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South East Coast Offender Health Project Board Final Report

Commissioned by NHS South East Coast Education Commissioning Board

Project Sponsor NHS Surrey

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1. Executive summary

1.1 Key aims and objectives

From 1 April 2005, responsibility for funding prison health care in England was transferred from the Prison Service to the Department of Health.

In this context of change the aim of the project was to conduct a comprehensive review of developments towards the achievement of change in one region, NHS South East Coast. The overall aims were to assess:

- Key factors informing staff development which will deliver a workforce of the right size and structure, sufficiently flexible and sustainable to meet the changing needs of how care is delivered to service users in prisons
- to what extent offender health workforce planning informs education provision, and commissioning and how education can be deployed to increase capability and capacity of the prison health workforce

1.2 Our approach

This project used methods that could be undertaken intensively over the short period of time available (1st January to 24th May 2010) and which could guarantee achieving good quality data in the timescale. In-depth observations/interviews/ focus groups with health care staff in selected prisons and surveys of healthcare work force in all prisons in the region, contracted Higher Education Institutions and prison governors were undertaken. Findings were presented at a one-day search conference to delegates invited to represent all the key staff groups across the region and feedback from the conference was incorporated into the study.

1.3 Key findings

Progress to achieving change: The study identified variable development of prison health care in different parts of the region towards achieving an NHS led service. There is a significantly greater NHS employment in Surrey and Sussex, and greater prison service employment in Kent.

Tensions between care and custody: Tensions between care and custody were found to impact on healthcare delivery across all three regions. The custodial aspect of prison regimes impacts at all levels on the ability of health care staff to undertake the work of meeting the health care needs of offenders. These manifest in different ways in the prison establishments across the region and bring about distinctive cultures and practices.

Barriers to delivering health care: Barriers to the effective delivery of healthcare varied across the region, including, notably

- lack of continuity of care
- long waiting times for services, leading to problems in assessing and responding to needs
- problems in recruitment and retention of staff
- widespread deployment of agency staff

This creates a critical situation for developing continuity of care, partnership working, the development of capacity and capability.

Difficulties in accessing relevant and essential training
Difficulties in access to relevant and necessary training are experienced across the region. HEIs are committed to inter-professional training rather than discrete and specific training for offender healthcare workers. There is a need for new training and CPD to be developed including training in substance misuse and understanding and working within prison cultures.

1.4 Conclusion

This study concludes that there have been some developments towards NHS-led services which aim to assess and meet individual health needs, and there are identifiable areas of good practice. On the other hand, there is variability within the region, to the extent that each county's model could be individually described and conceptualised. Within the broad picture of variable health care in the region, the project identified barriers to the achievement of an equitable health care system:

- Efficiency and effectiveness would be improved first and foremost by the establishment of a more stable workforce.
- The role of providing offender health care requires clinical skills equivalent to delivering health care in the community plus an additional range of skills in order to contend with the specific demands of working in a custodial setting.
- There is a gap in partnership working between commissioners, health care managers and HEIs in identifying and responding to the CPD and training needs of health care workers.
- The variable developments within each county demonstrate the need to maintain a strategic overview at regional level to ensure consistency of meeting strategic objectives.
- It is crucial that all stakeholders work together to improve the quality of health care in prisons, and to achieve the aim of equivalence.

1.5 Recommendations

1.5.1 The PCTs commissioners of service should ensure that local workforce and education development plans reflect the needs of the offender health workforce.

1.5.2 PCTs within Kent and Medway should reassess its current strategy and reposition itself closer to the objectives of *Improving Health, Supporting Justice*. This will necessitate developing and implementing a plan through which should ensure greater equity of health care is delivered by the NHS in Kent prisons.

1.5.3 Recognising the tensions between care and custody at all levels of offender health care delivery is central to partnership arrangements for health care delivery and the shared responsibilities of care for offenders undertaken by both the Prison Service and the NHS.

1.5.4 Commissioners including Public Health should ensure individual needs assessments are being made and treatment plans appropriately implemented in all establishments across the region.

1.5.5 Providers, Health Care Managers, and Governors need to work together to address issues of staff recruitment and retention and thus to create a basis for improving the quality of health care.

1.5.6 Health care managers, education leads with commissioning PCTs and in partnership with HEIs should develop and implement a model of clinical supervision for all front line staff. This may include developing CPD courses in supervision.

1.5.7 Kent PCT should reassess its current strategy and reposition itself closer to the objectives of *Improving Health, Supporting Justice*. This will necessitate developing and implementing a plan through which greater equity of health care is delivered by the NHS in Kent prisons.

1.5.8 HEIs in consultation with PCTs and Health Care Managers and front-line workers, should develop CPD which meets the specific needs of health care staff working in the care-and-custody contexts of prisons. HEIs should be encouraged to work together so that training opportunities reflect the individual strengths of all the HEIs.

1.5.9 HEIs should engage in dialogue with health care managers and front line workers to develop modules on award bearing courses that are specifically designed for offender health care staff.

2. Aims and Objectives of the Study

The aim of the project was to conduct a comprehensive review of the current offender health workforce in the South East Coast Strategic Health Authority. The overall aim was to ensure that offender health workforce planning informs education provision, commissioning and staff development that delivers a future workforce of the right size and structure, sufficiently flexible and sustainable to meet the changing needs of how care is delivered to service users.

Therefore the specific objectives of the project were to:

- scope and understand the existing offender health healthcare workforce across NHS South East Coast encompassing all aspects of health care provision and services
- identify short and longer term gaps in workforce capability and capacity
- clarify employer status of the offender health healthcare workforce
- identify and evaluate current education provision and CPD to identify investments needed for the offender health workforce education
- report and make recommendations for future development of these services

3. Background and Context

From 1 April 2005, responsibility for funding offender health care in England was transferred from the Prison Service to the Department of Health[1]. Initially, prisons retained local budgets for health care but these budgets were transferred to local NHS Primary Care Trusts, which then, by 2006, assumed full funding responsibility for offender health care.

Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system (DoH 2009) recognised the increasing numbers of people with mental ill health in prison, and difficulties in identifying the needs of people with learning disabilities. The recommendations of this report identified a direction of travel to deliver change through partnership under a National Programme Board, aiming to integrate all relevant government departments for criminal justice, health and social care. At a local level, a lead PCT should commission services. Explicit mention should be made of learning disabilities and mental illness. A programme of awareness raising and training for prison staff to work with offenders with mental illness was emphasised, and training should be undertaken jointly with other services to enhance shared understanding and partnership.

In accepting the recommendations and direction of travel of Lord Bradley's report, the Department of Health, in '*Improving Health, Supporting Justice; the National Delivery Plan of the Health and Criminal Justice Programme Board*' (DoH 2009) outlined a broad programme of change with the following key principles:

- Improving efficiency and effectiveness of the system to ensure needs based services delivered to high standards and achieving best value for money
- Partnership working between criminal justice, health and social care organisations to achieve effective, appropriate health, social care and criminal justice outcomes
- Improving capacity and capability through developing an informed and effective workforce to deliver services for offenders with health and social care needs, and having the confidence to work effectively across organisational boundaries
- Ensuring equity of access to services, for all offenders, irrespective of race, gender, disability, age, sexual orientation, religion or belief. Offenders should have the same access to health and social care services, appropriate to their needs and in line with standards set for the rest of the population.
- Improving pathways and continuity of care through focussing on assessment and intervention as early as possible.

[1] Clinical Governance – Quality in Prison Healthcare Prison Service Order 3100, 16/01/2003 http://pso.hmprisonservice.gov.uk

Joint audit of the provision of health care in prisons by the Healthcare Commission and Her Majesty's Inspectorate of Prisons in 2007/08 [2] identified that the quality of the provision of health care in prisons was "variable". Development of services was not always driven by the paramount consideration of assessment of needs, and thus: "the result of this is that the service delivered has not always best met the health needs of individual prisoners." The majority of PCTs did not have an assessment of health needs, and "further work" is required to improve commissioning of health care to ensure access to health services, assessment of health needs, and regular assessments are undertaken.

With these contexts in mind, NHS South East Coast Education Commissioning Board requested a comprehensive review of the offender health workforce, sponsored by NHS Surrey, with the aim of obtaining a greater understanding of the workforce characteristics, the extent and quality of healthcare services provided, education provision, gaps and funding to support education of the offender health care workforce.

NHS Surrey contracted the Centre for Social Work Research, Tavistock and Portman NHS Trust, in association with Tony McCaffrey Consultancy to review the offender health workforce, education commissioning and provision currently available to all staff within prisons in South East Coast (See Appendix A for information on Prisons in NHS South East Coast).

4. Methodology

This project required methods that could be undertaken intensively over the short period of time available (1st January to 24th May 2010). The objective was to achieve quick, immediate access to the systems and individuals within them and guarantee achieving good quality data in the timescale. The emphasis was therefore on generating data through the following methods:

- In depth interviews with key participants including offender health project board members
- In-depth observations/interviews/ focus groups with health care staff in selected prisons
- Survey of the healthcare work force in all prisons in the region
- Interviews/survey with the contracted Higher Education Institutions in the region
- Survey of prison governors

Findings were presented at a one-day search conference to delegates invited to represent all the key staff groups across the region. The conference facilitated in-depth feedback from delegates and this was incorporated into the study.

[2] Commissioning healthcare in prisons: The results of joint work between the Healthcare Commission and Her Majesty's Inspectorate of Prisons in 2007/08 (February 2009 Commission for Healthcare Audit and Inspection and Her Majesty's Inspectorate of Prisons)

5. Data Collection

5.1 In depth interviews with key participants including board members

An introductory email was drafted and sent to key participants, including board members. This email outlined the background, purpose and expectations of the research project. It also requested convenient times for the lead researcher to conduct a telephone interview. There was a positive response to the mail-out. Participants responded to the email request and scheduled convenient times to be interviewed.

An interview schedule was developed with the following questions:

- What is your role/ title?
- Where based?
- What are you responsible for?
- What are your responsibilities re health care delivery
- What is your take on this project?
- What is the principal driver for you?
- What happens in your part of the system re education of health care deliverers (single and mixed economy)
- Any obvious good practices?
- Any obvious blockages?
- What would you like to come out of this project
- Who should we talk to in your part of the system?
- Any other issues?

At the end of each interview the method of 'snowballing' worked effectively, in that interviewees suggested other key individuals that the research team may find useful to contact. Table 1 lists the interviewees according to their job titles.

Table 1: Job titles of interviewees

Interviewees
Prison service governors (including 1 ex governor) x 4
University lecturers x 4
Education Commissioner x 3
Heads of prison healthcare x 2
Specialist medical x 2
South East Coastal Ambulance service x 2
Metropolitan police
Mental Health In-reach manager
Interviews completed: 19

5.2 In-depth observations/interviews/focus groups in prisons

Researchers undertook in depth observations, interviews and focus groups in two prisons in the Kent Sheppey Cluster (10th/11th March), two prisons in the Surrey Cluster (15th/18th March) and 1 in the Sussex region (19th April).

Based on the interviews with key participants, these prisons were chosen as representative of the three counties within the region and also different models of health care delivery. The aim was therefore to study and develop findings for each prison cluster and, through making comparisons across the clusters, to develop understanding of and knowledge about the key issues at a regional level.

5.2.1 Interviews completed on-site:

Participants in on-site interviews are shown in Table 2

Table 2: Job title, establishment and region of on-site interviewees

Job title	Prison	Region
Head of Learning and Development	HMP Elmley	Kent
Inpatient Manager	HMP Elmley	Kent
2 nurses from the First Night Centre	HMP Elmley	Kent
2 Admin officers	HMP Swaleside	Kent
Pharmacy technician	HMP Swaleside	Kent
GP	HMP Swaleside	Kent
2 Healthcare managers	HMP Downview	Surrey
Head of healthcare and head of mental health in-reach	HMP Lewes	Sussex

5.2.2 Focus groups completed:

A focus group schedule was developed in which two key/trigger questions were asked to initiate discussion from the group. Researchers used a selection from a range of prompts to encourage in-depth responses to the initial trigger questions. The initial questions were:

1. What are the issues impacting on your effectiveness in doing your job?
2. What training and development needs should be addressed to help you in delivering healthcare?

The participants in the focus groups are listed in Table 3.

Table 3: establishment and number of focus group participants

Prison	Number of participants
HMP Elmley	13
HMP Swaleside	9
HMP Highdown	8
HMP Downview	6
HMP Lewes	9

5.3 Development and Distribution of the Offender Healthcare Staff Survey

A survey was developed to assess the perceptions of the healthcare workforce in each of the South East Coast prisons. The survey was refined through discussion with Project Board members. The survey was designed for use as a postal questionnaire and contained structured questions for

quantitative analysis together with open questions inviting responses which would be analysed qualitatively.

An email request was sent to each offender healthcare manager outlining the project aims and the importance of obtaining the views of health care workers. Several offender healthcare managers responded positively, agreeing to encourage their staff to complete the survey.

The survey comprised 4 main sections:

A – Background
Includes: staff type, employer, key responsibilities, qualifications

B – Establishment
Includes: prison category, opinion on healthcare delivery, strengths and weaknesses, available services

C - Staff Development
Includes: training received, process of CPD, appraisal, supervision, development needs, student placement provision

D - Issues/barriers to delivery of healthcare?

(The survey schedule is appended to this report as Appendix B)

320 surveys we sent by post on 26th March to each of the 17 prisons in the South East Coast (approx 20 - 30 surveys to each prison based on the size of each healthcare department). Each survey had a pre-paid return envelope attached for convenient returns. On 30th March each offender healthcare manager was provided with a courtesy call to discuss any issues arising from the receipt of the surveys and distributing. The healthcare managers confirmed they had received the surveys and were generally happy to distribute to their staff.

A database was established and data from returned surveys were inputted on receipt of completed returns. At the time of the closing date for returning surveys (7th May), 92 had been returned.

5.4 Higher Education Institution (HEI): Interview Schedule
The research team drafted an interview schedule to be undertaken with the four HEIs having contractual arrangements with the health authority. The schedule was refined in consultation with an academic member of the Board. South East Coast Strategic Health Authority provided a contact person at each of the four universities (Table 4) for a face to face or telephone interview, whichever was the more feasible.

Table 4: HEI interviewees

Universities	Interviewee's Job Title
University of Surrey	Head of Programmes – CPD/Postgraduate Education Division of Health and Social Care
Canterbury Christ Church University	Dean of Faculty of Health and Social Care & Senior Lecturer in Allied Health
University of Brighton	Assistant Head of School Head of CPD
University of Greenwich	Professional Lead for LD and LD Nursing

The questions in the survey were:

1) What courses are you currently delivering/have you recently delivered?
2) Can you provide approximate numbers and the work locations of healthcare staff that are current students (i.e. name of prison that student is based)?
3) How are the courses delivered? – Are organisers of a particular academic/professional discipline or are they staffed by visiting lecturers (including prison staff), practitioners etc?
4) Are there any particular drivers for the offender healthcare CPD that you offer? If so what are they?
5) What works well/not well and what would help you develop further what you offer?

(The interview schedule can be seen in Appendix C)

5.5 Development and Distribution of the Governor Survey
The research team liaised with the project board, including the prison governor Board member, to compile a survey to be undertaken with the governing governors at each of the 17 prisons.

An email request was sent to each prison governing governor outlining the project aims and how exploring their views as major stakeholders were vital for the project.

17 governor surveys were sent by post (with a pre-paid return envelope) and by email if governors preferred to reply electronically. The following areas were addressed in the survey;

- knowledge of their establishment and the healthcare needs of their offender population
- staff development for the offender healthcare workforce
- issues and barriers for delivery healthcare in their establishment

6 completed surveys were returned by governing governors, and 1 governor was interviewed by telephone. The survey can be seen in Appendix D.

6 Data Analysis

In-depth observations, focus groups, HEI interviews and the governor surveys were analysed using qualitative approaches. Content analysis of each interview/observation concentrated on identification of key themes. The research team applied the panel method to develop and test competing hypotheses. Themes thus generated were compared across the sample of interviews/ accounts of observations until no further or new themes emerged, i.e. saturation and been achieved.

The survey was analysed quantitatively using computer package SPSS. Appropriate statistical methods were applied to specific data to assess associations. The qualitative sections of the survey were analysed using the computerised qualitative analysis tool, NVIVO.

Comparison of the different data sources – i.e. interviews and surveys – were made and an initial triangulation of data from different sources was undertaken.

7. Findings

7.1 Summary of Key findings

Key findings from the visits to prisons, observations and focus groups at selected prisons across the region:

Overall, the study identified the variable development of offender health care in different parts of the region in response to the national delivery plan and the transfer of health care services to the NHS. Four main themes were identified in which the differences within the region were most apparent. These are:

Tensions between care and custody

Tensions between care and custody were found to impact on healthcare delivery across all three regions. Primarily this meant that the custodial aspect of prison regimes impacts at all levels on the ability of health care staff to undertake the work of meeting the health care needs of offenders. The tension also impacts through the relationships between health care staff and both prison officers and offenders. It has an important impact on professional identity as healthcare workers in a prison establishment. The pervasive influence of the tensions of custody and care, and the various positions held by individuals and groups in relation to the issues raised by custody-care tensions affected the development of partnership working. These manifest in different ways in the prison establishments across the region and bring about distinctive cultures and practices.

Barriers to delivering health care

Health care staff identified barriers and difficulties in attempting to deliver healthcare in their establishments. The key differences across the region were according to geographical location, that is, there were different barriers in each county.

In Kent, the main barriers identified were:

- Health services are not linked up with each other thus creating divisions in care pathways
- Different health services are delivered in the same setting; for example, offenders with long-term mental health problems are treated in the same room/locale as offenders with acute physical health problems.
- There are long waiting times for services and lack of working space

In Surrey the main barrier was the lack of continuity of care. Rapid placement turnover of offenders contributed to difficulties in providing continuous health care pathways and to delays, lack of communications, referrals and assessments. In Sussex a similar problem of lack of links between services was identified, though the problem was felt to be reducing

Recruitment, retention and deployment of staff
Across the region as a whole there are severe problems of recruitment and retention of health care workers. 70% vacancies were reported in Kent and high vacancy rates in the other counties. This creates a critical situation for developing continuity of care, partnership working, the development of capacity and capability. The widespread deployment of agency staff additionally adversely affects the planning and delivery of efficient, effective services.

In Kent and Surrey there are issues about how staff are deployed. Including particularly in Kent, health care staff being moved from health based to security led tasks.

Difficulties in accessing relevant and essential training
Difficulties in access to relevant and necessary training are experienced across the region. There is evidence of dissatisfaction with a perceived lack of connections with the PCT. The PCT was perceived not to have a full awareness of offender healthcare delivery.

Key findings from the staff survey
The key findings from the survey of offender health care staff were:

- There was a response of approximately 30% which is acceptable for a postal survey.

- It was found that there is a statistically significant variation within the region for who employs health care staff. The workforce in Kent is more likely to be employed by the prison Service. In Surrey/Sussex the employer is more likely to be the NHS. This demonstrates and confirms an overall finding that in Kent the transition to NHS employment of offender health care staff was being effected more slowly that in Surrey and Sussex and the implications of this finding require further analysis.

- Offender health care staff reported that they were at least partly satisfied with their capacity to deliver healthcare to offenders in their establishments. 94% of respondents assess that the healthcare needs of the population were ‘somewhat met’ or ‘fully met’. Alongside this, 56% assess that health care needs are not fully met (i.e. either partly met or not met).

- There are statistically significant differences within the region regarding perceptions of CPD/development opportunities. These include:

    a. Offender health care workers in Kent, compared with Surrey/Sussex, are significantly less likely to have a health care induction.
    b. In Kent, health care staff are significantly more likely to identify the prison service as providing CPD.
    c. only 35% of total sample identified HEIs as providing CPD

- The most commonly identified training and development need across all regions was for management and supervision training. This was the case for both management and clinical staff.

- The most commonly identified training needs in clinical areas were for training in substance misuse, mental health and CBT. Some participants identified the need for training that helped to understand the issues arising in working in prison cultures and with prison procedures.

Key findings from the HEI interviews:

- Currently none of the four contracted HEIs deliver specific CPD for the offender healthcare workforce.

- HEI interviewees are committed to inter-professional training and this discrete and specific training for offender healthcare workers is felt to be contrary to this principle.

- Several interviewees suggested new areas for training, i.e. not currently being offered. These included training in substance misuse and understanding and working within prison cultures.

- There are few health care professionals enrolling on HEI courses. Numbers of students on placement in prison settings is currently low. One interviewee stated; ‘they’re a hard to reach group’.

- Three main barriers to the current CPD system were raised by each of the HEI interviewees. Barriers included;

a. Access and funding issues. Interviewees felt that the offender healthcare workforce was unclear what funding was available and how to access it.
b. healthcare managers and potential student's lack of knowledge of the CPD system
c. Barriers to student placements which they believe would facilitate future recruits to the offender healthcare workforce.

Key findings from the Governor Surveys

- Recruitment and retention of staff is a major issue for all governors, especially as they felt applicants for jobs lack understanding of the prison system.

- 3 governors felt the health needs were being 'fully met' in their establishments and 3 stated 'somewhat met'.

- All governors place high importance on healthcare. This is evidenced by healthcare managers sit on Senior Management Team boards.

- Governors identified the main health needs for their offender population as substance misuse and mental health.

- Governors were concerned about:

  a. Funding
  b. staffing issues
  c. the characteristics and needs of their population
  d. insensitive and anxious commissioning undoing long- term developments of excellent services and leadership

7.2 Findings in detail

Overview of variable models of health care within the region
The variable development towards and NHS led service providing assessments of health needs of offenders and equitable access to services has led to distinctive differences within each of the three counties in the region. Through analysis of all the data from interviews, site visits and surveys, the following triangulated picture has been developed. Each county is described below with its salient features and 'cultural characteristics.

Kent Offender Health Care as "Colonial Dependency"
Healthcare in the Kent system sits in relationship to the prison regime like the subjugated colony of a greater power. Nursing staff metaphorically doff their caps and pay lip service to the regime while trying covertly to do the best for their patients. "Prison rules over healthcare" was the refrain. Nurses reported feeling pressurized and suborned by prison officer colleagues.

An interesting leitmotif emerged from discussions with nurses and healthcare officers linked to this insidious attack – a lack of professional confidence

undermining the core of their work - “we don't like to talk too deeply with the prisoners. It opens a can of worms...” “Our standards of mental health assessment are not good...”

There is a significant lack of clinical supervision for healthcare staff. Organisationally, over-flexible boundaries in the in-patients department can be observed. For example, offenders with mental health issues are mixed with offenders with medical and surgical problems. Or lack of bed space, subject to the vagaries of admission pressures in the wider prison system, can lead to “lodging” – the process whereby beds in the unit are taken over by healthy offenders short of a cell in the main prison.

There is a transient cohort of nursing staff – up to 70% agency in some situations. While the cohort of healthcare officers tend to be more stable, there is unease expressed - “our role is drifting towards the custodial.” The lack of power of the health system is also reflected in its disconnected relationship to the PCT and the external health system. For example there is poor communication with hospitals - “clumsy bureaucracy, muddled discharges, and problems with effective patients' notes”

Surrey “The Walls of Sparta”

A visitor asks of the Spartan leader, “You are the strongest city. But where are your walls?” The leader replies, while pointing at his army, “there are the walls – and every man a brick!”

The relationship between healthcare and the prison regime in the Surrey system is characterised by a high awareness of the tensions at the interface between care and custody, health care and the prison regime, at all levels from coal face staff to governor. It is as if each member of staff fights the good fight from the perspective of their own role, secure in the knowledge that they are all together in resisting the tug of the custodial.

The governor balances the two tensions, exercising a significant yielding of power to health. This is characteristically uncomfortable – a sense of responsibility without power. A good example of the encompassing nature of the prison regime being moderated is the delegation of control over all admissions to the in-patient unit to health care management.

There is significant yielding on the health side as well - “we have to bend our ethics to work with prison officers and prisoners.” The battleground for front line health care staff with prison officers is seen in issues such as confidentiality, where there is a tension between the offender being considered as a ‘patient’ by nurses, versus the custodial imperative of the prison officer.

Another issue is in the fraught area of “escorting” which runs along the fault line between the two systems – again the prisoner as ‘patient’ versus custodial necessity. There is also a battleground with offenders - “We can't trust them,” “They can threaten us when they feel baulked by us”…… “They scam us over prescription drugs and alcohol.”

Sussex "The castle and the keep"
Lewes Prison is a listed building. It sits on a hill top like a medieval fortress. The health care centre is the keep – an independent castle within a castle.

Sussex' staff's appreciation of the challenges of the task are similar to their colleagues in the other areas - "It's hard to be a pure nurse". But the solution is different - castle and keep. This physical layout is replicated in the "organisation in the mind" of the staff. Strong managers are used as boundary keepers. Front line staff just gets on with the job inside the keep walls.

There is a (necessary?) fiction of separateness – *as if* we are a normal health setting in the community – to establish the separation of care and custody 'Our own porters to do internal escorting, *just like a hospital*'………'Our own Housekeeping team do the cleaning, *just like a hospital'*

The reality of the custodial tug leaks through the keep walls due to the restrictions around *Control and Restraint*. This can only be done by prison officers inside prisons. There is one discipline officer deployed to healthcare, this one member of staff alone could not ensure 'discipline'. The officer is employed in recognition of the need to have a 'bridge' with the maintained 'discipline/order' but these are prison concepts that we would not use. At governor level ambivalence is expressed – do we give care it's head at the expense of custody? To enable health to flourish governors must cede power to health management. However, this leads once again to the dilemma of responsibility without power.

7.2.1 Detailed findings: categories and themes

Category 1 Care and Custody
This category encompasses the prison system and the relationship of healthcare within the institution. Participants in both the focus groups and interviews with staff in all three regions spoke about the ways in which the prison's custodial function impacts on their work in healthcare, which they view as more 'care' orientated. The following sub-themes form the Care and Custody category:

Prison regime/life
This sub-theme refers to the prison system and how the prison regime impacts on the tension between care and custody. This tension was expressed by staff in all three regions.

The regime refers to lock-up times which dictate when healthcare staff can access the offenders. Security and prevention issues have also emerged within this theme.

"Its very different from hospital….every day is a challenge", (pharmacy tech, Kent).

"You can't deliver the same level of care in prison as the NHS …… It's a big culture shock", (nurse, inpatients, Kent).
"Custody versus care dilemma is the other big divide" (manager grade, Kent)
"We have to follow security more…..it comes over patient care…..not sure if the resistance would be different if we had healthcare officers" (focus group, Surrey)
"Safety and custody wins over health care…..security preoccupies us as healthcare workers always" (nurse, Surrey).
"Escorting prisoners is the key tension and frustration in dealing with the prison regime……..they (officers) can only see it from a custody point of view" (manager grade, Surrey)
"you have to fit in with lock up times and understand the culture"…."the time restrictions mean you have to deliver medication in the allotted times" (Mental health nurse, Sussex)
"We are care-taking, not treating", (focus group, Sussex)

Relationships with offenders
The relationships between healthcare staff and the offenders emerged within the Care and Custody category. Interviewees talk about the difficulties they face when delivering care to patients who are in prison.

In Kent, there was a re-occurring issue about the demands offenders place on healthcare staff;

"There is conflict if they (offenders) really want something", (pharmacy tech, Kent)
"Prisoners learn to say 'it's urgent' to get moved up the waiting list" (focus group, Kent).
"I have to wait to see my GP and get dressed to see my doctor…they (offenders) don't have to", (Healthcare Officer, Kent)
"They (offenders) ask for things above and beyond entitlement" (focus group, Kent)

In terms of interacting with the patients, the following quotes are from Kent and Surrey;

"We as nurses' end up talking to them (offenders) which can open a can of worms"
(Focus group, Kent)
"It's difficult to fit in one-to-one time with the patients" (focus group, Surrey.)

In Surrey, one manager grade talked about how to approach patients with caution;
"We've become suspicious and distrustful of our patients"

Relationship with officers
Within the care and custody tension also lies the relationship between healthcare staff and prison officers. There were mixed views about this relationship across the three regions.

In Kent, it was felt there was less tension, although trust was referred to;

“There’s no hierarchy” (pharmacy tech)
“At first, officers were hesitant as we were strangers to them….there’s a trust issue” (nurse, first night centre)

In contrast, Surrey staff members talked of the barriers to their work due to conflict with prison officers;

“We have to justify to officers if we need to send a patient out for treatment” (focus group, Surrey).
“You need 2/3 officers for an escort – it’s a constant battle” (nurse, Surrey)
“Feel intimidated….officers would ask, ‘are you sure the prisoner needs it (treatment)?’” (Nurse, Surrey).

In Sussex, only 1 staff member in the focus group mentioned prison officers and stated;

“They’re much younger now, more modern….more healthy attitude” (nurse, Sussex)

Professional identity
The final sub-theme that completes category 1 is about the identities of the professionals. There was some tension between being a ‘nurse’ within the custodial system and this sub-theme was expressed across all three regions.

“*We lost our healthcare governor for the cluster so there is no one to fight our corner…….we’re dictated to by the prison and admissions” (focus group, Kent)*
“We’re only nurses” (focus group, Kent)
“It’s not an issue (being a healthcare officer)…..there are murmurs of getting rid if us” (healthcare officer, Kent)
“Medical confidentiality has been our most powerful tool in facing down prison officers…..being NHS gives us clout” …….“Hard to be a nurse in prison”, (manager grade, Surrey)
“Old healthcare officer role was too ambiguous. You have to signal who you are; care or control” (manager grade, Surrey)
“Healthcare workers used to be seen as civilians, not now” (nurse, Sussex)

Category 2: Barriers to delivering of healthcare
This category includes all aspects of the workforce delivering healthcare. Staff in the three counties talked with the researchers about the main barriers for them when delivering healthcare on a daily basis. The specific barriers varied across the three counties;

Disruptions to health care pathways
Disruptions to health care pathways was identified as the ways that services are separated from each other, rather than joined up. Thus at a number of levels there was a lack of continuity between inpatient/outpatient services,

those which encompassed mental health, physical health and substance misuse. Services were delivered more separately from each other in Kent.

"Integrated drug treatment service (IDTS) are not very collaborative, we need to improve collaboration" (focus group, Kent)
"A seriously psychotic patient could be next door to someone waiting for heart surgery"………. "Not conducive to care" (focus group, Kent)
"We have separate teams for inpatient and outpatient like the NHS" (nurse, Kent)

Staff in Surrey and Sussex referred to the existence of separateness of delivery for different health care services, though here the story was one of a gradual movement towards integration of care pathways.

"Mental health in-reach doesn't join us much…. (they're) distant"…."getting better though" (nurse, Surrey)
"good relationship between in-reach and rest of prison healthcare team….much less of a muddle now……..co-location is highly beneficial" (in-reach nurse, Sussex)

In Surrey the rapid movement of offenders affected the capacity to deliver continuous care:

"High turnover here, so we lack continuity of care. It affects communication and outside referrals" (focus group, Surrey)
"Can be difficult, they (offenders) come from all over the country." (Manager grade, Surrey)

Waiting times for services
This sub-theme emerged in the Kent region only. Waiting times for services were felt to impact on the workforce's ability to deliver healthcare. This was highlighted around the dentist mental health services.

"Dentist attends for half a day and never clears the waiting list. There's 18month waiting list" (focus group, Kent)
"Long delay to move mentally ill prisoners to secure hospitals, they deteriorate" (focus group, Kent)

Lack of Space
There were also barriers to delivery healthcare around the space available. This theme was again raised specifically in the Kent region;

"There is a lot of sharing of treatment rooms, like pharmacy and IDTS"……"The podiatrist uses the dentist's room", (focus group, Kent)
"Fighting for space is very frustrating …….its hard to make things happen", (pharmacy tech, Kent).
"Increase in population, but healthcare hasn't increased"……………. "Biggest impact (on delivery) is lack of space" (focus group, Kent)

Category 3: Staffing issues
Issues relating to recruitment and retention and the deployment of staff within establishments were identified in interviews and focus groups.

How staff are deployed
This theme refers to how the workforce experienced being deployed within the establishment. This issue was discussed in Kent and a large prison establishment in Surrey.

"Sometimes we can't do as much nursing as they are short of officers"……."We get dragged off to deal with custodial issues", (healthcare officer, Kent)
"Prevention (of violence) is key….we get dragged off to the wings", (healthcare officer, Kent).
"we get moved around a lot"….there are 5 band 5 vacancies presently" (focus group, Surrey)

Recruitment and Retention
All three regions referred to recruitment and retention issues in their establishments;

"It's the biggest problem"……………. "Staff are not qualified enough sometimes" (focus group, Kent)
"The bridge to Sheppey is psychological – people think it's another country", (nurse, Kent)
"Agency staff are not consistent and cancel last minute"…………"CRB checks take time" (focus group, Kent)
"It's an issue, we had 54 applications for a band 4 tech……… "HR is not helpful, we have to deal with recruitment ourselves" (pharmacist, Surrey)
"People don't take (staff) sickness seriously" (focus group, Surrey)
"It's getting better as it's good to use (recruit) student nurses on placement", (focus group, Sussex)

Category 4: Training and Development
This category includes the interviewees' perceptions about the training available to them and how they view the provider.

Training Issues
Staff expressed varying perceptions about training. In Kent and one establishment in Surrey they described a shortage of training opportunities:

"in 11 years I've only had 3 years IT training" (focus group, Kent)
"We're limited to do training as we need staff on the floor" (nurse, Kent)
"Agency staff can't do training but we rely on them" (focus group, Kent)
"Trying to get training is difficult"…. "It's full by the time you get the list" (pharmacist, Surrey)

In Sussex, staff were more positive about their training opportunities but did highlight how previous isolation before the transition to NHS meant this had not always been the case;

"Primary care training is really good", (focus group, Sussex)
"Before there was very little training and we were isolated" (focus group, Sussex)

Relationship with Commissioner PCT
All three regions expressed some dissatisfaction with the Commissioning PCT. Negative feelings toward the Commissioning PCT centred on their perceived lack of knowledge of what offender healthcare workers do and what they face.

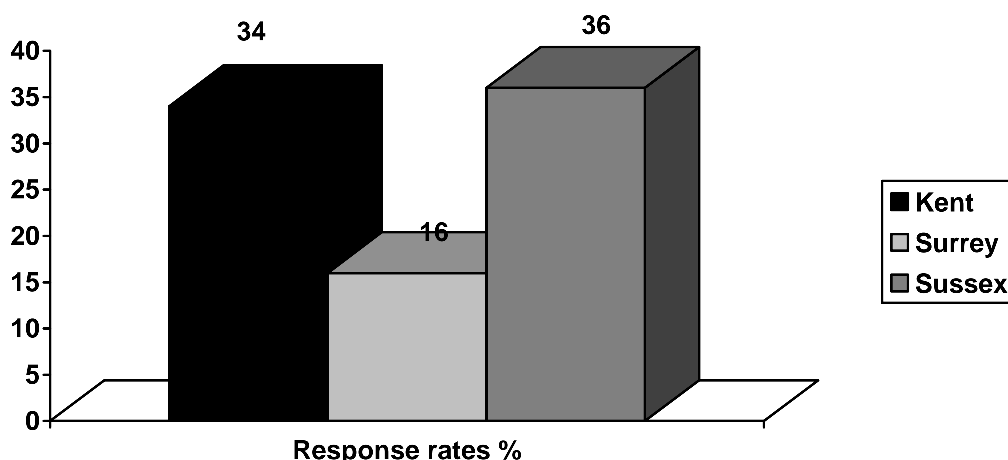
"The PCT is not aware of what's going on – they need to come and have a look", (focus group, Kent)
"There is a lack of understanding from the PCT" (focus group, Kent)
"I think we're excluded from the PCT" (focus group, Surrey)
"You got more recognition when we employed by the prison service…..in the NHS, we're just a number, not a name" (pharmacist, Surrey)
"PCT managers are too scared to come in here….it would be nice if they came in here and asked us how we feel, our concerns etc.." (Focus group, Surrey)
"PCTs seem to want to keep prisons at arms length….seeing them as exotic and different" (manager grade, Sussex)

7.3 Findings from the offender healthcare staff survey

Responses and response rates
92 surveys were returned from Kent (58), Surrey (16) and Sussex (18). Kent county has more prisons (10) compared with Surrey (5) and Sussex (2).

The overall response rate to the survey was acceptable for a postal questionnaire (29% returns). Surrey was relatively under-represented in survey returns, with 16% returns (see figure 1).

Figure 1: Response rates (%)



Because of these response rates, some caution was applied in interpreting the survey data, as it could not be convincingly demonstrated that the returns are representative of all staff in the region. The method adopted was therefore to undertake statistical analysis of specific questions. For some questions there were sufficient sample sizes to reach statistical conclusions, however for others there were insufficient numbers, especially when there are sub categories or sub samples.

Questions in the survey

The survey comprised 4 main sections:

A – Background
Includes: staff type, employer, key responsibilities, qualifications
B – Establishment
Includes: prison category, opinion on healthcare delivery, strengths and weaknesses, available services
C - Staff Development
Includes: training received, process of CPD, appraisal, supervision, development needs, student placement provision
D - Issues and barriers
(The full survey is appended to this report as Appendix B)

Findings from section A

This section of the survey focused on the respondent's professional backgrounds and experiences.

Employer

Table 5 shows that employment is consistent with the findings from the interviews and focus groups, with greater NHS employment in Surrey and Sussex, whilst there is greater prison service employment in Kent.
Agency staff that responded to the survey were from Kent prisons.

Table 5: Respondent's employer

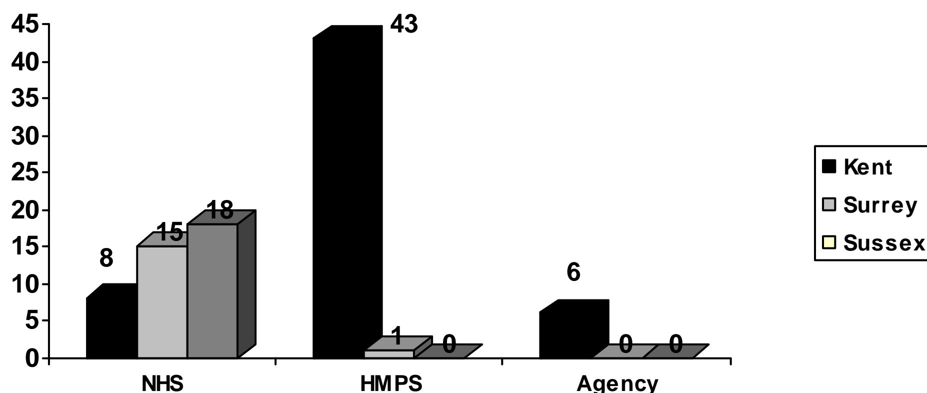
	Staff member's employer		
	NHS	Prison service	Agency
All respondents (1 not stated)	41	44	6
Regional responses			
Kent region	8	43	6
Surrey region	15	1	0
Sussex region	18	0	0

(Missing data = 1)

Statistical analysis revealed a significant association with the region of which the respondent belongs and their employer[3].

[3] Pearson's chi-squared test revealed a significant association between two county models (Kent and Surrey/Sussex) and whether staff was employed by NHS or prison service staff, X^2

Figure 2: Respondent's employer



Staff banding/grades

There was a concentration of responses from NHS nursing bands 5 and 6 (26% and 29% respectively).
Both Surrey and Sussex had no respondents with HMP officer grades which are consistent with the employer of each county.

Table 6: Banding and Grades

	Kent	Surrey	Sussex	Total
NHS agenda for change banding				
Band 2	1	0	0	1
Band 3	3	3	2	8
Band 5	12	6	3	21
Band 6	12	3	9	24
Band 7	4	1	1	6
Band 8	2	2	2	6
HM Prison Service Grade				
Healthcare officer	4	0	0	4
Senior officer	7	0	0	7
Admin officer	1	0	0	1
Other				
Specialist medical	3	0	1	3
Total	49	15	18	82

(Missing data = 10)

(1) = 55.97, p <.000. Cramer's V statistic is between 0 and 1 (.816) which indicates a strong significant measure of the strength of the association. 35% of the variation in employer is accounted for by the region (model) from which the respondent belongs.

Length of time in establishment and healthcare
The majority of respondents had worked in their establishment and in the department of healthcare for 1-5 years (42% in the establishment and 36% in healthcare).
42% of respondents from the Kent region had worked in Offender Healthcare for over 10 years.

Table 7: Respondents' employee length

Length of time in establishment				
	Kent	Surrey	Sussex	Total
> 1 year	12	7	1	20
1-5 years	18	6	14	38
5-10 years	11	3	0	14
10+	16	0	3	19
Length in healthcare department				
> 1 year	12	6	1	19
1-5 years	13	7	13	33
5-10 years	8	3	3	14
10+	24	0	1	25

(Missing data = 1)

Respondent's qualifications
There was a spread of qualifications across respondents. 'Diploma' was the most common qualification (37%). 23% had a degree.

Table 8: respondent's qualifications

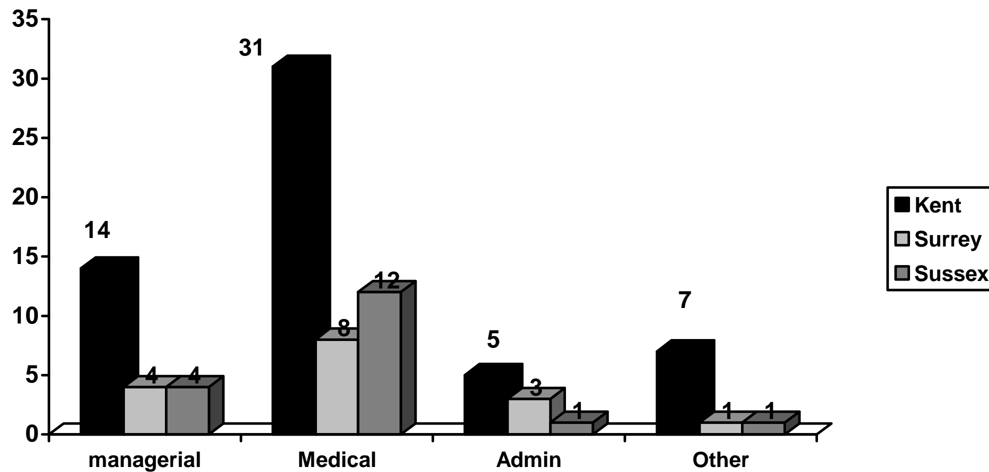
	Kent	Surrey	Sussex	Total
NVQ/BTEC	7	2	1	10
Degree	12	7	1	20
Diploma	21	5	6	32
General nurse registration	7	0	3	10
Mental health nurse registration	5	1	1	7
RGN & RMN	0	0	3	3
other	1	1	2	4
Total	53	16	17	86

(Missing data = 6)

Staff type
80 respondents were permanent members of staff. Only 8/92 agency staff responded. Given the large number of staff vacancies, and the high numbers of agency staff employed (particularly in Kent establishments) the number of agency staff responding is disproportionately low. This provides further evidence of the difficulty of planning for capacity building when agency staff are widely used.

Workforce category
Respondents were in both clinical (56%) and managerial categories (24%). 20% of respondents were from workforce categories; 'other[4]' and admin.

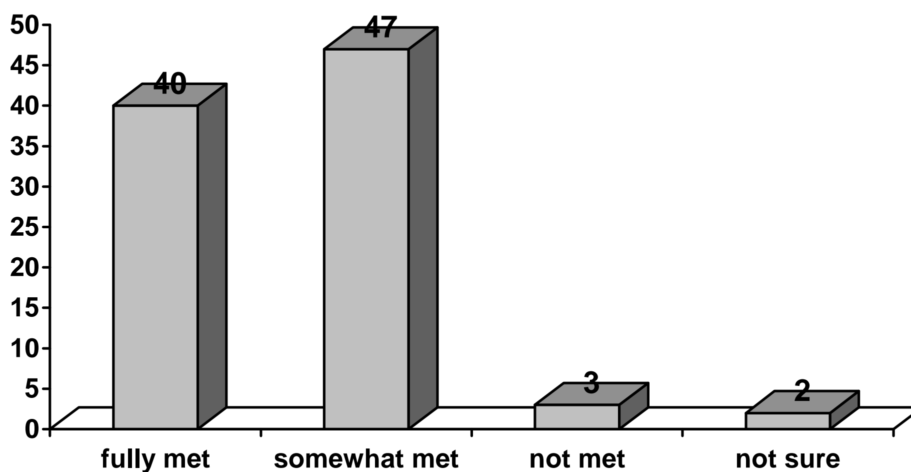
Figure 3: respondent's workforce category



Findings from section B
This section of the survey focused on how the respondent's perceive the establishment they work in meeting the healthcare needs of their offender population.

Respondent's perceptions of the capacity to meet offender health care needs
94% of respondents stated that the healthcare needs of the population were 'somewhat met' or 'fully met'. 56% believe health care needs are not fully met.

Figure 4: Respondent's perception's of offender's healthcare needs being met



[4] 'Other'; includes non-medical (3), trained, not qualified (5) and ancillary (1).

Prison health care staff perceptions of strengths and weaknesses in their services
Respondents were asked to identify three strengths and three weaknesses in their service. The data collected focused on three principal areas: a) the clinical workforce, b) the service offered and c) the management team.

Clinical workforce
The clinical workforce was commonly described as dedicated, knowledgeable and flexible. Respondents from management backgrounds were as likely to cite clinical staff as a strength as respondents from clinical backgrounds. The relationships between staff and offenders were generally regarded as positive, particularly where staff members had been in service long and were able to get to know offenders well.

However, the most commonly identified weakness was staff shortages and a lack of permanent staff. Issues around staff shortages were identified by approximately forty per cent of respondents, which was broadly similar across the regions. Some respondents expressed concern about an over reliance on agency staff because of lack of continuity. Respondents from management backgrounds were as likely to identify staff shortages as clinical, ancillary and administrative staff. Some respondents also identified lack of clinical supervision and access to training as important issues.

The service offered
The data relating to the service offered focused on the service being equivalent or better than general NHS services. Many respondents demonstrated pride in their service, with one person describing it as a 'Rolls Royce; service. A commonly identified strength was the accessibility of the services, with short waiting times and quick appointments. Specific developments were highlighted, such as the triage service and nurse led clinics. A few participants in the Kent region identified good public and patient involvement, e.g. wing reps and PALs.

A frequent identified weakness was lack of mental health services, particularly day care and access to psychological therapies, and long waiting times for dentistry. A lack of equipment and resources were also identified by a minority of respondents.

Respondents from both clinical and management backgrounds identified limitations arising from the prison setting, described by one respondent as "clinical staff time taken up with jail craft". Another stated that the prison service takes precedence over the medical service, which can lead to consideration duplication of NHS work because of a poor transfer of information.

The management team
Respondents in the Kent group were more likely to cite strengths in the management team, particularly respondents from clinical backgrounds. For example, strategic leadership and support for innovative practice However, some respondents in the same region felt that communication was lacking,

that there was a lack of clarity about what should be provided and there was a lack of understanding between the prison and the PCT.

Respondents from management as well as clinical backgrounds identified weaknesses in staff support and development, specifically lack of clinical supervision, access to training and mentorship.

There were minor regional differences. For example, Kent respondents were more likely to cite strengths in the clinical workforce and the management team whilst Sussex and Surrey respondents were more likely to focus on the quality of the service offered.

Perception/knowledge of the services provided

Respondents were asked to select which of the 22 listed services[5] are provided in their establishment. Dentistry was the most selected service available across all the 16 prisons that responded.

Table 9 shows the top 5 most selected services in each county and across the region as a whole.

Table 9: Most frequently selected services

Across the region	Kent	Surrey	Sussex
Dentist	Dentist	Dentist	Dentist
Sexual health	Sexual health	Substance misuse	Sexual health
Chronic disease clinics	Outpatient	Podiatry/chiropody	Chronic disease clinics
Outpatient	Chronic disease clinics	Chronic disease clinics	Podiatry/chiropody
Dispensing	Dispensing	Outpatient	Outpatient

Workforce Plan

Respondents were asked if they had awareness of a workforce plan.
47% (N= 42) of respondents said they knew that a workforce plan was in place for healthcare delivery (17 of the 42 were managers).
27% of respondents had no knowledge of a workforce plan and 27% were unsure.

Table 10: Awareness of a workforce plan

	Kent	Surrey	Sussex	Total
Yes	31	7	4	42
No	13	4	7	24
Not sure	14	4	6	24

(Missing data = 2)

[5] See appendix B for survey and full list of services

Perception of whether the governor prioritises healthcare
Respondents were asked whether they felt that their prison governor prioritised healthcare in their establishment. 34% felt that their governor does not prioritise healthcare in their establishment. "Somewhat" was the most selected response in Surrey and Sussex.

Table 11: Responses to whether governor prioritises healthcare

	Kent	Surrey	Sussex	Total
Yes	7	1	2	10
somewhat	18	10	9	37
no	22	5	4	31
Not sure	10	0	3	13

(Missing data = 1)

7.3.4 Findings from section C

This section of the survey focused on how the respondent's perceive their training, development and their support needs and opportunities. Respondents were also asked to comment on student placement provision in their establishment.

Staff Development
Respondents were asked if they felt that staff development was prioritised in their establishment. 28% said it was prioritised, with 45% of all respondents judging that staff development was 'somewhat' prioritised in their establishment. 20% judged that staff development is not prioritised in their establishment.

Table 12: workforce category and their opinion on staff development priority

	managers	Medical workforce	other[6]	Admin
yes	7	13	2	3
somewhat	11	2	4	4
no	3	14	0	0
Not sure	0	1	2	2

Healthcare Induction
Respondents were asked if they had received a healthcare specific induction training/programme in their establishment.
The majority of respondents said they had received a healthcare induction (56%). Most of the respondents who had not received any healthcare induction were employed in Kent. The difference between Kent and

[6] Other'; includes non-medical (3) and trained, not qualified (5).

Surrey/Sussex is statistically significant[7], thus identifying a difference between Kent and the 2 other counties.

Table 13: Attendance at healthcare induction

	Attendance of a healthcare induction		
	Yes	No	Not sure
All respondents	51	37	3
Regional responses			
Kent region	26	29	0
Surrey region	13	3	1
Sussex region	12	5	0

Of the 51 attendees of the healthcare induction, 49% felt it had equipped them for working with their population. 27% stated 'somewhat' and 16% said it had not.

Sources of CPD

Respondents were asked to identify where they perceive CPD to be available. They were asked to select up to 7 options to identify which applied to them. These were;

a) Prison, b) PCT, c) HEI, d) Further Education, e) agency, f) I don't know, and g) other.

Analysis of this information was in terms of sources where CPD is a) available, b) not selected as available.

Respondents identified PCT (59%) as the most likely source of CPD, followed by the HEI and the Prison. Not surprisingly due to employer status, the majority of responses identifying prison as a source of CPD were from Kent prisons.

Analysis was employed to compare responses from Kent and Surrey/Sussex and found three statistically significant associations with source and county model[8]; prison, PCT and further education.

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[7] There was a significant association between the two different models (1 – Kent, 2 – Surrey & Sussex) and whether staff had attended a healthcare induction, X^2 (1, N = 88) = 6.87, p <.009. Cramer's V statistic is between 0 and 1 (.279) which indicates a relatively weak association**.** 8% of the variation in attendance at healthcare induction is accounted for by the region (model) from which the respondent belongs.

[8](i) CPD in Prison had a significant moderate association with county, accounting from 15% of the variation X^2 (1, N = 88) = 13.87, p <.000.
(ii) PCT had a significant weak association with county, accounting from 8% of the variation (X^2 (1, N = 88) = 6.92, p <.009).
(iii) Further education had a significant weak association county, accounting from 8% of the variation (X^2 (1, N = 88) = 6.97, p <.008.)

Figure 5: Sources of CPD selected by all respondents

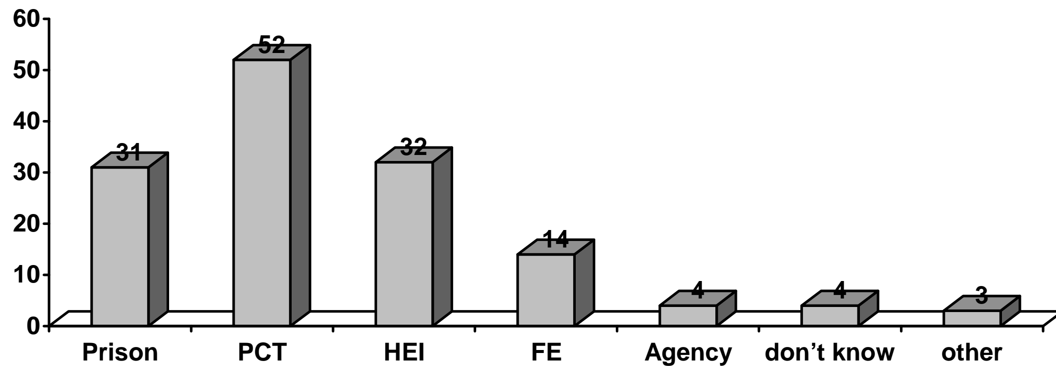
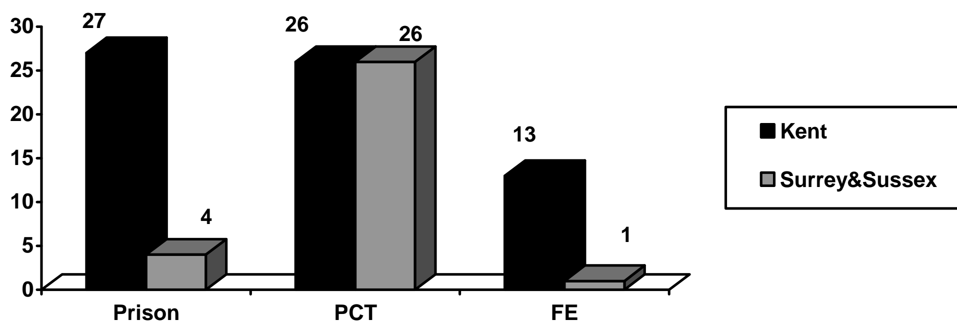


Figure 6: Statistically significant associations with CPD source and county model



Knowing how to access CPD?

Respondents were asked if they knew how to access CPD. 81% of respondents said they did know how to access CPD. Respondents were then asked to select the following routes for accessing CPD; a) Through their staff performance & development record (SPDR)/knowledge Skills Framework (KSF) b) their line manager c) training and development officer/department c) the PCT d) agency e) 'don't know' f) arrange myself g) other

Most respondents selected their line manager (63%). The route of access through SPDR/KSF had a statistically significant association with county model.[9]

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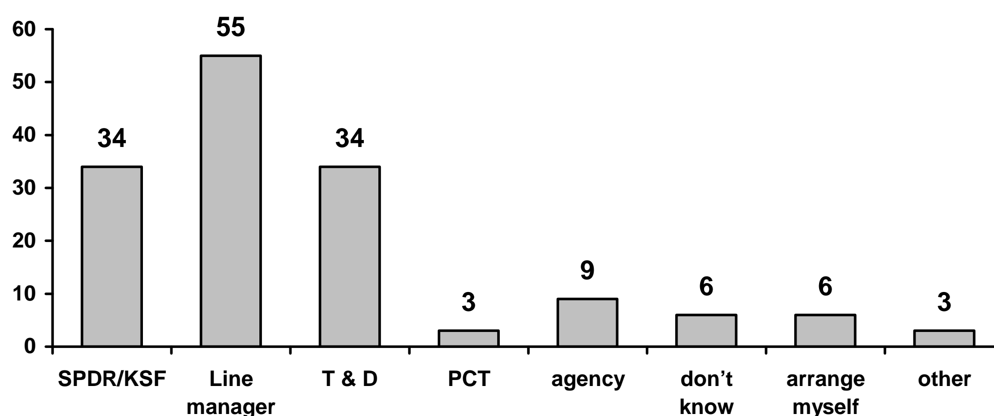
[9] There was a significant association between the two different models (1 – Kent, 2 – Surrey & Sussex) and whether respondents selected SPDR/KSF as a means of accessing CPD, X^2 (1, N = 87) = 11.70, p <.001. Cramer's V statistic is between 0 and 1 (.367) which indicates a moderate association**.** 13% of the variation in staff selecting access to CPD through the SPDR/KSF system is accounted for by the region (model) from which the respondent belongs.

Figure 7: Routes of accessing CPD



Appraisal system
Respondents were asked if they had an appraisal system. If they had, they were asked when was the last one and was if effective in meeting their development needs.

83% of respondents had an appraisal system in place and 79% had one within the last 12 months. 64% stated they found the appraisal effective in meeting their development needs.

Table 14 Appraisal System

	Kent	Surrey	Sussex	Total
Do you have an appraisal system? (3 respondents missing)				
Yes	50	8	16	74
No	4	5	1	10
Not sure	2	3	0	5
Was it effective in meeting your needs? (9 respondents missing)				
Yes	17	6	6	29
somewhat	19	1	6	26
No	10	5	3	18
Not sure	7	1	2	10

Clinical Supervision
Respondents were asked if they received Clinical supervision and from whom. Findings revealed that 33% had received clinical supervision either with their line manager or someone outside the department.
Nearly half of the total sample (47%) stated they had never received clinical supervision.

Table 15: Clinical Supervision

	Kent	Surrey	Sussex	Total
Yes	16	5	8	29
Ad hoc	13	3	2	18
No never	27	8	7	42

(Missing data = 3)

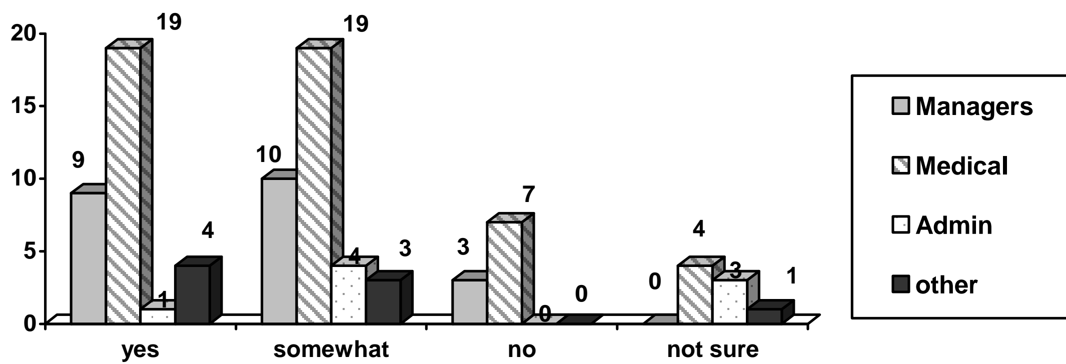
Are you meeting the needs of your career path?
Respondents were asked if they were meeting the needs of their career path. 38% of respondents felt they were meeting the needs of their career path. 41% felt they were 'somewhat' meeting their needs.
Findings revealed a slightly significant association[10] with the 3 counties and staff stating whether they met their career paths.

Table 16: Meeting the needs of your career path

	Kent	Surrey	Sussex	Total
Yes and somewhat	46	9	14	69
No and not sure	8	7	4	19

There was a relatively even spread of satisfaction in meeting the needs of their career paths across the different workforce categories. These are illustrated by figure 8.

Figure 8: Workforce category and meeting career path



[10] Meeting needs of career path – slightly significant. This was with yes and somewhat being collapsed into 1 variable and no and not sure in 1. X² (2, N = 88) = 6.110, p = .047 Cramer's V statistic is between 0 and 1 (.263) which indicates a weak association**.** 7% of the variation in staff stating their career paths are being met is accounted for by the region from which the respondent belongs.

Future Development
Respondents were asked where they would like to be in five years time. Approximately one third stated that they wished to be promoted to the next career band, mostly commonly band 6 or 7. A small number identified having a permanent post as being important for them.

Respondents from management and clinical backgrounds identified securing more senior management roles or a specialist nurse post. Approximately a quarter did not respond to the question or indicated that they were unsure, whilst a small number stated that they simply wished to be in employment. Less common aspirations included consultancy work, obtaining a PhD and ‘driving route 66’. Approximately 15%-20% of respondents indicated that they would be retiring, which was more common in the Sussex region.

Development needs
Participants were asked to identify up to five development needs. The most commonly identified need was for management and supervision training, which was identified by both management and clinical staff. Management training included strategic planning, HR, finance/budgeting, assertiveness and public speaking.

The most commonly identified clinical area was for training in substance misuse, mental health and CBT. Other clinical areas that were identified were female health, sexual health, immunisations, asthma, diabetes, respiration and first aid. Some participants identified training to understand prison culture and procedures. Approximately 15-20% of participants identified academic qualifications, e.g. a BSc top up qualification and an MSc in forensic mental health. Participants also identified professional updating, IT training, and NVQ qualifications. Trends were similar across the geographical areas.

7.3 Awareness of students in the establishment and the perceived barriers to placement provision

Participants were asked whether they were aware of student placements in their organisation and to identify any possible barriers there may be to placement provision. 63% of respondents were aware of student placements in their establishment

Table 16: Student placement provision

	Kent	Surrey	Sussex	Total
yes	38	4	14	56
no	15	10	3	28
Not sure	3	1	1	5

The most commonly identified barrier to student placements was security clearance and other security related issues. A second group of barriers related to a shortage of mentors and staff time to support students. Less commonly identified barriers were a limited range of patients and students

who were anxious about the prison environment and may lack life experience. Several respondents were very positive about student placements and could not see that there were particularly difficult barriers.

7.3.4 Findings from section D

This final section of the staff survey focus's on the respondent's view of the main issues and challenges in delivering healthcare.
Participants were asked to identify up to five main issues and challenges in delivering healthcare. Responses clustered around five main themes that were reasonably consistent across regions and different parts of the workforce:

Staffing and workforce issues
The most commonly identified issue across all themes was staff shortages, overload and lack of cover, particularly during evenings and weekends. Other issues that were identified including difficulties in staff recruitment, poor teamwork, lack of training opportunities and an ageing workforce.

Transfer of patient care
Several responses related to difficulties in transferring patients between settings, particularly when there was short notice of transfers and duplication of NHS work because information had not been shared.

Factors relating to the organisational setting and management of the prison Responses in this category focused on the difficulties of delivering healthcare in a prison setting and lack of support from prison staff and prison management. This included the limitations of the physical environment as well as a less common response that was expressed at the 'medicalisation' of prisoners' problems.

Factors relating to offenders A number of factors related to service users, who were described as having high substance misuse and mental health needs, poor attitudes, in denial or 'manipulative'.

Factors relating to the PCT Several participants described poor support and engagement with the PCT and expressed concern that it was a PCT responsible for mental healthcare rather than a specialist mental health trust.

7.4 Findings of HEI interviews

Representatives from each of the four contracted university faculties were interviewed about what courses they offer, how they cater for the offender healthcare workforce and barriers they face in their education delivery.

Current courses offered
None of the four contracted HEIs deliver specific CPD for the offender healthcare workforce. All their CPD programmes and courses are available for this workforce and as some interviewees stated, are relevant to them. Universities are committed to inter-professional training; 'I think inter-professional training is better, you learn more when there is variety and a mix'. Another interviewee felt it was actually better for offender healthcare

staff to study and train out of their establishment with other workers, exposing them to practices ‘outside’ and update their practice.
Therefore there is no separate/discrete training for offender healthcare staff.

This may not attract students as may not be offering something worthwhile to the offender healthcare workforce.

Several interviewees identified areas they felt they did not currently offer. For example, Surrey and Brighton Universities do not currently offer substance misuse related courses within the health and social care faculties, but would be willing to set up courses if the demand was there. Another interviewee thought a module/courses on the theme of prison culture could be developed, however they stated they were not ‘specifically set up to tackle that’.

How courses are delivered
All four universities stated that they organise their CPD programme by responding to current policy and practice needs. They all stated in the interviews that they can and would deliver work-based learning and have the ability to develop the content of modules to suit the needs of the specific service.

When asked how they deliver their courses, all interviewees stated that they draw from their own staff base but occasionally employ seasonal staff. One interviewee offered that if they had more offender specific courses they would consider employing specific offender staff on a seasonal basis.

Current level of access to CPD from offender healthcare workforce
Overall numbers of offender healthcare staff on current courses was difficult to obtain. It was explained to researchers that students are assigned to their PCT so the data base may not show their place of work/prison.

However, generally numbers of current offender workforce students was quite small. One interviewee stated; ‘they’re a hard to reach group’.

The feeling was that there are problems with access and they are not receiving requests from offender healthcare staff. One interviewee suggested that perhaps staff do not know which PCT they belong to or which HEI connects to them.

Another interviewee felt that since the PCT took over offender healthcare, there were fewer students and perhaps this was due to more skilled staff being recruited.

Drivers for health care CPD
Each interviewee was asked if there were any particular drivers for the healthcare CPD that they offer. The following list outlines the main drivers:

- Partnership to local providers
- Lord Darzi’s 8 care pathways (June 2008)
- Clinical practice, user involvement, social inclusion and mental health

- Policy changes
- Money(commissioning)
- Being approached
- Nurse practitioner awards
- Foundation course for band 4s
- The Bradley report
- "everybody's business" (1995)

What is not working well and what do you need?
There were three main areas raised by each of the HEI interviewees as where there are barriers and some suggested strategies for improving the current situation.

Access & Funding
There was general consensus that there are difficulties in accessing CPD. one interviewee felt that the numbers represented by healthcare managers was not an accurate reflection of staff on their universities' courses. Another interviewee felt that funding affects access; "If they (staff) knew they could access funded courses they would come". They also raised the issue that the amount of CPD funding varies across the PCTs. One interviewee stated, "There needs to be a commitment to funding……it's easier for NHS staff."…….. "The SHA need to work harder to make more accessible and let offender healthcare workforce know that they can access CPD".

Knowledge
All interviewees felt that there was lack of knowledge from both the HEI point of view and from the offender workforce. It was felt that as education providers they wanted to know what the workforce need and want. One interviewee gave the example that they set up a clinical supervision module within 4 weeks because there was demand for it. In terms of the workforce's lack of knowledge, it was felt that offender healthcare managers need to know the process of accessing CPD and therefore inform and encourage their staff. One interviewee felt it was crucial to know the users views. The interviewee explained that as NHS is all about choice, and offenders cannot choose what level of healthcare and the services they receive, they must endeavour to meet their needs by skilling staff in courses specific for the offender's needs. It was suggested by one interviewee that an assigned lecturer going into offender healthcare departments, completing an audit and then talk to staff would raise more awareness of how to access CPD and what is available to them.

Students
Several interviewees mentioned the lack of mentors for students in the offender workforce and suggested this as a barrier. It was also mentioned that the prison induction process is difficult and can cause delay in placements.

7.5 Findings from the Governor survey
The survey for governors focused on the following areas;

A. Knowledge of their establishment and the healthcare needs of their offender population

B. Staff development for the offender healthcare workforce
C. Issues and barriers for delivery healthcare in their establishment

Responses
Six out of a possible seventeen governors completed and returned the surveys (34% response rate). One governor was interviewed over the telephone so did not compete the survey.

Findings from section A: background and meeting the offender's health needs

Length of time as a prison governor and length of time in current post
Most of the respondents had been prison governors for less than 2 years and less than 1 year in their current post.

Table 17: Length of time as governor and in establishment

Length of time as prison governor	
Less than 2 years	2
2-5 years	2
5-10 years	1
10+ years	1
Length in current post	
Less than 3 months	2
6 months to a year	3
2-5 years	1

Issue of recruitment and retention of healthcare staff
All of the respondents felt this was a major issue in healthcare. It was generally felt that applicants have a lack of understanding of the prison system and are perhaps inappropriate applicants due to lack of this knowledge; "It's getting quality staff to apply with relevant experience that we need." "Those working outside of the prison don't understand what its like to work in a prison" *(extract from a governor returned survey).*

Health care needs of the offender population being met
All respondents felt the healthcare needs of their population were fully (3) or somewhat met (3).

Strengths and weaknesses
Governors were asked to identify three strengths and three weaknesses in their healthcare service. The data collected focused on four principal areas: a) The services offered b) the staff/team c) the relationship with the prison d) provider

a) Services offered
There was general consensus from the governors that the services offered by the healthcare department were strengths. These were around access,

variety and specific services such as substance misuse and mental health were mentioned.
Weaknesses were identified as lack of access to some services as well as the calibre of GPs.

b) Staff/team
The staff was another area mentioned as a strength and a weakness. Commitment, motivation, team work and stability were attributes related to strengths. Weaknesses identified were around recruitment and retention and staff shortages. One respondent mentioned interpersonal conflict within the staff team leading to conflicts.

c) Relationship with the prison
Two respondents mentioned that strengths of healthcare in their establishments was being part of the prison as a whole and having good relationships with the discipline staff (officers).

d) Provider
Two respondents mentioned the positive relationship with the PCT being strengths.
Two respondents also made reference to this as weaknesses, that change of provider and a lack of clarity of current health provision were weaknesses.

Workforce plan for healthcare, which includes education provision and commissioning
5 out of the 6 respondents were aware of a workforce plan for healthcare in their establishment. 1 stated they did not know.

How they prioritise healthcare in the establishment
Governors were asked how they prioritise healthcare in their establishment and in what ways. All respondents stated that they a place high importance on healthcare, that it is a key priority. They all evidenced this by placing their healthcare manager on their senior management team boards as the way.

The healthcare priorities for the offender population
Governors were asked what the healthcare priorities were for their offender population. The following priorities were raised; Substance misuse (4) Mental health (3), Smoking cessation, Health education and promotion, Preparation for removal to foreign countries and elderly prisoner population issues.

7.5.3 Findings from section B: Staff development

Staff development as a priority
Governors were asked if staff development was prioritised in their establishment and how. Respondents stated, yes (4) and somewhat (2) staff development being prioritised. Respondents stated that priority was evidenced by a specific training and development department with a contact person.

Continuing Professional Development (CPD)
Governors were asked where CPD is available for their healthcare staff and through which route is it identified.

All respondents selected the PCT (6), with the HEI (4) and the prison (3) also being identified. All respondents selected SPDR/KSF (6) and line managers (6) as the two main routes of access for CPD.

Governors were also asked to identify the main development needs for their healthcare service. Most respondents mentioned professional development needs, such as having an appropriate professional staff mix (1), succession planning and leadership skills (1) and diploma level education for nurses (1). One respondent felt the main development need in their establishment was for healthcare staff to deal with violence and aggression.

Staff support
Governors were asked if there was an appraisal system in place for their healthcare staff. All respondents stated 'yes'. They were then asked if staff supervision was in place and in what form; all respondents said it was in place whether regularly with line managers (3), someone outside of the department (2) or was an ad hoc arrangement (2).

Awareness of students in the establishment and the perceived barriers to placement provision
Participants were asked whether they were aware of student placements in their organisation and to identify any possible barriers there may be to placement provision. 4 of respondents were aware of student placements in their establishment and 2 were not.

As with the staff survey, the most commonly identified barrier to student placements was security clearance. Shortage of mentors and staff availability to support students was also identified. One respondent felt isolation was also a barrier.

7.5.4 Findings from section C: issues and barriers
The final section of the governor survey focused on the respondent's view of the main issues and challenges in delivering healthcare.

All governors raised the issue of staffing issues, specifically recruitment and retention and having an appropriate staff mix. Another dominant issue was about the population impacting on the work for healthcare, such as effective planning for the changing needs of a diverse population. In addition to this was the issue/barrier to delivering healthcare when there is a short time frame for treatment with a transient population. Funding issues were also mentioned by two respondents.

7.6 Search Conference
"Educating and Developing the Offender Health Care Workforce",

Monday 24th May 2010. The conference was hosted by NHS Surrey and was facilitated by the research team using a Search Conference model.

7.6.1 Aims of the conference

The conference was an integral part of the study. The overall objective of the day was to influence the future direction of education provision and commissioning to improve the quality of health care delivery across South East Coast. The following groups of stakeholders were invited Commissioners, Providers, HEIs, front line staff, heads of healthcare and governors. The aim was to bring these six stakeholders together, present the findings of the research and facilitate an interactive conference that aimed to inform final recommendations and future direction of healthcare delivery and education.

The 'Search Conference' methodology is designed for a system undergoing significant change and involved pulling together a group of stakeholders and enabling them to work together in small fluctuating groups throughout the day. This high energy activity enables everyone to find their voice. After the research presentation small groups spent the morning engaging in exploration and assessment of past, present and future. In the afternoon, the groups produced some ideas, about influencing and implementing the future direction. (See appendix E for delegate list).

7.6.2 Programme for the day

Welcome and Context for the day
Feedback from the Research
First Round - Histories
Second Round - Working together in the system
Third Round - Changes
Fourth Round - Influencing the Future Direction
Fifth Round - Presentation of action points to whole group
Reflections on learning from the event
Next Steps

Findings

The following findings are presented in the format that they were compiled on the day:

Round 1 – Histories

Attendees were asked; "What, for you, have been the positive and negative experiences of this journey, their impact on service delivery, user involvement and staff recruitment and retention"

Positive

- Access and opportunity for CPD
- Transition prison service – Department of Health
- Heath Promotion manager
- Healthcare better (perhaps) than secondary care- in relation to access to dentists, opticians, podiatry
- Developed links with HEIs

- Student Approved Health Practitioner placements
- Introduction of the system
- The use of GPs instead of medical offered
- Availability of new health services
- Encouragement for potential staff to spend time in environment prior to interview
- Collaboration work between stakeholders
- Potential access to CPD
- Champion within Lewes experience
- Student placements in prisons - happy days ahead
- Standard of healthcare has been driven up
- Having students in prison placements encourages good practice and helps with recruitment and retention
- To maintain health of offenders from HEI and PCT
- Student placements – nurses, SHO, GP rotation, student doctors, FD, Nursing students, OT students
- Clinical service improve scope of service to meet needs
- For engagement within NHS re: workforce commissioning
- GP contracts
- Mental health commissioning
- User involvement best practice acknowledged in certain areas
- User involvement focus groups
- Partnership working in house, e.g. telemedicine, ICATS, Sexual Health,
- Student placements – links with HEIs
- Improved CPD

Negatives

- Tensions/factions PCT-Providers- Healthcare isles strong
- Delivery of healthcare gets in the way of regime
- Partnerships between prisons – trusts – GPs
- Attitudes
- How unprepared healthcare staff are to work in a prison
- Medicines management with potential for errors
- Lack of user involvement
- 70% agency staff and poor supply of staff
- Healthcare culture in classroom
- Difficulty with accessing CPD
- Ineffective communication
- Prison voice not heard within the NHS
- Complaints not always dealt with appropriately
- Rime – back fill for staff
- Experimental rise in funding e.g. IDTS
- Detrimental to healthcare services for health care service for staff to be employed by HMPS service delivery and recruitment
- Employed by HMPS can affect career progression in NHS
- Commissioning should be based on health needs assessment

- Recruitment is very difficult, security clearance delays often leads to individuals often finding other jobs
- Protracted security clearance
- Nursing in security environment induction lost
- Issues re: preceptorship/mentoring
- 80% agency
- Barriers for commissioning services within Kent
- High risk current provision
- User involvement – perceived as receiving second rate service
- Student placements – again with clearance

Round 2 - Working together in the system
Attendees were asked: "Take a snapshot of where we are now in relationship to both: service delivery and the personal and professional development of the workforce."

Service Delivery

- Mix bag – excellent provision and some anomalies
- Cultural shift prison/NHS – barriers
- Needs action/ownership/commitment (risk adversity)
- Escorts/bed-watches
- Better than it was, but danger of comparing how it used to be in prisons, better test is how does it compare to community services – still a way to go
- Most offenders represent a failure of community health provision
- Placement show expectations of scope of service delivery have increase significantly
- Senior level buy in is better – lower down it need very assert healthcare staff to change attitudes
- Recruitment and retention – skill mix of nurses, use of agency staff, 80% vacancy unfilled
- Length of time to start jobs – security clearance
- Poor skills mix
- Good aspects of work not recognised
- Overcoming ignorance/prejudice from NHS staff outside the service
- Poor links between acute services
- Transition – complex systems
- Full range of services not available
- Inappropriate service for specific patient needs
- 70% agency staff – influences budgets – sustainability?
- Lack of exposure geographically and staff make up
- Lack of awareness between prison and community
- Good focus n day to day management can now shift to long term
- Up to date health needs assessment
- 80% vacancies
- Specialist nurses i.e. diabetes
- Telemedicine
- Turnover impacting on delivery

- Funding service designed by budget rather than need

Personal and Professional

- Mixed bag – as well – access
- Don't have the right CPD (it's more geared to health service rather than to prison service)
- Turnover and temporary staff makes it difficult
- Student placements goods but need to put people in supportive environment with plenty of other clinicians around
- Prisons can be inspirational places to work "I'll cry when I have to leave"
- Local politics can interfere with successful placements
- No rules of guidance for student placements
- Training issues – conditioning/jail craft, prison specific training
- A University linked to prison nursing
- Not a competent workforce
- Potential careers
- Inadequate commissioning of services (Kent area)
- Limited career development - re: promotion
- CPD available re: modular needs but minimal life long learning e.g. BSc/MSc
- Lack skill mix fit for purpose therefore recruitment and retention remains an issue
- Dual role skill exist compromising patient safety
- Bradley Report – uncertainty around focus and funding – prison health verses offender health – social inequalities
- Appointed Head of Training & Development
- Links with HEIs
- Establish Diploma/certificate for prison nurse to increase status
- Career pathway
- Student placements
- Valuing staff who delivery service – future in prison nursing – addressing biased and prejudice re: prison nursing

Round 3 Changes

Attendees were asked; "What are the implications for *you*, both personally and professionally, of the changes that are going on in your work role and across the wider system, over the next 6 months to a year."

Attendees were grouped by the length of time in their current post, thus groups were identified from 'toddlers' to 'wisdom of the ages'!

Group: 'Toddlers'

- Development of OT professions within the prison setting more promotion and awareness
- Aims to develop a PPCT
- Build more links between acute services and healthcare in the prison service

- Liaise with Highdown and Lewes to complete all research
- Access to further education and commissioning
- Finding more flexible methods of delivery CPD

Group: 'Kids'

- Great uncertainty – profession and personal
- Commercial support unit impact on commissioning expertise – distancing from local reality – details
- Low morale, staff turnover
- Uncertainty in prison re transferring community services
- Expectation of doing more for less
- Education and training at risk of always being pulled first
- Prison service cuts potentially further down the line from NHS, will come possible return to warehousing

Group: 'Teenagers'

- Doing more with less budget
- Removing inefficiencies in prison healthcare
- Information to HEIs to target training provision
- Contract shortfall (prisons)
- Positives around working in healthcare (not known)
- Healthcare should be in NHS (not for Kent)
- System changes (could be positive, but disrupted in short term)
- Engaging with right level (of government)
- Impact of SHA/contracting changes in prisons, HEIs, service delivery etc.

Group: 'Parents'

- New ways of working e.g. Telemedicine, new roles
- Possibly few targets and less audits
- Local agenda – grass root decisions
- Fewer prisons?
- Our knowledge and experience of previous "Storms" – we survive
- Continued development in spite of government changes
- Increased risk
- Change – uncertainty – energy?
- Recruitment and retention sickness levels
- Funding for training?
- Commissioning levels
- Overcrowding – people lost within the system
- Prisoner health – coping strategy increase medication
- Industrial relations – strikes, increase self harm, self induced deaths
- Most vulnerable and most at risk population

Group: 'Mid Life Crisis'

- Education cuts
- Movement from face-to-face to e-learning

- Provider changes
- Complex patients and inexperience – increased risk
- Redundancies in HEIs

Group: 'Wisdom of the Ages'

- Velocity of change in the NHS
- Insecurity of income
- "Have we not cycled through this before"?
- Deanery – is it a commissioner or provider?
- QIPP (Quality, Innovation, Prevention and Productivity) – Oxymoron?
- HEIs – supporting CPD/decline in income - where do established societal providers fit in?
- New roles – redefining of roles

Round 4 - Stakeholders Influencing the Future Direction

Attendees were grouped into their stakeholder group and asked to think about:

- *A* communication – a piece of information or a request to other stakeholder(s)
- Commitment to 2 pieces of practical action from your stakeholder group – what and by when

Each group was to prepare a 5 minute presentation to give to the whole stakeholder system and be prepared to respond to questions of clarification.

Presentation by Healthcare staff

- Provide more support and provision to students and newly qualified staff.
- To promote recruitment and retention – open days, advertisements, CPD i.e need to put ourselves out there i.e. crown courts, university open days,
- Practical action
- Put a case together and put to governor and heads of healthcare regarding research for OT – work in other prisons. EBP - music therapy
- Speak to HEIs – Heads of Healthcare and governor
- Liaise – open days, advertisements
- Promote jobs

Presentation by Heads of Healthcare

Message to commissioning:

- Utilise health needs assessment to inform commissioning decisions
- Engage staff at all levels as part of world class commissioning
- Greater engagement with service users, to comment both on service and commissioning decision.

We will do:

- Facilitate access to staff of all levels and service users to commissioning can gain accurate insight.
- Challenge pre-conceptions that prison health has to be different from normative/equate service to mainstream community services
- Engage all staff at all levels as they have a wealth of knowledge

Governors

- Our primary task is to care for people
- Shared training events e.g. mental health events, control and restraints, resuscitation, diversity.
- Risk assess mealtime clinics – potential efficiencies for healthcare and prison, normalisation benefit (what you would expect in the community)

Commissioners

- Prison governors to unblock timescales for security clearance
- Aim t improve recruitment and retention
- Improve the PR of prison and offender healthcare
- SHA to safeguard the prison and offender health agenda raising/maintaining profile and progress

Practical Action

We will commit to including prison and offender health workforce plans with commissioning services by March 2011.
We commit to supporting providers/governors in ensuring services are of a high quality i.e. clinically credible

HEIs
Key message

- All HEIs (already) provide a comprehensive flexible delivery CPD framework
- Kent needs to clarify funding stream
- Promote pre-reg activity
- HEI request dialogue to establish specific education/training needs

Actions

- Establish appropriate contact points Jan 2011
- HEI to promote prison service career development e.g. open days marketing materials ongoing

Provider

- National framework for all education
- Career pathway for all healthcare professions
- Making sure the agenda is actioned
- Scope ability to mentor students
- Explore resources for GP CPD engaged in service
- What professional support is available/appraisal

7.6.4 Evaluation of the Day

"Something I didn't get, that I would have liked".

- An understanding of actual training and education requirements
- More of post release in relation to healthcare
- Improving health, supporting justice, education requirements of offender pathway from offence to release
- What is the barrier commissioning and provider commissioning stepping over into provider function
- User perspectives but you can't have everything, cross-stakeholder encouragement was very encouraging
- Clarity on start time as flyer/programme stated 9.15am when sent out
- Is the research published – presented – I couldn't understand the context this would have been helpful
- Clarity on who should attend prior to day … which groups of staff would most benefit
- Would have liked a map of the prisons in the Kent/Surrey/Sussex
- To meet everybody that I would have liked to
- More about future workforce plans
- Social care got little mention i.e. not joined up with health
- Nil
- Speakers would have benefited from microphones as volume lost at times
- User feedback
- User involvement – to hear what the offenders want from healthcare
- To hear the voice of an offender who had experience of healthcare provision
- A sense of a commissioning policy to a proactive approach with the issues

"The key thing I am going to take back to my organisation"

- A greater understanding of opportunities the prison service can offer in regards to career and education
- To ensure prison healthcare is promoted amongst my student population
- Feedback to Head of School
- Persuade HEIs to come into the prisons. How can you deliver education without understanding the environment
- Need for dialogue with these in CPD lead positions in prisons
- Shared training opportunities
- Sharing of issues raised today and encouraging to tap into this group in future
- Engaging with healthcare staff at Ford, offering coursers available through trust for joint training
- The recognition of importance of further training
- The importance to network with appropriate stakeholders to establish staff educational need

- The opportunities
- Developing services to meet educational placement audit requirements
- I liked the fact that most groups found that there should be student placements
- Will promote prison employment within CPD with pre reg students
- Opportunities for HEIs
- Providing named link with HEI's for prisons
- I need to link with workforce/education and commissioning
- Opportunities for different commissioning team and for 2011/12 and better understanding of how systems work
- Finding out what/who I need to talk to, to progress/development of offender healthcare
- Prison work is an equivalent form of general practice as any other and does not need any special GP resources
- Dialogue of engaged across stakeholders

"My Eureka moment today"

- Seeing how a trainee can be extended by local politics
- To meet all the related workforce
- A realisation that the nursing profession in the prison service need educational support
- The healthcare needs of offenders is no different to the general population
- HEI want to engage
- Will make contact with my mentor colleagues and local HMP ref mentor development further education of mentor workforce
- That everyone finds it confusing
- What makes offender health different if anything
- Prison health and offender health is different
- Kent is different – should the SHA address this?
- General understanding of the prison/offender healthcare workforce starting from zero
- Defining of role within health

8. Conclusion: Discussion of findings

The barometer for assessing the findings from this project is the extent to which the region has engaged with the process of change for the deliver your health care in prisons that was initiated in 2003, and which has been underpinned by subsequent policy developments, notably the Bradley Report and *Improving Health, Supporting Justice*. These initiatives recognised the extensive problems faced by offenders in obtaining health care on a basis that is equivalent to the general population and initiated a programme of change towards greater effectiveness of offender health care services, based on the principle of equity and individual assessment of needs.

In the region as a whole the overall conclusion from this study is that there have been some developments towards an NHS-led service which aims to assess and meet individual health needs, and there are identifiable areas of good practice. On the other hand, as did the joint Healthcare Commission and

HM Inspectorate of Prisons (2009), this project found considerable variability within the region, to the extent that each county's model could be individually described and conceptualised. Within the broad picture of variable health care in the region, the project identified barriers to the achievement of an equitable health care system. From the data, it was possible to conduct an analysis which identified factors underlying problems in delivering equitable health care and increasing the capability and capacity of the workforce.

In conclusion, therefore this report will summarise the strengths and difficulties in the region, in terms of the four key principles outlined in *Improving Health, Supporting Justice,* as set out in section 3 of this report, above. The project thus identifies key factors that are necessary in the region for improving efficiency and effectiveness, partnership working, improving capacity and capability of the workforce and ensuring equity of access to health care for all offenders.

Efficiency and effectiveness would be improved first and foremost by the establishment of a more stable workforce. The workforce delivering offender health care is handicapped as long as it is subject to such high levels of problems of recruitment and retention, and employs large numbers of agency staff. The evidence from this study suggests that the clinical tasks of delivering offender health care is a difficult job, which requires high levels of support through clinical supervision and training and recognition of the unique and demanding aspects of delivering health care in prisons.

The role of providing offender health care requires clinical skills equivalent to delivering health care in the community. In addition it requires a range of skills in order to contend with the specific demands of working in a custodial setting. The tensions between custody and care, as we have shown, are ubiquitous and run throughout every establishment. There is a spectrum of responses to the balancing of the tension. At one end, in Kent, the issue is circumvented by the failure to make progress on the process of transition to an NHS led service. Thus custody predominates over care. As if they say "This is a prison after all, what do you expect?" At the other end of the spectrum in Sussex, in contrast, the impact of custody on care is denied through normalisation. It's as if they are saying "This is a health care setting just like in the community. The prison context can be ignored". In both these diametrically opposed situations, the burden in the conditions unique to offender health care delivery is passed to the front line workers. The impacts of the care-and-custody role are greater if they are not accurately or appropriately recognised and responded to. This might be the situation mid spectrum, as in Surrey, where a realistic balancing of the two can be observed.

Alongside this, as the Bradley report highlights, providing health care to the offender population demands skills, particularly, in working with people with mental ill health, learning disability, and substance misuse. Training for individuals, for teams as a whole and increased emphasis on clinical supervision are necessary to improve the capacity of front line workers to

withstand the pernicious impact of work in these contexts. Thus leaders, managers, educators and commissioners need to work together to respond to the realities of the impacts of care and custody tensions in prison settings. This is a key direction to travel in order to be able to provide increased equity of health care based on individual assessment.

This study has identified a gap in partnership working between commissioners, health care managers and HEIs in identifying and responding to the CPD and training needs of health care workers. Improved partnership working is necessary to provide an effective training strategy and its delivery.

The study identifies limits in partnership working between health care managers, the PCTs and the Prison service, especially the governing governors. There is evidence of good practice- for example health care managers are included in prison management boards. On the other hand there is a need to extend understanding of shared roles within the prison and the impacts of moving way from the previous unitary model.

The variable developments within each county demonstrate the need to maintain a strategic overview at regional level, not to clamp down on difference *per se*, but to ensure, firstly, that each model is consistent with meeting the strategic objectives of the process of change in the delivery of offender health services, and, secondly, to disseminate examples of good practice that are identified.

It is crucial that all stakeholders work together to improve the quality of health care in prisons, and to achieve the aim of equivalence. This requires following through on existing initiatives, improving partnership working across all stakeholders- specific areas are identified in the recommendations – and also introducing a qualitative change of gear to respond to the pressures and stresses in the system. New forms of training are needed including shared discussion of work issues and cross stakeholder discussions of the practical and professional implications of positions held regarding the care and custody tension.

This study has inevitably been limited by time and scope. Amongst the key limitations are the absences of discussions with prison staff, representing security and custody, and the voices of the users - the offender population. As this is a heterogeneous population, future studies including or focusing on the experiences of offenders would deepen and add specificity to the understanding of the task of meeting health care needs in prisons.

9. Recommendations

9.1 The PCTs commissioners of service should ensure that local workforce and education development plans should reflect the needs of the offender health workforce.

9.2 PCTs within Kent and Medway should reassess its current strategy and reposition itself closer to the objectives of *Improving Health, Supporting Justice*. This will necessitate developing and implementing a plan through which should ensure greater equity of health care is delivered by the NHS in Kent prisons.

9.3 Commissioners , Health care managers and governors should continue to work together to ensure the development of policy and practice for prisons that reflects the partnership arrangements for health care delivery and the shared responsibilities of care for offenders undertaken by both the Prison Service and the NHS. Recognising the tensions between care and custody at all levels of offender health care delivery is central will be central to these developments.

9.4 Commissioners and Public Health should ensure individual needs assessments are being made and treatment plans appropriately implemented in all establishments across the region. Priority should be placed on areas where health care is inappropriately delivered and where individual needs are not recognised, for example, where there is no differentiation between the needs of those offenders suffering from acute physical or medical and chronic mental health conditions.

9.5 Providers, Health Care Managers, and Governors need to work together to address issues of staff recruitment and retention and thus to create a basis for improving the quality of health care.

9.6 Health care managers, education leads with commissioning PCTs and in partnership with HEIs should develop and implement a model of clinical supervision for all front line staff. This may include developing CPD courses in supervision.

9.7 Kent PCT should reassess its current strategy and reposition itself closer to the objectives of *Improving Health, Supporting Justice*. This will necessitate developing and implementing a plan through which greater equity of health care is delivered by the NHS in Kent prisons.

9.8 HEIs in consultation with PCTs and Health care mangers and front-line workers, should develop CPD which meets the specific needs of health care staff working in the care-and-custody contexts of prisons. HEIs should be encouraged to work together – as a consortium or otherwise in partnership – so that training opportunities reflect the individual strengths of all the HEIs.

9.9 HEIs should engage in dialogue with health care managers and front lline workers to develop modules on award bearing courses that are specifically designed for offender health care staff.

Appendix A: NHS South East Coast Prison Details
(Information extracted from http://www.hmprisonservice.gov.uk/prisoninformation - updated 2008)

Prison	Category	Gender	Prison Region	Health Region	Capacity (approx)
Bronzefield	Cat A/Juvenile	Female	South Central	Surrey	465
Coldingley	Cat C	Male	South Central	Surrey	513
Downview	Closed	Female	South Central	Surrey	358
Highdown	Cat B/C	Male	South Central	Surrey	1103
Send	Closed	Female	South Central	Surrey	282
Cookham Wood	YOI/Juvenile	Male	South East Coast	Medway Teaching	157
Rochester	YOI	Male	South East Coast	Medway Teaching	620
East Sutton Park	YOI Open	Female	South East Coast	West Kent	100
Blantyre House	Cat C/D	Male	South East Coast	West Kent	122
Maidstone	Cat C	Male	South East Coast	West Kent	600
Ford	Cat D	Male	South East Coast	West Sussex	557
Lewes	Local	Male	South East Coast	East Sussex Downs & Weald	723
Canterbury	Foreign National	Male	South East Coast	Eastern & Coastal Kent Teaching	304
Dover	IRC	Male	South East Coast	Eastern & Coastal Kent Teaching	316
Elmley (Sheppey cluster)	Cat B/C	Male	South East Coast	Eastern & Coastal Kent Teaching	985
Standford Hill (Sheppey cluster)	Cat D	Male	South East Coast	Eastern & Coastal Kent Teaching	462
Swaleside (Sheppey cluster)	Cat B	Male	South East Coast	Eastern & Coastal Kent Teaching	1132

To access a map of prison locations please follow this link:
http://www.hmprisonservice.gov.uk/prisoninformation/locateaprison/

Appendix B: Healthcare Staff Survey

A) Background

1. What is your job title?
2. What is your banding/grade?
3. Who is your employer?

☐ NHS

☐ Prison Service

☐ Agency

4. How long have you been working in this establishment?

☐ Less than 3 months

☐ 3 - 6 months

☐ 6 months to a year

☐ Over 1 year

☐ Over 2 years

☐ 2-5 years

☐ 5-10 years

☐ 10+ years

5. How long have you been in offender healthcare?

☐ Less than 3 months

☐ 3 - 6 months

☐ 6 months to a year

☐ Over 1 year

☐ Over 2 years

☐ 2-5 years

☐ 5-10 years

☐ 10+ years

6. Please describe your key responsibilities (main 3)

a. …………………..
b. …………………..
c. ………………….

7. What are your professional and academic qualifications?

☐ NVQ/BTEC

☐ Degree (BA, BSC, MA, MSC)

☐ Diploma

☐ Other………………………………………………………………

8. What is your staff type?

☐ Permanent
☐ Temporary
☐ Agency
☐ Part time
☐ Seconded
☐ Night only

9. Which work force category does your role fall into?

☐ Managerial
☐ Non-medical
☐ Medical workforce
☐ Trained, not qualified
☐ Ancillary
☐ Admin

B) The Establishment

1. What is the category of the prison

☐ A
☐ B
☐ Open/D
☐ Local
☐ Young Offender/juvenile

2. What is the population like?

☐ Male
☐ Female
☐ Stable/sentenced
☐ Transient/remand

3. Do you feel the main health care needs of your prison population are being met?

☐ Yes, fully met
☐ Somewhat met
☐ Not met
☐ Not sure

4. Please state the **strengths and weaknesses** of prison healthcare delivery in your establishment (in your view)

Strengths:
1. …………………..
2. …………………..
3. ………………….

Weaknesses:
1. …………………..
2. …………………..
3. ………………….

5. Who is the healthcare employer?

☐ Mixed (HMPS & PCT)
☐ PCT
☐ HMPS
☐ Other

6. What services are available in your establishment?

☐ Inpatient
☐ Outpatient
☐ Dispensing
☐ Dentist
☐ Podiatry/chiropody
☐ Physiotherapy
☐ Sexual health
☐ Substance misuse
☐ Hepatitis C screening and treatment
☐ Chronic disease clinics (e.g. diabetes)
☐ Long term Conditions, e.g. respiratory care
☐ Speech and Language Therapies
☐ Ophthalmology
☐ Gynaecology
☐ Urgent Care e.g. wound suturing
☐ Neurosciences, e.g. epilepsy care, MS, MND
☐ Diagnostic screening
☐ Renal/Urology services
☐ Older People Services/over 60s clinic
☐ Counselling
☐ CBT
☐ Acupuncture

7. Are you aware of a workforce plan in your establishment regarding healthcare?

☐ Yes

☐ No

☐ Not sure

8. Do you think your governor prioritises healthcare in your establishment?

☐ Yes

☐ Somewhat

☐ No

☐ Not sure

C) Staff Development

1. Do you think staff development is prioritised in your establishment?

☐ Yes

☐ Somewhat

☐ No

☐ Not sure

2. Did you attend prison service induction training at your establishment?

☐ Yes

☐ No

3. Did you attend any local (healthcare) induction?

☐ Yes

☐ No

☐ Not sure

If yes, do you feel it equipped you to work with your patient population?

☐ Yes

☐ Somewhat

☐ No

☐ Not sure

4. Where is your Continuing Professional Development (CPD training) available for you?

☐ Prison

☐ Primary Care Trust

☐ Higher Education Institutions

☐ Further education
☐ Other…………………………………………….

5. Do you know how to access professional training (CPD)?
☐ Yes
☐ No

6. How would you access professional training courses?
☐ Staff Performance & Development Record (SPDR/CSF)
☐ Line manager
☐ Training and Development officer/department
☐ I don't know
☐ Other…………………………………………….

7. Do you have an appraisal system (SPDR/CSF)?
☐ Yes
☐ No
☐ Not sure

8. When was your last appraisal/review?
☐ Within the last 6 months
☐ Within the last 12 months
☐ Over 1 year ago
☐ Can't remember

9. Do you think with hindsight it was effective in meeting your CPD needs?
☐ Yes
☐ Somewhat
☐ No
☐ Not sure

10. Do you have clinical supervision?
☐ Yes regularly, with my line manager
☐ Yes regularly, with someone outside of the department
☐ Yes, it is mixed in with my managerial supervision
☐ Ad hoc with someone outside of the department
☐ Ad hoc with my line manager
☐ No never

11. Are you meeting the needs of your career path?

☐ Yes

☐ Somewhat

☐ No

☐ Not sure

12. Where would you like to be professionally in 3-5 years?

13. Please state your main development needs (up to 5)

1. …………………..
2. …………………..
3. ………………….
4. ………………….
5. …………………….

14. Are you aware of student placements in your organisation?

☐ Yes

☐ No

☐ Not sure

15. What do you think are the possible barriers to placement provision?

1. …………………..
2. …………………..
3. ………………….

E) Issues and Barriers

Please state up to 5 main issues and challenges in delivering healthcare (in your view)?

1. …………………..
2. …………………..
3. ………………….
4. ………………….
5. …………………….

Appendix C: HEI interviews Schedule (for telephone interview)

Questions:	
What are your roles/ title? Where based?	
What are your responsibilities regarding CPD for the Offender healthcare workforce?	
What courses are you currently delivering/have you recently delivered? *Are you able to forward a list?*	
Please provide titles, content, aims, level and qualifications offered for any training courses *Can you summarize this or perhaps refer us to your website/brochure?*	
Can you supply us with any examples of course outlines? *Perhaps you can send these*	
Can you provide approx numbers and the work locations of healthcare staff that are current students (i.e name of prison that student is based) *Perhaps you could supply from your database?*	
How are the courses delivered? – Is their a discipline of organizers or are they staffed by university or visiting lecturers (prison staff), practitioners etc?	
Are there any particular drivers for the prison healthcare CPD that you offer? If so what are they?	
In your CPD programme for prison healthcare staff, what works well/not well?	
What would help you develop further what you offer?	
Do you think that you are currently well equipped to meet the training and development needs of the of the offender healthcare workforce?	
Any other issues?	

Appendix D: Survey for HMP Governors

Background

1. What is the name of your prison?

2. How long have you been a prison governor?

☐ Less than 2 years
☐ Over 2 years
☐ 2-5 years
☐ 5-10 years
☐ 10+ years

3. How long have you been in this current post?

☐ Less than 3 months
☐ 3 - 6 months
☐ 6 months to a year
☐ Over 1 year
☐ Over 2 years
☐ 2-5 years
☐ 5-10 years
☐ 10+ years

4. What are the *approximate* proportions of healthcare staff from the following staff categories?

Permanent…………….

Temporary…………….

Agency………………..

Part time……………….

Seconded………………

Night only……………..

5. How much of an issue is the recruitment and retention of healthcare staff?

B) The establishment

6. What is the category of the prison

☐ A
☐ B
☐ C
☐ Open/D

☐ Local

☐ Young Offender/Juvenile

7. What is the population?

☐ Male

☐ Female

☐ Stable/sentenced

☐ Transient/remand

8. Do you feel the main health care needs of your prison population are being met?

☐ Yes, fully met

☐ Somewhat met

☐ Not met

☐ Not sure

9. Please state the **strengths and weaknesses** of prison healthcare delivery in your establishment (in your view)

Strengths:

Weaknesses:

10. Who employs the healthcare?

☐ Mixed (HMPS & PCT)

☐ PCT

☐ HMPS

☐ Other

11. What services are available in your establishment?

☐ Inpatient

☐ Outpatient

☐ Dispensing

☐ Dentist

☐ Podiatry/chiropody

☐ Physiotherapy

☐ Sexual health

☐ Substance misuse

☐ Hepatitis C screening and treatment

☐ Chronic disease clinics (e.g. diabetes)

☐ Long term Conditions, e.g. respiratory care

☐ Speech and Language Therapies

☐ Ophthalmology

- ☐ Gynaecology
- ☐ Urgent Care e.g. wound suturing
- ☐ Neurosciences, e.g. epilepsy care, MS, MND
- ☐ Diagnostic screening
- ☐ Renal/Urology services
- ☐ Older People Services/over 60s clinic
- ☐ Counselling
- ☐ CBT
- ☐ Acupuncture
- ☐ Other, Please state ……………………………………………

12. Are you aware of a workforce plan for healthcare that includes education provision and commissioning in your establishment?

- ☐ Yes
- ☐ No
- ☐ Not sure

13. As a prison governor, how do you prioritise healthcare in your establishment?

14. In what ways is Healthcare prioritised in your establishment?

15. What do you believe are the healthcare priorities in your offender population?

C) Staff development

16. Is staff development prioritised in your establishment?

- ☐ Yes
- ☐ Somewhat
- ☐ No
- ☐ Not sure

If yes, please state how……………………………………………………….

17. If there is Continuing Professional Development (CPD) available for your healthcare staff and where does it come from?

- ☐ Prison
- ☐ Primary Care Trust
- ☐ Higher Education Institutions
- ☐ Further Education
- ☐ Other…………………………………………….

18. How is personal and professional training identified for healthcare staff?

☐ Staff Performance & Development Record

☐ Line manager

☐ Training and Development officer/department

☐ I don’t know

☐ Other

19. Do you have an appraisal/personal development review system for your staff?

☐ Yes

☐ No

☐ Not sure

20. Do your healthcare staff have clinical/non-clinical supervision?

☐ Yes regularly, with their line manager

☐ Yes regularly, with someone outside of the department

☐ Yes, it is mixed in with managerial supervision

☐ Ad hoc with someone outside of the department

☐ Ad hoc with a line manager

☐ No never

21. Please state the main development needs for your prison’s healthcare service

22. Are you aware of student placements in your healthcare department?

☐ Yes

If yes, please state where

☐ No

☐ Not sure

23. What do you think are the possible barriers to placement provision within a secure environment?

a.

b.

c.

E) Issues and barriers

Please state up to 5 main issues what you believe the challenges are in delivering healthcare?

Appendix E: Delegate list from Search Conference

South East Coast Offender Health Event Delegate List	
Ahmad Janet **Senior Lecturer**	**University of Brighton**
Alner Joanne **Public Health Consultant**	**NHS Surrey**
Boyfield Jayne **Managing Director & Services & Surrey & Sussex Lead for Health & Social Care in Criminal Justice**	**East Sussex Community Health Services**
Briggs Stephen **Project Manager**	**Tavistock & Portman NHS Foundation Trust**
Bryan Karen Prof **Head of Divison of Health & Social Care**	**University of Surrey**
Caldicott Amanda **Head of Health Services**	**HMYOI Kent**
Clark Nancy **Senior Lecturer**	**Canterbury Christ Church University**
Cocks Steve **Commissioning Manager**	**South East Coast SHA**
Crapnell Denis	**University of Greenwich**
Croft Nicky **Lead Commission Prison Health**	**NHS Surrey**
Daniels Emma **Public Health Lead Offender Health**	**NHS Surrey**
Davies-Ebsworth Gary **Nurse Consultant Furensic Mental Health**	**East Sussex Community Services PCT / HMP Lewes**
Davis Sue **Lead of Prison Healthcare**	**Surrey Community Health**
Dawson Peter **Governor**	**HMP Highdown**
Demko Lorraine **Associate Director HR, L&D**	**NHS Surrey**
Dunn Debbie **Clinical Workforce Development Manager**	**Eastern Coastal & Kent**
Emerton Alice **OT Student**	**HMP Canterbury Prison**
Evans Julie **Head of Activities & Development**	**HMP/YOI Downview**
Foote Nigel	**HMP Lewes / East Sussex Downs & Weald**

Head of Prison Healthcare	**PCT**
Foster John **Principal Research Fellow**	**University of Greenwich**
Fulcher Ros **Healthcare Officer**	**Sheppey Cluster**
Gaylor Helen **Commissioning Manager Prisons & Substance Misuse**	**NHS Medway**
Hudson Andy **Governor**	**HMP Maidstone**
Jann Jeff **Custody Medical Services Consultant**	**Surrey Police Force**

South East Coast Offender Health Event Delegate List

Keeling Fiona **Senior Nurse Professional Practice**	**Western Sussex Hospitals NHS Trust**
Linford Hannah **Research Assistant**	**Tavistock & Portman NHS Foundation Trust**
Lowe David **Director Workforce & OD**	**East Sussex PCT**
MacCartney Deborah **Senior Tutor/Director of Studies**	**University of Surrey**
Maduako-Ezcanyika Obibugo **Head of Education**	**Surrey & Sussex Healthcare**
McCaffrey Tony **Project Manager**	**Tavistock & Portman NHS Foundation Trust**
McKnight Veronica **Practice Manager**	**HMP Standford Hill**
McLean Ian Dr **Deputy GP Dean/Head of GP School**	**KSS GP Deanery**
Nealson Edward **Head of Residence/Governor**	**HMP Lewes**
O'Connor Anne **Workforce Development Manager**	**Surrey & Border Partnership NHS Foundation Trust**
Poulton Sheila **Strategic Lead of Prison Healthcare Sheppey Cluster**	**HMP Elmley**
Robins Carolyn **Commissioner for Prison & Offender Health**	**East Sussex Downs & Weald PCT**
Semple Brian	**HMP Canterbury**

Healthcare Senior Officer RMN

Sowerbutts Jackie	**NHS Surrey**
Dental Advisor & Dental Public Health Lead	
Spiers Chrissie	**University of Brighton**
Principal Lecturer	
Start Kath	**SEC Ambulance Service NHS Trust**
Director of Workforce	
Swidenbank Helga	**HMP & YOI Bronzefield**
Director/Governor	
Taylor Julie	**Canterbury Christ Church University**
Senior Lecturer	
Taylor Trudy	**HMP Elmley**
Head of Prison Healthcare for Sheppey Cluster	
Thurgate Claire	**Canterbury Christ Church University**
Foundation Degree Programme Director	
Webb Julie	**Western Sussex Hospitals Trust**
Practice Learning Facilitator	
Williams Rebecca	**HMP Canterbury Prison**
OT Student	
Withall Liz	**West Kent Community Health**
Assistant Director Workforce Planning	
Woodgate Gervaise	**HMP Lewes / East Sussex Community Services**
Staff Nurse Mental Health In-Reach Team	

Appendix F: Project Board Membership

Lorraine Demko (Chair)	NHS Surrey
Associate Director, HR Learning & Development	
Steve Cocks	NHS South East Coast
Contracts Manager	
Tony McCaffrey, Stephen Briggs & Hannah Linford	Project Management Team
Sue Davies	Surrey Community Health
Head of Healthcare Surrey	
Nigel Foote	East Sussex, Down & Weald PCT
Head of Healthcare Lewes	
Prof Karen Bryan	University of Surrey
Denis Crapnell	University of Greenwich
Dr Shirley Bach	University of Brighton
Head of School Nursing & Midwifery	
Deputy Penny Lindley	
Julie Taylor	Canterbury Christ Church University
Senior Lecturer AHP	
Andy Newton	South East Coast Ambulance Service