



Royal College of Nursing
Scotland



FIVE YEARS ON:

ROYAL COLLEGE OF NURSING SCOTLAND REVIEW OF
THE TRANSFER OF PRISON HEALTH CARE FROM THE
SCOTTISH PRISON SERVICE TO NHS SCOTLAND

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ACKNOWLEDGEMENTS

RCN Scotland would like to acknowledge and thank the following people:

- The participants of the focus groups and interviews
- Respondents to the nursing survey
- The Scottish Prison Service Research Access and Ethics Committee and SPS staff who co-ordinated and facilitated the interviews with prison staff and focus groups with people in prison
- Health centre and prison staff who facilitated the focus groups with frontline nursing staff
- Members of the RCN project steering group, in particular Dr Elizabeth Walsh (previous Forum Chair of the RCN Nursing in Criminal Justice Services Forum) and Garry Campbell (RCN Scotland Board)
- Helen Malo, Policy Officer at RCN Scotland, who led on the research and writing of this RCN report



FOREWORD

Five years on from the transfer of the nurse-led prison healthcare service from the Scottish Prison Service to NHS Scotland this Royal College of Nursing (RCN) Scotland publication evaluates how far the aspirations behind the move are being evidenced in practice. Our research has highlighted some important areas of improvement and innovation in health care for the prison population and shows the commitment of nursing staff working with people in prison. But, overall, what we report makes for uncomfortable reading.

RCN Scotland continues to support the original aims of the prison transfer to: reduce health inequalities; integrate prison health care into our public system without discrimination; increase continuity of care; and improve

sustainability. But five years on there is too little evidence that the transfer has put health care in prison, definitively, on the right path to delivering better outcomes for people in prison across Scotland.

People in prison have some of the worst health in our population and are often disengaged from traditional health services before and after any prison term. Prison offers a unique opportunity to turn around the health outcomes and life chances of individuals. It can offer a period of stability to re-evaluate aspirations, assess and diagnose health issues, access specialist help, adhere to treatment regimes, build trust in the continuity of relationship with health staff and learn new skills to maintain good health on release. The potential benefits of engaging with people in prison effectively around their health are immense - not just to the life of the person serving time, but to the long term wellbeing of their families and the communities they will return to.

As I read this report I can only conclude that we are still a considerable way from achieving the outcomes set out in the original transfer. This report reveals the difficult reality for both people in prison and the nursing staff delivering healthcare to them. Our conclusion is that improvement must start with renewed and open collaboration. And so we set out two calls to action.

Firstly, RCN Scotland wants to see the health, and the health care, of people in prison at the forefront of open political debate, particularly given cross party commitments to reducing Scotland's persistent health inequalities. Meeting the aspirations of the transfer means that people in prison, and the staff who are working so hard to support them, cannot remain unseen and unheard. RCN Scotland will do what it can to raise our concerns with those in a position of influence over the coming months, but I call on anyone who reads this report and has a response to its findings – or an idea for improvement – to share it at **#prisonnhs5yo**. We can all play a part in championing equality in healthcare.

Second, RCN Scotland, with a wealth of expertise in its membership and the research of this report behind us, wants to be part of finding the solutions to improved equity in health care and outcomes for people in prison. But nursing does not have a monopoly on ideas or influence and cannot do this alone. So I invite any organisation which is working with staff or people in prison, which is commissioning or delivering services or which has a hand in setting the direction of health and justice in Scotland to contact me directly to discuss how we can pool thinking and efforts to lever the changes we wanted to see when the transfer took place in 2011. RCN Scotland's door is open.

I would like to thank the people in prison, staff and partners who spoke to us so openly and supported our work in writing this report. The level of passion and commitment we heard leaves me hopeful that, with a renewed, shared focus, we can still achieve the aspirations of the prison transfer.

A handwritten signature in black ink, appearing to read 'Theresa Fyffe'.

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2. EXECUTIVE SUMMARY

In November 2011, responsibility for health care in prisons transferred from the Scottish Prison Service (SPS) to NHS Scotland. The transfer was driven by the need to reduce health inequalities for people in prison, improve equity of access to health care, improve continuity of care for people when they enter or leave prison, and to have a more sustainable health service.

This review by the Royal College of Nursing in Scotland looks back at the reasons for the transfer and examines what progress has been made in the last five years. It also looks at the contribution and opportunities for nursing in prisons.

The review found that it is not possible to evidence the impact that the transfer has made on tackling health inequalities and addressing the health care needs of people in prison. This is because there are still some gaps in our understanding of people's health needs and a lack of national reporting and quality outcomes data for prison health care.

People who shared their views with us felt strongly that prison is a unique opportunity to address health inequalities, by enabling a vulnerable group of people, with typically poor engagement with health services, to access care. While positive work is happening and there have been areas of improvement in access to and provision of some services, there is variation across prisons and health boards, and overall progress

since the transfer was felt by some to be slow. While some people thought that access to services is as good as, or better, than in the community, pressure on staff and resources mean that core service areas, such as primary care and long-term conditions clinics, appear to be under particular pressure.

While some improvements have been made, continuity of care remains a real challenge. There have been national workstreams looking at health throughcare (**see section 5.3.1**) and a recent report from the National Prisoner Healthcare Network has made a number of recommendations for improvement. People raised concerns around IT systems and information sharing, health's involvement in throughcare, registering with GPs and out-of-hours care. Access to wider clinical expertise and links with some community health services appear to have improved since the transfer.

Overall, sustainability of health services in prison does not appear to have improved since the transfer, although some of the larger health boards did report some improvement. There are significant concerns around the morale of the nursing workforce in prisons, underpinned by recruitment and retention issues, staffing pressures and a lack of understanding from the wider NHS of the role of prison health care. There are opportunities for nursing that could be further developed, such as advanced nursing practice.

3. BACKGROUND

Up until 2011, health care in prisons was the responsibility of the Scottish Prison Service (SPS). In November 2011, responsibility for prison health care transferred from the SPS to NHS Scotland. This report looks back at the reasons for the transfer and examines what progress has been made in the last five years.

There are currently 15 prisons in Scotland, 13 managed by the SPS and two managed privately under contract to the SPS. Nine health boards have prisons in their area: Ayrshire & Arran, Dumfries & Galloway, Forth Valley, Grampian, Greater Glasgow & Clyde, Highland, Lanarkshire, Lothian and Tayside.

This background section provides an overview of the health needs of people in prison, the delivery of health care prior to the transfer, what led to the transfer taking place and the role of the National Prisoner Healthcare Network.

3.1 HEALTH NEEDS OF PEOPLE IN PRISON

There are currently just under 7,900 people in prison across Scotland¹, with the majority of prisoners being male, young and white. Prisoners typically have poor health, physically and mentally, and live chaotic, risk

prone lives². There are high levels of drug misuse and alcohol problems. Many have low education and literacy levels, low levels of employment and may have been in care. A health care needs assessment carried out in 2007², which was used to inform the decision to transfer prison health care to the NHS, clearly showed that the health of people in prisons was worse than the general population, with particularly high prevalence in addictions, mental health and dental problems (**Table 1**).

There is no data or routine screening on the prevalence of learning disabilities for people in the criminal justice system in Scotland⁴, however, there is likely to be a higher prevalence in prison populations². While the majority of people in prison are young, the number of prisoners over the age of 50 is increasing⁵. Health care staff increasingly have to support people with complex long-term conditions and provide palliative and end of life care.

3.2 HEALTH CARE DELIVERY BEFORE THE TRANSFER

The SPS model of prison health care was a primary care service, with enhanced care delivered in addictions, mental health and blood borne viruses.

Table 1. Comparison of health needs of people in prison compared to in the community from 2007, used by the Prison Healthcare Advisory Board³ to inform the recommendation to transfer prison health care to NHS Scotland.

	Prevalence on Admission to Prison	Prevalence in the Community
Alcohol Problems	41% male / 36% female	13% male / 7% female
Illegal Drug Use	67%	8%
Smoking Rates	78% male	26% all
Hepatitis C	20%	1%
Asthma	12%	5.4%
Epilepsy	2.1%	0.7%
Chlamydia	12%	0.8%
Sever Dental Decay	29% male / 42% female	10% male / 3% female
Schizophrenia	9% male / 36% female	0.5%
Depression	25%	5%
Personality Disorders	66% approx	5% approx

Source: Prison Healthcare Advisory Board, based on Graham L (2007) *Prison Health in Scotland A Health Care Needs Assessment*.

It was a nurse-led service with nursing staff employed directly by the SPS. The service was supplemented by contracted GPs, pharmacists, specialist addiction staff and agency nurses. Out-patient and secondary care was provided by local NHS boards. Local arrangements for certain health care services such as forensic psychiatric services, dentistry and allied health professional services varied from prison to prison.

Prisons had to meet SPS Health Care Standards⁶. These standards were the framework used by the SPS to support its commitment to providing prisoners with health care services equivalent to those available in the community⁷ and included standards around providing a primary care service, a multidisciplinary mental health service and substance misuse management.

The 2007 health care needs assessment presented an audit of how prisons self-assessed their compliance against the standards². It found very good compliance with delivering baseline primary care services, particularly around patient safety, such as suicide prevention and addictions management. Addiction services and blood borne viruses were highlighted as strengths, though a complete enhanced stepped-up care service (defined by the SPS as “care that extends beyond our normal primary care provision”) was not being fully delivered.

The audit found evidence of long waiting lists for mental health services and some mental health services being unable to provide a full range of therapeutic interventions. Prisoner involvement with health promotion, communication with external agencies on admission and discharge and communication to prisoners about services were also highlighted as weaknesses.

Prison inspections carried out by the HM Inspectorate of Prisons for Scotland (HMIPS) prior to the transfer raised issues around mental health services, including mental health team staffing and waiting times. Other common themes included medicines management, infection control and the suitability of health centre facilities.

3.3 DRIVERS OF THE TRANSFER OF PRISON HEALTH CARE TO NHS SCOTLAND

In early 2007, Scottish Ministers set up the Prison Healthcare Advisory Board (PHAB) to advise them on the legislative, operational and financial feasibility of transferring prison health care from the SPS to NHS

Scotland. The board advised Ministers in December 2007 that the transfer was feasible³. They set out a number of reasons for why prison health care should transfer from the SPS to NHS Scotland:

Tackling health inequalities: The prison population had profound health inequalities, with higher levels of physical and mental ill health, poorer prospects and shorter lives. The PHAB acknowledged that the SPS had invested in health considerably over the last 10 years and that there had been significant improvements in the enhanced primary health care service it delivered. However, it concluded that tackling health inequalities and poor health required considerable further development and access to specialist resources.

Meeting accepted international standards: Scotland was out of step with two international standards:

- Principle 9 of the UN (1990) Basic Principles for the Treatment of Prisoners: “Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation”
- The World Health Organisation Moscow Declaration on Prison Health as Part of Public Health (2003): “penitentiary health must be an integral part of the public health system of any country”

The PHAB concluded that prisoners in Scotland had poorer access to health services than people outside of prison. NHS national protocols and guidelines did not apply to all SPS health care and the SPS did not have access to the wider range of clinical expertise that the NHS had.

Continuity of care: The PHAB stated that care was not properly planned and co-ordinated when people left prison. Individuals were at their most vulnerable with increased risk of suicide and re-offending through inadequate continuity of care. With the high incidence of mental health, drug and alcohol issues, it was thought that giving NHS boards responsibility for continuity of care would help ensure that vulnerable and at risk people would have properly planned aftercare.

Sustainability: As a relatively small organisation, the PHAB concluded that the SPS was limited in attracting the wide range of expertise needed to keep pace with developments in the wider NHS. Medical services and clinical governance arrangements were fragile and could not be

sustained. The only way for the service to achieve longer term sustainability was for it to be part of a larger service and to have the support of a wider cohort of clinical expertise and community-based services to meet the changing needs of the prison population.

The PHAB also recognised that Her Majesty's Chief Inspector of Prisons in Scotland had recommended that health care should be provided by the NHS, on the advice of NHS Quality Improvement Scotland, who had raised significant concerns about the quality of health care provision.

3.4 THE TRANSFER PROCESS

Following the Prison Healthcare Advisory Board's report, Ministers approved the transfer in July 2008. The National Programme Board for Prisoners' Healthcare was established in March 2009 to oversee the transfer. In August 2010, the Scottish Parliament passed a legislative amendment to enable the change. The effective date for the transfer was 1 November 2011.

Health staff directly employed by the SPS underwent TUPE (Transfer of Undertaking (Protection of Employment) Regulations 2006) transfer to the NHS. Funds were transferred from the SPS to health boards on a historic spend basis. For 2012-13, NHS boards were allocated funding of £21.6m for the ongoing costs of prisoner health care, with additional funding of £1.6m to NHS Greater Glasgow and Clyde for the opening of the new HMP Low Moss prison⁸.

A Memorandum of Understanding between the SPS and the nine health boards with prisons in their area was agreed in 2011⁹, which sets out the relative responsibilities, governance and accountability relationships for prison health services.

3.5 THE NATIONAL PRISONER HEALTHCARE NETWORK

The National Prisoner Healthcare Network was established after the transfer to support the delivery of high quality, safe and consistent services

to prisoners. The Network's Advisory Board is accountable to NHS Chief Executives and "has a national coordinating and strategic role, supporting the delivery of primary and community healthcare to prisoners. The Network works with a wide range of partners including the SPS and aligns with the Scottish Government's priorities to improve health outcomes, reduce inequalities and reduce offending and reoffending"¹⁰.

There are a number of standing working groups, including the NHS Board Leads Operational Group made up of representatives from all health boards with prisons in their area. The group aims to "influence strategic thinking within their own Boards in respect of prisoner healthcare and in addition they will influence the strategic direction of the Network and the Advisory Board"¹⁰. There are also short life working groups looking at specific issues, such as throughcare, substance misuse, national screening services and new psychoactive substances. The Network produces workstream reports and guidance. Recent outputs have included reports on health throughcare, brain injury and offending, and substance misuse.

3.6 INTEGRATION OF HEALTH AND SOCIAL CARE

The integration of health and social care came into force in Scotland in April 2016 under the Public Bodies (Joint Working) (Scotland) Act 2014. There are now 31 integration authorities across Scotland with delegated responsibility for the planning and delivery of adult primary and community health care, adult social care and some aspects of adult unscheduled care in hospitals. The intention is for services to be more joined-up and person centred, with people getting the right care and support whatever their needs, at any point in their care journey. Prison health care is not mentioned specifically in the legislation, however some of the new integration authorities have delegated responsibility for prison health care. Integration authorities may also decide to integrate criminal justice social work.

4. AIMS AND SCOPE OF THIS REPORT

Five years is a short amount of time to assess whether the transfer of health care to NHS Scotland has led to significant change. Reducing health inequalities, for example, can take generations. However, we would expect to see some progress in that time, such as improvements in the provision of and access to health care services within prison and improvements in the sustainability of the workforce. Five years is therefore a useful point to reflect on the impact the transfer has had to date, whether things are on the right trajectory and what is needed in the future.

In addition, the integration of health and social care will bring changes to how health care in prisons will be planned and delivered in some parts of Scotland. This report is therefore particularly timely in looking at what is needed as we move forward into a new integrated landscape.

This report assesses what progress has been made against the original drivers for the transfer. It is primarily taken from the nursing perspective and looks at the nursing contribution to health care in prisons. It is not intended to be a comprehensive review of the health needs of people in prison or of the clinical services available. Rather it is a snap shot of where we are five years on from the transfer.

The report is intended to support reflections on, and improvements in, the delivery of health care in prisons and build on existing work being carried out by health boards, the SPS, the National Prison Healthcare Network and other partners. It is aimed at the Scottish Government, MSPs, health boards, the SPS, integration authorities, health and care professionals working in criminal justice services and service users and organisations representing service users.

To inform this report RCN Scotland carried out a primarily qualitative review comprising:

- An online survey of nurses and health care support workers currently working in criminal justice nursing. The survey was sent to RCN members who work in criminal justice nursing in Scotland. It was also circulated to nursing staff in prisons via the operational leads for prisons in health boards.

108 responses were received. Of these 101 were from nursing staff working directly in prisons. The latest national workforce figures show that there are 356 nursing staff employed in prisons as at June 2016¹¹, which represents a response rate to the survey of approximately 28%. Respondents were based across all 15 prisons in Scotland. 40% of the responses (43 respondents) were received from nursing staff employed by the SPS prior to the transfer

- Five focus groups held with frontline nursing staff working in prisons
- Three focus groups held with people currently in prison who had been in prison since before the transfer
- 36 semi-structured qualitative interviews with stakeholders in person or over the phone. Interviewees included health centre managers, nurse and health board leads for prison health care, public health specialists, community health staff, staff from SPS headquarters and governors in charge/senior managers from seven prisons
- An analysis of the recommendations, areas of weakness and areas of strength from 41 prison inspection reports from February 2007 to February 2016. This comprised 20 inspections from before the transfer and 21 after the transfer. The standards and indicators used in prison inspections have changed over time so a direct comparison is not possible, however broad trends were identified
- An analysis of the questions relating to health care from the SPS prisoner surveys
- A desk-based review of relevant policy reports, guidelines, available data and other literature relating to prison health care

Themes from the focus groups, interviews, nursing survey and other sources outlined above were identified. These are presented in the following section of the report.

The report also includes quotations from individuals who responded to our survey. These reflect their personal experiences from the particular context in which they were working at the time of completing the survey.

5. IMPACT OF THE TRANSFER: KEY FINDINGS

Sections 5.1 – 5.4 provide an assessment of progress against each of the original drivers for the transfer of prison health care. Section 5.5 looks at the opportunities for nursing and Section 5.6 looks at some of the wider context and enablers that prison health care sits within.

5.1 TACKLING HEALTH INEQUALITIES

A key driver for the transfer of prison health care to NHS Scotland was to tackle the stark health inequalities that people in prison face. The Prison Healthcare Advisory Board concluded that tackling inequalities and poor health will require considerable further development and access to specialist resources available from the NHS³.

5.1.1 WHAT PROGRESS HAS THERE BEEN?

Summary: *It is not possible to evidence the impact that the transfer has made on tackling health inequalities and addressing the health care needs of people in prison. This is because there are still some gaps in our understanding of people’s health needs in the criminal justice system and a lack of national reporting and quality outcomes data for prison health care. People felt strongly that prison is a unique opportunity to address health inequalities, by enabling a vulnerable group of people, with typically poor engagement with health services, to access care. While positive work is happening, progress since the transfer was felt by some to be slow and that more could be done.*

It is clear that people in prison have poorer health and outcomes and internationally there is a well-established evidence-base on prisoner health. However, there are still some gaps in our understanding of the health needs of people in Scottish prisons.

The 2007 health needs assessment of people in prisons said that there is “evidence of likely under-diagnosing, under-recording and under-treatment”². It recommended strengthening detection and treatment of long-term conditions, carrying out a more in-depth needs assessment of mental health problems, and improving screening for less severe mental health problems, alcohol problems, sexual health and chronic disease.

Some work has been done since then, for example a needs assessment on alcohol problems¹². In addition, a number of workstreams of the National Prisoner Healthcare Network have discussed the need for updated health needs assessment, for example around mental health¹³. The SPS also regularly publishes the Scottish Prisoner Survey, which includes self-reported prisoner health needs. However there has not been a further comprehensive prison health care needs assessment since 2007.

From the interviews for this review, people reported that there are still information gaps in understanding the health needs of people in prison, for example around mental health, long-term conditions, learning disabilities, the needs of young men, especially around trauma and bereavement, and the needs of older people.

There was strong feedback from the interviews that prison is an opportunity to address health inequalities. People saw it as a chance to reach a vulnerable group of people, with complex health and care needs, who typically have poor engagement with health services.

People at a management and strategic level thought that the transfer of prison health care was the right thing to do. However some thought that progress overall had been slow, with the focus initially after the transfer on maintaining ‘business as usual’. There are examples of excellent practice and innovation happening across health care delivered in prison, however there was a view from some people that they had greater expectations from the transfer five years down the line and that there was an opportunity to do more.

5.1.2 BARRIERS TO TACKLING HEALTH INEQUALITIES

The following issues were raised as barriers to addressing health inequalities:

Understanding health needs: Feedback from some interviews suggested that there are still some gaps in health intelligence around people in the criminal justice system in Scotland, for example around the prevalence of long-term conditions, mental health and learning disabilities. People suggested that there needs to be better surveillance and

monitoring of needs and improved understanding of the wider determinants of health for people in the criminal justice system. Some people also raised that obtaining robust data on the extent of prisoner health care needs is complex due to how information is currently recorded. It can be challenging for prisons to have the resources to adequately code clinical data, which is necessary to assess health needs and monitor outcomes.

Clinical IT system: All prisons had the GP IT system VISION installed by May 2012 to record clinical information. However VISION does not meet the requirements of the prison environment, particularly around recording prescribing information. Though VISION has the functionality to do this, the process is complex, requires duplication of effort by staff and raises governance issues. The National Prisoner Healthcare Network has looked at the functionality requirements needed to make VISION fit for purpose and is currently engaged in talks with the Scottish Government e-health department.

National reporting and quality outcome indicators: One of the early priorities for the National Prisoner Healthcare Network was to develop outcome indicators for prison health care. An interim set of indicators was developed and distributed in 2013 and these are being used by some health boards. However, a final set has not yet been developed. This limits the ability to allow benchmarking across health boards as well as help drive service quality improvement. In addition, there is no routine national reporting from the VISION IT system, though there is some reporting from prison health care to other national datasets such as to the Alcohol and Drug Waiting Time Database, Scottish Drug Misuse Database and Naloxone and Smoking Cessation Database.

Priority of prison health care: There was strong feedback that there is a lack of understanding from health boards about the high level of health needs of people in prison and what prison health care involves. Less than a third (31%) of respondents to the nursing survey thought that the care of people in the criminal justice system is a priority for their health board. Some interviewees felt that health boards are too focused on government targets and breaking even financially to make the investment in prison health care. Investment, resources and support for prison health care was seen to vary across health boards, with a corresponding impact on the care people receive.

“I am disappointed to discover prisoner health care will always be at the bottom of the pot for funding.”

Respondent to nursing survey

Strategic leadership: The lack of strategic leadership and national approach around prison health care was raised consistently from senior staff both within health and the SPS. This was also reflected by frontline staff who commented on a lack of direction. Senior prison staff especially thought that there is a lack of national consistency and co-ordination, and this presents challenges in working with individual health boards with differing priorities. People raised issues around there being no dedicated policy unit within Scottish Government for health and justice and the lack of an overarching strategy. It was felt that if the Scottish Government was serious about tackling health inequalities for this very vulnerable population then they needed a long-term strategy with clearer leadership, governance and accountability at a national level.

Resources: The money transferred to health boards was based on historic spend by the SPS on health care. In June 2012, the Scottish Government Finance Department reviewed the baseline budget for prisoner health care in all NHS Boards and concluded that funding provided to NHS Boards “appears adequate at [a] national level to support provision of existing services previously provided by SPS”⁸.

However, this was just looking at the provision of existing services, and not what was needed to ensure services were equivalent to the community or to close the inequalities gap. Prior to the transfer, the Prison Healthcare Advisory Board was clear that additional investment would be needed to help close the inequalities gap³.

As part of the 2012 review, health boards highlighted future pressures around providing particular services⁸. In some cases this was because services were currently provided within prisons at a lower frequency than in the community, including optometry, dentistry, podiatry and substance misuse. Some NHS boards reported that services were either not funded in the transfer or that the budget appeared to be lower than required to provide a sustainable service, including nursing, psychiatric services, mental health advocacy and administrative support. Some NHS boards anticipated significant cost pressures around

medical services. The transfer of prisoners between establishments in different NHS board areas was also highlighted as a potential pressure.

In 2015, the Technical Advisory Group on Resource Allocation (TAGRA) developed a basic costing model for prisoner health care¹⁴. The model applies different weightings to three broad population groups: adult males aged over 21; male young offenders (who are weighted lower); and women (who are weighted significantly higher). However TAGRA acknowledged that the model was limited by a lack of activity-based data and other relative cost measures of prisoner health care. This means, for example, that it is unable to take into account unmet health care need or differences in need within the groups identified, such as older prisoners.

During the interviews for this report, resourcing was consistently raised as a challenge, and the need to invest in particular services, such as mental health. While people recognised that resourcing is an issue across the NHS, they thought that health boards needed to recognise the disproportionate level of need of people in prison. Some interviewees commented that investing in prison health care could save money on community services when people are released from prison. People also raised the implications of wider funding cuts, for example cuts to health boards' drug services budgets and voluntary sector organisations with specialist services closing due to lack of funding.

5.2 MEETING INTERNATIONAL STANDARDS AROUND EQUITY OF ACCESS TO HEALTH CARE

One of the main drivers of the transfer of prison health care was to move Scotland in line with international standards that prisoners should have equitable access to health services and that health care in prison must be an integral part of the public health system of any country. The Scottish Government has made a commitment that "offenders and ex-offenders should have access to the health and other public services they need and benefit from the same quality service as the rest of the population¹⁵".

5.2.1 WHAT PROGRESS HAS THERE BEEN?

Summary: *While there have been improvements in access to and provision of some services there*

is variation across prisons and health boards. The lack of performance data means it is not possible to clearly assess the impact of the transfer or build a consistent national picture. While some people thought that access to services is as good as, or better than, in the community, pressure on staff and resources mean that some areas, such as primary care and long-term conditions clinics, appear to be under particular pressure.

Provision of and access to services

The lack of national performance and outcomes data on prison health care means it is not possible to build a clear national picture of the impact of the transfer. While it was beyond the scope of this review to map the clinical services available in each prison before and after the transfer, feedback from the interviews and focus groups reveal a mixed picture of the impact the transfer has had on services across prisons and health boards.

Some interviewees reported that there are a wider range of services available or that access to services had improved since the transfer, for example around dentistry, access to allied health professionals and blood borne virus services. They have seen improvements in accessing care and thought that there is equitable, or better, access to services in prison compared to the community, especially around waiting times for some services. Four out of seven governors in charge/senior managers of prisons interviewed reported that the transfer has had a positive impact on health services in prison. Similarly one of the focus groups with people in prison revealed improvements in accessing services such as dentistry and opticians.

Others reported limited changes to services. Three out of seven governors in charge/senior managers interviewed commented that access to care has not changed significantly since the transfer. This was reflected by some health staff interviewed. For some, this was because they thought access to services were already good prior to the transfer and that it had remained good following it. Others reported that attention during the transfer process had been focused on ensuring a smooth transition, avoiding disruption and maintaining 'business as usual'. One of the focus groups with people in prison said that they had not felt a difference from the transfer, as the staff and waiting lists had stayed the same.

However there was also evidence from the staff focus groups and the nursing survey that there are increased pressures on services in some prisons.

This has negatively impacted the provision of, and access to, some services, particularly around primary care and long-term conditions clinics (discussed below).

“No difference. [Patients] receive the same level of care they received pre-transfer”

Respondent to nursing survey

The SPS prisoner survey shows there has been a slight increase in people reporting they have accessed a doctor, nurse or dentist during their sentence since the transfer. In 2011, 71% or prisoners reported that they had seen a doctor during their sentence, 77% reported seeing a nurse and 29% a dentist¹⁶. In 2015, this had risen to 79% seeing a doctor, 82% a nurse and 36% a dentist¹⁷.

It has not been possible to carry out a comprehensive comparison of the difference in access to health care and services in prison compared to the community because of the lack of national data. Reported waiting times in the SPS prisoner survey were broadly similar in 2011¹⁶ to 2015¹⁷. However this did vary widely across different prisons. Feedback from the interviews and focus groups with health and SPS staff suggested that waiting times were often the same as, or better, than in the community. However, participants in the focus groups with people in prison commented that access to services can be uneven and they were frustrated at the long waiting times for particular services, such as mental health and physiotherapy,

as well as poor communication about appointments and waiting times. They also reported that though they may get to see a nurse quickly, it may take weeks to see a doctor.

Meeting people’s health care needs

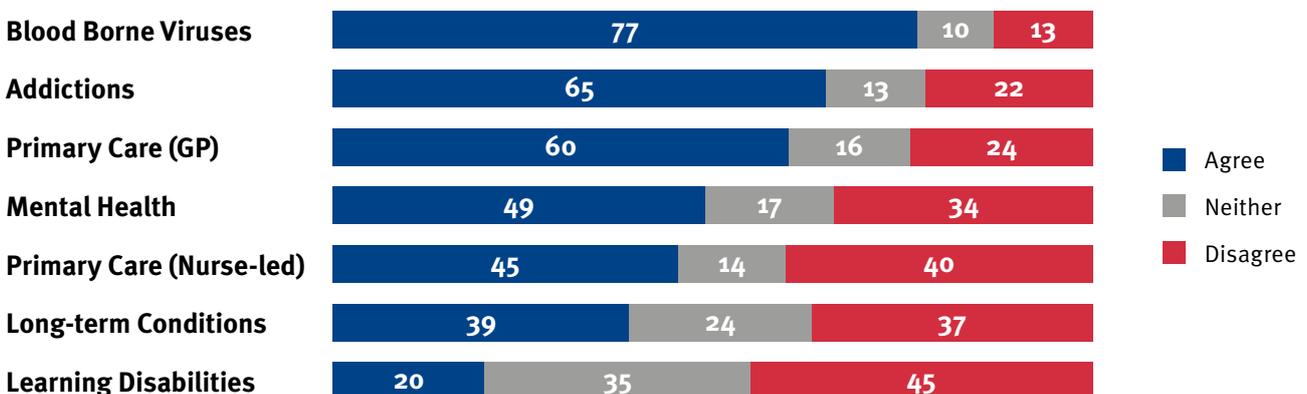
The online survey of nursing staff asked if the health care needs of people in prison were being met currently (Figure 1). In some areas, such as blood borne viruses, the clear majority of respondents (77%) agreed that health needs were being met. In addition, half of people (48%) who had worked for the SPS before the transfer reported that that care around blood borne viruses had improved since the transfer.

However for other areas, for example, learning disabilities, only a fifth (20%) of respondents thought that the needs of people with learning disabilities in prison were being met and only a very small minority (7%) of respondents who had been employed by the SPS prior to the transfer had seen any improvement since the transfer.

Primary care

In some prisons, nurse-led primary care services and the management of long-term conditions appear to be under pressure. Just under half of survey respondents (45%) thought that nurse-led primary care services were meeting the health care needs of people in prison currently, with 40% of respondents saying they were not. 39% thought that people’s health care needs in relation to long-term conditions were being met, with 37% of respondents thinking they were not. Furthermore, out of those who had been employed by the SPS prior to the transfer, 58% of respondents,

Figure 1. % of respondents to nursing survey who work in prisons who agreed, disagreed, or neither agreed or disagreed that people’s health care needs in the criminal justice system were currently being met.



All percentages have been rounded to the nearest full number.

based across eight prisons, thought that nurse-led primary care services had worsened since the transfer and just over half (52%) thought that the management of long-term conditions had declined. While staff reported that they wanted to provide equivalent clinics to the community, such as asthma, diabetes and sexual health, a lack of staff and resources prevented this. Only a small minority (13% for nurse-led primary care services, and 16% for long-term conditions) reported seeing an improvement.

“There are no nurse led clinics. No chronic disease management. This has reduced since the transfer”

Respondent to nursing survey

Substance misuse services

Two thirds (65%) of respondents to the nursing survey based in prison thought that people’s health care needs around addictions were currently being met, with 22% thinking they were not. Out of those who had been employed by the SPS before the transfer, 41% thought that addictions services had improved since the transfer, while 19% thought things had worsened.

The national standard for drug and alcohol treatment waiting times require 90% of people to receive specialist drug and alcohol treatment services within 3 weeks of referral¹⁸. Data is collected separately for people in prison. Figures from April to June 2016, show that 98.7% of people in prison received treatment within 3 weeks of referral, with all health boards meeting the 90% standard for people in prison¹⁹. This compares to 95.0% of people across Scotland receiving treatment within 3 weeks of referral, with all but three health boards meeting the 90% standard.

However, in the SPS prisoner survey, fewer prisoners are currently reporting that they have been given the chance to receive treatment or that they have received treatment for drug use, compared to before the transfer. In 2011, 41% of prisoners reported that they were given the chance to receive treatment for drug use and 36% said they received treatment during their sentence¹⁶. In 2015, this had decreased to 28% reporting they were offered treatment and 24% reporting they received treatment¹⁷. There is wide variation in these figures from prison to prison. In addition, more people are being tested positive for illegal drugs when leaving

prison currently than before the transfer. This has increased from 20% in 2011-12, to 27% in 2015-16²⁰.

Recent prison inspections carried out by HMIPS identified issues around the use of novel psychoactive substances and waiting times for addictions services. HMIPS identified fewer areas of weakness around addictions services after the transfer than before, with issues identified in four prisons after the transfer, compared to eight prisons before.

The National Prisoner Healthcare Network recently published a detailed review and guidance on drugs, alcohol and tobacco services in prisons²¹. This highlighted areas of good practice but also raised issues around screening, staff capacity, the high throughput of prisoners and the prison environment, as well as the challenge of novel psychoactive substances. It made a series of recommendations, including aligning and meeting national standards for substance use services, developing quality indicators and improving data collection. It also stated that substance use services needed to be adequately resourced to meet service demand and be delivered by trained and competent staff.

Mental health

Just under half (49%) of respondents to the nursing survey who work in prison thought that people’s health care needs around mental health were currently being met, with 34% thinking they were not. Out of those employed by the SPS before the transfer, just over a third (34%) thought that mental health services had improved since the transfer, while 22% thought things had worsened.

“Mental health nurses deliver good quality care within certain constraints. The lack of psychological intervention availability results in restricted routes of referral and support for the Mental Health Team. This must change if we are to achieve equivalence of care for our patient group.”

Respondent to nursing survey

HMIPS identified fewer recommendations around mental health after the transfer than before, with issues identified in nine prisons before the transfer compared to six prisons after the transfer. In recent inspections, they have identified a lack of assessment tools and care plans for mental health, long waiting lists, issues around the provision of clinical psychology services, and staffing and resource pressures within mental health teams.

Feedback from the interviews suggested that mental health should be seen as a priority for investment within prisons. Some people said that there had not been adequate investment in mental health either before or after the transfer.

The National Prisoner Healthcare Network's mental health sub group was established to "create a mental health and learning disability service within prisons where the provision of care for prisoners is equivalent to the care received for people in the community"¹³. It is taking forward and monitoring progress against various recommendations it made in 2014, including service mapping, the requirement for a needs assessment and reviewing models of care. The group found significant differences in staff complements and skill mix across prisons and that mental health care is under-resourced. It is taking forward various actions, including requesting that the Scottish Government develops a workforce planning toolkit for prisoner health care, which includes mental health care¹³. The 2015 Report of the Ministerial Group on Offender Reintegration²² also reflected on the variation in mental health provision and that services available are based on historic spend rather than an assessment of needs. It concluded that less severe mental health issues such as anxiety, depression and personality disorder traits are not being adequately addressed at present. Audit Scotland is considering carrying out an audit on prisoner healthcare, including mental health issues, potentially in 2018/19.

There have been reports of limited access to psychological therapies within prisons²¹. While there is a national HEAT standard that health boards need to meet around waiting times for psychological therapies, prisons are still not included within this.

One interviewee raised that while high level interventions around mental health were working well, lower level interventions such as talking therapies and cognitive behavioural therapy are not being resourced. One of the patient focus groups also commented that mental health staff focus on people with the most complex mental health needs,

which meant that other prisoners were not given the support they needed. They stressed how the mental health of individuals has a big impact on other prisoners, and if people are not able to engage with mental health services then it stops other people progressing.

Other issues around mental health that were raised in the interviews and focus groups included the need for better provision of clinical psychology and improved links with community services. Adolescent mental health was also raised as a gap, with a lack of specialists in adolescent psychiatry or psychotherapy both in the community and in prison.

Older people

Meeting the complex health and care needs of a growing population of older people in prison was raised as a key challenge across the interviews, staff focus groups and nursing survey. Just under a third (31%) of people who responded to the nursing survey felt that the health needs of older people in prison were being met currently.

The number of people in prison aged over 50 has increased by 50% in the last five years⁵. This is due to the trend for increasingly longer sentences; people surviving longer into old age; and the older age at which some sexual offenders are sentenced²³. In 2013-14 approximately 10% of people across all prisons in Scotland were aged over 50¹. In some prisons this is significantly higher.

The care needs of older prisoners represents a significant challenge. Prisoners are often said to have a health status of someone 10 years older than them²⁴. Nearly half (46%) of prisoners over the age of 50 report having a long-term illness. More than a third of prisoners (37%) over the age of 50 report having a disability²⁵. Palliative and end of life care is increasingly a reality in prisons in Scotland.

There was strong feedback that health care services need to respond to meet the complex needs of older people with multiple conditions. This will require more of a focus on the screening and management of long-term conditions, anticipatory care planning and care pathways for conditions such as cancer and dementia. Prison inspections have raised issues around the use of care plans and reviewing people with long-term conditions in some prisons. Poor facilities within some prisons are also cited as a challenge.

Social care

The provision of social care was highlighted in the interviews as another key challenge. In the

most recent SPS prisoner survey²⁷, 30% of people reported having a long term health condition, 26% reported having a disability and 5% of respondents reported difficulty with at least one activity of daily living. The prison population is ageing rapidly and older prisoners are more likely to require assistance with ‘activities of daily living’, which suggest that the number of people in prison who require social care assessment, equipment and care is likely to increase in the future²³. However the provision of social care is not just an issue for older prisoners and internal SPS work indicates that there are people in Scottish prisons in all age brackets who have social care needs.

Under the 2011 Memorandum of Understanding, the SPS is responsible for “personal and social care”⁹. However the provision of social care, assessment and equipment remains a grey area and there is ambiguity over who provides it and how this is carried out. Feedback from the interviews suggests that current practice varies. SPS contracts agencies to provide social care in prisons, however, in reality a national shortage of care workers and agencies not prioritising prisons over other contracted work means that this can be challenging. Frontline staff reported a lack of clarity around roles and responsibilities, assessments and the provision of equipment. It can be difficult to distinguish between whether someone’s need should be categorised as health or social care. While in England and Wales the provision of social care in prisons has been clarified in legislation^{26,27}, this has not happened in Scotland.

The SPS is doing work to assess social care need across the prison estate. This will inform future strategy and partnership work with Scottish Government, local authorities, NHS boards and integration authorities on the provision of social care, equipment and assessments in Scottish prisons.

5.2.2 WHAT IS WORKING WELL

There are many examples of good practice across prisons, which came through from the interviews and focus groups and are highlighted in prison inspections. Because of the wide variation in services and priorities in prisons and health boards it is not possible to draw these into themes. However a few examples are highlighted below.

NHS Forth Valley is the first health board to introduce low intensity (LI) psychological interventions in its three prisons as part of the

development of a ‘matched stepped-care’ model where patients have access to the most appropriate level and intensity of treatment required to meet their needs. A large proportion of the prisoner population have mild or moderate underlying mental health needs that may benefit from lower intensity psychological interventions. Mental health practitioner nurses have been trained in delivering these interventions, which has freed up high intensity psychological therapy practitioners to target people with more complex mental health issues while also supervising the LI interventions as part of clinical governance standards. Outcomes to date suggest that it is both feasible and acceptable to continue with the delivery of LI interventions within the prisons.

In another example, staff reported they were working well to meet people’s high care needs. They have dedicated facilities and multi-disciplinary teams that include occupational therapists, rehabilitation support workers and a band 7 nurse in rehabilitation and chronic conditions.

Health improvement was one area that several staff highlighted as an example of what is working well and an area where the SPS and the NHS work well together. Examples included smoking cessation programmes, Well Man/Well Person initiatives and the Keep Well Programme. Health improvement in prisons is delivered through the Better Health Better Lives framework²⁸, which was launched in 2012 and was a collaboration between the Scottish Prison Service, the Scottish Health Promotion Managers and the Scottish Public Health Network. The framework advocates the use of a whole prison approach to deliver improved health and wellbeing outcomes for prisoners, families and staff.

There has been progress around the delivery of palliative care in prisons, with joint working by Macmillan, health boards and the SPS. One prison has been working with a Macmillan Nurse Consultant to implement cancer and end of life care pathways. There is further work, being led by Macmillan, around creating a national nursing post to lead on the implementation of Macmillan standards for end of life care in prisons across Scotland.

5.2.3 BARRIERS TO ACCESSING CARE

A number of barriers to people being able to access care were raised both from staff and from the patient focus groups.

Staffing: The majority (84%) of prison nursing staff who responded to the online survey said that nurse staffing levels are a barrier to providing care. Some staff reported that they felt like they were ‘fire-fighting’. As soon as a team is short-staffed, the priority is medications management, which impacts other services such as long-term condition clinics or providing follow-up services. Inspections also highlighted that in some prisons mental health and addictions nurses do not have protected time to carry out their role and are carrying out general nursing roles that they do not have training for.

“Addictions and mental health staff are having to fulfil a practitioner nurse role more often, outwith their training and capability”

Respondent to nursing survey

75% of survey respondents said that other health care staffing is an issue. Access to GPs was raised as a particular issue from the focus groups and interviews. Lack of staff, long waiting times and having no continuity between health care staff was a strong theme from the focus groups with people in prison. They also felt that staff were not able to give them time for in depth assessments.

Medications management: The sheer amount of time spent on dispensing medication was raised consistently across all staff groups and from the focus groups with people in prison. Controlled drugs, such as methadone, and supervised medication, must be dispensed by a registered nurse and one other competent witness (commonly another nurse). Because of the high proportion of people in prison on controlled drugs, nurses can spend a huge amount of time each day dispensing medication. An interviewee from one health board reported that in an audit they found 40% of nursing time was spent on medication. This impacts the amount of time nurses have available for other clinical activity. The focus groups with people in prison also raised that nurses had to deal with so many people with addiction problems, who were on medication, that they do not have time to address other health issues. Staff from some prisons reported positively that they have been training up colleagues in support roles to assist with medications management, which has helped free up nurses’ time.

“We spend our days medicating, chasing and sorting medication. Clinics are so busy and rushed the care isn’t good enough.”

Respondent to nursing survey

Prison regime and escorts: Health staff reported that the day to day schedule of the prison meant that there were limited opportunities for them to see patients. The availability of prison officers to accompany patients to appointments in the health centre was a particular issue. G4S are contracted by the SPS for a range of services, including escorting patients to hospital appointments. The contract with G4S was written before the transfer. Health staff raised issues around the availability and willingness of G4S escorts to take patients to hospital appointments.

“We frequently have hospital appts cancelled due to G4 not arriving on time to collect the patient or G4 not arriving at all. One patient had their appt rescheduled 4 times due to G4 being a no show.”

Respondent to nursing survey

IT infrastructure: Over half (56%) of survey respondents said that the IT infrastructure in prisons is a barrier. Some people were frustrated by having separate IT systems for the prison and for the NHS, and reported issues with the NHS VISION system not working correctly.

Prison environment: There were issues raised around the lack of suitable facilities in some prisons to meet people’s health and care needs. Some of the older prison estates do not have cells or facilities adapted for people with disabilities or high care needs. Similarly, the suitability of the environment for people with disabilities has been raised as an issue during some prison inspections. NHS managers also reported that it can be harder to apply clinical standards in a prison setting, for example around infection control.

“Lack of appropriate accommodation prevents nursing staff from delivering care required to meet patients’ needs in particular around mental health and long term physical condition management.”

Respondent to nursing survey

Confidentiality: The focus groups with people in prison raised issues around privacy and confidentiality, for example, that health assessments and the dispensing of medication is carried out in front of other prisoners. People with poorer literacy skills were having to ask other prisoners or prison officers to fill in referral forms for health care appointments on their behalf. The focus groups with people in prison also raised that nursing staff and prison officers would discuss individual prisoners. They were concerned that decisions made by nursing staff about their treatment or medication were being influenced by the prison officers and that their health information was not being kept confidential. Issues around confidentiality and dignity were also raised in prison inspections.

Trust: Some of the issues around confidentiality led into a wider concern from the focus groups with people in prison around lack of trust between patients and health care staff. They felt that health care professionals did not believe them. They acknowledged the challenging environment and drug-seeking behaviour of some prisoners, but felt that everyone was being ‘tarred with the same brush’. One of the focus groups said that, initially, following the transfer there was an improvement, with a change in atmosphere and health staff taking them more seriously. However, they said that over time this slipped again to how it was before. The focus groups consistently raised that they did not feel like they were being treated with respect or as individuals.

Complaints: Patients raised issues around the response time for the NHS complaints process being slow or that they do not get response. Time spent on managing the high number of complaints

was also raised as an issue by staff. While in some prisons people were positive about the introduction of dedicated patient relation teams and increased administration staff, this was not happening across all prisons.

5.3 CONTINUITY OF CARE

The split between the responsibility of care between the SPS and the NHS and the impact that this had on care following release from prison was one of the drivers for the transfer.

5.3.1 DEFINING CONTINUITY OF CARE AND THROUGH CARE

This section of the report looks at continuity of health care in its widest sense: from when people enter prison; people transferring between different prisons; people going into and coming out of hospital from prison; and people going back into the community on release from prison. It also looks at continuity of care in prisons in the out-of-hours period (evenings, overnight and at weekends).

The term ‘throughcare’ is commonly used. Throughcare is defined by the Scottish Public Health Network (ScotPHN) as “the provision of a range of social work and associated services to prisoners and their families from the point of sentence or remand, during the period of imprisonment and following release into the community. The services have a primary objective of public protection, though they are also concerned with assisting prisoners to prepare for release and helping them to resettle into their community within the law”²⁹.

Statutory throughcare is provided for long-term prisoners (serving sentences of over four years). Generally NHS involvement is not mandatory, with the NHS only being involved if the prisoner has enduring needs²⁹. Voluntary throughcare assistance is available to prisoners receiving shorter prison sentences.

Within health, the term ‘health care throughcare’ is used more loosely in relation to the continuity of health care people receive from the point of admission into prison to their release from prison and links with community-based services.

5.3.2 WHAT PROGRESS HAS THERE BEEN?

Summary: *While some improvements have been made, continuity of care remains a challenge. There*

have been national workstreams looking at health throughcare and a recent report from the National Prisoner Healthcare Network has made a number of recommendations for improvement. People raised issues around IT systems and information sharing, health’s involvement in throughcare, registering with GPs and out-of-hours care. Access to wider clinical expertise and links with some community health services appear to have improved since the transfer.

A 2014 review of throughcare by the Scottish Public Health Network²⁹ found that the current arrangements are failing to deliver continuity of care for a potentially vulnerable group of people. While the report found that the transfer of prison health care services was a positive step forward, effectiveness could be enhanced if the NHS was more fully integrated into throughcare planning. This was also reflected by the Ministerial Group on Reoffender Reintegration in 2015²².

Health throughcare has been a priority of the National Prisoner Healthcare Network. It published a report earlier this year on health care throughcare³⁰ that found that “some improvements have been made to smooth the transition into community based secondary care services” however a number of challenges remained. It makes a series of specific recommendations designed to lead to improvements in the use of integrated case management system and community integration plans; the GP registration process; electronic information systems between prison health care and community services; links between prison health care teams and local health networks, support services and third sector organisations providing mentorship programmes. The recommendations reflect many of the issues raised around continuity of care from the interviews for this report.

42% of respondents to the nursing survey agreed that there is effective continuity of care for people when they are released from prison,

while a third (33%) of respondents thought it was ineffective. Continuity of care was seen as slightly more effective for people coming into prison (57% of respondents agreed) and transferring between prisons (51% of respondents agreed) (Figure 2).

The majority of survey respondents who were employed by the SPS before the transfer said that continuity of care for people coming into prison, transferring between prisons or on release from prison had not changed since the transfer.

The NHS is responsible for providing out-of-hours health care for people in prison. How this is provided varies by health board, with different prisons having different arrangements. Typically, there are no nurses in the prison after 9pm during the week and after 6pm at weekends. During the day at weekends, nurse staffing varies across different prisons but will be at a much lower level than in the week and will only be providing core services, such as dispensing medication.

Prisons have GPs available on call during out-of-hours or have arrangements with local NHS out-of-hours services in their area. Feedback from the interviews revealed issues with providing GPs on call in some prisons and challenges around how out-of-hours services work in a prison context.

“The current out-of-hours health care provision for the community setting is a very poor fit with prison health care needs, particularly in regard to call out/emergency out-of-hours care”

Respondent to nursing survey

Just over half (54%) of respondents to the nursing survey agreed that the health care needs of people in prison were being met at weekends, 41% agreed

Figure 2. % of respondents to nursing survey who agreed, disagreed or neither agreed or disagreed that there is effective continuity of care for people coming into prison, for people transferring between prisons and for people when they leave prison.



All percentages have been rounded to the nearest full number.

that health care needs were met during evenings and 27% of respondents agreed that the health care needs of people were being met overnight.

Two of the focus groups with people in prison raised concerns around accessing health care after 9pm. They felt that response times were slow and they were not comfortable with prison officers assessing whether to phone the doctor or nurse. Furthermore, one of the most common areas of weakness identified by prison inspections, raised in eight prisons since 2011, was inconsistency in ensuring 24 hour access to trained and competent first aid care. The inspection reports flagged issues related to maintaining competency amongst first aid trained prison staff and having adequate numbers of trained first aiders on duty, particularly at night. These weaknesses present concerns for the health of people in prison when health staff are not available.

5.3.3 WHAT IS WORKING WELL

The SPS recently introduced a national throughcare model for short-term offenders aged over 25 who do not have any statutory conditions placed on them. SPS now has over 40 Throughcare Support Officers who work with people from six weeks prior to liberation to three months after release. They work collaboratively with the prisoner, families, colleagues and partners to prepare them for the transition from custody into the community. Though it is early days, there have been positive reports of the links and communication between prison-based and community-based staff, onward referral to community services and discharge medication³⁰. However, staff report they can be limited in what information can be shared between NHS and SPS.

“Throughcare has helped many people.”

Respondent to nursing survey

There have been some very positive examples of NHS services in the community delivering in-reach services care in prison, for example around blood borne viruses. Patients are able to see the same nurse they saw in prison when they are released back into the community, thereby providing continuity of care.

Some community NHS staff interviewed also commented that communication between prison health care staff and wider NHS staff has improved

since the transfer. Previously they thought that communication and information sharing was poor and could impact on patient care. For example, the prison would not pick up on the urgency of cancer appointments. Since the transfer, they reported that communication has improved and there is closer working with specialist nursing services from the community.

Some staff were positive about having electronic records since the transfer and how access to the clinic portal gave improved access to test results. When people come into prison, health staff are able to access the Emergency Care Summaries from GPs in the community. There has also been agreement, and work is being progressed, to allow health staff in prisons to access read-only health information about patients coming from police custody.

“Access to the NHS IT patient records has been advantageous to patient care delivery.”

Respondent to nursing survey

People working in community health services were positive about community partnership working, with systems in place for multi-disciplinary teams involving health, housing, criminal justice social work, police, addictions and mental health services, to manage complex integrated cases. The National Prisoner Healthcare Network also had examples of good practice, including the involvement of the third sector in Public Social Partnerships and prison health care teams initiating a pre-release planning process with community services using case management systems³⁰.

Inspection reports have highlighted areas of good practice around throughcare, for example, services and systems in place to provide the continuation of addiction support from prison into the community. They have highlighted good practice in relation to discharge letters and processes for ensuring that community prescribers are aware of current prescriptions for prisoners being unexpectedly liberated from court.

5.3.4 BARRIERS TO CONTINUITY OF CARE

The following issues were raised as barriers to continuity of health care:

Information systems and information sharing:

There are different clinical IT systems used by NHS staff within prisons, GPs in the community and other NHS services, which impacts continuity of care. This reflects a broader issue about the lack of compatibility of IT systems across different NHS settings, which is not just limited to prison health care. There is also a different clinical IT system used in police custody, although work has been agreed to support the sharing of information between police custody and prisons. The SPS has an Integrated Case Management system, however this is not routinely populated with health information. Lack of understanding about what information can be shared between different agencies was also highlighted as a challenge.

Awareness of prison health care from the wider NHS:

Nursing staff reported that there can be a lack of understanding of prison health care from the wider NHS. For example, a patient may be discharged from hospital to prison late on Friday night with the hospital staff assuming the prison has nursing staff available to do observations overnight, which is typically not the case. The patient focus groups also gave examples of people being prescribed medication by psychiatrists or by hospital staff which the GP in the prison would remove from them because the medication was not suitable for use in prison. Some staff also raised that community services did not always see prison health care as having authority or being credible, and this resulted in care plans developed in prison not being followed in the community.

Memorandum of Understanding: The Memorandum of Understanding between the SPS and the NHS only includes the nine health boards with prisons in their area. Some people raised that this should include all 14 health boards to improve continuity of care, as they will have people being released from prison returning to the health board.

Continuity of health care staff in prison: Because of staffing pressures, patients see multiple health care staff. Both staff and people in prison stressed the importance of building up a therapeutic relationship. One of the focus groups with people in prison raised a particular issue of how they would see any one of five part-time GPs, where in the past there was only one and how this made it difficult to build relationships.

Registering with a GP when leaving prison: People serving sentences of more than six months are de-registered by their community GP while they are in prison. Those serving shorter sentences typically remain registered with their community GP, though there are reports of some people being removed from GP lists regardless of the length of their sentence. On release from prison, people must re-register with a GP in the community. Issues with re-registering were raised consistently from the interviews with health staff. People leaving prison often do not have a home address, which is needed by the GP to register. Some staff reported that some GPs are unwilling to register people who have been in prison, or that people face extra barriers to registering, such as only being able to register at a particular time on a particular day of the week. A high proportion of people leaving prison will apply for disability allowance, which needs a GP to assess them as unfit to work. If there are delays with them registering with the GP then this means they will be delayed in accessing benefits. One interviewee suggested that the GP in prison should be able to assess someone's fitness to work for the transition period when someone is released. One of the patient focus groups with people in prison raised how challenging it is to deal with services in the community if you have been in prison for a long time.

“It can be difficult to refer on to the correct services especially mental health if they have no GP practice (homeless) which many of my patients are.”

Respondent to nursing survey

Involvement of health in SPS throughcare: The National Prisoner Healthcare Network health throughcare group found that health care throughcare varied across Scotland and currently sits outside the SPS-led throughcare process³⁰. It found that the roles and responsibilities of health care staff in prison-led throughcare are unclear and that the integration of health throughcare into prison-led throughcare needs to be prioritised. The Memorandum of Understanding between the SPS and NHS does not require the NHS to be fully integrated into SPS throughcare planning

processes. For example, there is no formal requirement for a health care assessment as part of a throughcare plan.

“SPS appear to do more with throughcare than NHS does.”

Respondent to nursing survey

Court: Some people are freed from court without notice. This means no plans have been put in place to ensure the continuity of their health care back into the community. Interviewees gave examples of people being released from court on a Friday afternoon and not being able to access pharmacy services. In addition, while the NHS provides health care in prison and in police custody, it does not provide health care in court or when travelling to court. G4S employs a health agency but it is not standardised. Interviewees gave examples of patients who are on regular medication, such as methadone or insulin, not being able to access their medication during days when they have court appearances. This issue has been raised by the National Prisoner Healthcare Network’s Prison Pharmacy Group and they are taking forward discussions with the SPS³¹.

Varying approaches in different prisons: The patient focus groups reported that care plans developed in one prison are sometimes not followed when people are transferred to a different prison. For issues such as mental health, patients may have built up a therapeutic relationship with health care staff, which is then interrupted when they move prison. In addition, they raised the issue of their medication changing when they transferred between prisons. Feedback from some staff also raised issues of inconsistent prescribing by GPs, lack of consistency around discharge medication and that different prisons have different detox regimes. However, there has been national work carried out to try and address this.

5.4 SUSTAINABILITY AND THE NURSING WORKFORCE

One of the drivers for the transfer of prison health care was a concern about the sustainability of the health service in prisons. As a relatively small organisation, the SPS was limited in attracting the range of expertise needed. Being part of the larger

NHS was thought to be the only way for the service to achieve long term sustainability, where it had access to a wider cohort of clinical expertise and community-based services to meet the changing needs of the prison population³.

This section of the report looks at the impact the transfer has had on sustainability of the nursing workforce.

5.41 WHAT PROGRESS HAS THERE BEEN?

Summary: *Overall, sustainability of health services in prison does not appear to have improved since the transfer, although some of the larger health boards did report improvement. There are significant concerns around the morale of the nursing workforce in prisons, underpinned by recruitment and retention issues, staffing pressures and a lack of understanding from the wider NHS of the role of prison health care. There are opportunities for nursing that could be developed, such as advanced nursing practice.*

Prisons are a challenging environment to provide health care services in. Health centres cannot predict when they will have an increased demand on their services. While there is a prisoner transfer protocol in place whereby healthcare issues are considered prior to transfer, prisoners are transferred from one prison to another at short notice. Such transfers may add to resource pressures as health boards are responsible for funding but do not have oversight of when or where transfers within or outside their boards will take place, making it difficult to plan.

In some of the bigger health boards, managers and operational leads thought sustainability had improved, for example, because they can move staff to cover shortages between different prisons. However, in other health boards they had little flexibility to move staff and the impact of staff shortages was particularly challenging. In the nursing survey, 70% of staff employed by the SPS before the transfer said that sustainability of the health workforce had worsened since the transfer.

Nursing workforce

Nurses spoke passionately about their commitment to their patients and the impact they have. SPS staff recognised the excellent work health centre staff did and praised them for ‘going above and beyond’.

However, the online survey found significant concerns around the morale of the nursing workforce in prisons since the transfer. RCN Scotland carried out an online survey of 68 nursing staff in prisons prior to the transfer in early 2011 and repeated some of the questions in the current 2016 survey. Table 2 shows that fewer nurses feel that criminal justice nursing is a rewarding career now compared to before the transfer, fewer are satisfied with their present job and fewer think they will stay in the same or similar job in two years' time. While the majority of respondents (75%) in 2016 said that most days they are enthusiastic about their job and the vast majority (89%) are still happy to go the 'extra mile' at work when required, only just over half (54%) would recommend their workplace as a good place to work. There was variation between survey respondents in different prisons and from respondents in the same prison.

Prior to the transfer, 36% of nurses who responded to the 2011 RCN survey reported they felt positive about the transfer. They thought it would help improve health care for a vulnerable population, improve career opportunities and access to training and allow NHS staff to have a better understanding of prison nursing. Respondents from prisons that had already been developing relationships with the local health board tended to be more positive about the transfer.

40% of nurses reported they did not feel positive about the transfer in 2011. They raised concerns about the agenda for change process, terms and conditions, that the relationship between prison staff and health staff could deteriorate and a lack of consistency and continuity of care because of multiple health boards being involved. Staff felt that they had not been consulted about the transfer.

In 2016, the proportion of respondents who felt positive about the transfer (who had previously

been employed by SPS) decreased from 36% to 28% and the proportion who did not feel positive had increased from 40% to 56%.

“We were promised so much prior to transfer (improved banding, support etc) and it didn’t transpire.”

Respondent to nursing survey

It was clear from the focus groups with frontline staff that morale varied widely across different prisons, with some being more positive and others being very negative about the current situation and the transfer. Health centre managers were generally more positive about the transfer than frontline staff. Team leaders and clinical managers had mixed views.

5.4.2 WHAT IS WORKING WELL

The respondents to the nursing survey who said they felt positive about the transfer were more likely to report that they had been supported by the health board during the transfer process, than those who had a negative view of the transfer. They were also more likely to report that opportunities for training, career development and practice development had increased since the transfer.

“When transferred I was band 5, I am now band 7, I have been given the opportunity for promotion, which was not accessible in SPS.”

Respondent to nursing survey

Table 2. Proportion of respondents to the nursing survey, based in prisons, who agreed or strongly agreed that criminal justice nursing is a rewarding career, that they feel satisfied with their current job and that they will be doing the same or similar job in two years' time.

% of respondents who	2011 survey	2016 survey
Agree/strongly agree that criminal justice nursing is a rewarding career	90%	63%
Agree/strongly agree that they feel satisfied with their present job	76%	53%
Think that they will be doing the same job or a similar job in criminal justice nursing in two years' time	90%	59%

All percentages have been rounded to the nearest full number.

Nearly half of nursing staff (44%) reported that access to wider expertise had improved. Staff reported better access and links to wider clinical expertise and resources since the transfer, for example being able to speak to a hospital consultant or accessing other disciplines.

“[There is] easier access to multidisciplinary agencies.”

Respondent to nursing survey

Interviews with NHS managers also highlighted that there is improved governance, more focus on patient safety and patient care, and improved management structures since the transfer to the NHS. They reported feeling more supported and protected by having NHS governance and policies, and feeling less professionally isolated. Some also commented that there was stronger supervision and focus on maintaining skills of health staff since the transfer. Some senior SPS staff reported that the professionalism of health care staff had improved since the transfer, with increased clinical skills and expertise of staff.

A number of health boards have reviewed or are in the process of reviewing their nursing workforce models to meet patient need. As a result, they are training up health care support workers and investing in nurse prescribers and advanced nursing practice.

5.4.3 BARRIERS FOR THE NURSING WORKFORCE

For nurses where morale was low, some of the issues underpinning this were:

Recruitment and retention: Recruitment and retention of the nursing workforce was consistently raised as an issue, with high staff turnover and sickness rates. Nearly three quarters (72%) of nursing staff who were employed by the SPS prior to the transfer said that they had seen an increase in sickness absence. In some prisons staff reported high vacancy rates, though this is not currently recorded separately for prisons in national workforce data. Staff acknowledged that the prison environment is challenging and not for everyone. They felt that new staff do not know what working in a prison is like before starting and this contributes to the high turnover of staff. In addition,

health boards are recruiting more newly qualified nurses who are not always prepared for working in a custodial environment. The induction process for new staff is less in depth than before the transfer.

“There is no support for new staff who are overwhelmed by working in prison. There is no longer a core induction at prison service college.”

Respondent to nursing survey

Staffing pressures: As outlined earlier, staff shortages have a big impact on what services can be provided, with medications taking priority over other services. Nursing staff felt frustrated that they are not getting the opportunity to use their skills and that they are becoming de-skilled. For health boards with more than one prison in their area, staffing issues in one prison may impact staff in another prison as they are moved to provide cover. Prison inspections identified issues around health staffing levels in six prisons since the transfer, including needing to review workforce and skill mix.

“I do not feel that my individual expertise is used to its maximum.”

Respondent to nursing survey

Some felt that the staffing model did not reflect patient need. While in some prisons nursing staff had increased, staff said that this still does not meet the increasingly complex needs of their patients. Currently, there is no national nursing workforce and workload planning tool specifically for prisons and managers reported that they have to adapt and mix together different tools. The NHS Boards Leads Operational Group of the National Prisoner Healthcare Network has a workstream looking at staffing and has been engaging with the Scottish Government about considering an appropriate workforce model for prison health care.

Career structure and Agenda for Change banding: Some of the low morale relates to people feeling that they were not banded appropriately under Agenda for Change. Some people felt that they had been banded differently to similar roles based in prisons in other health boards or to similar roles

based in the community. Other staff reported tension between primary care nurses, the majority who were on band 5, and addictions and mental health nurses, where there were more band 6s. The staff focus groups and interviews also raised the issue of the career structure for nursing in prisons being flat and not allowing progression. Some staff gave an example of a band 5 nurse completing a non-medical prescribing course but their role remaining at a band 5. They would then leave for a band 6 post outside of prison nursing. Ironically, the transfer of prison health care to the NHS means it is easier for staff to be aware of job opportunities outside of prison health. Some staff pointed out that there was a better career structure now, with roles available from band 5 to band 8. Overall, less than a quarter (21%) of nurses employed by the SPS prior to the transfer felt that career development had improved since the transfer, and over a third (35%) thought it had worsened.

Skills, development and training: Some nursing staff said that the transfer had raised their expectations around skills, development and training, that have not been realised. Just over a quarter (26%) of respondents, who had previously been employed by the SPS, thought access to training had increased since the transfer, with 42% saying it had decreased. Some staff praised the training opportunities they had when employed by the SPS. Some reported that there were training opportunities available under the NHS but because of staffing and resource issues, they could not take them up. They also thought that training is not always relevant to the prison setting. 21% of people thought that access to clinical supervision had increased since the transfer, with 30% thinking it had decreased.

“Experienced staff are leaving due to the lack of support, training and opportunities for development.”

Respondent to nursing survey

Feeling undervalued: Nursing staff talked about feeling like they did not belong or were not wanted by either the NHS or the SPS. After the transfer, some people said that they felt that the SPS viewed them as a ‘bought service’ and that the relationship changed. The focus groups with staff where morale was particularly low often focused on issues and

relationships with NHS managers, with staff feeling far removed from decisions made by managers and the health board.

“I feel most staff try their best to give a high level of professional care at all times. Frustrations come from management not resolving issues which hinder or interfere with staff doing their job and this can be very disappointing and leave staff feeling they are not appreciated or being fully supported in their efforts to deliver patient care. Moral [sic] is very low due to this.”

Respondent to nursing survey

Nearly two thirds (63%) of respondents to the nursing survey said they do not feel part of their wider health board and the same proportion do not feel valued by their health board. Fewer than half (46%) said they understand how their work fits into the overall aims of their health board or are kept well informed by their health board. Staff felt that there is a lack of awareness of their role and the prison environment from the wider NHS, with some health board staff being unaware that the transfer has taken place. Staff felt that the NHS needs to better understand the prison environment and they want better recognition for the role they do.

“NHS was also not prepared to recognise that we are a unique service, and frustratingly kept wanting to liken us to other areas. For example, asking us to use acute setting hospital care plans and preventing us from formulating our own to suit our setting.”

Respondent to nursing survey

5.5 OPPORTUNITIES FOR NURSING

People felt there were strong opportunities for nursing within prison health care and a number of health boards have already reviewed, or are in the process of reviewing, their nursing workforce models. Some of the opportunities for nursing raised are:

Enhancing nurse-led models and career development:

There was strong feedback that there are opportunities to review and enhance nursing models to ensure that nurses are making the best use of their skills to meet patients' needs. People also raised that there is a need for clearer career progression for nurses within prisons, especially for band 5s. A few people thought that there is learning from the police custody model of enhanced nurse-led care where band 6 nurses, who are nurse prescribers, carry out the vast majority of health care, with input from a doctor when needed, and are managed by band 7 senior charge nurses. Some health boards are looking at the potential for cross-over between the prison and police custody nursing workforce.

Nurse prescribers and advanced nurse practitioners:

The prison environment was seen as the ideal opportunity for advanced nursing practice. Several health boards are already actively looking into developing the advanced nurse practitioner workforce within prisons. People in prison have complex needs, spanning mental health, primary care and addictions. With an ageing population, the complexity of needs and co-morbidities are likely to increase further. Advanced nurse practitioners would be able to provide enhanced levels of care and also improve continuity of care. This would also respond to the increasing challenge of recruiting GPs to work in prisons. One interviewee reported that an audit showed that two thirds of the work currently done by prison GPs could be done by nurses. There are also upcoming changes to the Act 2 Care policy³², around identifying people at risk of suicide and self-harm in prison, which mean that a nurse, with the appropriate skills, knowledge and experience, will be able to carry out assessments that are currently conducted by a doctor.

When discussing the concept of nurses in advanced roles with one of the focus groups with people in prison, participants felt this could be a positive development as long as patients had a way of clearly identifying which nurses had the skills

and experience to prescribe medication, assess and diagnose patients without consulting a doctor.

Role of health care support workers: Some health boards are looking at upskilling their health care support workers to allow nurses to make better use of their time. One health care support worker who had worked in a hospital prior to working in a prison, felt that the health care support worker role needed to be more clearly defined. Some prisons have also increased their administrative staff and created dedicated patient relation teams to deal with complaints, which has freed up nursing staff's time.

5.6 WIDER CONTEXT AND ENABLERS

During the review, there were several themes identified that cut across all aspects of prison health care.

5.6.1 RELATIONSHIP BETWEEN THE SPS AND NHS SCOTLAND

The importance of good relationships came through very strongly, between prison health care and the SPS, prison health care and the rest of the NHS, and with wider community and justice services.

Relationships between the SPS and the NHS are at multiple layers, from operational to strategic. At a strategic level, people generally reported positive relationships. However, this varied across different health boards and prisons. Some reported very strong relationships, with a focus on multidisciplinary working, shared objectives and joint initiatives. Those who had developed strong relationships between the SPS and health board prior to the transfer, reported a much smoother transition.

At an operational level, issues and tensions were commonly reported, particularly from health staff. These focused on the prison regime, medication, escorts and information sharing.

Senior SPS staff consistently raised that the structure of the NHS makes it challenging to work with. They need to develop relationships with individual health boards, each with their own priorities and funding, instead of having a single relationship with NHS Scotland as a whole. They felt this raises challenges of how to create more consistency across the prison estate and around governance, for example the process for signing-off policies. Some NHS staff felt that the SPS's traditional hierarchical structure can be challenging.

They also felt that governors in charge move around prisons frequently and that this can be destabilising for health services in the prison.

Both SPS and NHS staff raised that there can be a lack of understanding about each other's roles and responsibilities, and that the wider NHS can lack understanding of the prison environment. There was a lot of discussion around care versus custody and prisoners versus patients, and the different cultures and priorities of the SPS and the NHS. Some people from health thought that the SPS do not see health as a priority. Some SPS staff wanted the NHS to have a greater understanding of the wider context that health fits into within re-offending, and to recognise that if prisoner health care is low down on a health board's priorities then this will have a big cost to justice.

5.6.2 NATIONAL PRISONER HEALTHCARE NETWORK

A strong theme emerged around the effectiveness of the National Prisoner Healthcare Network. People praised the individual outputs it produces, however, they felt it lacks the teeth and momentum to effect real change. The prison governors in charge/senior managers spoken to felt that it is not working well and does not drive consistency across different prisons. As an advisory network it produces guidance, but it cannot mandate implementation, although the Network is looking at self-assessment audits to try and benchmark prisons. Some interviewees raised that the board leads involved are at different levels of seniority and some do not have the authority to make decisions. They also felt that the governance and accountability of the network are not clear. For example, there is some confusion around the sign-off process for SPS policies that impact health and whether this goes to the network or direct to health board leads. Some SPS staff reported that they would bypass the network and go straight to health boards, in order to get something done.

The annual conference of the National Prisoner Healthcare Network considered a number of suggestions around the network's infrastructure, including stronger NHS operational lead direction, enhancing communication links between the network, SPS and health boards and service user involvement³³. There was also feedback that the network could have wider influence with Scottish Government, integration authorities, regional planning and health boards.

Some people compared the National Prisoner Healthcare Network to the health care network for

police custody. They felt the police custody model is more dynamic, with stronger leadership, more formal governance and better links into regional planning.

5.6.3 STANDARDS, SCRUTINY AND IMPROVEMENT

There was feedback around the lack of performance measures or national standards for prison health care since the transfer. Some people spoken to thought that there should be joint performance measures for health and justice. There are also inconsistencies around how prisons are included in national standards for health. Data is recorded separately for prisons around national standards for drug and alcohol treatment waiting times. However, health boards do not need to include prisons in reporting against the HEAT standard for access to psychological therapies.

HMIPS carry out a rolling programme of prison inspections with Healthcare Improvement Scotland (HIS) providing health input and expertise. HMIPS has a standard relating to health and wellbeing, with various quality indicators that are looked at under this as part of the inspection process. There was some feedback from interviewees that the current health indicators need to be reviewed, and HIS is looking at this. Inspection reports for prison health care look quite different to inspections for other health services, such as hospitals, carried out by HIS. For example, current HMIPS inspections do not make recommendations for improvement, whereas other inspections that HIS carry out provide recommendations for improvement which feed directly into an action plan. HIS is keen to develop more monitoring and follow-up visits to prisons and look at how the prison inspection process can align with their wider remit around improvement.

HIS and the Care Inspectorate are currently reviewing the National Care Standards. The intention is for new standards, based on human rights, to set out what people can expect from health and social care services, no matter where they receive that care.

5.6.4 INTEGRATION OF HEALTH AND SOCIAL CARE

In some areas, prison health care has been delegated to the new integration authority, in other areas it has remained with the health board and in other areas it is a hosted service. From an initial

analysis of the joint strategic commissioning plans that integration authorities have to publish, only five out of 31 mentioned prison health care. Sixteen out of 31 mentioned wider criminal justice services.

People generally seem unsure of the impact that integration will have around criminal justice health and care services. Some saw it as an opportunity, for example by allowing greater joined up working, but others were uncertain or concerned that it would not be a high priority for integration authorities.

5.6.5 HEALTH'S WIDER ROLE

Though this report was looking specifically at

prison health care and the transfer of responsibility to the NHS, people raised the importance of looking at health's role in the wider context of justice and reoffending. This includes looking at earlier opportunities for intervention, including the importance of early years, and how to avoid people going into prison in the first place. There are many current partnerships and future changes around justice that health has an important role in, including Community Justice Authorities, Community Planning Partnerships, involvement of third sector organisations and Public Social Partnerships and the move towards women's community justice centres.

CONCLUSION

Five years on from the transfer of responsibility for prison health care from the SPS to NHS Scotland, it simply is not possible to clearly evidence the impact the transfer has made nationally on tackling health inequalities and meeting the health care needs of people in prisons, due to ongoing gaps in data and a lack of national reporting and quality outcomes data for prison health care.

There is an extremely mixed picture across prisons and health boards in Scotland in relation to improvements in the provision of, and access to, some services since the transfer. We have heard examples of good practice and innovation and some areas in which improvements clearly have been seen. But the people who engaged with us noted that core areas of service – such as nurse-led primary care, long-term conditions management and care for older people in prison or those with learning disabilities – are falling short in many areas.

At a strategic level, the people who we spoke to agreed that the transfer has been the right thing to do, but progress was felt by some to be slow. Pressures on staff and resources, and a lack of support have impacted some core services and underpin a worrying fall in morale among the nursing workforce on the ground who work to support prisoners, day in day out.

Overall, RCN Scotland is clear from this research that there is real work to do to ensure that the aspirations of the prison transfer from SPS to the NHS are translated into consistent delivery of service equity and improved health outcomes for people in prison across the whole of Scotland. With all political parties in the Scottish Parliament committed to reducing inequalities, a renewed strategic and practical focus on improving health care for one of the most vulnerable populations in our society – people in prison - would be a positive and practical way to effect genuine, positive change.

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