

Integrated Health and Social Care in Prisons

Tests of Change Findings Report

**Appendices 1-11**

# Contents

# Appendices

1 [Health and Justice Collaboration Board Programme Structure](#Appendix1)

2 [Workstream and Report Advisory Group membership](#Appendix2)

3 [Phases of the project](#Appendix3)

4 [Costs and structures of the tests of change](#Appendix4)

5 [Mapping of actions, standards and outcomes](#Appendix5)

6 [Tests of change data set](#Appendix6)

7 [Aids and equipment draft protocol](#Appendix7)

8 [Third Sector in prisons](#Appendix8)

9 [Related Scottish Government policy areas](#Appendix9)

10 [Recommendations for implementation and essential tasks for the integrated team](#Appendix10)

11 [An active implementation approach](#Appendix11)

## Appendix 1: Health and Justice Collaboration Board Programme Structure

## Appendix 2: Health and Social Care in Prisons Integration Workstream Members

|  |  |
| --- | --- |
| **Name** | **Representing** |
| **Chair: Iona Colvin** | Chief Social Work Advisor, SG |
| Nicola Rogerson | Social Work Scotland, Justice Social Work |
| Brian Nisbet | SG Integration Division |
| Kevin Fulton | SG Throughcare policy |
| David Fotheringham | SG Adult Social Care |
| Lisa Taylor | SG Justice - Prisons Policy Team |
| Morag Stirling  Finlay Begg | Scottish Prison Service |
| Jane Kellock | Social Work Scotland |
| Alison Bavidge | Social Work Scotland |
| Rhoda MacLeod | Glasgow - Integrated Joint Board |
| David Pickering-Gummer | General Manager, NHS Lothian |
| Anil Gupta/John Wood | COSLA |
| Helen Happer | Care Inspectorate |
| Karen Hedge | Scottish Care |
| Lyndsey Hague | Coalition of Care Providers in Scotland |
| Anne Tavendale | Scottish Social Services Council |
| Maria Mcilgorm  Claire McGrath  Kim McGibbon | SG Chief Nursing Officer Directorate |
| **Programme Team** |  |
| Helen Forde | SG Health and Social Care in Prisons Team |
| Rachel Wallace | SG Health and Social Care in Prisons Team |
| Lynne Smith | SG Health and Social Care in Prisons Team |

**Members of the Report Advisory Group:**

Finlay Begg, Scottish Prison Service

Nicola Rogerson, Social Work Scotland

Carla Plasberg-Hill, SG Health and Social Care

Kerry Brooks, SG Health and Social Care

Rhoda MacLeod, as Test of Change Lead, Glasgow HSCP

Ian MacNeill, SG Analytical Services

Fiona Macdonald, SG Analytical Services

Hannah Ross, COSLA

## Appendix 3: Phases of the project

**Phase 1: Analysis and review of current arrangements**

This phase delivered a [report by the University of Dundee](https://socialworkscotland.org/wp-content/uploads/2019/03/A-New-Vision-for-Social-Care-in-Prison-Report-.pdf)[[1]](#footnote-2) on existing arrangements in Scotland. It concluded that people in prison cannot as a matter of course, access their right to equivalence of social service. The report surmises that this is problematic from a legal, human rights and equalities perspective. The report included a wide ranging action plan that has informed the set up and evaluation of the later tests of change. A matrix aligning the actions to National Outcomes, the National Care Standards and the Standard for Prisons is at Appendix 2.

**Phase 2: Developing models**

During this phase, we focussed on engagement with partners to describe options in terms of models of referral, assessment and the delivery of care and support. A report[[2]](#footnote-3) was submitted to the Scottish Government Workstream.

**Phase 3: Testing the models**

All the Health and Social Care Partnerships (HSCPs) that have prisons sited within their boundary were invited to propose a test of change for six months. Six proposed integrated models and received funding to enable them to bring in practitioners and administrative project support. One, East Ayrshire wanted to test out two much smaller models:

1. Improving health and social care assessments in criminal justice social work reports to try to ensure that more is known about the likely impact of a custodial sentence and to prepare prison reception.
2. Creating a core team of carers with a care at home provider. Ensuring they are trained and able to go to deliver personal care at HMP Kilmarnock whenever that is needed.

## Appendix 4: Costs and make-up of the tests of change

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **HMP** | **Grampian** | **Kilmarnock** | **Kilmarnock** | **Low Moss/ Greenock** | **Shotts** | **Perth/ Castle Huntly** | **Totals** |
| **HSCP** | **Aberdeenshire** | **East Ayrshire** | **East Ayrshire** | **East Dunbartonshire and Inverclyde** | **North Lanarkshire** | **Perth & Kinross** |  |
| **Areas of focus** | Used community team focussing on physical and frailty needs | Inclusion of more health and social care information in Justice Social Work Reports | Training to deliver a reliable care at home service for the prison | Generic approach | Rehabilitation approach | Generic approach |  |
| **Social Workers/ Care Managers** |  |  |  | £53,665.00 | £11,726.36 | £52,620.00 | £65,391.36 |
| **Social Work Assistants** | £9,842.00 |  |  |  |  |  | £9,842.00 |
| **OT** | £9,842.00 |  |  | £21,737.00 | £4,690.54 | £11,894.00 | £36,269.54 |
| **Senior OT** |  |  |  |  | £2,550.98 |  |  |
| **Physio** |  |  |  |  | £3,964.16 |  | £3,964.16 |
| **Management support/professional supervision** |  |  |  |  |  | £2,394.00 |  |
| **Project/ admin support** | £19,200.00 |  |  | £17,395.00 | £10,000.00 | £14,997.00 | £46,595.00 |
| **Healthcare support workers** | £16,074.00 |  |  |  |  |  |  |
| **Care and support commissioning** | £13,932.00 | NOTE: This budget was to help to buy in other supports quickly if necessary. SPS continued to pay for personal care procured from agencies. | | £15,000.00 | £5,000.00 | £10,000.00 | £33,932.00 |
| **Training** | £2,000.00 |  | £1,440.00 |  |  |  | £3,440.00 |
| **Recruitment** | £1,000.00 |  |  |  |  |  | £1,000.00 |
| **IT costs** |  |  |  | £1,000.00 |  |  | £1,000.00 |
| **Travel** | £500.00 |  |  |  |  |  |  |
| **Total** | £72,390.00 | £0.00 | £1,440.00 | £108,797.00 | £37,932.04 | £91,905.00 | **£312,464.04** |

## Appendix 5: Matrix of University of Dundee Actions against National Outcomes and relevant National Standards

**Thematic Evaluation Framework**

**Thematic evaluation framework**

| **Theme** | **Focus** | **Recommendations/ for Development/Action** | **National Outcomes and indicators** | **Health and Social Care Standards and Principles** | **Adult Social Care Reform Programme Themes and Statements** |
| --- | --- | --- | --- | --- | --- |
| **Knowledge and Understanding** | 1. Defining social care | 1.1 We recommend that our Six Principles of Empowering Social Care and the Dilnot Commission’s (2011) definition of social care be adopted to frame a broad and holistic approach to defining social care.  1.2 Social care in prisons should focus on developments for older prisoners as well as younger disabled prisoners. | 1 People are able to look after and improve their own health and wellbeing and live in good health for longer. | 1: I experience high quality care and support that is right for me  2: I am fully involved in all decisions about my care and support  3: I have confidence in the people who support and care for me  4: I have confidence in the organisation providing my care and support  5: I experience a high quality environment if the organisation provides the premises   * Dignity and respect * Compassion * Be included * Responsive care and support * Wellbeing (including safety, preferences, achieving potential and taking risks) | **Models of care and support**   * Support that fits round a person * Shared agreement on the purpose of social care * Equity of experience and expectations across Scotland |
| 2. Understanding disability | 2.1 Policy, service planning and activity programmes should be developed according to global best-practice indicated by the UN *Convention of the Rights of Person with Disabilities* (2006) which recognises disability as *evolving* and shaped by interactions with the person in their environment.  2.2A broader understanding of disability, including social and environmental perspectives, should be adopted to reduce the likelihood of disabled people experiencing more challenging conditions and fewer opportunities than their non-disabled peers.  2.3 Psycho-social and therapeutic interventions should be introduced to support the transition to and development of an affirming disabled identity run by disabled people or disabled ex-offenders.  2.4 Awareness-raising is required for staff and prisoners to develop understanding of disability and working/living with diversity, including the accumulative effects of exclusion. | 1 People are able to look after and improve their own health and wellbeing and live in good health for longer | 1: I experience high quality care and support that is right for me  3: I have confidence in the people who support and care for me  5: I experience a high quality environment if the organisation provides the premises   * Dignity and respect * Responsive care and support * Wellbeing (including safety, preferences, achieving potential and taking risks) | **The purpose and value of social care support and self-directed approaches**   * Shared agreement on the purpose of social care support   **Commissioning and procurement**   * Look at funding and investment |
| 3. Learning and training | 3.1 Incorporate learning from related developments and research, for example, the 2011 transfer of health from SPS to NHS and Macmillan Palliative Care in Prisons.  3.2 Identify ways for sharing best practice and knowledge across all domains of practice, including through research with academic partners and other external organisations to evaluate and inform future work and to support the development of a culture of learning and inquiry.  3.3 Develop opportunities for joint learning for health, social care and SPS staff on understanding social care, disability, working with diversity and the impact of prison on health and wellbeing. | 8 People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide. | 3: I have confidence in the people who support and care for me  4: I have confidence in the organisation providing my care and support   * Responsive care and support | **Workforce conditions and skills**   * Value the workforce * Evaluate and learn from data and experience |
| **Legal Frameworks** | 4. Framework for responsibility and resource | 4.1 The responsibility for delivery of social care in prison needs to be explicit. This may include extending or clarifying current legislation on health and social care, Public Bodies (Joint Working) Scotland Act 2014, Social Care (Self-directed Support) (Scotland) Act 2013, the Management of Offenders (Scotland) Bill and the Prison and Young Offenders Institutions (Scotland) Rules to make direct reference to health and social care in prisons.  4.2 People in prison should be entitled to the same quality of integrated health and social care that is available in the community. This should be more clearly articulated in policy and legislation.  4.3 Resources need to be allocated appropriately to meet the social care needs of people in prison. | 3 People who use health and social care services have positive experiences of those services, and have their dignity respected. | 1: I experience high quality care and support that is right for me  4: I have confidence in the organisation providing my care and support   * Dignity and respect * Compassion * Be included * Responsive care and support | **Investment in care and support**   * Look at funding and investment   **Commissioning and procurement**   * Look at funding and investment |
| 5. Transition between community/prison/ community | 5.1 Enact more fully the current Standards around  Throughcare, National Objectives for Social Work Services in the Criminal Justice System: Standards – Throughcare.  5.2 There is significant scope to improve the information and care provision arriving with people at reception into prison and leaving with them at release.  5.3 Continuity in the provision of medication from community to prison is essential for the wellbeing of prisoners.  5.4 All case and care management processes should be aligned into a holistic assessment and delivery system whether the issues are around risk/offending or regarding support to improve health and well-being and reasonable adjustment.  5.5 Prisoners should be able to contribute meaningfully to plans that seek to support their transition back to the community.  5.6 Issues relating to the consistency of health and social care on transitions into, out of and through the prison estate should be addressed including decisions on the nature of ‘residency’ and the meaning of ‘home’. | 4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services | 1: I experience high quality care and support that is right for me  4: I have confidence in the organisation providing my care and support  5: I experience a high quality environment if the organisation provides the premises   * Be included * Wellbeing (including safety, preferences, achieving potential and taking risks) | **Consistent experience and expectations**  **Models of care and support**   * Support that fits round a person * Equity of experience and expectations across Scotland   **Commissioning and procurement**   * Look at funding and investment * Co-produce with people who use social care support and unpaid carers |
| 6. Rights based approach | 6.1 The European Convention on Human Rights 1950 and the UN Convention on the Rights of Persons with Disabilities 2006, in tandem with the Equality Act 2010 (UK), should be used as overarching frameworks guiding the development of social care in prisons.  6.2 We recommend framing social care in prisons within a Human Rights Based Approach (HRBA) and the Scottish Human Rights Commission’s PANEL Principles.  6.3 Prison itself should be the punishment for crime and that people in prison retain their rights as citizens to health and social care that is equivalent to people in the community. | 1 People are able to look after and improve their own health and wellbeing and live in good health for longer.  3 People who use health and social care services have positive experiences of those services, and have their dignity respected.  4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.  5 Health and social care services contribute to reducing health inequalities. | 1: I experience high quality care and support that is right for me  2: I am fully involved in all decisions about my care and support   * Dignity and respect * Compassion | **The purpose and value of social care support and self-directed approaches**   * Based on human rights * Shared agreement on the purpose of social care support |
| 7. Equality duties and reasonable adjustment | 7.1 Approach social care needs first and foremost as an *equality* *duty* that enables disabled prisoners to be on a commensurable footing with other prisoners, and secondly as a mechanism for meeting the health and developmental goals of the disabled prisoner.  7.2 Reasonable adjustment should be a core plank of working within an equalities framework, central to social care assessment processes and accessibility in a way that anticipates needs rather than reacts retrospectively, and considers social dimensions as well as the physical environment. | 2 People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. | 1: I experience high quality care and support that is right for me  4: I have confidence in the organisation providing my care and support  5: I experience a high quality environment if the organisation provides the premises   * Dignity and respect * Compassion * Be included * Responsive care and support * Wellbeing (including safety, preferences, achieving potential and taking risks) | **Communities, care and support**   * Change attitudes towards social care support * Base on human rights |
| **Delivering Social Care** | 8. Role of social work | 8.1 Social work need to be more visible and involved with  offenders at each stage of their journey through the criminal justice system: from sentencing, time in prison, through to release.  8.2 The commitment of social work to prevention and early intervention work with people in prison should be enhanced.    8.3 Local authority responsibility for people who are temporarily living within their jurisdiction, should be re-examined. | 5 Health and social care services contribute to reducing health inequalities. | 1: I experience high quality care and support that is right for me  4: I have confidence in the organisation providing my care and support  Wellbeing (including safety, preferences, achieving potential and taking risks) | **Workforce conditions and skills**   * Value the workforce   **Consistent experience and expectations**  **Models of care and support**   * Support that fits round a person * Equity of experience and expectations across Scotland     **The purpose and value of social care support and self-directed approaches**   * Based on human rights   Shared agreement on the purpose of social care support |
| 9. Integrated working | 9.1 The multi-disciplinary team, its role and composition should be key to the delivery of integrated health and social care in prisons.  9.2 We recommend that social work play a lead role in  coordinating and assessing social care in prisons and that teams have a diversity of professionals involved, including medical or nursing staff, occupational therapists, mental health staff, rehabilitation workers and others.  9.3 The role of the prison officer is pivotal in ensuring people in prison are able to access health and social care. | 8 People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.  9 Resources are used effectively and efficiently in the provision of health and social care services. | 3: I have confidence in the people who support and care for me  Responsive care and support | **Workforce conditions and skills**   * Value the workforce |
| 10. Outcomes approach | 10.1 Embed person-centred and outcomes-based approaches in prisons and explore issues around power dynamics and ‘learned helplessness’.  10.2 Identify ways of empowering prisoners to have personal agency and a voice over issues impacting on them at an individual level, over areas of prison life and supporting contact with family and friends outside of prison. | 1 People are able to look after and improve their own health and wellbeing and live in good health for longer. | 2: I am fully involved in all decisions about my care and support  Dignity and respect  Be included | **The purpose and value of social care support and self-directed approaches**   * Based on human rights * Shared agreement on the purpose of social care support * Co-produce with people who use social care support and unpaid carers |
| 11. Holistic assessment | 11.1 The means by which people in prison identify their needs and desired outcomes should be through a holistic and multi-disciplinary assessment process.  11.2 Assessment timing, nature, tools and referral pathways should be considered and developed.  11.3 People in prison need to be able to self-refer for health and social care in a way that will promote outcomes and address inequalities arising through ill-health or disability.    11.4 The concept of managing risk in the context of prisoners who are vulnerable in prison and potentially on their return to the community needs to be incorporated into assessment. | 4 Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. | 1: I experience high quality care and support that is right for me  Responsive care and support  Wellbeing (including safety, preferences, achieving potential and taking risks) | **The purpose and value of social care support and self-directed approaches**   * Based on human rights * Shared agreement on the purpose of social care support * Co-produce with people who use social care support and unpaid carers   **Commissioning and procurement** |
| 12. Peer carers | 12.1 Review the approach to peer carers in light of the judgement that the State cannot shift its duties for care onto other prisoners whilst recognising that for many people in prison, caring for or being cared for by a peer is a positive experience.  12.2 Explore issues of care service/carer registration and training.  12.3 We recommend introducing group peer mentoring programmes run by disabled people or disabled ex-offenders. | 6 People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being.  8 People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide. | 1: I experience high quality care and support that is right for me  4: I have confidence in the organisation providing my care and support  Dignity and respect  Compassion | **Communities, care and support**   * Change attitudes towards social care support * Co-produce with people who use social care support and unpaid carers |
| **Working with Diversity** | 13. Cultural change | 13.1 There needs to be development in relation to the idea that prison is a place where people live, as “home”, and their lives continue.  13.2 Shared ethos, values and principles to underpin cultural change should be explored at all levels in the organisations involved and the notions of “leadership” as a mechanism to drive cultural change.  13.3 The current prison regime makes the delivery of health and social care on a 24 hours basis difficult. Aspects of the security rules that stop people getting the care they need should be reviewed and innovative solutions explored.    13.4 The process of change must include the ‘voice’ or experience of the prisoner. | 2 People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. | 1: I experience high quality care and support that is right for me  4: I have confidence in the organisation providing my care and support  Dignity and respect  Compassion  Responsive care and support  Wellbeing (including safety, preferences, achieving potential and taking risks) | **Communities, care and support**   * Change attitudes towards social care support * Co-produce with people who use social care support and unpaid carers   **The purpose and value of social care support and self-directed approaches**   * Based on human rights * Shared agreement on the purpose of social care support |
|  | 14. Data and diversity | 14.1 Consider the need for segmentation (intersectionality) of data about the characteristics and needs of people in prison to allow analysis that recognises the range of people in prison, their individual characteristics so that the needs of complex population groups (protected characteristics) are taken in account in service monitoring and evaluation. | 3 People who use health and social care services have positive experiences of those services, and have their dignity respected. | 1: I experience high quality care and support that is right for me  Dignity and respect  Responsive care and support | **Investment in care and support**   * Evaluate and learn from data and experience * Based on human rights |
| **Wellbeing and Quality of Life** | 15. Purposeful activity | 15.1 Social workers and prison officers need to be pro-active in ensuring and supporting access to purposeful activities that reflect individual strengths, interests and needs.  15.2 Purposeful activities should include developing skills for work and employment on release irrespective of protected characteristics.  15.3 Disabled prisoners should have the same access to and payment from involvement in purposeful activities as all prisoners.  15.4 Peer caring should be explored as a purposeful activity. | 2 People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. | 1: I experience high quality care and support that is right for me  3: I have confidence in the people who support and care for me  Dignity and respect  Wellbeing (including safety, preferences, achieving potential and taking risks) | **Communities, care and support**   * Change attitudes towards social care support * Co-produce with people who use social care support and unpaid carers * Based on human rights |
| 16. Wellbeing and offending | 16.1 Incorporate the evidence that improved access to welfare and services can improve wellbeing and reduce the likelihood of further offending behaviour.  16.2 The impact that prison can have on health and wellbeing should be overtly recognised.  16.3 Develop understanding of prison as “home” for the people who are living there.  16.4 Recognize the value of relationships to be people in prison and develop innovative approaches to support people in prison to maintain external relationships, contact with family and friends outside of prison. | 2 People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. | 1: I experience high quality care and support that is right for me  Dignity and respect  Compassion  Responsive care and support  Wellbeing (including safety, preferences, achieving potential and taking risks) | **Communities, care and support**   * Change attitudes towards social care support * Co-produce with people who use social care support and unpaid carers * Based on human rights * Support that fit round person |
| 17. Alternatives to custody | 17.1 There should be wider discussion about using community alternatives to prison for people with particularly high level care needs.  17.2 Effective multi-disciplinary work is required to introduce community alternatives to prison and to ensure that risk is fully incorporated into care planning and that Courts and the Parole Board are confident in the approaches recommended. | 9 Resources are used effectively and efficiently in the provision of health and social care services. | Not directly applicable | **Commissioning and procurement**   * Look at funding and investment |

## Appendix 6: Data sets request from the tests of change

|  |
| --- |
|  |
|  |
| Remand or sentenced |
| If sentenced, length of sentence |
| Specific sentence |
| Local Authority of Ordinary Residence |
| Date of prison admission |
| Date of prison referral for adults services |
| Date of prison adults services assessment |
| Date of prison care package delivery |
| Date of delivery of other support in the prison |
| **Days referral to assessment** |
| **Days assessment to care package delivery** |
| **Days assessment to other support delivery** |
| Unmet need: if yes, complete sheet 4 |
| Previously known to community adults services? (KtS) |
| Which LA area were they last known to |
| If new to service (NtS), when was the first referral? |
| Referral source |
| Age range at point of referral |
| Sex |
| Did this person turn out to be known to services but this wasn't picked up at reception/induction? |
| Did the prison based assessment lead to a care plan? |
|  |
| **Conditions** |
| Alcohol dependency |
| Alcohol related brain injury |
| Autism/Asperger’s |
| Blood borne virus |
| Dementia, memory, incapacity |
| Drug dependency |
| Hearing impairment/deaf |
| Learning difficulties |
| Mental health |
| Neurological condition (not dementia) |
| Frailty |
| Physical disability or long-term condition |
| Visual impairment |
| Other |
| No related condition |
|  |
| **Hours per week for on-going regular service provision** |
| Adult support and protection |
| Palliative |
| End of life care |
| Support for learning (education or SPS programme) activity |
| Support for social or physical activity |
| Support for work activity |
| Personal care |
| Support for daily living |
| Support for relationships |
| Planning for release - housing |
| Planning for release - finance |
| Planning for release - work or education |
| Planning for release - health and social care |
| Mothers and children in prison |
| Physical support - equipment and adaptations |
| Rehabilitation (health related) |
| Other (text) |
| **Total hours per week for regular service provision** |
|  |
| **Referral/assessment/time limited work hours per case** |
| OT |
| Social Worker |
| Administrative Support |
| Physiotherapist |
| Third sector |
| Health |
| Other (text) |
| **Total referral/assessment/time limited hours per whole case** |
|  |
| **Onward referrals in the prison** |
| OT |
| Physio |
| Third sector |
| Health |
| Other (text) |
|  |
| **Weekly hours by profession in integrated care plan** |
| OT |
| Physio |
| Third sector |
| Health |
| Social Work |
| Prison Officer |
| Other |
| **Total** |
|  |
| **If this person transferred to or from another prison** |
| Transferring prison |
| Transferred with care plan in place in receiving prison |
| Receiving prison |
|  |
| **People with a care plan released** |
| Released with care plan in place |
| Released to same LA as prison |
| Receiving LA |
|  |
| **Case completed/closed in your prison** |
| Date case completed/closed |
| Reason |

## 

## **Appendix 7: Providing community equipment to prisons** protocol

**Providing Community Equipment to Prisons:**

**A protocol for the Assessment, Delivery and Uplift of Community Equipment in Prisons**

# Contributors

Forth Valley Health & Social Care Partnerships (Falkirk and Clackmannanshire & Stirling)

Alison Docherty, Independent Advisor, Equipment, Housing, & Occupational Therapy, on behalf of iHub

Scottish National Association of Equipment Providers

Scottish Prison Service

Contents

[Appendix 1: Health and Justice Collaboration Board Programme Structure 1](#_Toc50633837)

[Appendix 2: Health and Social Care in Prisons Integration Workstream Members 2](#_Toc50633838)

[Appendix 3: Phases of the project 3](#_Toc50633839)

[Appendix 4: Costs and make-up of the tests of change 4](#_Toc50633840)

[Appendix 5: Matrix of University of Dundee Actions against National Outcomes and relevant National Standards 5](#_Toc50633841)

[Appendix 6: Data sets request from the tests of change 19](#_Toc50633842)

[Appendix 7: Providing community equipment to prisons protocol 21](#_Toc50633843)

[Contributors 21](#_Toc50633844)

[Key Principles 23](https://socialworkscotland.sharepoint.com/staff/Documents/Projects/Social%20Care%20in%20Prisons/Phase%203%20Tests%20of%20Change/Evaluation/National%20Evaluation/HSCiP%20Evaluation%20Report%20Appendices%20v0.5.docx#_Toc50633845)

[Introduction 23](#_Toc50633846)

[Scale of the Issue 23](#_Toc50633847)

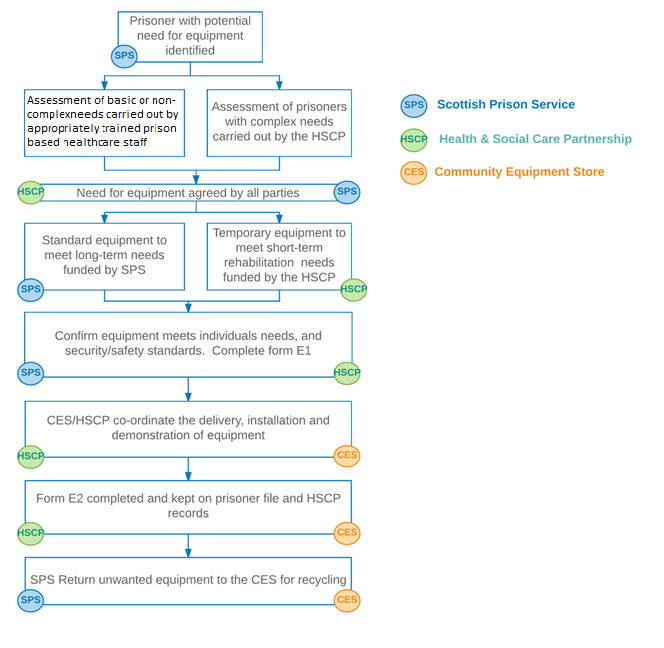
[What is Community Equipment 23](#_Toc50633848)

[Assessment 24](#_Toc50633849)

[Health and Social Care Integration 24](#_Toc50633850)

[Roles and Responsibilities 26](#_Toc50633851)

[Documentation 27](#_Toc50633852)

[**Appendix A:** Process for the Referral, Assessment, Provision and Recycling of Community Equipment to people in prison 28](#_Toc50633853)

[Appendix B: Form E1, Equipment agreement for IA and SPS re suitability, safety and security of equipment. 29](#_Toc50633854)

[Appendix C: Form E2, Confirmation equipment is fit for purpose 30](#_Toc50633855)

# Key Principles

  

Equipment will be provided on the basis of eligible assessed need.

All assessments will be carried out either by appropriately trained HSCP staff for complex needs, or relevant prison based NHS healthcare staff for non-complex needs.

SPS will provide a range of standard equipment to meet long-term needs.

The HSCP will provide equipment to meet short-term, temporary needs.

Wherever possible, equipment should be procured, maintained, and paid for through local community equipment stores.

Access to, and use of, recycled equipment should be encouraged.

SPS and the HSCP should agree arrangements for the tracking, maintenance, decontamination and recycling of community equipment across the prison estate.

# Introduction

The objective of this Protocol is to promote a consistent and reliable approach to the assessment, provision and uplift, of community equipment to people in custody in prisons across Scotland.

Numerous national and international statutes, including the UN declaration of human rights[[3]](#footnote-4) and the World Health Organisation[[4]](#footnote-5), affirm the right of those in custody in prison to healthcare equivalent to that available to those not in custody in prison.

This guide provides an example of how the Scottish Prison Service (SPS) and Integration Authorities (Health & Social Care Partnerships) could work in partnership to assess need, and provide appropriate equipment to meet those needs. This guide is based on the principles of the Protocol for the Provision of Equipment to Care Homes[[5]](#footnote-6) and work carried out by the Forth Valley Health & Social Care Partnerships (Falkirk and Clackmannanshire & Stirling) to develop a joint protocol.

## Scale of the Issue

The SPS 2015 Prisoner Survey 30% of respondents described themselves as having a long term condition while 26% described themselves as having a disability[[6]](#footnote-7).

The Prison Reform Trust highlights that disability and mobility needs within the prison population are commonplace. It estimates that 36% of people in prison have a physical or mental disability, compared to 19% of the general population.

The Scottish Prison population is also growing older. As of 5th September 2017 of those SPS had in custody over 980 were aged over 50 (13%) and over 150 (2%) were aged over 65. Between 2010 and 2016 the number of men aged over 50 in the Scottish prison population rose by over 60% while the number of men in prison aged over 65 increased by 68% over the same period[[7]](#footnote-8).

# What is Community Equipment

The Guidance on Equipment and Adaptations[[8]](#footnote-9) describes community equipment as ‘Any item or product system, whether acquired commercially off the shelf, modified or customized that is used to increase the functional capabilities of individuals with disabilities. Community equipment can include, but is not limited to:

* Equipment for those who are more dependent, such as Moving & handling equipment, pressure relieving mattresses and hospital beds.
* ‘Daily living’ equipment, for example shower chairs and stools, bathlifts, raised toilet seats, commodes, rails, transfers aids, and seating.
* Mobility equipment such as walkers, walking frames and sticks.
* Telecare products including flood detectors, falls monitors, smoke detectors and motion sensors. These are often linked to a call centre and trigger a response when activated.
* Sensory equipment such as flashing doorbells and text phones
* Communication equipment, including Alternative and Augmentative Communication (AAC) devices to assist people who have difficulty with speech.

It does not include any medical devices or anything that is invasive to the body (e.g. PEG feeding equipment).”

# Assessment

With appropriate training and support, the assessment of need, and provision of equipment can be carried out by a wide range of professionals, including prison based NHS healthcare staff. Partnerships should consider local need for the development of training and support to prisons in their locality.

A range of online tools are also available to support prison based NHS health care staff to work with people in prison to identify any need for equipment. See good practice example below.

|  |
| --- |
| Good Practice Example – Training prison based clinicians to assess for basic equipment  In Dec 2017 managers with responsibility for the Community equipment service within Perth & Kinross HSCP, met with the Head of Nursing for NHS Tayside Prisoner Healthcare. It was agreed that a number of nursing staff based in Perth prison will be given access to the *Elms* on-line ordering system, to allow them to directly access core stocks of daily living aids, pressure care, handling and moving equipment, and basic walking aids.  Training on assessing and use of the equipment is planned to be delivered in February 2018 and once each member of the prison nursing team have completed their training, they will register their details on Elms so accesses can be opened up for use. In particular it was identified that opening up access for basic walking aids would reduce the need for people in prison to attend hospital for a physio assessment.  In 2019, Equipu Community Equipment service trained prison based health care staff in Barlinnie prison to directly order equipment on the web-based ordering system. As above, this has allowed a more direct route to the provision of equipment and better knowledge of potential needs and solutions within the health care staff. |

# Health and Social Care Integration

The Public Bodies (Joint Working) (Scotland) Act 2014[[9]](#footnote-10) established the legal framework for the integration of health and social care in Scotland. The Act requires each Health Board and Local Authority to delegate some of their statutory functions, and associated budgets, to their Integration Authority (Health & Social Care Partnership). The HSCP is then responsible for the planning and delivery of the related services.

Local Authorities, along with other relevant partners, need to consider how the delegation of functions can best be implemented for the benefit of all individuals assessed as requiring support. Where equipment and adaptations are provided, these services, along with the resources which fund this support must be included in the integration arrangements[[10]](#footnote-11).

Each HSCP must prepare a Strategic Commissioning Plan[[11]](#footnote-12) which sets out how they will plan and deliver services, including community equipment, for their area over the medium term. Stakeholders must be fully engaged in the preparation, publication and review of the strategic commissioning plan, in order to establish a meaningful co-productive approach.

Good practice would suggest that partnerships with prisons within their locality should work with the SPS to assess the needs of their prison population, and agree appropriate arrangements for the provision, maintenance and review of community equipment provided to meet assessed needs.

Further guidance on the Integration of Health and Social Care is available at <http://www.gov.scot/Topics/archive/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance>.

# Roles and Responsibilities[[12]](#footnote-13)

|  |  |  |  |
| --- | --- | --- | --- |
| HEALTH & SOCIAL CARE PARTNERSHIP (HSCP) | NHS Prison healthcare staff | SCOTTISH PRISON SERVICE (SPS) | COMMUNITY EQUIPMENT STORE (CES) |
| Work in partnership to agree a range of core stock suitable for use within the prison environment, taking into account the potential need for increased security, health and safety standards and other environmental factors. | | | |
| Work in partnership to agree procurement and funding arrangements for all community equipment provided to people in prison. | | | |
| Work in partnership to agree arrangements for the tracking, maintenance, decontamination and recycling of community equipment across the prison estate. | | | |
| Work in partnership to provide training to prison based healthcare staff (e.g. prison nurses) on the assessment of basic needs, and provision of simple equipment to people in prison | | | |
| Work in partnership to agree a list of relevant leads/contacts to support effective communication between agencies. | | | |
| Undertake an assessment of people in prison with higher level/complex needs, and ensure any equipment proposed is “fit for purpose” - meeting the person’s needs while considering the environment. | Carry out assessment of people in prison with simple/low level/standard needs  **Refer** more complex cases to HSCP for assessment of needs. | **Identify people in prison** who may have a need for community equipment. |  |
| Following assessment will recommend appropriate equipment to meet the assessed need. | Following assessment will order the required equipment directly from the Store service | Confirm the equipment meets SPS safety/security standards and assess any implications of providing recommended equipment to individual (see above). |  |
| Fund equipment to meet short-term, temporary (3 months or less) needs, to aid recovery and rehabilitation. Recommend to SPS, equipment required to meet complex long-term needs |  | Fund equipment to meet the long-term needs of people in prison. | Process equipment **orders** and liaise with the relevant named prison contact to agree a time and named contact for delivery of the equipment. |
|  | Complete form E1 to confirm equipment will meet assessed needs (HSCP assessor) and that SPS security and safety standards have been considered (SPS named contact). | |  |
|  | Co-ordinate the delivery, installation and demonstration (if necessary) of the equipment to the person, and any other relevant person who may use the equipment (e.g. guard, prison buddy). | | |
| Copy of Form E3 will be saved into relevant IA records/ | Form E3 will be completed and placed on person’s file. | |  |
| Complete assessment once equipment is in situ to ensure needs are appropriately met. | | |  |
| Agree procedure/timescale for regular review and maintenance of equipment. | | | |
|  |  | Liaise with the relevant named prison contact to confirm a mutually agreed uplift time and place for equipment, when no longer required. | |

See also appendix A for process flowchart.

# Documentation

Form E3 (see Appendix 1) will be signed by the assessing HSCP professional to confirm that equipment is fit for purpose and then counter-signed by an SPS representative to confirm that any safety/security implications of the provision of the recommended equipment have been considered and that SPS standards are met.

SPS will retain Form E3 within in the person in prison’s file on the Prison Hall and a copy will be also placed within the person in prison’s NHS vision record? by the relevant health professional.

If there is a disagreement about the equipment recommended by the HSCP assessor this will be documented as above and escalated to senior management within the IA and SPS.

# **Appendix A:** Process for the Referral, Assessment, Provision and Recycling of Community Equipment to people in prison

# 

## Appendix B: Form E1, Equipment agreement for IA and SPS re suitability, safety and security of equipment.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | | | |
| **Spin:** | | **CHI:** | |
| The person above has been assessed by a IA (HSCP) staff member as requiring the following item/s of equipment to meet their health & social care needs. The equipment is suitable for their functional ability and for the structural environment. The equipment has also been agreed by an SPS staff member as appropriate for the individual in terms of security and the prison environment. | | | |
| **Purpose of equipment**  *e.g. showering* | **Type of product**  *e.g. shower chair* | | **Name of product** |
| Health & Social Care Partnership | | Scottish Prison Service | |
| Name (Print) | | Name (Print) | |
| Signature | | Signature | |
| Date: | | Date: | |

## Appendix C: Form E2, Confirmation equipment is fit for purpose

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | | | |
| **Spin:** | | **CHI:** | |
| The person above has been assessed by a HSCP staff member as requiring the following item/s of equipment for health/rehabilitation purposes. The equipment is suitable for their functional ability and for the structural environment. The equipment has also been agreed by an SPS staff member as appropriate for the individual in terms of security and the prison environment.  1  2  3  4  5  6 | | | |
| Health & Social Care Partnership | | Scottish Prison Service |
| Name (Print) | | Name (Print) |
| Signature | | Signature |
| Date: | | Date: |

**Appendix 8**

**Third sector snapshot: 137 support services across eight prisons (May 2019) from National Prison Health Network Working Group**

|  |
| --- |
| Alcohol Brief Intervention |
| Bereavement Counselling |
| Circus Group |
| Craft |
| Dance Group |
| Debt Advice |
| Employability/Training Advice |
| Football |
| Housing Information |
| Petting Animal Interaction |
| Practical/Emotional Support |
| Reading Group |
| Sexual Abuse Counselling |
| Restorative Justice |
| Music Therapy |
| Addictions and recovery |
| Football -peer support |
| Mentoring/Advocacy (Women only.) |
| Support/Mentoring |
| Rehab following release |
| BBV Awareness |
| Addictive behaviours sessions |
| Mental health support |
| Fitness pathway to promote positive mental health |
| Pet therapy |
| Support on release |
| Parenting |
| Art Therapy |
| Counselling |

**Appendix 9: Scottish Government – related policy areas**

*Integration*

*Adult care reform*

*Prisons*

*Community Justice*

*Throughcare*

*Homelessness*

*Carers*

*Mental health*

*Learning Disability*

*Autism*

*Dementia*

*Alcohol*

*Substance use*

*Self-directed support*

*Ordinary residence*

*Adult support and protection*

*Adults with incapacity*

*Eligibility criteria*

*Charging policies.*

**Appendix 10**

**Recommendations arising from this report for local implementation**

|  |  |
| --- | --- |
| **A** | Improved multi-disciplinary screening (by NHS, LA and SPS) to identify specific social care need as people arrive in prison to enable early and tailored intervention. Regular communication in the prison and with friends and family would enable interventions earlier and ensure they are tailored to need |
| **B** | Support and training for HSCP and SPS staff should be arranged to ensure greater understanding of the operational contexts across the multi-disciplinary team both at the point of mainstreaming but also on an ongoing basis |
| **C** | HSCPs should consider their preferred model of personal care delivery based on the needs in their local prison(s) at an early stage of implementation and work with SPS on addressing issues around 24/7 delivery. |
| **D** | HSCPs should consider developing a social work role for prisons that encompasses all adults’ service areas and is connected to local specialist teams. |
| **E** | Develop clear protocols across partners for the ordering, delivery and installation of aids and equipment |
| **F** | As IT systems that are used in the prison setting (NHS, LA, SPS) develop, data on diversity should be improved to support equalities and ensure a range of appropriate services are available |
| **G** | Loved ones should be involved, as far as they and the person in prison wish, in assessment and care planning. This may enable support to be delivered earlier and to ensure those supports are tailored to the needs of the individual. |
| **H** | Early intervention and prevention services should be developed together with the existing Third Sector in prisons around those areas where need is greatest. |
| **I** | SPS, SSSC and Scottish Government policy officers should consider the implications for peer carers and healthcare assistant roles that deliver personal care. |

**Key tasks and decisions for setting up integrated services in prisons**

* Communicate at the earliest stage to people in prison and SPS staff. Keep communicating.
* Ensure your data sharing agreements across the local authority, health board and SPS allow you to share and amend privacy notices if necessary.
* Investigate the IT situation in the prison. What will your teams need?
* Agree strategic and operational decision making bodies that can respond to release barriers quickly.
* Consider the population needs of your prison and decide on a model of personal care that will meet those needs.
* Engage with all professions to ensure they understand the services available.
* Ensure that all multi-disciplinary meetings about people in prison include the SPS, health and social work colleagues.
* Understand the third sector in your prison. What is used and where are there gaps? What voluntary throughcare is available?
* Be creative about designing services to support people to take part in daily activities in the prison.

Appendix 11 - An active implementation approach

The Tests of Change revealed the extraordinary complexity of delivering integrated health and social care in prisons.

This appendix is the result of work between Alison Bavidge at Social Work Scotland and implementation experts based in Celcis. It is intended to guide next steps in delivering integrated health and social care support in prison so that the learning from the tests of change has the anticipated impact.

Based on the findings from the Tests, the following next steps are recommended to facilitate effective implementation.

1. Health and Social Care Partnerships (HSCPs) and the Scottish Prison Service (SPS) leadership should work together to coordinate, establish, and authorise a **local multi-agency management team** in each prison area to guide the next steps.
2. A **national team** should be developed to work with the local multi-agency teams. Their role will include sharing the learning from the tests of change and any early implementation sites, making links to stakeholders with national perspectives such as the Scottish Government, Health and Social Care Scotland and COSLA amongst others.
3. The **local multi-agency management team** and the **national team** together should review the dimensions described in the Heptagon Tool to consider the “pre-conditions” for effective implementation of the findings from the Tests of Change. (See Heptagon Tool in Table 1.)
4. The **local multi-agency management team** will use the information gained from this Heptagon analysis to develop a local action plan to progress the Integration of Health and Social Care into prisons. The **national team** will support the development and implementation of the action plan from their national perspective (See sample template in Table 2.)

The evidence of what is required to achieve full and effective implementation is quite consistent. Given that there are no mature examples of local systems that have fully and effectively implemented health and social care in prison, the next step towards effective implementation requires further analysis and exploration based on the learning from the tests of change.

**Recommendation 1:**

Health and Social Care Partnerships (HSCPs) and the Scottish Prison Service (SPS) leadership should work together to coordinate, establish, and authorise a **local multi-agency management team** in each prison area to guide the next steps.

**Local Team make up**

Include as a minimum one person from each of the following professional areas:

* Community adults services social work
* NHS prison health
* SPS
* Prison based or justice social work
* Local voluntary throughcare providers

Each of these members should be of an organisation level where they can confidently speak on behalf of their organisation and make decisions about human and financial resources.

In addition, this team should ensure links with their own governance and local authority/HSCP commissioning services are made at an early stage.

**Recommendation 2:**

A **national team** should be developed to work with the local multi-agency teams. Their role will include sharing the learning from the tests of change and any early implementation sites, making links to stakeholders with national perspectives such as the Scottish Government, Health and Social Care Scotland and COSLA amongst others.

**National Team make up**

This team should consist of at least 3 – 5 people[[13]](#footnote-14) in order to ensure they can cover the geographic areas and prisons involved.

Team members should be representative of different parts and levels of the system and closely aligned to the work.

Team members must have the dedicated time to support the work and have knowledge and expertise both of the practice being implemented and what it takes to implement change.

**Recommendation 3** The **multi-agency management team** should review the dimensions described in the Heptagon Tool (pages 40-43) to consider the “pre-conditions” for effective implementation of the findings from the Tests of Change.

**Recommendation 4**

The **local multi-agency management team** will use the information gained from this Heptagon analysis to develop a local action plan (page 44) to progress the Integration of Health and Social Care into prisons. The **national team** will support the development and implementation of the action plan from their national perspective

After these initial pre-implementation steps, the next actions should include:

Following any recruitment to posts, each prison should have an **operational group** of key members of the multi-disciplinary team from:

* Prison health
* Adults’ social work
* SPS
* Justice social work (PBSW)
* Third Sector Throughcare

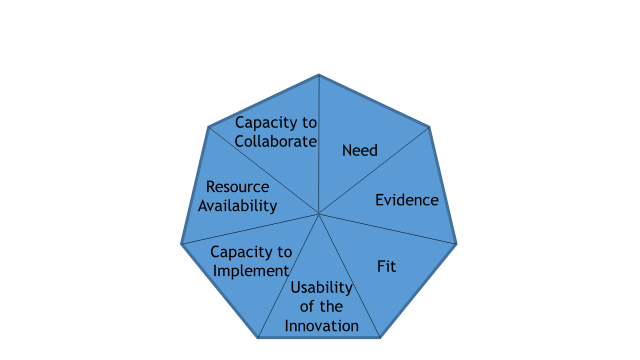
This team will meet regularly and involve each other in key meetings about people who need support in the prison. They will agree lead workers for each case as appropriate and ensure that SPS case management, integrated health and social care and Throughcare are experienced by the person in prison as a single function as far as possible. This team will have frequent contact with the multi-agency management team to enable issues to be resolved locally and quickly.

The **national team** will develop communications and engagement strategies and supports to enable **the multi-agency management team** and **the operational group** to learn from other sites and escalate issues that require additional consideration to the Prison Care Network and or other stakeholders such as the Scottish Government.

.

**The Heptagon Tool**

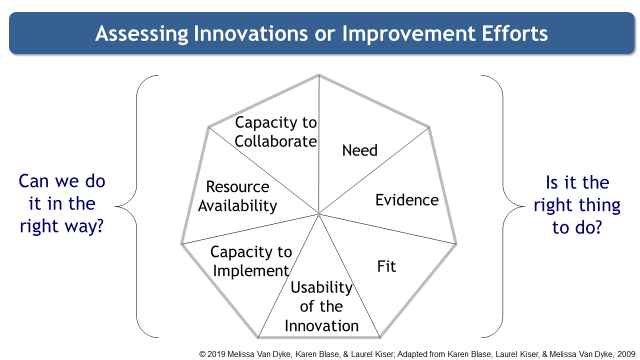
* History of effective collaboration?
* Exploration with all key stakeholders?
* Transparent decision-making processes and communication methods in place?
* Broadly held shared purpose?
* Data on ‘the problem’?
* Data on underlying needs of the population?
* Perspectives of key stakeholders?



* Resources and supports available to meet the programmatic requirements (staffing, training, data systems, coaching and supervision, enabling organisation procedures, mechanism to address system barriers)?
* Existing workforce meet minimum qualifications?
* Ability to sustain necessary support to maintain staff competence, organisation supports?
* Commitment to developing buy-in with key stakeholders?
* Outcomes – Is it worth it
* Strength of the evidence?
* Cost-effectiveness data?
* Aligned evidence?
* Innovation addresses one of the highest priority problems?
* Innovation aligns with the organisational structures?
* Innovation aligns with community values?
* Available expert or technical assistance?
* Mature sites to observe?
* Other successful sites?
* Operational definitions exist for essential functions?
* Implementation supports are well-defined?

**The Heptagon Analysis Tool**

**A Guide for Exploration Discussions**

****

Van Dyke, M., Kiser, L., & Blase, K. (2019)

The Heptagon Tool provides a useful guide for discussions during exploration (Van Dyke, Kiser, & Blasé, 2019; adapted from Blase, Kiser, & Van Dyke, 2009). The tool helps to operationalise many of the “pre-conditions” specified by Kilbourne, Neumann, Pincus, Bauer, and Stall (2007): the “identification of the need for a new intervention for a target population; identification of an effective intervention that fits local settings (e.g., mission of organisation and benefits to the organisation) and the intended target population (e.g., behavioural risks and culture); identifying implementation barriers; and drafting a user-friendly manual of the intervention.” The Heptagon Tool also supports the analysis of the critical system factors described by Greenberg, Domitrovich, Graczyk, and Zins (2005) to be considered during the pre-planning stage: (a) need for change; (b) readiness for change; (c) capacity to effect change; (d) awareness of the need for change; (e) commitment or engagement in the change process; (f) incentive for change; and (g) history of successful change.

For Heptagon discussions, information gathering is focused on the community, relevant governance, workforce, structure and programs, infrastructure and technology, as well as resources. Key stakeholders generally are individuals who could have a negative or positive effect on the implementation of the innovation. Many of these key stakeholders may be affected by the innovation through training, changes in practice, or additional responsibilities.

The Heptagon Tool can be used by a staff group in an organisation in a self-guided discussion, an external facilitator, or a discussion led by an Implementation Team. The dimensions and items for discussion draw attention to the factors that often are cited as enablers and barriers to using innovations and producing intended benefits. During Exploration, sub-committees can be formed to focus on one or two dimensions and develop information for decision making by the group.

As demonstrated by the Heptagon Tool, need, fit, resource availability, evidence, usability of the innovation, capacity to collaborate, and capacity to implement are key dimensions to consider. As the discussion proceeds to answer questions about the dimensions outlined in the Heptagon Tool, it is likely that the composition of the organisation and stakeholder group will change to include people who have knowledge of relevant factors. The literature emphasises securing “buy-in” and support from relevant stakeholders for the proposed new ways of work (e.g. effective innovations). Buy-in begins to be developed by the Implementation Team and local leaders during the Exploration Stage, as key stakeholders and other members of the broader community are engaged in the analysis of the identified problem or concern and have the opportunity to hear about the growing interest in identifying an effective and sustainable solution to be implemented.

|  |  |
| --- | --- |
| **Heptagon Categories and Questions to Guide Exploration Discussions**  © 2019 Melissa Van Dyke, Karen Blase, & Laurel Kiser | |
| **Need** | * What data demonstrate the need for this innovation or improvement? * What data demonstrate the social significance of this issue? * What do the data tell us about the underlying needs of the population to be served? * How do organisational leaders, practitioners, key partners, service users, families, and community members understand the issue or underlying needs of the population to be served? |
| **Evidence** | * Outcomes – Will implementation of this change be worth it? Will the innovation or improvement effort make a big enough difference to be worth the effort? * What is the strength of the available evidence? * Is there cost-effectiveness data? * Does the available evidence align with the needs and context for this innovation or improvement effort? |
| **Fit** | * To what extent does this innovation or improvement effort align with at least one of the highest agency, community, or national priorities? * To what extent does this innovation or improvement effort align with organisational structures? * To what extent does this innovation or improvement effort align with community values? |
| **Usability of the learning from the tests of change** | * Is expert or technical assistance available? * Where are there more mature sites to observe? * Are the essential functions of an integreated health and social care in prisons service well defined? How well-defined are the necessary implementation drivers (recruitment and selection, induction and ongoing training, supervision and coaching, performance/fidelity assessment, decision-support data system, facilitative organisational policy, procedures, and administration, systems intervention to address barriers, adaptive and technical leadership)? |
| **Capacity to Implement** | * Does the existing workforce meet the minimum qualifications for this innovation or improvement effort? * Will it be possible to sustain the necessary support to maintain staff competence, to maintain organisation supports, to financially maintain this innovation or improvement effort? * Can sufficient attention be given to developing buy-in with organisational leaders, practitioners, key partners, service users, families, and community members? |
| **Resource Availability** | * Are the following resources and supports available to meet the programmatic requirements for the innovation or improvement effort? * Recruitment and staffing * Inductions and (re-)training * Data systems * Technology supports * Coaching and supervision * Administration (internal policy and procedures) * System alignment or to address barriers |
| **Capacity to Collaborate** | * Is there a history of effective collaboration in this sector, across related partners, and in this geographic region? * Have key stakeholders been engaged in the exploration of this innovation or improvement effort? * Have transparent decision-making processes and communication methods been established? * Is there a broadly held shared purpose that aligns with this innovation or improvement effort? |

**References**

Blase, K. A., Kiser, L., & Van Dyke, M. (2009). *The hexagon tool*. Retrieved from Chapel Hill, NC: Active Implementation Research Network: www.activeimplementation.org/resources

Greenberg, M. T., Domitrovich, C. E., Graczyk, P., & Zins, J. E. (2005). *The study of implementation in school-based preventive interventions: Theory, research and practice (Volume 3)*. Retrieved from Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Kilbourne, A. M., Neumann, M. S., Pincus, H. A., Bauer, M. S., & Stall, R. (2007). Implementing evidence-based interventions in health care: Application of the replicating effective programs framework. *Implementation Science, 2*(42). doi:10.1186/1748-5908-2-42

Van Dyke, M., Blase, K. A., & Kiser, L. (2019). *The heptagon tool*. Retrieved from Chapel Hill, NC: Active Implementation Research Network: www.activeimplementation.org/resources

**Exploration: Local Action Planning**

This tool will help the team review their progress in exploration, help the team to assess what activities have already begun and help to guide planning of next steps.

|  |  |
| --- | --- |
| **Review of Key Exploration Activities** | **Notes or Questions to Consider** |
| **ENGAGE STAKEHOLDERS:**  **Progress-to-date:** Who has already been engaged as a part of exploration?  **Action Planning:** Who still needs to be engaged in exploration? | Exploration will be more successful if a diverse group of stakeholders are included.  Key stakeholders include those who will be impacted by the change process:   * Workers, supervisors, managers, executives * Authorised professional bodies (inspection, union, etc.) * Community partners * People in prisons, their partners, families, * “Experts” or champions |
| **FORM EXPLORATION/IMPLEMENTATION TEAM:**  **Progress-to-date**: Who is on the ‘Exploration/Implementation Team’?  **Action Planning:** Who is missing from the ‘Exploration/Implementation Team’? | The Exploration/Implementation multi agency team is an organized and active group that guides exploration activities with key stakeholders.   * Exploration/Implementation Teams consist of a national core group of at least 3 – 5 members that links with local implementation teams. * These team members have adequate and dedicated time to allocate to exploration/implementation activities. * These team members have special expertise with regards to the effective innovations, implementation, and improvement strategies. |
| **COMMUNICATION PLAN:**  **Progress-to-date**: Which elements of a communication plan, describing the exploration process, have been developed and shared with key stakeholders?  **Action Planning:** Which elements of a communication plan, describing the exploration process, are yet to be developed and/or shared with key stakeholders? | During exploration, a communication plan is developed to describe the exploration process to key stakeholder group (e.g. activities, participants, timeline, benefits, risks).   * What are the key messages for various groups of key stakeholders? * What are the best mechanisms to communicate with each group of key stakeholders? |
| **TARGET AREA/INTENDED OUTCOME:**  **Progress-to-date**: Have we reached consensus about the intended outcome of this improvement or transformation process for the population of concern?  **Action Planning:** What is our understanding of the intended outcome, at this point? | During exploration, the intended outcome of the innovation or improvement effort is articulated.   * What is the intended outcome of this improvement or transformation process for the population of concern? |
| **REVIEW OF EXISTING PROGRAMMES:**  **Progress-to-date**: Which programmes, practices, models have been reviewed?  **Action Planning:** Which additional programmes, practices, and models still need to be carefully reviewed? | During exploration, existing, well-defined, effective programmes and practices are reviewed so that they can be assessed for their ‘fit’ for this improvement effort.   * Based on the identified need to address, what programmes, practices, or models have been identified? * For each programme, practice, or model, consider each of the seven ‘heptagon’ dimensions: need, evidence, fit, usability of innovation, capacity to implement, availability of resources, capacity to collaboration (see the seven following sections). |
| **ASSESS NEED:**  **Progress-to-date**: Which aspects of ‘Need’ have we fully assessed?  **Action Planning:** What additional aspects of ‘Need’ must still be assessed? | Key questions related to NEED are:   * What data demonstrate the need for an innovation or improvement? * What data demonstrate the social significance of this issue? * What data are available to determine the prevalence of the need? * What do the data tell us about the underlying needs of the population to be served? * How do people in prisons, partners, and families understand the issue or underlying needs of the population to be served? |
| **REVIEW EVIDENCE:**  **Progress-to-date**: Which aspects of the evidence have we fully reviewed?  **Action Planning:** What additional aspects of the evidence must still be reviewed? | Key questions related to the EVIDENCE are:   * Outcomes – Is it worth it? Will the innovation or improvement effort make a big enough difference to be worth the effort? * What is the strength of the available evidence? * Is there cost-effectiveness data? * Does the available evidence align with the needs and context for this innovation or improvement effort? |
| **ASSESS FIT:**  **Progress-to-date**: Which aspects of ‘fit’ have we fully assessed?  **Action Planning:** What additional aspects of ‘fit’ must still be assessed? | Key questions related to FIT are:   * To what extent does this innovation or improvement effort align with one of the highest agency, community, or national priorities? * To what extent does this innovation or improvement effort align with the organisational structures? * To what extent does this innovation or improvement effort align with community values? |
| **USABILITY OF THE INNOVATION:**  **Progress-to-date**: Which aspects of ‘the usability of the innovation’ have we fully assessed?  **Action Planning:** What additional aspects of ‘the usability of the innovation’ must still be assessed? | Key questions related to the USABILITY OF THE INNOVATION are:   * Is expert or technical assistance available? * Where are theremore mature sites to observe? * Are the essential functions of an integreated health and social care in prisons service well defined? How well-defined are the necessary implementation drivers? |
| **CAPACITY TO IMPLEMENT:**  **Progress-to-date**: Which aspects of ‘capacity to implement’ [each innovation being considered] have we fully assessed?  **Action Planning:** What additional aspects of ‘capacity to implement’ [each innovation being considered] must still be assessed? | Key questions related to the CAPACITY TO IMPLEMENT are:   * Does the existing workforce meet the minimum qualifications for this innovation or improvement effort? * Will it be possible to sustain the necessary support to maintain staff competence, to maintain organisation supports, to financially maintain this innovation or improvement effort? * Can sufficient attention be given to developing buy-in with practitioners, service users, and families? |
| **RESOURCE AVAILABILITY:**  **Progress-to-date**: Which resources are available? Which are unavailable?  **Action Planning:** Which resources still need to be assessed for availability? | Key questions related to RESOURCE AVAILABILITY are:   * Are the following resources and supports available to meet the programmatic requirements for the innovation or improvement effort? * Staffing? * Training? * Data systems? * Technology supports? * Coaching and supervision? * Administration (internal policy and procedures)? * System alignment or to address barriers? |
| **CAPACITY TO COLLABORATE:**  **Progress-to-date**: Which aspects of ‘capacity to collaborate’ have we fully assessed?  **Action Planning:** What additional aspects of ‘capacity to collaborate’ must still be assessed? | Key questions related to the CAPACITY TO COLLABORATE are:   * Is there a history of effective collaboration in this sector, across related partners, and in this geographic region? * Have key stakeholders been engaged in the exploration of this innovation or improvement effort? * Have transparent decision-making processes and communication methods been established? * Is there a broadly held shared purpose that aligns with this innovation or improvement effort? |
| **ASSESS ‘BUY-IN’/CREATE READINESS:**  **Progress-to-date**: What is our plan to continuously engage stakeholders to assess and strengthen buy-in and to create readiness for implementation?  **Action Planning:** What is our next right step to assess buy-in and create readiness? | During exploration, stakeholders are continuously engaged to assess and strengthen ‘buy in’ and to create readiness for implementation.   * Which key stakeholders will be most critical to engage? * What rationales for ‘this change’ may be most important to these stakeholders? |
| **ANALYZE FINDINGS FROM EXPLORATION:**  **Progress-to-date**: Given progress to date, how do we understand the ‘problem to be addressed’, and what are key findings from the exploration process?  **Action Planning:** Given progress to date, what additional steps (*not already covered in an ‘AP’ above*) must be taken before finalizing the findings from exploration? | After completing the key exploration activities, the exploration team analyzes the information and findings from the exploration process.   * Which Exploration findings are critical to inform the usable innovation decision? |
| **TRANSFORMATION ZONE:**  **Progress-to-date**: Given discussions to date, what are the exploration team’s recommendations for the ‘slice’ of the system in which the ‘high reliability system’ will be developed?  **Action Planning:** What are the right next steps to define the transformation zone in which the ‘high reliability system’ will be developed? | A Transformation Zone is a vertical slice of the entire system from the practice level to the policy level and includes all major levels within the system. The slice is big enough to encounter nearly all the issues that likely will arise in system change, and small enough to keep issues at a manageable level until the beginnings of the ‘new system’ are established and functioning well.   * What needs to be considered in this system before establishing this Transformation Zone? |
| **RECOMMENDATIONS:**  **Progress-to-date**: Given progress to date, what recommendations are we ready to make to key decision-makers?  **Action Planning:** Given progress to date, what additional steps (*not already covered in an ‘AP’ above*) must be taken before making a final recommendation to decision-makers? | After analyzing the information and findings from the exploration process, the exploration team makes a recommendation to the appropriate decision-makers (e.g. strategic leadership team, community planning partnership, alliance, funder) |

**Exploration: Progress-To-Date and Action Planning**

**Signature lines: Date:**

|  |  |
| --- | --- |
| This analysis was completed by the following exploration team members and key stakeholders: | |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

<http://creativecommons.org/licenses/by-nc-nd/3.0>

This content is licensed under Creative Commons license CC BY-NC-ND, Attribution-NonCommercial-NoDerivs

Under this license, you are free to share, copy, distribute and transmit the work under the following conditions:

Attribution — You must attribute the work in the manner specified by the author or licensor (but not in any way that suggests that they endorse you or your use of the work);

Noncommercial — You may not use this work for commercial purposes;

No Derivative Works — You may not alter, transform, or build upon this work. Any of the above conditions can be waived if you get permission from the Active Implementation Research Network, the copyright holder.

1. <https://socialworkscotland.org/publication/a-new-vision-for-social-care-in-prisons/> [↑](#footnote-ref-2)
2. <https://socialworkscotland.org/projects/health-social-care-prisons/> [↑](#footnote-ref-3)
3. Principle 9, The United Nations (1990) Basic Principles for the Treatment of Prisoners - <http://www.ohchr.org/EN/ProfessionalInterest/Pages/BasicPrinciplesTreatmentOfPrisoners.aspx> [↑](#footnote-ref-4)
4. The World Health Organisation: Prisons - <http://www.who.int/topics/prisons/en/> [↑](#footnote-ref-5)
5. Protocol for the Provision of Equipment to Care Homes, 2012 - <http://www.gov.scot/Topics/Health/Support-Social-Care/Independent-Living/Equipment-Adaptations/Carehomes-Protocol> [↑](#footnote-ref-6)
6. SPS Prisoner Survey 2015

   <http://www.sps.gov.uk/Corporate/Publications/Publication-4565.aspx> [↑](#footnote-ref-7)
7. SPS Estatewide Social Care Needs Assessment 2017

   <http://www.sps.gov.uk/Corporate/Publications/Publication-4941.aspx> [↑](#footnote-ref-8)
8. Scottish Government Guidance on the Provision of Equipment and Adaptations, 2009 - <http://www.sehd.scot.nhs.uk/publications/CC2009_05.pdf> [↑](#footnote-ref-9)
9. Public Bodies (Joint Working) (Scotland) Act 2014 -<http://www.legislation.gov.uk/asp/2014/9/pdfs/asp_20140009_en.pdf> [↑](#footnote-ref-10)
10. Health & Social Care Functions Supporting Note - <http://www.gov.scot/resource/0046/00467396.pdf> [↑](#footnote-ref-11)
11. Strategic Commissioning Plans Guidance - <http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance/SCPlans> [↑](#footnote-ref-12)
12. Where local, joint working arrangements fall within the spirit of this protocol we would not expect partnerships to change these arrangements, simply to fall in line with this guide. [↑](#footnote-ref-13)
13. Fixsen, Blasé and Van Dyke 2019 [↑](#footnote-ref-14)