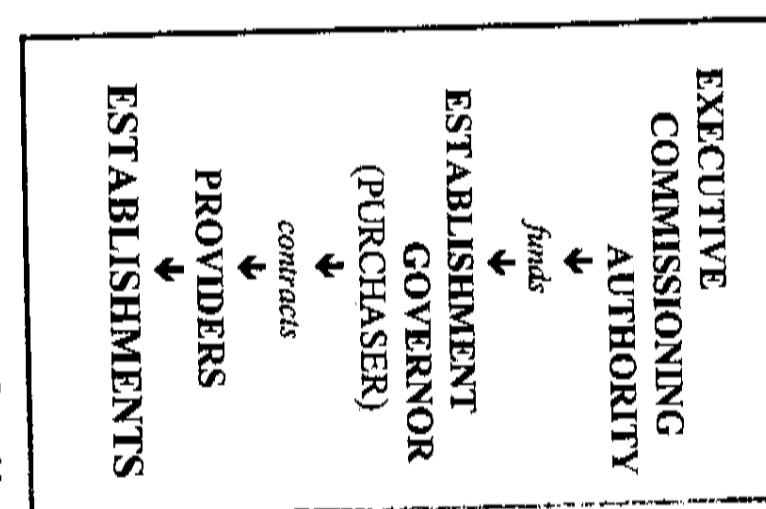
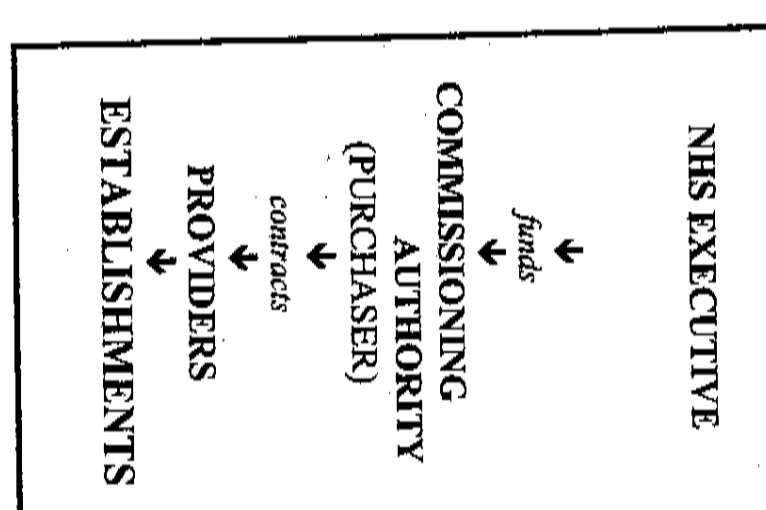
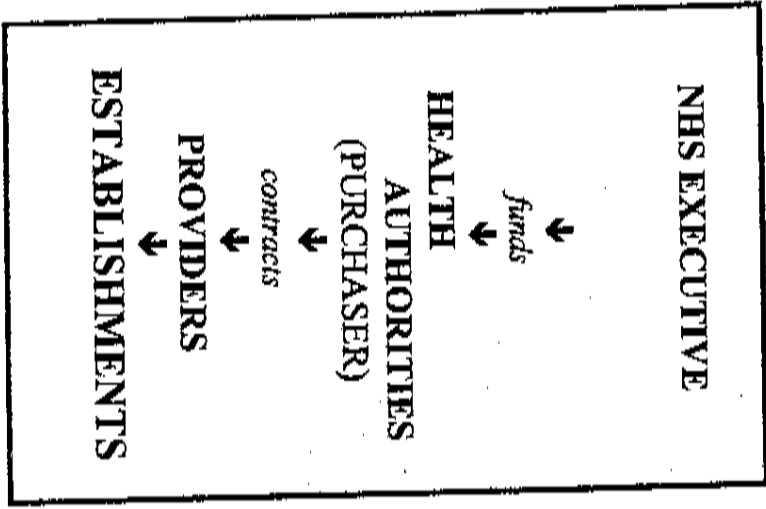
There is a range of possible ways in which this could be brought about. This paper does not pretend to consider them all, but aims to promote the discussion needed to identify the most appropriate solution.

MINISTERIAL RESPONSIBILITY

A central issue is ministerial responsibility. The argument is often put forward that it is unworkable to have two Departments of State responsible for what happens in one organisation, and hence transfer of the responsibility of health care provision to the NHS is impossible. But there are already examples of successful co-operation between the Home Office, the Department of Health and the NHS in the delivery of health care. The Home Secretary's role in the supervision of mentally disordered offenders subject to restriction under the Mental Health Act 1983, shows how effectively two departments can discharge their respective responsibilities within one organisation. These arrangements might provide a model for responsibilities for the delivery of health care in prisons.

RESPONSIBILITY FOR PURCHASING AND PROVIDING HEALTH CARE

Responsibility for the commissioning and provision of health care in prisons in England would pass to the National Health Service Executive (NHSE) and for prisons in Wales to the Welsh Office. Overleaf, we present three models which demonstrate possible approaches to a health care service to prisons funded and operated by the NHS:



NOTES

MODEL 1: The National Health Service Executive (NHSE) would require District Purchasing Authorities with prisons in their area to include prison health in their strategy and annual business plans. The purchasing authorities would be funded by the Department of Health (with the Prison Service's medical budget transferring to them) to carry this out to a standard set by the NEC. The DPA would let the contracts (in consultation with prison advisers) to provider units (public or private) and monitor them. All health care workers in the prison would be employees of the provider unit.

MODEL 2: The NHS would set up and fund a commissioning authority which would be solely responsible for purchasing medical services to standards set by the NHSE. The health care workers are envisaged as employees of the provider unit(s).

MODEL 3: In this model the Commissioning Authority would be responsible for policy and setting the standards required, but it would be the Governor (to whom funds would be made available) to purchase health services. This model also envisages the health care workers as employees of the provider.

In our view, at least during the period of change and until new arrangements are well established, it would be better for a central organisation to control purchasing strategy closely to ensure uniform standards and controlled development. A comparable arrangement (The High Security Psychiatric Services Commissioning Board) has recently been set up within the NHSE to commission and oversee the future provision of high and medium secure psychiatric services. Several variants of this model, involving different purchaser/provider relationships could be developed. For instance, health authorities could, under the supervision of the central agency and in consultation with the prison governor, purchase health care for prisons in their area. Contract monitoring would, in close co-operation with the governor, be by the health authority and by the regional office of the NHSE with accountability for the delivery of a suitable service resting with the Chief Executive of the NHS. Alternatively, the provision of health care in prisons might become the responsibility of a Special Health Authority.

The Prison Service is looking to cluster prisons, to ensure efficiency and the proper financing and management of specified specialist areas. This approach could be applied to the provision of health care, with certain establishments providing, for example, wider facilities, both in health care centres and in 'out patient' settings, for particular groups of patients (for example, those with mental illness). Health care

services to these establishments could be purchased by their local health authority and provided by local NHS trusts or independent providers.

PRIMARY HEALTH CARE

General practitioner practices at present provide much of the primary care in prisons. These arrangements could be widened and, as in the present arrangement for dental services in prison, be comparable to NHS services.

Larger establishments, with 24-hour medical cover and in-patient facilities, would need to establish special arrangements with GP practices and trusts, to ensure the provision of both primary and specialist care.

FINANCE

It is commonly held that the current funding of the Health Care Service for Prisoners is insufficient to provide services which meet NHS standards. This belief needs to be tested as part of the process of discussion of the future provision of health care in prisons.

The Prison Service currently finances all health care and health promotion within prisons. This includes the payment of staff, the provision of clinics for dentistry, opticians' services, genito-urinary medicine, pharmacy, visits by external consultants and other health care services. Appendix 5 sets out the present budget for

health care in prisons: the Prison Service spends some £1,000 per prison place per year on health care. The NHS spends £415 per year on the age group 16-64.

If the NHS is to fund all health care for prisoners, whether in prison or on transfer, then clearly they would need to have oversight of financial arrangements. Initially there would be a transfer, from the Prison Service to the NHS, of not less than the equivalent of the current health care budget. Whether more would be necessary would depend on the results of the analysis of the use of funding in the present health care service. It may be that some of the current costs of providing a separate prison health care service will be mitigated by integration into current NHS arrangements. If more were necessary, a very strong case could be made for additional funding based on major service improvement.

The benefits from transferring the responsibility for prison health care to the NHS are so great that financial constraints alone should not preclude such a move being considered.

PRESENT HEALTH CARE STAFF: THEIR POSITION

care in a custodial setting. Quite apart from the need to explore the situation of staff in relation to employment protection legislation, it will be essential to ensure that skilled staff are not lost to the service as a result of the changes proposed.

PRISON SERVICE HEADQUARTERS

The importance of health care as an ingredient in the effective management of the Prison Service is recognised by the Director of Health Care having a seat on the Prisons Board. Any new arrangement should ensure that that status was not compromised. Prison Service headquarters will need to retain a unit responsible for ensuring that any new health care arrangements reflect and meet the wider needs of the Prison Service. There might well be common membership between such a unit, and any body in the NHSE responsible for the oversight of the commissioning and provision of health care in prisons.

ACHIEVING THE NEW SERVICE

Before the NHS can become responsible for the

This will certainly take not less than two years.

Important steps along the way will be:

- agreeing responsibilities between the Home Office and the Department of Health and between the Prison Service and the NHSE
- agreeing the necessary levels of finance, the transfer of money (and identifying any necessity for the provision of new money)
- establishing structures, within the NHSE, the wider NHS and the independent sector, to ensure the purchasing and provision of health care in prisons

- conducting negotiations, relating to the transfer of staff between the Prison Service and the NHS
- establishing a protocol for the assessment of need for health care in prisons
- establishing model contracts and systems for contract monitoring
- agreeing contracts between new purchasers and providers

FINALLY.....

There is an over-riding need to ensure health policies within the Prison Service are properly integrated with all other developments. Health care goes beyond just the immediate provision of medical assistance. It must look to the whole development of care both for staff and inmates. It is within this broad approach that the National Health Service and Prison Service health care should ensure prisoners are provided with services that work, not only in terms of health care, but in relation to all other aspects of their life within a prison and on their discharge. Staff should be confident that their needs, as they work alongside those in their care, are also properly provided for and monitored.

The purpose of this paper is to encourage urgent dialogue and discussion about the issues that it raises. It is hoped that there will be no instant rejection of the proposal that the NHS should take over responsibility for health care in the Prison Service, any more than it is expected that there will be instant agreement. The need is there now; it may be said that the resources are not. But what is important is that the need and resources are reconciled, so that those in the care of the Prison Service, untried or serving a sentence, are treated in exactly the same

RESPONSE BY THE ACTING DIRECTOR OF PRISON HEALTH CARE, DR MIKE LONGFIELD

I am grateful to Her Majesty's Chief Inspector of Prisons for the opportunity to provide a Prison Service perspective on the important issues raised in this discussion document. We are fully committed to improving health care for prisoners which is why we are extending the range of demanding Prison Service Health Care Standards and devising better methods for auditing their achievement. We also believe that there is considerable potential for delivering better health care services and better value for money by exploring contracting with the NHS and other providers.

In fact the Prison Service has already contracted a range of health care provision from the NHS as well as from providers in the independent and private provision, and we believe this has led to more cost-effective and improved services. We are committed to continuing and increasing this process and in so doing moving the Prison Service from being a provider to being a net purchaser of such services. In this respect the Chief Inspector's discussion paper is a timely and helpful rehearsal of one of the options for change that may be available to the Government in this area.

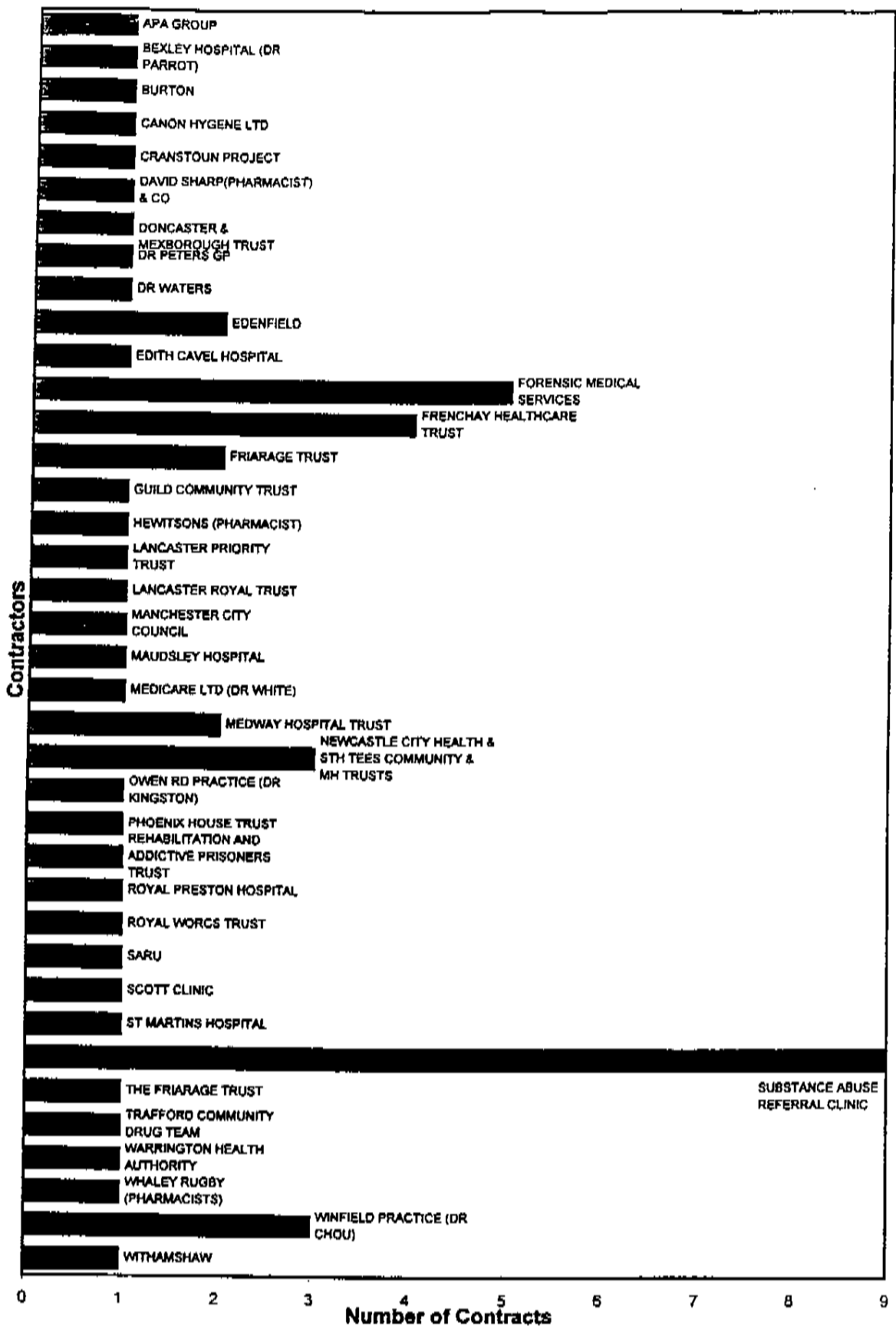
I should, of course, add that the Prison Service currently believes that purchasing from a mixed economy of NHS, independent and private sector health providers, together with a shrinking directly-managed sector, is the most practical and realistic way forward, at least in the short to medium term. We welcome the opportunity to rehearse thoroughly the potential costs and benefits of a more central role for the NHS, so that Ministers in the respective Departments may take reasoned decisions on the matter.

However, we do not underestimate the difficulties that would arise from attempting to implement the Chief Inspector's suggestion. It will be essential, but not easy, to: demonstrate value for money; avoid unnecessary bureaucracy; meet the particular statutory requirements of the 1952 Prisons Act; sensitively respond to industrial relations consequences; assure the Service that it can act as a commissioning board contracting with possibly hundreds of potential providers; obtain clear evidence that the NHS can in all cases provide better services than are currently available on an in-house basis or via the independent or private sectors; and mitigate the potentially severe impact on some health authorities of taking on growing prison populations, for example, where large prisons are set in rural areas or where, as on the Isle of Wight, the prisoner population is disproportionately large.

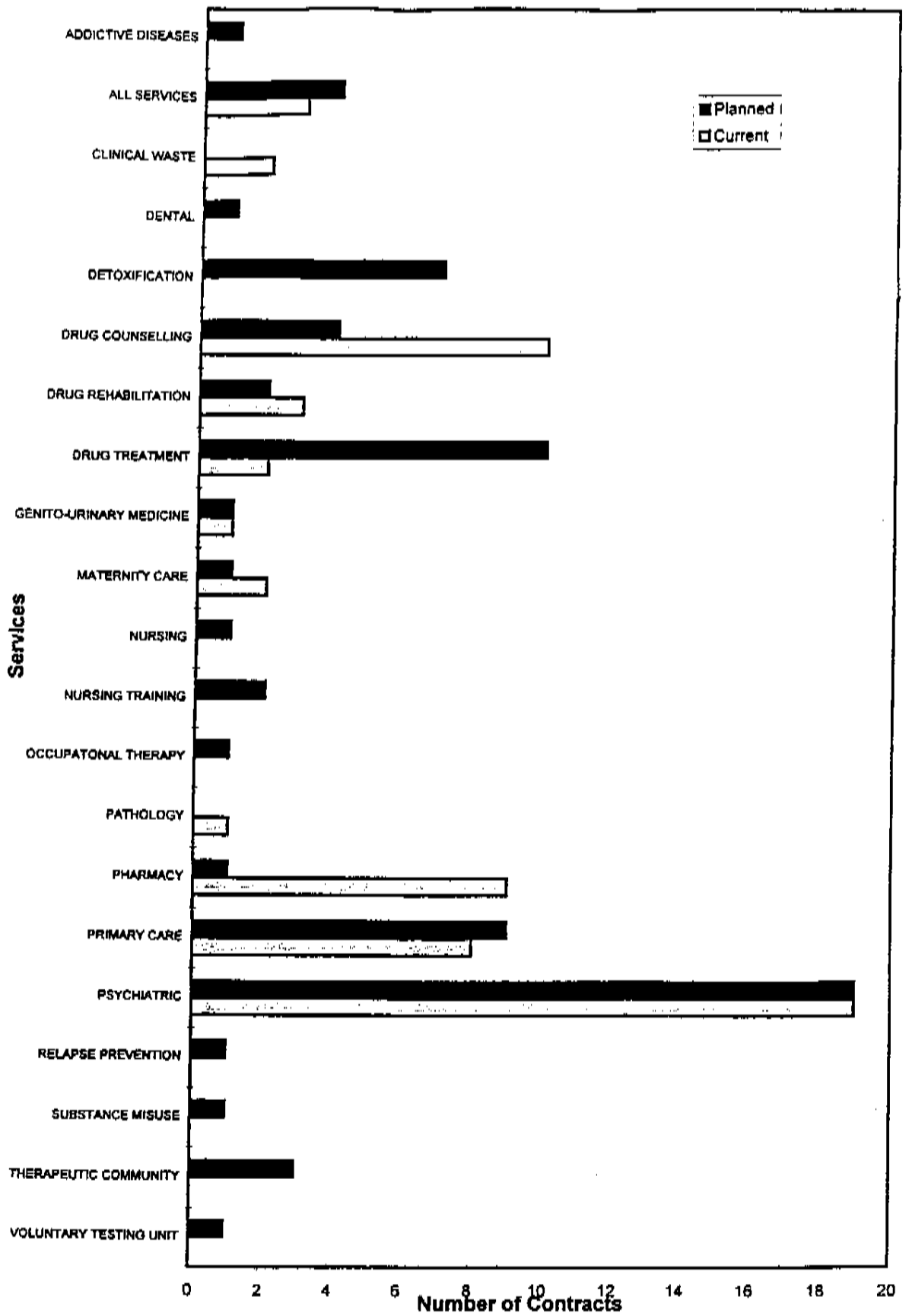
Nevertheless, this is a debate which the Prison Service is keen to enter and one for which we are grateful to the Chief Inspector for encouraging with this discussion document.

APPENDICES

APPENDIX 1: Directorate of Health Care - Contractors as at 1 August 1996



DIRECTORATE OF HEALTH CARE CONTRACT SERVICES AS AT 1 AUGUST 1996



APPENDIX 2: Profile of Health Care staff in HM Prison Service
(based on returns from 126 establishments out of 136 on 31 March 1996)

[1992 Nursing Policy targets in square brackets]

TOTAL NUMBERS: Nurses	557	(38%)	[50%]
HCOs & Governors	917	(62%)	[50%]
	<u>1474</u>		

DIFFERENTIALS:

HCOs & Health Care Governors without Nursing Registration

443 HCO
143 SHCO
51 PHCO
8 G5
6 G4

<u>651</u>	651 =	71% of HCOs & Governors	[50%]
	651 =	44% of total workforce	[25%]

HCOs & Health Care Governors with Nursing Registration

245 HCO
28 SHCO
7 PHCO
2 G5

<u>282</u>	282 =	31% of HCOs & Health Care Governors	[50%]
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Percentage of each grade with Nursing Registration

HCOs	245 out of 688	=	36%
SHCOs	28 out of 171	=	16%
PHCOs	7 out of 58	=	12%
G5s	2 out of 10	=	20%
G4s	0 out of 6	=	0%

HCOs, Health Care Governors & Nurses with Nursing Qualifications

557 Nurses
280 HCOs
2 G5s

<u>839</u>	(57%)	[75%]
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QUALIFICATIONS HELD:

<u>1st Level</u>	General	Psychiatric	Learning Disability	<u>Totals</u>
Nurses	353 RGN	194 RMN	8 RNMH	555
HCOs & Governors	106 RGN	71 RMN	10 RNMH	187
	—	—	—	
Totals:	459	265	18	
 <u>2nd Level</u>				
Nurses	61 EN (G)	16 EN (M)	2 EN (MH)	79
HCOs	54 EN (G)	29 EN (MH)	4 EN (MH)	87
	—	—	—	
Totals:	115	45	6	

NB: Some people hold more than one, therefore these figures do not reflect people but qualifications

CONVERSION:

Maximum number of second level registered nurses/HCOs requiring to convert to 1st level = 166

APPENDIX 3 Extract from Liverpool City Health Plan

Our Health and Quality of Life

Health is complex and our current health concerns require co-ordinated solutions. The City Health Plan seeks to raise awareness of this complexity, to enable everyone to play their part in creating a Healthy City.

Influences on Health

There are many influences on health and quality of life. These have been expressed by Dahlgren & Whitehead (1991) as layers of influence:-



Individual Health

Individual Health is a state of being and where we feel ourselves to be in relation to other people. It is not an activity like keeping fit, or eating well, or not smoking or living in a good environment, or being employed. It is the outcome of these and other activities.

It would appear that feeling in control and being able to make choices is a key factor in improving individual health and in people being able to realise their full potential. Survival itself and managing life on a day to day basis is necessary before people can hope to begin to realise their full potential and improve their health and lifestyle.

Community Health and Quality of Life

Our health depends then on our ability to feel in control of our lives and to a large extent also on the level of resources that we have for our everyday lives. These resources will influence our access, for example, to:-

APPENDIX 4 Annual Report of HM Chief Inspector of Prisons 1993-94, Chapter 5

Introduction

5.01 The medical needs of establishments depend to a large extent on their primary function for this will affect the turnover of inmates and their general health problems. In this chapter we start by considering establishments from this point of view.

5.02 Local prisons and Remand Centres have to deal with a very large number of prisoners from courts and police stations arriving and leaving every day. Each prisoner has to have a medical assessment on reception and on leaving. It is the nature of the remand population that it will contain the highest percentage of seriously ill people with physical and mental disease. It will include those mentally disturbed who have been arrested in the community and brought in to the legal system. There will also be a relatively high percentage of prisoners coming in who have been abusing alcohol or drugs right up to arrest and who will be experiencing the effects of withdrawal both major and minor. Some will have been living on the streets and will show the effects of parasitic infestations, and even malnutrition. Dental health will be neglected in many. Some prisoners are likely to be extremely anxious, worrying about their offence and trial as well as any domestic, financial or work problems. The full extent of all this morbidity will become apparent with the results of various surveys into the remand population. Such studies have concentrated on the mental health of inmates. They should be extended to include physical and dental conditions.

5.03 Local prisons and Remand Centres have to provide a health care service which can cope with all these factors. There must be a primary health service which can cope with the need for an initial assessment of large numbers of prisoners every day and a daily clinic for roughly 5% of the population. There must be a service for those withdrawing from substance abuse. There must be an inpatient service to assess and treat psychiatric emergencies and find places in the NHS, and an inpatient service for physical illnesses. The health care service must also be involved in the general medical education of inmates and prevention of suicide.

5.04 The need for medical assistance in a training establishment will be much less than in a local prison. There are far fewer prisoners passing through. Seriously ill prisoners will have been detected at the initial receiving establishment. Most training establishments will not require a full inpatient service on site as the number of cases using it would be too small to justify the cost of a fully staffed health care centre. There may be an argument for a room or two for observation or for the care of a convalescent prisoner.

5.05 In training establishments there will be a need for a good primary health care system with ready access to specialist services in the NHS and access to a prison inpatient service probably based in a nearby local prison. We would expect to see relatively more physical disorders (especially sports injuries) and much less serious psychiatric illness. The opportunity can be taken to develop prisoner education on good health practices including education and treatment on substance abuse and HIV/AIDS as part of the general education and training to improve social functioning.

5.06 In institutions which have large numbers of Category D prisoners it is possible to make use of the facilities in the wider community to provide health care. We were pleased to see this

happening at Kirklevington Grange and East Sutton Park where dental and optical services were obtained in this way. Prisoners similarly could take themselves to the local hospitals for specialist opinions and X-rays. The same was happening to a lesser extent at Ford prison.

5.07 The purely medical needs in Young Offender Institutions are relatively small. They tend to have a small health care centre with a part-time medical officer and a few health care officers to provide day nursing cover. There is no need for a full inpatient service. A room for the occasional convalescent prisoner or for observation could be useful. The arrangements for ordinary medical and dental care generally resembled those in training establishments.

Psychiatric services

5.08 In local prisons caring for the psychiatrically ill we would like to see psychiatrically trained staff looking after patients and having excellent links to the community. The system at Wolds when we visited seemed a good one with a forensic psychiatrist seeing all psychiatrically disturbed prisoners on a regular basis and arranging their admission to hospital very rapidly. When we visited there were no psychotic patients awaiting transfer. Valiant efforts were being made at Pentonville, Exeter, Preston and Moorland but transfers to hospital were not always very swift. Sometimes this was due to the inefficiencies of the NHS and sometimes to the failure to make use of the transfer powers of the prison doctor quickly enough. We believe there are lessons to be learned from Wolds and, as we have said before, Belmarsh and Brixton. One is that very good results are obtained by involving forensic psychiatrists and giving them responsibility for psychiatric cases. **However improvements should be made to the speed and efficiency of the arrangements for the transfer of seriously mentally ill patients from prisons to NHS hospitals or regional secure units. Where delays occur the cost of care of these patients should be met by the responsible health authorities.**

5.09 The psychiatric need in training and open prisons is generally for the provision of reports for parole purposes and the occasional opinion needed for diagnostic purposes. Seriously mentally ill prisoners were usually moved very rapidly to a prison with suitable nursing facilities though such cases were not very common. Psychiatrically disordered prisoners with less severe illness were usually seen and treated by a visiting psychiatrist. All the training and open prisons we inspected had provision for psychiatric sessions which were used for assessing and treating individuals. But there were prisons where procedures were slow and ineffective, and mentally disturbed prisoners kept for too long before transfer to where they could get proper care.

5.10 In Young Offender Institutions serious mental illness, for example schizophrenia, was unusual. There were occasional cases of prisoners becoming psychotic from the effects of illegal substances. In theory those with a serious mental disorder or serious suicidal behaviour were transferred to a "parent" young offender establishment with 24 hour nursing care. This usually worked but occasionally there was no bed available and the prisoner would have to be managed somehow. This was sometimes done by keeping the prisoners in a room in the segregation unit on 15 minute watch. This practice is unsafe and unacceptable. Continuous observation should be used.

5.11 We found that many young offenders had considerable temperamental, emotional and behavioural problems which often seemed to be linked to extremely damaging life experiences. This could, in extreme cases, express itself in self harm and suicidal behaviour. It was particularly noticeable at Wetherby (which specialised in juveniles) and Moorland which had a large remand population including juveniles. There is a sharp contrast between the higher staffing levels in Social Service establishments looking after such youths and the low levels in

Young Offender Institutions. **If such establishments are to try and have some impact on the youths they hold, including liaising with the community to which they are going to return, it seems to us that there should be more staff and greater interaction. This is a field which deserves further study.**

Services for physical illness

5.12 Services for the physically ill prisoner seemed generally very good in all establishments in the sense of getting a speedy appropriate referral to the NHS. No doubt this reflects the much better service the NHS can provide for this group. The impression gained is that people in prison are seen by specialists more quickly than they would be in the NHS.

5.13 Most establishments had excellent relationships with local NHS services and were easily able to obtain specialist medical and surgical help. The problems with charging for services had been solved by giving the hospitals the home address of the prisoner so that the bill could be sent to the "home" health authority. Prisoners in open establishments had even better access to NHS services, usually being released on licence to attend local hospitals.

Management of health care centres

5.14 During the course of our inspections into large health care centres we observed confusion and overlap between the roles of the Senior Medical Officer and the governor grade in charge of the health care centre. It was not clear to us, and frequently to them, who was accountable to whom. This meant that no one person was holding personal responsibility for the general management of the health care centre. This was also the case in the NHS until the Griffiths Report (1986). The report noted that:

"Absence of this general management support means that there is no driving force seeking and accepting direct and personal responsibility for developing management plans, securing their implementation and monitoring actual achievement."

5.15 It seems to us that general management principles should be introduced into health care services. In our inspections we have frequently seen confused, expensive management structures which paralyse individuals' potential and create anxiety as well as avoidance behaviour. **A new role of general manager should be created and selection of the post holder should be based on a management track record of achievement. The primary profession is irrelevant.**

Training of doctors in the Prison Service

5.16 In May 1994 the report of the Working Party of Three Royal Medical Colleges on the Education and Training of Doctors in the Health Care Service for Prisoners was published, though the document itself is dated June 1992. The report noted that medical care provided for prisoners should not only be appropriate for their needs but also equal to that found in the NHS. To this end the report recommended that a series of training programmes should be established for doctors working in prisons. These included an induction course and extended training programmes. The proposed syllabus for these courses was included in the report. The report also suggested that there should be a post induction course for psychiatrists working in prisons.

5.17 The report further recommends that a full range of specialist advice should be made available on referral and no prisoner should be denied medical care which would normally be available through the NHS.

5.18 We very much welcomed the report by the three colleges. The aims and ways forward seem entirely appropriate. We are however concerned at the delays in implementing the recommendations. Two years after the report was delivered we have noticed little difference in the training of prison doctors. This is unacceptable. **Full training for prison doctors, as outlined in the report, should be introduced without further delay.**

Staffing of health care centres

5.19 The nursing care for prisoners in local prisons was increasingly shared by health care officers and nurses who together formed the health care nursing team. This mixture of disciplines did not always work well. There could be considerable rivalry between them, there was a lack of job descriptions, muddle about management responsibilities and resentments at taking orders from another discipline. In establishments where there was a core of old fashioned health care officers lacking modern therapeutic attitudes working alongside newly appointed nurses there was often open disagreement and tension. There must be considerable effort given to solving this problem. It is possible for health care officers and nurses to work together if there is a will, good management and the participants have similar therapeutic attitudes. We were frequently impressed by the quality and enthusiasm of the teams which did work together.

5.20 We were disappointed to find that there were still sometimes failures of training for nurses new to prisons, for example in the use of radios, breakaway techniques and the use of keys. **A full induction programme should be made available for all nurses joining the Prison Service.**

5.21 A mixture of health care officers and nurses in training and open prisons and Young Offender Institutions was not uncommon and in these settings it seemed to work well. A typical small prison would have some three health care staff, and a larger one six, who would provide day time nursing cover only. Blundeston also had a nurse on call to give a first assessment of medical complaints in the evening, many of which were very minor in nature. The staff would offer assessments of prisoners if they became unwell during the day (calling the doctor where necessary) and give simple treatments. They would be responsible for the distribution of prescribed medication. Staff would also make an assessment of new receptions on the day of arrival. Generally all these arrangements worked well.

Primary care

5.22 At Wolds, patients for the doctor's morning surgery were seen by the prison doctor by appointment (as in the community), with sufficient time allowed, in privacy, in a pleasant office. This seemed to us a very good system.

5.23 In the old local prisons the doctor's morning surgeries were often carried out by the visiting general practitioners. There was usually no appointment system. The general practitioners were often pressed for time (to get back to their own surgeries) and tended to rush through surgeries. Prisoners are hypersensitive to rejection or interference with their rights. They resent being dealt with too quickly. The average time given to prisoners in the surgeries was relatively short (less than 5 minutes per case) and most practitioners were conscious that this was so. Some doctors also adopted a more confrontational style with prisoners whom they often suspected of exaggerating symptoms or manipulating in order to get drugs or medicines which their condition did not merit. Many doctors were unjustly accused by prisoners of the over-use of simple analgesics, eg aspirin, but this often reflected the ignorance of the prisoners who expected antibiotics for a cold or magical treatment for a sprain.

5.24 Clinics should be conducted at a less hectic pace with time for proper explanations. We also noticed that they were conducted without privacy because a health care worker was always present. In very busy clinics there were sometimes several health care workers in the room. They would bustle around the surgery during the interview and even talk to each other or interrupt whilst the interview was going on. We have commented on this in the individual reports. **We believe that surgeries should ideally be in private as they are in the community.** If a health care workers has to be present for security reasons then they should sit discretely and quietly in the background.

5.25 A further contrast between primary care in prisons and that in the community lies in the difference of facilities. In the community the doctor would be assisted by practice and community nurses. Health care staff should develop these skills.

5.26 In training and open prisons and Young Offender Institutions appointment systems to see the doctor were uncommon. We hope they will be developed. Medical care on the wings was generally offered from a daily surgery by a part-time medical officer, usually a local general practitioner who, with his partners, also offered 24 hour emergency cover. The doctor usually saw new receptions (those who had arrived the day before) during the surgery as well as prisoners leaving the establishment. We often found that this had some disadvantages. The doctor would have limited time available due either to the pressures of the NHS practice (many practitioners spent less hours in establishments than they were paid for) or occasionally the small number of contracted hours. Only a minority were involved with the management of the establishment. This lack of time became most significant in bigger establishments with larger numbers of prisoners reporting sick. Surgeries there were often conducted at speed so that the time spent with each prisoner would be less than expected in a modern practice.

5.27 Surgeries were rarely conducted in private (Kirklevington Grange was an exception). A health care worker generally remained in the room with the patient. Surgeries should be in private. We were pleased to find that prisoners no longer had to go to the doctor to get a change of shoes or to get an appointment to see the dentist or optician in most places. Such practices should be adopted in all establishments.

Pharmacy services

5.28 There has been an increase in the number of pharmacists employed in local prisons. However Wolds did not have one in post. Exeter had one for only a few sessions though they needed more. Preston had successfully contracted out the service to the local hospital.

5.29 Medication was distributed in a variety of ways. At Preston it was distributed in the traditional prison way: in separate doses from a stock bottle by the health care staff three times a day. At Pentonville "safe" medication was dispensed in personalised containers by a pharmacist as it would be in the NHS and distributed by health care staff to the inmate to be held in possession in cell. Other medication, for example psychotropic medication, was given out by the health care staff three times a day as at Preston. At Wolds each prisoner's daily medication was put in a container and labelled. The containers were then taken to the wings and given to the landing officer to distribute to the prisoners.

5.30 Staff have a fear that medication will be abused and become a form of currency. Prisoners may be intimidated to hand over their medication to bullies. Care needs to be exercised in this area but in general we believe that prisoners should be allowed to hold "safe" medication in possession.

5.31 In training and open prisons medicines were often obtained from a bigger prison or by buying in a pharmacy service from the private sector. In some prisons health care staff were still ordering and dispensing the medication. Pharmacy practice should be managed by a pharmacist. The security of the treatment rooms where the drugs were stored was sometimes deficient. Most prisons were moving to a stage where prisoners were being given their medication for several days at a time except for that which was dangerous or likely to be used as currency. We welcome this move.

5.32 We encountered some perceived difficulties about the distribution of simple household medications (aspirin, indigestion tablets). In our view these should be available from discipline staff particularly when health care staff are not available. The risks from their use are only very slight.

Dental health

5.33 In local prisons dental facilities were variable and reflected the general standard of the plant. The new prisons had excellent facilities. The worst was at Pentonville where the equipment and room had been condemned (though there was a new surgery waiting to be used in a converted block into which the health care service was to move). Facilities at Exeter were less than ideal. Sometimes we met complaints that there was a big gap between a prisoner asking to see a dentist and being put on a waiting list. At Liverpool dental sessions were frequently lost due to prisoners not getting to the session (often due to lack of escorting staff). This is the sort of thing which could usefully be subject to clinical audit.

5.34 At training and open prisons we found that there was generally a good dental service with reasonably well equipped surgeries (except at Brockhill) though few were without some deficiency. It was baffling to find that it might require an inspection to put these right. All dentists should be working in conditions which meet modern hygiene standards.

X-ray services

5.35 X-ray services were provided entirely from the local NHS services at Preston, Exeter and Northallerton, where there were no X-ray rooms in the prisons. Where there were such rooms (for example at Liverpool, Pentonville and Moorland) the equipment was generally good with appropriate machines and trained personnel using them. Only Liverpool had some over-elaborate equipment and this was broken. All these prisons supplemented their service by sending inmates to local hospitals for emergencies or complicated work. Wolds had an excellent X-ray suite but found it more convenient to use the local NHS service. The decision to do so must depend in part on the relative costs and ease of escorting. Clinically all the prisons seemed to find a way of getting X-rays done.

5.36 Most training and open prisons used local NHS services but some had X-ray equipment. Generally a radiographer attended to use the prison equipment. It was very rare to find the outdated (and illegal) practice of health care staff using equipment without proper qualification though we did find one example (Blundeston).

HIV and AIDS

5.37 Most establishments had a multi-disciplinary management group dealing with HIV/AIDS issues. Such management groups should be formed in all establishments. A number of establishments failed to provide the basic awareness training for prisoners in HIV/AIDS that

now should be routine. The training video produced by the Prison Service was not shown to new prisoners at a large number of prisons. Even where we found the video shown it was rare for a member of staff to be present to answer prisoners' questions. Staff training was equally poor at Liverpool, Pentonville, Preston, Exeter, Downview and Coldingley.

5.38 All establishments provided a confidential HIV testing scheme. Some put the results of tests into the medical notes. This, in our experience, could lead to loss of confidentiality. This practice should stop. Many establishments however lacked sufficient counsellors trained to deal with HIV and AIDS issues. The worse practice in dealing with prisoners who were HIV positive was to be found at Liverpool where at the time of our inspection a partial Viral Infectivity Regime was employed on the main wing. Prisoners known to be HIV positive were placed in a cell with another affected prisoner. They had limited work opportunities and were forced to avoid cutting implements and contact sports. Such restrictions have no place in the Prison Service and should cease.

5.39 Condoms were becoming increasingly available at a number of prisons for men going on home leave: this may well prove a useful contribution to public health.

General education in health matters

5.40 In many prisons, especially busy locals, there was little in the way of general education in health matters. We might have expected that in the relatively calmer atmosphere of a training prison it would be possible to provide good education in these matters. We found that this was generally not so. A number were developing 'well man' or 'well woman' clinics. More establishments should do so and provide a fuller range of general education in health matters. We must repeat a recommendation we have often made, which has frequently been agreed and then ignored by those in authority. **We believe every prison should have a "disability officer", whose job it is to check on those with a physical, sensory or mental disability, and make sure they are appropriately located and in contact with whatever expert or group may be locally appropriate.** It is rare to find such an officer, although we have found many officers with an interest, and a concern for example with signed speech for the deaf.

APPENDIX 5 Extract from the Annual Report of HM Chief Inspector of Prisons
1994-95

Chapter Five

HEALTH CARE

5.01 *PRISONERS' HEALTH NEEDS broadly reflect those of similar age groups within the community, though the prison population as a whole is more vulnerable. It presents a greater concentration of health care problems resulting from drug abuse and its associated risks, mental illness, general medical conditions and physical violence. The Prison Health Care Service is designed and operated to meet those specific and general needs through the provision of clinical assistance to all prisoners, some of whom have episodic illnesses and may require admission to a prison health care centre, or an outside general hospital. Others may be mentally disordered offenders requiring transfer to suitable NHS psychiatric facilities.*

Managing prison health care

5.02 The health care policy statement by the Prison Service has created substantial expectations among clinical staff in prisons. But we have repeatedly found that these expectations are not being met in, for example, the provision of levels of staffing levels equivalent to those found in the National Health Service, staff training, the provision of a 24-hour therapeutic environment for patients, multi-disciplinary care, planning, and implementation of national policies like the Patients' Charter Standards.

5.03 At a time when the Prison Service as a whole is undergoing fundamental change, developments in prisoner healthcare require first-class management skills to convert policy into practical plans for implementation.

5.04 Changes in recent years in prisoner health care have included -

- implementation of the policy statement on NHS equivalent health care
- implementation of Government policies like 'Health of the Nation' and the Patients' Charter
- introduction of 'civilian' nurses
- ending of the health care officer training programme
- integration of Prison Service nurses and health care officers and associated manpower planning and training
- introduction of a Health Care Standards portfolio
- an audit of nursing services
- a clinical audit

Need for planning

5.05 In almost all establishments inspected, we failed to find a plan describing the health care service for prisoners, still less one setting out its aims and objectives. We frequently found neither commitment nor understanding that the planning of the health care service for prisoners was an absolute essential to good management. In many of the large, complex prisons we visited, we found a complete management vacuum in health care, with resulting confused interpretations and, at times, ignorance of policy.

5.06 It is clear that there are few identifiable individuals held personally accountable for the direction of health care policy implementation and for planning, implementing and controlling performance for health care as a whole. The task of management in health care

is demanding and continuous and requires a high level of skill.

Responsibility for health care

5.07 The problem appears rooted in the way the responsibility for the management of health care in prisons is framed in Standing Order 13 (Health Care, April 1991, Home Office) which sets out the duties of the Managing Medical Officer (the most senior of the medical officers by grade). It describes the dual role of the Managing Medical officer (the responsibility for health care as well as acting as a medical officer)

5.08 The Managing Medical officer is accountable to:

(i) the Director of Prison Medical Services for maintaining appropriate standards of medical and nursing care; and,

(ii) the Governor of the establishment for the general performance, efficiency and cost effectiveness of medical, nursing and pharmaceutical services, and the conduct of medical staff.

5.09 Standing Order 13 notes that "*in the discharge of these responsibilities, he/she will be advised and assisted by a Health Care Manager.*" At paragraph 8 it describes the Health Care Manager as the most senior nursing officer by grade.

5.10 The Health Care Manager also has dual reporting lines, being professionally accountable to the Managing Medical Officer and to the Governor for the general conduct of nursing staff.

5.11 The outline job description in Standing Order 13 for the Managing Medical Officer is substantially clinical in nature and the same is true for the Health Care Manager. Responsibility for the overall direction and setting of management objectives for the health care service is absent.

5.12 We believe that when jobs are combined, there is a natural and understandable tendency for the employee to concentrate on those tasks which he or she most enjoys and is best qualified to carry out. Standing Order 13 creates these conditions and offers opportunities to doctors to be good clinicians rather than good managers. It places unfair burdens on the shoulders of individual doctors who have not been trained, or who are less skilled, in management. Inevitably the management responsibilities of the role suffer by omission.

5.13 We have seen Managing Medical Officers absorbed by clinical responsibilities, some spending 90 per cent of their time on clinical work. Many were overworked. The experience gained on our inspections demonstrates that the present management arrangements are muddled and dysfunctional. Doctors are not to blame for this. It is part of the traditional structure and needs review.

5.14 The lack of a clearly defined general management function has been one of our most regular observations during inspections of many prisons with large health care centres.

One general manager

5.15 We believe there should be one person under whom all the general management functions - planning, implementing and control of performance - are drawn together. This named person should be appointed on the basis of management skill and ability and should be ultimately responsible for the delivery of health care in each establishment.

5.16 How this is to be achieved is a matter for the Prison Service. Appropriate management skills must be the criteria, not the seniority of a professional clinical group.

5.17 Health Care Managers must be given time to fulfil the duties and responsibilities of the post. Doctors must retain their clinical independence, and any new management arrangements should work to ensure this.

Benefits from improvement

5.18 We believe that the changes we have outlined would bring immediate benefit by -

- providing the necessary leadership to capitalise on the existing high levels of dedication and expertise among prison health care staff of all disciplines, and to stimulate initiative, urgency and vitality
- better identifying the healthcare needs of prisoners, and gearing services and staff skills to meet demands

- bringing together all those involved in healthcare to produce a vision, set of values and precise management objectives in a five year strategic plan from which the annual business plans would flow
- ensuring that one person is held to proper account for performance and achievement.
- better and more focussed staff morale and attitudes
- integrating the skills of health care officers and Prison Service nurses to meet the demands of both security and clinical care
- translating national policy into practical and achievable local plans
- managing in an orderly way, avoiding a fragmented and non-directional approach to changes
- ensuring that management plays an active, rather than reactive, role in relation to the health care service for prisoners, making them central to its activity
- securing the most effective use of all resources

Health care in adult local remand prisons and Parkhurst

5.19 The health care centres of twelve local prisons were inspected. They varied from brand new to very old and worn out buildings. Parkhurst, although not a remand or local prison, shared many of their features from a health care centre point of view, in particular, that of having a large inpatient area including a substantial psychiatric inpatient population, as well as providing a primary health care service.

Accommodation

5.20 We were pleased to find a move towards acquisition of decent accommodation for health care centres. A number had plans for improvement, though at the time of inspection, some were still grossly unsatisfactory such as Wandsworth Prison. Others, including Parkhurst Prison, seemed to have no plans despite awful conditions for psychiatric patients and those with physical conditions. There should be no delay in bringing all health care centres up to modern standards.

5.21 In Leeds Prison the brand new health care centre was squeezed into a very awkward site. The resulting problems included windowless rooms, ventilation difficulties which had been resolved by the installation of intrusively noisy mechanical systems, and a lack of staff toilets in the right places.

5.22 None of the new prisons had outstanding designs for their healthcare centres. At Woodhill Prison, the design was particularly disappointing with some very poor inpatient areas which were short of day space and natural light.

5.23 A problem which has not been solved anywhere is the access to patients for nurses after lock-up. Nurses working at an outside hospital would regard it as essential that they could easily observe and talk to their patients throughout the 24 hours, if necessary.

5.24 The designs in a number of new health care centres did not facilitate this. There was no satisfactory nursing observation in the wards in most prisons after lock-up. Various ways of relieving this were being developed, for example, bigger observation windows and closed-circuit television. Prison designs should provide for good continuous observation.

5.25 Most modern designs did not give enough space for a psychiatric nursing section separate from that for the physically ill. This should be taken into account in the future.

5.26 The designs of a number of new health care centres did not provide adequate toilet facilities for staff of both sexes within the working areas. For example, in the Elmley Prison design there was no staff toilet for women in the inpatient area.

Regimes for inpatients

5.27 Overall there had been an improvement in the amount of time inpatients were allowed out of their cells each day. None provided 12 hours out, though Hull Prison reached 11 hours. Nine hours was not uncommon, but High Down Prison provided only six hours out a day. Individual patients might be out of their cells for a much shorter time because of staffing difficulties or inefficiencies. There should be regular monitoring of time out of cell.

5.28 The amount of formal activities provided for patients out of their cells was generally rather sparse with only occasional sessions (often only 2-3 a week) provided by the education department. Time out of cell alone is not enough. A good proportion of it should be used in structured appropriate activities. We would like to see greater use of education, physical education and the wider introduction of the services of occupational therapists.

Staffing

5.29 Nurses and Health Care Officers were integrated in all the health care centres in the larger local prisons. We still found some difficulties in this area, rivalries and suspicious hostility at worst but there were areas of very successful integration, for example at Elmley Prison, where the nursing management structure was particularly clear with good job descriptions, regular staff meetings and the introduction of nursing teams. In the Elmley health care centre, the day's tasks were listed at each work station to everyone's benefit. This was particularly helpful when staff moved from their regular area to a new one.

5.30 A frequent complaint from nurses everywhere was to be the lack of induction training to work in the prison before taking up the post and the lack of in-service training once in post. Many nurses were also worried that they would not get the necessary regular training to maintain their registration. Staffing levels must allow for the release of nurses for essential training.

5.31 The provision of a diploma course in prison medicine for medical officers was being prepared but had not started during this last year. A number of doctors had attended a national course on drug abuse.

Pharmacy and the distribution of medicine

5.32 We were pleased to find that all the local prisons, except Hull, had good pharmacy services. Most had a full-time pharmacist. Blakenhurst had contracted

in a service from the local hospital trust which seemed to work well.

5.33 We were also pleased to find that where there was a pharmacist employed, personalised medication was commonplace (though not everywhere) and increasingly, 'safe' medicines were dispensed to be kept in the prisoner's possession. Nevertheless there was room still to increase 'in-possession' medication in a number of prisons, for example Risley and Blakenhurst, and there was still some dispensing from stock supplies. We also saw an example of the bad practice of doses of medication being carried in small plastic cups around a prison.

5.34 The security of pharmacies was generally good. Some were too small and overcrowded. There needs to be sufficient storage space if economies are to be made through bulk buying. In some new prisons built to a particular design, for example Elmley, the pharmacy had been placed on the first floor without a lift. There was a problem in moving very heavy packages up the stairs to the pharmacy became problematical. The logistics of getting medication into the pharmacies should always be kept in mind.

Dental services

5.35 We were pleased to find that dental surgeries in the new prisons were generally in very good order with only minor deficiencies. The situation was less satisfactory in the old prisons particularly Risley. None reached the low standards of some surgeries we have seen in the past. Usually, waiting times were reasonable and standards good.

5.36 Abrasive dental powder was still being issued at some prisons, for example at Leeds, as well as unsatisfactory (too hard) toothbrushes. Dental powder and unsuitable toothbrushes should be withdrawn.

Psychiatric services

5.37 A number of prisons reported a reduction in the number of seriously mentally ill patients being admitted to prison on remand. This was thought to be due to court diversion schemes or to a greater awareness of the problem in the NHS. Despite this and the increased speed of transfer of mentally ill inmates to hospital, we found there was still a need to provide inpatient care in prisons for such cases. Mentally ill patients generally stayed in prison for several weeks (occasionally months) before transfer though the overall time had decreased. Furthermore there was evidence that at least one excellent diversion scheme (at Birmingham) was having problems in reducing the number of mentally ill prisoners because of increasing difficulties in finding psychiatric hospital beds. We found, therefore, no reason to reduce the need for a good psychiatric service in the local prisons.

5.38 We believe that psychiatric reports are best done by psychiatrists and that the doctors in charge of psychiatric inpatients should be psychiatrically qualified or working in close association with those who are so qualified.

5.39 We found that reports were in fact increasingly being done by psychiatrically qualified staff. However, this was not universal, for example, at Blakenhurst Prison, which might in part

explain the low referral rate the NHS there. Sometimes psychiatrists were inexperienced in forensic matters and were uncomfortable dealing with these patients. Experience in forensic psychiatry is important for the visiting psychiatrist.

5.40 Not many health care centres involved a psychiatrist in the day to day care of the mentally ill in the prison. Occasionally the medical officer was psychiatrically qualified. Some had made arrangements for mentally ill prisoners to be cared for by a visiting psychiatrist. We think this is a good development.

X-ray service

5.41 The larger local prisons had their own X-ray services which were regularly inspected. We were pleased to find that these were generally in good order. However, three prisons had been supplied with portable X-ray machines which are not entirely satisfactory. We believe that fixed machines should normally be supplied.

Primary care on the wings

5.42 In some prisons the daily surgeries were run by local general practitioners attending on a sessional basis. In others it had not been possible to find general practitioners willing to take on the tasks and they were done therefore by the medical officers. At Blakenhurst the clinics were run by the medical officers as part of the contract. This seemed to work well.

5.43 We found that the clinics were almost never conducted in private. The nurse or health care officer was nearly

always present. Sometimes the nurse or health care officer would join in the interview, offering information or trying to clarify matters. At best the health care worker remained quietly in the background and did not intrude but would be available if needed. At worst, two or more people would be bustling about the surgery independently or talking independently to each other whilst the patient was being seen by the doctor.

5.44 Inmates did not complain to us about this but, in extreme cases, doctors did. Mostly, however, everyone accepted the practice and doctors found it helpful (in providing instant information) and safer (some inmates could be intimidating if refused their favoured medication). We feel that interviews should resemble normal practice as far as possible and be in private. If security is a problem and a health care worker is required in the room, then the worker should be as inconspicuous as possible.

5.45 Some prisons had an appointment system to see the doctor resembling those in the community, for example at Blakenhurst and Wandsworth Prisons, which seemed to work well and was seen as improvement. We think this is a good development. Care has to be taken that there are sufficient clinics to avoid a long delay before an appointment can be made and that the appointments allow enough time for the doctor to see the patient properly.

5.46 Computerisation (as in general practice) has not yet been introduced into the prison medical practice. A number of practitioners drew our attention to this 'deficiency' and expressed the view that there would be considerable benefits to the service if computerisation were to

become available. We believe that computerisation should be promoted.

5.47 There were usually good arrangements for health care staff to see emergency cases and deal with daily routine minor disorders. We still found that in many places health care staff were being unnecessarily called up out of hours to give simple 'domestic' medication. Wing staff should be able to give out simple everyday remedies, for example, ordinary painkillers or indigestion tablets.

New prisoners

5.48 Generally new inmates were seen on the day of arrival by a doctor and a health care worker. Only at one establishment, Elmley, was the medical interview done routinely the following day, a practice we thought unsafe for a local prison where inmates are received directly from the community.

5.49 There had been a considerable overall improvement in reception facilities. However, not all prisons, and particularly the older ones, have yet reached the prescribed standard of accommodation for health care workers in the reception area. Some rooms were windowless, bare, uninviting and grubby, for example at Leeds and Hull and others had an irritating number of minor faults such as no telephone, too noisy ventilation, or an alarm bell out of reach.

5.50 It was often difficult to provide the desirable continuous medical cover in reception which would prevent prisoners having long waits there. It is difficult to envisage a solution without increases in staffing.

5.51 Routine blood pressure measurement was becoming commonplace though urine testing for illness was not. Urine testing for illness is a useful screening device and should be increased.

Promoting good health practices

5.52 Prisons were still edging forward in this area, and in local prisons, with very large throughputs of inmates, it is intrinsically more difficult to organize. We were pleased to find that no-smoking policies were gradually being adopted. Woodhill seemed to have the best arrangement with a ban on smoking in all communal areas.

5.53 A number of establishments like Elmley Prison, had started 'well-person' clinics for staff and inmates but these were usually in the early stages of development. Woodhill had developed an occupational health service for staff. Both developments, we think, should be replicated elsewhere.

Young offenders

5.54 The health care centres of six Young Offender Institutions (YOI) and one Young Offender Centre (YOC) in Northern Ireland were inspected. Five of these establishments were remand centres.

5.55 Most of these YOI health care centres were in good order and kept very clean (Lancaster Farms exceptionally so), though Hindley and Deerbolt were in need of attention through age and neglect. The remand centres were

provided with inpatient accommodation. Generally the need for inpatient beds was much less than in adult establishments. As a result there tended to be an excess of inpatient accommodation in remand centres. We were pleased to find that most of the establishments had in-patient rooms fitted with integral sanitation. Stoke Heath Prison and YOI was an exception.

5.56 Finding ways of continuously observing in-patients is always a problem. Some establishments had no observation wards. Lancaster Farms YOI and RC had a number of rooms with doors with no flap so that it was difficult to speak to the patient after lock up. Brinsford YOI and RC had developed a closed circuit television system system with 24 hour recording to improve observation of the ward area (which was also said to have produced a reduction in bullying there). As far as possible staff directly observed the ward.

Inpatient regimes in YOI health care centres

5.57 As in adult prisons the regimes generally did not meet the Directorate of Health Care standard of 12 hours out of cell. Lancaster Farms and Brinsford reached 10 hours. None had 6 hours of planned activity a day. Hydebank Wood in Northern Ireland had a very good programme involving inmates in looking after the health care centre. In too many places inmates had nothing to do most of the time. At worst, inmates might be locked up for some 18 hours out of 24.

5.58 We particularly liked the way nurses at Brinsford linked up with the

wings to support former inpatients when they returned to normal location.

Staffing YOI health care centres

5.59 In some of these establishments, for example Brinsford and Lancaster Farms nurses were the core of the health care centre staff and this worked well. Hydebank Wood was staffed mainly by Higher Clinical Officers and this also worked well. At Deerbolt the mixture of Health Care Officers and nurses had lead to considerable unresolved friction. Overall, we were impressed by the enthusiasm of staff for their task.

Pharmacy services

5.60 Generally the use of medication in Young Offender Institutions was much less than in adult establishments. There was a particularly low level of use at Brinsford. We wondered if this might reflect the involvement of the nurses in seeing inmates who presented as unwell.

5.61 Not all establishments had a full pharmacy service. Some, such as Deerbolt, were still providing medication from stock. There should be a proper pharmacy service in each establishment. This can be obtained by employing a pharmacist or by contracting in from the NHS (as at Brinsford) or from a private pharmacist.

5.62 A number of pharmacies failed to meet proper security standards. Pharmacy security should be reviewed and where necessary improved.

Dental services

5.63 Dental services were generally good but there was a shortage of instruments in some surgeries which could lead to unsatisfactory standards of hygiene. This should not happen.

Psychiatric services

5.64 Seriously mentally ill inmates are rarer in YOIs than in adult prisons. A lot of the admissions to health care centres were inmates who were distressed, anxious and depressed, often in reaction to their plight. Some would express suicidal ideas or have mutilated themselves. The health care staff provided relief. However, there was rarely a psychiatrist overseeing the care of these mentally disturbed people as would be desirable. We liked the arrangement at Lancaster Farms where a psychiatrist was contracted in to give such care.

5.65 Generally court reports were prepared by psychiatrists, though this was not always the case. Psychiatric court reports should be prepared only by psychiatrists.

5.66 We noted in all YOIs (as in adult establishments) a big difference in the regimes for psychiatrically disturbed in-patients in a health care centre compared to a psychiatric unit. We draw attention particularly to the periods of lockup in a room, the inability of nursing staff to communicate directly with patients after lock-up and the lack of power of staff in a health care centre to treat a mentally ill patient against their will when he or she is suffering from a crippling mental illness and is without insight. A solution

should be found to these problems as long as health care centre staff have to provide extended care to the seriously mentally ill because of the NHS inability to give rapid admission to an outside hospital.

5.67 Mentally ill patients who behaved violently were often secluded in an unfurnished room. We were impressed by the care with which this was done at Brinsford where nurses remained in contact to calm the inmate. Seclusion was thus minimised. Nevertheless there should be a formal policy in all establishments that seclusion in the health care centre should be governed by the guidance in the Code of Practice for the Mental Health Act 1983.

Primary care on YOI wings

5.68 The population of the YOIs seemed healthier than the population of adult prisons. Although a good number might present as unwell each day the complaints seemed to be very minor and easily dealt with by nurses at Brinsford. Most YOIs did not have an appointment system to see a doctor or nurse though some were planning to do so. An appointment system had been tried at Lancaster Farms but it had not been liked by inmates or staff and so had been abandoned. An appointment system had been retained for the dentist and optician.

5.69 Interviews with the doctor in YOIs were rarely in private, except at Lancaster Farms and Huntercombe. We think there should be privacy at all establishments.

5.70 Accommodation for these primary care services was mostly, but not always, satisfactory. At Hindley, for example,

the clinic room was rather dirty and poorly equipped. Accommodation should match a high professional standard.

Arrivals and discharges

5.71 We saw reasonable reception procedures and good facilities at some establishments, for example at Brinsford and Lancaster Farms. At Hydebank Wood YOC and Deerbolt there was no room in which the duty nurse could see patients.

5.72 Inmates being released were seen in many establishments (as were many adult prisoners) by a nurse only. If there was a medical reason, for example if the prisoner was currently under treatment, then a doctor would also see them. This arrangement is against Standing Orders which require that all inmates leaving a prison should be seen by a doctor. We are not sure that on clinical grounds this

is necessary we think that the standing order might be reconsidered

Promoting good health

5.73 Health education was not well developed in any of the YOIs we inspected

5.74 Lancaster Farms had done a lot to develop healthy conditions for inmates and had given a presentation of its work to the World Health Organisation. However, it had not yet developed health education. Brinsford had developed a good occupational health scheme for staff which we welcome and recommend. General health education had been started on a voluntary basis for inmates and an anti-smoking policy begun there. Other establishments were not so well developed though most were developing anti-smoking policies. A number offered voluntary classes on aspects of health education.

**APPENDIX 6: Financial Resources - Extract from the Annual
Report of HM Prison Service Director of Health Care
1994-95, Chapter 8**

HEALTH CARE EXPENDITURE 1990/91-1994/95 £MILLION IN REAL TERMS¹

	1990/91	1991/92	1992/93	1993/94	1994/95
Pay, allowances etc	31.177	32.272	33.169	33.629	34.238
Superannuation	6.453	6.443	6.575	4.561	4.644
National Insurance	2.284	2.462	2.249	2.593	2.640
Outside staff (fees etc)	2.642	2.691	2.808	2.032	2.069
Locums	1.944	2.439	2.855	3.009	3.063
Dentist	1.592	1.720	1.756	1.750	1.782
Opticians	377	448	486	468	476
Psychiatrists	1.260	1.446	1.372	1.475	1.502
Travel	315	257	300	376	383
Subsistence (inc research)	346	233	196	444	452
Public utilities	792	918	984	883	899
Fuels	505	219	255	171	174
Rates and rent	505	2.241	689	2.398	2.441
Medical/pharm supplies	3.140	3.492	4.072	4.249	4.326
Miscellaneous	1.429	936	637	177	180
TOTAL	54.764	58.217	58.403	58.215	59.269
ANNUAL VARIATION		+6.3%	+0.3%	-0.3%	+1.8%

¹ Real terms refers to output costs revalued to 1994/95 prices using the average movement in prices on the economy as a whole measured by the deflator for GDP at market prices.

APPENDIX 7: Individuals and organisations consulted in the preparation of this Discussion Paper.

Dr M Faulk, former inspector/HM Insp of Prisons

Miss M Lyne, Inspector/HM Insp of Prisons

Dr R Wool, former Director of Health Care, Prison Service

Mrs Y Wilmott, Head of Nursing Services, Prison Service Directorate of Health Care

Ms P Lutterloch, Home Office / C3 Division

Mr B Higgins, Director / HMP Blakenhurst, and staff

Mr D Waplington, Governor / HMYOI Lancaster Farms, and staff

Dr Finnigan, Clinical Director / Scott Clinic

Mr Parry, Contracts Manager / Scott Clinic

Dr G Shetty, Consultant Psychiatrist, Ashworth Hospital

Mr D McDonnell, Director / HM Remand Centre Wolds, and staff

Mr R Bailey, Project Manager, Forensic Medical Services Ltd, HM Remand Centre Wolds

Dr N Tong, GP Fundholder, Crosby, Liverpool, and Mrs E Drummond

Mr R Hoyle, Liverpool Regional Health Authority

Dr D Jones, High Security Psychiatric Services

Mr A Thaker, Commissioning Team - NHS Executive

Mr G Sandell, NACRO

Sir Donald Acheson, former Government Chief Medical Officer

APPENDIX 8: References

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