COMMUNITY JUSTICE SCOTLAND

Achieving Community Justice Outcomes

Targeted resource to support national outcome improvement planning in local authority areas

National Outcome: More people have access to, and continuity of, health and social care following release from a prison sentence

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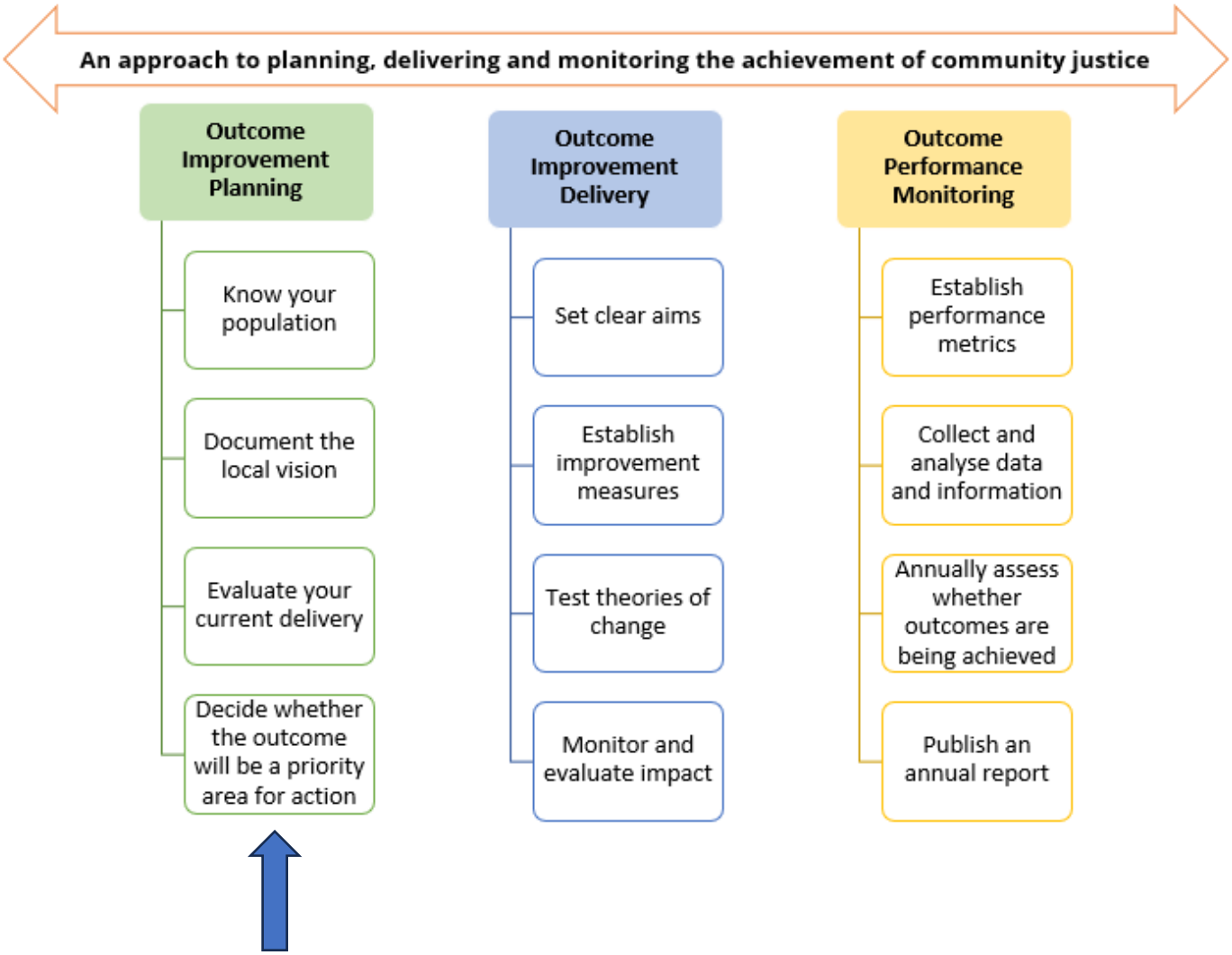
Outcome improvement planning

An approach to support partners in the planning, delivery and monitoring of community justice outcomes in local authority areas was published in June 2024. The approach is intended to provide community justice partners, acting jointly at a local level, with a practical framework to work within to plan, deliver and monitor outcome delivery.

The approach methodology defines three **processes** to meet this aim, each with a distinct number of steps:



This targeted resource focuses on the first process within the approach: **outcome improvement planning** and relates to the following national outcome:

"More people have access to, and continuity of, health and social care following release from a prison sentence."

National outcomes

Nationally determined outcomes are set out in the Community Justice Performance Framework (the framework) and describe the result of implementing the priority areas for action in the National Strategy (the strategy).

This targeted resource provides a detailed step by step process intended to support partners in the planning and assessment of progress towards the national outcome "***more people have access to, and continuity of, health and social care following release from a prison sentence***."

Local Outcomes

Community justice partners may have identified other outcomes in their Community Justice Outcome Improvement Plan (CJOIP). These outcomes will reflect local priorities and will be consistent with the national outcomes, or may relate to priority actions in the strategy where there is no associated national outcome. Partners can use the principles outlined in each step of this process to plan for the achievement of these local outcomes.

Outcome overview

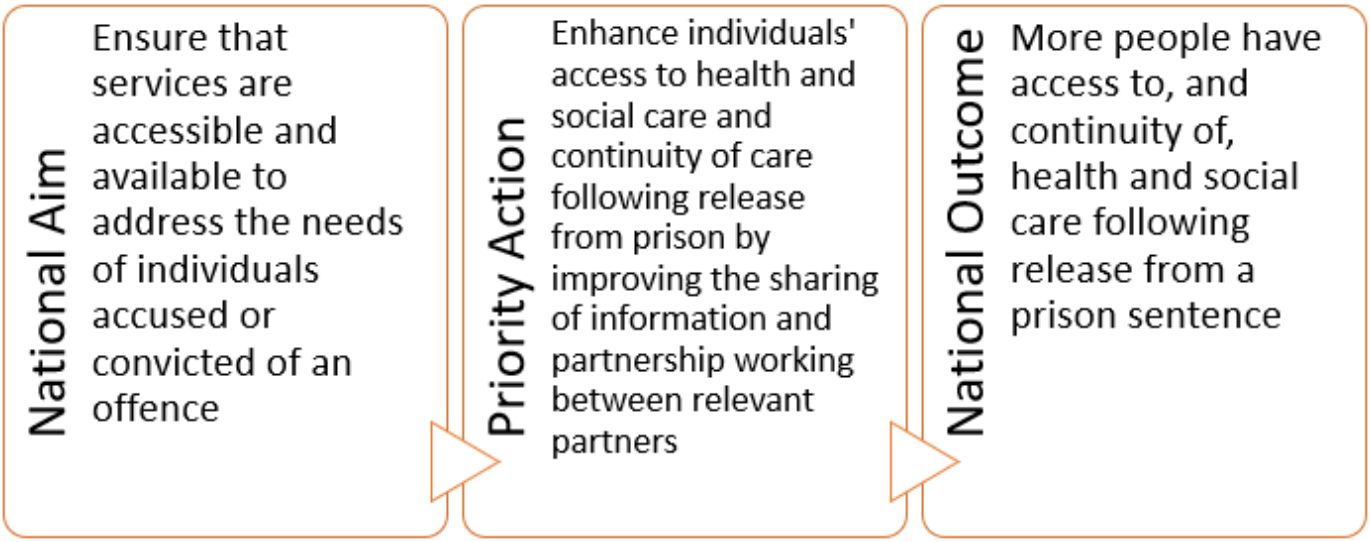
The strategy states that: "Prisons should be health promoting environments which support good health and wellbeing. There are many complex needs for which individuals require person-centred support on entering and leaving custody, including: rising social care needs as the population ages, neurodivergent people, those with learning disabilities, those who have experienced trauma and adversity and those who may experience complex physical and mental health needs, and substance use difficulties. We are clear that early intervention, person-centred, trauma-responsive, rights-based and collaborative approaches are key to improving outcomes.

Partners should work together to ensure that both relevant information is made available on admission to support the healthcare needs of individuals while they are in custody and that transition from custody to community is seamless, with health needs supported to ensure successful reintegration where people do not experience stigma and discrimination upon accessing services. This is particularly the case when an individual is being released from prison to a different location in Scotland, and it is key that all health boards commit to having robust arrangements in place which facilitate the appropriate sharing of health information across geographical boundaries.

This will involve collaborative working across multi-agency partnerships, digitalisation, ensuring that there are information sharing agreements where required, and shared support plans, including, where appropriate, care packages, and ensuring that there is shared awareness and understanding about what each organisation involved in health does and that guidance and training is in place. For example, the Scottish Prison Service should, where appropriate, issue individuals with a liberation letter, which provides a proof of identity (which can be used to help register with a GP practice) and GP practices should ensure that they comply with the relevant guidance. The relevant NHS Circular notes that no documents are required to register with a GP and that the inability by a patient to

provide identification or proof of address is not considered reasonable grounds to refuse or delay registering a patient."

The strategy sets out aims and priority actions for partners to focus on over the duration of the strategy. The framework describes what the desired change looks like in the form of national outcomes. The aim, priority action and national outcome relevant to health and social care needs for people in prison are:



Step 1 - Know your population

Strategic planning information about the prevalence of health and social care needs on admission and liberation to prison, and about the people in your local area who are experiencing it, will significantly help in planning the delivery and achievement of this outcome. It will also help you to assess the scale and depth of the challenge in meeting the outcome.

Knowing your population involves applying principles of strategic needs and strengths assessment (SNSA)[1] and appreciative inquiry[2]. This involves using quantitative and qualitative data and information to help partners collectively understand the people for whom you are striving to meet the outcome for, and supports partners to look at old problems and issues in new ways. A good quality evidence base will enable partners to gain knowledge and wisdom about the delivery of community justice locally, and to use these insights to plan improvement.

[1] Find out more: Strategic Needs And Strengths Assessment: Guidance - Community Justice Scotland :Community Justice Scotland

[2] Find out more: Forming new futures through appreciative inquiry | Iriss

To understand the health and social care needs of the prison population in your local area, you will need to find out as much as you can about prevalence, who is experiencing it, what their needs are, and whether the right services are available locally and in custody to address those needs.

And pause for a minute....

What do we mean by quantitative and qualitative data and information?

It is worth taking a moment here to explain what we mean by quantitative and qualitative data and information and what we want to use it for in outcomes planning.

Quantitative data (or numerical data) is helpful for answering basic questions such as “who”, “what”, “where”, and “when” and is helpful for measuring the extent, prevalence, size and strength of an outcome. Quantitative data on its own (as in raw, unprocessed facts and figures) are seldom meaningful or useful and numbers alone do not tell the whole story. However, when processed and analysed, quantitative data can produce a succinct picture which is easy to compare, such as when presented as a baseline and trend.

Qualitative data enables a richer understanding of how outcomes are being delivered and provides important context to the numbers. It is helpful for exploring more complex issues, generating hypotheses and gaining deeper insights into human behaviour and experiences. It can also highlight issues and priorities which are important to the workforce or people with living experience of community justice, which may not fall within a performance remit. Qualitative data helps to answer questions such as “why” and “how”.

Ultimately, we want you to use a range of data and information, both qualitative and quantitative, to establish a good quality evidence base on which to make decisions about outcome improvement.

What data and information should we source and what if it isn’t available?

We know that the provision of data and information within community justice is an evolving process and some data points, and mechanisms to capture insights, are more readily available than others. There is work ongoing at a national level to discuss community justice data development and improve the publishable evidence base in community justice.

The example data collection plans in the following sections provide a wide range of questions to be answered, and include signposting to potential types of data and information in terms of whether it is quantitative or qualitative and where it might be sourced. These example data collection plans are

provided to engender curiosity amongst partners and provide a 'pick and mix' of examples that local areas may wish to choose from. They are not mandatory or directive and local areas can decide what is most meaningful and proportionate when establishing their data collection plans.

The availability of some data and information identified in the example data collection plans may be unavailable currently. This relates to both quantitative and qualitative data. If partners collectively agree that the data and information is meaningful to collect, and it is currently unavailable, partners should consider whether this in itself should be considered as an improvement action. For example, you might identify an improvement activity to work with a local statutory partner to produce a data sharing agreement. Or you might have an improvement activity to develop a survey that collects insights from the workforce in the delivery of the outcome.

If partners have tried to source the data and information and it proves to be unavailable, and won't be available in the foreseeable future, it may be worth including this in the outcome progress report (described in Step 3 this document) as an audit trail of local data and information development. This will help to inform both the local area and national picture of community justice data and information availability.

Once you have a data collection plan for each national and local outcome, it is worth reviewing them collectively to see what data and information you need to source directly from national partners, the workforce and people with living experience of community justice. For example, you may have a number of data items or insights that you want to request from SPS or COPFS and these might need to be coordinated or collated into a single request to make it easier for partners and organisations to respond to.

Understanding People

A demographic data profile collates information relating to people in prison who have a health and social care need. The demographic data profile should include data and information that enables you to describe the prevalence of health and social care needs within the prison population in the local area, and where possible give insights into the people experiencing them, and their characteristics.

Sources of data for the demographic data profile will vary. Some data will be national, some may be published and broken down to local authority level, and other data may be held locally.

A simple data collection plan should set out the questions you want to ask, possible sources of data and information received. An example of how a data collection plan for people experiencing health and social care needs in prison might look is provided:

Sample questions – answered with quantitative data (possible sources provided in brackets)
How many transfers were there in drug/alcohol treatments from custody to community? (national indicator – provided annually by JAS)

Sample questions – answered with qualitative data sourced from local workforce and people with living experience
What do we know about people's GP registration status, on entering and leaving prison?
Are people from the local area, leaving prison, issued with a liberation letter?
How do local people experience treatment on admission to prison?
Is their treatment continued or interrupted (including prescription services)?

The data in your final data collection plan may be able to be broken down to give further information about people's characteristics (such as gender, age, employment status etc.).

Using the information gleaned from your data collection plan you should be able to establish a picture of people's health and social care needs on admission and liberation from prison. Data that is able to be broken down into specific characteristics should enable some insight into the local population and whether the population profile is changing over time.

Understanding Needs

A needs data profile builds on the demographic data profile. Now that you know who is receiving community sentences, it will be important to try and understand what their needs are.

Some questions that you may wish to ask partners, and source data for, are provided:

Sample questions – answered with quantitative data (possible sources provided in brackets)
How many people received opiate replacement therapy whilst in prison? (Prison Health Information Dashboard) [3]
How many people upon reception at prison tested positive for illegal drugs? (Prison Health Information Dashboard)[4]
How many people attempted to quit smoking whilst in prison? (Prison Health Information Dashboard) [5]
How many take home naloxone kits were provided by prison? (Prison Health Information Dashboard) [6]

[3] Only available at national level
[4] Only available by prison establishment
[5] Only available by Health Board area
[6] Only available by prison establishment

Sample questions – answered with qualitative data sourced from local workforce and people with living experience
How do people experience support for their health and social needs on admission and liberation from prison?
What do we know about local people, on entry to prison, and their identified health and/or social care needs?
What do we know about the physical needs of local people in prison? Do people require adaptations to their living environment on admission and liberation?
What can we glean from prison admission screening and LS/CMI[7] data from prison based social work about people's health and social care needs?
What insights can local GP practices give into the practicalities of de-registering and registering people serving prison sentences?

Further analysis of the demographic data may also indicate the health and social care needs of people on in prison.

Understanding Services

A services profile provides an overview of the services that are available in your local area in relation to supporting people with their health and social care needs on admission and on liberation from prison. It will be particularly important to collect information about service availability in relation to the needs data profile and to establish how easy it is to provide continuity of care for individuals.

Once you have collated all of the information it will be important for partners to consider what it means in terms of the local vision for providing, and ensuring continuity of, support for health and social care needs for those going in to and leaving prison. For example, the demographic data profile may reveal trends in age or gender that require a specific focus in delivery. Similarly, the needs data profile may highlight specific needs that require particular focus in terms of local and national service provision. The services profile may reveal gaps and/or duplication in service provision or may highlight the need to improve the interface between community and prison services.

Step 2 - Document the local vision

This step in the process requires partners to collectively define what good delivery looks like for people from the local area with health and social care needs in prison. A good way to visually represent the process by which the outcome will be achieved is to document this as a 'theory of change' using a logic model.

[7] Level of Service / Case Management Inventory (LS/CMI) is an assessment that measures risk and need factors for adults.

Policy landscape

Creating the local vision involves taking cognisance of legislation and national standards and guidance, alongside reflecting what is known about the local population (established by applying Step 1). The following policy documents may assist partners when developing the local vision:

- Bail and Release from Custody (Scotland) Act 2023 (s12)
- Health and Healthcare Prison: A Literature Review
- Prison population health needs: synthesis report
- Prison population: mental health needs
- Prison population: social care needs
- Prison population: physical health needs
- Prison population: substance use and wider support needs
- A New Vision for Social Care in Prisons
- Reducing offending, reducing inequalities

Theory of change

A sample logic model setting out the theory of change for supporting people with health and social care needs in prison has been produced by CJS (in consultation with national policy colleagues). Partners should adapt the logic model to reflect any additional partner activities and outcomes that require to be a focus to meet the needs of the local population and to realise the local vision.

National improvement actions

The strategy delivery plan, published by the Scottish Government, expands on the strategy by setting out a number of tangible, time-limited deliverables, detailing exactly what work will be undertaken to drive improvement nationally towards the national outcomes. These activities form an important part of the theory of change for meeting national outcomes and have therefore been included in the logic models (identifiable in brackets by the action number from the delivery plan). Progress towards the deliverables will be monitored by a Community Justice Programme Board which brings together community justice partners at a national level. Keeping up to date with the progress of these activities will be important in the evaluation of your current delivery as some local improvements may be dependent on national improvement progress.

Step 3 - Evaluate your current delivery

Once the local logic model is complete you will need to identify how you are going to tell whether the model works as predicted. To do this, partners should consider **each activity** identified in the logic model and discuss whether, and how, it happens in practice. Formulating some questions to ask relevant partners as part of this process is a powerful way of teasing out the facilitators and barriers to local delivery. These are known as evaluation questions.

Ask evaluation questions

A simple data collection plan should be prepared and completed as part of this step. Consider each activity from the logic model and think about what you might want to know, from whom, about how the activity is working in practice. For example:

Activity from Logic Model	Question For	Question
Lawfully share information to support continuity of care (Health)	Community GP practices	How are you notified if someone is admitted to prison? Do you have processes in place to share appropriate information with prison based healthcare colleagues to ensure continuity of care?
	Prison based healthcare	How do you request and receive information from community based health colleagues to ensure continuity of care on admission and liberation from prison?
	Individuals	Were prison based healthcare colleagues aware of your health and social care needs on admission to custody? If you take regular medication, did you have access to that medication immediately on admission or release from prison?

Individual sessions with partners and stakeholders to ask questions and collect information about how the activities are carried out can be a good way of establishing the realities of local delivery. It is also important to talk to partners collectively to ensure the support of people with health and social care needs in prison is considered as a whole system and to test whether the predicted outcomes are being achieved. A facilitated workshop can be an effective way of doing this.

Set specific indicators

In addition to formulating evaluation questions, partners should identify specific indicators that will measure or signal whether the logic model is or isn't working as expected. Often, the demographic and needs data that you collected in the 'know your population' step of the process will be helpful. As a minimum, partners should consider using the indicators specific to this outcome outlined in the framework, the improvement tool and the self-evaluation guide:

Source	Indicator
Performance framework	Number of transfers in drug/alcohol treatments from custody to community
Improvement tool	Health and social care circumstances/care plans are reflected in collaborative plans for release
	Referral pathways and information sharing arrangements are in place to support timely access to health and social care supports upon release

Self-evaluation guide[8]	Improving the life chances and outcomes of people with living experience of community justice (quality indicator 1.1)
	Impact on people accused or convicted of offences (quality indicator 2.1)

Summarise the evidence

You should now have a range of quantitative and qualitative data and information available about how people's health and social care needs are supported on admission and liberation from prison locally. What can be said (either conclusively or hypothetically) about this support and the continuity of care for people being admitted and liberated from prison to the local area? What inferences or conclusions can be made from the data and information?

To help structure this step it might be helpful to prepare an outcome progress report that can be shared and reviewed by partners collectively. The report should summarise what has been established in the steps of this process, particularly:

- Information about the **prevalence** of health and social care needs of people in prison over time.
  - ✓ Are the needs increasing or decreasing over time?
  - ✓ Are people regularly issued with a liberation letter when they leave prison?
  - ✓ Are there any gaps in the information and how can this be rectified for the future?

- Information about the **population** being admitted and liberated from prison with health and social care needs.
  - ✓ What is known about their demographics and does this necessitate targeted interventions?
  - ✓ Are there any gaps in the information and how can this be rectified for the future?

- The **needs** of the population.
  - ✓ What is known about the health and social care needs of people being admitted and liberated from prison?
  - ✓ Are there any trends apparent?
  - ✓ What does the LS/CMI data tell you about need?
  - ✓ Does this necessitate accelerated pathways into certain services?
  - ✓ Are there any gaps in the information and how can this be rectified for the future?

- Health and social care **services**.
  - ✓ What is known about the accessibility and continuity of services for people being admitted and liberated from prison to support with their health and social care needs?
  - ✓ Based on the needs profile, which services are particularly relevant in release planning (for example physical health, housing adaptations, employability and mental health)?
  - ✓ How do partners ensure that there are no gaps in provision for people receiving regular prescribed medication such as insulin or statins?

[8] These quality indicators have been identified by the Care Inspectorate as particularly relevant in the assessment of the continuity of health and social care leaving prison. However, this is not definitive and the Care Inspectorate would urge partners to promote flexibility in the use of other quality indicators to evaluate impact.

- ✓ How easy is it for third sector services who were supporting people on admission to prison to maintain a relationship and provide continuity of support when they leave?
- ✓ What information is shared with pharmacies and prison healthcare to ensure there is no interruption to an individual's opiate replacement therapy?
- ✓ How is the transfer of prescriptions managed?
- ✓ Are there any established fast-track pathways into treatment or support services?
- ✓ Are community and prison based support services comparable and are they joined up to maximise continuity of care for the individual?
- ✓ Are there any gaps in the information and how can this be rectified for the future?

- The **local vision** for community sentence delivery.
  - ✓ What does good support for people with health and social care needs on admission and liberation from prison look like locally?
  - ✓ Has a logic model been developed that clearly sets out the process by which the outcome will be achieved for the local population?
  - ✓ Does the logic model set out who the crucial partners are and the crucial activities they will carry out to meet the outcome?
  - ✓ Are there any gaps in the information and how can this be rectified for the future?

- An **evaluation** of current support for people with health and social care needs on admission and liberation from prison.
  - ✓ How did partners, stakeholders and individuals answer the evaluation questions?
  - ✓ What have you learned about how the activities outlined in the logic model are, or are not, working in practice?
  - ✓ Where are the strengths in delivery and where are the main areas that need improvement?
  - ✓ What did the specific indicators tell you about local delivery?
  - ✓ Are you confident from the information and data collected that the needs of people can be addressed and continuity of care can be delivered?
  - ✓ Are there any gaps in the information and how can this be rectified for the future?

Assess progress towards the outcome

The **conclusion** of the outcome progress report should be a collective agreement by partners as to whether the local area is meeting, or how close the local area is to meeting, the national outcome of "more people have access to, and continuity of, health and social care following release from a prison sentence". If the outcome is not being met, the conclusion should clearly state why and list the required improvements. If your theory of change is correct, most of the improvement activity should link directly to the activities outlined in the local logic model. It is important to note that identified gaps in data and information may also form an improvement action.

Step 4 - Decide whether the outcome will be a priority for action

The assessment of whether this outcome will be a priority for action in the CJOIP will include consideration of the other outcome progress reports for both national and local outcomes.

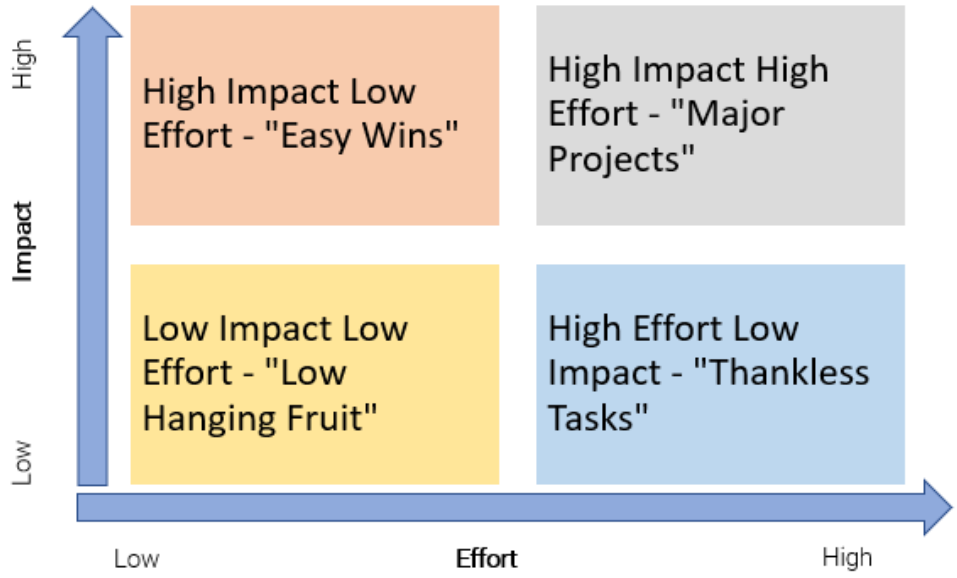
This step involves putting the outcome progress reports in a hierarchical order according to how close or far away from being met the local and national outcomes are assessed to be. Prioritisation of the outcome improvement reports is best done as a collective activity by partners. A facilitated workshop can be an effective way of doing this.

There are a number of techniques that partners can use to aid this step.

Impact vs effort matrix

An impact versus effort matrix is a simple tool that can help generate conversation and aid partners in their decision making regarding prioritisation.

The axes for the matrix can be set according to what will be the most helpful to make an informed choice regarding prioritisation. As well as impact and effort, as shown in the example, you might consider changing the axes to importance versus urgency, cost versus benefit or risk versus reward.



Scoring criteria

Developing a scoring criteria is another method that can be helpful in prioritising the outcomes. This involves partners assigning a score for each identified improvement activity across a range of criteria. For example:

Outcome	Imp activity	Critical to meeting standards	Strategic value	Ease	Benefit to the individual	Cost	Resource impact	Overall priority (average)
More people have access to, and continuity of, health and social care following release from a prison sentence	Imp activity 1	4	1	3	3	5	2	**3**
	Imp activity 2	5	2	4	4	4	5	**4**
	Imp activity 3	1	1	5	1	3	4	**2.5**
								3.2

For this table, you could set the following priority ratings:

Critical to meeting standards?	Is the improvement activity crucial to ensure effective access and continuity of health and social care following release from a prison sentence?	1 = Critical	5 = Not critical
Strategic Value?	Is the improvement activity important to your overall strategy?	1 = Highly important	5 = Not important
Ease?	Will the improvement activity be fairly easy to complete?	1 = Very easy	5 = Very difficult
Benefit to the individual?	Will the improvement activity likely yield significant benefit to the individual?	1 = Highly likely	5 = Not likely
Cost?	Will the improvement activity likely cost a lot?	1 = Low cost	5 = High cost
Resource impact?	Will the improvement activity have a great impact on CJP resource?	1 = Low impact	5 = High impact
Overall priority:	Priority for each individual improvement activity is the average score of all five criteria. Total priority for the outcome is the sum of all overall priority scores, divided by the number of improvement activities.		

Note: The lower the score the higher the improvement activity and overall outcome priority.

There are many other techniques that can be used to aid prioritisation.

Narrative assessment for the CJOIP

At the end of the process, partners should use the outcome progress report to clearly articulate:

- whether the access to, and continuity of, health and social care following release from a prison sentence outcome is being achieved in the area
- if not, how near the outcome is to being achieved
- whether the outcome requires to be a priority for action
- the action they intend to take to achieve, or maintain achievement, of the outcome.

This narrative assessment should be included in the CJOIP.

Health and social care needs following a prison sentence - sample logic model

National Goal / Priority	Inputs	Activities – What we do					National Outcome
		Police Scotland	Scottish Prison Service	Health	Scottish Government	Local Authority	
What we want to achieve Over the duration of the National Strategy community justice partners will: Enhance individuals' access to health and social care and continuity of care following release from prison by improving the sharing of information and partnership working between relevant partners.	**What we invest** Workforce Staff training Data Information sharing processes National standards and guidance Legislation	Establish pathways to support at the earliest opportunity (from point of arrest) in order to maximise the efficacy of interventions. Lawfully share information about individuals being considered for a custodial sentence. Engage with release planning processes.	Screen for vulnerabilities on admission to prison. Undertake release planning and link with community case management to ensure continuity of care. Lawfully share information to support continuity of care. Issue individuals with a liberation letter (which provides a proof of identity). Identify opportunities for supporting continuity of care through the development of suitable Clinical IT solutions, facilitated via the Prisons Digital Health & Care Systems Provisioning Programme (action 21). Develop and implement a revised Information Sharing Agreement between SPS and NHS Boards (action 24).	Improve the health of prisoners, ensuring equivalence of health services to those available in the community. Reduce professional isolation for prison healthcare staff. Engage with release planning processes. Lawfully share information to support continuity of care. Bring partners together (via the National Prison Care Network) to collaborate and improve the quality of life of people in prison. Support a 'Once for Scotland' approach to the planning, design and delivery of an integrated, holistic, person centred care pathway across the health and social care system. Implement the revised Memorandum of Understanding between SPS and the NHS (action 24).	Amend GP contract regulations to allow the pre-registration of prisoners in advance of liberation (action 23).	Support a coordinated approach to continuing support to those entering or leaving prison. Engage with release planning processes. Lawfully share information to support continuity of care.	**What we ultimately want to achieve** More people have access to, and continuity of, health and social care following release from a prison sentence.
					Skills Development Scotland	**Third Sector**	
					Engage with release planning processes.	Engage with release planning processes. Provide support to people to address need. Collaborate with justice social work and SPS to support continuity of care on admission and liberation from prison (such as mentoring and assertive outreach).	

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Community Justice Scotland

R1 Spur, Saughton House,

Broomhouse Drive,

Edinburgh EH11 3XD

T: 0300 244 8420

www.communityjustice.scot

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Community Justice Scotland