

ACKNOWLEDGEMENTS

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1. INTRODUCTION

This evaluation was sponsored by Dorset Primary Care Trust and the South West Strategic Health Authority to examine the local commissioning relationship established to provide police custody healthcare across Dorset's three 24/7 custody suites, located in Poole, Weymouth and Bournemouth. This initiative has the status of a national pilot, and the evaluation is expected to carry lessons for a wide range of audiences in and beyond Dorset.

A police custody medical service has operated within Dorset for many years using General Practitioners contracted on a part-time basis as Forensic Physicians (previously referred to as Forensic Medical Examiners or Police Surgeons). Historically, this has been customary practice in the UK, where GPs have been contracted to the police on a part-time basis, although increasing numbers are specialising in forensic work and work as full-time Forensic Physicians, particularly since the establishment of the Faculty of Forensic and Legal Medicine in 2005.

The switch to provision commissioned by the NHS was introduced to Dorset in 2008, as a Department of Health/Home Office national pilot. Its purpose was essentially to examine the efficacy of the NHS taking a strategic lead in commissioning police custody healthcare, and, more specifically, to pilot the transfer of commissioning and budgetary responsibility from Dorset Police to Dorset Primary Care Trust. Throughout this trial period, the service has continued to be contracted to an independent provider but is now governed by a partnership agreement between the NHS commissioner and Dorset Police, as the two lead organizations, and through a local partnership board.

This shift to mainstream health provision likely reflects the following key areas of thinking:

- a) concern that a disproportionate number of people entering the criminal justice system present in police custody with significant complex health and social care problems, particularly involving mental illness and/or drug or alcohol dependency, and often require urgent treatment and care;
- b) perception that the former medical approach to police custody healthcare was inadequate in terms of addressing the complex needs of people entering the criminal justice system, particularly in preventing deaths in custody, a source of intensifying political and professional concern;
- c) successful reform of prison healthcare, with the shift of commissioning and provision to the NHS in 2006; and
- d) an emerging 'offender pathway' health policy focus, led by the Department of Health, that is advocated by the Bradley Report (Bradley 2009 - into which this Dorset pilot fed its experience), and which implies a continuous and integrated approach to the management of health and social needs of people who move through the criminal justice system, between community and custody settings. At the heart of this innovation is the principle of health and social care as a fundamental citizen right.

Furthermore, the Audit Commission's 1998 review of the provision of forensic medical services to the police concluded that the service needed to be reformed for the following reasons: [1] difficulties recruiting Forensic Physicians; [2] variable standards of service around the country; [3] inadequate clinical facilities within some custody suites; [4] poor communication and feedback; [5] lack of formal contractual arrangements in some areas; and [5] lack of clear management structure and scrutiny (Audit Commission 1998).

The service delivered through this pilot represents a shift from the more traditional forensic medical service to one led predominantly by custody nurses. In place of physicians on call, the pilot, as agreed between the NHS Commissioner and Dorset Police required a 24 hour, 7 day nurse presence in each custody suite. An innovative feature of the pilot was the aspiration to link constant nursing presence to a broad triage service, linking police custody detainees to a range of integrated community-based services to address alcohol and drug dependency and other mental and physical healthcare needs.

The focus of the evaluation was to understand the *commissioning relationship* and its impact, given that the key innovative aspect of the Dorset scheme was the introduction of NHS commissioning via an NHS organization (a Primary Care Trust). This particular case of commissioning involves the NHS contracting services on the premises and in the area of action of another public sector service. All Primary Care Trusts are now required to operate as 'commissioners' in procuring and developing health services, and they are held accountable for their effectiveness as commissioners. Commissioning is defined by the Department of Health (2007)¹ as:

"... the process of deciding what services or products are needed, acquiring them and ensuring that they meet requirements. Commissioning in the NHS is the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers."

The underpinning rationale for commissioning is to establish an economic relationship based on a contract – the accountability relationship is one between a 'purchaser' and a 'provider' (or 'customer' and 'contractor'). The PCT is the 'purchaser', who can seek 'providers' both in-house and from the private and Third sectors. Commissioning gives rise to a form of accountability based on commercial conditions – expectations are proscribed by price, and performance is driven by incentive and competition (i.e. with other potential providers). It allows for services to be procured from the NHS or from the private or Third sectors on equal terms.

Commissioning is an alternative to in-house, professional forms of relationship and accountability, where performance expectations are negotiated on the basis of institutional resources and agreements and proscribed by professional values. Though contemporary resource-based management still requires in-house services to be limited by cost (i.e. the

¹ http://www.dh.gov.uk/en/Managingyourorganization/Commissioning/DH_865

equivalent of internal contracting), there is, nonetheless, more leeway to vary expectations of performance, cost and quality according to the judgments of practitioners and their managers.

This is not to say that commissioned services ignore professional values, or that professional, in-house services should not be assessed for their financial viability – both are true. It is a matter of balance, and of which is emphasized or eased by the modality of procurement. This is a practical matter and affects both the quality and the development potential of services, as we have found conducting this evaluation. The evaluation does not start from the assumption that commissioning is the only modality for procuring effective and desired healthcare (in custody), though we note that guidance documents for *World Class Commissioning* appear to imply this².

This report provides a descriptive account of the evaluation, conducted by a team from the University of the West of England, Bristol. The team, comprising five senior researchers, has expertise in:

- Programme evaluation
- Criminal justice health research
- Prison and offender health and social care
- Health economics and NHS commissioning
- Field-based observation of professional action

² For example, the *Commissioning Assurance Handbook* (2008 – Gateway Reference 9968) claims that World Class Commissioning, “will deliver better health and wellbeing for all...better care for all...better value for all”. The claim is not substantiated.

2. BACKGROUND AND CONTEXT

National Policy

This initiative was the first of its kind in England and Wales, and has occurred in the wake of the reform of prison healthcare with which this Dorset initiative shares many issues and characteristics. It reflects a broader shift of criminal justice health and social care accountability and provision from the criminal justice sector to the NHS, where the aim is to develop an integrated system of health and social care for detainees³, equivalent to rights enjoyed by the general population. Specifically, the criminal justice health and social care strategy consultation paper, *Improving Health, Supporting Justice* (DH, 2007), emphasized that through

“... Working in partnership, the police service can provide the gateway to health engagement. Many behaviours that lead people to have contact with the police are driven by both physical and mental health needs. As the initial point of contact with the CJS [criminal justice system] for most people, we will work with the police service to implement a framework encouraging their role as a first gateway to health and social care.”

Police custody healthcare provision has traditionally operated through contractual relationships between Police forces and healthcare providers, with the purpose of meeting acute physical and mental healthcare needs of detainees and providing a forensic and legal medical service. Custody healthcare has tended to be located outside the NHS, subcontracted to independent sector providers who have most commonly employed Forensic Physicians and custody nurses. They often have liaison schemes in place with other health and social care services, and, increasingly, police forces are experimenting with nurse-led provision. However, police custody healthcare is a key stage of the criminal justice pathway where NHS-commissioned healthcare is not routinely available, which can impede an individual's access to NHS services when most needed. Furthermore, quality of police custody healthcare has not been subject to the same governance and performance measures as other NHS services (Bradley 2009), a concern raised in the Corston Report into women with particular vulnerabilities in the criminal justice system (Home Office 2007) and the 2007 Department of Health consultation on Developing an Offender Health and Social Care Strategy (DH 2007).

Under the new arrangements piloted in Dorset, it is anticipated that regional and local criminal justice health and social care partnerships will provide a commissioning context where services are planned and delivered according to need, bringing consistency, integration and quality across the criminal justice 'pathway', and fulfilling detainee and offender rights to appropriate health and social care services. This scenario means that NHS commissioning organizations will develop an expanded strategic leadership role for health

³ Much of the policy, professional and research literature uses the term 'offenders' to describe a person in police custody. However, since the British legal system regards an arrested person as innocent until *proven* otherwise, we use the less ambiguous term, 'detainee' when referring in general terms to people within the criminal justice system.

and social care across criminal justice settings, where they will need to meet the following objectives:

- a) Create 'joined up' health and social care services that enable continuous care and treatment pathways, appropriate access to services and, ultimately, greater efficiency and effectiveness;
- b) Establish an accountability framework, based on a robust system of clinical governance and public service, consistent with the governance requirements of criminal justice sector partners (e.g. the Police and Criminal Evidence Act 1984);
- c) Ensure that criminal justice sector health and social care providers are suitably skilled and resourced to undertake forensic and medico-legal roles, where appropriate, to meet the needs of detainees, of victims and of the legal system; and
- d) Build a more robust system for the management and prevention of avoidable morbidity and mortality associated with detention within the criminal justice system.

These formed the core aims of the Dorset initiative.

Police custody marks a crucial stage in the criminal justice pathway for identifying health and social need and providing access to appropriate treatment, care, diversion and referral. The Bradley Report highlighted that the majority of police custody detainees are subsequently found to have poor mental health, which is sometimes the underlying cause of their detention. Bradley emphasized that the police are therefore uniquely positioned to provide intervention and liaison with health and social care services. However, it was also stressed that this remains the least developed stage of the criminal justice health and social care pathway, in terms of engagement with health and social services, yet it provides the greatest opportunity to effect change through improving access to services for detainees, improving safety for individuals and the public, and providing valuable information to agencies at the later stages of the criminal justice system (Bradley 2009). This is not a view shared universally, as we will see below.

Nonetheless, all police practices and responsibilities within custody suites fall within the stipulations and guidance of the Police and Criminal Evidence Act 1984 (PACE). This guides the police in matters relating to detention, treatment and questioning of suspects. Under PACE, the police are required to provide a clinical response to those presenting with physical and mental health needs, fundamental to risk management and prevention of deaths in custody. If a detainee therefore requires medical attention, it is the responsibility of the custody officer to ensure that healthcare professionals have access to all available information relevant to the detainee's treatment and care (Home Office 2008; Bradley 2009). However, this pilot raises complex questions about how such requirements and responsibilities rest upon relationships between custody officers and resident health professionals.

Commissioning for Criminal Justice Health and Social Care

Police custody healthcare provision is likely to move in a new direction in coming months, as a result of the Bradley Review, the Carter Review of Prisons, the Darzi Report and Commissioning Healthcare in Prisons (Lord Carter of Coles, 2007; Lord Darzi, 2008; Bradley, 2009; Bradshaw, 2009; Healthcare Commission, 2009).

A consistent message from these reports is that measures that improve health and wellbeing of offenders, or of those at risk of offending, can reduce re-offending, inequality and social exclusion. Moreover, health and social care services for detainees should be equivalent to those for the general population and be integrated (part of and not separate from) services available to the general population. It is acknowledged (DH 2007, SEU 2003) that detainees are generally exposed to high levels of social inequality, have unaddressed mental healthcare and learning disability needs, lack access to appropriate primary healthcare and social care services in custody settings, and that this manifests in high levels of re-offending and overcapacity in custody settings. Under this scenario, a system of 'contracting' health and social care across criminal justice settings is likely to be costly, given the range of possible innovations required to achieve these ambitious goals. Through World Class Commissioning, there is potential to release resources that could have positive impact on both health and offending. Lord Carter's Review considered options for improving the balance between the supply and demand of prison places, which not only included expansion of prison capacity, but reforming the approach to sentencing and reviewing the way prisons are structured, managed and organized (Lord Carter of Coles, 2007).

The Healthcare Commission (2009:7) has argued that PCTs can be instrumental in improving the health and wellbeing of people in the criminal justice system, through their responsibilities for prison healthcare, as follows:

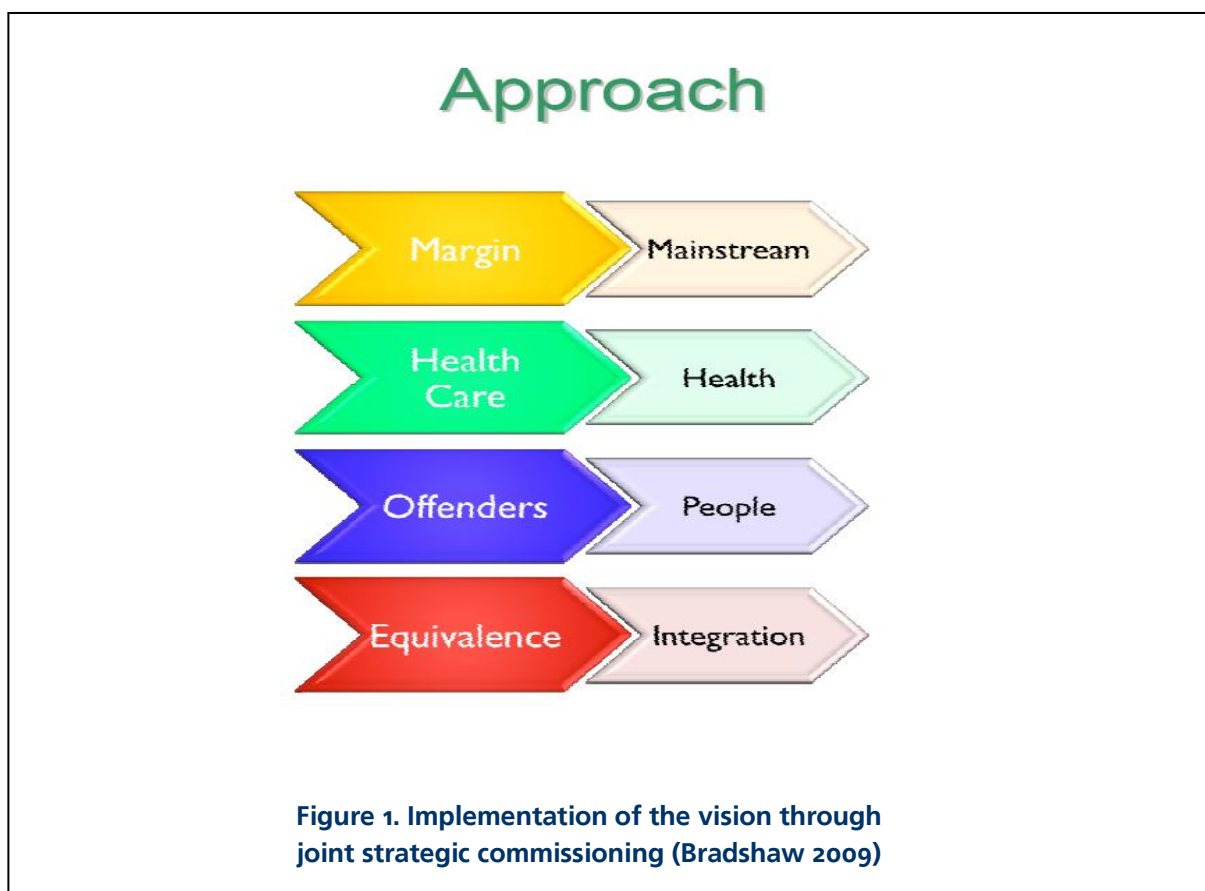
- ensuring prisoners' healthcare needs are regularly assessed and agreed by partnership boards;
- clarifying budgetary resource allocations for prison healthcare;
- measuring prison healthcare performance against wider offender health performance targets;
- promoting use of electronic records to improve clinical audit;
- providing healthcare staff with specific training to address prisoners' healthcare needs;
- improving strategies that ensure prisoners receive equal access to healthcare;
- identifying the needs of BME groups more effectively;
- regularly evaluating prisoners' views on healthcare services to improve effectiveness;
- ensuring prisons implement Integrated Drug Treatment Systems;
- continuing to ensure effective arrangements are in place for transferring and releasing prisoners according to need.

The Bradley Report recommended that PCTs and the Criminal Justice System (CJS) work in partnership to commission services that reduce re-offending and tackle inequalities in settings beyond prisons (Bradley, 2009).

Bradley's key recommendations focus on:-

- early intervention to reduce offending and reoffending;
- better information sharing between agencies across the Criminal Justice system (including GP registration);
- more joined up approach between the Criminal Justice System and the NHS to increase access to primary and secondary healthcare in the community and increase continuity of care;
- creation of a national Health and Criminal Justice Programme Board and a National Advisory Group to implement, through Local Area Agreements (LAAs), Joint Strategic Needs Assessment, commissioning, and sound financial investments (Bradshaw, 2009).

Figure 1, from Bradshaw (2009), summarises the vision arising from this new policy environment.



The Bradley report examined the scope for diverting offenders with mental health needs and learning disabilities from the courts to settings more appropriate than prison. It is anticipated that this will help to reduce the pressure on the prison estate, especially overcrowding, and have a significant impact on re-offending levels. In this regard, World Class Commissioning is viewed as a way of controlling costs that has been implemented for mainstream health provision but can be applied to special settings like custody care (Lord Carter of Coles, 2007; Bradley, 2009; Bradshaw, 2009; Healthcare Commission, 2009). We will take a critical look at World Class Commissioning later.

Police Custody Health and Social Care Provision

Better understanding of the health needs of prisoners, principally through health needs assessment, has led to improved prison healthcare services, based on an NHS commissioned model of planning, delivery, governance and accountability. Following the Bradley Report, this approach is likely to be extended across the criminal justice system (DH 2007; Bradley 2009).

There is limited available evidence on the health and social needs of police custody detainees, yet it is established that around one third of detainees are not registered with a general practitioner and do not therefore have immediate access to primary healthcare services. Additionally, between one quarter and one third of detainees have no fixed abode and only a small proportion of those with drug dependence are engaged with appropriate services (Payne-James et al 2003; 2008). Roberts et al (2005) have suggested significant under-reporting of mental illness in police custody suites, largely because the proportion of detainees examined whilst intoxicated renders mental health assessment difficult or impossible, and this may result in detainees not being appropriately referred for mental health assessment or treatment. Moreover, annual reports from the Independent Police Complaints Authority between 1998 and 2005 showed that approximately half of all deaths in police custody were related to self-injury, alcohol or drugs (Payne-James et al, 2008). It is further suggested that information supplied to the police by detainees through the formal risk assessment process is often incomplete, inaccurate or can even be deliberately misleading (Payne-James et al 2008).

A recent review of health and social care services across the criminal justice system, carried out by the Offender Health Research Network (Rennie et al 2008), established that medical care, provided by Forensic Physicians was not always available to police custody detainees when required, often only available within normal working hours. Secondly, it was reported that up to a third of Forensic Physicians were under-qualified in terms of being skilled to appropriately manage the complex mix of health problems presented by detainees, particularly relating to mental health. This was a concern highlighted by Laing (1996), who established that the specialist training for Forensic Physicians did not include a formal psychiatric component. However, the introductory training for Forensic Physicians, currently provided by the Faculty of Forensic and Legal Medicine, offers a broadly comprehensive syllabus that includes mental health and substance misuse. Wall and Jenkins (2008) have suggested that Forensic Physicians who do not have forensic and legal training are likely to

compromise patient safety by placing detainees at unnecessary risk of adverse events, and may miss crucial forensic evidence required for a fair judicial process. Significantly, around a third of Forensic Physicians do not have this basic level of training (Wall and Jenkins 2008). While there is no firm evidence of the impact this may have on detainee health or on the judicial process, several studies have highlighted the deficiencies of training and regulation within the UK (Rix 1993; Davis 1993; Stark 1994). It has, nonetheless, been emphasized that forensic medical and legal training should become a requirement to guarantee a safe and appropriate level of custody medicine for people with complex health problems (Norfolk 2006; Bradley 2009). Indeed, the BMA (2009) recently published guidance from the BMA Medical Ethics Department and the Faculty of Forensic and Legal Medicine recommending that for forensic practitioners to deliver high quality healthcare, equivalent to NHS best models of practice, training must equip them with skills to practice ethically and appropriately to meet the particular clinical needs of this patient population. Specifically,

“They need a good understanding of the requirements of vulnerable detainees including mentally disturbed offenders and those under the influence of, or dependent on, alcohol or other drugs, who make up a high proportion of detainees.”

A further aim should be “... to protect detainees against human rights abuses and inhuman or degrading treatment or punishment.” (BMA 2009:3).

The Faculty of Forensic and Legal Medicine currently recommends that, in addition to basic medical training, Forensic Physicians should also have specific training in the range of core competencies identified in Box 1.

BOX 1. CORE COMPETENCIES FOR FORENSIC PHYSICIANS (Home Office 2001; FFLM 2007)

- *knowledge of the legal framework governing police powers and procedures;*
- *consent, confidentiality and ethics with particular reference to the custodial setting;*
- *understand the particular requirements relating to the care and custody of individuals regarding fitness to be detained and fitness to be interviewed;*
- *the importance of contemporaneous, comprehensive, clinical note taking, statement and report writing, giving evidence in a confident and precise manner, court procedures including the laws of evidence and the role of the professional and expert witness;*
- *the requirements for obtaining, handling and packaging forensic samples;*
- *a basic understanding of forensic science;*
- *documentation and interpretation of injuries;*
- *a knowledge of police organization and structure;*
- *the role of the doctor in suspicious and sudden deaths;*
- *knowledge of the legal requirements of the doctor in driving offences;*
- *the performance of intimate searches;*
- *mental health assessments;*
- *assessment of substance misuse detainees;*
- *the law relating to sexual offences and the role of the doctor in the examination of complainants and suspects in assault cases; and*
- *the role of the doctor in child protection matters.*

The Revolving Doors Agency has reported that the majority of Forensic Physicians are highly experienced, skilled and committed to their work, and provide an invaluable service for detainees and the police, although the quality of the service remains variable. Their report emphasized, however, that private healthcare contractors used by around half of all police forces in England relied heavily on under-qualified General Practitioners (Kuchinsky 2006).

The employment of nurses in police custody suites has led to a gradual shift in the division of labour and to the reallocation of some traditional Forensic Physician roles to custody nurses. During this period of flux, it must be recognized that nurses and physicians have continued to be employed almost exclusively by independent sector providers, completely detached from the NHS.

Bond et al (2007) and Payne-James et al (2008) independently assessed the operational efficiency of on-site police custody nursing services, and established that nurses commonly performed important screening and triage functions in terms of prioritising the clinical needs of detainees, usually more efficiently than on-call physicians. Nurses were also perceived by custody staff to be more approachable than physicians, particularly because they were on-site to continuously share relevant information about detainees. Police custody nursing, like prison nursing, is an emerging specialism within the wider NHS context, but it has no agreed professional benchmark that identifies specialist skills and competencies (Gannon, 2002). What remains unclear is whether custody nurses should be specialists or generalists, on the one hand operating predominantly as liaison and referral agents or, on the other, as forensic specialists (Bond and Kingston 2004; Bond et al 2007). Roberts et al (2006) and Gannon (2002) have recommended that custody suites employ nurses with a mix of specialist backgrounds and experience, to enable custody healthcare teams to respond effectively to the variety of health and social care needs of detainees.

Delineation of roles between Forensic Physicians and the custody nurses remains a contested issue, though there is a case for maintaining both professional groups within the custody arena. Controversy surrounds the degree to which nurses take on forensic and medico-legal responsibilities – whether indeed there is a case to be made for a *Forensic Practitioner* role and how this then impacts in terms of training and differential pay and status. This may be resolved with the introduction of a graduate-entry profession for nursing. The Audit Commission (1998) has distinguished between forensic and non-forensic work within custody suites, with forensic work making up about 15% of the workload of which around two-thirds involves examinations relating to fitness for detention or interview. It recommended that consideration be given to some Forensic Physician work being undertaken by other health professionals, such as paramedics or nurses, which could resolve the issue of shortage of doctors to undertake the role, reduce costs to the police, and enable Forensic Physicians to focus more on the forensic aspects of the work (Audit Commission 1998). Amendments were made to the PACE Codes of Practice in 2003 to enable appropriate health professionals – principally nurses and paramedics – to work alongside Forensic Physicians. Local protocols are required to clarify the relative roles of different health professionals and the levels of responsibility of different members of the health care team (BMA 2009). The Home Office has provided guidance on appropriate procedures/duties to be undertaken by healthcare professionals in the custody environment (Home Office 2001). This guidance emphasises the

importance of health professionals receiving appropriate training before undertaking tasks that fall outside the usual sphere of practice for their profession. Furthermore, the BMA and Faculty of Forensic and Legal Medicine support the need for adequate and appropriate training before other health professionals share the range of tasks previously undertaken by Forensic Physicians. They state that there are certain tasks that should remain within the domain of a registered medical practitioner, such as caring for detained prisoners with significant physical disease or undertaking a full assessment of mental health state. Issues such as safety and legal liability need to be fully explored (BMA 2009).

In this regard, Payne-James et al (2008) and Bond et al (2007) have discussed the issue of competence in relation to other healthcare professionals taking on forensic roles without basic forensic medical training, arguing that they are likely to be ill equipped to competently examine, diagnose and manage detainees with complex physical and mental health needs. Bond et al (2007) suggest that professional roles should be more clearly defined along with lines of accountability and appropriate chains of command within the multidisciplinary clinical teams. Payne-James et al (2008) recommend, moreover, that 'non forensic' general health assessments should be carried out by properly trained and qualified healthcare professionals.

The Sainsbury Centre for Mental Health (2008) suggests that future involvement of the NHS in the provision of police custody health services would enable more effective and equitable access to health care, through partnership working, and increase the opportunity for effective diversion to services in the community. There are clearly concerns about the variable quality of custody healthcare services and the lack of integration of forensic medical and custody nursing services with NHS, social care and Third sector providers (DH 2007; Rennie et al 2008). Bradley (2009) has stressed the potential benefits of working towards an integrated criminal justice health and social care pathway model, where police custody plays a pivotal role in assessment, liaison and diversion of detainees with health and social needs.

Regional and Local Context

The South West region was a good candidate for a national pilot. It has strong and established partnership arrangements between health and criminal justice agencies. These are coordinated through the South West Offender Health and Well Being Board, which has representation from the South West Strategic Health Authority, the regional team of the National Offender Management Service, Government Office South West (Department of Health), the region's police, probation and prison services, and a range of local strategic partnerships and Third Sector organizations. This partnership structure reflects the core national philosophy and objectives for developing criminal justice health and social care, as outlined in *Improving Health, Supporting Justice*, where the overall goal is to address health inequalities and reduce offending, by maximising opportunities provided by better integration of health, social care and criminal justice systems (DH 2007). From a regional perspective, therefore, this pilot is an attempt to meet two linked objectives – to improve health and to reduce reoffending.

One stakeholder interviewed for the pilot said:

“Why do we bother with custody diversion schemes and mental health diversions schemes? Because we have captured these people for a short time and it allows other agencies to come into contact with them at a time when we have great influence over them ... I see our role as not just pushing them through the system but engaging with that wider agenda, with other agencies, and the NHS plays a key, key role in that ... It’s not just about giving someone their methadone to stop them crawling up the walls so we can interview them.”

The South West Regional Delivery Plan for Offender Health and Wellbeing (GOSW 2008) has the following objectives:

- *improve access to health services for detainees with mental health, physical health or substance misuse needs, through partnership working with local organizations and communities;*
- *support the implementation of the National Service Frameworks, the NHS Plan, Social Exclusion Unit recommendations, and other related policy guidance across the criminal justice system.*
- *contribute to reducing re-offending within the region;*
- *improve the quality of commissioning processes for detainees and offenders;*
- *enable service developments to be informed by local experience and stakeholder participation;*
- *monitor and review progress in service development, targets and milestones, and assist local partnerships to achieve these;*
- *develop the use of Prison Health Performance Indicators (PHPIs) and support service improvement issues arising from these; and*
- *support research and development activities, encouraging the South West to lead national practice in key developmental areas.*

The decision to introduce NHS commissioning to the Dorset police custody health service was endorsed nationally by the Department of Health (Offender Health), the Home Office Police Leadership and Powers Unit, the South West Strategic Health Authority (NHS South West) and the former Care Services Improvement Partnership, South West (South West Development Agency), with the intention that the service would operate as a pilot to inform developments at national level. Dorset was selected from among fourteen PCTs within the South West region, of which seven have experience of commissioning offender health services.

The current partnership between Dorset Police and NHS Dorset has two levels:

- (1) It is governed by a Police Healthcare Services Partnership Board, whose membership comprises senior level representatives from NHS Bournemouth & Poole, the South West Criminal Justice Team, Dorset Police, NHS Dorset, Dorset Health-Care NHS Foundation Trust, Independent Custody Visitors, the Youth Offending Team, Dorset Race Equality Council and the Local Authority. Essentially, the Partnership Board oversees the progress of an Operational Group, monitoring its performance against service evaluations, ensuring compliance with appropriate clinical and

corporate governance frameworks, facilitating partnership working between the Police, the PCT and other key stakeholders, and ensuring other agencies and institutions are able to function in an integrated way.

- (2) The Operational Group, represented by Dorset Police, NHS Dorset, Dorset HealthCare NHS Foundation Trust, the independent provider, South West Ambulance Service, and Social Services, is responsible for managing the implementation of the police custody healthcare service in accordance with the service specification, and reports regularly to the Partnership Board.

In the longer term, it is envisaged that the Partnership Board will have a more strategic function in developing jointly commissioned health and social care services across all sectors of the criminal justice system, involving police, courts and prisons, via Local Area Agreements. It is envisaged that this will lead to improvements in liaison and diversion, training and workforce development, and more equitable access to services for socially excluded individuals with complex needs (Dorset PCT 2007).

At the operational level, Dorset has three 24 hour custody suites, situated in Weymouth, Poole and Bournemouth, nine part time custody suites, a further five local police stations and four victim suites. In 2006, there were approximately 10,000 requests by custody officers for healthcare attendances. Prior to 2006, police custody healthcare for the Dorset Police area was outsourced to an independent provider, Veritas. This arrangement ceased when it was determined that the provider could no longer deliver an effective service⁴. Dorset Police then entered into negotiations with Dorset Primary Care Trust to consider developing an NHS commissioned service in partnership with the police. A second independent provider, Solutions for Health, later to become For Health, was contracted to provide forensic medical and nursing cover from January 2007 to June 2008. This was a direct service arrangement between Dorset Police and Solutions for Health “based”, say the PCT, on “response times”. Commissioning to a new specification, including 24-hour cover, commenced on July 1st 2008. The Partnership Agreement stipulated provision of a 24 hour, 7 day nursing service with on-call Forensic Physician support for the three 24 hour custody suites, with the aspiration to have a tele-link system to support the 16 outlying police stations across the county. During 2009, Harmoni For Health replaced For Health, a new company borne out of the previous company. The current contract is priced at £79,326.00 per calendar month (for 2009-10).

The full NHS contract between NHS Dorset and the independent provider at the start of the evaluation stipulated, in a comprehensive way, the contractual responsibilities of the provider in terms of meeting the full range of requirements, competencies and responsibilities as a forensic healthcare service. In summary, the provider is required to work collaboratively with local NHS partners to deliver a service that:

- *provides seamless healthcare for detainees, offenders and victims of crime by integrating health and offender services;*
- *carries out collection of forensic samples from suspects and/or victims of crime under the direction of Dorset Police, ensuring a prompt response to requests;*

⁴ Dorset Police Authority Independent Custody Visiting Panel minutes, 29th January 2007

- *is provided by Healthcare Practitioners who comprise accredited doctors and nurses with appropriate further training and skills;*
- *realises the efficiency gains from effective integration;*
- *increases the number of referrals to intervention schemes and initiatives, which may result in a reduction of re-offending rates and “revolving door offenders”;* and
- *maximises NHS potential benefits from pre-established governance, training and IT structures as well as nationally recognised experience and achievements by NHS Dorset in offender healthcare.*

(NHS Dorset 2007: section 2.3)

At the time of the evaluation, the provider employed a Nurse Manager, nine Registered Nurses and two Forensic Medical Examiners (FMEs) to provide Dorset Police’s custody healthcare service. The nurses had already taken on many of the conventional clinical roles and responsibilities of Forensic Physicians, and were performing an important management and triage function within the custody suites – at recruitment they were anticipated to operate at the level expected of Band 7 nurses⁵. The two FMEs were independently contracted (self-employed) to provide an on-call service and were required to provide immediate medical support or oversight at the suites. The custody nurses, based within the custody suites, mainly sought support, advice and technical assistance from the off-site nurse manager, although they could speak to the FMEs if they felt that more appropriate.

⁵ Home Office guidance on *The Safer Detention and Handling of Persons in Police Custody* (2006) is specific about the qualifications required: “a registered nurse with a minimum of 2988 Whitley Grade G level”, which is referenced in the Partnership Agreement between NHS Dorset and Dorset Police.

3. WHAT THE EVALUATION FOUND

Introduction

The evaluation took place in two phases. The first phase, up to December 2008, involved direct observation at two of the custody suites (Bournemouth and Weymouth) and at the PCT. The custody suite visits involved prolonged periods of observation over several hours (night and day, mid-week and at weekends) and interviews with personnel on site (including custody sergeants, detention officers, custody nurses, Forensic Physicians and duty solicitors). Fieldwork also involved interviews with key stakeholders at the PCT and observation at partnership board meetings. All commissioning and partnership documentation relating to the project, including minutes of meetings, the partnership agreement, the contract with Solutions for Health, and other relevant documentation, were sought for secondary analysis.

Phase Two of the evaluation, which took place subsequent to presentation of the interim findings, involved follow-up, sometimes repeat interviews with key participants and repeat visits to the sites, and telephone interviews were conducted with community-based services. The main purpose here was to clarify discrepancies, to fill gaps in our perceptions as evaluators, respond appropriately to feedback and follow up on leads or themes emerging from responses to the Interim Report – i.e. the generate second-order data. While our earlier attention – in seeking to understand the context, culture and practice of police custody healthcare – had been primarily focused on the nature and quality of the healthcare service outsourced to the provider, in Phase Two the evaluation was focused on the commissioning relationship, this being the principal objective of the evaluation. A further element to Phase 2 involved the development of alternative scenarios for commissioning.

A range of key issues and themes emerged throughout this process. Our earlier findings, which are integrated into this report along with more recent findings, were presented to a partnership board consultation meeting on 12th February 2009. This meeting was convened to enable participants to discuss the key issues that had arisen from the first phase of fieldwork. This partnership board consultation meeting provided an opportunity to explore with stakeholders areas of uncertainty or contention, and enabled us to agree an evaluation focus.

A range of questions emerged for the evaluation team during the course of the fieldwork, which we pursued through further questioning and observation and which fall broadly under the categories 'accountability', 'purpose', 'detainee status' and 'professional culture' (see Table 1). These questions reflect the variety of value positions among participants, different levels of responsibility and involvement, and the complexity and multi-dimensional nature of the commissioning relationship.

TABLE 1. KEY QUESTIONS THAT EMERGED FROM THE PHASE 1 FIELDWORK

ACCOUNTABILITY	PURPOSE	DETAINEE STATUS	PROFESSIONAL CULTURE
<p>What is appropriate commissioning?</p> <p>What constitutes ethical commissioning?</p> <p>What is safe and humane commissioning?</p> <p>What influence do health professionals have in this non-health environment?</p> <p>Do stakeholders share a clear value position regarding healthcare provision?</p> <p>What is the potential for effective partnerships?</p> <p>Is clinical leadership & governance possible / present?</p> <p>How do the public and private sectors relate to one another?</p> <p>How is the nature of the contractual relationship or service specification?</p>	<p>What are the core values of respective partners?</p> <p>What are respective partners' service objectives?</p> <p>Do partners share common aims and objectives for the service?</p> <p>What are perceived to be the commissioning outcomes?</p> <p>What are realistic or expected deliverables?</p> <p>What is the funding stream and does this imply a sense of 'ownership'?</p> <p>What are the provider's roles and responsibilities?</p> <p>What are the health or clinical outcomes of the service?</p> <p>Who benefits from this innovation?</p>	<p>Is the service equivalent to services provided within the NHS?</p> <p>What rights do detainees have as patients?</p> <p>Can the detainee have patient or client status?</p> <p>Can healthcare providers be effective patient advocates?</p> <p>What measures exist for user involvement / patient liaison?</p> <p>Are the decency and respect agendas of the prison service a consideration for police custody?</p>	<p>What are appropriate practitioner skills or competencies?</p> <p>Is it feasible or appropriate to provide comprehensive health and social care provision?</p> <p>Can professionals be accountable for their professional practice?</p> <p>Is effective healthcare management possible in this setting?</p> <p>Are there appropriate conditions of employment for healthcare staff?</p> <p>Are workplace conditions safe and appropriate for providing healthcare?</p> <p>Are custody suites adequately staffed</p> <p>Is there a strategy or scope for professional and workforce development?</p> <p>Is integration with the NHS possible or desirable?</p> <p>Is it possible for health professionals to make effective healthcare decisions?</p> <p>Can multi-disciplinarity in healthcare be achieved and is it desirable?</p> <p>Is there a sense of synergy with other sectors?</p>

During the evaluation, innovations were regularly introduced, partly resulting from our observations but mainly through the continuous dialogue between strategic and operational level players. The findings are presented under headings: 'Purpose and Function of the Commissioning Partnership', 'Professional Roles and Status', and 'Capacity and Capabilities'.

Purpose & Function of the Commissioning Partnership

As explained, the partnership agreement was organized through two main tiers of decision making, the strategically focused Partnership Board and the Operational Group to which it reported at regular intervals on developments and performance at the custody suites. The Partnership Board provided the forum for PCT and Police senior colleagues to discuss and oversee the development of the project.

The Partnership Relationship

According to the Department of Health, effective partnerships depend upon good formal and informal working relations, based on trust, reciprocity and shared responsibility, whilst respecting differences (DH et al 2007). To facilitate this, the Department of Health recommends that partnership building should focus on:

- *building trust and a mutual respect for each other's roles and responsibilities;*
- *being open, honest and transparent in all communications;*
- *harnessing senior level commitment to the relationship;*
- *sharing a positive and constructive outlook and approach;*
- *being prepared to work with and learn from each other;*
- *engaging early on in, and maintaining, discussion of emerging issues, policies and priorities;*
- *being collectively committed to achieving high quality outcomes;*
- *agreeing, where appropriate, confidentiality boundaries and agreed external positions;*
- *making best use of available resources; and*
- *ensuring a "no surprises" culture.*

Longer term benefits from partnership working are then expected to accrue, including improved services; improved cross sector / inter-professional understanding; the sharing of different experiences and ideas; wider consideration of implications on workforce development; more effective and meaningful policy implementation; better employment practices; and more transparent and streamlined structures (DH 2007).

However, the now extensive research literature on service integration and multi-agency action points to more complex issues underlying partnerships and which require a more robust approach than the implication in the above recommendations for relationships moderated through leadership. The research literature suggests more structural challenges, including:

- *competing accountability systems and tolerances for autonomous practitioner action;*
- *distinct and sometimes competing budgetary/resource allocation processes;*
- *overlapping but distinct bodies of professional knowledge and principles;*
- *different systems of judgment and assessment within diverse timelines;*
- *distinct forms of management and leadership;*
- *professional cultures that conceptualise the individual (citizen) in different ways.*

These levels of complexity were revealed in this evaluation. For example, it emerged that the success of the service hung on the relationships between individual health professionals, particularly custody nurses and their relations with custody sergeants and other police personnel. Likewise, a key dimension in terms of achieving strategic agreement on the quality and scope of the service would seem to be the degree of alignment between NHS clinical governance and the regulatory framework of PACE.

As in all service integration (multi-agency) projects, the heart of the challenge lies in the reconciliation of different professional cultures. Here, the situation involves a number of different cultures converging around the detainee – the NHS, the Police, the nursing profession, the medical profession and a private business. Each views the detainee in distinct ways. The reconciliation of professional cultures has been extensively debated. Hall (2005) points out that each profession's culture, based upon its respective values, beliefs, attitudes, customs and behaviours, is sustained through a socialisation process intended to reinforce the common values and ideology of the profession. Understanding a profession's culture can therefore help to develop effective interprofessional relationships. In the case of Dorset, it was felt that the process of cultural convergence would be protracted:

"it's going to take time. There are two large organizations trying to sort things and a lot of committees to sit through. The pace is how I would expect it to be. It is a process of cultural change for both organizations. The Police have to learn to understand the NHS and the NHS has to learn to understand the Police. The private provider is stuck in the middle and has to please both parties!"

For example, the traditional model for police custody health services, based on outsourcing to independent contractors or consultants, perpetuates a model of service where the healthcare specialist is brought into the custody setting to provide clinical judgments on individuals referred to them. The healthcare provider is then an invited guest into what is essentially the territory of the police. This makes it difficult to envisage custody environments as healthcare settings or to build a professional culture of shared values between health and police staff.

Commissioning or Contracting?

The Home Office and the Department of Health share a common value position regarding the status and management of detainees and offenders: the cost of social provision within society needs to be greatly reduced, and this is probably best achieved by tackling social exclusion and reducing inequalities. This value position is evident in the strategy for World Class Commissioning (DH 2007), which requires that NHS organizations work with other key

agencies to build effective services for those with greatest need; people entering the criminal justice system (particularly young offenders) are identified as one of the most vulnerable and needy groups in society – but which also reduce the cost of social service provision. Commissioning, in this sense, is both an economic and legal tool, and a system for ensuring that services are ethical, equitable, safe and humane. It also provides the conditions for workforce development, clinical leadership, and governance.

As with all social innovations, the Dorset model fulfils the aspirations of different stakeholders in different ways, and therefore the service will continue to be defined and interpreted differentially. Indeed, interviews with stakeholders revealed variation in perceptions of the purpose of a custody healthcare service, of commissioning, and of the values that underpin the innovation. To some extent, this reflects the relatively recent emergence of a ‘commissioning culture’ within public sector organizations.

When asked about the purpose of commissioning, stakeholders provided a range of interpretations. In summary, perceptions were that commissioning should provide the conditions to:

- *facilitate robust clinical governance and quality assurance of the service;*
- *cement accountability among key players and partners;*
- *evolve an effective custody nursing service;*
- *create health and social need oriented services for people in the criminal justice system;*
- *build services that tackle social exclusion and inequality;*
- *work consistently with criminal justice partners to reduce (re)offending;*
- *create integrated ('offender pathway') health and social care provision;*
- *develop an inter-disciplinary, multi-agency culture of health and social care provision;*
- *build partnerships with other commissioning and provider organizations;*
- *deliver 'offender' health and social care policy.*

While these indicate strategic aspirations, when asked about the purpose of the custody healthcare service, perceptions were variable:

- *to prevent custody deaths and custody related morbidity ("harm reduction");*
- *for acute (reactive and responsive) treatment and referral;*
- *provide safety under Section 136 of the Mental Health Act;*
- *primary and secondary healthcare provision;*
- *a "health service" - more than a custody nursing or forensic medical service;*
- *confer 'patient rights' through a user / needs led approach;*
- *public health function, to reduce inequalities (prevention, promotion, protection).*

A stakeholder suggested that *"... the ideal would be to have nurses available 24/7 with all the agencies in one place so people don't need to traipse round separate agencies."* Such a viewpoint suggests something more ambitious than a custody nursing service. The current NHS contract between NHS Dorset and the independent provider does however state unequivocally that the police custody healthcare service will *"provide seamless healthcare for detainees, offenders and victims of crime by integrating health and offender services"*; in addition, it will provide an efficient forensic service *"under the direction of Dorset Police"*, be

provided by accredited doctors and nurses with appropriate training and skills, and operate in an integrated way, maximising referrals with the aim of reducing the numbers of “revolving door offenders” (Dorset PCT 2007: 2.3.1-2.3.5). This broad purpose was evidently not reflected in the views of many operational level professionals.

Interestingly, one year on from the start of the evaluation, the view of the PCT commissioner had altered, from the position that a full health service should be delivered within custody suites to the position that detainees should be comprehensively assessed on entering custody, and appropriately referred on. This change of viewpoint was reached through ongoing discussion with the police about the purpose of custody.

“I realise now that, because of the time they spend in custody, we can’t expect to provide a prison-like health service. We need to do a really good assessment of their health needs. The assessment must be robust enough to pick up any needs and refer them to the NHS. I have changed my mind ... I don’t think we need to see everyone who attends a custody suite.”

On the whole, mixed perspectives among stakeholders regarding commissioning and the purpose of the service, reflected their different professional ‘locations’. Those who worked at the operational level of the custody suites placed quite clear limits on the nursing function – primarily as a resource to *support* the police. Among these, there was variation in the perceived scale and scope of provision, some viewing it as limited to a basic outsourced function, using nurses and Forensic Physicians employed on a sub-contractual (‘agency’, ‘locum’ or ‘on-call’) basis, while others perceived the service developing more as a mixed team function and identity. More strategically located individuals tended to perceive the development of provision in terms of the wider criminal justice health and social care agenda, with nurse-led provision being the preferred model against the more traditional outsourced specialist FME approach. There was evidently a concern among all stakeholders to develop the clinical skills and competencies of custody nurses, whilst maintaining the Forensic Physician role as a medical specialism – and to develop their professional skills. Although there is commitment within the contract to guarantee a standard of training for all healthcare staff working with detainees, the level and nature of this training is not specified. The custody healthcare workforce clearly needs to develop in such a way as to balance different professional, ethical, clinical and legal requirements, but whether this is achieved via employment of specialists, generalists or via a mixed team approach offering a more comprehensive health and social care service is to be determined in context.

Governance, Accountability and World Class Commissioning

The prevailing belief, certainly at national government level and evident within the Bradley Report, is that an NHS-Police partnership provides great potential for integration and innovation, with NHS commissioning organizations providing access to good quality - or World Class Commissioned - health and social care services, based on recognised NHS standards, practices and procedures, and tied into a professional and workforce development culture and a well-established clinical governance framework.

Through talking to stakeholders, at strategic and operational levels, it became clear that

people believed that the purpose of the new NHS-Police partnership was to establish a clear system of governance, which was essentially interpreted as a management structure with clear lines of accountability, based on a current policy framework. A commissioned healthcare service with a contractual set of obligations provided the mechanism for this to happen. The benefits of an NHS-commissioned police custody healthcare service were summed up in terms such as “clearer focus”, “transparency”, “proper clinical governance” and “accountability”, and there were references to improved and more competent forensic and legal provision. From a regional perspective, an objective for the Dorset pilot was to explore alternatives to private provision.

Previous experience of managing health services across a broad spectrum was recognised as a valuable prerequisite, especially NHS Dorset’s involvement in successfully commissioning local prison healthcare services, having been one of the ‘first wave’ PCTs to achieve this in 2005. From a commissioning point of view, as expressed by senior level decision makers in the PCT and with the strategic health authority, an integrated NHS-commissioned service would arguably make effective management of detainees’ and offenders’ often complex health and social problems more feasible, with better joining up of services across the offender management pathway. In this respect, senior level stakeholders viewed the project as contributing to the wider ‘offender health’ strategy.

Tables 2 and 3 provide an analysis of the contractual relationship between NHS Dorset and the independent provider, given the requirements of World Class Commissioning (DH 2008). In general, it would appear from the contract that there was a strong commitment, on the part of NHS Dorset, to underwrite the relationship between commissioner and provider with World Class Commissioning principles and objectives. In Table 2 we have attempted to crudely map key statements within the contract against World Class Commissioning goals.

However, contracts are relatively inflexible instruments designed, not to broker consensus, but to outsource and minimize risk for the organization while controlling costs. The aspirational set of values represented in WCC are inevitably mediated and adapted in the realities of commissioning – as we see in Table 3.

TABLE 2. ANALYSIS OF THE CONTRACTUAL RELATIONSHIP BETWEEN THE COMMISSIONING PCT AND THE INDEPENDENT PROVIDER	
<i>World Class Commissioning stipulates that commissioning relationships should ...</i>	<i>The contract between NHS Dorset and the independent provider revealed ...</i>
<i>“reflect vision, long term planning and change”</i>	<p>Commitment to [1] “seamless healthcare for detainees, offenders and victims of crime by integrating health and offender services”; [2] realising “efficiency gains from effective integration with the NHS”; [3] increasing referrals to intervention schemes and initiatives, which may help reduce re-offending rates and the ‘revolving door’ effect; [4] maximising benefits of NHS governance, training and IT systems; [5] building on prison healthcare commissioning experience. (2.3)</p> <p>“NHS Dorset will act as an enabling organization to ensure the provision of high quality services from a range of partner organizations and deliver a seamless healthcare service to Dorset Police. The value to Dorset Police of a single local enabling organization is to avoid the complexity of multiple arrangements with different NHS bodies and produce a service fit for purpose.” (3.6)</p> <p>“The provision of a custody healthcare service integrated with local NHS mental health and community services, social care and voluntary sector is expected to reduce re-offending and improve health.” (5.10)</p> <p>A question remains as to whether a contractual – economic – relationship is the appropriate means of achieving long-term commitment to a developmental (i.e. inherently open-ended) process.</p>
<i>“recognise the community interest”</i>	<p>Commitment to integrated healthcare across agencies, to ensure that people with healthcare issues are actively linked to local NHS, social care and voluntary sector support and treatment. (1.3)</p> <p>‘Community interest’ is non-specific and incapable of being verified. Even if it were clear which ‘community’ was referred to at any one time, all communities are characterized by plural and diverse interests.</p>
<i>“provide clarity on commitments that need to be made to stakeholders”</i>	<p>Extensively explained in sections 1 and 2. Most specifically, it is stipulated that the purpose of the service is to:</p> <p>“Equip commissioners, providers and practitioners with necessary knowledge and skills, service and implementation details to effectively deliver an innovative service providing healthcare advice, assessment and treatment where appropriate to detainees and victims of crimes, police officers and police staff.” (1.1)</p> <p>“Ensure Healthcare Practitioners have the necessary training and guidance to efficiently and effectively support Dorset Police in the investigation of crime with the collection of forensic samples and examinations of detainees and victims of crime. (1.2)</p> <p>In any event, some ‘commitments’ in a development process cannot be pre-specified and it may be unfair to impose this criterion on both commissioner and provider.</p>

<p><i>WCC stipulates commissioning relationships should ...</i></p>	<p><i>The contract revealed ...</i></p>
<p><i>"clarify and define respective roles and responsibilities"</i></p>	<p>Healthcare, forensic and legal responsibilities are detailed but roles are defined using general terminology, as follows:</p> <p>"Carry out the collection of forensic samples from suspects and or victims of crime under the direction of Dorset Police, ensuring a prompt response to requests." (2.3.2)</p> <p>"Be provided by Healthcare Practitioners comprising accredited doctors and nurses with appropriate further training and skills." (2.3.3)</p> <p>"The service will be provided by healthcare professionals with appropriate skills and training to carry out the required duties." (5.7)</p>
<p><i>"recognise that open information is required to manage the contract"</i></p>	<p>"All service developments will be discussed and agreed in conjunction with the Police Healthcare Partnership Board." (25.1)</p> <p>"The healthcare in custody service will fall within the comprehensive integrated governance arrangements for NHS Dorset [which] ... include: Quarterly reports through NHS Dorset clinical governance system to NHS Dorset Board. These reports will be simultaneously shared with the Dorset Police Authority." (19.1)</p> <p>'Open information' is non-specific: 'open' to whom? What constitutes 'open'?</p>
<p><i>"underpin a relationship between equals"</i></p>	<p>"A nominated Director from NHS Dorset will have overall responsibility for the service." (8.1)</p> <p>"The following appointees will provide professional supervision and leadership for the healthcare team. These senior appointments will be made in consultation with Dorset Police: Forensic Physician, Project Manager, Clinical Manager, Mental Health Adviser." (8.1-8.2)</p> <p>"The lead professionals ... will form an education and training committee for the service. As well as determining foundation training for new staff, the education and training committee will develop arrangements for joint multi-professional and multi-disciplinary training programmes. These will include protected time for case and scenario reviews, clinical supervision and six monthly updates for healthcare/custody staff taking advantage of e-learning opportunities." (20.3)</p> <p>'Equals' in what sense? These are diverse and heterogeneous systems where there is no symmetry of risk, vulnerability, responsibility, remuneration, accountability or power.</p>

<p><i>WCC stipulates commissioning relationships should ...</i></p>	<p><i>The contract revealed ...</i></p>
<p><i>“understand mutual dependency and benefit of the parties in aiming for a partnership approach”</i></p>	<p>“Joint working between Dorset Police, NHS Dorset and partner NHS, social care and voluntary organizations is critical to achieving the service objectives and intended health outcomes.” (5.1)</p> <p>“Mutual dependency’ has a cogent meaning in relation to Commissioning. There was, throughout, a strong sense of ‘we are all in this together’.</p>
<p><i>“support co-operation and collaborative behaviours that benefit all parties and cement the positive relationship between them”</i></p>	<p>This is covered under Section 16, ‘Care Pathways and Treatment Protocols’, where it is stated that “the service will require healthcare professionals to use and follow care pathways based upon national and local best practice and guidance issued by expert advisory committees” ... and “healthcare Practitioners will also adhere to policies and procedures developed by Dorset Police.”</p> <p>‘Positive relationship’ is an aspirational term. It is an accomplishment of a successful partnership process (sometimes achieved in Dorset) but cannot be specified as a goal – much less, as a performance indicator.</p>
<p><i>“be based on terms that are deliverable in practice.”</i></p>	<p>Section 23 states that regular performance monitoring arrangements will be developed, including response time audits, Interim and annual review and reporting, patient and staff experience evaluation, and value for money analysis.</p>

TABLE 3. SERVICE OBJECTIVES REQUIRED UNDER WORD CLASS COMMISSIONING PLOTTED AGAINST THE DORSET PILOT	
Objectives	The Dorset pilot reveals ...
<i>"find and support win-win solutions"</i>	All three parties worked hard to support win-win solutions the realities proved more complex and seemed to always involve 'winners' and 'losers'. Both the provider and NHS Dorset verbally evidenced that they were providing the service at a loss. In all cases it was the detainee's health while in custody that was kept in mind.
<i>"appropriately share risks and benefits accrued through mutual effort"</i>	Certain risks have to be accepted by certain stakeholders and during the evaluation the parties worked together to reduce risk wherever possible. However, the reality of commissioning involves the outsourcing of risk. It is not clear which benefits are to be 'shared'. Commercial contracting involves financial benefit to shareholders as a result of the efforts of all, though these cannot be shared.
<i>"maintain mature, regular dialogue within a professional code of conduct"</i>	'Mature' is a non-operational term with no direct referent in contractual relationships, and 'professional code of conduct' is non-specific and with no purchase on accountability. Dialogue, however – in the sense of symmetrical exchange and conversation - was achieved, including when there were awkward issues to be dealt with.
<i>"ensure flexibility where genuine problems arise in delivery"</i>	Contracts are, in their nature, 'inflexible' instruments – i.e. to ensure meeting minimum expectations under threat of penalties. However, Dorset partners sought and achieved non-contractual (e.g. negotiated) solutions to problems through partnership relationships.
<i>"provide performance incentives as well as penalties"</i>	Contractual incentives focused on financial benefit and further contracting (although individual practitioners aspire to professional quality as the primary incentive)
<i>"recognise realistic investment required to achieve goals over a reasonable time frame"</i>	'Realistic' is non-operational and non-specific. In contracting services there is a danger that a 'ceiling figure' becomes a 'floor'. It became clear by the end of the evaluation that the budget will not maintain the service as it stands, let alone as what it aspires to be. A change and development agenda might not be predictable at the contracting stage and may lead to the Provider <i>"being asked to undertake new tasks which have implications on resources and for which there is no proposed reimbursement"</i> .
<i>"support contracted provider to modify the service over time to respond to changes in patient need/demand"</i>	The provider seemed open to changes in service and cooperative and NHS Dorset did what they thought they could to help with this. Though progress was slower than some stakeholders would have liked. In any event, a contract with minimum specifications is not an ideal instrument for the implied flexibility in this requirement.
<i>"maintain honesty and transparency, with partners, with service users and with the public"</i>	'Honesty' and 'transparency' are moral expectations and not operational criteria – and in any event might sometimes be in tension with each other. For example, they are not always commercially viable where confidentiality may be essential to maintain market edge and competitive integrity. Where commissioning relies on commercial principles and practices a more nuanced and pragmatic approach to ethics may be required.

World Class Commissioning is a set of criteria for commercial contracting of services. Many of the criteria identified in tables 2 and 3 are aspirational, with limited purchase on the realities of commissioning challenges, some incapable of being operationalised within an accountability framework. In the light of the Dorset experience, a number of these terms reflect moral stipulations rather than performance criteria and would benefit from a more nuanced and pragmatic understanding of the challenges.

The existing partnership agreement between NHS Dorset and Dorset Police commenced in July 2008 to run for three years in the first instance, subject to satisfactory quarterly reviews. Thereafter there was the option to extend for a further two years in annual increments, giving a potential five years in total. This has resulted in the development of what appears to be a progressive contractual relationship with the provider, which has been renewed on an regular basis, but should issued for competitive tender at the beginning of 2010.

There was a view, particularly among the Police, that a partnership agreement represented more than a contractual relationship –

“It feels a lot like a contract, but there’s a lot of aspirational stuff in there that’s been quite difficult for us to deal with ... We’re used to a service contract which states that this is what you’re going to get for your money.”

There was some concern that the partnership agreement raised expectations of an evolving, developmental and strategic process (consistent with the wider ‘offender health’ strategy), whereas a short-term renewable contractual relationship with a single independent provider could limit what was feasible in the longer term. The use of a contract establishes an economic relationship, which is not an ideal vehicle for service values. There was some tension throughout this pilot between the anxiety of the independent provider to focus on basic logistical demands in the contract, and the hopes of the PCT to enter into a developmental, even exploratory, process. The question is the appropriateness of a contractual relationship for a values-driven service.

Thus a contractual relationship of this kind can be effective in achieving short term targets but may be less effective in delivering longer term development goals – i.e. goals that cannot be pre-specified. So while the current arrangement specifies many deliverables, efforts to meet performance targets may supersede the broader strategic agenda. A provider’s obligation – in general terms, to shareholders – is to meet immediate service specifications, essentially as a platform for tendering for future contract opportunities.

Working with the Independent Sector

A “mixed economy” approach of working with independent sector providers is increasingly recognized as an option for NHS commissioners, seen as a way of bringing greater independence and competition to services. The Partnership Board’s original intention was to continue to outsource to the provider until 31st March 2009 and then consider developing a more closely linked and integrated NHS-led service. However, given the work achieved with the provider in developing the service, the Board decided the existing relationship should continue. There were two additional reasons for this decision. Firstly, during the early part of 2009, NHS Dorset was restructured, splitting the commissioning and provider functions. It was therefore considered prudent to maintain the status quo at a time of flux and instability within the PCT. Extending the contract with what was considered preferable, especially in allaying fears the police may have had over the potential changes to the service. Secondly, these changes evidently created an unstable managerial environment within the PCT at the time, with what was felt to be uncertain commitment towards developing the local offender health strategy. This came with a restructure of the PCT to affect the ‘purchaser-provider’ relationship and the retirement of the PCT lead for offender health. This had a bearing on the Partnership Board’s subsequent decision to maintain the existing relationship with the provider. When NHS Dorset took over the management of the service from Dorset Police, it was determined that the provider did not have the managerial support and guidance in place that could be expected from a provider that had gone through the commissioning process. It was felt they needed time to get that in place, which it is now deemed they have. The subsequent employment by the Provider of the retired PCT lead will have contributed to this perceived capacity development.

This unsettling period of reorganization within the PCT had been felt by the independent provider, who had perceived their position to be unstable:

“It’s been a roller coaster ride for us ... First we were given a nine month contract and we told them we would have to lay off staff ... And then we were told it’d been extended to eighteen months. I think a lot of the staff were sitting around scratching their heads, wondering what was going on with the contract ... it’s been a bizarre series of events”

The Provider’s perception was that it might have to compete with the provider arm of the PCT for the next police custody healthcare contract. However, NHS Commissioners have sought to assure that there is no conflict of interest, managed through a robust procurement process. This has been aimed at in Dorset by setting up a subgroup of the Partnership Board which excludes any individual with a conflict of interest and all members of the subgroup have signed a ‘conflict of interest’ declaration. This subgroup will oversee the procurement process and make recommendations to the Partnership Board

Professional Functions and Status

Professional Autonomy

During the evaluation, it became evident that while custody nurses and Forensic Physicians were required to adhere to established clinical procedures, protocols and NHS clinical governance requirements, their accountability to the commissioning PCT was ambiguous, being essentially independent in their employment status from the NHS. This approach provided a satisfactory level of clinical service and supervision for custody nurses, but owing to the short-term nature of the contract (until the NHS took over the contract it was renewable on a three monthly basis) had limited potential in terms of developing professional roles, clinical autonomy and leadership, and achieving effective workforce development. Alongside police custody teams, custody nurses tended to function in professional isolation, in deference to custody sergeants, therefore with limited professional autonomy in terms of their ability to make independent clinical decisions.

"We don't have a lot to do with what goes on out there, that's nothing to do with us. We are only here as medical people, we don't have anything to do with the custody side of things ... the sergeants make the ultimate decisions."

The range of clinical responsibility for custody nurses was steadily increasing, as they absorbed more primary, secondary and forensic healthcare procedures. They were situated to perform an important triage function, in terms of liaising with appropriate services and diverting detainees away from custody, although was controlled by the degree to which custody sergeants referred detainees to them, as well as whether links existed with outlying services.

Duty of Care, Duty of Custody

Providing health and social care within police custody settings raises questions about the status and rights of detainees, given the convergence of different professional cultures. Interviews with police and nursing personnel brought to light an apparent tension between providing a 'care' service and providing a 'custody' service; this manifested in terms of identifying, labelling and treating individuals, on the one hand, as "detainees" and, on the other, as "patients", "clients" or "service users". Such labels can convey different status and rights, which can be perceived as contradictory where it is unclear which identity takes precedence.

Detainee health and social care, when viewed from an 'offender pathway' or criminal justice system perspective, infers a wider interpretation of the status of the detainee, the prisoner, the victim of crime and of the professional, than is discernible from a single professional standpoint. On the one hand, the notions of 'ill-health' or 'offending' can be interpreted as individualistic problems requiring individualistic interventions (treatment, care, punishment, rehabilitation); alternatively, they may be interpreted as systemic, societal problems that require systematic and societal responses. This raises the distinction between individualistic approaches to intervention – treating the patient or criminalizing the detainee – and socio-

environmental approaches, where the individual's condition is believed to arise from the system (of inequality, exclusion or deprivation). We commonly acknowledge rights and responsibilities at the level of the individual (e.g. via the Police and Criminal Evidence Act, the Law, clinical diagnosis, etc.), yet responsibilities may also be levied at collective and structural levels (population, community, organization, family), which, in part, privilege or deprive certain individuals of legitimate rights or responsibilities as citizens. Such differences of perception are likely to manifest where professional groups with contrasting values come together to manage people according to very different agendas; a partnership approach is intended to create a site for working out differences and achieve compromise.

PACE is an overriding authority on the procedural management of detainees and provides limiting parameters on defining custody places in healthcare terms. While Department of Health and Home Office policies call for an "integrated approach" towards tackling social exclusion and addressing health and social inequalities, and both advocate a symmetrical and synergistic approach to custody and care, it may be that the demands of PACE essentially restrict broad health and social care policy aims. NHS commissioning introduces a competing accountability framework and an alternative professional culture, and potentially brings new roles, responsibilities and risks into police custody settings.

Given this, an important question emerged from the evaluation regarding the status of detainees: can an NHS commissioned police custody healthcare service respect and protect the rights and status of detainees given their potential dual status as detainees and as patients? An individual detainee's status and rights as a patient are only acknowledged once the healthcare provider enters the scenario. Therefore, if the role of the custody nurse is to assess the healthcare needs of all individuals entering custody, healthcare rights and status are assumed when the detainee enters the suite; whereas, the detainee who is referred to a healthcare provider is only granted those particular rights and status at the point of referral. Differential status in this regard then incurs differential rights in relation to healthcare ethics, especially in relation to 'need', 'consent', 'privacy', 'confidentiality', and 'respect', and in terms of the role of the professional in providing support, care and advocacy.

The Decency Agenda was introduced to prisons as a mechanism for ensuring safe and dignified conditions for prisoners. Two key objectives were to reduce the suicide rate and to improve the way prisons upheld the rights of prisoners and staff (especially in relation to race equality). For police custody, this implies that the conditions for detainees, for victims and for staff should ultimately be safe, fair, humane, healthy and respect individuals' rights. Whilst this agenda has not yet been extended to police custody settings, the principle of decency (with its emphasis on rights and equal opportunities) is central to clinical governance and to the detainee public health approach advocated by the World Health Organization.

Detainee rights (under PACE) do not entirely coincide with patient rights as envisaged by the DH, and it is here that the key points of tension between *care* and *custody* are felt. For patient rights to underpin custody care (within PACE), this might imply that:

- *healthcare professionals must operate as advocates for patient rights;*
- *healthcare professionals should have automatic access to all detainees as they enter custody, so they can assess their patient rights (or 'healthcare needs'), as a form of universal triage;*
- *a point within custody processing should be identified and agreed upon at which detainees assume patient rights and status.*

These imply different models of provision:

- i. *Conventional Model: The police custody detainee enters custody with no special need (“healthy until proven otherwise”). The role of the healthcare professional is to respond to the custody sergeant’s judgment of need. Referral then occurs on an emergent or reactive basis, where the detainee is ‘screened in’ for treatment or care. The relationship between the healthcare professional and the custody-sergeant is crucial.*
- ii. *Healthcare Model: The detainee is pre-supposed to have health or social care needs, and therefore to be at risk of poor health (“vulnerable unless proven otherwise”). The role of the healthcare professional is to screen all detainees to eliminate the need to health or social care intervention. Those with identified needs are then treated or referred to appropriate health or social care services via effective liaison and diversion. Healthcare and police custody professionals operate as a team with clear lines of accountability.*
- iii. *Public Health model: This approach is really an extension of the Healthcare Model, but takes a more proactive approach towards health protection, health promotion, disease prevention and tackling inequalities. It is pre-supposed that detainees are likely to present with complex health and social needs, since they are considered to represent a larger ‘socially excluded’ demographic of the general population, which shares a disproportionate level of health inequality. The detainee is presupposed to be at risk of poor health. Under this more radical scenario, healthcare providers perform an active ‘front-line’ function alongside local partnership organizations operating in the community, working with people considered at greatest risk of offending.*

While the third model is ambitious, it was envisaged as an upstream goal within the PCT, and reflects the principles that underpin Joint Strategic Needs Assessment and World Class Commissioning, where PCTs have a lead responsibility in identifying “strategic priorities [which] should include investment plans to address areas of greatest health inequality.” (DH 2007)

CAPACITY AND CAPABILITIES

Central to the commissioning arrangement is the NHS contractual relationship between NHS Dorset and the independent healthcare provider, a legally binding agreement through which service provision is guaranteed to a specified standard, and against which a system of penalties applies should the service fall below the specified standard.

The first phase of fieldwork revealed perceived deficiencies in the quality of the service provided by the provider, where it appeared that contractual obligations were not being met. Further investigation revealed a discrepancy between the Partnership Agreement and the contract. The Partnership Agreement stated there would be nurse cover in the suites 24/7. The contract with the provider stated they would respond to a request from the custody sergeant within 45 minutes at least 95% of the time. Throughout the course of the evaluation, there remained concerns around the differing expectation of the service between the Police and the Provider. This, at the time, raised questions about the quality, appropriateness and sustainability of the service, especially in terms of its capacity to develop

inter-professional working and an appropriate organizational culture for healthcare professionals. Particular problems were identified relating to recruitment and retention of custody nurses, working conditions for health professionals, their status relative to custody staff, and the lack of a workforce development culture in terms of opportunities for career progression and development. However, evaluation fieldwork ended in October 2009 and, during negotiation of this report, the Provider stated:

"this paragraph does not recognize the significant developments implemented in partnership with the PCT and the police during the contract period".

Maintaining 24/7 Presence

During the first phase of fieldwork (autumn 2008), the independent provider experienced difficulties in the recruitment and retention of nursing staff, which resulted in the 24 hour, seven day cover not being provided across the three main custody suites as expected by Dorset Police. The evaluators determined that though it was a Dorset Police expectation, to the provider this 24/7 cover was *"an aspiration"*.

An area of tension evident between the Police, the PCT and the provider became this varied interpretation of *"24/7 custody nursing cover"*. It emerged that this divergence was due to the wording of the two separate agreements between the NHS and the provider and the NHS and the Police. At the start of the pilot, the contract between the PCT and the provider identified the *"aspiration"* to provide a nurse 24/7 in each custody suite. The NHS Dorset agreement with the Police, however, was that a nurse *would* be provided on this basis.

This lack of continual presence of a nurse in the custody suite, remained the main concern for the Police and came up repeatedly in interviews with Police personnel:

"To allow the service to develop in the way that's hoped, to allow the health screening to happen and to allow the healthcare pathways to develop appropriately, will only be possible if we have three nurses in three suites 24/7 ... Otherwise, there will be too much travelling to and from each site by the nurses and they won't have time to devote to care pathways. I think this is really quite instrumental in making the whole process work."

On our visits to the suites, we experienced the effects shortages of nursing staff was having in terms of staff morale, particularly when custody suites had no custody nurse on site. This created stress for custody sergeants who had to suspend judgments on detainees with health problems and it impacted on custody nurses at other suites who were travelling long distances to provide cover, often late at night. These nurses expressed dissatisfaction with the conditions they were being expected to work under, especially having to provide 12 hour cover across a wide geographic area. We learned that a key contributory factor was the high attrition rate of staff, due to sickness and nurses leaving the job. Nurses who were interviewed suggested that the high attrition rate arose from difficult working conditions (environments, equipment, facilities), low status relative to the police custody team (in terms of being able to operate as an autonomous professional), working solo for 12 hour stretches, feeling professionally isolated, and the unacceptable pressures associated with low staffing; these were perceived by a good proportion of nurses and police teams to be antithetical to

building a sustainable and effective service. It also emerged that in some cases the Police Vetting assessment process, which new staff applicants are expected to undergo, was delaying the recruitment process.

The current contractual relationship with the independent provider stipulates a 24 hour, 365 day custody healthcare service delivered by “healthcare practitioners” on site at the 24 hour custody suites. Without clearer definition within the contract of the nature of the provision, the PCT commissioner has little influence in how the service is designed and delivered, so long as it performs as contracted to do so. It may be appropriate to stipulate more clearly the character and function of the service.

Skills Mix

In terms of custody nursing provision, there were mixed views among nurses and police staff regarding the appropriate skills mix for custody nurses. This was partly because Registered Nurses were being employed from different backgrounds (i.e. trained or experienced in mental health nursing, accident and emergency nursing, intensive care nursing, prison nursing, community nursing and general nursing), with no apparent consistency on the part of the Provider for the skills mix. It also became evident that there were inconsistencies in the practices and procedures some nurses were expected to, and accustomed to, performing, which tended to vary according to the different experiences they brought from other settings. Furthermore, there were roles some nurses had performed at NHS sites that they were not permitted to perform within custody suites, partly because the custody suite environments were not always conducive to conducting clinical procedures. Key questions that arose from speaking with operational level staff, where there appeared to be lack of clarity, included:

- *What is the appropriate skills mix for nurses?*
- *Where does the line of responsibility and role lie between the custody nurse and the on-call Forensic Physician / GP?*
- *Should all custody nurses share the same level of skills and competency and what should this level be? Should all custody nurses be employed on the same Band level, and what should this level be?*
- *Should the independent provider employ only custody nurses and Forensic Physicians?*
- *Could Health care Assistants be employed to carry out some tasks?*
- *What level of managerial responsibility should a custody nurse have, and therefore what is the appropriate Band?*
- *Is the healthcare provision a situated healthcare service or a specialist practitioner function?*
- *Can custody nurses share equivalent roles, responsibilities and professional status as their counterparts in NHS settings?*
- *Is it feasible, under current resource constraints, to recruit a custody nursing team with a mixed portfolio of skills and experience?*

In Dorset, there has been a change to the historical tradition of medical and paternal authority. The FMEs provide the nurses with a much greater decision making role:

“I never question a nurse’s decision, as I know them and trust them, and I know they would never do anything wrong.”

To date, this relationship has not really been reviewed in terms of the reconfiguration of the service. It is evident that the Faculty of Forensic and Legal Medicine and the General Medical

Council recognise the forensic *practitioner* role but have yet to determine how to extend training and regulation to health professionals with non-medical training. At the local level, there also remains the issue of what constitutes an appropriate level of training for Forensic Physicians and the legal responsibilities they have.

The skills mix review conducted by the PCT revealed that most custody nurses possessed a good range of clinical skills, which enabled them in other (non-forensic) healthcare settings to perform invasive procedures (e.g. venepuncture, taking tissue specimens, administering controlled drugs, etc.). For legitimate legal reasons, such tasks can only be performed by Forensic Physicians, which can cause delay and is probably not cost effective. The perception of custody nurses was that they “have their hands tied behind their backs.” This suggests a review of current legislation may be timely, with consideration of extended forensic practitioner training to enable custody nurses to perform forensic tasks. At present, it would appear that service demands and professional practice are running ahead of professional regulation. One aspect of this is lack of clarity and articulation at the political level, whereas relevant government departments must review and reframe legislation and regulation to respond to innovations on the ground.

Workforce Development

The capacity of the funding base of commissioning to deliver effectively was questioned by many stakeholders, including the Police, the PCT and those working for the independent provider. There were concerns about *what* should be delivered and *who* should deliver the service. In terms of service specification, the contract identified many functions of the service and, certainly, a perception of the evaluation team was that the range of provision expected of custody nurses was steadily widening.

Over-riding concerns were with recruitment and retention of staff, skills mix and workforce development. The lack of any integrated workforce development strategy – regionally or nationally – arguably impacts on the effectiveness of the service in terms of capacity and capability. This problem was seen as one which is paralleled within the prison estate, since health professionals working within criminal justice settings are invariably marginalized from the mainstream NHS workforce. In particular, there is no dedicated specialist training for NHS staff to work in CJ settings. Apart from continuing professional development opportunities available at some universities in the UK, the only form of recognised validated forensic training is provided by the Faculty of Forensic and Legal Medicine, on a voluntary basis, for Forensic Physicians.

This issue of the “marginal” or “detached” status of healthcare professionals relative to their NHS counterparts was raised by a number of interviewees, particularly those in operational roles. The viability of the service was felt to be at risk where employees did not share comparable terms and conditions of service to those in the NHS. The contract with the independent provider stipulates that all healthcare professionals should be adequately trained to perform their roles, yet their location outside the NHS meant that they remained detached professionally, economically, socially and politically from the NHS system, and dislocated from their professional peer culture. Moreover, there remains no formal link to workforce development, clinical governance and career progression opportunities. Nonetheless, the provider has expressed its commitment to providing in-service training and

support for its nursing team.

The problem of building staff capacity to run the service was illustrated in a range of comments. Firstly, the independent provider was considered to be *“too small”* to provide basic in-service training though they are now part of a large group of companies which enhances their capacity; secondly, many stakeholders were aware that despite advertising, the provider was unable to recruit nurses; thirdly, it was felt that being detached from the NHS was a disincentive to most nurses applying for jobs:

“it’s difficult to entice someone away from the NHS, especially with the pay and pension that we don’t get working for this private company. It’s difficult to jump ship because they will lose all the benefits.”

The nurses are entitled to three-to-five days sick leave at which point they move to statutory sick pay, though the view of nurses highlights the differences between working for the provider and the NHS.

The current contract does not provide the scope to develop the workforce on an equivalent basis to the NHS, and therefore arguably a strategy should be developed at local, regional and national levels to ensure that that skills mix standards can be met. Workforce development should be a priority that underpins service development. However, such innovation requires heavy financial commitment to realistically develop the service as part of the wider ‘offender health’ policy agenda. At local level, in the short to medium term, the priority should probably be to nurture the relationship with the current independent provider, considering how best to evolve the contractual relationship so that it is sensitive to local needs, demands and aspirations. A sustainable way forward would be to ensure that ‘accountability’ is built in, with clear lines of management and greater linkage and involvement with allied health and social care agencies, to foster a team approach that is not solely nursing focused or nurse resourced. The range of clinical and professional judgments demanded of custody nurses continues to expand, yet there remains meager managerial and clinical support, and they continue to lack the status and influence to enable them to negotiate healthcare agendas.

The current commissioning arrangement is not geared towards providing managed professional workforce development in this sector. If this pilot becomes a driver for innovation – with its potential to develop a recognised nursing specialism, clear governance arrangements and innovative partnerships with the independent and third sector – then the power of commissioning must be used to develop contractual relationships that have the impact to develop services with a broad vision. At present, the Dorset experience illustrates how policy might be running ahead of itself in terms of capacity and capability of the human resource base; it remains unclear who should be responsible for developing the workforce. In Dorset, much of the responsibility has fallen to the independent provider, for whom it presents as a recruitment problem and not a professional development one. Again, the question of an NHS service or an outsourced service is implicated; an NHS service provider allows for the resources of the NHS to provide the context for the development of a specialism. At the national level, this becomes a question of how we learn from the diversity of arrangements that is likely to emerge across Police forces and PCTs about the challenge of professional role development within custody suites.

Implementation of SystemOne

An area of frustration for the operations team has been the delay to the implementation of System-1. It was hoped that it would be in place by December 2008 but is looking more likely to be December 2009. System -1 is the computerised medical records system that is used practically throughout the prison service and was pioneered by Dorset NHS. Having System 1 in the custody suites would be one large step in creating the continuous healthcare pathway for offenders.

“Once we have the IT system in place in the suites, specifically system 1, hopefully the care pathways will follow. But that will be a progressive period as well because we need to make sure the nurses are comfortable using it and that the detainees are comfortable with it as well.”

By the end of the evaluation period the screens were in place and the cabling installed and they were conducting an audit of the nurses to see what training is required.

“It is quite an intrinsic part of the care pathway because they will be able to look back at previous consultations and see the care pathway rather than going over old ground and especially with nurses going from one suite to another you will get to build a rapport with the detainees and stop that revolving door scenario. Hopefully system 1 will give us that. That is my expectation anyway. That is how it has been sold to me anyway – let’s put it that way!”

It is the production of the templates that need to be put on the system that is causing the hold up. There are certain aspects of the data that needs to be unavailable to other organizations. For example if someone is arrested and a forensic sample taken but then no further action is taken against the person this information cannot be accessed by others. So it means that ‘evidence gathering’ tests cannot be put on the system as these will need to be documented in the usual way. Therefore, there will be two systems: the paper documented collection of forensic evidence and the healthcare treatment of the individuals.

However the nurses seemed concerned that this system wouldn’t link up to the GP computer system which they felt they were led to believe it would.

“We were told we would be able to access the detainees doctors records, which would have been very helpful, because lets face some of them tend to lie to us. It is very disappointing that this won’t happen. It makes it much harder for us to pass on any medical information we may gather to their GP”

4. BENEFITS OF COMMISSIONING

The Partnership Board's original plan was to continue in the short term (to March 2009) to outsource the service to the independent provider until the PCT had established its role as commissioner, after which time the service would be maintained as a NHS Dorset provider function. It was expected that this would yield an annual saving of £70,000, against the annual expenditure of £951,912. However, at the time of completion of the evaluation (July 2009), the service was still outsourced to the independent provider, whose contract had been extended to October 2010. Rather than these cost savings being realised, it is evident that NHS Dorset has overspent as a consequence of taking on this commissioning role. Some of this expenditure was towards equipping new facilities in Bournemouth and Poole. While the principal share of the budget is provided by Dorset Police, the current commissioning perspective is that the service in its current form is barely financially viable, given there has been a need for the PCT to subsidise the project. As one stakeholder declared,

"With hindsight the expectation of what could be delivered within the financial envelope was unrealistic."

"I'm not sure how it [the PCT] is going to make decisions on what services need priority funding. It may be that offender health is not considered to be a priority service – they may decide to focus on cancer care, for example, so it's important that our commissioning expertise is used to reshape services rather than expect additional funding."

It seems unlikely that further funding will be available at the local level or at a national level, unless the commissioner can persuade Dorset Police to raise the annual budget. In the intermediate term, there is still an expectation that the custody healthcare service will be re-costed and put out to competitive tender. However, there remains uncertainty about future funding and a limit to what can be achieved at an aspirational level in terms of improving and developing the service.

"I don't think Dorset Police will be very sympathetic to the position we have found ourselves in. Transfer of funds from the Home Office to the NHS would help, but it is a very political situation and I am not sure what will happen."

A further concern regarded the future valuation of police custody healthcare in general, were the responsibility for commissioning to be transferred nationally to the NHS. Stakeholders perceived that the Dorset model was quite cost effective but provided relatively high quality, which could lead to cuts in expenditure for other more expensive localities. What this suggests is that there are potentially different criteria upon which to cost the service – for example, by size of Police Force, by the number of custody suites per PCT, through a demographic analysis of detainee profiles, through Joint Strategic Needs Assessment. In the Dorset case, there were no explicit, evidence-based criteria – simply, the transfer of a budget determined historically.

Transfer of funds from one sector to another has an added political dimension. Service integration at the local level is not necessarily matched at the national political level, where

criminal justice health and social care policy falls between the Department of Health and the Home Office. Transfer of funds from a Police Force to a PCT represents, at the national level, a large fiscal transfer between two government departments, which would otherwise be competing for funding.

Scenarios for NHS Commissioned Custody Healthcare Provision

Analysis of the tone and direction of current offender health policy and its aspirations for police custody healthcare suggests flexibility in the way healthcare services can be delivered, provided that they meet the commissioning requirements and goals of lead PCTs. A review of the nursing skill mix and nurse-led healthcare provision within Dorset Police's three 24 hour custody suites was recently completed by NHS Dorset (Snowdon, 2009). The review offered three models for the future provision of custody healthcare and has helped inform the four scenarios offered in this report.

The scenarios presented below are suggested options for structuring police custody health provision, based on different resource allocations and commissioning environments. Option 2, an enhanced NHS model of provision, is not part of the current commissioning models of police custody healthcare in England at present. It is without precedent, but it is illustrative and included below to provide a good basis for comparison with other scenarios. It offers a mid-way in terms of potential resource savings and potential outcomes. The more expensive options come closer to the NHS vision of World Class Commissioning and the Bradley recommendations. For the first three options, likely resource savings and overall outcomes are described. Each scenario is illustrative rather than definitive, but can be used as a basis for analysing real cost data, resource savings and service outcomes as they become available. Each scenario is described below in Table 3. These scenarios are both descriptive and hypothetical, given the absence of actual financial data upon which to base accurate estimation.

Option 1 represents the current model in which the police custody healthcare service is outsourced to an independent provider, on a contractual basis, to provide a healthcare service across three custody suites. Under this scenario, a minimum of nine Registered Nurses (RNs) are employed to provide twenty-four hour, seven day a week nurse cover for the three suites. However, ideally there should be a minimum of twelve nurses allowing for cover during absence. Two independently contracted GPs are employed to provide a 24/7 forensic on-call service. The nurses are located within the custody suites, enabling them to provide an important triage function, to be immediately available to manage primary and secondary healthcare needs of detainees, enabling an efficient liaison, referral and diversion process, and to reduce likelihood of deaths in custody compared with previous arrangements. A key disadvantage under this scenario relates to the nursing resource, where there is at any one time a maximum of one nurse in each suite, which is compromised should individuals take sickness or annual leave. Conditions of service are not equivalent to the NHS (though nurses receive sick pay, annual leave and enhanced rates for weekend and bank-holidays) and this may impact detrimentally on staff attrition rates and limit the range of health and social care provision available. Under this scenario, nursing staff operate as individual referral agents rather than as nursing teams, with low influence within the police custody environment. There is limited option for workforce development and training, compared with the

mainstream NHS.

Option 2 represents an 'enhanced' nurse-led service, situated within the custody suites, ideally by an NHS provider though could equally be provided by an independent provider, though some of the benefits may be reduced if this was the case. This option is illustrative and presented for comparison purposes with the other options. Twelve Registered Nurses are employed under a team leader whose responsibilities include line management, clinical supervision, clinical governance, and staffing. The service is supported either by NHS-based GPs with specialist forensic training or by independent contracted Forensic Physicians. An administrator is also employed to provide systems, infrastructure and secretarial support to the team, to process referrals and to operate as the communication hub for the service. Under this scenario, terms and conditions of employment for all NHS employed staff are equivalent to their counterparts within NHS organizations. *Option 2* brings a range of potential benefits, compared with *Option 1*, in terms of clinical governance, a clear management structure, greater linkage, integration and coherence with the wider NHS. There is greater opportunity for workforce development and training via the existing NHS infrastructure, a more skilled nursing team with a richer skills mix, and a greater sense of control over the resource, on the part of the NHS commissioner, particularly in terms of compliance with NHS clinical governance protocols. Through building stronger links with the NHS (particularly the nursing profession), it is feasible that compared with *Option 1* nursing staff attrition rates will be reduced and the skill mix will improve, which may yield qualitative service improvements (e.g. where there is capacity for nurses to train for extended roles, such as prescribing or carrying out forensic / legal responsibilities). However, these potential benefits are not as great as those generated by *Option 3*.

Option 3 represents a post-Bradley, enhanced NHS commissioned service, situated within the custody suites, but which employs a multidisciplinary health and social care team. The team is led by a Team Leader, with two nurse practitioner appointments (prescribers), Nine Registered Nurses (mix of mental health and general health expertise), along with three social workers (with mental health expertise), Forensic Physician cover for 24 hours per week on-call cover, and an administrator. A key potential advantage of this option compared with *Options 1 & 2* is that it provides a team more fully equipped to manage complex health and social care needs; it therefore strives to more effectively meet the aspirations of World Class Commissioning. It also provides the skill and capacity to deliver a more efficient and effective treatment, liaison, diversion and referral service, thereby reducing the burden on the police and offender management teams. Developing workforce capacity and effectiveness is central to this option. Furthermore, compared with *Options 1 and 2*, this scenario is most likely to bring about integration with health and social care services within the community and within other NHS and local authority settings, and have a real impact on reducing the likelihood of people becoming unnecessarily locked into the criminal justice system ("revolving door" scenario).

	Option 1 (current)	Option 2	Option 3
Scenario	Situated Outsourced Nurse-led Service	Situated Enhanced Nurse-led Service	Post-Bradley Enhanced Multidisciplinary Service
Lead Provider	Independent Sector Company	NHS Organization (PCT) or Private Provider	NHS Organization or Private Provider in partnership with Local Authority
Scope of Service	Primary and secondary care Triage Referral	Responsive primary and secondary care Triage Liaison, referral and diversion	Responsive primary & secondary care Triage Liaison, referral and diversion Social care / welfare support
Illustrative Staffing levels	Nine Registered Nurses (RNs & 2 on-call GPs)	One team leader (pro rata basis) Twelve RNs (pro rata) One administrator (pro rata) Two on-call forensic physicians (48 hour week)	One team leader (pro rata) Two nurse prescribers Nine RNs (mixed mental & general training) (pro rata) Three social workers with mental health expertise One administrator (pro rata) One on-call forensic physician (24 hour week)
Potential Positive Outcomes	Improved triage function Reduced deaths in custody Referral to allied healthcare services	Improved staff retention Clinical governance High quality healthcare (stronger team) Effective liaison, referral and diversion Likelihood of workforce training / development Reduced risks for police custody teams	Reduced unnecessary detention Appropriate management of social care and welfare needs Liaison, referral and diversion scheme based on inter-sectoral / partnership approach Allegiance to World Class Commissioning principles
Potential Resource Savings or Dis-savings	Staff absenteeism / lack of cover Incomplete cover across sites (cost to employees) High staff attrition	Higher banding of nursing staff, enabling extended roles (e.g. prescribing, referral, forensic skills, etc.)	More effective liaison and diversion of offenders to appropriate outlying services
Workforce Development	Weak	Adequate	Appropriate

Option 4 - Beyond Commissioning

As we have described, Commissioning defines relationships in economic terms. Nested within the commissioning process is the procurement phase in which the 'customer' defines the need, the 'contractor' (provider) supplies the service and payment is duly made. The relationship is regulated by contract and accountability is underpinned by economic sanction. Central to commissioning is a core dimension of the customer-contractor principle – that of the 'intelligent customer'. This involves the agency issuing the contract to be sufficiently knowledgeable about the area of provision as to be able to specify the work to be done⁶.

This pre-specification of the work to be procured signifies that control over the definition of the problem and its solution lies with the customer (the PCT) – with little room for negotiation. In the case of PCT commissioning, control lies with NHS managers, and will tend to be shaped by PCT health policy agendas. This is equivalent to a target-setting process supported by performance oversight. Commissioning can involve the procurement of external or internal services (i.e. it can involve internal transfer of funds) but often implies external procurement (part of the basis for claims that health services are being 'privatised' by stealth). The coherence of the relationship and of the work carried out is its compliance with the specifications of the contract.

The alternative to commissioning is an in-house professional, rather than an economic, relationship. Here, the manager may set the broad strategic aims – even specify the problem or service need to be addressed, though this may subsequently be open for negotiation. The solution, however, is left to the practitioner to determine, and this will tend to mean that it is underpinned by local conditions, complexities and priorities. Coherence is given by correspondence of the work primarily with local conditions, and this means that there may be diversity in the kind of response.

Though a professional service may be commissioned externally (outsourced) it most typically is an NHS service. In the case of police custody healthcare, this would consist, for example, of a team being identified within the NHS and assigned on a project basis to develop the specialism. Dedicated staff would be responsible both for providing the service and exploring its boundaries. In this model there is an emphasis on clinical management – i.e. oversight of both professional practice and professional development. In accountability terms, since the professional model relies on the judgment of the practitioner, there are relatively high levels of professional autonomy and a high-trust approach to accountability.

This evaluation does not favour any one of these four options, and it does not make any judgement as to the choice of 'public' or 'private' provision. Our task is to outline their rationale and consequence. In any event, any *in principle* preference someone might have for public or private, full or partial provision has to be mediated through local circumstances and contexts.

⁶ The Commissioning Cycle under 'World Class Commissioning' includes a step titled '*Understand the current position*'.

5. CONCLUSIONS AND SUMMARY

World Class Commissioning is the new goal for Primary Care Trusts, which moves Trusts from a provider to a Commissioner role. This reflects a logic of governance that sees services as outsourced with the public authority acting in a role for procurement and subsequent regulation. The conditions under which PCTs play this role are closely regulated, including a set of underpinning management competencies. In this evaluation, we have looked at the Dorset experience of developing a police custody health service against this broad NHS commissioning context. These have been assessed against what the Police Partnership Agreement said the service will do.

The task of pilot projects is to enter into uncertain territory, explore, experiment and learn. They are the ones who embrace risk. The task of evaluation is to capture that learning and make it available. The evaluation acknowledges that this project has been challenging and confirms that it has fulfilled its obligations as a pilot. This has been a productive and fruitful process. It has developed and implemented a nurse-based custody care system, developed appropriate structures of governance and professional development, laid the basis for a referral system, and identified the parameters of new specialist forensic roles. In doing so this project has introduced a new set of (health-based) detainee rights in custody settings and has laid the foundations for addressing the social and healthcare sources of offending. Whether the arrangements lead to an attributable reduction in re-offending is too early to determine, though we can confirm that it lays the foundations for putting into operation the logic of interrupting re-offending by treating underlying causes. Similarly, the goal of reducing the risk of deaths in custody may well be brought closer by this pilot through its enhanced capacity to address more immediately and effectively vulnerabilities in the mental health of detainees.

Some of this success is due to:

- the logistics of (near) 24/7 cover;
- the enhancement of capacity in custody suites by nursing presence;
- the presence of a referral resource;
- the expanded possibilities of professional exchange and productive relationships between custody nurses and custody sergeants;
- the development of appropriate and shared information systems;
- the introduction of clinical governance to custody suites;
- the capacity for systematic learning about forensic care treatments and the development of forensic practitioner roles;
- the strategic understanding of the limitation of commercial contracts in regulating obligations and commitments.

Not all of these are fully developed or entirely effective as yet, and nor would we expect that. Our task as an evaluation is not to make judgments about the quality of this pilot, but to support Dorset and other decision makers to make their own informed judgments about appropriate ways of implementing this learning. What follows is a set of summary statements

within a broad umbrella of affirmation of the work of this commissioning process. It takes a frank and somewhat critical view of the challenges that have been faced. The statements come from the brief for this evaluation to critically examine the custody care service in its capacity to:

- **Provide timely, consistent healthcare expertise and advice, in the assessment and treatment of detainees, victims of crime and police staff where appropriate**

During the formative period it was not within the capacity of the Provider to meet the service demands as first agreed in the Police Partnership Agreement. Initially this was due to the provider retaining their existing contract which transferred directly from the Police to the PCT. This contract had particular targets for times and efficiency of response to a request from a Custody Sergeant whereas the partnership agreement stated a minimum level of cover. However on realisation of the discrepancy between the two agreements the provider contract was renegotiated to bring the two closer to alignment. It is still an aspiration in the provider contract to reach the level of service as outlined in the Police Partnership Agreement.

Consideration can be given to ensuring that Partnership Agreements and commissioned contracts align.

- **Be provided by healthcare professionals with the appropriate skills and training to carry out the required duties in obtaining forensic samples and providing statements of evidence**

Efforts have been made by the commissioners and the provider to make sure all professionals have the required skills and training. Initially, there were concerns that the provider was too small a company to be able to train staff as required. As the pilot moved forward it was clear the provider had made progress towards providing relevant training for nursing staff with the aid of the Commissioners and the Police. The provider has now merged with a larger company, thus, it claims, enhancing this capacity to meet the skill demands that have emerged as essential during the learning of this pilot.

There is no nationally recognised qualification or training to be a custody nurse. Nurses are employed on their previous nursing training and experience. Additional training is then required where appropriate to give them the skills mix suitable for working in a custody suite. This is regarded by both Police and PCT as a key issue. Contracts and agreements stipulate recruitment and training strategies to develop these skill sets. This disguises the possibility (necessity?) that a new nursing specialism is under development. 'Necessity' derives from (a) the particularity and complexity of the required skills and professional understanding to operate effectively in custody settings; and (b) unusual demands on custody nurses such as discrete forensic operations and legal requirements in relation to PACE and court procedures, but also to sustain negotiations and integrated judgments with custody officers.

Consideration can be given to the point at which the development of a new skills mix elides

into the broader national development of a new nursing specialism.

- **Ensure a seamless healthcare service by integrating health and offender services**

A more holistic service is being worked towards with the introduction of the computer record system, SystemOne. It is hoped that with this system detainee records will be able to be accessed as they move through the offender pathway. As well as the records being able to transfer with the detainee as they move through the pathway the original intention was that custody nurses would be able to access and detainee's NHS medical records and add to the NHS medical notes allowing for follow up with the detainee's own GP. This may be limited by confidentiality restrictions, but the provider and commissioners are working towards having a network of GP's that are amenable to registering detainees who do not have a GP and may want one.

It has been noted that SystemOne is not necessarily country wide though does appear to be used by the majority of criminal justice institutions. Careful consideration would need to be given by other commissioners as to which computerised records system is installed in suites to allow for a seamless flow of information. There remain important considerations concerning the compatibility and overlap between SystemOne and the Police National Computer – not least in respect of detainee confidentiality and legal requirements for disclosure. There is no such compatibility between computer systems at present, nor expectations that there will be.

Useful interactions are still difficult to achieve between the medical custody nurses and the mental health professionals that visit custody. The services are currently commissioned separately. Third sector and statutory organizations who spoke to the evaluation were cautious about service integration. They currently had limited interaction with the nursing staff or the PCT commissioning service or the medical nurses in the custody suites other than on an individual basis. The basis of resistance is anxiety about destabilising customary practices which currently work effectively.

Consideration can be given to the capacity for commissioning to promote strategic-level negotiations across custody care and community services – but also at the level of professional practice and the adaptation of customary practices to embrace the work of the custody nurse. It may be important to monitor the use and impact of multiple information systems in custody suites in terms of confidentiality, legal requirements, possibly conflicting evidence bases and different sources of professional judgment.

- **Increase the number of referrals to intervention schemes and support initiatives ensuring clear communication links with clients General Practitioners to ensure follow-up support. This will directly support initiatives, which assist in a reduction of re-offending rates and “revolving door offenders”**

There was no qualitative evidence by the end of the evaluation period that the number of 'revolving door' patients had been reduced or of a reduction in re-offending rates attributed to interventions and referrals by custody nurses. However it is early in the process and full time-

series data is not yet available. There appeared to be little follow-up with GP's to ensure follow-on support by the custody nurses, much of this was due to confidentiality requirements as much as workload and communication issues. However, the evaluators are aware that follow-up can occur for some cases involving mental health practitioners who work in custody suites (but see the previous item).

Significant progress was made in the critical operational aspect of referrals to custody nurses by Custody sergeants. Throughout the evaluation period the number of referrals increased to custody nurses while the number of call outs of the FME's decreased.

This was seen by stakeholders as an affirmation of the increased confidence and trust in the service and of the good relations between the custody nurses and police staff.

In any event, the evaluation was not able (for ethical restrictions) to work in an in-depth way with detainees and offenders.

Further consideration can be given to qualitative understanding of individual offender pathways so as to understand the nature of causal relationships between custody nursing, referral/liaison and reduction in re-offending.

- **Support robust lines of communication across the organizations**

This aspect of the initiative was clearly successful and suited to the need for collaboration at discrete levels. There were three project management boards set up: The Management Group, the Operational Board and the Partnership Board. The Management Group dealt with issues as they arose on a daily basis at the start of the evaluation, by the end of the evaluation they were meeting on a fortnightly basis. The Operational group met on a monthly basis and dealt with any operational issues and determined the implementation of services. The partnership Board involved custody stakeholders at a county level and maintained the strategic overview. This set up seems to have enabled 'robust lines of communication' across all the relevant organizations in Dorset and at a regional level within the NHS.

Consideration can be given to appropriate deliberative and liaison infrastructures to allow for appropriate interactions at the policy, management and practitioner levels.

- **Realise the benefits of working with the local NHS using pre-established governance, training and IT links**

Throughout the evaluation period the NHS commissioning could be seen to implement procedures to allow the custody suites and nurses to comply with pre-established governance. This process appeared to be slower than expected due to the conditions of the medical rooms in two of the custody suites (old Victorian buildings) although these building are due to be replaced within the next 18 months with the opening of new stations in Poole and Bournemouth. It was not helped by the restrictions on staff and practices when working in a

police custody suite with regard to detainee and staff health and safety. Physical conditions have a direct impact on professional practices. Consideration needs to be given to the planning of custody suites in consultation with architects, custody nurses and commissioners – perhaps incorporated in Home Office guidance for custody build planning.

The IT links have already been mentioned; the implementation of SystmOne will improve the knowledge base on detainees and allow for a smoother offender health pathway. Computers have been introduced into areas available to nurses so they can access email and the web for computer based training and information gathering, easing communication between nurses and with the provider managers.

- **Encourage training and development of police and healthcare custody teams**

In the case of Dorset many of the nurses and FME's had been working within the suite for a number of years so there was already a team ethos and a close working relationship. However the PCT and Police Partnership allowed for the opportunity for joint training to be undertaken to strengthen this. The evaluation identified as central to the success of this initiative close and symmetrical relationships between custody nurses and custody sergeants and officers.

Consideration can be given to the close analysis of how professional judgments by police and health service staff are integrated in dealing with detainees.

- **Develop the Nurse Practitioners role in custody and forensic services**

This is ongoing. There was some evidence of this within the evaluation period with the implementation of additional services such as Chlamydia screening and changes to the issuing of methadone.

It was, nonetheless, clear that for certain areas of development to take place consideration can be given to legal developments that would allow the realisation of the discrete role of the 'forensic professional'. This requires engagement at the political level.

- **Integrate high quality evidence- based care pathways and treatment protocols ensuring a coordinated approach across a range of settings**

(See previous comments regarding limitations to integration with community services)
There was movement towards this throughout the time of the evaluation. A limiting factor was the number of different NHS and other organizations that are located within the custody suite areas. Some do not overlap and have differing protocols making a coordinated approach difficult to negotiate. In Dorset this was proving problematic with the Police force area located over two NHS Primary Care Trusts – though it should be emphasised that Dorset Police found the partnership with NHS Dorset highly useful as a 'broker' and in terms of 'finding paths through'. For larger forces, a coordinated approach involving a greater

number of non-coterminus Trusts may be harder to broker. This mirrors resistance to 'joined-up' professional practices elsewhere – for example, the difficulty of establishing Common Assessment Frameworks in children's services.

Consideration can be given to the development of shared cultures of professional practice centred around the particular demands of custody health care and offender management.

- **Incorporate the use of innovation technology, including tele-medicine (the use of web-cameras and video links to show and discuss health problems with a specialist or colleague in another centre) and electronic records**

During the evaluation period there was some movement towards this with the introduction of computers that allowed for nurses to access email and the internet for training and information. This addresses an important consideration which is the professional integration of custody nurses with nurses in other specialisms and in the in-house NHS. Otherwise the evaluation has no information on this dimension. Clearly, however, careful consideration needs to be given (see above) to issues in confidentiality and the integrity of legal evidence.

- **Be regularly monitored and reviewed with an emphasis on development and continuous quality improvement**

The Operational Board met on a monthly basis and the Partnership Board on a bi-monthly basis throughout the evaluation which allowed for monitoring of developments and formative feedback for service improvement.

Summary

Developments in police custody healthcare must be viewed with the wider political context. The national policy framework, articulated by Bradley (2009), is oriented towards a "pathway" model of criminal justice health and social care, which is consistent with the Ministry of Justice's approach to offender management. Under this model, PCTs have a central role in developing and governing health and social care services across police custody, prisons, the courts, the probation service and the Youth Justice System, in partnership with lead organizations; their purpose is to build quality, effective, integrated health and social care services that meet the needs of local populations.

However, the ease with which the Bradley report talks about integrated services and partnerships belies the high levels of complexity in melding professional and organizational cultures – what, in other areas of public service, have so far proved intractable in varying degrees. The separation of the Ministry of Justice from the Home Office – separating out offender management and policing, for example, merely adds to the complexity of interdepartmental negotiations which embrace the Department of Health. For example, commissioning these services represents the transfer of funds on a large and potentially expanding scale from police budgets (Home Office) to PCTs (DH) with significant oversight

responsibilities for the Ministry of Justice.

Fragmentation at the political level intensifies the challenges of partnership development, where, in the Dorset case, there is an *evolving* (not a stable-state) relationship between the Police and the NHS, occurring within an organizational context of differing professional values and ideologies. Two traditionally distinct public service cultures are endeavouring to work together towards a common cause, whilst upholding their respective core values and principles around 'care' and 'custody' and responding to sometimes quite separate policy agendas of their respective professions or institutions. A key example is the Police and Criminal Evidence Act (PACE) and NHS Governance. Other institutional and professional challenges arise in terms of the way sectors 'intersect'; for example, the Police, the nursing professions, Forensic Physicians, allied health and social care professions, and the Third sector; all have different organizational imperatives and are guided by particular codes and principles. The key challenge for commissioners, and indeed for stakeholders at all levels, is to create synergy between partners, where they can work effectively together on common goals. The broad commissioning goal is to forge healthy, supportive and safe custody environments, whilst meeting the ethical standards of the Home Office, the Ministry of Justice, the NHS and lead professional bodies and supporting the rights, status and needs of detainees, professionals, the public and the institutions themselves. This is an ambitious project and presents a major challenge for new criminal justice health and social care partnerships.

Stakeholders, however, seemed to be in agreement that having an NHS commissioned service does make a difference – and we leave the last word to them:

"I think when you get a good service your expectations rise and your aspirations rise. I have to remind my staff now and then about what we used to get and what we get now"

"my honest answer; for the safety and benefit for the detainees coming though, the PCT makes it 100% better. I can see that."

"we would have got there eventually, but this has helped us to get there much quicker – you are given access to the right people and that networking has been of great benefit"

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APPENDICES – Evaluation Design

A: SUMMARY OF EVALUATION PLAN FROM ORIGINAL TENDER PROPOSAL, SUBMITTED JANUARY 2008

This proposal is indicative. Uncertainty over the scale of resources means we cannot commit our team either to too much work for the resource, nor to too little. What follows, however, is the shape and the character of how we propose to work for the Dorset PCT and its partners. We propose to start the evaluation in July 2008, but to use the rare opportunity of free time between commissioning and commencement in order to negotiate our role and the specific design of our work; to publish our intentions; to negotiate an ethics protocol governing the conduct of the evaluation; and to discuss sampling and negotiate access. We would also see this period as an opportunity to build a relationship with Dorset PCT and the Police founded on mutual understanding.

Mar-Jun 2008	Pre-preparation – negotiating the budget, design and ethical conduct of the evaluation and agreeing the scope of a review of Commissioning. In May/June we will hold a Stakeholder Meeting to publicise the evaluation plan and to negotiate the Ethics Protocol. Documentation analysis will also be conducted during this time.
June	First of two policy briefings on the PACE Review and its implications for care in custody (i.e. raising and negotiating questions for the case studies). Continued documentation analysis.
July – Dec	Conduct case studies in each of three main custody centres at Bournemouth, Poole and Weymouth to observe directly the impact of Commissioning, the particular qualities of service it generates and diverse perspectives on it.
Oct – Dec	Conduct first round interviews with key informants including service heads, a sample of practitioners, families and ex-‘s’ and all commissioners in order to document the range of perspectives on Commissioning identifying its processes currently and in the recent past and its impact; stakeholder recommendations for its further development; diverse views on partnership and service integration. Historical top line, baseline data on commissioning will be examined from accounting documents. The models of commissioning in each of the custody centres will be constructed for comparison purposes. This will enable the inputs and outcomes of commissioning to be assembled for comparison purposes. We will also identify the mechanisms through which each commissioning model is applied to its context.
Jan – Feb 2009	Negotiate and publish the case studies and an Interim Issues Framework for wide dissemination across the initiative and Dorset stakeholder groups. This to include a second briefing on the PACE review in response to the Interim Issues Framework. Interim Issues Framework to document principal concerns, controversies and options in relation to Commissioning, patient experience, professional perspectives on Care in custody and <i>qualities</i> ⁷ in service provision. The issues report starts the process of building on the evidence base and moving towards final reporting – i.e. the <i>shape</i> of the evaluation is in three phases: (1) fieldwork + first-order data, (2) second round of fieldwork+ second-order data, (3) reporting and dissemination.
Jan – Mar	Conduct second round interviews based on the Interim Issues Framework
Feb – Mar	Publish preliminary analysis of the commissioning process drawing from documentation and the evidence base
Apr	Two consultation groups involving stakeholder groups reflecting on case study data, the Issues Framework and the preliminary analysis of Commissioning (use here of Nominal Group Technique).
May	Stakeholder Conference to begin the process of review and negotiation of the Draft Final Report.
Jun – Jul	Final reporting: written report, briefings and dissemination planning. “

⁷ We use the term *qualities* advisedly. In relation to performance measurement and accountability we often have to settle on unitary definitions of what quality means. However, in evaluation it is more important to acknowledge that quality criteria vary across interest and practitioner groups.

B: EVALUATION APPROACH

The evaluation commenced in July 2008, during the transition period outlined above, which was approximately one year into the negotiations between Dorset Police and Dorset PCT. The independent provider had been contracted to provide an interim service for one year, and PCT commissioning was scheduled to commence on 1st July 2008, with The provider continuing as the contracted provider. The evaluation was scheduled to take place over a calendar year from July 2008 to July 2009.

The original tender required evaluation of the PCT commissioning process and its perceived impact, the quality of the commissioned service, and perceived benefits arising from the innovation, particularly relating to:

- clinical governance;
- workforce development;
- integration with other services (e.g. substance / alcohol misuse and mental health);
- the patient / user perspective;
- the police perspective;
- record keeping and information sharing.

The Principal Investigator of the evaluation team (de Viggiani) is a specialist in custody care and another member of the team (Last) subsequently accepted a role to co-ordinate the South West Regional Network for Offender Health. However, the Evaluation Director (Kushner) is a professional evaluator (currently President-Elect of the UK Evaluation Society) and provided methodological and ethical oversight to the project. Kushner has a background which includes evaluation of criminal justice and health sectors, but has no experience of custody care or procedures. This guaranteed the impartiality of the evaluation which might otherwise have been challenged on reasonable grounds. To employ a substantive specialist to conduct an evaluation (e.g. a public health researcher to evaluate a public health initiative; a software expert to evaluate an IT programme) has obvious benefits of familiarity and access. However, it does not guarantee evaluation expertise (e.g. managing complex evaluation relationships) and reduces the claim to independence – especially where the evaluator is known to hold views of what is being evaluated.

The evaluation adopted a negotiated, observation-based methodology. The evaluation team spent extended periods of time conducting observations in police custody suites and interviewing healthcare and police personnel. These were supplemented with interviews in the PCT and the police force. No detainees were interviewed given the ethical complexities involved (see below), and we acknowledge this as a significant limitation on the evaluation. Though the evaluation was originally conceived as a case study-based investigation this did not fully materialise. It would, for example, have required a more sustained narrative reporting of events within context and including an exploration of the values and personal life and career trajectories of the main players, in a way we did not accomplish. To understand innovation we have to understand innovators – especially in initiatives like this which are values-driven.

What we did do was to take an 'issues-based' approach – identifying and elaborating key issues as perceived by the range of stakeholders, all issues grounded in the evidence. Often these were matters of interpretation by the evaluation, and sometimes we chose to propose an issue for negotiation and verification even though we were uncertain of its origin or salience. These were negotiated, however, inside the Dorset Programme and, later, at a regional conference bringing together many interested parties in custody care. This approach is exemplified in our Concluding sections which set out a range of options and end with a series of key focuses for further consideration.

The stance of the evaluation was non-judgemental, which is to say that our task was to help the PCT, the Police and others to analyse the experience of this pilot, to feed their judgements and to support

(not displace) decision making. We had no warrant – no expertise, in fact – to make judgements of the performance of professionals in these demanding and unusual settings. The focus of the evaluation was on the *quality* of the programme as it was perceived by different audiences. Its outcomes and impact are not yet available (and we were not, to repeat, able to talk to detainees to elicit their judgement), and there are few metrics that adequately represent the qualities, accomplishments and the challenges of the initiative. But where measurement fails to explain we rely on judgement, and this was the basis of this report.

This does not neatly box the evaluation into a ‘formative’ as opposed to a ‘summative’ role – such terms are too coarse-grained to describe the range of possibilities in evaluation, a sensitive and potentially controversial practice at the best of times. For some people, a formative report has a summative impact; for decision makers a summative report is usually used (formatively) to make further decisions about the continuation of the action.

C: ETHICAL APPROVAL

Ethical approval for the evaluation was sought from and granted by the University of the West of England, Bristol's Research Ethics Committee (UREC). Given that this was not a *research* project, but an *evaluation* tendered by an NHS Organization, permission from the National Research Ethics Service was not sought. The team was advised by UREC, however, that it would not be ethical to interview police custody detainees during the evaluation. Moreover, a consensus reached through consultation with Dorset PCT, Dorset Police and NACRO was that it would be inappropriate to seek consent from detainees while in custody and to interview them given that (i) they may not be in a proper state of awareness; (ii) the evaluation team could interrupt legal procedure; (iii) detainees are not permitted to handle pens and therefore to sign consent forms (since pens are regarded as potential weapons); and (iv) the evaluation team could engage in no form of physical transaction with detainees (e.g. passing of pens/paper) to avoid risk of transmissible infection. Moreover, consent could not be audio recorded since the use of recording equipment for non-police purposes was vetoed in the custody sites. The Partnership Board agreed that this was how the evaluation should proceed. It became clear towards the end of the evaluation that the Police would have preferred to have the detainee perspective, but at this late stage this was beyond our control as an evaluation team.

Based on the advice of the UREC, the Partnership Board and NACRO, the evaluation team prepared the following statement for evaluation participants and stakeholders, which was made available to all participants and distributed at the custody suites:

Evaluation Ethics

Our task is to help identify key issues as this programme develops, to help improve its practices and its decision making. At best, we will strengthen this service and the way it works for both professionals and detainees. We are not inspectors and we will not be making judgments about 'good' or 'bad' practices. We will not report on anyone's performance – in fact, we will only identify an individual with their permission (see below).

We will be talking to people in Dorset Primary Care Trust, Dorset Police and Solutions for Health, as well as in collaborating agencies in the community.

We will conduct a small number of direct observations in custody suites to familiarise ourselves with care practices and to look at patterns of work and response.

At all times we will be aware of and sympathetic to the sometimes intense pressures in custody suites and will take every effort not to detract from people's work or to take them away unnecessarily from their business.

Clearly, there is a lot at stake here as the PCT, the Police and Solutions for Health enter uncertain territory with ambitious goals. The evaluation will be sensitive to the risks people are taking and will design its activities accordingly – for example, making sure that all reports are carefully scrutinised by programme people and negotiated for their fairness, relevance and accuracy.

We will work by talking to people, watching practices and reading documentation. In doing so we will be guided by these principles which we invite participants to challenge and amend:

- All data which identifies people and organizations or units will be regarded as confidential until it has been cleared for use. The data will be subject to negotiation in which people have the opportunity and the right to change their (but not others') data. People own the data on their own lives and work.
- Where the evaluators come into possession of any information that by statute should be disclosed or where it provides evidence of potential harm or damage, the enquiry and this ethics protocol will be suspended and appropriate disclosures made, irrespective of confidentiality.
- We will collect documentary data on the commissioning process, but no documentary data on any individual, including detainees.
- We will conduct observations and interviews for the specific purpose of auditing the impact of the

commissioning process and key programme objectives on practices, and for the exclusive purposes of service improvement and programme analysis.

- All data held by the evaluation team will be held in secure (where electronic, password-protected) sites as is customary on university projects.
- Data which is anonymised and does not reveal identities may be used without negotiation – but we remain sensitive to the fact that it will sometimes be reasonable and prudent to negotiate that data, too.
- Where we negotiate accounts – sometimes individual transcripts of conversations, other times sections of reports – we will encourage people to take ownership and control of these accounts so as to achieve the best possible expression of how, what and why people think as they do about the procedures we are observing.
- We will generate data with professional practitioners and their managers – where appropriate and reasonable, with citizens. However, we will not collect data on or from any detainee in police custody. When an evaluator is in a secure police location (e.g. a Custody Suite) and an arrested person enters we will suspend the study immediately and, where feasible, physically withdraw until advised to the contrary. Under no circumstances will we approach a current detainee asking for their consent to participate.
- The evaluators will be available at all times to explain what they are doing and to give examples of the kind of records we are making – so long as this does not breach others' confidentiality.
- People can choose to withhold their data. However, if this compromises an evaluation report we reserve the right to include an explanation of this in the report to cover the gap.
- At all times we will resort to the principle of 'what is reasonable'. A set of rules and agreements cannot cover all eventualities, and all projects have surprises. However, if we are alert to the principles given above and to the need to keep talking and maintain contact, we are most likely to complete this evaluation as an authentic collaboration with mutual tolerance.

