Audit in prisons: views from outside and inside

Prisoners are a disadvantaged population in terms of their social background, their health status, and the health care that they receive. Recently, audit has been advocated as part of a major restructuring of the former prison medical service.

**NHS view**
Health care in prisons is managed separately from that in the NHS and is the responsibility of the prison service. Large prisons employ full-time medical officers, and smaller establishments have visiting doctors, often local general practitioners. The health care reforms which have engulfed the NHS for the past three years are only just beginning to impinge on service provision in prisons.

Much criticism has been levelled at the quality of health care in prisons, in part a reflection of a penal system whose primary purpose is to incarcerate rather than care for people; other contributing factors may be the low professional status of prison health care staff, the often poor physical environment within prisons, and the fact that prisoners evoke little sympathy or priority from the public or parliament. Improving the quality of health care in prisons is essential if any impact is to be made on the high morbidity among prisoners.

The current reform of prison health care services aims at ensuring their equity of provision for prisoners: collaboration with the NHS is increasing and emulation of some of the recent NHS changes, such as pilot contracting schemes and the requirement to establish audit, is part of the drive to improve quality.

**Challenge to audit in prisons**
The recent call for the NHS to support audit in prisons presents a real challenge. Hierarchical working relationships hinder the development of audit, especially clinical audit. Successful multidisciplinary team working is relatively rare in the NHS and is not a characteristic of prison health care. Hence the frank discussion needed for sharing potential mistakes and weaknesses will inevitably be slow to develop among prison staff. Clinical audit may be the only avenue in prisons as even large establishments have relatively few doctors. Multidisciplinary clinical audit has the added benefit of sharing workload. Joint audit across several prisons would have a similar advantage and would also contribute to standard setting and might encourage comparative audit. Regular meetings among prison staff could also help to reduce professional isolation, as it does for small specialties in the NHS.

However, important practical barriers to clinical audit need to be considered. Although generally accepted that good audit does not depend on having a computer, access to routine information is helpful. Simple activity data in prisons is fairly minimal, and computerisation of health information, where it exists, is often limited to the pharmacy. Details of who is being treated and for what are not easily available. Data collection will therefore be time consuming. In the early days of the audit activity resulting from the NHS reforms this aspect was often quoted as a major barrier.

The combined commitment of managers and clinicians has been essential for establishing audit in the NHS. Prison governors, as they now hold healthcare budgets, will need to make a similar commitment and provide the necessary financial and other support. To be enthusiastic enough about audit to provide resources they will have to be persuaded of its benefits, whereas in the NHS reforms funds were provided before the benefits of audit were considered in depth.

**Prison service view**
Unlike the NHS, the Health Service for Prisons has received no pump-priming money for audit, any funding having to come from existing healthcare budgets. Although prison governors are encouraged to provide time for prison healthcare staff to engage in audit, the time allocation is often insufficient. General enthusiasm for audit expressed by prison doctors is also tempered by pessimism about the likelihood of adequate resources, given the competing priorities of security and control. To ensure audit receives the attention it deserves prison governors will have to rely on some support from the NHS.

In 1992 the director of the Health Service for Prisons secured the support of the NHS Management Executive and professional bodies (Royal Colleges of Physicians, Psychiatrists, and General Practitioners) for prison doctors to participate in local NHS audit arrangements. Operational managers within the prison service agreed to facilitate prison doctors participation. In March 1993 the director wrote to all prison doctors encouraging them to embark on medical audit, initially by participating with local medical audit advisory groups and hospital or community audit committees. A review of audit arrangements later that year showed that prison doctors efforts at integration had largely been ineffective. In some regions the NHS has now responded by inviting prison doctors to attend regional training programmes and to submit project proposals for consideration for funding. Within the Health Service for Prisons audit training is included as a component...
A way forward together

Many of the difficulties faced by prison healthcare staff in establishing audit are shared by staff in the NHS. Specific problems relate to size and structure, but more particularly to the scale of problems that need to be addressed. If audit is to become an active integral part of the work of the Health Care Service for Prisoners further help is needed from the NHS. A lead has been taken by the Department of Health and the management executive, and this needs to be transformed into local action and communication.

NHS audit coordinators should provide information about audit training programmes to those who work in local prison services, and prison healthcare staff should ask local audit officers to run basic multi-disciplinary audit workshops for prison healthcare staff. Help from visiting NHS consultants and other professionals in designing and implementing audit would be a way of transferring expertise.

The impact audit will make on the quality of care provided in prisons will depend, as it does in the NHS, on the ability to implement change. Audit will identify training needs and many other issues that require resource commitment. Both the prison service and local prison establishments will have to be prepared to respond to such findings if audit is to be anything other than a paper exercise.

The primary culture in prisons is of discipline and punishment rather than care. This presents dilemmas to those healthcare staff working within the prison setting and is alien to those used to the NHS. The recent experience of a learning set involving London prisons and the NHS has highlighted how this can generate prejudice in members of both organisations. Difficult though it may be, open acknowledgement of such feelings is an essential step towards collaboration. Audit is an opportunity to work together, to help understand each other’s organisations and each other’s difficulties. This can only be beneficial for the care provided to a disadvantaged group of our population.

The predicament of the Health Care Service for Prisoners is profound. Poorly resourced, under researched, and generally kept out of view, the health care problems of the prison population are known to too few. To expect audit alone to be able to improve appreciably the quality of prison health care is to expect a nut to break a sledgehammer. Little formal liaison exists between the NHS and the Health Care Service for Prisoners; however by encouraging collaboration through audit the two services may come closer together. A first step might be an awareness of the existing situation. Are you aware of the health care situation in your local prison?

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Keyword indexing: brief guidance for authors

From 1994 onwards the method of compiling the subject index in Quality in Health Care will change, whereby papers will be indexed by a keyword system. Authors of papers are requested to include up to three, occasionally four, keywords (words or phrases identifying the subject) on their manuscript, which will contribute to the compilation of the annual index in the December issue. The subject index will be different, with the title of the paper repeated after each keyword for every entry; cross references will not appear in the subject index. The author index will no longer include the title of the paper and will comprise a list of authors and page numbers only.

Choosing keywords may not seem intrinsically difficult, but there are unforeseen problems. An index should be as consistent as possible, and entries should not be split between, for example, “antenatal care” and “care, antenatal.” Whereas some decisions may reasonably be made about the entries that can be predicted, authors will not know what other work is being published in the same volume or under what titles. Therefore, some modifications by the technical editor may be necessary.

General points

Authors should scan their paper for keywords that may not be in the title, use British approved names for drugs rather than proprietary names, and avoid general terms such as clinical, complications, adverse effects, and patient. As the subjects of the journal are “quality” and “health” it would be better to avoid these terms as keywords whenever possible. Retaining accepted phrases and concepts is preferable – for instance, “health district” rather than “district, health”. Some shortened forms may be acceptable as keywords – AIDS, HIV, TQM. Keywords should be widely known and understood – but generally the full form of abbreviations should be used.

Within this framework authors are encouraged to consider their choice of keywords carefully to facilitate location of their published work by readers.