



# **Health and Justice Commissioning Intentions 2017/18**

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## **Health and Justice Commissioning Intentions 2017/18**

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## 1 Executive summary

NHS England commissions health care services in prisons, immigration removal centres and other secure and detained settings in England. NHS England's national and regional teams are responsible for the overarching policy and strategy for commissioning these services; but also, for the local commissioning of services for the populations in these settings.

NHS England's Health and Justice commissioning intentions for 2017/18 outline the priorities for the commissioning of services in secure and detained settings in England. They also set out those priorities for liaison and diversion services, sexual assault referral centres and major national programmes (such as, smoke free prisons, the Health and Justice Information System, children and young people (CYP) mental health transformation work stream and substance misuse services).

The intentions are intended to support commissioners, providers and the management of the secure and detained estate, to make preparations for health care services in 2017/2018 and have been developed to support NHS England's overarching strategy, the *Health and Justice Strategic Direction: 2016-2020*.

These annual commissioning intentions reflect NHS England's ambition to commission services that are live to the current deliverables across the estate. Whilst these are annual intentions they are aligned to NHS England's two-year business planning cycle.

This document sets out the purpose of the document and context of commissioning in a fast changing environment. It details the strategic context within which commissioners are operating, sets out our commissioning intentions and enabling actions and, lastly, provides a brief summary of contractual requirements for 2017/18.

## 2 Introduction

### 2.1 Purpose

This document sets out NHS England's commissioning intentions for 2017/18. It is intended to provide advanced notice to providers about the changes and planned developments in the commissioning and delivery of health services by NHS England.

Together with the planning guidance, the NHS standard contract, national tariff and CQUIN guidance, they form a plan to be reflected in contracts, developments, service reviews and procurement opportunities for 2017/18.

The commissioning intentions are intended to enable healthcare providers to make early preparations to engage with clinical leaders and to make changes that benefit patients and improve outcomes for them. These intentions should inform providers' plans at all levels.

They provide the context for constructive engagement with providers, to achieve shared goals, be patient centred, and reduce health inequalities, one of the core duties set out in the Health and Social Care Act 2012.

NHS England is committed to securing alignment across all aspects of NHS commissioning and will work with Government departments and agencies, clinical commissioning groups (CCGs), partner NHS bodies and local government in order to secure the best possible outcomes for patients and services users within available resources.

This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities it is responsible for, including policy development, review and implementation.

### 2.2 Equality and Health Inequalities

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as set out in the Equality Act 2010) and those who do not share it; and

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- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

## 3 Context

### 3.1 NHS England's responsibilities

NHS England was established in April 2013 as part of the changes introduced by the Health and Social Care Act 2012. As part of its mandate, it is responsible for directly commissioning a number of health services, including those for people in a range of custodial and secure settings.

Our vision is to obtain the best health benefit within available resources by commissioning high quality, safe and effective care in secure and detained settings in accordance with the NHS Mandate.

NHS England has commissioning responsibility for health care services including a described set of public health section 7a services which constitute: stop smoking services; substance misuse services; cancer and blood-borne virus screening services; and immunisation services. Our commissioning responsibility includes services in the following settings:

#### **Residential settings**

- Prisons;
- Young Offender Institutions;
- Secure Children's Homes (welfare and youth justice);
- Secure Training Centres;
- Immigration Removal Centres and Short-term Holding Facilities.

#### **Non-residential settings**

- Liaison and diversion services working with police custody suites, courts and Sexual Assault Referral Centres (SARCs).

Therefore, NHS England is responsible for commissioning care for individuals at a particular point in their life which is solely defined by the setting they are in, not by their need or the nature of the service. This makes improving the pathways of care in and out of these settings a priority for our work (for example, 74% of the prison population will be released within 12 months from the start of their sentence).

This patient population experience a disproportionately higher burden of illness (including infectious diseases, long term conditions and mental health problems) and poorer access to treatment and prevention programmes and problems with substance misuse (drugs, alcohol and tobacco). For example, liaison and diversion trials have shown that over 50% of cases have comorbidities of mental health, drugs or alcohol with 11 % presenting with all three.



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Higher rates of hepatitis B and C, tuberculosis, HIV and sexually transmitted infections impact physical health: over a quarter of young men and a third of young women have a long standing physical complaint. In managing the care of this patient population, a decade is generally added to their chronological age to address their physical presentation caused by poor diet, poverty, dependencies and lifestyles including homelessness and long-term unemployment.

This population also disproportionately suffers mental ill-health, with 72% male and 70% female sentenced prisoners suffering from two or more mental health disorders. 50% of adult prisoners present with levels of anxiety or depression compared to 15% amongst the general population. 31% of children and young people in youth justice system have a diagnosed mental health condition. Approximately 7% of the prison population have a learning disability, compared with 3% of the population. However, it is estimated that up to 30% of prisoners have a learning disability or learning difficulty.

77% of sentenced men and 82% of sentenced women smoke. 81% of those entering prison report they have taken drugs (40% report injecting within 28 days before custody). A high proportion of people in prison are dependent on over the counter medicines and there is a high level of alcohol use and dependency with 64% of young people in detention self-reporting they drank alcohol daily and 77% of adults reporting the use of illegal drugs or excessive alcohol use in the past 12 months.

We continue to see a rise in the numbers of older prisoners. The number of prisoners who are over the age of 50 rose to 12,577 in March 2016. This brings its own unique set of challenges for this cohort of patients, as whilst (for example) older prisoners report lower levels of drug use, there is likely to be increased reliance on primary care, higher rates of long term conditions, social care needs and disability, and greater need for palliative care provision when compared to younger patients.

The following services are commissioned by NHS England across the secure and detained estate:

- GP services
- Dentistry services
- Nursing services
- Mental health services
- Learning disability services
- Integrated substance misuse services
- Optometry
- Podiatry
- Pharmacy and medicines management
- Smoking cessation

- Information Management, Technology and Information Governance

## **3.2 Developments in Health and Justice**

### **3.2.1 Prison reform**

In February 2016, the Prime Minister David Cameron announced major reforms to prisons, including naming six autonomous reform prisons: HMP Wandsworth, HMP Holme House, HMP Kirklevington Grange; HMP Coldingley; HMP High Down and HMP Ranby. The Governors at these prisons will have control over how their budget is spent and have operational control over much of the prison's activities (for example, education, visits, prison work and rehabilitation), representing a significant increase in the powers of the prison authorities. The Government announced that it would also be investing £1.3 billion in building nine new prisons across the country. NHS England's national team is working with partners, including the Ministry of Justice and National Offender Management Service, on these changes and what they are likely to mean for commissioners of healthcare.

### **3.2.2 Mental health**

NHS England is also working on a significant review of mental health provision for the secure and detained estate which will result in revised specifications for mental health services, more efficient hospital transfers and effective mental health pathways across the estate and into community provision. The Stephen Shaw review into the welfare of vulnerable persons in detention described six recommendations for NHS England, four of which were around the improvement of mental health provision for this patient population. The resolution of these recommendations is reflected within these commissioning intentions.

### **3.2.3 Reconfiguration of the women's estate**

During the summer of 2016, the National Offender Management Service (NOMS) closed HMP/YOI Holloway (London), part of the women's estate. In May 2016, HMP/YOI Downview (Surrey) was reopened and it is planned that it will take most of the population that would have been held at HMP/YOI Holloway. NOMS also announced that all women's prisons will be resettlement prisons, which is intended to allow women to be closer to their families and prepare them for life after prison.

Whilst the overall changes will be positive in the longer term, the immediacy of the changes required NHS England to re-plan the commissioning of healthcare, compensating for the closure of HMP/YOI Holloway and the movement of women to other prisons across the South. Our planning has taken account of the reopening of HMP/YOI Downview; but also, the reallocation of prisons to become resettlement prisons across the women's estate.

### **3.2.4 Reconfiguration of the adult male estate**

Similarly, NOMS is leading a reconfiguration of the adult male estate. Over the next five years, this will see a change in prisoner population management, including changes to prison purposes and categories, with greater focus on rehabilitation and preparation for release. As this work develops, this will have an impact on commissioning of health services and the provision required for each population.

### **3.2.5 Youth Justice Reforms**

The departmental review of the youth justice system being led by Charlie Taylor was commissioned by the Ministry of Justice in September 2015 and was due to be published in July 2016. Although publication has been delayed, we anticipate that this report and the Government's response to this review will be published in the Autumn of 2016.

These commissioning intentions reflect the significant developments relating to the potential redesign of the young people's estate. Further, they reflect the expectation that we will commission services to support the child and adolescent mental health services transformation agenda where this aligns to the services across CYP secure settings.

### **3.2.6 Adult substance misuse services**

In 2013, in preparedness for NHS England taking forward their procurement planning programme, national specifications were developed which presented a framework for service delivery across all NHS England's health and justice commissioning responsibilities. The national substance misuse specification was part of this suite of specifications, and current activity is to ensure that this specification is reviewed and revised to take account of the changing face of substance misuse across the secure estate, an opportunity to re-visit the Patel Report 2010 (Prison Drug Treatment Strategy Review), the emerging findings in relation to the growing use of new psycho-active substances (NPS) and the reports from NPS service users that the current services being delivered across the secure estate do not meet their needs.

In addition, there is a need to take account of the revised NICE 'Orange Book' clinical guidelines update which includes prison based substance misuse service delivery and a significant focus on the management of NPS.

The Government's reform agenda has placed a significant focus on abstinence oriented services. We need to ensure that the review of our service specification instils confidence across the secure estate that, in delivering patient centred services, progress towards abstinence is available on the menu of interventions in order to support the best patient outcomes.

From October 2016 to March 2017, we will develop these into a detailed service specification designed to meet a range of outcomes, and will consider the

implementation of the specification between NHS England, national partners, regional commissioners, prison governors and healthcare providers.

### **3.2.7 Smoke free prisons**

There has been a long standing commitment from successive Governments to implement smoke free prisons “in a safe and controlled way”. Alongside this commitment, concerns regarding exposure to second hand smoke featured in two judicial reviews brought by prisoners and trade union concern from the Prison Officers Association. Air quality monitoring (2015) in 10 sites showed significant risk of exposure to second hand smoke at higher levels than World Health Organisation guidance.

The implementation of Smoke Free Prisons began in September 2015, when a number of early adopter sites were announced. Prisons in Wales have already moved to smoke free, as have four sites in the South West of England. The next tranche of 12 Prisons are preparing to go smoke free from October 2016 to March 2017.

Implementation involves reviewing and optimising pre-existing smoking cessation services, extension of voluntary smoke free wings, brief interventions, nicotine replacement therapy (including self-purchase e-cigarettes), individual and group counselling, pharmacotherapy, self-help materials, mass media and communications, and the commissioning of additional provision to enhance pre-existing smoking cessation services.

### **3.2.8 Sexual Assault Referral Centres (SARCs)**

Over the last 12 months, NHS England has continued to commission both paediatric and adult SARCs with partners, including Police and Crime Commissioners. NHS England’s investment in SARCs has increased this year which has allowed further procurement of services, including the successful procurement of a region-wide service for the West Midlands. For those survivors who do not wish to attend a SARC following an assault, we have been engaging with clinical commissioning groups to improve services for these individuals. SARCs remain an important commissioning intention as we seek to build these services and improve pathways for survivors into community services.

## 4 NHS England's priorities

### 4.1 Strategic context

NHS England has set out its strategic objectives for the commissioning of health care services in justice settings in its five year plan, *Strategic direction for health services in the justice system: 2016-2020: care not custody; care in custody; care after custody*. Each of our commissioning intentions aligns to one or more of the seven priority areas set out in the *Strategic Direction 2016-2020*. These priority areas are:

1. A drive to improve the health of the most vulnerable and reduce health inequalities;
2. A radical upgrade in early intervention;
3. A decisive shift towards person-centred care that provides the right treatment and support;
4. Strengthening the voice and involvement of those with lived experience;
5. Supporting rehabilitation and the move to a pathway of recovery;
6. Ensuring continuity of care, on reception and post release, by bridging the divide between healthcare services provided in justice, detained and community settings;
7. Greater integration of services driven by better partnerships. Collaboration and delivery.

### 4.2 Health and Justice Strategic Commissioning Intentions 2017/18

Our 2017/18 commissioning intentions build upon the progress made over the last three years. The emphasis is on addressing the strategic challenges faced by the NHS in delivering improved outcomes for patients in justice settings. For 2017/18, our commissioning intentions are:

1. Commission services in all programme areas which meet the national **patient and quality safety standards**.
2. Commission services to meet the **Intercollegiate Healthcare Standards for Children and Young People (CYPSS)** across the Children and Young People's Secure Estate (CYPSE) and support the work of the **children and young people mental health transformation programme**.
3. Continue to support NHS England's ambition to **reduce the incidence of suicide** as set out in the Mental Health Five Year Forward View, through the ongoing implementation of the agreed recommendations for healthcare from the Harris Review and Prison and Probation Ombudsmen investigations into **deaths in custody**.

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4. To improve the **quality assurance** of health care services commissioned across the secure and detained estate.
5. **Engage and involve patients**, families and the public in the planning, commissioning and delivery of healthcare services within the secure and detained estate.
6. Delivering specific pathways within prisons and detained settings to **support stepped care approaches in meeting mental health needs**. We will develop mental health treatment pathways between establishments and into the community and ensure mental health hospital transfers are timely and appropriately managed.
7. We will seek to implement **specialist dementia care services** across appropriate prison settings.
8. Reduce health inequalities by improving delivery and uptake of **national screening and immunisation** programmes.
9. Further develop NHS England's public health section 7a commissioning responsibilities by ensuring the delivery of the phased roll-out of **smoke-free** prisons in England by improving and enhancing the delivery, uptake and effectiveness of smoking cessation programmes.
10. Implementation of our new service specification for **adult substance misuse services** to support and drive improvement and continue to make effective links and care pathways with community provision with a focus on recovery (including new psychoactive substances, alcohol and dual-diagnosis and incorporating stop smoking services).
11. Commission **sexual assault services** in-line with specification 30 of the delegated public health responsibilities ensuring appropriate and qualitative adult and paediatric services and supporting pathways into community based support services.
12. **Liaison and Diversion** services will be further rolled out on an incremental basis across England providing enhanced coverage across courts and police custody suites for individuals in the criminal justice system and supporting their engagement with services for their treatment and contribute to their rehabilitation.
13. Further establish **pathways for those moving through the custodial or detained estate** to better support and manage integrated care, the national "through the gate" programme and CYP transitions agenda. Continue to

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establish these pathways during the ongoing reconfiguration of the male and female estate.

14. Embed phase 1 of the **Health and Justice Information System** and complete the phased roll-out during 2017/18.
15. Continue to improve the quality of data and reporting of the **Health and Justice Indicators of Performance**, further extend the dataset to support key strategic programmes. Embed the new performance dashboard for individual establishments to improve transparency and commissioning.
16. Support for the **justice reform agenda** which constitutes reforms to the adult prison estate, children and young people's secure settings, the courts and sentencing guidelines. We will support the development of **local co-production and commissioning arrangements** with prison governors and ensure a focus on reducing health inequalities, strengthening rehabilitation and supporting the contribution healthcare services can make to the reduction of reoffending.

### 4.3 Service developments

NHS England has a prioritisation framework to guide the work of its direct commissioning functions and a clinical reference group (CRG), which enables decisions to be made regarding investment and if necessary dis-investment in services to best meet healthcare need within available resources. These proposals are assessed by the Health and Justice CRG which advises NHS England on all health commissioned services in secure and detained settings.

Investment in new services and interventions will be prioritised using the prioritisation framework to ensure that the range of services and interventions are optimised to best meet the needs of patients within available resources.

Service developments with a financial impact for existing providers of a given service will only be approved where they were initiated with NHS England's formal agreement. They will need to demonstrate measurable outcome and value improvements and will need to be agreed as part of the national prioritisation process and where resources have been released from elsewhere within an achievable balanced national financial plan. Where development or changes to the clinical eligibility policy for a treatment would warrant new provider entry or revisiting the assessment of existing providers as the most capable to provide a significantly changed service, this will be managed through the service and commissioning review process with existing and potential providers considered for procurement.

For the avoidance of doubt, the regional commissioning teams are unable to give support to cost increasing business case proposals outside of the national process.

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Providers should not initiate service changes or developments without prior commissioner approval.



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#### 4.4 National Enabling Actions – 2017/18

The following actions support our commissioning intentions and assist in their delivery.

A	We intend to deliver a model for health care services across the secure and detained estate for adults and CYP that promotes sustainability, quality, improved patient outcomes and better value
B	Through our contracting and procurement processes, we will continue to develop the provider market across the secure and detained estate for adults and CYP to ensure our patient groups are receiving sustainable, high quality integrated services.
C	Develop the <b>workforce model</b> for health services across the secure and detained estate for adults and CYP.
D	Through partnership agreements with Government departments and agencies, and healthcare, we will promote integrated services across health and social care in all of our programme areas and areas of commissioning responsibility.

## 5 Our approach to contracting

### 5.1 Practical arrangements

NHS England expects providers to produce sufficient data and information to allow all invoices to be validated. This includes full transparency of pricing both of providers and also sub-contractors, whose terms and conditions inform pass-through payments. This information needs to be clearly set out in the local pricing schedules.

#### 5.1.1 The NHS Standard Contract

Where a single provider provides both primary medical care and non-primary care services commissioned by NHS England, there is now an option available to use a single hybrid form of contract which will cover both of these. This is an NHS Standard Contract with an additional schedule (Schedule 2L) of provisions relating to primary medical care. (Further detail is available via <https://www.england.nhs.uk/nhs-standard-contract/>.)

However, where a single provider provides primary care other than primary medical care, alongside non- primary care services commissioned by NHS England, there will still need to be separate commissioning contracts, in the appropriate form, for the different strands of service.

#### 5.1.2 Single Provider Contract

The intention for 2017/18 is that NHS England should normally only hold (or be party to) one NHS Standard Contract with any provider, which includes the five areas of direct commissioning with contract schedules.

Providers will be expected to agree and obtain written approval in advance from the commissioner to enter into any **material sub-contracts**. Existing sub-contract arrangements should be jointly reviewed and documented within the 2017/19 contract.

#### 5.1.3 eContract

The eContract system will continue to be available for 2017/18 as a convenient method for commissioners to produce tailored contract documentation.

#### 5.1.4 Procurement

NHS England will advertise intended contract awards and any market testing or procurement through the Government 'Contracts Finder' website.

In line with the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013, and guidance issued by Monitor entitled 'Substantive guidance on the Procurement, Patient Choice and Competition Regulations', NHS England is committed to ensuring that when it procures health

care services it satisfies the procurement objectives laid down in the regulations, namely to act with a view to: securing the needs of the people who use the services; improving the quality of the services; and improving the efficiency in the provision of services. An integral element of this is ensuring the existence of an improved process to support the timely access of those patients with mental health needs requiring a transfer from prison to secure hospital settings.

## **5.2 Prior Approvals and Individual Funding Requests**

There are a number of clinical commissioning policies that are subject to prior approval. These include the assisted conception policy and a number of policies for procedures that may be considered to be cosmetic. Treatments that have not secured prior approval will not be funded.

[www.england.nhs.uk/commissioning/policies/ssp/](http://www.england.nhs.uk/commissioning/policies/ssp/)

Arrangements for Individual Funding Requests (IFRs) will continue in 2017/18. Further details on IFRs, including the application form, are available at:

[www.england.nhs.uk/wp-content/uploads/2013/04/cp-03.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/04/cp-03.pdf)

## **5.3. CQUIN**

Due to the APEX/APMS contracts we use within the secure and detained estate CQUINs are not routinely being incorporated into contracts, although this is not a consistent approach across Health and Justice commissioned services. Where CQUINs are not included in the contracts there is an expectation that commissioners encourage innovation and service development.

## **5.4 Quality, Innovation, Productivity and Prevention (QIPP)**

The majority of our providers have their own QIPP groups that bring together skilled teams across each pathway to improve health outcomes. In many cases QIPP proposals are discussed with provider clinical teams as they are in the best position to identify local opportunities and should add to the portfolio of planned change, to ensure that the volume growth and efficiency of pathways and episodes of care are addressed in plans.

## 6 Key contacts

### 6.1 NHS England Regional Team

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