Royal College of Nursing

Sexual and Reproductive Health Competency Framework for Women Cared for in Prison

CLINICAL PROFESSIONAL RESOURCE

Acknowledgements

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Notes

It is recognised that care may be provided by registered nurses and midwives, health care support workers, assistant practitioners, nursing associates, student nurses and midwives, and trainee nursing associates. For ease of reading, the generic terms ‘nurse’, ‘nursing’ and ‘nurses’ are used throughout this document, unless specified.

The RCN recognises and embraces our gender diverse society and encourages this guideline to be used by and/or applied to people who identify as non-binary, transgender, or gender fluid.

The RCN also recognises that not all those born female or male will identify with the same gender nouns, but for ease of reading we use the term woman/man/men and where appropriate, acknowledge non-binary terms.

Background

This project's intention is to develop a framework of sexual and reproductive health competencies for nurses, midwives, and those supporting nursing teams, who provide health care to women in prison, and may have limited experience caring for pregnant women. This includes registered nurses, nursing associates and non-registered health care support workers.

This project was conceived following two independent investigations by the Prison and Probation Ombudsman (McAlister, 2021 and 2022) of Baby A and Baby B at two women's prisons. These investigations identified serious failings in care related to knowledge and understanding of sexual health, contraception and pregnancy risk assessment on admission to prison. Recommendations from these investigations referred to the RCN training directory (**rcn.org.uk/clinical-topics/Public-health/Sexual-health/Sexual-health-education-directory** member login required) and noted that staff working in these settings required further training and education to support best practice.

When reviewing the training directory, a gap was identified relating to the education and preparation of staff working in these services. This identified need is a fundamental skill set for those staff making risk assessments of women, for example, in custody, prison reception, and immigration detention centres. However, the project team have focused on prisons, as the complexities of different services may require a different approach. There is also recognition of the scope of accessing and referring to secondary care settings, and the competencies identified can be used in all settings.

Introduction

Care of women in prison necessitates a different pathway to care of women in acute or community settings. The prison setting has competing priorities, where the prison's security and provision/access to health care can sometimes be challenging. Practitioners need to be cognisant of the context within which women in prison live. People in prison are entitled to health care that is equivalent to that which they can access within the wider community.

Statistics indicate an increasing population of women being detained in prison, with a disproportionate number of women of childbearing age among them.

- The most recent prison population statistics are published weekly for England and Wales: **gov.uk/government/collections/prison-population-statistics**
- The figures for Scotland are available at: **gov.scot/publications/scottish-prison-population-statistics-2022-23**
- The figures for Northern Ireland are available at: **justice-ni.gov.uk/topics/statistics-and-research/ni-prison-service-statistics**

  As in the wider community, people in prison are encouraged to take responsibility for their own health, seeking health care and making decisions regarding their treatment. Processes and systems are in place to ensure health care services are available to prisoners equivalent to those found in the community. As a result, health care staff are involved in a wide range of health service provision. This includes health screening, health promotion, contraceptive advice, treating and managing long-term conditions, managing acute and emergency care needs, maternity care, and supporting planned care and treatment.

As elsewhere, providing health care for prisoners requires a multi-disciplinary approach that includes all those who have contact with women, including prison officers, to enable ongoing support and care.

The provision of these health care services varies depending on the type of prison and assessed health needs of the population. Some prisons have 24-hour health care cover, with nurses always available, whereas others will provide health care during designated hours, for example between 7am and 7pm. Where there are no health care services available in a prison overnight, local operating policies are in place to determine the way in which they can be accessed. Prison staff are required to seek the most appropriate assistance for the prisoner. This may be advice via the 111 services for non-emergency care, an emergency response via 999, or the local pregnancy assessment unit for pregnant women.

Non-emergency services

England	NHS 111 **111.nhs.uk**
Scotland	NHS 24 111 **nhs24.scot/111**
Wales	NHS 111 Wales **111.wales.nhs.uk/SelfAssessments/default.aspx?locale=en&term=A**
Northern Ireland	nidirect: advice about illnesses and conditions **nidirect.gov.uk/campaigns/illnesses-and-conditions?_id=111Website**

The Nursing and Midwifery Council (NMC, 2018) Code provides professional standards that registered nurses, midwives and nursing associates must uphold. Nurses, midwives and nursing associates must follow the Code, whether they are providing direct care to individuals, groups or communities; or bringing their professional knowledge to bear on nursing and midwifery practice in other roles, such as leadership, education or research. The values and principles set out in the Code can be applied in a range of different practice settings, and are not negotiable or discretionary.

Trauma-informed care and health care in prison

Providing high quality care requires a good understanding of the impact of trauma on an individual and, in particular, how that trauma may affect their care and wellbeing.

Trauma-informed care is an overarching principle when applied to caring for women in prison. (Link to new RCN page on TIC – in production at present). As trauma can alter the way an individual responds to certain circumstances, trauma-informed care means practitioners have an awareness of trauma potentially suffered and seek to prevent re-traumatisation (DHSC, 2023).

The type and presentation of trauma suffered by women is nuanced, and this increases for women in prison. Almost all young women in the criminal justice system have a pattern of offending driven by trauma, violence, or abuse with 63% of girls and young women who are serving community sentences experiencing rape or domestic abuse (Agenda Alliance, 2022).

"The Young Women's Justice Project report shows that almost all young women (17-25) in the criminal justice system have a history of violence, abuse or trauma which drives their offending – whether that's being coerced into crime by a partner or sexually exploited, or by using drugs or alcohol as a coping mechanism. They are also likely to have experience of poor mental health, exclusion from education, economic inequality and racism.

In addition, Black, Asian and minoritised women and those with experience of the care system are significantly overrepresented among young women who have come into contact with the criminal justice system, with Black, Asian and minoritised women forced to endure systemic racism and young women who have been in care facing additional stigma and negative stereotypes." Agenda Alliance, 2022

Adverse childhood experiences are traumatic events occurring during childhood or adolescence. Those who have one or more of these experiences are 11 times more likely to be incarcerated (MIND, 2024).

Five core values of trauma-informed services have been developed by Harris and Fallot (2001) and Covington (2012).

1. **Safety**: eye contact, consistency, explanations, and following procedure to report abuse.
2. **Trustworthiness**: following through; model trust; maintaining appropriate boundaries.
3. **Choice**: emphasising the individual's choice and control; providing informed consent.
4. **Collaboration**: allowing the individual to have solicited input in their rehabilitation and recovery journey.
5. **Empowerment**: teaching skills and providing tasks where individuals can succeed.

(CLINKS, 2020)

Applying the above principles to the care of women in prison supports better holistic care, ensuring their needs are well considered throughout their care journey.

How is prison health care delivered?

Understanding how care is provided and delivered enables a better understanding of what is possible and what is required.

Service provision is different across the UK:

- NHS England (NHSE) is responsible for commissioning high quality health care in prisons in England, ensuring individuals' safety, equity and safeguarding. Find more information about commissioning at: **england.nhs.uk/commissioning/health-just**

  Health care services in prison are provided by both NHS and independent providers. All are commissioned and funded by NHS England.

- In Wales, health provision for public sector prisons is managed by HM Prison and Probation Service, devolved to the Welsh Government, with health services provided by NHS Wales, delivered vial Health Boards local to the prison. HMP Parc is a privately run prison, where primary health care services are commissioned by HM Prison and Probation Service (HMPPS). For further information please visit: **phw.nhs.wales/topics/prison-health-in-wales**
- In Northern Ireland, prison health care services are provided by South Eastern Health and Social Care Trust. Further details are available at: **setrust.hscni.net/service/healthcare-in-prison**
- In Scottish prisons health care services are provided directly by the NHS **prisonsinspectoratescotland.gov.uk/publications/inspecting-and-monitoring-standard-9-health-and-wellbeing**

Prison health care provision differs across establishments. Some services are available 24 hours a day, seven days a week and operate from a large central health care centre, which contains clinic rooms providing outpatient services; a dentist; and a pharmacy dispensing to treatment rooms, where patients can collect their medicines. In some prisons there are also residential health care units providing care for prisoners with serious or complex physical and/or mental health issues. Other prisons provide health care services during the day, much like a general practice in the community. Some prisons also use telemedicine and link with their local acute hospitals.

The prison health care team includes nurses, advanced nurse practitioners, midwives, non-medical prescribers, health care support workers, nursing associates, pharmacists, pharmacy technicians, doctors, physiotherapists, occupational therapists, dentists, opticians, chiropodists, podiatrists, and professionals treating people with substance misuse issues.

Other members of staff with whom the health care team work closely include (but are not limited to) the prison psychology team, the chaplaincy department, prison officers, Samaritans, peer workers, education staff, voluntary organisations, and prison governors.

Prison health care settings provide many opportunities to explore public health. These include management of infectious diseases (including COVID-19), infection control, vaccination programmes and the management of blood borne viruses. Find more information at: **gov.uk/government/collections/public-health-in-prisons**

Prison also provides a good opportunity for health care professionals to work with people who come from underserved communities. These include those with difficult lifestyles, people who do not routinely prioritise their health, and those who may be homeless and without easy access to health care services. Sexual health services in prison were historically provided by staff from community genitourinary medicine clinics, but are now often provided by nurses employed by prison health care providers.

Initial assessment on entering prison, included screening

On arrival into custody or a detained setting, every person undertakes an initial health reception screen, designed to identify any risk to their health or safety, before being allocated to a cell. This is in line with the National Institute for Health and Care Excellence (NICE) Guideline 57 (NICE, 2016).

The initial health screening (NICE NG 57) looks at different elements. This includes any outstanding hospital appointments, ongoing health needs, medications, and identification of possible substance misuse. Specifically for women in prison, it also includes identification of a current pregnancy; possible pregnancy from recent unprotected sex or sexual assault; or a recent pregnancy that may have resulted in a live birth or miscarriage, ectopic pregnancy or still birth. It also identifies women who are in the postnatal period and/or if the arrival into prison has resulted in separation from children. If unprotected sex has taken place in the last five days, emergency contraception should be considered.

All women should be offered a pregnancy test on arrival to prison and if negative, the recommendation is to repeat at day 7 and 28. If a woman declines a pregnancy test, this should be clearly documented within the reception screening tool, then followed up in line with local policy.

Identification of a pregnancy should be followed up and acknowledged through site-specific policies and/or pathways, with the woman referred to a midwife or GP. Women in prison with an identified pregnancy should be cared for jointly with custody and health care colleagues, following guidance from the Women's Policy Framework (Gov.UK, 2021a)

In line with female specific screening, any pregnancy within the last 12 months – including stillbirth, live birth, miscarriage, ectopic pregnancy or termination – should be identified, as outlined within NICE Guideline 57 (NICE 2016), referrals should be made, as appropriate, to maternity services, general practice, the postnatal care team or mental health/perinatal health teams.

Within seven days of the initial health screen, a second full health assessment should be undertaken. This is similar to that provided by general practice in the community. It should gather a full health history, including obstetric and sexual health, and provide another opportunity for pregnancy testing and screening, including opt-out HIV testing. As women in prison have a higher prevalence of HIV, routine testing should be encouraged (BASHH, 2023).

This more in-depth assessment should also identify if women are currently or have recently, undergone any fertility treatment, allowing appropriate ongoing referrals to be continued or made. If ongoing fertility treatment is noted, the woman may need to liaise with the fertility centre offering the treatment. Further information around other women's health issues, including menstrual wellbeing, incontinence and symptoms of menopause, should be considered and care options discussed.

National screening programmes are also included within this more indepth assessment, including cervical and breast screening, which should continue whilst in a detained environment.

Older women in prison

Women in prison between the ages of 45-55 will be affected by perimenopause and menopause. 70% of women in perimenopause and menopause experience moderate or severe symptoms, impacting on wellbeing, quality of life and the ability to work. A wide range of symptoms includes hot flushes, night sweats, brain fog, joint aches, mood swings and fatigue (RCN, 2020). Women may also experience genitourinary symptoms of menopause, including vaginal dryness and itching, dysuria, urinary frequency, and incontinence. Lack of oestrogen in menopause is associated with increased risk of cardiovascular disease and osteoporosis.

It is important that women are asked about symptoms and are supported to access appropriate treatment options to manage wellbeing and promote healthy ageing. Further details may be found in the recently published guidance on menopause in prison by the Self-Care Forum available at: **selfcareforum.org/menopause**

Pregnancy and childbirth, midwives and health visitors

All women should be offered a pregnancy test on arrival to prison, with negative tests recommended to be repeated at day seven and 28. If a pregnancy test is declined, this should be clearly documented within the reception screening tool, alongside initiating any local policy follow-up that may be required. Women should be asked if they had any recent unprotected sex before they arrived in custody and, if appropriate, there should be a conversation about emergency contraception choices.

Identification of a pregnancy should be followed up and acknowledged through site specific policies/pathways and referred to a general medical practitioner or midwife.

In the history-taking, consideration should also be given to any pregnancy within the last 12 months, including still birth, live birth, miscarriage, ectopic pregnancy, or a termination. Referrals should be made if appropriate including, for example, to the maternity services, general practitioner/nurse, postnatal care team or mental health care professional.

Being pregnant in prison

All members of the health care team who are deemed competent by a registered staff member, and are confident, can perform pregnancy testing, along with analysis of the results. The registered nurse and midwife should be informed of the result immediately, with positive results escalated following local policy.

Pregnancy testing and sexual health screening should be offered to all women at the point of initial reception screening and repeated within subsequent weeks, if required or requested. This may follow a disclosure about unprotected sex prior to arrival into prison, and in open prison settings, where women may be released on temporary licence. Notices and information in a relevant language should be provided to women, ensuring they are aware that testing is available throughout their time in prison.

Once a pregnancy is confirmed, the woman should be enabled to make an informed decision about continuing the pregnancy or considering alternatives, such as a termination. Further information on termination and abortion care is available in the RCN's updated guidance at: **rcn.org.uk/Professional-Development/publications/rcn-termination-of-pregnancy-and-abortion-care-uk-pub-011-285**

Maternity care

Pregnancy can be a daunting prospect for many women, and especially so for those in prison. Physical and mental wellbeing are priorities for those providing care, including midwives, nurses, and health visitors.

Care of all pregnant and postnatal women in prison should be provided following the NHSE national service specification for the care of women who are pregnant or postnatal in detained settings (NHSE, 2022). As with any care setting, midwives are accountable for the care and support of women, newborn infants, and partners and families (NMC, 2021). Some prisons have a permanent (specialist) midwife within their setting, who provides midwifery care from the point of a positive pregnancy test. In prisons where a specialist midwife is not part of the health care provision, community midwives are allocated time to provide antenatal care, usually once a week, as well as providing postnatal care as and

when needed. If no on-site midwifery care is available, the woman should be seen in the local maternity unit for antenatal care.

Any woman with a positive pregnancy test or birth within the last six weeks should ideally be referred to either the specialist midwife or community midwife attached to the prison and reviewed within 72 hours of identification.

Midwives book appointments within the prison environment, referring the woman to the local maternity unit for any obstetric consultations or scans. All women in prison are deemed as high risk due to the increased vulnerabilities of being pregnant in prison. Usually, pregnant women remain in shared care – between midwives and obstetricians -throughout pregnancy. The Royal College of Obstetricians and Gynaecologists (RCOG) *Position statement on maternity care for women in prison in England and Wales* (2021) was clear that the standards set out in the *Birth Companions Birth Charter* (2019), and the *RCOG Maternity Standards* should be used to provide high quality care and support to all women in prison, and be the basis of all policy and best practice for maternity care here.

Referral to hospital for medical review is undertaken by the prison-based midwife. This may include long-term conditions, for example, diabetes. Without a specialist midwife, or at times when they are not available, health care staff in prison should escalate any pregnancy-related concerns to the local maternity unit, where the woman is receiving advice and individualised care planning.

Routine antenatal care is provided by the midwife, following NICE guidelines (NICE, 2021) or equivalent standards across the UK. Where specialist midwives are on-site, weekly face-to-face meetings are held with the woman in preparation for labour, birth and the postnatal period, alongside building trust and a good working relationship. Access to information for pregnant women can be limited within a prison setting, therefore weekly contact allows women opportunities to discuss public health and pregnancy-related advice, tailoring care to be more individualised. Where community midwives provide antenatal care, women should also be seen weekly.

Women are transferred to the maternity unit when medical review or a fetal wellbeing assessment, such as ultrasound or cardiotocography (CTG) monitoring, is required. CTG monitoring is a continuous recording of the fetal heart rate via an ultrasound transducer placed on the mother's abdomen. It may or may not be available in the prison setting. If a midwife is on site, they should perform the initial assessment, arranging any further reviews within a hospital setting. If the midwife is not available, prison health care staff should escalate any concerns to the maternity services, as soon as a concern is raised by the woman.

Intrapartum care is provided within a hospital setting.

Once the woman is considered well/fit for discharge from hospital following the birth, they will be cared for by either the specialist midwife or community midwife. Within the postnatal period, prison health care staff should escalate any concerns to the local maternity unit, if a midwife is not available.

Babies in prison

Of the 12 female prisons in England, six have on-site mother and baby units (MBUs). There are no female prisons in Wales. Scotland has one female prison, which has a mother and baby unit, while Northern Ireland has one prison, with two mother and baby rooms.

Women in prison who have their baby with them are responsible for the care of the child throughout this period. They can be supported by agencies within detained settings, such as Action for Children, mother and baby liaison officers and visiting health visitors.

Women who are either pregnant or have a child are eligible to apply for a place on one of the units. This may mean women applying to a MBU that is not local to them, so they have a chance of remaining with their baby after the birth. Women are supported with this process by mother and baby liaison officers within the prison. Further information is available within the HMPPS Pregnancy Mother and Baby Units and *Maternal Separation up to the age of two Policy Framework*, available at: **assets.publishing.service.gov.uk/media/64650161e14070000cb6e14a/mbu-pf.pdf**

If successful in their application and a place is granted in the MBU, women are located within that unit as soon as possible. Each case is individual, and it is a prison decision, with the timing of the transfer guided by other professionals, including midwifery and perinatal mental health. Success of applications is also determined by local authority children's social services' recommendations.

Women who are placed on an MBU can remain with their baby for up to 18 months. An application for an extension up to two years of age can be made. This is reviewed by the prison women's team for review and approval.

Babies and postnatal women are routinely cared for by midwives up to six-eight weeks postnatal, with the earliest point of discharge from midwifery care being day 10. Individual care plans are created for each mother and baby for postnatal care. In prisons where full-time specialist midwifery provision is not in place, community midwives provide care for pregnant and postnatal women and babies.

Women who are separated from their baby post birth, due to social services' plans or not gaining a place on a mother and baby unit, will return to the main prison after discharge from hospital. Either the specialist midwife within the prison, or a community midwife provides postnatal care. If mother and baby are separated by a court order, women are supported by the prison to have contact visits with the baby, where appropriate. These are set using recommendations from social services and what the prison can accommodate.

Health visitors

All women who are pregnant within a prison setting should be referred to the relevant health visiting team by midwifery services, following local maternity guidelines. Prisons with mother and baby units should have access to health visiting services, which provide the same care they would at home, ensuring the healthy child programme is followed.

The NHSE service specification (NHSE, 2023) recommends commissioners should review local arrangements for health visiting services, including recommending that pregnant women in prisons without mother and baby units have access to health visiting services, ensuring information about the healthy child programme is delivered to women, including those separated from their baby.

Sexual and reproductive health competencies for supporting women in prison

Focused on the sexual and reproductive health (SRH) needs of women in prisons, these competences have been designed for:

- health care support practitioners (HCPs), under the supervision of a registered nurse
- nursing associates (England only)
- registered nurses and midwives, both newly qualified, or new to the sector
- those with more enhanced/specialist skills and knowledge, including midwives.

The four pillars used to underpin this practice are (RCN Definition and Principles of nursing):

- Clinical knowledge and skills
- leadership
- education
- research.

Their development acknowledges that all health care provision is underpinned by key practices

- Provision of physical care to support general health and wellbeing, as well as that which is specific to sexual and reproductive health.
- Consideration of mental wellbeing of the individual – The National Women's Prisons Health and Social Care Review (NHSE, 2023), was established to consider how best to improve health and social care outcomes for all women in prison and when they are released. It identified that mental health needs, in particular, were not well supported, and all of the competencies below should consider physical and mental wellbeing.
- Communication skills, which may include counselling.
- The need to identify/act on interventions, provide care when competent to do so and refer for expertise where required.

The competencies focus on:

- history-taking /risk assessment/reception screening
- health promotion
- menstrual health
- sexual health
- contraception
- miscarriage/pregnancy loss
- termination of pregnancy/abortion care
- menopause care.

Table 1: Who the framework is for and how it can be used

Who is the framework for?	What is the framework for?
Registered nurses, nursing support workers (including nursing associates), midwives	Standards of care Career pathway
Non-health care custodial staff	Information and developing understanding of health care professional roles
Managers including nurse leaders	Workforce planning; professional performance review; training needs analysis; continued professional development
Employers	Workforce planning; recruitment; standard job descriptions
Commissioners	Background for monitoring fitness for purpose against key performance indicators (KPIs)
NMC and regulatory/ inspection bodies for Prison and Probation Ombudsman	Benchmark standards for care for quality assurance measure Benchmark for measuring standards of care in fitness to practice hearings

Adapted from RCN Tuberculous Career Framework

How can the competencies be used?

The aim of this competency framework is to set the minimum standards of knowledge and skills required to provide safe and effective sexual and reproductive health care for women in prison. The framework explicitly states the expectations for each level of nursing and for midwifery staff, to distinguish between baseline requirements for nursing support staff, registered nurses, and specialist nurses and midwives.

The framework may be used as a baseline to undertake a training needs analysis to identify any additional education needs. For ease of use, the competencies are linked to the relevant national guidance, and to the RCN Sexual and Reproductive Health Education Directory that provides details of nationally recognised training programmes and online resources, available at: **rcnlearn.rcn.org.uk/Search/Sexual-health-education-directory**

Access to continuing professional development is essential for all nursing teams and is often best achieved through a self-assessment of needs, which can then be discussed with managers. The competences can be used as a basis for self-assessment.

All registered nurses, nursing associates and midwives are required, as part of their continuing registration, to demonstrate competence through the process of revalidation with the NMC, which should include evidence of their ability to continue to practise safely and competently. More detail is available at: **nmc.org.uk/revalidation**

Part of the process of ensuring competence is an individual's reflection on their own practice and validation of that practice by peers and other experienced health care professions. Actively and honestly engaging with a peer review process supports best practice and enhances standards of care, by ensuring personal practice remains contemporary and evidence-based, whilst promoting professional development. Further support may be accessed through the RCN guidance on critical reflective practice: **rcn.org.uk/Professional-Development/Revalidation/Reflection-and-reflective-discussion**. This provides guidance on using supervision and reflective practice to deepen understanding and develop skill.

The framework also highlights areas for audit and research that may be used by organisations to assess training and development needs.

The project team has not identified separate standards for midwives, as the NMC *Standards of Proficiency for Midwives* (NMC, 2019) and the *My Future, My Midwife* NMC programme (NMC, 2020) apply in all settings. However, it is recognised that some midwives may wish to extend their practice to include the following competencies as well.

Table 2: Sexual and reproductive health competencies for supporting women in prison

Competency Details	Clinical (C) Education (E) Leadership (L) Research (R)	Health care support practitioners (HCP)	Nursing associates (ENGLAND ONLY)	RN & M newly qualified/ new to prison care.	RN & M enhanced/ specialist practice	Existing competence frameworks/ information to support best practice
History-taking/risk assessment/reception screening						
Completion of initial reception screen, which includes history of pregnancy within the last 12 months, identifying any possibility of pregnancy etc.	C	✓ *	✓	✓	✓	nice.org.uk/guidance/ng57/chapter/Recommendations gov.uk/government/publications/womens-policy-framework * HCP to be deemed competent and practice under the supervision of a registered nurse
Completion of secondary assessment to identify any ongoing fertility treatment, more detailed obstetric history and sexual health history	C	✓ *	✓	✓	✓	gov.uk/government/publications/womens-policy-framework * HCP to be deemed competent and practice under the supervision of a registered nurse
Completion of clinical observations including NEWS2 (National Early Warning Score2), COWS (Clinical Opiate Withdrawal Scale), CIWA -A/B (Clinical Institute Withdrawal Assessment for Alcohol scale)	C	✓	✓	✓	✓	
Pregnancy testing	C	✓	✓	✓	✓	

Health promotion						
Demonstrate an initial understanding of health coaching and motivational interviewing skills to provide education individually and in groups	C	✓*	✓	-	-	gov.uk/government/publications/sexual-and-reproductive-health-and-hiv-applying-all-our-health rcn.org.uk/clinical-topics/public-health/sexual-health (requires member login) ukhsa.blog.gov.uk/2018/01/08/its-good-to-talk-making-the-most-of-our-conversations * HCP to be deemed competent and practice under the supervision of a registered nurse
Demonstrate regular use of health coaching and motivational interviewing skills to provide education individually and in groups	C	-	-	✓	✓	
Promote and provide information about available health and wellbeing assessments, specific to their sexual and reproductive health	C	✓	✓	✓	✓	
Provide information on how to seek further specialist input, as required	C	✓	✓	✓	✓	
Understand the needs of your population in terms of health disparities, health inequalities and inclusion health	C and E	✓	✓	✓	✓	Inclusion Health: applying All Our Health gov.uk/government/publications/inclusion-health-applying-all-our-health/inclusion-health-applying-all-our-health Health disparities and health inequalities: applying All Our Health gov.uk/government/publications/health-disparities-and-health-inequalities-applying-all-our-health/health-disparities-and-health-inequalities-applying-all-our-health All our Health e-learning NHS England portal.e-lfh.org.uk/Catalogue/Index?HierarchyId=0_41737_42670&programmeId=41737 National Centre for Smoking Cessation and Training (NCSCT) elearning.ncsct.co.uk
Demonstrate a critical understanding of population in terms of health disparities, health inequalities and inclusion health, and adapt care to meet those needs, where appropriate	C and E	-	-	✓	✓	
Recognise where there is a need for safeguarding referrals and further discussion with individuals	C and L	✓	✓	✓	✓	rcn.org.uk/Log-In?returnUrl=https%3a%2f%2frcn.org.uk%2fclinical-topics%2fSafeguarding (requires member login)
Regularly audit and review the health promotion provision in the local service	R	-	✓	✓	✓	

Menstrual health						
Comfortably initiate a conversation about menstrual wellbeing and provide sanitary products and issue a menstrual diary if required	C	✓	✓	✓	✓	rcn.org.uk/Professional-Development/publications/promoting-menstrual-wellbeing-uk-pub-010-375 rcn.org.uk/clinical-topics/Womens-health/Promoting-menstrual-wellbeing nice.org.uk/guidance/ng88 rcn.org.uk/professional-development/publications/what-are-pms-and-pmdd-uk-pub-010-006 elearning.rcgp.org.uk/mod/book/view.php?id=12534
Provide evidence-based advice on comfort and wellbeing, able to provide management of menstrual cramps	C	-	✓	✓	✓	
Identify and appropriately assess women with prolonged or heavy bleeding, referring appropriately for further investigation and support	C	-	✓	✓	✓	
Identify and support women with premenstrual syndrome (PMS) and premenstrual dysphoric disorder (PMDD) and refer appropriately	C	-	✓	✓	✓	
Identify women with missed periods, scanty or irregular bleeding and refer appropriately	C	-	-	✓	✓	
Discuss treatment options and initiate management plan for menstrual problems	C	-	-	-	✓	
Regularly audit and review the health promotion provision in the local service	R	✓	✓	✓	✓	
Regularly audit and review service provision in relation to supporting and promoting menstrual wellbeing	R	-	✓	✓	✓	

Sexual health **1 Communication**						
Practitioner can recognise an appropriate location to discuss any sexual health concerns, for example, sexually transmitted infections (STIs), in a confidential setting	C	✓	✓	✓	✓	BASHH (2023) Standards for the Management of Sexual Health in UK Prisons bashh.org/professionals/special_interest_groups/28/prison_sig/public BASHH guidelines for those working in sex industry bashh. org/news/1408/invitation_to_respond_to_a_consultation_on_clinical_standards_for_the_sexual_health_management_of_people_involved_in_sex_work Making Every Contact Count e-lfh.org.uk/programmes/making-every-contact-count Specialist Pharmacy Service sps.nhs.uk/?cat%5B0%5D=2995&cat%5B1%5D=3639&s= eLfH e-lfh.org.uk Sexual health education directory rcn.org.uk/Log-In?returnUrl=https%3a%2f%2frcn.org.uk%2fclinical-topics%2fPublic-health%2fSexual-health%2fSexual-health-education-directory Integrated Sexual Health Service Specification 2023 assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1143246/Integrated-sexual-health-service-specification-2023.pdf
Practitioner can outline limitations of confidentiality discussed with patient, providing reassurance about confidential nature of the conversation where appropriate	C	✓	✓	✓	✓	
Practitioner can raise the subject of sexual health/STIs in an appropriate and sensitive manner	C	✓	✓	✓	✓	
Practitioner can discuss sexual risk and ensure that relevant interventions are made when starting time in prison, in particular if they are time-dependent for example, post-exposure prophylaxis for HIV after sexual exposure/emergency contraception	C	-	-	✓	✓	
Confidently provide education on sexual health topics, including safer sex practices and STIs, in preparation for release from prison, as a part of the release plan	C and E	✓	✓	✓	✓	
Confidently share information about STIs and where to access community help, if due to be released	C	✓	✓	✓	✓	
Practitioner seeing patients with their results for STIs, including blood borne viruses, can advise on the result in an informed, sensitive manner, and advise on appropriate treatment	C	-	-	✓	✓	
Practitioner can recognise any partners who may need treating and discuss in a sensitive manner	C	-	-	✓	✓	
Practitioner can take into account any neurodiversity, sensory impairment, physical or learning disabilities, where English is not their first language, and those with low/limited literacy skills, adapting the consultation accordingly	C	✓	✓	✓	✓	
Practitioner can discuss confidently with the patient the risks and benefits of opting out of "opt out" testing	C	-	-	✓	✓	
Undertake nationally recognised qualification relevant to sexual health specialist practice	C	-	✓	✓	✓	rcn.org.uk/clinical-topics/public-health/sexual-health/education-and-training

Confidence to engage with patients in a Make Every Contact Count approach who have continued to opt out of screening and are engaging with prison healthcare	C	✓	✓	✓	✓	Hepatitis B Green Book assets.publishing.service.gov.uk/media/6200f92ad3bf7f78df30b3d3/Greenbook-chapter-18-4Feb22.pdf
Confident in communicating with patients about how/when/where to access sexual health care within the prison setting	C	✓	✓	✓	✓	
Practitioner can provide information, taking in to account the prison environment which may cause a confidentiality breech/reluctance to engage, for example, cell searches/shared cells	C	✓	✓	✓	✓	
Practitioner can STI risk assess for those patients who do not present as their birth gender	C	-	-	✓	✓	Trauma-Informed Care gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice
Practitioner can make an STI risk assessment for those who present as LGBTQUIA+	C	-	-	✓	✓	
2 Consideration of mental health and wellbeing:						
Practitioner can demonstrate a trauma informed approach to care delivery	C	✓	✓	✓	✓	england.nhs.uk/long-read/a-review-of-health-and-social-care-in-womens-prisons
Practitioner can communicate with patient, taking in to account any sexual violence or trauma which may affect the person's mental and emotional well-being	C	-	-	✓	✓	
Practitioner can refer to appropriate service if the patient identifies any sexual violence, where there is on-going need for emotional support	C	-	-	✓	✓	
Practitioner can take an appropriate safeguarding risk assessment, in line with prison population. For example, young offenders should have BASHH/Brook "Spotting the Signs" completed, taking in to account specific safeguarding concerns relating to the prison environment	C	-	✓	✓	✓	
Practitioner can recognise when further emotional support is required when adjusting to STI diagnosis, for example new HIV diagnosis/HSV (Herpes Simplex Virus) diagnosis	C	✓	✓	✓	✓	

3 Provision of physical care to support general health and wellbeing, as well as that which is specific to sexual health:						
An effective triage process should be in place, so those with clinically urgent needs, those who can be managed by non-specialists within the prison health care setting and those who require specialist care (Level 3) can be assessed and referred to most appropriate care setting	C and L	-	✓	✓	✓	england.nhs.uk/long-read/a-review-of-health-and-social-care-in-womens-prisons
Able to offer routine screen for chlamydia as part of the chlamydia screening (CT) programme (local policy/where eligible)	C	✓	✓	✓	✓	
Able to provide information on HIV/Hep B/Hep C and STIs testing, to enable an informed decision, as part of the first stage health assessment on entry in to prison	C	✓	✓	✓	✓	
Opt-out testing for HIV/Hep B/Hep C (and syphilis, if risk discussed) should be offered to all prisoners on 1st or 2nd reception	L		✓	✓	✓	
Routine screening for those with identified sexual health risks should, as a minimum, include HIV, syphilis, chlamydia and gonorrhoea and able to advise the patient how and when they can access their results. This should include ensuring cervical screening is up to date	C and L	-	✓	✓	✓	
HIV risk assessment should be implemented, including discussion with the patient about preventative strategies (e.g. pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis for HIV after sexual exposure (PEPSE))	C and L	-	-	✓	✓	
Practitioner should be confident in discussing condom, dental dam and water-based lube use, including understanding of local policy provision and availability	C	✓	✓	✓	✓	
PEPSE assessment and use of national patient group direction (PGD) to ensure no delay in deliver of time-dependent medication	C	-	-	-	✓	
Practitioner can risk assess the patient's on-going sexual risk of blood borne virus (BBV) transmission and offer any vaccinations as required (Hep B) via national PGD/PSD	C and L	-	-	✓	✓	

Practitioners providing treatment are using BASHH guidelines for specific STIs and where required national PGDs	C and E	-	-	✓	✓	
Practitioners can confidently recognise a pattern of infection presentation/increased numbers (outbreak) and respond accordingly, to prevent further onward transmission	C and L	-	-	✓	✓	
Practitioner can initiate partner notification and manage any patients who are at risk of infection transmission, both inside and outside prison estate	C	-	-	✓	✓	
Practitioner can adapt clinical advice, taking into account type of prison, for example, open/closed/ young offender, and manage risks associated with prison regime, for example, if home visits are allowed	C	✓	✓	✓	✓	
Undertake nationally recognised qualifications relevant to sexual health specialism	C	-	✓	✓	✓	rcn.org.uk/clinical-topics/public-health/sexual-health/sexual-health-education-and-training
Audit and review sexual health care of women in prison	R	✓	✓	✓	✓	
Consider research opportunities for enhancing sexual health care provided to women in prison	R	-	-	✓	✓	
4 The need to identify situations/conditions, provide care when competent to do so and referral for expertise where required:						
Practitioner is aware of internal pathways available to those who identify any sexual health concerns	C and R	✓	✓	✓	✓	rcn.org.uk/Professional-Development/publications/promoting-menstrual-wellbeing-uk-pub-010-375
Practitioner can recognise when the subject matter is outside the person's scope of practice and refer to a more appropriate practitioner	C and L	✓	✓	✓	✓	
Recognition of level of care required for patient presenting, with referral to appropriate provision, for example, levels 1/2/3 (either internal or external to prison) as per the Integrated Sexual Health Service Provision 2023	C	-	-	✓	✓	

Contraception						
Pregnancy testing	C	✓	✓	✓	✓	fsrh.org/standards-and-guidance/uk-medical-eligibility-criteria-for-contraceptive-use-ukmec fsrh.org/standards-and-guidance/fsrh-guidelines-and-statements nice.org.uk/guidance/qs129
Demonstrate understanding of the need to consider repeat pregnancy testing based on incidents in prison and changes in level of supervision, for example, home visits	C and R	✓	✓	✓	✓	
Physical observations relevant to contraception provision, including blood pressure, pulse, body mass index (BMI)	C	✓	✓	✓	✓	
Broad contraception discussion and awareness of available methods	C	-	✓	✓	✓	
Counselling and initiation of non-LARC (long-acting contraceptive) methods	C	-	-	✓	✓	
Counselling and initiation of LARC methods	C	-	-	-	✓	
Follow-up after initiation of method and take appropriate action to manage any side- effects, including unscheduled bleeding	C	-	-	✓	✓	
Maintain mandatory training (BLS) and professional development as needed	E	✓	✓	✓	✓	
Undertake nationally recognised qualifications relevant to contraception	E	-	-	-	✓	rcn.org.uk/clinical-topics/public-health/sexual-health/sexual-health-education-and-training
Evaluate and develop local pathways and policies as needed, including PGDs	L	-	-	-	✓	
Develop and maintain communication with local services, commissioners and strategic level partners	L	-	-	-	✓	
Deliver training locally	E and L	-	-	-	✓	
Regularly audit and review and consider research opportunities in contraception care	R	-	-	-	✓	

Miscarriage/pregnancy loss						
Pregnancy testing	C	✓	✓	✓	✓	The Miscarriage Association: Pregnancy Loss Information and Support miscarriageassociation.org.uk Cruse Bereavement Support cruse.org.uk Sands – Saving Babies Lives: Supporting bereaved families. sands.org.uk/about-sands/our-work/supporting-families
Discussion of local services and referral pathway	C	-	✓	✓	✓	
Refer to appropriate service for management and liaise with the service accordingly	C	-	-	✓	✓	
Discussion of management options, facilitating choice	C	-	-	✓	✓	
If woman raises concerns about their wellbeing, escalate appropriately	C	✓	✓	✓	✓	
Monitoring and recording of observations using Modified Early Obstetric Warning Score (MEOWS) if woman becomes unwell or expresses concerns	C	✓	✓	✓	✓	
Review any observations taken (use MEOWS) and escalating if urgent care required	C	-	✓	✓	✓	
Ensure access to early pregnancy assessment units and/or maternity services as needed, preferably facilitating direct contact between woman and service	C	-	✓	✓	✓	
Contraception advice/discussion	C	-	-	✓	✓	
Ensure any follow-up care is complete and escalate to acute services as needed	C	-	-	✓	✓	
Offer and ensure access to emotional support, escalating as required	C	✓	✓	✓	✓	
Maintain mandatory training (basic life support) and professional development	E	✓	✓	✓	✓	
Evaluate and develop local pathways and policies as needed	L	-	-	-	✓	
Develop and maintain communication with local services, commissioners and strategic level partners	L	-	-	-	✓	
Deliver training locally	L	-	-	-	✓	
Regularly audit and review care of women who receive care for pregnancy loss whilst in prison	R	-	-	-	✓	

Termination of pregnancy/abortion care						
Pregnancy testing and advice for example, repeat testing/window period/risk?	C	✓	✓	✓	✓	rcog.org.uk/media/ujmfhg0h/national-service-specification-for-abortion-care-nov-2022.pdf nice.org.uk/guidance/ng140 rcn.org.uk/Professional-Development/publications/rcn-termination-of-pregnancy-and-abortion-care-uk-pub-011-285 fsrh.org/education-and-training/essential-contraception-for-abortion-care-providers
Pregnancy options discussion	C	-	-	✓	✓	
Discussion of service providers and local referral pathway	C		✓	✓	✓	
Refer to appropriate service for treatment and liaise with the service accordingly	C	-	-	✓	✓	
Treatment options discussion, facilitating client choice, gestation dependent	C	-	-	✓	✓	
If client raises concerns about their wellbeing during or after treatment, escalate appropriately	C	✓	✓	✓	✓	
Monitoring and recording of observations using TEWS (Triage Early Warning Score) /MEOWS if client becomes unwell or expresses concerns during/after treatment	C	✓	✓	✓	✓	
Review any observations taken (using TEWS/MEOWS) and escalating if urgent care required	C	-	✓	✓	✓	
Ensure access to aftercare services as needed, preferably facilitating direct contact between client and aftercare	C	-	✓	✓	✓	
Contraception advice/discussion	C	-	-	✓	✓	
Ensure follow-up pregnancy test is complete and escalate any positive results appropriately	C	✓	✓	✓	✓	
Maintain mandatory training (BLS) and professional development as needed	E	✓	✓	✓	✓	
Evaluate and develop local pathways and policies as needed	L	-	-	-	✓	
Develop and maintain communication with local services, commissioners and strategic level partners	L	-	-	-	✓	
Deliver training locally	L	-	-	-	✓	
Regularly audit and review care of clients who receive abortion care whilst in prison	R	-	-	-	✓	

Menopause						
Recognise common symptoms of perimenopause and menopause and refer for assessment	C	✓	✓	✓	✓	nice.org.uk/guidance/indevelopment/gid-ng10241
Provide appropriate evidence-based resources and signpost to support	C	-	✓	✓	✓	
Advise on lifestyle management options, environment, nutrition and movement and exercise	C/E	-	✓	✓	✓	selfcareforum.org/menopause
Support and advise on practical strategies to address stress and anxiety	C	-	✓	✓	✓	rcn.org.uk/Professional-Development/publications/menopause-and-mental-health-uk-pub-010-330
Undertake a full clinical assessment and advise on medical management options	C	-	-	-	✓	rcn.org.uk/Professional-Development/publications/nurse-specialist-in-menopause-uk-pub-010-335
Assess effectiveness of treatment and manage any side-effects, referring as appropriate, using local pathways	C	-	-	-	✓	
Deliver training locally	E	-	-	-	✓	
Undertake audit of menopause care to inform service development	R and L	-	-	-	✓	

Conclusion

Health care provision for the female population in secure and detained settings is a specialised arena of practice for all nurses and midwives, and these competences are designed to support best practice across a range of settings. The competences are underpinned by the key principles of nursing, to provide high quality support and care to vulnerable women.

Nursing and midwifery are safety critical professions founded on clinical practice, education, research, and leadership, using evidence-based knowledge, professional and clinical judgement to assess, plan, implement and evaluate high-quality person-centred nursing care. Their vigilance is critical to the safety of people, the prevention of avoidable harm and the management of risks, regardless of the location or situation, and this is particularly relevant for women in prison (RCN 2024).

It is well documented that women generally are more exposed to physical and mental health challenges, due to socio-economic status, lifestyle, and socio-cultural norms, which make them more vulnerable to discrimination. As Agenda Alliance identified in 2022, many young women in the criminal justice system show patterns of offending, which are driven by trauma, violence, or abuse.

The statistics surrounding women in secure and detained settings are concerning and as most women in prison are of childbearing age, sexual and reproductive health needs are an important part of their ongoing health and wellbeing. The statistics also suggest approximately 15-20 % are older women, who may need support with menopause, as well as sexual health care, remembering that sexual health and wellbeing is not just for younger women.

The National Women's Prisons Health and Social Care Review (NHSE, 2023) was established, to consider how best to improve health and social care outcomes for all women in prison and for when they are release. Appendix 2 of that report provides an outline of statistics of the women in prison at the time of the report, clearly demonstrating the need to focus on physical, mental health, and in particular taking account of the principles of trauma-informed care.

It goes on to state that "that prison can provide an important and much needed opportunity for women to engage with health and social care services, both during their time in prison and upon their release" (3.12 NHSE, 2023). The report outlines areas of good practice across the prison service which aim to fulfil this ambition.

Care of women in prison requires a different pathway, because there are competing priorities in the prison setting, where the security of the prisoner and provision/access to health care can sometimes be discordant. Consequently, to provide quality effective care health care professionals need a better understanding of the vulnerabilities and challenges women face in the system, remembering that women in prison should be able to access and use health care that is equivalent to that available in the wider community.

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RCN quality assurance

Publication

This is an RCN practice guidance. Practice guidance are evidence-based consensus documents, used to guide decisions about appropriate care of an individual, family or population in a specific context.

Description

This competencies framework has been developed for nurses, midwives, and those supporting nursing teams, who provide sexual and reproductive health care to women in prison. It takes account of nursing teams who may have limited experience caring for pregnant women.

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Evaluation

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