NHS England

Health in the Justice System Commissioning Intentions 2014/15

London Region

THE NHS CONSTITUTION
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NATIONAL CONTEXT
The Health and Social Care Act 2012 created a new set of responsibilities for the commissioning of health services for adults, young offenders and others detained in secure settings or other prescribed accommodation. *Securing Excellence in Commissioning for Offender Health (2103)* and *Securing Excellent in Commissioning of Sexual Assault services (2013)* sets out the national strategy for commissioning of health services for those in contact with the justice system while *Who Pays? Determining responsibility for payments to providers* (2013) sets out responsibility for payments. The intention of doing this is to move away from regionally and locally isolated commissioning to a clear and consistent national approach. This will include national standards based on the best available evidence to ensure efficient provision of care, and improved health outcomes. From 1st April 2013 this responsibility sits with NHS England.

In 2009 Lord Bradley published a review into how the Criminal Justice System (CJS) interacted with those suffering with mental ill health and learning disabilities. The Healthy Children, Safer Communities report, published in December 2009, also identified the needs of children and young people in contact with the CJS. The needs of women in the CJS were identified in the 2007 Baroness Corston review and were again referenced in the Bradley Report. The recommendations made in these reports were accepted by the previous government under the "Improving Health, Supporting Justice" delivery plan and have now been adopted by the coalition government.

In 2013 Lord Adebowale published the Independent Commission on Mental Health and Policing that reviewed the work of the Metropolitan Police Service with regard to people who died or have been seriously injured following police contact or in police custody where mental health was a key issue. The report made recommendations on the ways in which police forces and health services across the country could work together to prevent deaths in custody and improve healthcare assessment and treatments for those in contact with the police or in police custody.

LONDON CONTEXT
Based on the national delivery framework, the London local operating model sets out how effective co-ordination and consistency will be delivered throughout the commissioning cycle:

- assessment of need
- review and assessment of current services
- gap analysis
- assessment and understanding of risk
- establishing priorities and options with key stakeholders
- contract implementation
- provider development
- pathway redesign
- capacity analysis
- service de-commissioning and/or procurement
- implementation and delivery and on-going monitoring and evaluation

Our local operating model is based on the national partnership agreement between NOMS, NHS England and Public Health England for the Co-Commissioning and Delivery of Healthcare Services in Prisons in England.

All individuals within a prescribed accommodation should have consistent access to health care services that are:

- needs-led
- in line with demand

- equitable to those available to the general population
- address health inequalities
- Support rehabilitation and sustainable recovery and continuity of care.

We are expecting to work with Prescribed Accommodation commissioners, Clinical Commissioning Groups, Specialist Commissioning Groups and Local Authority commissioners to develop and implement local delivery arrangements in line with the national and local partnership arrangements. This includes the development and implementation of any local delivery agreements relating to the future role of the prescribed accommodation.

It is our intention to continue to work collaboratively in partnership with NOMS, PHE, the Home Office, Mayor's Office for Policing and Crime, Metropolitan Police Service, British Transport Police, City of London Police, and other partners in respect of commissioning health care within prisons, police custody suites, sexual assault referral centres, Immigration Removal Centres and Liaison and Diversion Schemes to ensure services:

- Are informed by up to date Heath Needs Assessments and procurement plans taking account of the reconfiguration of the environment of delivery for example the reconfiguration of the custodial estate including the creation of Resettlement Prisons
- Support improved pathways of care for offender/detainees/victims with physical health, mental health and substance misuse needs;
- Promote continuity of care between justice and community settings for example from community to custody, between establishments and through the prison gate in partnership with new providers of probation services;
- Are implemented alongside efforts to reduce the supply of drugs and alcohol in to prisons and the diversion of prescribed medication.
- Are implemented alongside efforts to divert those mental health needs away from the criminal justice system.
- Ensure the transition of responsibilities for commissioning of Healthcare across the Immigration Removal Centres (IRC) and police custody suites is timely and appropriate as required by the Health and Social Care Mandate;
- Support a more robust clinical understanding of the healthcare needs of detainees;
- Review the current arrangements for the provision of healthcare in detained settings particularly addressing inequalities in health care across the estate;
- Agree principles on information sharing to drive transparency and continuous improvement of services and commission accordingly;
- Support sustainable recovery from addiction to drugs and alcohol and improved mental health including dual diagnosis.

The overall principles we are working to within NHS England (London) mirror the national principles, and can be defined as:

a. Improve patient access
b. Encourage transparency and choice
c. Ensure patient involvement and participation
d. Identify better data to drive improved outcomes and better commissioning
e. Deliver higher standards and safer care
f. Consistent values and principles are used when driving priority setting
g. Comprehensive services are covered within the NHS budget
h. Fair and rational decision making
i. Priority setting covers all services commissioned by NHS England

j. Equal access for equal clinical need, but can be targeted to improve a group with poorer outcomes. Interventions should not be commissioned unless they can be offered and afforded equitably to an eligible population
k. Investment should only be made in cost effective intervention, for both new and existing services, and prioritised for value
l. Seeks value for money whilst meeting needs of population
m. Only NHS England can prioritise commissioned services.
n. It is important that prioritisation is not just used at the 'margin' for new services and developments but is used as a core approach to review and reassess the overall investment of commissioning resources in a program and from this establish a set of priorities for investment and re-investment of savings when decommissioning.

COMMISSIONING INTENTIONS (Health in the Justice System – London)

Nationally we said…	1. **We would implement a single operating model as outlined within "Securing Excellence in Offender Health"** 2. **We would ensure that commissioned services in Health in the Justice System are patient focussed and clinically led** 3. **We would drive the improvement of standards and outcomes and reduce variation and inequalities within Health in the Justice System** 4. **We would provide assurance that there are robust systems and processes in place for monitoring and assessing the quality of healthcare services and referral pathways within Health in the Justice System** 5. **We would provide leadership in ensuring integration of direct commissioning activities with other commissioning partners such as CCGs, Local Authorities', National Offender Management Services etc.** 6. **We would continue to develop continuity of care and referral pathways for those moving between custodial and community healthcare setting**	
What this means to us in the London team is …		National intentions related to:
Direct Procurement Healthcare Services (London)	• Commission integrated healthcare services at 3 prisons (HMP Belmarsh, HMP Thameside and HMYOI Isis) • With the Home Office, co-commission integrated Healthcare services at 3 Immigration Removal Centres (IRCs -Harmondsworth, Colnbrook and Yarl's Wood)	1, 2, 5
Procurement Support (Nationally)	• Linked to above point, deliver co-commission healthcare services at an additional 3 IRCs and 1 pre-departure accommodation site alongside commissioning colleagues in the other area teams	1, 2, 5
Service Review and Developments	• Initial accommodation: work with GSTT and Croydon Health on implementing the service improvement strategy • Sexual Assault Referral Centres services currently commissioned jointly by the Metropolitan Police Service and NHS England and previously three separate contracts and now commissioned as one service. Joint improvement plans now in place to identify efficiencies and consistent governance arrangements with a view to review pathways to ensure consistency and equivalence if care across London	3, 4, 6
Transfer of Commissioning Responsibility	• NHS England is currently working with the London police forces (Metropolitan Police Service (MPS) and the British Transport Police (BTP) and City of London Police (CoLP) Healthcare transfer) to implement the transfer programme for the commissioning responsibility for healthcare in police custody suites within each force to NHS England by April 2015	1, 2, 5
Develop Liaison and Diversion Schemes	• Liaison and diversion services are intended to improve the early identification of mental health problems, learning disabilities and/or substance misuse issues at the point a young person or adult enters the criminal justice system. The service also aims to improve the health and justice outcomes for these individuals. NHS England (London) inherited a number of diverse schemes form the Department of Health and have identified the following immediate	1, 2, 4, 5, 6

	priorities: ○ Map existing provision of L&D service across London ○ Develop service specification and performance management frameworks for services ○ Work with NHS England National support team to develop a national operating model for L&D services ○ Support business case to HM Treasury for the rollout of L&D Funding	
Promoting Healthy Prisons	• Develop plans to meet the delivery elements for healthcare on the move towards smoke-free prisons in conjunction with the National Offender Management Service - decision to test in early adopters is still subject to approval (January 2014) and the order for the national roll out has not yet been confirmed.	3, 5
Re-Commissioning of non-direct healthcare services in prison	• Phased reallocation of NHS funding, starting in 2014, currently being spent on prison officers for the purposes of prisoner movements to healthcare services and security related services such as the supervision of medicine management queues	5
Information Management and Technology	• Procurement of NHS N3 connectivity Police healthcare custody suites • Procurement of Electronic Medical records Systems for Police healthcare custody suites • Rollout of Prescribing Module for prisons electronic medical records system (SystmOne) • Supporting the Health and Social Care Information Centre to consider the future healthcare information management needs of residential detention settings replacing the national clinical IT system in place for prisons, and some immigration removal centres	1, 4, 6
Research and Development	• Build a research and development framework to evaluate key service pathways including MH and Substance Misuse • Review MH Transfers from custody (e.g. prisons) to secure hospitals to ensure consistency, improve access and shorten waiting times • Review continuity of care in relation to primary and specialist sexual health services e.g. HIV care for prisoners being released or transferred to community services to ensure a seamless pathway	3, 4, 5, 6
Clinically Led and Patient Involvement	• Establishment of Health in the Justice System strategic clinical network • Involving patients in the design and monitoring of services including development of peer mentoring	2, 3
Links with CCGs	• Develop continuity of care pathways and in particular GP registration, for people leaving custody to address offender health inequalities and better manage long terms conditions • Develop referral pathways from Liaison and Diversion schemes to primary care services (and MH Services) to ensure continuity of care and to provide a seamless pathway • Develop pathways to support care of those being released from custody or on bail to ensure continuity of care and support in primary care including Emergency and Urgent Care services	2, 3, 4, 5, 6
Links with Public Health England	• Continuity of care in relation to Substance Misuse Services • Ensure on-going development of infection control environmental standards (commissioned by NHS England and maintained by the prison and healthcare providers) and infection control policies in	2, 4, 5, 6

	prisons (overseen by the provider led and prison supported clinical group within each establishment)	
Links with CCGs/Specialist Commissioning/MH Trusts	• Continuity of care in relation to primary and specialist sexual health services e.g. HIV care • Improve the timeliness and access with regard to MH transfers from custody (e.g. prisons) to secure hospitals • Links to local MH services from courts and police custody as part L&D development • Implement section 136 of the Mental Health Act in CCGs' commissioning intention and contracts with Mental Health Trusts • Implement the recommendations of Lord Adebowale's report on Mental Health and Policing	2, 4, 5, 6