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CLINKS BRIEFING

Health commissioning:
An engagement approach

About this briefing

This briefing has been written by ACEVO, in partnership with Clinks.

The key principle underlying the provision of health and social care to prisoners is that there should be equivalent quality of service to that which is available for the general population.[1] There are many roles the voluntary sector can play here, both in promoting and offering high quality healthcare, and in supporting prisoners and offenders or ex-offenders in the community to gain access to healthcare.

This briefing covers:

- potential opportunities for voluntary sector organisations to be more closely involved in the delivery of healthcare services to people in contact with the Criminal Justice System (CJS)
- how healthcare is commissioned for prisoners following the 2012 Health and Social Care Act
- guidance on how to make partnerships with commissioners work.

A problem that needs a solution

It is recognised by practitioners and policy makers that the healthcare needs of people in contact with the CJS are high. The health of the prison population and of ex-prisoners is reported to be generally poor,[2] and commissioners have often considered them to be a 'hard-to-reach' segment of the general population.

People in the CJS are often struggling with problematic drug and alcohol abuse, have high instances of mental ill-health, suffer the ill effects of homelessness or unstable accommodation, and are often disengaged with, or excluded from, mainstream healthcare services. Figures show that many prisoners have poor access to their General Practitioner and community healthcare due in large part to high levels of social exclusion prior to beginning their sentences.[3] Because of this, people in the prison system are reported as being disproportionately more likely than the rest of the population to use accident and emergency services.[4] The quality of healthcare across different prisons is reported by Her Majesty's Prison Inspectorate as highly variable; this could lead to unmet healthcare needs in some instances.[5]

Older prisoners are the fastest growing group in the prison population, presenting the CJS with the significant challenge of changing services to meet the different healthcare needs of an ageing client group. Between 2002 and 2014 the number of prisoners aged 60 and over grew by 146%.[6] These prisoners have complex health needs, which are consistently reported as much worse than other elderly people in the general population. The physiological age of these prisoners is, on average, 10 years greater than their chronological age.[7]

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There is an above average incidence of **mental ill-health** amongst offenders both in in and out of prison. In 2013, 46% of women and 40% of all those aged 40 or older serving community sentences had a mental health condition.[8] In 2009 the Department of Health published the Bradley Report which reviewed mental health problems or learning disabilities in the CJS, this highlighted a number of areas where mental health needs all too often go unmet and, amongst many others recommendations, referred to a lack of talking therapies for prisoners.[9] After leaving prison, people with mental health difficulties still require support to avoid relapses, and to make sure they can comply with the conditions of their release and any supervision requirements. The rising suicide rate has been noted as an indication that better support is required for prisoners suffering from mental ill-health.

The sexual relationships of prisoners, and the sex they have in prison, produces other health risks, which have recently been well documented by the Howard League for Penal Reform's *Commission on sex in prison*.[10] This commission has highlighted incidence of poor treatment of Sexually Transmitted Diseases (STDs) amongst prisoners, and The Howard League's ongoing research into sex in prisons suggests that consensual and non-consensual sex behind bars is more widespread than originally thought. This suggests a need for further discussions of appropriate action to promote better use of contraception to improve sexual health.

There is concern about **the continuity of care for prison leavers**. People in prison are likely to disproportionately use emergency healthcare rather than community healthcare, this can mean that they have no GP to return to when they are released into the community. Prison healthcare services cannot provide certain (often vital) medication for more than a few days post-release because of a considerable overdose risk. The aforementioned Bradley Report noted that there was a futher challenge with services for people serving short-term custodial sentences, highlighting an additional risk that people may be released from prison before the diagnostic process has been completed by healthcare staff.

There is an opportunity for voluntary sector organisations with an understanding of the health needs of people in custody to improve the delivery of, and access to, appropriate health and social care services. Two examples of the voluntary sector's role in this area include:

- Joining up care for people leaving prison can create positive health outcomes, as shown in Clinks' case study of HIV charity Sahir House, where people leaving prison without sufficient medicine are put in touch with community nurses and treatment centres and supported to access services. This has allowed for essential treatment to continue uninterrupted.[11]
- Involvement in Liaison and Diversion services; for example Together (the mental health charity) has a Forensic Mental Health Practitioner Service working as part of the Court Liaison and Diversion scheme in London. They work with courts and the probation service to divert vulnerable individuals from prison, support people leaving prison, and provide mental health awareness training to people working within the Criminal Justice System.[12]

The Health and Social Care Act (2012)

The Health and Social Care Act (2012)[13] created an independent NHS commissioning board – NHS England - with responsibility for commissioning "services and facilities for people in prison and other places of detention". The act completed the transfer of responsibility for prison healthcare to NHS England and Public Health England (PHE). More detail on the co-commissioning and delivery of healthcare services in England's prisons can be found in NOMS' national partnership agreement with NHS England and PHE.[14]

Who commissions services for prisoners?

A number of different bodies are responsible for commissioning health and care services for offenders. Clinks' Navigating the Health Landscape in England guide provides an 'at a glance' overview of these bodies and an explanation of the role of each.

The majority of health services for people in custody are commissioned by the ten NHS England Health and Justice area teams. They commission all physical health, mental health and substance misuse services in places of detention (including prisons, young offender institutions and secure children's homes). They are also responsible for commissioning the new model liaison & diversion programmes currently being rolled out across the country, and Sexual Assault Referral Centres. By April 2016 it is planned that they will assume responsibility for healthcare services in police custody.

PHE's Health and Justice regional teams cover offenders in custodial and community settings. They offer support to NHS England's Health and Justice Teams, for example in quality assuring prison health needs assessments, and they can offer commissioning advice around health promotion as well as prevention of poor health outcomes. They also work with local authority Directors of Public Health to help them understand the needs of people in contact with the CJS in their area, and advise on how to address them.

Voluntary sector organisations may find it helpful to link up with these teams in the areas in which they operate. Proper, well managed contact with the relevant bodies can help to set the correct expectations, commission the right services, and provide the best quality of care for offenders and ex-offenders. The voluntary sector can play a valuable role in helping ensure people in contact with the CJS receive the healthcare they need.

This is particularly key with local Health and Wellbeing Boards when developing Joint Strategic Needs Assessments (JSNAs). Here, the voluntary sector can play a vital role in ensuring that the needs of the offender population are understood adequately and taken into account: without this representation, offenders are unlikely to have their needs considered in JSNAs.

How to engage with commissioners

There are many different levels and kinds of commissioners providing healthcare for offenders and the prison population – and many large healthcare providers working in this area. However, through careful engagement with the relevant commissioner, you can ensure that your organisation knows what is being commissioned and where these services align with the support you provide to your beneficiaries. ACEVO have published a briefing, in partnership with the NHS Central Southern Commissioning support unit, on the voluntary sector working in partnership with the NHS listing seven principles for effective joint working; this can be read in conjunction with the guidance provided below.[15]

With services being increasingly decentralised, the emphasis should be on building long term relationships with your more local commissioners. A starting point for relationships can be to encourage them to share their strategic operating and commissioning plans. Mutual respect is central to this process, and organisations must be open about the pressures that they face, in particular about the money they have available, and the services that they can provide. This engagement is likely to focus on how the services a voluntary sector organisation delivers is able to impact on the support needs that the commissioners have identified, or it may be that a voluntary sector organisation has identified an unmet, or unrecognised, need. Greater collaboration and integration between the statutory and voluntary sector services are likely to reduce inefficiency and, more importantly, improve the outcomes for service users.

There is an essential role for voluntary sector organisations in innovating to bring better healthcare to individuals that may not use existing services. The NHS England Health and Justice Teams may set priorities and define directions for improvement, but they will benefit greatly from local on-the-ground knowledge in which many voluntary sector organisations specialise. Charities have the knowledge and the capability to re-shape and create better services and pathways to treatment for people in prison and those released back into the community.

End notes

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