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Introduction, Aims and Approach

1. This report by the Health and Sport Committee follows our short inquiry into healthcare in prisons. The inquiry was established with the following aims:

    - To consider how health and social care is delivered in prisons and the cost of the service;
    - To consider access to health and social care and medicines in prison; and
    - To consider the effectiveness of health and social care in prisons.

2. Within the prison environment there is an opportunity to engage with people many of whom do not engage with the healthcare system, often due to chaotic lifestyles. In our inquiry we wanted to consider the extent to which prisons take advantage of this unique opportunity to address and reduce health inequalities. We also wished to consider what health support was offered following release.

3. In addition, we wished to consider the current and future pressures on the delivery of healthcare in prisons, not least the ageing prison population which will inevitably bring with it the need to care for people with end of life and other social care requirements.

4. There are 15 prisons in Scotland, 2 are privately owned and operated under contract to the Scottish Prison Service (SPS), the remainder are run by the SPS. The daily average prisoner population in 2015/16 was 7806. [1]

5. Our inquiry was carried out in the first 3 months of 2017 and limited to the provision of healthcare in prisons. We did not seek to address other areas such as justice policy and wider societal equality factors which have an impact on the prison population.

6. We surveyed those responsible for providing health care in prisons. We issued a targeted call for written evidence to the SPS, representatives of those delivering health care in prisons and Her Majesty's Chief Inspector of Prisons in Scotland (HMIP). We sent a questionnaire to all Health Boards and integration authorities seeking financial and staffing information. We also obtained information from the Scottish Public Services Ombudsman (SPSO) in relation to the prison complaints they handle.

7. Thereafter, we held two informal discussion sessions listening to key stakeholders, health care staff working in prisons, and another with former prisoners to understand their respective experiences.

8. We took oral evidence at two meetings. On 14 March with the Royal College of Nursing Scotland (RCN) and representatives of organisations focusing on drug and alcohol use and palliative care. On 28 March we heard from those responsible for the delivery of health care in prisons including Integrated Joint Board (IJB) representatives, a Health Board, SPS, HMIP and the National Prisoner Healthcare Network (NPHN). Finally, also on 28 March, we heard from the Minister for Public Health and Sport and her officials.

9. We are extremely grateful to all those who have given up their time to provide us with evidence or information, in particular those who attended our informal sessions and gave freely and openly of their own lived experiences. Much of the information we received during these sessions is referred to in this report although, in line with the promises of anonymity provided for the informal sessions, attribution is not always given.

Background

10. In 2007 the Prison Healthcare Advisory Board (PHAB) was established to advise the Scottish Government on the feasibility of transferring prison health care from the SPS to NHS Scotland. The driver for that transfer being the need to ensure prisoners received healthcare equivalent to that of the wider community in Scotland.

11. The PHAB reported in December 2007 that such a transfer was feasible setting out 4 main reasons[2]:

    - To tackle ongoing health inequalities within the prisoner population;
    - To meet international standards on prison health and treatment;
    - To provide continuity of care to prisoners on leaving prison; and
    - To provide sustainability of services with the support of community based services.

12. The PHAB report noted that HMIP had also recommended, on the advice of NHS Quality Improvement Scotland, that healthcare should be provided by the NHS .

13. On 1 November 2011 responsibility for the provision of health care in prisons transferred from the SPS to the NHS.

14. Existing healthcare staff in prisons and funding transferred to the NHS. A Memorandum of Understanding (MoU) between the SPS and health boards with prisons in their area was agreed setting out relative responsibilities, governance and accountability. The provision of social care in prisons was not subject to transfer and remains the responsibility of the SPS.

15. Each health board is responsible for the delivery of healthcare in those prisons situated within its area. The care available within prison and in the community should be consistent and on a parity. [3] Given the generally poorer physical and mental health experienced by the prison population, in order to address inequalities, health care in prison is required to be more intensive.

16. The Minister and others acknowledged a frustration “that since the transfer of responsibilities to the NHS [in 2011] progress [on the provision of healthcare in prisons] has felt slow”.[4]

Costs and Staffing

17. The Committee's survey of all health boards and integration authorities, responsible for prisons, obtained information around resourcing, demand and performance of the prison health service. All providing services responded and the following is taken from those responses, all of which are available on our web pages.

18. The general model of care provided in prison health services employs staff in the following areas:

    - Primary care
    - Mental health
    - Addictions.

19. Most staff are nurses, but in-house staff also included GPs, pharmacists, clinical psychologists and administrators. These core services are supplemented by specialist staff from other areas, either working in-house or, more usually, visiting professionals from outside. Outside specialists tend to include consultant psychiatrists, dentists, opticians and allied health professions such as physiotherapists.

20. In the first full financial year following the transfer, 2012-2013, NHS Boards forecast total expenditure of £23.5m on prisoner healthcare. In addition the health boards were expected to incur indirect costs, covering management time, including HR, finance and IT services. Indirect costs were estimated as being £0.4m across 2011-12 and 2012-13.[5]

21. The budget for the financial year 2016-17 was reported from our survey as being £28,090,172.

22. Issues were raised about the deployment of healthcare staff across the prison estate and the differences arising between establishments. There are no national workforce standards in place which, we were advised, was because health boards are expected to "marshall resources in an appropriate way to cope with the health issues experienced."[6] Sir Lewis Ritchie adding "needs assessment is why you cannot have one size fitting all."[7] The NPHN told us it is looking to create a new workstream to develop a national workforce tool.

23. **We look forward to the resolution of this issue and while recognising the force in Sir Lewis's argument would expect to see at the very least the identification of minimum workforce standards and levels.**

24. Staffing was an issue which exercised a number of our witnesses, who made reference to recruitment and retention difficulties; although the majority of responses to our survey reported no long term vacancies. Four health boards reported difficulties in recruiting GPs to work in prisons, with recruitment issues also arising in clinical psychology and mental health nursing. Overall the responses did

not disclose undue difficulties. We note from the recent RCN report[8] a different picture with a reported increase in sickness levels and high vacancies.

25. **We understand national health workforce data does not record staffing numbers separately for prisons and recommend this is addressed.**

26. We also heard, particularly in our informal session, frustrations from staff around not being able to fully utilise their skills and it was suggested the amount of clinical time not properly utilised due to missed appointments etc. was up to 50%. We discussed this with witnesses on 28 March.

27. A number of submissions, including from HMIP, made reference to problems that result from SPS staff not being available to accompany prisoners to healthcare appointments. The British Dental Association noted that "due to SPS operational reasons, the transfer of prisoners to the health centre is not being carried out in a timely and effective manner therefore time within dental sessions is lost" [9] .

28. While the SPS disputed the extent of the problem they recognised logistical issues that arise both from the need to keep different categories of prisoner segregated and other prison activities such as meal times, visits and recreation. We were provided with examples of practical difficulties from HMP Edinburgh which have not been overcome in the six years since female prisoners were housed there. We also heard about external hospital appointments being missed as a consequence of G4S escorts or the contracted delivery service not being available.

29. The Scottish Prisoner Advocacy and Research Collaborative observed a "fundamental need to understand and address possible organisational culture differences between health and punishment sectors". They noted that SPS operational issues have affected medical delivery in relation to the timing of medical rounds and the use of medical interventions to support SPS staff.

30. At the informal evidence session with staff who work in prisons we heard that access to prisoners to some extent varied on a prison by prison basis but also, in part, worked better when there was a supportive and collaborative approach between SPS and NHS staff.

31. Another major cause of sub-optimal use of time relates to the requirement on highly trained and qualified nursing staff to supervise the administration of certain dispensed medicines. The Royal Pharmaceutical Society highlighted this issue as did a number of staff during our informal session. Resolution of this operational issue would clearly allow healthcare staff to spend more time addressing prisoner health needs.

32. Overall it was agreed the actual time when medical staff could expect to access patients was between 4 and 6 hours a day.

33. **We are disappointed at the waste of resources highlighted above and expect the SPS, contractors and health boards to ensure that patients are able to attend healthcare appointments. We also seek reassurances that**

staff working in prisons do so at an appropriate level maximising the utilisation of appropriate skill levels as a matter of priority.

Leadership and Governance

34. A number of written submissions questioned the leadership and governance of prison healthcare. The British Psychological Society Division of Neuropsychology commented that "strong central support and guidance is needed from the Scottish Government Health and Social Care Directorate, together with NHS Boards and Integration Joint Boards and local primary care and community services". The Mental Welfare Commission stated "there needs to be a clear strategic plan in relation to what Health Boards should be providing in prisons".

35. We asked our witnesses if they knew who leads on prison healthcare. The NPHN advised accountability lay with the respective health boards while others suggested the NPHN provided direction. Our first panel of witnesses on 28 March was unable to identify government leads, at either ministerial or civil service level.

36. The Minister indicated a "blurriness around the lines [of leadership at ministerial level]"[10] while arguing multiple ministerial and civil service responsibilities, coupled with the need for collaborative working across portfolios, was appropriate given the cross cutting nature of the subject and the complexity and needs of the prison population.

37. **Given the agreed need for leadership, the passing of 5 years without measurable improvement and the poor record and implementation of NPHN recommendations, we recommend ministerial and civil service leads be immediately identified as being accountable.**

38. In our survey we asked health boards for detail of service innovations made since the transfer. We were impressed by the range of initiatives reported, principally relating to the provision of new groups and services. We also asked about public health measures put in place and heard about smoking cessation, alcohol interventions, blood borne virus testing and various screening programmes that have been introduced across the country.

39. We also asked about any service redesign and responses confirmed some had occurred. Generally this consisted of staff restructuring and adjustments to the skill mix or specialties available. Other examples of service redesign included the implementation of care recording systems, the implementation of specific clinics (e.g. long-term conditions clinic) and the implementation of person-centred care plans and multi-disciplinary meetings.

40. We also asked how performance was assessed through performance indicators. Each health board has its own indicators which can broadly be divided into clinical (complaints, suicides, waiting times and uptake of screening tests and treatments), staff (absences, agency/locum, training and reviews) and financial (budget management and efficiency savings).

41. **We have been unable to identify any national indicators directly applicable to prison healthcare and we recommend an agreed set of Performance Indicators is adopted universally by each health board.**

42. A theme from the informal sessions and written evidence was the relationship between the SPS and the NHS. HMIP's written evidence commented that “Good working relationships are necessary at a strategic level between the governor/ director and the health board, at an operational level between the health centre staff and the operational staff in the prison, and between the health care team and the wider NHS board. The provision of good healthcare needs to be seen as a joint venture, where there is clarity about responsibilities and a shared sense of leadership”.

43. The British Psychology Society noted a need for “necessary collaboration between the different agencies operating within the prison, including the NHS, the Scottish Prison Service and the various third sector organisations providing mental health services.” They commented that this may be hindered by competing organisational priorities, different cultures and staff groups which are not yet well-integrated.

44. HMIP acknowledged the above was something "we frequently notice in inspection and monitoring" and “they see things going well for prisoners when there is a clear shared vision and joint leadership.” [11]

45. In their 2016 report the RCN covered the “importance of good relationships …. between prison health care and the SPS, prison health care and the rest of the NHS, and with wider community and justice services.” [12] The report noted issues and tensions being commonly reported by health staff with a focus on the prison regime, medication, escorts and sharing information.

46. SPS staff raised issues, also reported by the RCN in their above report, with the difficulty caused by the NHS structure in developing relationships. Both indicated a lack of understanding about the other's roles and responsibilities with a clash between care and custody.

47. We heard from the SPS and Perth and Kinross Health and Social Care Partnership how at operational level there can be both positive working relationships and local working to improve relationships.

48. **It is vital to the delivery of prison healthcare that any cultural difficulties between the SPS, NHS and others are addressed. Only by close cooperation and collaboration coupled with strong leadership can any tensions be overcome and agreed health standards delivered.**

The National Prisoner Healthcare Network

49. The NPHN was established after the transfer and is a collaboration of key stakeholders, principally the National Health Service, the Scottish Prison Service and other agencies and bodies who are collectively driving improvements in prisoner healthcare.

50. When responsibility for the provision of healthcare to prisoners transferred to NHSScotland in 2011, Healthcare Improvement Scotland (HIS) took on responsibility for hosting the NPHN. In 2014, responsibility for the Network transferred to the Scottish Government.

51. The NPHN is led by an advisory board accountable to the NHS chief executives. The membership is drawn from NHS Boards, Scottish Prison Service, local authorities, third sector organisations and Scottish Government.

52. HIS continues to employ the members of staff who support the work of the Network (two national health advisors), HIS hold the budget for their work. The Network is accountable direct to the Scottish Government and its operation is not included in the HIS Local Delivery Plan.

53. HIS also provides healthcare expertise for HMIP for the Scotland inspection programme, looking specifically at the healthcare elements of the Standards for Inspecting and Monitoring Prisons in Scotland. HIS employs one inspector to undertake this work, who is supported by both national health advisors of the NPHN.

54. **We recommend HIS or a Scottish Government department takes on direct responsibility for the work of the National Prisoner Healthcare Network.**

55. The role of the Advisory Board and associated groups and workstreams is in part to meet the Scottish Government's goal of reducing health inequalities. The aim being that by improving the health outcomes of those in prisons and by ensuring better healthcare support for prisoners after their liberation there will be a beneficial impact on the health and well-being of the wider community.

56. Specifically, the aim and purpose of the Network and its Advisory Board is to achieve better health outcomes by performing the following;

- Advising NHS, SPS, Scottish Government and other associated bodies on Prisoner Healthcare
- Collaborating with justice and health agencies and the third sector
- Influencing and responding to Government policy
- Commissioning and directing workstreams in relation to offender health
- Providing expert advice and opinion as required
- Improving outcomes in prisoner healthcare

- Providing leadership
- Improving throughcare.[13]

57. The NPHN has been fairly active since the transfer and has a developed workplan produced in collaboration with those groups and bodies who are members of the Network, derived from discussion around the most important aspects of healthcare for those in prison. Workstreams were established, with representation from the membership of the Network and individuals with expertise in the particular subject matter.

58. The workstreams report to the Advisory Board although it does not have any authority to enforce or implement recommendations. Final reports and recommendations are disseminated for individual health boards to consider and implement where they consider necessary and appropriate.

59. We were advised only a few of the recommendations made by the NPHN have been fully implemented. We asked for a list of all reports and recommendations made to date and this is reproduced in Annexe C.

60. **We ask the Scottish Government to update us on the progress towards implementation of all outstanding recommendations together with proposed dates for each.**

61. **We have noted the NPHN developed interim outcome indicators for prison healthcare in 2013 which are being used by some health boards. We recommend these indicators are now finalised and completed by all health boards.**

IT Compatibility

62. A constant theme throughout the inquiry was concerns about the IT system used in prisons. Virtually every person we spoke to and many submissions highlighted concerns about the lack of a comprehensive clinical information system providing access to records. Current provision was described as being “not fit for purpose”. [14]

63. We heard that problems can arise from prison healthcare staff not being able to access prisoners' GP records and vice versa, although prisons have access to the Emergency Care Summary. Prisons have a system called “GP Vision” which differs from the "GP vision" system which is used by GPs in the community. The two systems cannot communicate with each other and patient records cannot be shared. This means healthcare staff in prisons cannot access a person’s GP records and also causes problems on release with GPs unable to access the health record from time spent in prison.

64. Another area of concern is that prison healthcare staff cannot electronically prescribe, all information on prescribing and administration is retained on a manual Kardex system. This was described as “challenging” given the number of patients and the extent of prescribing, with around 75% of prisoners estimated to be in receipt of prescription drugs, and around 50,000 items dispensed monthly, a large increase in the last 10 years[15]. Prescribing records cannot be shared between prisons which can cause problems when prisoners are transferred.

65. Work is taking place nationally around GP IT reprovisioning however the prison side is not within the scope of that work.

66. We discussed the implications of this issue using the example of a newly admitted prisoner. Prison healthcare staff could not access their community GP records and require to rely on interview with the prisoner to ascertain their medical history and any drugs being prescribed. Given the extent of mental health and substance misuse problems, in many instances they would have to rely on phone conversation with previous GPs, only possible during GP opening hours. Prison healthcare staff have access to the emergency care summary[16] but this leaves a gap in available information, which was termed a “significant challenge”.

67. The lack of functionality with the prison IT system has other drawbacks, for example the clinical decision support software to support evidence based prescribing and/or diagnosis cannot be used.

68. We noted the NPHN have been raising IT issues for 5 years and we asked the Minister for an update. She advised this was now being analysed by the Government’s e-health division “to establish more functionality” for the prison Vision system as well as e-prescribing. [17] The same issues were also raised by Sir Lewis Ritchie when considering out of hours services (in 2015) and recommendations were made to “unleash the considerable potential of electronic records”. Sir Lewis told us:-

“One of the principles that we identified was that any development of services should be intelligence led. That takes us back to the point about the importance of

data collection, electronic systems that can communicate more effectively and the capacity to shape services with up-to-date information and diligence." [18]

69. The Minister indicated the issue was complex and an initial piece of work was due to report in May but was unable to predict when a new system might be in place.

70. **The difficulties and dangers inherent in the current lack of IT functionality and connectivity have been known for many years. This also prevents proper planning, monitoring of delivery of services and collection of robust data including outcome and performance measures. It is disappointing prisons have been omitted from ongoing IT developments for the wider NHS and we recommend this is now addressed and rectified as a matter of urgency. We request a full update on progress with this work.**

The Health of the Prison Population

71. Among the aims of our inquiry was to consider access to health and social care and medicines in prison and the effectiveness of such treatment. We recognised there was a unique opportunity to tackle health inequalities within a discrete section of the population likely to be disproportionally affected.

72. The Chief Inspector of Prisons summarised the position as follows:-

> "Given the poor health of many people in prison, I believe that prisons should be well placed to contribute to tackling health inequalities in Scotland. Serving a sentence in prison gives a short window of opportunity to improve the health of the prisoner and to identify prisoners with long-term conditions – such as diabetes, obesity, heart disease and cancer. HMIPS has found some excellent examples of health promotion, such as diet, exercise, health education, addictions, tackling underlying health conditions, smoking cessation, and preventive practices. I have seen good examples of health promotion not only with people in prison, but with their families too, with events for children and partners, covering such subjects as oral health and diet. The families of people in prison can often benefit from such interventions." [19]

73. We heard the prison admissions process is quite robust in helping to identify any healthcare needs, including those relating to mental health and substance misuse. It gives access to national screening. [20] In particular there is an opportunity to test for blood borne viruses (BBVs) such as HIV and HCV using dried blood spot testing but we were told testing is inconsistent and poorly managed with access to treatment not being confidential which discourages testing and treatment. [21] Members did hear during our informal session from former prisoners that a custodial sentence can improve diagnosis of BBVs and compliance with medication for treatment of BBVs, this was seen as one of the positives of healthcare in prison.

74. **We recommend the opportunity is taken through the admission process to undertake dried blood spot testing on all prisoners.**

75. There are a number of health conditions which disproportionately affect the prison population and are discussed in the following chapters.

Mental Health

76. It is well documented that a proportionally higher number of people in prison have mental health problems than the general population. We were given an estimate that 70% of prisoners will have a mental health problem,[22] which is supported by various submissions and pieces of research.[23] In evidence we were also told there is considerable variation across prisons in relation to the mental healthcare available.

77. We asked the SPS how many prisoners have mental health needs but they were unable to tell us, as this is the responsibility of individual health boards.[24] We note the 2014 report "Evaluation of High Care Needs Within the Scottish Prisoner Population" which highlights a list of conditions that could have formed a baseline of statistics for use in assisting the SPS in identifying the care needs of their prisoners.

78. We understand the 2015 Report of the Ministerial Group on Offender Reintegration[25] also reflected variations in mental healthcare and indicated services were available based on historical spend as opposed to an assessment of needs. That report concluded by noting that less severe mental health issues are not currently being adequately addressed.

79. In their submissions both the Care Inspectorate and the Mental Welfare Commission (MWC) noted considerable variation across prisons and health boards in relation to mental healthcare available to prisoners. The MWC highlighted findings from prison visits and commented that a "big and ongoing issue is access and input from psychology and also access to lower level and psychological interventions, therapies and support for trauma".

80. We were told by the British Psychological Society that the 18 week referral to treatment time for accessing psychological therapies does not apply to prisoners.[26] ISD Scotland[27] confirmed that prisoners, in common with members of the non-prisoner community, have the same right of access to mental health services from their local health service as they do to physical health services. They explained that during the development of the HEAT [28] targets for access to psychological therapies it emerged that, due to a number of complex issues including IT and resourcing, many health boards were not in a position to submit data on prisoner access to psychological therapies.

81. **We recommend that steps are taken to ensure that the mental health needs of all prisoners are addressed and prisoners are able to access psychological therapies if appropriate.**

82. **We recommend the 18 week referral time for accessing psychological therapies is applied to prisoners.**

83. An Advisory Committee for Psychological Therapies in Prisons was commissioned by the former Director of Health and Justice at the Scottish Government. The purpose of this group was to develop a framework for the delivery of psychological therapies in Scottish prisons, and on to throughcare.

84. **We look forward to the report on the work of this group expected in spring 2017.**

85. HMIP expressed a "frustration that people with mental ill-health are kept in prison, when a hospital setting would be more appropriate, but is not available on account of a shortage of psychiatric beds available in the community" [29]

86. A number of submissions commented on prisons being used as safe refuges for people with mental health conditions. This is a matter for the justice authorities as the prisons have no alternative but to accept those sent to them until such time as transfers to more appropriate facilities can be made.

87. **We ask the Scottish Government to advise what steps are being taken to ensure prisoners are not kept in the wrong setting due to a shortage of psychiatric beds.**

88. In their 5th report 2013-14 "Older Prisoners" the House of Commons Justice Committee [30] noted "the unmet mental healthcare needs of older prisoners are extensive. The way to combat this is to raise awareness and enhance training among all those in the prison community – to recognise where mental health problems exist and to refer appropriately." They encouraged officers to obtain relevant training and for this to be integrated into standard prison officer training.

89. Since the transfer of responsibility it is not clear to us the extent to which SPS staff consider that they have any responsibilities for addressing the mental health of prisoners. While delivery of health is clearly a matter transferred the extent of awareness of mental health by SPS staff is unclear although we understand the development of mental health first aid as a core skill within the Prison Officer workforce has been transformational and we commend the SPS on this work.

90. **We note Action 15 in the Mental Health Strategy 2017-2027 is for an increase in the workforce to give access to dedicated mental health professionals in our prisons. We ask the Scottish Government to explain what that means in practice and the timescale for implementation within prisons.**

Alcohol and Drugs

91. A significant proportion of prisoners are likely to have drug and alcohol issues, we were advised 1,136 started drug or alcohol treatment between October and December 2016.[31]

92. One of the HEAT (Health improvement, Efficiency and Access Treatment) targets is that 90% of people who need help with their drug or alcohol problem will wait no longer than 3 weeks for treatment that supports their recovery. The target applies to prisons and ISD Scotland collects and collates figures relating to drug and alcohol treatment in prisons. 5391 people started their treatment in the year to 31 March 2016 with 97.6% waiting less than 3 weeks of which 77.5% waited one week or less. Of the total number 1672 started alcohol treatment and 3719 drug use treatment.

93. We agree and endorse the comment from the Scottish Drugs Forum:

"A prison sentence should be viewed as an opportunity for people with drug problems to work with professionals to address their drug and other health issues and they should be encouraged to engage in treatment and accept support and to engage in treatment which can be continued in the community after liberation."

94. And we note the World Health Organisation (WHO) have indicated addressing alcohol harm in prisons can potentially reduce the risk of re-offending with health savings of £4.3m and crime savings of £100m per year possible as a result of appropriate alcohol interventions.[32]

95. We are aware NPHN in 2016 published a review and guidance on drugs, alcohol and tobacco services in prisons. The review highlighted a lot of good practice while raising other issues and making a series of recommendations.

96. **As indicated above more generally we look forward to receiving an update from the Scottish Government on progress in meeting the outstanding NPHN recommendations**.

Older Prisoners

97. An older person in custody is someone over 50 years, some 10 years younger than in the general population due to the health issues presented by people in prison.[33] According to Scottish Government prison statistics and population projections (2013-14) the number of people in prison aged over 50 years has increased by 50% in the last 5 years.[34] With improved life expectancy, longer sentences for serious crimes and more convictions for historic offences numbers of older prisoners are projected to continue to rise.

98. A significant number of written submissions highlighted that one of the challenges over the next 15 years will be caring for older prisoners with more complex health and care needs. The ageing profile of the prison population will also bring challenges for specialist areas such as dementia care and end of life care. Some submissions noted that the physical layout of the prison estate can mean it is ill-suited and inflexible for adaptations to accommodate need arising from age, health and disability.

Social Care

99. The provision and delivery of social care to prisoners is a statutory responsibility which lies with the SPS. There are national care standards to which the SPS must adhere. HMIP along with the Care Inspectorate is responsible for inspections. Returns from our survey by health boards and integration authorities suggested there were 236 prisoners with high care needs.

100. The SPS said[35] they did not have a budget for the provision of social care nor do they maintain any central register of who is receiving care across their estate. The SPS provided a variety of estimates relating to social care numbers and costs. Costs provided by SPS varied from an actual spend in 2015/16 of just under £300k, to a projected spend in 2016/17 of just over £250k. Social care was estimated to cost an average per person of £5600 which, when they grossed up on estimated numbers in custody requiring such care, produced a figure of £969k. They also indicated they have had in the past to spend almost £6k per week on a single individual's care needs.

101. With a population that is ageing the SPS recognise that the need for social care can only grow. In addition to ongoing costs there will inevitably be a need for appropriate equipment and physical alterations within prisons. We were told the SPS currently has "particular difficulty in accessing social care for individuals." And they "sometimes have difficulty in accessing equipment."[36]

102. We cannot understand why the SPS, despite commissioning a report on high care needs in 2014, do not hold records of needs and costs nor set a budget to monitor expenditure.

103. **We recommend this is rectified immediately. We also recommend the establishment of a suite of indicators to assess SPS performance in providing social support on an ongoing basis.**

104. In relation to the provision of social care we received evidence that in some places, for example, HMP Dumfries and Glenochil, this was delivered by other prisoners. Assistance provided includes help with mobility, feeding, cleaning and laundry. This chimes with findings from England and Wales as reported by the House of Commons Justice Committee.[37] They reported instances of prisoners receiving training to work as disability helpers and achieving a college diploma in Health and Social Care.

105. **We recommend the SPS consider the extent to which this offers an opportunity that could be introduced across all prisons.**

106. We make no recommendation in relation to the responsibility for the provision of social care, noting the unique position of the SPS who are responsible for accommodation and feeding prisoners. We also acknowledge security and access requirements and can understand why this did not change with the introduction of

the Integration Joint Boards. The justification for different leads will dilute over time as the Integrated Joint Boards become responsible for the delivery of increasing amounts of health care within the prison environment.

107. **We recommend responsibility for the delivery of social care within prisons be kept under review.**

Palliative and End of Life Care

108. In relation to Palliative and End of Life Care we were made aware of good practice and arrangements between the SPS and Macmillan Cancer Support and were told others are brought in on palliative care standards as required.[38]

109. We also congratulate the staff from NHS Forth Valley and the SPS who in 2016 won a Scottish Health Award for Integrated Care for Older People which included caring for prisoners approaching the end of their lives.

110. In their submission Macmillan Cancer Support said support for prisoners requiring cancer, palliative and end of life care across the SPS has varied enormously with no consistent approach.

111. **In line with Macmillan Cancer Support we recommend a partnership approach between the NHS, HIS and the SPS to develop an integrated approach.**

Throughcare, After Care and Continuity of Care on Liberation

112. Throughcare is defined in a report by the NPHN published in January 2016. At paragraph 7.3 they define statutory throughcare, which applies to those serving sentences of 4 years or more. It is the provision of a range of social work or similar services for prisoners and their families from the point of sentence or remand, during the period of imprisonment and on release into the community. And helping them to resettle into their community within the law.

113. **As indicated earlier we look forward to information on each of the recommendations in the above report which have not yet been implemented.**

114. For the purposes of this inquiry we are principally concerned with the continuity of healthcare people receive in the immediate period following their release.

115. The statutory system (defined above) does not reach the largest group of prisoners, those serving less than 4 years and those on remand. This, according to the above report, omits approximately 95% of the 21,000 individuals returning from custody each year.

116. Voluntary throughcare provision is available on request but the level of take up remains limited. Statistics show take up as around an average of 2700 per year over the 5 years of published data (to 2013)[39] with levels in the last 2 years falling. And, according to the report, the majority of those receiving voluntary provision only do so to meet basic welfare needs.

117. The Guidance, Reducing Reoffending Change Fund assessment in 2013 found a low level of uptake of voluntary throughcare and inconsistent provision. SPHN's 2014 review found “that the current arrangements are failing to deliver continuity of care for a potentially vulnerable group of people.”

118. We were told that in 2015 the SPS introduced throughcare support officers across Scotland. We also heard during one of our private sessions about the good work this scheme provides directly from one such officer. They work with a prisoner from 6 weeks prior to liberation and for up to 3 months after release “to ensure they are in a stable environment”[40] Support includes assistance with housing, employment, benefits and with GPs.

119. We also heard in our informal session about Sacro's veterans monitoring service and the work they are doing to support military veterans in or on the periphery of the criminal justice system. This is a further example of a service designed to support sustainable independent living.

120. **We commend the SPS throughcare initiative and would like to see this fully evaluated and the numbers of prisoners being supported substantially increased.**

121. It is the areas covered above (housing, employment, benefits and GP registration) that we heard are the most problematical. While our remit does not cover the first three, based on what we heard unless each of these areas are addressed it is clear the likelihood of reoffending will increase and health inequalities will persist. In relation to housing and benefits we heard from the Minister about collaborative Ministerial work "to get the holistic picture right and to make improvements……to ensure that vulnerable individuals are given the support they require" [41]

122. **We look forward to an update on progress with this work.**

123. People serving sentences 6 months and over are automatically de-registered by their community GP. On release they must re-register but to do so they require a home address. Without that they not only cannot register and access continuity of care but also cannot be certificated, if appropriate, as being unfit to work which is a requisite of a benefit claim. In relation to registration with a GP we note the tragic result that occurred in a case considered by the SPSO [42] in which they found registration was unreasonably withheld and the prisoner died 3 days after refusal.

124. We consider the MoU, that exists between the SPS and the NHS, requires to be reviewed as a matter of urgency. Matters brought to our attention (in the RCN 2016 report) which should be considered include:

- All health boards should be party to the MoU, as on release a prisoner could settle in any board area;
- The NHS and the SPS should work together on throughcare planning, including registering prisoners with a GP surgery and other health services in advance of their release. (Any bureaucratic issues arising around records caused by IT deficiencies should be identified and resolved without any disruption to care.)
- Prison GPs should be able to assess and certify a person's fitness to work

125. **We recommend the MoU is reviewed to include the three points above and look forward to an update on such progress.**

Remand Prisoners

126. The issue of remand prisoners arose throughout our inquiry, particularly in relation to continuation of care. There is a particular problem when release at court occurs.

127. We expect provisions to be put in place to address this difficulty and look forward to hearing how this is to be resolved.

Complaints by Prisoners

128. One measure of the effectiveness of the healthcare provided in prisons is the number of complaints made. We asked the SPSO to provide us with a breakdown of the number and type of complaints they receive from prisoners. They reported[43] that in 2015-16 they determined 138 cases with another 49 being premature and 44 not duly made or withdrawn. Of the138, 36 were investigated and 12 upheld; an upheld rate of 33% which contrasts with the upheld rate across all health complaints of 56%.

129. It therefore appears complaint numbers were not unusually high although HMIP submitted evidence which stated; “Both inspection and monitoring have found that from the prisoner’s perspective, the way that they experience healthcare services is often poor. This might be in spite of the correct clinical decision being made. Prisoners may not be informed about what decision has been made, nor how long they might expect to wait for an appointment or for treatment. Poor communication about healthcare adds to levels of anxiety, frustration and worry for prisoners, who are dependent on members of staff to keep them informed.” [44]

130. “Both inspection and monitoring have found that from the prisoner’s perspective, the way that they experience healthcare services is often poor. This might be in spite of the correct clinical decision being made. Prisoners may not be informed about what decision has been made, nor how long they might expect to wait for an appointment or for treatment. Poor communication about healthcare adds to levels of anxiety, frustration and worry for prisoners, who are dependent on members of staff to keep them informed.” [45]

131. We note the issue of complaints, the numbers raised and the difficulties around confidentiality and communication that arise in a closed environment such as a prison.

Conclusion

132. **The overriding impression we have received from our evidence is of a population which has been very much underserved by the change in responsibilities. The promised improvements have not materialised and we do not accept the suggestion or expectation that progress and change within the health service takes a long period of time. It does not need to if the will is there and sadly within prison healthcare this has been conspicuous by its absence at senior management levels.**

133. **We are disappointed to discover the unique opportunity to address health inequalities within the prison environment is not being taken. We recommend the extent to which this is tackled should be a key performance indicator for all of those involved.**

134. **We recommend the Scottish Government prepare a strategic plan covering prison social and healthcare. The plan should set out how the aims of parity of healthcare within and outwith prisons will be fully met within the next 2 years including addressing the real challenges the ageing population will bring. A plan requires to be underpinned by clear, measurable indicators across at least the range of issues we have covered in this report.**

Annexe A -Minutes of Meeting

2nd Meeting, 2017 (Session 5), Tuesday 24 January 2017

6. **Healthcare in Prisons (in private):** The Committee considered and agreed its approach to work on this issue.

3rd Meeting, 2017 (Session 5), Tuesday 31 January 2017

5. **Healthcare in Prisons (in private):** The Committee considered and agreed its approach to work on this issue.

7th Meeting, 2017 (Session 5), Tuesday 14 March 2017

2. **Healthcare in Prisons:** The Committee took evidence from—

- Alison Douglas, Chief Executive, Alcohol Focus Scotland;
- Professor Aisha Holloway, Professor of Nursing Studies, The University of Edinburgh;
- Theresa Fyffe, Director, Royal College of Nursing Scotland;
- David Liddell, Chief Executive Officer, Scottish Drugs Forum;
- Sandra Campbell, Macmillan Nurse Consultant for Cancer & Palliative Care, Representative for the Scottish Partnership for Palliative Care;
- Paul Noyes, Social Work Officer, Mental Welfare Commission for Scotland.

3. **Healthcare in Prisons:** The Committee discussed the recent informal evidence sessions.

4. **Healthcare in Prisons (in private):** The Committee considered the main themes arising from the oral evidence heard earlier in the meeting.

9th Meeting, 2017 (Session 5), Tuesday 28 March 2017

2. **Healthcare in Prisons:** The Committee took evidence from—

- Beth Macmaster, National Prison Monitoring Coordinator, Her Majesty's Inspectorate of Prisons for Scotland;
- Teresa Medhurst, Director of Strategy and Innovation, Scottish Prison Service;
- Fiona McNeill, Head of Adult Services South, Prison & Police Custody Healthcare, Glasgow City Health & Social Care Partnership;
- Jillian Galloway, Head of Prison Healthcare, Custody and Forensic Healthcare and Out of Hours, NHS Tayside, representative for Perth and Kinross Health & Social Care Partnership;
- John Porter, National Nurse Advisor, National Prison Healthcare Network;

and then from—

- Aileen Campbell, Minister for Public Health and Sport,
- Daniel Kleinberg, Head of Health Improvement,
- and Professor Sir Lewis Ritchie OBE, Adviser, Primary Care, Scottish Government.

4. **Healthcare in Prisons (in private):** The Committee considered the main themes arising from the oral evidence heard earlier in the meeting.

Annexe B - Evidence

HCP001 McMillan Cancer

HCP002 Royal College of Nursing Scotland

HCP003 Royal College of Pathologists

HCP004 Mental Welfare Commission

HCP005 NHS Tayside

HCP006 NHS Dumfries and Galloway

HCP007 Scottish Drugs Forum, Hepatitis Scotland and HIV Scotland

HCP008 Youthlink Scotland

HCP009 British Psychological Society, Department of Neuropsychology

HCP010 Perth and Kinross Health and Social Care Partnership

HCP011 East Ayrshire Health and Social Care Partnership

HCP012 Scottish Directors of Public Health and NHS Health Scotland

HCP013 National Prisoner Healthcare Network

HCP014 NHS Highland

HCP015 Re:D Collaborative

HCP016 NHS Lothian

HCP017 Aberdeenshire Health and Social Care Partnership

HCP018 Alzheimer Scotland

HCP019 ASH Scotland

HCP020 British Dental Association

HCP021 Royal Pharmaceutical Society of Scotland

HCP022 Scottish Prisoner Advocacy and Research Collective

HCP023 Centre for Youth and Criminal Justice - University of Strathclyde

HCP024 Samaritans Scotland

HCP025 Positive Prison? Positive Futures

HCP026 Howard League Scotland

HCP027 Glasgow City Health and Social Care Partnership

HCP028 Families Outside

HCP029 Gilead Sciences

HCP030 BMA Scotland

HCP031 British Psychological Society

HCP032 Care Inspectorate

HCP033 Criminal Justice Voluntary Sector Forum

HCP034 East Ayrshire Health and Social Care Partnership

HCP035 SPSO

HCP036 University of Edinburgh and Teesside University

HCP037 University of Edinburgh and NHS Lothian

HCP038 Anonymous

HCP039 Her Majesty's Inspectorate of Prisons

HCP040 Scottish Prison Service

HCP041 NHS Lanarkshire (HMP Shotts) and North Lanarkshire Health & Social Care Partnership

HCP042 Hepatitis C Trust

HCP043 Alcohol Focus Scotland

HCP044 Scottish Centre for Telehealth and Telecare (SCTT)

HCP045 Scottish Prison Service (submission 2)

HCP046 UNISON Scotland

HCP047 The Forensic Network and School of Forensic Mental Health

HCP048 NHS Forth Valley

HCP049 Children in Scotland

HCP050 Falkirk IJB

HCP051 National Prisoner Healthcare Network

Annexe C

Extract from Submission by the National Prisoner Healthcare Network.

Request for information on key recommendations from the National Prisoner Healthcare Network workplan

The Health and Sport Committee at the formal session on the Prisoner Healthcare Review on 28 March 2017 sought to establish recommendations and outcomes from a number of the key workstreams of the Network. This paper shows those recommendations that have been successfully implemented and highlights others that remain. The reasons for some of the recommendations not being implemented as yet range from fiscal constraints to the need for national approval. Where this information is known the reasons have been specified.

In addition to the information requested an indication of the key issues and challenges that will be faced within Prisoner Healthcare going forward has also been provided.

National Prisoner Healthcare Network Workplan

The workplan was developed in collaboration by those groups and bodies who are members of the Network and was derived from discussion around the most important aspects of healthcare for those in prison. Workstreams were established, again with representation from the membership of the Network. Also included in the membership of workstreams were individuals from across Scotland with expertise in the particular subject matter. These workstreams reported findings and gave recommendations to the Advisory Board. The Advisory Board then disseminated the final reports and recommendations to individual NHS Boards for them to consider and implement where necessary and where appropriate. The Advisory Board does not have any authority to enforce the recommendations or their implementation.

Examples of completed workstreams include:

1. Mental Health Report (published 2014)

Mental Health is a significant matter for prisoner healthcare as a proportionately higher number of prisoners, than in the population in Scotland in general, experience mental health problems.

1.1 The workstream made a number of recommendations that are now embedded across Boards in Scotland:

- Health Boards apply key messages and recommendations from Mental Welfare Commission Report on Prisons (2011).
- Royal College of Psychiatrists Prison Standards (2015) adopted.
- Mental Health Implementation Group established.
- Request made to Scottish Government to develop workforce tool.
- Engagement with NHS Education for Scotland in posting learning material on Prison Portal.

1.2 Recommendations that remain outstanding;

- An updated national assessment of the mental health needs of prisoners has not been implemented as yet due to the financial implications of securing researcher/s to establish and analyse the data.

2. Substance Misuse Report (published 2016)

Again this is a significant matter for prisoner healthcare and is supported by a number of staff in each of the establishments who have knowledge and expertise in addiction services. A workstream developed recommendations for NHS Boards and SPS in the management of substance misuse in the context of the prison environment. This report was premised on the knowledge that prison can provide an opportunity, through education, to support prisoners to address their addiction habits prior to their release.

2.1 The workstream made a number of recommendations that are now embedded across Boards in Scotland.

- All prisoners should be effectively engaged in a range of purposeful activity which strengthens recovery and reduces reoffending.

- Those who test positive for drug misuse, and are in withdrawal, should receive a prescribed protocol for safe management of withdrawal symptoms until confirmation of provision of a community-based opiate substitution treatment can be obtained or assessment for initiation of treatment can occur.

- Arrangements should be made to ensure that details of healthcare delivered in police custody suites can be accessed by prison-based healthcare staff, by a suitable IT linkage, to inform continuity of care.

- Those screening positive or who claim to have a drug misuse problem should have their urine tested for the presence of drugs.

- Those who are in alcohol withdrawal should receive a prescribed protocol for safe management of withdrawal symptoms.

- All prisoners coming into custody from the community should be screened for tobacco use.

2.2 Recommendations that remain outstanding are;.

- Data should be captured and shared where appropriate to baseline, measure and benchmark access, uptake, engagement, success and sustained recovery to inform local and national planning. The Outcome and Performance Indicators Workstream of the NPHN will specify the data to be captured.

- This is interlinked with the need for the development of robust and effective Clinical IT.

- Prison smoking cessation services should be equitable with community smoking cessation services (quality, access and choice). This would require funding and capacity to provide services equitable to those in the community.

3. Throughcare

This workstream was a close collaboration of bodies and groups who provide support to prisoners at the point of their release to enable them to return to the community successfully. This work included consideration of the ongoing healthcare support required for example through General Practitioners and offered guidance to NHS Boards to ensure prisoners were registered and had access to healthcare immediately on release. This is particularly important for those who are dealing with addiction habits. The aim of this workstream and the recommendations made by it were to support reduction in reoffending after release.

3.1 The workstream made a number of recommendations that are now embedded across Boards in Scotland.

- All Prison Healthcare Teams should ensure patients CHI number is used as the default unique health identifier.
- The Throughcare Officer role is recognised as good practice and should be shared.
- Improving the GP registration process for prisoners transferring back to a community.
- NHS Boards to encourage Protected Learning Time for GPs.
- Third sector organisations, and mentors should be engaged in community reintegration planning.
- NHS Boards and Scottish Prison Service to ensure that the health throughcare pathway is integrated with the Offender Case Management System.
- NHS Boards to consider Prison Healthcare Teams having access to the Key Information Summary (KIS)
- Prisoners are supplied with a minimum quantity of their medication on liberation that will ensure continuity of care until such times as a further prescription can be obtained from their community GP.

3.2 Recommendations that remain outstanding;.

- NPHN and the Centre for Youth and Criminal Justice continue developing a throughcare map for prisoners under the age of 18.
- NPHN and SPS to review Placement of Prisoner policy.

4. Brain Injury

The National Prisoner Healthcare Network report on Brain Injury and Offending was published in July 2016. The report contains a series of recommendations on how best to support these individuals with an emphasis on developing a greater understanding of the service need (not simply the numbers with head injury), and to establish reliable systems that identify those in need of services. Thereafter importance would then shift towards education for staff and interventions for prisoners.

Implementation of these recommendations is at a very early stage and closely associated with liaison between NPHN, SPS and other agencies including Police Scotland, for example in relation to data capture and systems.

There is also a recognised need for further evidence in relation to the use of screening tools, estimating service need, understanding head injury in female prisoners and developing education about head injury for prisoners.

Efforts are currently being made to secure funding of £60k to secure a part time research worker for 18 months to undertake this essential activity. Thereafter the findings of this research will be shared with a view to further recommendations being implemented.

Status of current workstreams:

5. Workforce

There is no recognised national workforce tool that enables service providers to establish workforce complements within a prison environment. A workstream was established to consider workforce issues and has recognised the challenge for the NHS in Scotland of there being appropriate numbers of trained and experienced healthcare professionals to meet the needs of the prisoner population.

Updated progress from the workstream is that it has secured engagement with Scottish Government workforce leads and work has commenced to scope and establish a nationally recognised workforce model for prisoner healthcare.

6. Clinical IT - This workstream is attempting to address the challenges of existing IT systems. It is widely acknowledged that the currently IT system is not fit for purpose and requires significant investment to ensure it supports the delivery of care applied in the prison environment.

7. Performance Indicators

As a result of the Clinical IT system for prisons being unable to perform a number of essential functions there is limited capacity at the present time to extract reliable health outcome and performance data. The lack of access to reliable information has a significant impact on our ability to undertake effective governance measures including;

- audit and assurance, including progress against key network recommendations,
- Health status of prisoner population,
- service provision gaps,
- identifying what our priorities are,

This has been a common issue raised in the course of the discussions and submissions with the Health & Sport Committee. The aim of this workstream is to begin to establish a core set of health performance indicators and to address the means through which this can be gathered to enable effective monitoring and assurance to be implemented.

8. Physical Estate

This workstreams, which was led by the NHS Prison Board Leads, considered the suitability of the physical prison estate to manage the health needs of the prisoner population effectively. Further work is undoubtedly required to ensure actual physical settings, particularly in some of the older prison establishments, can assure equivalence. There is some recognition however that there have been significant achievements across

the establishments in areas such as palliative care provision despite the challenges of the physical environment.

In addition the governance of matters such as infection control was considered by the workstream in an attempt to ensure that all parties understood and applied appropriate standards of cleanliness.

9. Clinical Strategy

The NHS National Clinical Strategy for Scotland has been considered by the NPHN and its pertinence to prisoner healthcare. A NPHN workstream is in place to produce a clinical strategy for prisoner healthcare to ensure that the recommendations of the national Strategy are being applied equally within a prisoner healthcare setting.

10. Safe and Effective use of medicines

There are a number of key workstreams looking at particular challenges around the safe and effective use of medicines within the prison environment for prisoners. Examples include the scope for self management of medicines and the implications of New (Novel) Psychoactive Substances (NPS) Recommendations were given to NHS Boards.

1 Figure at 7 April 2017 http://www.sps.gov.uk/Corporate/Information/SPSPopulation.aspx

2 **Prison Healthcare Advisory Board (2007) Potential Transfer of Enhanced Primary Healthcare Services to the NHS: Report to Cabinet Secretaries for Health and Wellbeing, and Justice. Volume 1 of 2. Available from: http://www.scotland.gov.uk/Resource/Doc/924/0063020.pdf**

3 Minister for Public Health Official Report 28 March col 26

4 Minister for Public Health Official Report 28 March col 25

5 Executive Summary of Finance Review Templates undertaken by Scottish Government.

6 Minister for Public Health Official Report 28 March col 33

7 Official Report 28 March col 34

8 https://www.rcn.org.uk/about-us/policy-briefings/sco-pol-five-years-on

9 http://www.scottish.parliament.uk/S5_HealthandSportCommittee/Inquiries/HCP020_BDA_Scotland.pdf

10 Official Report 28 March 2017 column 37

11 Official Report 28 March 2017 column 8

12 https://www.rcn.org.uk/about-us/policy-briefings/sco-pol-five-years-on 5.6.1

13 http://www.scottish.parliament.uk/S5_HealthandSportCommittee/Inquiries/HCP051_National_Prisoner_healthcare_network.pdf

14 Official Report 28 March 2017 column 22

15 HCP 21

16 Emergency Care Records “might not contain information about any opioid substitution therapy or any items not on repeat prescribing” this includes any medicine prescribed at hospital) Submission 21

17 Official Report 28 March 2017 column 30-31

18 Official Report 28 March 2017 column 31

19

20 Official Report 28 March 2017 column 14

21 Submissions from the Scottish Drugs Forum, HIV Scotland and Hepatitis Scotland Also Official report 14 March 2017 column 28-30

22 Official Report 28 March 2017 column 6

23 Angiolini Commission on women offenders 2012 suggests 80% female prisoners affected; Royal College Nursing report 5 years on suggests 66% have personality disorders alone; House of Commons Justice Committee 5th report 13-14

24 SPS submission available here

25 **https://www.rcn.org.uk/about-us/policy-briefings/sco-pol-five-years-on**

26 BPS submission available here

27 Personal correspondence.

28 **HEAT = H**ealth Improvement, **E**fficiency, **A**ccess to treatment and **T**reatment

29 http://www.scottish.parliament.uk/S5_HealthandSportCommittee/Inquiries/HCP039_HMIPS(1).pdf

30 House of Commons Justice Committee Fifth report 2013-14 Older Prisoners

31 Official Report 26 March column 25.

32 Submission 36 per Aisha Holloway

33 Official Report 28 March 2017 column 19

34 **https://www.rcn.org.uk/about-us/policy-briefings/sco-pol-five-years-on**

35 Submission 40

36 Official Report 28 March 2017 column 19

37 House of Commons Justice Committee Fifth Report 2013-14

38 Official Report 28 March 2017 column 30

39 Criminal Justice Social Work Statistics 2012-13 published May 2014.

40 Official Report 28 March 2016 column 21

41 Official Report 28 March 2016 column 35

42 SPSO Report number 201305288 March 2015

43 http://www.scottish.parliament.uk/S5_HealthandSportCommittee/Inquiries/HCP035_SPSO.pdf

44 http://www.scottish.parliament.uk/S5_HealthandSportCommittee/Inquiries/HCP039_HMIPS(1).pdf

45 http://www.scottish.parliament.uk/S5_HealthandSportCommittee/Inquiries/HCP039_HMIPS(1).pdf