HCP002

Scottish Parliament Health and Sport Committee
Inquiry into healthcare in prisons
February 2017

Background
In November 2016, RCN Scotland published a report ‘Five Years On’ which evaluated how far the aspirations behind the 2011 transfer of prison healthcare from the Scottish Prison Service (SPS) to NHS Scotland are being put into practice.

The report concluded that there is not enough evidence to fully assess the impact that the transfer has made on meeting the needs, and tackling the health inequalities of people in Scotland’s prisons. RCN Scotland found that the picture across prisons and health boards was extremely mixed. Whilst the RCN found examples of good practice and innovation in some areas, there were also numerous examples of where core healthcare services are falling short.

Overall, the RCN concluded that the transfer was the right thing to do, but shared the frustration of many of those trying to access and provide services, who felt that progress was slow.

‘Five Years On’ showed that there is significant work to do to ensure that the aspirations of the prison transfer from SPS to NHS Scotland are translated into services which demonstrate consistency and equity, and which deliver improved health outcomes for people in Scotland’s prisons.

RCN Scotland carried out a survey of nursing staff in prisons ahead of the transfer in 2011 and repeated some of the questions in its 2016 survey. All survey statistics relate to the 2016 survey unless stated otherwise.

What do you consider are the current pressures on health and social care provision in prisons?

Not unlike other services within Scotland’s NHS, budget and workforce were seen as the main pressure points in terms of delivering healthcare in prisons. The demand for services in prisons outstrips the resources available to fund and deliver care.

The money transferred to health boards was based on historic spend by the SPS on healthcare. In June 2012 the Scottish Government reviewed the baseline budget for prisoner healthcare across NHS boards through the Prisoner Healthcare Post-transfer Financial Review and concluded that funding ‘appears adequate at national level to support provision of existing services previously provided by SPS’. The problem with this Review is that it looked exclusively at the provision of existing services, and failed to consider the services which were needed to reduce health inequalities, as well as to bring patient care in line with the care that others receive in the community. During the Review process health boards did raise concerns around the future pressures to provide services.

Throughout RCN Scotland’s research for ‘Five Years On’, resourcing was raised consistently as a challenge. There was a shared feeling that NHS boards failed to recognise the disproportionate level of need required by people in prisons. There were particular concerns around some services, like mental health, where only 49% of respondents to the RCN’s nursing survey of those working in prisons, felt that the mental healthcare needs of people in prison were being met.
Staffing is also a very real pressure in delivering adequate healthcare in Scotland’s prisons. The vast majority (84%) of nursing staff working in prisons and surveyed by the RCN said that inadequate nurse staffing levels are a barrier to providing care. Some staff reported that they felt that they were constantly ‘fire-fighting’. What the RCN discovered in its research was that as soon as a nursing team is short-staffed, priority is given to medications management. This means that other services, like long-term condition clinics and follow-up services, are reduced. Inspections have also found that in some prisons mental health and addiction nurses do not have protected time to carry out their role, and are also required to carry out general nursing roles which detract from their specialism.

Nurses working in prisons also felt that access to the wider healthcare team is an issue. Of those nurses surveyed by the RCN, 75% said that staffing levels of other health professionals is an issue. Access to GPs is a particular problem. Staff numbers, long waiting times, a lack of continuity of staff and time pressures leading to short assessments were raised time and again in the course of the RCN’s research.

Meeting the complex health needs of a growing population of older people in prison is also a significant challenge. The number of people in prison over the age of 50 has, according to Scottish Government prison statistics, increased by 50% in the last five years and in 2013/14 around 10% of people in prison in Scotland were over 50. The higher age profile is due to increasingly lengthy sentences; historic cases being prosecuted and the overall increase in life expectancy.

For health services, this changing age demographic represents a disproportionate challenge because of the already complex nature of the health needs of many people in prison, and their general health status which is around that of someone 10 years older than them. In addition, 46% of people in prison over the age of 50 report having a long term condition and 37% report having a disability. The ageing profile of the prison population brings challenges around specialist areas like dementia care and end of life care.

How well do you consider that these pressures have been responded to?

The inadequacy of the funding, inherited from SPS, to deliver health services in prisons has not been addressed since the 2012 Prisoner Healthcare Post-transfer Financial Review concluded that it was adequate to support existing services.

What needs to be examined is not only the funding required to deliver current services, which will undoubtedly have changed, but also a clear idea of what additional services are required to actually meet the health needs of Scotland’s prison population. There are still gaps in the health intelligence about people in the criminal justice system, with things like the prevalence of long-term conditions, mental health and learning disabilities all being unclear. Part of the lack of clarity around need is due to a lack of robust data on the extent of the prison population’s health needs because of the way that information is recorded at present.

One of the drivers for the transfer of prison health care from SPS to NHS Scotland was a concern about the sustainability of the delivery model, and a recognition that as a small organisation SPS was limited in attracting the range of health expertise needed and that as part of the NHS prisons would have access to a wider cohort of clinical expertise and community based services to draw upon.

In spite of the hopes of the transfer, there are still significant concerns around the morale of the nursing workforce in prisons, which are underpinned by recruitment and retention issues, staffing pressures, and a lack of understanding from the wider NHS on the role of prison healthcare. A general feeling of being undervalued was evident amongst the prison nursing workforce, with 63% of respondents to the RCN survey stating that they felt neither a part of nor valued by their wider health board.
The RCN’s 2016 survey found that fewer nurses now feel that working in the criminal justice field is a rewarding career (90% in 2011 compared to 63% in 2016). Only 53% of the 2016 respondents feel satisfied in their current role, compared to 76% in 2011 and only 59% thought that they would be doing a similar criminal justice nursing role in two years, a stark comparison with the 90% of respondents who said that they would still be working in the field in 2011. One of the nurses surveyed by the RCN said “we were promised so much prior to transfer (improved banding, support etc.) and it didn’t transpire.”

It was clear in RCN’s research that morale of the nursing workforce varied widely across different prisons. Health centre managers were also found to be more positive about the transfer than frontline staff, whilst team leaders and clinical managers had mixed views. Frontline staff who felt positive about the transfer has generally had a higher level of support from their health board during the process, and they were also more likely to report that training, and practice and career development opportunities had increased since 2011.

Recruitment and retention was raised with the RCN consistently as an issue, with reported high staff turnover and sickness absence. 72% of nursing staff employed by SPS prior to the transfer said that they had seen an increase in sickness absence. The induction process for new staff was also observed to be less in depth than prior to transfer, which staff felt could account for some of the high turnover as new staff were not fully prepared for working in a custodial environment. Nurses often felt that they were becoming de-skilled because ‘key tasks’ such as medications management took priority over other services when services were short staffed. As with other areas of the NHS there were problems around staffing models not reflecting patient need, and the skill mix not being correct. At present there is no national nursing workforce planning tool specifically for prisons and managers have had to adapt tools, or mix tools.

**To what extent do you believe that health inequalities are/ could be addressed in the prison healthcare system?**

A key driver for the transfer of prison healthcare to the NHS was to tackle the stark health inequalities faced by those in prison. To date, however, it is not possible to evidence the impact that the transfer has had on tackling health inequalities. This is because there are still knowledge gaps - both around the health inequalities faced by those in prison as well as their health needs – driven by the lack of a national reporting and quality outcomes data for prison healthcare.

One of the first steps towards addressing health inequalities experienced by those in prison is to develop and implement robust methodologies for capturing and reporting data about their healthcare needs at both local and national level. Reliable data could aid better resource allocation. Quality outcome indicators would contribute to forming a national picture of prison health which, as well as flagging areas for improvement, could highlight areas of good practice and opportunities for learning from it.

Whilst the RCN’s research highlighted some positive work that has taken place since transfer, there was a general feeling that progress was slow and that more could be done to address health inequalities in prison and through a continuity of care both in prison and when individuals are released.

In spite of the current lack of data, and the slow pace of change, the RCN and the criminal justice nursing workforce feel that the custodial environment offers a unique opportunity to address health inequalities and to ensure that these vulnerable people, with typically poor engagement with health services, get the health interventions and care which they require.

**What are the current barriers to using the prison healthcare system/ improve the health outcomes of the prison population?**
As well as challenges in relation to budgets, resources, and data collection there are issues around the clinical IT system, VISION, which is used in prisons not being fit for purpose. Less than a third (31%) of nurses working in prisons who responded to the RCN survey said that they felt that healthcare in the criminal justice system was a priority for their board. As such, there is work to do to ensure that NHS boards prioritise the health needs of people in prison, affording them the same commitment to person centred care as people receive if they are in the community. This includes listening to what people in prison say about the services they require.

The lack of strategic leadership and a coordinated, overarching strategy at Government level was also raised as a barrier to improving the healthcare and health outcomes of those serving a custodial sentence.

In addition, the nature of the prison regime and the need for escorts means that there are limited opportunities for health professionals to see people in prison. Particular concerns were raised around the availability and willingness of G4S to take individuals to hospital appointments, with one nurse telling the RCN that ‘one patient had their appointment rescheduled four times due to G4S being a no show.” In some instances the prison environment itself was seen as a barrier because of a lack of facilities for those, for example, with high care needs.

Out of hours care is a big challenge: just over half of the respondents to the RCN survey of prison nurses felt that the health care needs of people in prison were being met at weekends and only 27% felt that health needs were met overnight. Two focus groups with people in prison raised concerns around accessing healthcare after 9pm, when they felt response times were slow and when they felt uncomfortable with a prison officer assessing whether to call a nurse or doctor.

Staffing pressures are one of the barriers to continuity of care because patients see multiple health staff. Building a therapeutic relationship between health practitioner and patient is crucial when dealing with vulnerable people and could help to improve the health outcomes of individuals in prison.

Overall, many of the challenges mean that individuals in the criminal justice system experience a lack of continuity of care which is unacceptable, and which does nothing to tackle health inequalities and health outcomes in the long term.

Can you identify potential improvements to current services?

There needs to be a strategic vision for the delivery of health services in prisons which is built on evidence of the health needs of those serving sentences. This requires investment in data collection so that benchmarking and monitoring can take place.

Staff pressures and low morale need to be addressed as a matter of urgency. Investment in staff numbers, staff training and CPD are first steps towards helping to ensure better outcomes for people in prison.

There also needs to be significant work done to improve the continuity of care which people receive both inside prison and upon release.

What do you think the main pressures will be in the next 15 years?

Budgets and staffing will continue to be sources of pressure over the next 15 years. If the challenges around continuity of care continue are not tackled and resolved then this will put increased pressure on both health services in prisons and in communities. In addition, the challenge of caring for older prisoners with increasingly complex care needs, such as dementia, will need to be addressed fully.