Physical health of people in prison

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments 17:00 on 27/06/16 **email:** PhysicalHealthInPrisons@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the short version and any comments you may have on the evidence presented in the full version. We would also welcome views on the Equality Impact Assessment. We would like to hear your views on these questions: 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) 4. [Insert any specific questions about the recommendations from the Developer, or delete if not needed] See section 3.9 of Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.

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<table>
<tr><td>Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):</td><td>Her Majesty's Inspectorate of Prisons
6th floor, Victory House
30-34 Kingsway
London
WC2B 6EX
We welcome the opportunity to submit a response to the NICE Consultation Physical Health of people in prison: assessment, diagnosis and management of physical health problems of people in prison. NICE guideline Methods, evidence and recommendations 16 May 2016

1. Her Majesty's Inspectorate of Prisons (HMI Prisons) is an independent inspectorate whose duties are primarily set out in section 5A of the Prison Act 1952. HMI Prisons has a statutory duty to report on conditions for and treatment of those in prisons, young offender institutions (YOIs) and immigration detention facilities. HMI Prisons also inspects court custody, police custody and customs custody (jointly with HM Inspectorate of Constabulary), and secure training centres (with Ofsted).

2. HMI Prisons coordinates, and is a member of, the UK's National Preventive Mechanism (NPM) the body established in compliance with the UK government's obligations arising from its status as a party to the UN Optional Protocol to the Convention Against Torture (OPCAT). The NPM's primary focus is the prevention of torture and ill treatment in all places of detention. Article 19 (c) of the Protocol sets out the NPM's powers to submit proposals concerning existing or draft legislation.

3. The following response is based on inspection evidence. All inspections are carried out against our Expectations - independent criteria based on relevant international human rights standards and norms.</td></tr>
<tr><td>Disclosure
Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.</td><td>No current or past direct or known indirect links to funding from the tobacco industry</td></tr>
<tr><td>Name of commentator person completing form:</td><td>Paul Tarbuck</td></tr>
</table>

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Type	[office use only]			
Comment number	**Document** (**full** version, **short** version or the **appendices**)	**Page number** Or **'general'** for comments on the whole document	**Line number** Or **'general'** for comments on the whole document	**Comments** Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
Example 1 Example 2 Example 3	Full Full Full	16 16 16	45 45 45	We are concerned that this recommendation may imply that ………….. Question 1: This recommendation will be a challenging change in practice because …… Question 3: Our trust has had experience of implementing this approach and would be willing to submit its experiences to the NICE shared learning database. Contact……………….
1	Appendices	6	4.2 a	The overall guideline covers NHS-commissioned care provided in prisons, young offender institutions and when people move from prison to another setting e.g. court. Improving health & wellbeing in prison, first reception and secondary health screen, coordination and communication between Health Professionals, Use of Medication; Urgent and emergency management in prison and continuity of healthcare on admission, transfer and release. We are concerned that with reform agenda and the potential changes to commissioning to increase Governor control that this may limits its usefulness in the future, arguably health provision in prison should be community equivalent regardless of who commissions it. We are also concerned that this suggests it is not applicable to private prisons where health services are commissioned by NOMS, which could generate difference in care and non-equivalence with the community and other prisons. The commissioning stream should not determine whether NICE applies.
2	Short Version	6	2.8	The inclusion of a screening question regarding needing help to live independently is positive. The guideline advises the nurse/HCA completing the assessment record the prisoner's needs and liaise with prison disability lead. It appropriately stresses the need to ensure staff know that aids to independent living the

				prisoner came with should follow them to their accommodation and the nurse/HCA should liaise with the kitchen. It would be helpful to also advise that the nurse/HCA liaise with custodial staff to ensure an initial appropriate management plan including Personal Emergency Evacuation Plan is put in place as there may be a time delay until the disability liaison officer is available, if there is one and that the nurse/HCA may need to consider a referral for a social care assessment.
3	Full guideline	101	47-56	On page 101 of full guideline when discussing reception screening the GDG noted that prisoners are not allowed to know when external hospital appointments are, if they are aware of these dates they will be changed (due to security issues) when entering prison. Security will decide if any original dates can be kept or if healthcare admin staff will re-arrange. We suggest the decision to rearrange should be made in partnership with healthcare and security rather than security alone to ensure that clinical risk and security risks are both addressed.
4	Full guideline			Secondary Screening - Non attendance at secondary screen is often high however in recommendations it suggests physical observations be done at that time. We wonder if observations should be done on primary screen as it may identify concerns that require more urgent follow up.
5	Full guideline			**Recommendation 8** indicates the screen should happen within 7 days – HMI Prisons has previously advocated that it occur within 72 hours however Systm One (single shared electronic clinical record system) reduces risk by improving continuity of care and we accept that 7 days may be more achievable in establishments with high throughput, providing those on short sentences or with urgent issues are appropriately prioritised for review.
6	Full guideline			**Recommendation 15**: Suggests circumstances in which the use of the Correctional Mental Health Screen be considered. It may be more useful to be more specific in indicating that the tool be used in those circumstances to support increased consistency both of assessment and referral. all prisoners are screened for TB within 48 hours of arrival.
7	Full guideline			**Recommendation 25** states healthcare professionals in prison should ensure all prisoners are screened for TB within 48 hours of arrival. To meet this time frame and ensure prompt identification of TB it would be preferable to include some screening questions in the initial screen as otherwise it floats between the initial screen on arrival

				and secondary within 7 days, and active cases may be missed.
8	Full guideline			**Recommendation 26** Within 7 days for routine XRays may be a more realistic expectation for X Ray in prisons that have such facilities.
9	Full guideline			**Recommendation 32:** We are not sure that this is realistic or community equivalent and may be counterproductive. In large prisons this would result in each member of health staff having a large allocated caseload, most of whom have no significant health needs but the staff member could not be fully conversant with them all. A prisoner with routine needs could experience delays while waiting to access an allocated care coordinator. Generally in a GP practice a patient with routine needs would access whichever practitioner is available or be triaged by a duty practitioner and allocated to the most appropriate service. It would be more appropriate to recommend that prisons have an up-to-date register of patient with complex physical and social care needs, each of whom has an allocated care coordinator who is identified to the patient and prison staff. This would be achievable and ensure effective resource allocation.
10	Full guideline			**Recommendation 33** - Overall positive re focus on communication and effective coordination included structured regular communication. However this could be strengthened to ensure a lead care coordinator is identified to ensure more cohesive management. HMP Stocken have been doing this very effectively.
11	Full guideline			**Recommendation 40:** No recommendation made re nutrition made due to lack of evidence but the food choices in prison are often limited and do not always meet Department of Health guidelines on calorific and fruit and vegetable intake. We often report concern about portion size particularly in relation to breakfast packs in male prisons. It is important to educate prisoners about healthy eating but prisoners can only choose from what is offered to them. There is potential here to make a recommendation about people in prison having access to the appropriate calorific intake through a menu that has been created with dietician input to ensure easy access to at least 5 portions of fruit and vegetables a day and appropriate healthy options on menus and in the prison canteen as choice is often restricted.
12	Full guideline			**Recommendation 42:** Easy access to barrier protection is an admirable and appropriate harm reduction goal that we have long advocated. However in a prison setting there may be risks in just being able to pick them up without recourse to confidential health advice and

				support. We are concerned that just having bowls of condoms out could create risks for vulnerable people.
13	Full guideline			**Recommendations 46 to 49** focus on supervised medication and having systems in place with prison staff to ensure administration is supervised to reduce diversion and ensure confidentiality which is commendable. It would be helpful to include in recommendations about the timing of supervised medication ensuring that appropriate therapeutic gaps are maintained as we often see the efficacy of supervised medication being drastically reduced by medication times that meet the needs of the regime and not the patient e.g. 0900, 1100 and 1600 or night sedation being given at 1630.
14	Full guideline			**Recommendation 46:** It would be helpful to specify a tool or specifically include the need to assess the person and the drug as currently this implies risk assessing the person is sufficient, however in prison the drug and access to secure in cell storage is also relevant.
15	Full guideline			**Recommendation 50:** Positive that review of In Possession risk assessment is advised and all the identified triggers for review are pertinent, however it would be helpful to specify to review at least annually and sooner if circumstances change.
16	Full guideline			**Recommendation 51** : only says consider providing secure storage it would be preferable to say provide secure storage particularly in shared cells – the GDG discussion recorded indicates that provision would be community equivalent.
17	Full guideline			**Recommendation 67** Completing the pre-release interview a month before release may increase the number seen but may create risk for some as additional issues may occur leading to duplication or things being missed. A week may be more reasonable for those with non complex needs, however it would be useful to specify at least a month prior to release for those with complex physical health or social care needs. The recommendation reads as though the care summary should be given at this point to the patient however it may be incomplete and it may be difficult for a prisoner to keep it confidential e.g. in a shared cell. It may be preferable to print it on the day prior to release and ensure it is given to them on release.
18	Full guideline			**Recommendation 68**: discusses that if detainee expected to be in prison less than a month should plan pre-release during reception secondary screen, which is positive. It may be helpful to include that in the secondary screen recommendations alongside discharge planning for those on remand to ensure it is not missed.

Insert extra rows as needed

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NICE Feedback questions

We would like to hear your views on the draft recommendations presented in the short version and any comments you may have on the evidence presented in the full version. We would also welcome views on the Equality Impact Assessment.

We would like to hear your views on these questions:

1. **Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.**

Overall this is a comprehensive piece of work which pulls together best practice and should generate increased consistency across all areas covered. Prisons we inspect generally struggle most with:

o Staffing – both for custody staff and across all aspects of the health team administrative, pharmacy, nursing staff, medical, substance misuse) which significantly impacts on prisoners ability to access health services and for health care teams to provide an effective service.

o Unpredictable workload particularly in local prisons exacerbated by medical emergencies including the impact of New Psychoactive Substances which takes resources away from other activities.

o Secondary Health Screens – due to staffing issues, lack of facilities, prisoners not prioritising the appointment the non attendance rate is often high. We advocate a separate secondary screen particularly in local prisons where people come in exhausted, confused and have a lot of information given to them and are asked a lot of questions. Separating out the secondary screen reduces the time in reception, increases the usefulness of the responses as they will have rested and gives another opportunity to assess them once they have been in prison a couple of days. However non-local prisons may struggle to implement a separate secondary screen due to resources and often combine them to maximise resource effectiveness and prisoner uptake. It may be worth considering if different types of prison can take a different risk based approach.

o Officer supervision of medication queues - we believe this is important and essential to reduce opportunities for bullying and diversion however it will have cost implications and be difficult to implement depending on staffing levels in establishment and the duration of the medication administration session. It may also impact adversely on other aspects of the regime

o Chronic Disease Management – many prisons struggle to recruit and retain staff who have the requisite skills and training to effectively complete chronic disease reviews, particularly within current grading structures. Embedding the NHS over 40 health check and effective chronic disease management that meets NICE guidance in prisons would significantly improve prisoners' health outcomes, but some areas may need increased funding to ensure it happens. It may be very useful to standardise templates and tools on the electronic clinical system alongside reducing the read codes to increase consistency.

o External hospital appointments – this is not included in this guideline but we increasingly observe prisoners experience delays which exceed national guidelines due to appointments being cancelled to accommodate emergencies or due to lack of escort staff. Delays in external appointments introduce inequality in healthcare for prisoners as they may not access services within the target timeframes expected for patients in the community. it would be

useful to address that within the guideline as it is essential for effective care that prisoners have equivalent access to the community.

- Continuity of health care can be difficult to implement when it is not clear where the prisoner will be released to or when prisoners are released suddenly. Many prisons struggle to set up effective release plans as a result. Joint planning for complex cases with offender managers and the Community Rehabilitation Companies (CRCs) is essential.

2. Would implementation of any of the draft recommendations have significant cost implications?

Please see above.

3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)

Training is central to ensuring some aspects of the guideline are achieved including chronic disease management and training in the electronic clinical record system for example using recall systems etc to make it work effectively. Some prison staff struggle to access relevant training, depending on the specialism and size of the provider organisation. Greater access to approved training including web based, face to face and practice based would be helpful. Review of health related Prison Service Orders to ensure they adequately reflect current best practice and service specifications

Checklist for submitting comments

- Use this comment form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include page and line number (not section number) of the text each comment is about.
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms do not include attachments such as research articles, letters or leaflets (for copyright reasons). We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received during our consultations are published in the interests of openness and

transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.