Healthcare in prisons
BMA Scotland written submission, February 2017

The British Medical Association is a politically neutral registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of over 168,000. In Scotland, the BMA represents over 16,000 members.

We welcome the opportunity to provide written evidence to the Health and Sport Committee on healthcare in prisons.

It has been five years since responsibility for healthcare within Scottish prisons was transferred from the Scottish Prison Service (SPS) to NHS Scotland. Since the SPS’s Prison Health in Scotland, A Health Care Needs Assessment there has been no comprehensive work carried out on prisoner health care needs in Scotland. The original assessment concluded that “there was difficulty in precisely defining the burden of health problems in Scottish prisoners with evidence of likely under-diagnosing, under-recording and under-treatment” and that prisoners suffered from poorer health than that of the rest of the population.

The majority of those serving time in prison are less likely to have engaged with the health service in the past and more likely to have complex needs. Many of the health problems seen in the general Scottish population are reflected within the prison population and even more concentrated. As the Royal College of Nursing stated in their recent review ‘Five years on’, there are gaps in our knowledge and understanding of the healthcare needs of those in prison particularly around mental health, long term conditions and the needs of older people. With no national performance and outcomes data on healthcare in prisons it is difficult to fully understand the health needs of people in the criminal justice system and how best to direct resources in order to meet those needs.

What do you consider are the current pressures on health and social care provisions in prison and how have these been responded to?

Recruitment and retention of healthcare staff
Scotland is facing a significant GP recruitment problem. An ever increasing workload, combined with falling resources, has led to fewer doctors choosing to train as GPs, while senior GPs are choosing to retire early or work abroad for a better work-life balance. Working within the prison sector can be seen as an unattractive placement with a higher proportion of confrontational consultations and complaints than in mainstream general practice. Health boards around the country operate different approaches to how they address providing GPs for patients in prison. Some have dedicated GPs doing full time prison work while other areas contract groups of GPs or partnerships to provide services. Both models offer benefits depending on the needs of the health boards and the prisons within that area. It is important to ensure that those doctors working in the prison environment are able to do so in a safe and supported manner. There are examples of good practice but issues have arisen with

2 Royal College of Nursing, ‘Five years on: Royal College of Nursing Scotland review of the transfer of prison health care from the Scottish Prison Service to NHS Scotland’, November 2016
some prison staff not fully understanding why some medical decisions are made and healthcare staff not fully appreciating the challenges and operational constraints that might lead to delays or problems with access to patients.

There should be a duty of care to ensure that all prisoners receive equivalent care to that provided in the wider community. Staff shortages will have an effect on patient access to health services. The RCN review reported that 75% of their survey respondents said that healthcare staffing is an issue in prisons.

Continuity of care is important, especially to people who may have no previous experience of the healthcare system, or a chaotic one. Many within the prison population have complex healthcare needs and multiple morbidities. For those serving longer sentences, prison can offer the opportunity to address health inequalities and there are examples of patients taking the opportunity to raise longstanding health concerns once other issues have stabilised such as addiction or substance misuse.

**IT systems**
One of the main issues that has been raised is the IT system. While all prisons now have a version of VISION for clinical recording there is no system for the electronic prescribing and dispensing of medication. This can be particularly problematic when patients on medications are transferred between prisons as hand written prescriptions sheets are more likely to be lost. It is also more likely to allow for transcription errors with reading handwriting or re-writing prescriptions and delays to medications.

**Movement of patients around the prison estate**
The movement of patients around the prison estate can also lead to difficulties when treatments or medications are interrupted. This can be particularly problematic when a patient is moved between prisons in different health boards. Each board has its own policies and priorities and may make its own decisions regarding medications and treatments that are available locally. This is entirely appropriate and based on the safe provision of services within the context in which they work but it can lead to changes in a patient’s medication and this can have significant effects, especially if it is in regards to addiction stabilising therapies. Work is being done by the National Prisoner Healthcare Network to minimise these variations where possible.

Given the erratic and chaotic lifestyle of many of those in prison, continuity of care and building relationships of honesty and trust between patients and healthcare professionals are extremely important. Where it is appropriate and available continuity of care should be a focus.

**To what extent do you believe that health inequalities are/ could be addressed in the prison healthcare system?**
For some patients prison offers the ideal opportunity and time to receive and work through long term neglected health problems particularly substance abuse, mental health issues and long term physical health conditions. There are examples of patients in prisons accessing some types of health care more quickly and/or effectively than they would have within their communities such as dentistry, psychiatry or physiotherapy but as the RCN’s, ‘Five years on’ document points out, this varies across health boards and prisons. Due to the lack of performance and outcomes data it is hard to build up a national picture.
These issues are harder to address for those on shorter sentences or for patients who are moved between prisons facilities were continuity of care is less likely.

**What are the current barriers to using prison healthcare system/improve the healthcare outcomes of the prison populations?**

**Prison turnover**
The high turnover of prisoners remains an ongoing challenge. Managing patients who repeatedly come in and out of prisons and often for a very short time creates a high workload for health services with very little opportunity to improve health concerns, particularly interventions to deal with long term issues such as substance misuse.

Technology barriers between the GP clinical record in the community and in prison prevent significant improvement in through care, particularly for those on shorter term sentences. At present those on short term sentences remain registered with their community GP. This avoids a patient having to re-register if they are only in prison for a matter of weeks. It does mean, however, that the prison health care team only have partial access to short term prisoner medical records, as attempting to obtain records from the community practice can be time consuming and labour intensive. In turn, unless a patient decided to disclose, the community GP may not be made aware of changes made to treatment while in prison.

**NHS/Outside agencies**
Since the transfer of healthcare there has been a better understanding across the NHS of some of the challenges facing those providing healthcare within a prison and the limited control they have over what may happen to their patient. Sometimes patients can be released direct from court without the prior knowledge of the prison healthcare team and at times assumptions are made about the level of healthcare provided in prison, particularly out of hours.

**Can you identify potential improvements to current services?**
Anecdotally there are examples of good practice from across the prison estate and health boards particularly the move from paper medical records to an IT system. There is however room for further improvement. More work needs to be done to allow for electronic prescribing for patients. This would make transferring patients between prisons a smoother process.

**What do you think the main pressures will be in the next 15 years?**
Recruitment and retention of doctors will have an impact on what services will be able to be provided for patients in the prison service. Coupling this with an ageing population means that more patients in prison will present with complex conditions; without significant new resources, continuing to provide healthcare in the same manner is unsustainable. Action needs to be taken to make sure that Scotland is an attractive place for doctors, nurses and allied health professionals to work, in order to ensure that appropriate numbers of staff can be recruited and retained to deliver an effective service.

Decisions need to be taken about what kind of health service we want to provide in Scotland and that must include those patients who access services in prison.
For further information, please contact:
Erin Robertson, Public Affairs Officer
T: 0131 247 3071 | M: 07788 565 216 | E: erobertson@bma.org.uk