1 # Physical health of people in prison

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3 ## NICE guideline: short version

4 ## Draft for consultation, May 2016

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This guideline covers assessing, diagnosing and managing physical health problems of people in prison. It aims to improve health and wellbeing in the prison population through health needs assessment and health promotion, improving communication and coordination between healthcare and prison staff and ensuring continuity of healthcare on entry, transfer and release from prison. It explores the most effective approaches to prescribing, dispensing and supervising medicines. It aims to improve responses to health emergencies and support people with rapidly deteriorating health.

Who is it for?

- Providers of care and support to people in prisons or young offender institutions
- Front-line practitioners and managers in prisons or young offender institutions
- Adults (aged 18 and over) in prisons or young offender institutions, and their families and carers

This version of the guideline contains the recommendations, context and recommendations for research. Information about how the guideline was developed is on the guideline's page on the NICE website. This includes the guideline committee's discussion and the evidence reviews (in the full guideline), the scope, and details of the committee and any declarations of interest.

Please note:

This guideline includes recommendations on mental health assessment at a person's reception into prison, but not on their ongoing mental health care. These will be covered by an accompanying NICE guideline, Mental health of adults in contact with the criminal justice system. The mental health guideline is currently in development and the draft will be available for stakeholder comments in September 2016.

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Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Assessing health

First-stage health assessment at reception into prison

1.1.1 A healthcare professional (or trained healthcare assistant under the supervision of a registered nurse) should carry out a health assessment for every person on their first reception into prison. This should be done before the person is allocated to their cell. It should include identifying:

- any issues that may affect the person's immediate health and safety before the second-stage health assessment
- priority health needs to be addressed at the next clinical opportunity.

1.1.2 The first-stage health assessment should include the questions and actions in table 1. It should cover:

- physical health
- alcohol use
- drug use
- mental health
- self-harm and suicide.

1 1.1.3 Take into account any communication needs or difficulties the
2 person has, and follow the principles in NICE's guideline on patient
3 experience in adult NHS services.

4 **Table 1 Questions for first-stage health assessment**

Topic questions	Actions
1 Status	
Has the person been charged with murder or manslaughter?	Yes: refer for urgent mental health assessment by the prison mental health in-reach team. Ensure that the person is seen by the GP while they are in reception. No: record no action required.
2 Physical health	
2.1 Prescribed medicines	
Is the person taking any prescribed medicines, including preparations such as creams or drops, and if so: • what are they? • what are they for? • how do they take them?	Yes: make a note of any current medicines being taken and generate a medicine chart. Refer the person to the GP for appropriate medicines to be prescribed and continued. If medicines are being taken check that the next dose has been provided (see recommendation 1.7.10). No: record no action required.
2.2 Physical injuries	
Has the person received any physical injuries over the past few days, and if so: • what were they? • how were they treated?	Yes: assess severity of injury, any treatment received and record any head, abdominal injuries or fractures. Refer the person to the GP at reception. In very severe cases, or after GP assessment, the person may need to be transferred to an external hospital. Liaise with prison staff to transfer the person to the hospital emergency department by ambulance. Document any bruises or lacerations observed. If the person has made any allegations of assault, record negative observations as well (for example, no physical evidence of injury). No: record no action required.
2.3 Head injuries or loss of consciousness	
Has the person ever suffered a head injury or lost consciousness, and if so: • how many times has this	Yes: refer the person to the GP at reception. No: record no action required.

happened? • have they ever been unconscious for more than 20 minutes? • do they have any problems with their memory or concentration?	
2.4 Other physical health conditions	
Does the person have any of the following: • allergies, asthma, diabetes, epilepsy or fits • chest pain, heart disease • tuberculosis, sickle cell disease • hepatitis B or C virus, HIV, other sexually transmitted infections • learning disabilities • neurodevelopmental disorders • physical disabilities?	Ask about each illness listed. Yes: make short notes on any details of the person's condition or management. For example, 'Asthma – on Ventolin one puff daily'. Make appointments with relevant clinics or specialist nurses if specific needs have been identified. No: record no action required.
2.5 Are there any other physical health problems the person is aware of, that have not been reported?	Yes: record the details and check with the person that no other physical health complaint has been overlooked. No: record no action required.
2.6 Are there any other concerns about the person's physical health?	Make a note of any other concerns about physical health. This should include any health-related observations about the person's physical appearance (for example, weight, pallor, jaundice, gait). As with recent injuries, both negative and positive signs are relevant. Yes: refer the person to the GP at reception. No: note 'Nil'.
2.7 Additional questions for women	
Ask the woman if she has reason to think she is pregnant.	Yes: refer the person to the GP at reception and to a midwife. No: record response.
Ask if she would like a pregnancy test.	Yes: if requested, provide a pregnancy test. Record the outcome and if positive make an appointment for the person to see the GP. No: record response.

<table>
<tr><td colspan="2">2.8 Independent living and diet</td></tr>
<tr><td>Ask the person if they need help to live independently.</td><td>Yes: note any needs. Liaise with the prison disability lead in reception about:
• the location of the person’s cell
• further disability assessments the prison may need to carry out.
No: record response.</td></tr>
<tr><td>Ask if they use any equipment or aids (for example, walking stick, hearing aid, glasses).</td><td>Yes: remind prison staff that all special equipment and aids the person uses should follow them from reception to their cell.
No: record response.</td></tr>
<tr><td>Ask if they need a special medical diet.</td><td>Yes: note the medical diet the person needs and send a request to catering.
No: record response.</td></tr>
<tr><td colspan="2">2.9 Past or future medical appointments</td></tr>
<tr><td>Ask the person if they have seen a doctor or other healthcare professional in the past few months, and if so what this was for.</td><td>Yes: note details of any recent medical contact. Arrange a contact letter to get further information from the person’s doctor. Note any ongoing treatment the person needs and make appointments with relevant clinics, specialist nurses, GP or other healthcare staff.
No: record no action required.</td></tr>
<tr><td>Ask if they have any outstanding medical appointments, who they are with, and the dates.</td><td>Yes: note future appointment dates. Ask healthcare administrative staff to manage these appointments or arrange for new dates and referral letters to be sent if the person’s current hospital is out of the local area.
No: record no action required.</td></tr>
<tr><td colspan="2">3 Alcohol and drug use</td></tr>
<tr><td>3.1 Ask the person if they drink alcohol, and if so:
• how much they normally drink
• how much they drank in the week before coming into custody.</td><td>Urgently refer the person to the GP at reception or the drug services team if:
• they drink more than 15 units of alcohol daily or
• they are showing signs of withdrawal.
No: record response.</td></tr>
<tr><td colspan="2">3.2 Type and frequency of drug use</td></tr>
<tr><td>Ask the person if they have used drugs in the last month. If yes, ask about frequency of use, and last use of, for example:
• heroin
• methadone
• benzodiazepines</td><td>Ask about use of different drugs including those listed.
Yes: refer the person to drug services if there are concerns about their immediate clinical management and they need immediate support. Take into account whether:
• they have taken drugs</td></tr>
</table>

• amphetamine • cocaine or crack • novel psychoactive substances.	intravenously • they have a positive urine test for drugs • their answers suggest that they use drugs more than once a week. Refer the person to the GP at reception if there are any physical health concerns. No: record response.
3.3 Intravenous drugs	
Ask the person if they have taken any drugs intravenously.	Yes: check injection sites. Refer the person to drug services if there are concerns about their immediate clinical management and they need immediate support. Refer the person to the GP at reception if there are any physical health concerns. No: record response.
3.4 Prescription drugs	
Ask the person if they have used prescription or over-the-counter medicines in the past month that: • were not prescribed or recommended for them, or • for purposes or at doses that were not prescribed. If yes, ask what this medicine was and how they used it (frequency and dose).	Yes: refer the person to drug services if there are concerns about their immediate clinical management and they need immediate support. Refer the person to the GP at reception if there are any physical health concerns. No: record response.
4 Mental health	
4.1 Previous contact with mental health services	
Ask the person if they have ever seen a health professional or service about a mental health problem (including a psychiatrist, GP, psychologist, counsellor, community mental health team or learning disability team). If yes, ask: • who they saw • the nature of the problem.	Yes: consider referring the person for mental health assessment by the prison mental health in-reach team) if they have received care for mental health problems. Refer the person to the GP at reception. If the person has been in contact with learning disability services refer them to the GP in reception No: record response.
Ask the person if they have ever been admitted to a psychiatric hospital. If yes, ask them: • the date of their most recent discharge • the name of the hospital • the name of their consultant.	Yes: refer the person for mental health assessment by the prison mental health in-reach team if they have received inpatient care for mental health problems. Refer the person to the GP at reception. No: record response.
4.2 Medicine for mental health problems	
Ask the person if they have ever been	Yes: consider referring the person for

prescribed medicine for any mental health problems. If yes, ask: • what the medicine was • when they received it • what the current dose is (if they are still taking it).	mental health assessment if they have received medicine for mental health problems. Refer the person to the GP at reception. No: record response.
5 Self-harm and suicide	
5.1 History of self-harm or suicide attempts	
Ask the person if they have ever tried to harm themselves. If yes, ask: • whether this was inside or outside prison • what the most recent incident was • what the most serious incident was.	Yes: consider referring the person for a mental health assessment if they have ever tried to harm themselves. No: record response.
Ask the person if they: • have a history of previous suicide attempts • are currently thinking about or planning to harm themselves or attempt suicide.	Yes: refer the person for an urgent mental health assessment. Open an Assessment, Care in Custody and Teamwork (ACCT) plan if there are: • serious concerns raised in response to questions about self-harm, including thoughts, intentions, or plans • a history of previous suicide attempts. Refer the person to the GP at reception. No: record response.

Following the first-stage health assessment

1.1.4 Give the person advice about how to contact prison health services and book GP appointments in the future.

1.1.5 Ask the person for consent to transfer their medical records from their GP to the prison healthcare service (see recommendations 1.7.1 and 1.7.2 for more information about transfer of medical records).

1.1.6 Enter in the person's medical record:

- all answers to the reception health assessment questions

- health-related observations, including those about behaviour and mental state (including eye contact, body language, rapid, slow or strange speech, poor hygiene, strange thoughts)
- details of any action taken.

1.1.7 Carry out a medicines reconciliation (in line with NICE's guideline on medicines optimisation) before the second-stage health assessment. See also recommendations 1.4.1 and 1.7.10 for recommendations on risk assessments for in-possession medicines and ensuring continuity of medicine.

Second-stage health assessment

1.1.8 A health professional (for example a registered general nurse) should carry out a second-stage health assessment for every person in prison. This should be done within 7 days of the first-stage health assessment. It should include as a minimum:

- reviewing the actions and outcomes from the first-stage health assessment
- asking the person about:
  - any previous use of alcohol and illicit drugs
  - smoking history
  - the date of their last sexual health screen
  - any history of serious illness in their family (for example, heart disease, diabetes, epilepsy, cancer or chronic conditions)
  - their expected release date
  - (for women) whether they have ever had a cervical screening test or mammogram
  - (for women) whether they have, or have had, any gynaecological problems
- measuring and recording the person's height, weight and blood pressure, and carrying out a urinalysis.

1.1.9 Review the person's first- and second-stage health assessment records, medical history and GP records and:

- refer the person to the GP or a relevant clinic if further assessment is needed. See for example NICE's guidelines on cardiovascular disease (recommendations on identifying people for full formal risk assessment) or type 2 diabetes (the recommendation on risk assessment)
- arrange a follow-up appointment if needed.

1.1.10 Consider using the Correctional Mental Health Screen for Men (CMHS-M) or Women (CMHS-W) to identify possible mental health problems if:

- the person's history, presentation or behaviour suggests they may have a mental health problem
- the person's responses to the first-stage health assessment suggest they may have a mental health problem
- the person has a chronic physical health problem with associated functional impairment
- concerns have been raised by other agencies about the person's abilities to participate in the criminal justice process.

1.1.11 If a man scores 6 or more on the CMHS-M, or a woman scores 4 or more on the CMHS-W, or there is other evidence supporting the likelihood of mental health problems:

- a practitioner who is trained to perform an assessment of mental health problems should carry out a further assessment, or
- a practitioner who is not trained to perform an assessment of mental health problems should refer the person to an appropriately trained professional for a further assessment.

1 1.1.12 Offer people tailored health advice based on their responses to the
2 assessment questions. This should be in a variety of formats
3 (including face-to-face). It should include advice on:

4 - alcohol (see NICE's guideline on alcohol-use disorders)
5 - substance misuse (see NICE's guideline on drug misuse).
6 - exercise (see recommendations 1.3.3–1.3.4)
7 - diet (see recommendation 1.3.5)
8 - stopping smoking (see recommendation 1.3.6)
9 - sexual health (see recommendations 1.3.7–1.3.8).

10 1.1.13 Ask the person if they want to attend any health-promoting
11 activities, for example exercise or going to the gym, help with
12 stopping smoking or other courses.

13 1.1.14 Offer the person advice on:

14 - how to contact prison health services and book GP
15 appointments
16 - where to find health information that is accessible and
17 understandable
18 - how to attend any health-promoting activities in the future (see
19 recommendations 1.3.1–1.3.8)
20 - medicines adherence (see recommendation 1.4.7).

21 1.1.15 Enter in the person's medical record:

22 - all answers to the second-stage health assessment questions
23 - health-related observations
24 - details of any action taken.

25 1.1.16 Plan a follow-up healthcare review at a suitable time based on
26 clinical judgement, taking into account the age of the person and
27 length of their sentence.

1 **Other health assessments**

2 1.1.17 Ensure that there is a system and processes in place to carry out
3 other assessments in line with recommendations in NICE
4 guidelines[1].

5 ***Hepatitis B and C***

6 1.1.18 Prison healthcare services (coordinated with, and supported by, the
7 NHS lead for hepatitis) should ensure that:

- 8 all prisoners are offered a hepatitis B vaccination when entering
9 prison (for the vaccination schedule, refer to the Green Book)
- 10 all prisoners are offered access to confidential testing for
11 hepatitis B and C when entering prison and during their
12 detention
- 13 prisoners who test for hepatitis B or C receive the results of the
14 test, regardless of their location when the test results become
15 available
- 16 results from hepatitis B and C testing are provided to the
17 prisoner's community-based GP, if consent is given.

18 ***HIV***

19 1.1.19 Primary care providers should ensure annual HIV testing is part of
20 the integrated healthcare offered to men who are known to have
21 sex with men.

22 1.1.20 Provide information on HIV testing and discuss why it is
23 recommended (including to those who indicate that they may wish
24 to decline the test).

25 1.1.21 Conduct post-test discussions, including giving positive test results
26 and delivering post-test and general health promotion interventions.

[1] The recommendations in this section are from the following NICE guidelines: hepatitis B and C testing: people at risk of infection; HIV testing: increasing uptake in men who have sex with men; sexually transmitted infections and under-18 conceptions: prevention and tuberculosis. As these recommendations have been taken from other, older guidelines in some cases style and language may be inconsistent with the rest of this guideline.

1.1.22 Recognise illnesses that may signify primary HIV infection and clinical indicator diseases that often coexist with HIV.

Sexually transmitted infections

1.1.23 Identify individuals at high risk of STIs using their sexual history. Opportunities for risk assessment may arise during consultations on contraception, pregnancy or abortion, and when carrying out a cervical smear test or offering an STI test. Risk assessment could also be carried out during routine care or when a new patient registers.

1.1.24 Have one-to-one structured discussions with people at high risk of STIs (if trained in sexual health), or arrange for these discussions to take place with a trained practitioner.

Tuberculosis

1.1.25 Healthcare professionals in prisons should ensure all prisoners are screened for TB within 48 hours of arrival.

1.1.26 Prisons with Department of Health-funded static digital X-ray facilities for TB screening should X-ray all prisoners (including people being transferred from other establishments) if they have not had a chest X-ray in the past 6 months. This should take place within 48 hours of arrival.

1.1.27 Prison health staff should report all suspected and confirmed TB cases to the local multidisciplinary TB team within 1 working day.

1.1.28 Multidisciplinary TB staff should visit every confirmed TB case in a prison in their locality within 5 working days.

1.1.29 If a case of active TB is identified, the local Public Health England unit, in conjunction with the multidisciplinary TB team, should plan a contact investigations exercise. They should also consider using mobile X-ray to check for further cases.

1.1.30 Prison health services should have contingency, liaison and handover arrangements to ensure continuity of care before any prisoner on TB treatment is transferred between prisons or released. In addition, other agencies working with prisoners should also be involved in this planning.

Health checks and screening programmes

1.1.31 Offer people equivalent health checks to those offered in the community, for example:

- the NHS health check programme for people aged 40 and over
- relevant NHS screening programmes, such as those for abdominal aortic aneurysm and bowel, breast and cervical cancer.

1.2 Communication and coordination

1.2.1 Ensure that every person in prison has a named healthcare coordinator who is responsible for managing their care. Ensure that the person and all healthcare and prison staff know who this is.

1.2.2 Ensure that the different teams that manage a person's care in prison communicate with one another to coordinate care.

1.2.3 Share relevant information about people with complex needs with prison staff using prison record systems in line with legislation and national guidance. This should include information about any high-level risks, such as:

- risk of self-harm
- risk to others
- communicable diseases
- epilepsy
- diabetes
- allergies
- deteriorating health conditions

- learning disabilities.

1.2.4 Review people in prison with complex health and social care needs. Ensure that if a person is supported by a multidisciplinary team the teams meet regularly to plan and coordinate ongoing management. These meetings should be facilitated by primary care.

1.2.5 Document all health and social care patient interactions and any information related to health and social care in the person's primary care patient record.

1.2.6 Share information with other health and social care staff who are involved in the person's care in prison if it is in the person's best interests.

1.3 Promoting health and wellbeing

General health advice

1.3.1 Consider using peer support and mentoring to help promote a healthy lifestyle while in prison.

1.3.2 Offer people in prison tailored health information in a variety of formats, including face-to-face. Include advice about:

- exercise
- diet
- stopping smoking
- sexual health
- personal hygiene.

Exercise

1.3.3 Encourage people to be physically active. Offer them information about:

- the benefits of exercise

- what exercise facilities are provided, where they are and how they can use them, for example:
  - going to the gym
  - using the exercise yard
  - exercises that can be done in the cell.

1.3.4 Offer people information and advice in line with recommendations in the NICE guidelines on:

- physical activity: brief advice for adults in primary care
- physical activity: exercise referral schemes
- preventing excess weight gain
- obesity: identification, assessment and management (the section on physical activity).

Diet

1.3.5 Offer people information about:

- the benefits of a healthy diet
- healthier food options available in the prison.

See the dietary section in NICE's guideline on obesity: identification, assessment and management.

Stopping smoking

1.3.6 Offer people in prison information about:

- the risks of smoking
- support available to stop (for example nicotine patches or motivational support).

See the NICE pathway on smoking.

Sexual health

1.3.7 Offer people in prison information about sexually transmitted infections and available sexual health services.

1.3.8 Ensure that people in prison have discreet access to condoms, dental dams and water-based lubricants without the need to ask for them.

1.4 Managing medicines

Access to medicines

1.4.1 Carry out an individual risk assessment to determine if the person can hold their medicines in-possession. Allow people in prison to hold all medicine in-possession unless the person does not pass the risk assessment.

1.4.2 Directly observe the administration of all schedule 2 and 3 medicines (see NICE's guideline on controlled drugs) and medicines for tuberculosis (see NICE's guideline on tuberculosis).

1.4.3 Directly observe the administration of any medicine that is not in-possession.

1.4.4 Work with prison staff to ensure a system is in place to:

- supervise the administering of medicines not held in-possession to maximise adherence
- reduce diversion (passing medicines on to other people)
- protect confidentiality.

See the section on supporting adherence in NICE's guideline on medicines adherence.

1.4.5 Review and (if necessary) repeat a person's risk assessment for in-possession medicine if the person's circumstances change. Involve a multidisciplinary team if needed, including prison staff. Examples of when the risk assessment should be repeated include:

- when carrying out a medicines review
- if a person is considered able to manage their own medicines after a period of having medicines not in-possession

- if there is a medicine safety incident, including evidence of self-harm
- if someone has raised security concerns (for example, about bullying, diversion or hoarding)
- if the person has not been taking their prescribed medicines
- if there is concern about the person's ability to self-medicate
- following the Assessment Care in Custody and Teamwork care planning approach
- if the person is transferred to a segregation unit.

1.4.6 Consider providing storage for in-possession medicine in prison cells, for example, a lockable cupboard.

1.4.7 Give people in prison information and education about medicines adherence (see the section on patient involvement in decisions about medicines in NICE's guideline on medicines adherence).

1.5 Monitoring chronic conditions

1.5.1 Monitor people with chronic conditions in accordance with the following NICE guidelines (see appendix Q in the supporting evidence for this guideline for specific recommendations):

- chronic heart failure
- chronic kidney disease
- chronic obstructive pulmonary disease
- epilepsies
- hypertension
- myocardial infarction
- type 1 diabetes and type 2 diabetes.

See also the NICE quality standard on asthma.

1.5.2 Monitor people with chronic conditions that need specialist management in line with relevant NICE guidelines (for example on hepatitis B).

1.5.3 Consider more frequent monitoring for older people and people with chronic conditions (such as diabetes) who are serving longer prison sentences.

1.6 Managing deteriorating health and health emergencies

1.6.1 Ensure a local protocol is available for responding to and managing situations in which a person's health quickly deteriorates, or in a health emergency. This could include, for example:

- essential training for front-line prison staff, including the first person likely to be on the scene in an emergency
- processes to enable healthcare staff to reach a person in prison quickly, such as how to gain access to their cell
- processes to ensure a person can be quickly seen by a healthcare professional if their health deteriorates quickly
- availability of emergency equipment, such as emergency 'grab bags'
- recording the actions and observations taken by prison and healthcare staff when assessing people with rapidly deteriorating health or in an emergency situation, such as:
  - updating a person's care plan or
  - recommendations for immediate follow-up
- a clear care plan for supporting people with rapidly deteriorating health
- guidance on sharing information between prison staff and healthcare staff, such as details on standardised clinical handovers and follow-up.

1.6.2 Ensure prison and healthcare staff are made aware of people who have underlying chronic conditions and allergies:

- if the person agrees (in line with the local information-sharing policies)

- in emergencies, in line with the duty of healthcare staff to share relevant confidential patient data.

1.7 Continuity of healthcare

On entry into prison

1.7.1 Arrange for the person's medical records to be transferred from primary and secondary care to the prison healthcare team on the person's entry to prison (see recommendation 1.1.5).

1.7.2 Primary and secondary care services should provide information from the person's medical records to the prison healthcare team that is:

- relevant
- in the person's best interests.

Transit between custodial settings

1.7.3 Ensure continuity of care between custodial settings, including court, the receiving prison or during escort periods by, for example:

- providing access to relevant information from the patient record
- providing any medicines (including controlled drugs) – see also the section on continuity of medicines
- issuing an FP10 prescription.

Before release from prison

1.7.4 Carry out a pre-release health assessment. This should be led by primary healthcare and involve multidisciplinary team members and the person. It should take place at least 1 month before the date the person is expected to be released.

1.7.5 For people who may be in prison for less than 1 month, plan pre-release health assessments during the second-stage health assessment (see recommendation 1.1.8 for details of this assessment).

1.7.6 Include the following in the person's care summary and post-release action plan:

- any significant health events that affected the person while they were in prison, for example:
  - new diagnoses
  - hospital admissions
  - instances of self-harm
- any health or social care provided in prison
- details of any ongoing health and social care needs, including:
  - medicines they are taking (see also recommendations 1.7.10–1.7.12)
  - mental health or substance misuse
- future health and social care appointments, including appointments with:
  - secondary and tertiary care
  - mental health services
  - substance misuse services
  - social services.

1.7.7 Give the person a copy of the care summary and post-release plan and also send a copy to the person's GP (if they are registered with one).

1.7.8 Help people who are being released from prison to find and register with a community GP if they are not already registered with one.

1.7.9 Before the person is released, liaise with services that will be providing care and support to them after they leave prison. This should include (as needed):

- secondary and tertiary specialist services (for example HIV, TB, oncology)
- mental health or learning disability services
- substance misuse services

- social services
- external agencies such as home care.

Continuity of medicines

1.7.10 Ensure the person can keep taking their medicines after coming into prison. Use the examples of critical medicines in table 2 in conjunction with clinical judgement and any safety alerts.

Table 2 Examples of critical medicines where timeliness of administration is crucial to prevent omitted and delayed doses

This table contains examples only and should be used in conjunction with clinical judgement. It is important to assess each person on an individual case basis.

Area	Medicines
Cardiovascular system	Anticoagulants Nitrates
Respiratory system	Adrenoceptor agonists Antimuscarinic bronchodilators
Central nervous system	Anti-epileptic drugs Drugs used in psychoses and related disorders Drugs used in parkinsonism and related disorders Drugs used to treat substance misuse
Infections	As clinically indicated, such as anti-infectives or anti-retrovirals
Endocrine system	Corticosteroids Drugs used in diabetes
Obstetrics, gynaecology and urinary tract disorders	Emergency contraceptives
Malignant disease and immunosuppression	Drugs affecting the immune response Sex hormones and hormone antagonists in malignant disease – depot preparations
Nutrition and blood	Parenteral vitamins B and C
Eye	Corticosteroids and other anti-inflammatory preparations Local anaesthetics Mydriatics and cycloplegics Treatment of glaucoma
Based on UKMi NPSA Rapid Response Report: Reducing Harm from omitted and delayed medicines in hospital. Revised January 2016.	

1.7.11 Hold a one-to-one discussion with the person to agree a plan for how they will take their medicine after their release from prison. This should include education about taking prescribed medicines.

1.7.12 Consider carrying out a medicines review for people who are assessed as needing extra support to manage their medicines on release or transfer from prison. For example:

- people with tuberculosis, HIV, diabetes, substance misuse or mental health problems
- people with neurodevelopmental disorders or learning disabilities
- people receiving end of life care
- older people
- people serving long-term sentences.

1.7.13 When a person is discharged or transferred from prison give them a minimum of 7 days' prescribed medicines or an FP10 prescription.

1.7.14 Set up a process to ensure that people being discharged or transferred at short notice from prison are given a supply of their medicines or an FP10 prescription.

1.7.15 For recommendations on care for people moving from one care setting to another, see the section on medicines-related communication systems in NICE's guideline on medicines optimisation.

Terms used in this guideline

Diversion

The transfer of any prescription medicines from the person for whom they were prescribed to another person for misuse.

FP10

A prescription form. People who are released from prison unexpectedly can take an FP10 to a community pharmacy to receive their medicines free of charge until they can arrange to see their GP or register with a new GP.

Grab bag

Medical emergency bags containing equipment and medication for dealing with common medical emergencies. The equipment may include dressings, automated external defibrillator and oxygen. It may also include medicine, for example for treating allergic reactions (anaphylaxis).

In-possession

Medicine is said to be held in-possession if a person (usually in a prison or other secure setting) is responsible for holding and taking it themselves.

Multidisciplinary team

A group of experts from different disciplines who each provide specific support to a person, working as a team. In prison settings, a multidisciplinary team may include physical and mental health professionals, prison staff, chaplains, staff from other agencies, such as the UK Border Agency and social care staff.

Putting this guideline into practice

[This section will be completed after consultation]

NICE has produced tools and resources to help you put this guideline into practice.

[Optional paragraph if issues raised] Some issues were highlighted that might need specific thought when implementing the recommendations. These were raised during the development of this guideline. They are:

- [add any issues specific to guideline here]
- [Use 'Bullet left 1 last' style for the final item in this list.]

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Changes recommended for clinical practice that can be done quickly – like changes in prescribing practice – should be shared quickly. This is because healthcare professionals should use guidelines to guide their work – as is required by professional regulating bodies such as the General Medical and Nursing and Midwifery Councils.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

1. **Raise awareness** through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.

2. **Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.

3. **Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision.

4. **Think about what data you need to measure improvement** and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. **Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. **For very big changes** include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. **Implement the action plan** with oversight from the lead and the project group. Big projects may also need project management support.

8. **Review and monitor** how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

1 NICE provides a comprehensive programme of support and resources to
2 maximise uptake and use of evidence and guidance. See our into practice
3 pages for more information.

4 Also see Leng G, Moore V, Abraham S, editors (2014) Achieving high quality
5 care – practical experience from NICE. Chichester: Wiley.

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Context

In April 2013 NHS England became responsible for commissioning all health services for people in prison in England. Healthcare in prison has a very important role in identifying significant health needs, maintaining health and detecting chronic conditions. This guideline supports equivalence of healthcare in prisons, a principle whereby health services for people in prisons are provided to the same standard, quality and specification as for patients in the wider NHS. Providing equivalence of care aims to address health needs, reduce health inequalities, prevent deterioration, reduce deaths due to natural causes and ultimately assist rehabilitation and reduce reoffending.

The guideline population includes adults over 18 in prisons or young offender institutions. The prison population includes highly vulnerable groups such as:

- people with a learning disability who find it difficult to understand the prison regime and what is happening to them
- older prisoners and those serving longer sentences whose physical health often deteriorates or is exacerbated by previous lifestyle choices during imprisonment
- people serving short sentences, making it difficult for prison healthcare staff to achieve any sustainable change in their health
- people who have particular healthcare needs such as:
  - people with physical disabilities
  - people with a history of substance misuse
  - pregnant women.

Since 2006 there have been considerable changes in prison health services. But there continue to be barriers to delivering health services within custodial settings that make providing healthcare equivalent to that provided in the community a significant challenge. There are many recognised areas of pressure that both the prison system and healthcare need to address to manage the overall safety of prisoners. Key areas of focus for this guideline include:

- The initial reception assessment and subsequent general health assessments. This includes liaison and communication with external health organisations for the benefit of people's care while in prison or hospital, between establishments and on release.
- Continuity of healthcare for those moving around the prison estate, including continuity of medicine, a coordinated approach between prison health services and visiting health services and prison staff;
- Effective communication between teams, in particular when dealing with complex needs and sharing information to support people's care in the wider prison.
- Managing emergency situations, which can include high levels of complex needs within the prison population, the staff skills needed to work with this client group and the large numbers of people in prison moving across the prison estate.
- Procedures and methods to support prisoners in transit between custodial settings or on release to the community.

This guidance should be read in tandem with NICE's guideline on the mental health of adults in contact with the criminal justice system, taking a holistic approach as the two are interwoven. People in prison can often have a mix of physical and mental health issues during their sentence. Health professionals working in prisons need a range of skills to deal with the assessment, diagnosis and management of physical health, mental health and addiction problems, as well as underlying complex social and behavioural issues.

More information

> To find out what NICE has said on topics related to this guideline, see our web page on prisons and other secure settings.

Recommendations for research

The guideline committee has made the following recommendations for research.

1 Subsequent health assessment

When should subsequent health assessments be carried out in prison for people serving long-term sentences?

Why this is important

Case management of chronic conditions in prison is difficult, and opportunities for self-care may be limited. The number of older people and people serving long sentences in prison is increasing. There is emerging anecdotal evidence that long-term incarceration exacerbates chronic ill health and causes early onset of conditions associated with old age. No evidence was identified for this question and an answer would help inform whether additional health checks may be needed to prevent potential health deterioration and quickly identify any new health-related conditions.

2 Chronic conditions

What is the prevalence of disease in the UK prison population?

Why this is important

At the time this guideline was published it was estimated that there were around 90,000 people in prison in the UK with an annual throughput of around 180,000. To date, there is little clear evidence of the prevalence of disease among people in prison so we have had to rely on anecdotal experience. This was highlighted by our reviews of chronic conditions (for which there was no disease prevalence data) and when searching for prevalence data for the health economic model. Systems are now in place that will allow the relevant data to be gathered to inform a longitudinal study. Such a study would provide a useful foundation for better understanding how to shape healthcare provided to people in prison, both in terms of:

- meeting the needs of the prison population, and
- providing commissioners with priority areas for developing and delivering health services.

3 Promoting health and wellbeing

What is the most effective method for delivering health promotion activities and who should lead them (peers or professionals)?

Why this is important

There is little data on how health promotion interventions should be delivered and who is best to deliver them. People in prison sometimes find it challenging to use services that require them to interact with people they perceive to be in authority, such as prison officers and health professionals. This is acknowledged in the qualitative review in this area.

There are many examples of health promotion activities, ranging from information leaflets to one-to-one sessions and group-based learning. If it can be established which methods of health promotion are more effective then both the NHS and prisons would be able to better target their resources to inform, educate and support people to take a more active role in looking after themselves. This would lead to greater equivalence of service, a better ‘real world’ experience and create more confidence in overall health provision.

4 Assessment tools for health promotion

What are the most effective tools to determine the health promotion needs of people in prison?

Why this is important

Health promotion in prison can vary and may not be seen as a priority by healthcare staff. But people in prison are entitled to an equivalent standard of healthcare to that which they would receive in the community. Prison offers an ideal opportunity to help people who perhaps have not previously attended health services. The prison population is known to have a high prevalence of smoking, often a poor diet and difficulties in accessing exercise programmes or information on sexual health. All of these may exacerbate existing health conditions or lead to poor health or infection.

No evidence was identified for health promotion needs assessment and a study would inform future recommendations in this area. An effective, valid assessment tool for identifying health promotion needs would ensure that people received care that met their needs. It may also identify specific healthcare needs more quickly so people can be given information and advice about self-care, both in prison and after release.

5 Access to medicines

Does the use of directly observed supply of named high-risk medicines (that is, not supplying the medicines to people to hold 'in-possession') reduce diversion, abuse and non-adherence?

Why this is important

Since 2003 self-administration of medicines by people in prison (known as holding medicines 'in-possession') has been encouraged. Directly observed administration is reserved for high-risk medicines and vulnerable patients. But different medicines are categorised as high-risk by different prisons so the approach has been inconsistent. This is influenced by local factors including capacity. Delivering directly observed medicines is labour-intensive and difficult to include in the daily schedules of people in prison.

There is no evidence base underpinning which medicines should be administered under observation. This research would provide evidence to inform the development of a more consistent list of high-risk medicines that require direct observation to improve safety. The research would also inform commissioners of health and offender management services about the need to provide the workforce and operational capacity to administer high-risk medicines safely.