THE HARRIS REVIEW
Independent review into self-inflicted deaths in custody of 18-24 year olds

Stakeholder Hearing 5, 19 June 2014
Department of Health (DoH)

Anne McDonald and Angela Hawley

SUMMARY

Organisational Change and Service Delivery

There are changes across the Health and Social Care landscape, including the DoH role. From 1st April 2013, responsibility for providing healthcare in custodial settings transferred from PCTs (Primary Care Trusts) to NHS England. DoH retained the policy interest and the boundaries are still quite fluid between NHS England and DoH. The DoH is responsible for ensuring that Young People in custody have equal access to good quality health and social care as they would in the community. This can often be the first time that health and care services can begin to address the inequalities that this population has had in their life up to the point of them being taken into custody.

The government has a Mandate with NHS England describing the objectives for the NHS. This includes a commitment on offender healthcare "developing better healthcare services for offenders and people in the criminal justice system which are integrated between custody and the community, including through development of liaison and diversion services"

In addition regulations (The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012) set out the health services which NHS England is directly responsible for commissioning, including healthcare services in prisons and other prescribed accommodation. NHS England will commission services in welfare only beds in Secure Children's Homes through an amendment to these regulations which has yet to come into force. When NHS England's responsibilities outlined in the Standing Rules are extended there has to be clear agreement between DH and NHS England that the service can be provided within NHS England's budget.

Direct commissioning by NHS England has brought about improvements to the standard of service commissioned. However, there are still improvements to be made to patient safety and the way in which the boards work together as a single organisation.

Care Act 2014

The Care Act 2014, which clarifies the responsibility of local authorities for social care for adults (over 18) in prisons and bail accommodation, is a good example of cross government work to develop legislation. Joint events with Local Authorities (LAs), VCS (Voluntary and Community Services), NHS and prison staff are being held to look at the implementation of these new responsibilities, including surveys of the prison population which will enable local authorities to estimate numbers of prisoners with eligible care needs in prisons for which they have responsibility. While funding is not ring-fenced funding, it will be allocated according to where a prison is located and the age demographic of the prison. The funding formula is being consulted on (https://www.gov.uk/government/consultations/care-act-2014-funding-allocations-for-new-adult-social-care-duties). The consultation ends on 9 October.

Liaison and Diversion[1]

Concern has been raised that some young adults might be too vulnerable to be placed in a custodial setting. However, the Liaison and Diversion programme is available in police custody or court so the young person should have already been assessed and their support needs identified when they arrive in the custodial setting.

NHS England, DH, MoJ and Home Office are all partners in the Liaison and Diversion Programme. (For further information on this, see http://www.england.nhs.uk/ourwork/commissioning/health-just/liaison-and-diversion/ld-about)

There are 10 trial L&D schemes running with standard all age, all stage (custody and courts) specification from April 2014. These schemes will be the basis of a full evaluation and business case, which will be the basis of a national roll out. Any concerns or feedback should be fed into the evaluation process. The evaluation will be looking at equalities issues, particularly for effective models for children and young people. There is a focus on making Liaison and Diversion services accessible and suitable for young BME groups.

Mental Health and Custody

DoH recognises the importance of putting health, including mental health, at the core of custody. Since 2011 offender personality disorder services are being reconfigured to provide a pathway of care. Good health and mental health is the catalyst for other things such as education that prisoners can benefit from.

There is an NHS England-NOMS strategy to deliver the Offender Personality Disorder pathway, which includes treatment in prisons which provide a psychologically

[1] Dinesh McGinty declared an interest in terms of his work with NHS England Liaison and Diversion

supportive environment. There is a £50-60 m NHSE budget to commission these services.

(For further information, see: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_130566)

Views on prescribing medication and the misuse of medication are for NHS England, but the panel should be aware of the McFeeley and Gilvay reports around prescribing in prisons (http://iapdeathsincustody.independent.gov.uk/news/noms-publish-their-review-of-unclassified-deaths/).

Managing Self-Harm from DoH perspective

All health services should be safe and of good quality. The work of Professor Louis Appleby speaks to this, particularly concerning risk assessment and this work feeds into NHS England practice. By embedding safe practice into contracts NHS England is able to monitor delivery through contract management.

Substance Misuse

NHS England commissions all substance misuse services in prisons integrated with health care; this integration is a good outcome of the new system. There is pilot work in 9 prisons in the North West to provide an end to end service in prison and through the gate substance misuse programmes. This has been running for 6 months (as of June 2014) and anecdotal reports and peer monitoring is suggesting that this has value. It may have an effect on the culture of drug use in prison and a positive affect on bullying.

Information Sharing

Improving information sharing about health and mental health is a difficult issue. There is a staged approach to ensuring that the CJS can access health information and vice versa, 'work arounds' are being developed, but a cultural change is also needed. There needs to be a culture where it is a duty to share safeguarding information and there needs to be a mechanism to do this safely and fairly. NHS England can provide further information on the Health and Justice Information project.

Ineffective information sharing can affect any organisation. There are no particular patterns in prison culture that are unique. There used to be a culture clash between punishment and therapy, this seems to be breaking down but there is still a legacy.

The Liaison and Diversion programme has an information sharing work strand. This is part of the data collection work for the full business case.

Assessments and information sharing for children and young people are being enabled through CHAT (Comprehensive Health Assessment Tool) being rolled out to YOIs. All relevant staff are being trained and this should be used in the secure estate for under 18s and the information should transfer with the individual into the adult estate.

Accessing Primary Health Care Services

There is an ongoing long term piece of work to ensure that prisoners are registered with a GP in the community.

The aim is to ensure that prisoners register with a GP before they leave custody. There is a process for those who are of No Fixed Abode.

Health and well-being boards are responsible for ensuring that services are commissioned to meet the health needs of all the community, identified through a Joint Strategic Needs Assessment (JSNA). A focussed piece of work is being done to look at commissioning primary care which is not accessed via a GP and may better suit those with chaotic lives.

Most IAPT (Improving Access to Psychological Therapies) services can take self-referrals.

If the Incapacity Act were to be used in prisons, part of the prison would need to be defined as a hospital under primary legislation.

Staff Training

Staff training could be improved around mental health awareness. Joint training would underpin the information sharing culture. For non-medical staff this should be to understand risk and vulnerability, crisis care and next steps, so that they will be able to recognise risk, know what to do and who to call (not to turn them into mental health professionals).

DoH has noted the general knowledge of mental health issues and Autism in prisons. Training to have a basic understanding should be mandatory for all staff. Knowledge of mental health issues needs to be inculcated by renewing learning. In order to have a culture that supports and reinforces the learning needs the leadership of a learning organisation.

DoH will provide the Harris Review with:

1. Standing Rules on standards of health care to be provided by NHS.
2. Details of what prisons are entitled to ask for under the Care Act.

3. The NHS England strategy document on Personality Disorder and treatment in the secure setting which provides for a psychologically supportive environment.
4. Health and Justice Information project.
5. The McFeeley and Gilvay reports around prescribing in prisons. (We have asked for this from the Ministerial Board secretariat, no need to provide.)
6. Commissioning strategy pathways documents on managing self-harm.
7. Details of their information sharing initiative