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

Stakeholder Engagement 1
NHS England
Kate Davies and Christine Kelly

Summary

It was confirmed that NHS England is responsible for commissioning and providing Healthcare for people in secure and detailed settings in England, which includes the population in prisons, Young Offender Institutions (YOIs), Immigration Removal Centres (IRCs), Secure Training Centres (STCs) and Secure Children's Homes (SCHs). Reducing deaths in custody is a top strategic priority.

PREVENTING DEATHS IN CUSTODY AND IMPROVING HEALTH, MENTAL HEALTH AND WELL BEING

Early intervention and assessment work 'upstream' to meet the needs of vulnerable young people is seen as vital, including CAMHS (Children and Adolescent Mental Health Services) and Tier 2 interventions. NHS England needs to ensure the delivery of quality patient outcomes and manage risk to help reduce the number of deaths in custody more effectively. Integrated pathways to support a 'care not custody' approach, partly through liaison and diversion that provides suitable decisions at a time of crisis and follow up support should be a 24/7 service. The same level of service provision should apply to young people with a personality disorder, who self-harm, or have autism as those diagnosed with mental illness.

NHS England would welcome a strong recommendation from the Harris Review that if NHS practitioners consider that a young person should not be in custody or go into custody and make that recommendation, there should be strong outcomes if this is not considered, this would require changes to Young People policy.

The quality of support provided in STCs and SCHs should be imported into other secure environments. Commissioning and Quality Assurance looks at gaps in provision and where improvements are needed, it has recognised that YOIs and IRCs need to improve, this is now being led. The families' involvement element in the interventions really needs improving particularly to aid diversion from custody for the very vulnerable individual.

There is now a suite of service specifications to inform consistent cross England service delivery to support best l practice for Children and Young people and provider performance will be measured against these specifications.

A standard NHS England assessment tool, which captures general health and mental health needs is available in prison reception, training should make its use more systematic and a core model could be consistently used. There has been a good piece of work in YOIs and STCs on a new tool (Children's Health Assessment Tool CHAT) but there is no evidence yet of its success. Better definition of health and mental health needs are required at all points (children and adults) throughout the Criminal Justice System.

WORKING WITH THE CRIMINAL JUSTICE SYSTEM (CJS)

NHS England and the CJS need to understand each other better in order to deal with the plethora of problems that present in a secure environment. More needs to be done to make sure good health and well being are the drivers behind the range of interventions available, which should reduce both risk and re-offending. Service specifications require that induction, training and professional reviews of staff are undertaken and only providers who undertake these should be commissioned. NHS England are working with the Royal College of Nursing, looking at the CJS area to improve the baseline for nurses and clinicians.

The Workforce Development Strategy for Health and Justice has been set up. This will help parties to 'know your market' with a drive to improve the whole professional Commissioning can also drive what good service should look like and what it provides.
There are good partnership arrangements in place and contract variations can be applied to services that have already been commissioned relatively quickly where they are needed to urgently improve practice. All services are currently being scrutinised and a re-procurement plan has been identified to re-procure all care services across the secure and detained environments between 2014 and 2017. The newly developed National Performance Management Framework will be used to measure the services provided and provide commissioners with the ability to regularly assess standards of delivery.

Leadership in YOIs and prisons can influence the respective cultures and get them to work well together.

NHS England do not always receive as much notice as would be desired to respond to changes, such as Transforming Youth Custody's creation of the Secure Colleges and secure estate closures and re-rolls. The organisation need regular reviews of the prison population to accurately determine needs.

INFORMATION SHARING

Sometimes the CJS may not be aware of prior problems, including mental health issues. There is fragmentation in the systems around the sharing of information between the primary care element and the CJS, particularly at reception in prison. Some of this is in part due to a lack of confidence around how and what can be shared and they have identified training needs in data sharing. Sometimes there may not be much information to transfer. It was noted that some young people do not have a General Practitioner in the community. Issues with information sharing are most notable at reception and early days in prison.

There is additional funding for information sharing and technical standards and NHS England are putting forward a robust business case for integrating capacity across health and CJS it is hoped this will be available from 2016 onwards.

FOLLOWING A DEATH IN CUSTODY

NHS England follow up on recommendations made to them from reports following a death in custody and there is a centrally held audit process to support this.

Recommendations are picked up through the 10 Area teams who report back to the Health and Justice Clinical Reference Group (H&CRG) where there will be a quarterly review of lessons learned, and a pro-active preventative approach will be taken so that the learning is consolidated into a cross organisational reach that is shared among co-commissioners. Where there is a need to

develop the workforce or respond to particular recommendations these will be escalated to the Medical Director in NHS England.

NHS England feel that the Clinical Reviews following a death are not of a consistent standard, and so they are trying to baseline the 'Gold Standard' for these supported by the Director of Nursing who is leading a Quality Assurance (QA) post primarily looking at this piece of work and cross referencing this with YJB and NOMS. The correct clinical expert will scrutinise each death.