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Research papers

Modernising beyond the NHS: prison healthcare can benefit too

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ABSTRACT

Modernisation is usually thought of as an NHS phenomenon but already its influence has spread. Here we outline the development of modernisation in prisons. From our experience of supporting a local prison in undertaking health needs assessment and developing its health improvement planning we have been able to observe modernisation beginning to work in prison healthcare and taking effect over a relatively short period of time. Although it is too early to provide conclusive evidence of direct benefits to prisoner-patients we have found some encouraging signs. Here we report on a brief survey of how prison healthcare staff currently view modernisation and its perceived benefits for patients, and discuss the need to initiate systematic robust evaluations of some of the small-scale initiatives that modernisation has generated.

Keywords: health needs assessment, health planning, modernisation agenda, prison health

Introduction

Modernisation is usually thought of as an NHS phenomenon but already its influence has spread beyond health and social care. There are challenges associated with providing good continuing healthcare to people who become prisoners, but we believe that prison healthcare can benefit greatly from participating in modernisation activity alongside the NHS. From our experience of supporting a local prison in undertaking health needs assessment and developing its health improvement planning, we have been able to observe modernisation beginning to work in prison healthcare planning and this has occurred over a relatively short period of time. Evidence that planning has moved on is easy to generate, but demonstrating direct benefits to patients is less easy. Nevertheless it will ultimately be important to do so because improving the health of people who become prisoners can potentially benefit not only the individual but also the communities to which they return, and it is therefore essential to be sure that innovations are effective. Here we report on a brief survey of how prison healthcare staff currently view modernisation and its perceived benefits for patients.

Background

Prisoners and their health

In outlining the case for a major reform of prison healthcare, the NHS Executive recognised that it is inappropriate when considering prison healthcare to regard prisons as 'distinct entities which have little relevance for or impact on the wider community'.[1] They highlighted the transient nature of the prison population, most of whom will ultimately return to the wider community 'taking with them their health and social problems'.[1] Data compiled by the Home Office showed that over half (56.8%) of prisoners were serving less than six months.[2] Even life-sentenced prisoners are likely to serve a limited time in prison

– for example the 127 life-sentenced prisoners who were released from prisons in England and Wales in 2000 had served an average of 13.3 years.[2]

It is also significant that many prisoners come from sections of the population that may be 'difficult to reach in any other situation, and for many a spell in prison represents an opportunity for consistent contact with health services'.[1] According to the Home Office, 91.7% of people entering prison in 2000 were men, with around half (50.2%) aged under 30 and around four-fifths (82.9%) under 40.[2] The 1997 survey carried out by the Office for National Statistics (ONS) indicated that a high proportion had been taken into local authority care as children (ranging from around a quarter of female sentenced prisoners to a third of male remand prisoners).[3] The vast majority had experienced at least one stressful life event such as running away from home, serious money problems, relationship breakdown or bereavement, and about half had experienced five or more such events. Around half of those surveyed had no educational qualifications and many (around two-fifths) reported having left school before their 16th birthday with almost 1 in 10 reporting that they had left school before age 13.

Although the benefits of better healthcare in prisons both for prisoners themselves and for the wider community are clear, the provision of healthcare presents particular challenges. There is a high incidence of mental health issues, for example. The ONS survey reported that about 20% of male respondents and 40% of female respondents had received treatment for a mental or emotional problem in the 12 months before entering prison.[3] In addition the reported rates of suicide attempts were very high, especially amongst the remand prisoners, with 27% of male remand prisoners reporting that they had attempted suicide at some time in their lives, 15% in the year before interview and 2% in the previous week. It has been reported that around 80% of male sentenced prisoners smoke and around 24% of adult prisoners have injected drugs at some time.[4,5] Of those who reported having injected drugs 20% were infected with hepatitis B and 30% with hepatitis C.[5] There is also the transient nature of the prison population and the issues that this raises for providing continuity of healthcare.

Given the challenges of providing good continuing healthcare to people who become prisoners, but the obvious potential benefits for addressing health inequalities by improving their general health, it is important that the modernisation agenda extends to and is effective in the prison setting.

Modernisation and prison healthcare: intentions

Historically, prison healthcare has been separate from the NHS. In 1996, Her Majesty's Chief Inspector of Prisons called for the responsibility for healthcare provision to move from the Prison Service to the NHS.[6] A working group was jointly established by the Home Secretary and the Secretary of State for Health to look at this issue and reported in 1999.[1] The working group found that some prison establishments were making progress towards meeting the existing aim of giving 'prisoners access to the same quality and range of healthcare services as the general public receives from the National Health Service'.[1] However, they also reported that there was considerable variation in the 'organisation and delivery, quality, funding, effectiveness and links with the NHS'.[1] They described prison healthcare as having been characterised by services developed on an *ad hoc* basis to suit custodial or organisational requirements rather than based on the health needs of prisoners and this has led to 'questions about equity, standards {and} professional isolation'.[1] The working group recommended the establishment of a formal partnership between the NHS and the Prison Service but that funding and departmental accountabilities remain with the Home Office.

At a national level, this resulted in the establishment of a Prison Health Policy Unit and Prison Health Taskforce in April 2000 and a Development Work Programme which encompasses services, workforce and performance management. In December 2002 to aid effective integration between the Prison Service and the NHS these two bodies formed a single Prison Heath Development Unit.[7]

Regional prison health taskforces were established to support prisons and health authorities to 'drive forward the assessment of need' and prison health improvement programmes.[1] In 1999, health authorities had joint responsibility alongside their prison partners for conducting a health needs assessment and developing a prison health improvement programme. As a result of *Shifting the Balance of Power* the NHS side of this responsibility has devolved to the host primary care trust (PCT) i.e. the PCT within which the prison is geographically located.[8] Guidance on the process of needs assessment and health improvement planning has been issued and prisons and their NHS partners will shortly start their third round of needs assessment activity.[9–11]

From April 2003, the budgetary responsibility for commissioning prison healthcare will be transferred from the Home Office to the Department of Health with the ultimate aim of devolving commissioning of prison healthcare to the host PCT level.[12]

Modernisation and prison healthcare: reality

Within the prison establishments themselves, modernisation has primarily focused on the systematic identification of healthcare need and the development and implementation of health improvement plans to meet this need. We have supported prisons in two rounds of needs assessment and planning within prison healthcare in which we have had the opportunity to observe directly how modernisation has been taken up and to confirm and test our impressions by consulting with colleagues elsewhere. Specifically, we decided to survey prison healthcare staff within the prisons that make up the government offices for Yorkshire and the Humber and the North East (GO Y&H and NE) to:

- identify what NHS–prison partnership arrangements are in place in prisons within the geographical region GO Y&H and NE
- explore the experience of healthcare staff involved in the development of needs assessment and health improvement planning
- identify evidence of examples of direct benefits to patients arising out of the development of health improvement plans.

We recognised that a survey at this early stage of the uptake of modernisation by prisons would not demonstrate conclusively that patients were directly benefiting. However, we hoped to provide initial insights into how modernisation was operating and whether a larger survey or more detailed evaluation is warranted.

Survey of the prisons within GO Y&H and NE

Methodological approach

We aimed to explore how prison healthcare staff have found the experience of working with NHS colleagues to assess health need and plan prison healthcare, and in particular to gather examples of developments which they felt had improved patient care. We drew on our experiences of needs assessment and planning in prisons to design and interpret replies to a brief two-page survey instrument (see Box 1 for content) which we administered via each establishment's governing governor. Governing governors were asked to pass the questionnaire on to an appropriate member of their healthcare team, i.e. someone who had been involved in the development of their health improvement plan.

Box 1 Two-page survey instrument

- Name, job title and professional background of respondent

Open questions

- How long have you worked within the Prison Service?
- How long have you worked with NHS colleagues?
- How did you first become involved in working with NHS colleagues to plan prison healthcare?
- Can you please outline what this work has involved and whom you have worked with, i.e. PCT etc?
- Do you have any other comments on experience of working with NHS colleagues?

Closed questions leading to an opportunity to comment further

- Has working with NHS colleagues made any difference to your working life or how you do your job? If yes, please explain how.
- Did you find this work time consuming? If yes, please explain why.
- Did you encounter any problems in carrying out this work? If yes, please explain.
- Did your health improvement plan make recommendations for change? If yes, has work continued to implement the plan's recommendations? If yes, can you give us an example of what work is continuing?
- Can you think of any examples, arising out of your work with NHS colleagues that you feel have improved patient care in your prison? If yes, please give examples.

Ethical approval

We sought and gained ethical approval for the survey from Hull and East Riding Local Research Committee and gained support from the Regional Prison Health Taskforce (Northern and Yorkshire).

Findings

Respondents

We received responses from 14 of the 22 prisons surveyed. For the most part the survey was completed by prison healthcare staff with a nursing background. Of these, there was an equal split between general and mental health nursing. We also had respondents from both a medical and prison governor background. Generally, the survey was answered by the people we expected it to be passed on to, i.e. people whom we

were aware had been involved in implementing the modernisation agenda. The respondents had worked for the Prison Service for between 14 months and 26 years but even the longer serving respondents had only fairly recently engaged with NHS colleagues, i.e. post-1997, to plan services.

Partnerships

Every prison from which a response was received was able to demonstrate the existence of partnerships with the NHS. Many referred to formal joint arrangements, e.g. a Prison Health Steering Group and even of those who did not, all but one described having a range of contacts within the NHS. PCTs, strategic health authorities, health action zones, NHS workforce confederations, acute trusts, community trusts, public health departments and the prison health taskforce were all referred to.

Achievements and problems

We found clear evidence that the modernisation agenda has taken a hold in prisons for example:

- The majority of respondents identified aspects of the modernisation agenda in prisons (i.e. the task of completing a health needs assessment etc) as the main stimulus for working with their NHS colleagues although pre-existing relationships sometimes made this easier.
- Virtually all respondents described undertaking new initiatives that are clearly linked with the modernisation agenda. For example: health needs assessment, mental health needs assessment, mental health in-reach, clinical governance, electronic medical records, shared protocols, joint conferences etc were all mentioned by our respondents.
- In addition, there were several examples whereby existing services were enhanced because of easier access to specialists, e.g. specialist diabetic nurse or specialised services, e.g. CCDC (Consultant in Communicable Disease Control).
- There were also several positive comments around the reduction of professional isolation and the ability to access support, advice and up-to-date knowledge. One respondent stated '{I} feel more part of a team and less isolated, now {I} have people that I can contact in a professional capacity'.

However, the majority of respondents described difficulties with developing a health improvement plan beginning with needs assessment. One of the biggest difficulties was the time-consuming nature of this process especially given the lack of familiarity with health needs assessment at a population level within the Prison Service. Also, the lack of additional resources and dedicated time meant that within some prisons a single person 'had to do most of the work'. One respondent described the process as time consuming because of the need to 'go into depth and identify deficits'. Some respondents felt that needs assessment requires the collection of a great deal of background information and quantitative data. This was described as particularly difficult because of the lack of information technology in the prison setting. There was also the need to spend time outside the prison attending meetings with NHS colleagues. Reference was made to the various quality improvement initiatives of which needs assessment and planning is but one alongside prison health standards audit, clinical governance, 'traffic lights' etc all requiring individual action plans.[11,13] Finally, several respondents reported that their partnerships had to work to overcome the differing cultures and objectives of the NHS and Prison Service, in particular the compromise between care on the one hand and correction on the other. One respondent expressed this as 'the main problem is that both organisations have vastly different cultures and structures which can lead to difficulties; also, both organisations have different primary goals/objectives', and another respondent emphasised that 'trying to balance NHS policies with those of the Prison Service has been a major difficulty'. Additionally, one respondent made the distinction between 'orders and instructions' in the Prison Service and 'protocols and guidelines' within the NHS.

Nevertheless, all respondents stated that their health action plans included recommendations for change or development and that further work had been undertaken to implement the recommendations. In particular, most respondents stated that new services had been developed, e.g. day care, sexual health, nurse-led clinics, additional external staff sessions, e.g. psychiatry, genitourinary medicine etc. Many of the respondents also described setting up mental health in-reach services. Another aspect that many of these prisons had looked at was reviewing skill-mix and staff development, and examples of progress in this area were cited. Some respondents also described developing clinical governance mechanisms and the regular review of the health action plans. Respondents also welcomed the increased accountability and one respondent linked the introduction of clinical governance with 'enhanced patient care'.

We asked respondents whether they could give us examples, arising out of their work with NHS colleagues that they felt had improved patient care in their prison. The vast majority of respondents were able to list numerous examples, which are summarised in Box 2.

It is encouraging that despite the difficulties presented by modernisation and outlined above there was a strong perception that healthcare in prisons had

Box 2 Improved patient care examples

- Asthma and diabetes clinics
- Chronic disease clinics and registers
- Nurse-led clinics
- Named nurse system
- Mental health in-reach
- Counselling services
- Staff exchange schemes, increased nursing expertise
- Improved healthcare standards
- Multidisciplinary team meetings
- Access to PHLS (Public Health Laboratory Service) information
- Implementation of *National Service Frameworks*
- Links with specialist nurses, e.g. diabetes

already improved. As a result, several respondents were able to describe their overall experience of working with the NHS in a positive light. We noted the following responses in particular:

> 'These have been demanding times in which all staff have been stretched. However, the experience has been rewarding in regards that all staff have put in increased effort but have the satisfaction of seeing a better service in partnership with the NHS.'

> 'I have found the NHS to be responsive, helpful and above all enthusiastic to the idea of taking forward healthcare {in this prison}.'

> 'The relationship with the PCT and local prison{s} in {...} appears to improve constantly, building trust and effective partnership working.'

Discussion

Although we did not set out to demonstrate conclusively that modernisation of health services within prisons has resulted in direct benefits for patients, we consider we have found some encouraging evidence that this is probably the case. Our findings are limited by this not being a national survey. Also the response rate was lower than we would have liked but we opted not to follow up non-responders. In any case this is not an epidemiological study, for which response rate would be crucial. Rather our aim at this early stage of evaluation was not to quantify *how many* prisons could demonstrate benefits from modernisation but rather to determine if *any* considered that they could. We considered that a larger, more sophisticated study though ultimately desirable was not warranted at this early stage, if indeed it is currently possible.

We feel that our approach of gathering the impressions from staff, backed up by concrete examples has provided encouraging evidence that the processes of modernisation are embedding in prisons. As to whether modernisation has had benefits for patients, all but one of the 14 responding prisons were able to cite numerous examples of modernisation-linked service developments. We therefore feel it is likely that there is a multitude of similar examples throughout the prison estate. An early task should be to initiate systematic identification of the range of initiatives in place as a precursor to generating robust evidence of what works and specifically what works and why in specific prison settings. Unfortunately, prisons currently lack both the culture and the capacity to undertake systematic evaluation. Even within PCTs, robust evaluation of small-scale modernisation initiatives such as those described here seems uncommon. Nevertheless, there is real opportunity to build upon the momentum generated by the modernisation agenda to build research and evaluation capacity by capitalising on the new dynamic partnerships that have been created. We would encourage prisons and PCTs to seek academic partners to support them in this.

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