The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

JUSTICE COMMITTEE

Tuesday 28 May 2013

Session 4

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JUSTICE COMMITTEE
17th Meeting 2013, Session 4

CONVENER

*Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP)

DEPUTY CONVENER

*Jenny Marra (North East Scotland) (Lab)

COMMITTEE MEMBERS

*Roderick Campbell (North East Fife) (SNP)
*John Finnie (Highlands and Islands) (Ind)
*Colin Keir (Edinburgh Western) (SNP)
*Alison McInnes (North East Scotland) (LD)
David McLetchie (Lothian) (Con)
*Graeme Pearson (South Scotland) (Lab)
*Sandra White (Glasgow Kelvin) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Frank Gibbons (HMP Barlinnie)
Dr Lesley Graham (NHS Scotland)
Dr Richard Groden (Glasgow Community Health Partnership)
Anne Hawkins (National Prison Healthcare Network)
Mark McEwan (NHS Grampian)
Joe McGhee (NHS Forth Valley)
Jayne Miller (National Prison Healthcare Network)
Ruth Parker (Scottish Prison Service)
Pete White (Positive Prison? Positive Futures)

CLERK TO THE COMMITTEE

Irene Fleming

LOCATION

Committee Room 1

Scottish Parliament

Justice Committee

Tuesday 28 May 2013

[The Convener *opened the meeting at 09:31*]

Decision on Taking Business in Private

The Convener (Christine Grahame): I welcome everyone to the 17th meeting of the Justice Committee in 2013. Please switch off mobile phones and other electronic devices completely, as they interfere with the broadcasting system even when they are switched to silent. We have apologies from David McLetchie; John Lamont will attend as his substitute.

Item 1 is a decision on whether to take items 4, 5 and 6 in private. It is proposed that item 4 be taken in private because it is a discussion about our approach to scrutiny of the Tribunals (Scotland) Bill, which will include a discussion about potential witnesses. Item 5 is consideration of a draft stage 1 report on the Victims and Witnesses (Scotland) Bill, including our final conclusions and recommendations to the Parliament. Item 6 is consideration of a draft report on our inquiry into the effectiveness of the provisions in the Title Conditions (Scotland) Act 2003—the item was deferred last week. Do members agree to take those items in private?

Members *indicated agreement.*

Prison Healthcare

09:32

The Convener: Item 2 is a round-table evidence session on the transfer of prisoner healthcare from the Scottish Prison Service to the national health service. Members and some of the witnesses will recall that we held an evidence session on 20 November and agreed to review progress after six months.

I welcome our witnesses: Anne Hawkins and Jayne Miller are from the national prison healthcare network; Dr Lesley Graham is from the Information Services Division of NHS Scotland; Dr Richard Groden is from the Glasgow community health partnership; Joe McGhee is from NHS Forth Valley; Mark McEwan is from NHS Grampian; Ruth Parker is from the SPS; Frank Gibbons is from HMP Barlinnie; and Pete White is from Positive Prison? Positive Futures.

In the previous evidence session we let the witnesses make opening remarks, but this time members will put questions. Please indicate if you want to respond.

Alison McInnes (North East Scotland) (LD): Before we start, I should say that John Lamont will not be here this morning. He sends his apologies, as does David McLetchie.

The Convener: Thank you very much. That is on the record.

John Finnie (Highlands and Islands) (Ind): There is a reference in our papers to the introduction of the Vision information technology system. The committee deals with a lot of areas in which compatibility of IT systems is important. Will the witnesses comment on electronic records and the Vision system?

Jayne Miller (National Prison Healthcare Network): The system that has been introduced in the prison service is the In Practice Systems—INPS—Vision system, which is one of the two main general practitioner IT systems in Scotland. Members might know that the general practice administration system for Scotland—GPASS—was stood down some time ago and there was a procurement exercise to pick two systems.

The Vision system, which we chose for the prison service, works a bit like a system for a GP practice that has a lot of branch surgeries. It is hosted in NHS Grampian, which is Mark McEwan's area, and it links all the prisons. It also links to each health board, so we can make electronic referrals and so on. It moves records around prisons as well as into and out of the community.

The Convener: Mr McEwan, you have been named in dispatches. Do you wish to say something?

Mark McEwan (NHS Grampian): Yes. Jayne Miller is exactly right: the branch is Grampian and the satellites are the prisons. As Jayne said, the system allows information to move electronically with the prisoner.

The Convener: Does it move with them? When Alison McInnes and I visited Polmont we heard that when prisoners left Polmont the records did not go with them unless they had a general practitioner. If they did not have a GP there was a dead stop. Is that still the case?

Dr Richard Groden (Glasgow Community Health Partnership): The records can be transferred electronically. If the prisoner is in prison for six months or longer they will be registered with the prison health service as their practice. If they are in for any less than that, they will still be registered with their community GP practice and therefore their records will not transfer in, given the logistics of the transfer. That is in keeping with what would normally happen in the community setting. Somebody who was temporarily resident in an area for a period of up to three months would register with a practice only temporarily and would not deregister from their existing GP. If somebody is registered with the prison healthcare practice, there should be no reason why their record would not transfer automatically—as would happen in the community—once they were released from prison and registered with a practice in the community.

The Convener: What about when they are not registered with a practice—when they are of no fixed abode? That is the issue, is it not?

Dr Groden: All residents in Scotland who are eligible for NHS services can register with a GP practice. GP practices should not refuse people—

The Convener: I am not talking about people being refused; I am saying that some people just do not register. They disconnect themselves. Is there any way that we can encourage people to register?

Dr Groden: Certainly in NHS Greater Glasgow and Clyde we try to ensure that people are registered before they leave the prison setting. I hope that that approach is reflected across the prison estate.

John Finnie: There are certainly issues regarding registration of people with dependency issues or who are homeless. The fact that records transfer if someone has a custodial sentence of more than six months has been mentioned. If the sentence is less than six months, can the prison health authorities access any record that may be available?

Jayne Miller: The six-month guideline was really meant to try not to destabilise the prisoner's registration with a practice in the community. If they are in prison for only a short time, we do not want to destabilise their relationship with a GP in the community. The prison healthcare staff can register a patient—a prisoner—permanently at any time if there is a clinical need to do so. If a prisoner is undergoing treatment or waiting for a referral, the prison healthcare staff can register them permanently and their record will automatically come in from the GP. In practice, if the prison healthcare staff do not get the record automatically, they will try to contact the GP to get it.

John Finnie: I imagine that that is the crucial bit.

Jayne Miller: Absolutely.

John Finnie: To me, it is immaterial where the record sits and whether it is a hard copy or an electronic copy. It is the information in it that is compelling. Is there any dubiety about whether prison authorities can access the best possible information at an early point—which should be on admission? We hear about procedures taking place within 24 hours of admission.

Jayne Miller: We also have the electronic emergency care summary, which is available in prisons so that we can at least track a prisoner's latest episode with their GP, their medication and so on. That is a kind of double check, if you like. If the prison healthcare staff cannot get the GP on the phone, they can use the electronic emergency care summary.

The Convener: Mr Gibbons is nodding.

Frank Gibbons (HMP Barlinnie): I was going to say that the emergency care summary is available for people who are serving a sentence of less than six months. It is very useful, because we can see their latest interactions with their GP or, if they have been in hospital recently, we can see the latest care that has been provided.

Homeless people who are asked to register but do not do so often make contact with the HAT team, which gets in touch with us. We can make the information available quite quickly.

The Convener: What is the HAT team?

Frank Gibbons: Sorry. It is the homeless addiction team, which picks up prisoners who leave prison and do not have a fixed address. It is very useful.

Anne Hawkins (National Prison Healthcare Network): I think that it is fair to say that the picture will vary across Scotland, because different

boards have different standards of homelessness services. Provision is not the same across the country. The HAT service that is provided in Glasgow is not necessarily replicated throughout Scotland.

The Convener: Does anyone else want to comment on the fact that such provision is not replicated in other areas?

Mark McEwan: We have certainly tried to address some issues through dental provision. We have a community dental team that deals specifically with homeless people and substance misusers. The idea is that that team goes into the prison, treats them there and picks them up on their release—assuming that they are Grampian residents.

I think that health boards are aware of the need to provide continuity of care. I feel fairly strongly that it is a two-way process. It is necessary not just that the health service tries to provide continuity of care, but that prisoners feel valid enough to access NHS services within and outwith prison. That is certainly a challenge.

Colin Keir (Edinburgh Western) (SNP): My question follows up on something that the convener said. I am not 100 per cent sure of what the process is when someone comes out of prison—whether they are on a short-term sentence or a long-term sentence—who was not registered with a GP when they went into prison. There is a problem, as the convener said, if they are not registered with a GP.

I have found that, because of pressure of numbers in one or two of the GP surgeries in my constituency, those surgeries are imposing a boundary and are accepting only patients from within that boundary, and they are writing to patients who are outwith that boundary to ask them to find a new GP. What is the process for ensuring that a prisoner who is not registered—whether or not they are homeless—will have access to a GP when they return to an area such as the one that I described?

Dr Groden: I am happy to explain the registration process. All practices work within a practice-defined area, which is agreed with the health board. The health board has a responsibility to deliver primary medical services to the whole of its population—regardless. In a postcode area in which there was potentially a gap, the health board would be within its rights to sanction the opening of another practice in that area.

As far as registration is concerned, practices cannot refuse to take on people on any grounds—that is against their contract and they could breach it by doing so. If that is happening, information needs to come back to the health board so that it can act on it. We can deal with such issues only if we receive feedback to that effect.

Practices cannot put people off because they change their boundaries. They can write to people and suggest that they might want to look for another GP, but patients do not have to leave a practice because it is redefining its geographical area.

Therefore, everyone should have access to a GP practice. Essentially, GP practices cannot refuse to take on people who are within their practice-defined area.

Health boards have a responsibility to deliver primary medical services. The other element is that each health board has a registration department. If people are having difficulty in accessing GP practices or knowing where they are, they can contact the registration department and it will allocate them to a GP practice in the area.

The Convener: I want to clarify something. Are you saying that a GP cannot refuse to take on someone who is within the geographical area that has been agreed as part of the contract with the board? That is absolute.

Dr Groden: That is correct—unless the practice has closed its list, perhaps because of pressure of numbers or an illness, but that has to be agreed with the health board. However, the health board has a responsibility to ensure the provision of services, and closed lists are very rare. Attempts would be made to work round that. A health board could sanction the opening of another GP practice in an area, and most GPs do not like the thought of someone else opening a surgery down the road.

The Convener: But a GP can refuse to have a patient after a while, if there are problems—to use the word in a general sense. Is that right?

Dr Groden: The contract is with the practice. Patients register with a practice, rather than with an individual GP. A practice can remove a patient from its list under certain circumstances—for example, if they have been violent towards a member of staff or have displayed other forms of aggression. There are valid reasons for a practice removing someone from its list, but such action has to be justified.

Practices have to tell the health board at the end of each year how many—if any—patients they have taken off their list and the reasons for doing that, and those reasons can be challenged by the health board. A GP's contract could be challenged if they were perceived to be acting unfairly.

The Convener: John Finnie seems to disagree but I will let Colin Keir in first.

09:45

Colin Keir: There are two issues here. First, I obviously have some letters to write to the practice in question. Secondly, how do we make sure that people have access to a GP when they walk out the prison door, no matter the length of time that they have been in prison? Given the problems with some surgeries, such as the situation that I mentioned, how do we make sure that those people are taken on by a practice?

Dr Groden: I can speak only for Glasgow but we will act as the patient's advocate and ensure that they are registered with a practice prior to their release from prison. I do not know what happens in the rest of the country but, for me, the best model is that, prior to prisoners leaving prison, they are either allocated to a practice through the health board or registered with a practice.

Frank Gibbons: We arrange for most prisoners in Glasgow to be registered, particularly if they flag up with us that they do not have a GP before they leave. We provide an advocacy service and occasionally get phone calls from prisoners saying that they have had a problem registering with a GP. We will contact the practice, and if we cannot get them into that practice, we will find them an alternative.

The Convener: What about NHS Forth Valley?

Joe McGhee (NHS Forth Valley): There can be problems for NHS Forth Valley because we have three national prisons and most of the prisoner population are not from the area. We need to communicate with other boards across Scotland, so there are sometimes problems for us.

The onus is on the prison nursing staff to work with the prisoners and encourage them to engage with their GP or register with a new GP prior to release. There is a big onus on the healthcare staff within the prison establishment itself to encourage and facilitate that contact. As I say, dealing with three national prisons that release into our area prisoners from all over Scotland can be a problem.

We talk about throughcare, but from a health perspective we should be looking at continuity of care. Talk of continuity of care is very much encouraged in prison nursing staff. There should be continuity of healthcare at the point of release.

Jayne Miller: Partnerships have been set up with Sacro and the Wise Group that are looking at the new routes programme, and I have had discussions with them about encouraging people to register with GPs. Once the prisoner has a mentor, we offer to do some training on working through the system and how to contact practitioner services and get patients allocated. We are actively working on all that with the third sector.

The Convener: Is that happening in what Joe McGhee calls the "national" prisons, such as Polmont? They might be different from local prisons.

Jayne Miller: The new routes programme will cover all prisons in Scotland, and we will encourage that approach. For example, if a prisoner from Lanarkshire is in prison in the Forth valley area, we would make sure that they had the appropriate contact with practitioner services in Lanarkshire. It is about giving them contact details so that they know who to go to if, when they leave, they go to another area.

The Convener: Is that followed through? It is one thing to give someone a phone number or other contact information but it is important to follow it through.

Jayne Miller: The mentor would do the work, not the prisoner, so the mentor would talk the prisoner through the process and then follow it up as part of the new partnership that has been set up.

The Convener: John Finnie disagreed with what was said earlier about GPs.

John Finnie: I do not doubt that everyone here is acting in good faith and seeks to have the best possible service delivered for everyone. However, from the evidence that the Equal Opportunities Committee took in relation to Gypsy Travellers and from my personal experience of dealing with homeless people and, in particular, intravenous drug users, I understand that some general practitioners are far from welcoming, to the extent that one health board provided a general practitioner for those people to visit. The fact that GP practices are commercial businesses is not always appreciated, and I favour a salaried practitioner model where a GP is obliged to deliver healthcare. I am just saying that my personal experience and the evidence that I have heard elsewhere do not mirror what has been said. I am absolutely delighted if the situation has changed.

The Convener: How recently was that evidence taken?

John Finnie: Within the past three months, and my personal knowledge comes from within the past six months.

The Convener: What area was refusing to treat people?

John Finnie: There were issues across Scotland.

Dr Groden: I would like to respond to that. What I have described is the contractual obligation on practices. I have not described what might happen

in practices in certain areas. If you are aware of concerns in certain areas, I suggest that you take them up with the local health board, which can act on them. One of the great difficulties is obtaining intelligence about the behaviours of certain practices. Such behaviours are frustrating for the other practices in the area, because they have to bear the brunt of the impact of what should be a shared-out population of people who can be more challenging. I absolutely agree that some practices do not behave in the contractually correct way. However, as I said, I have tried to describe the obligations on GP practices to take patients on.

The Convener: There is a follow-up opportunity for the Equal Opportunities Committee, John.

John Finnie: I am waiting to hear back from the Government on that. I am sure that the response will be interesting.

The Convener: Well, there you are.

Sandra White (Glasgow Kelvin) (SNP): I think that we have agreed that the transfer has been a good thing and has made an improvement, but that there are still some areas that need to be considered, such as throughcare and continuity of care.

I am interested in how substance misuse care is followed from the prisons right through to the various agencies outside. Are there particular problems in certain health board areas or certain prisons? I am particularly interested in Addiewell and Kilmarnock, as they are private prisons. Are there any issues that you would like to raise? Should more work be done on issues around throughcare with regard to the misuse of drugs and so on?

Anne Hawkins: We know that many people in prison have major drug and alcohol misuse problems. At your previous meeting on prison healthcare, someone from Phoenix Futures spoke to you about the service that it has provided to the Scottish Prison Service for some years under a contract. The position has been reviewed by all health boards, which are at various stages of the reorganisation of their addiction services. I think that it is fair to say that every health board has created a different addictions pathway and that most have moved away from the Phoenix Futures contract or are in the process of doing so.

NHS Greater Glasgow and Clyde has been reviewing its community addictions service, too, and that work is being done in tandem with work on changing the shape of service in the three prisons.

Health boards have considered the staffing that is required in individual prisons. Where Phoenix Futures staff are being moved over into the NHS, that is being done under the Transfer of Undertakings (Protection of Employment) Regulations. However, because those people are not necessarily qualified nursing staff, they do not fit into NHS structures. That means that, in some boards, individuals will have to be redeployed into other roles. That might cause those individuals some consternation but, as you know, the NHS in Scotland looks to redeploy staff rather than making people compulsorily redundant.

The models are changing quite significantly. Perhaps Jayne Miller can add something to that.

Jayne Miller: The network has asked each board to give us a summary of its addictions and substance misuse services. You might have seen some private papers in that regard. We are collecting that information.

The plan is to have a workshop day, perhaps in a few months' time, when we will look at what all the boards are doing. Every single board has introduced a new substance misuse pathway. Some boards are further ahead than others, but the main aim is to integrate prison substance misuse services with community addiction services. That will allow cases that are picked up while people are in prison to be followed up when they go back into the community.

As Joe McGhee said, the difficulty is that some people who have been in one of the national prisons do not necessarily stay in the same board area. A case might be picked up by substance misuse services in Forth valley, for instance, but then the person goes back to Lanarkshire, Grampian or another health board area. That can cause problems, but the network will be focusing on the issue over the next few months.

Pete White (Positive Prison? Positive Futures): It is fantastic that we are having this discussion at a time of tremendous change. Some prisoners are in a state of flux given the new change fund programmes that are coming through. For the NHS, integration into the Scottish Prison Service represents a fantastic opportunity to rebuild, rather than retain, some of the procedures and practices.

The people we are talking about will have had a sense of cultural agoraphobia before going to prison. They are then given an institutional life in prison. When they are released, they still have a sense of general cultural and personal agoraphobia. They are profoundly disadvantaged in many ways. The idea of networks, systems, procedures, plans and pathways, although that is comfortable language in this setting, is alien territory for many prisoners, and it remains so when they become human beings and citizens again in the community. It is important that we make an effort to remember that.

Many of us here will have encountered people in the medical profession who, although they might be very well trained and perhaps well intentioned, can be quite fearsome and foreboding. To someone who has been in prison and who has knocked on a GP's door to ask for help but has been told no, the idea of complaining is verging on farcical. We need to find some way of helping those people not to reintegrate but to integrate. We need to bring the process to a point where it deals with people as human beings who have had a difficult and complicated start to their life, or part of it. That might have been at their own hand, but I still think that we have to help them. We have to go with the open hand of help, rather than saying, "Come and knock on my door, although I might say no," in which case they will have to go and complain somewhere.

Let us get people—human beings—into this. We can match them with the right people, and we can then build networks round them, rather than delivering networks to them.

The Convener: We have mentioned personal advocates or mentors. Do they help?

Pete White: The role of the mentor has become multifunctional when it comes to programmes. The term "mentor" has been stretched to cover a variety of roles, all of which are very well intentioned. The idea is that a mentor helps someone to make decisions for themselves and to recognise that they have a place in society that allows them to make decisions for themselves. The mentor does not make decisions for them. Mentoring itself is in a state of flux, and mentors have to learn that it is not so much about supporting people as guiding them towards making decisions, and that it is not about doing things for them. Advocacy and mentoring are related, but they are not the same.

Frank Gibbons: That was very well put. The pathways can sometimes be alien for people working on the front line, not just the prisoners. The policies can be a bit overbearing. I am really pleased that, in Glasgow, people are considering the quality side of what can be pulled from the documents, recognising that it is not a case of one size fits all.

Some prisoners have started to recognise the fact that they do not like sitting in groups, for instance. We run a number of prisoner focus groups at which we tell people what they are entitled to and what they should be asking for in relation to GP registration. That is a positive approach, but we recognise that we have to see the guys who do not want to engage with other people individually and offer them alternative ways of trying to deal with things.

10:00

Some guys are fairly awkward—I am talking about guys because I work with males. If we just accept that they are awkward, we are always going to see them in that way. Sometimes we have to work around that and look for something that breaks the chain. There are some tremendous workers in both the NHS and the SPS who really make that effort. I am not saying that we do that every day, but we recognise the issues.

There is a really positive feeling about some of the stuff that is happening just now, and my gut feeling is that we are heading in the right direction. I am not saying that we will not get things wrong, but collectively we are trying to move in the right direction.

Pete White: I make it clear that I regard the people who work in the SPS and in prisons as human beings, and to err is human.

The Convener: Mr White, I saw that you and Mr Gibbons were smiling at each other as you said that.

Pete White: Absolutely. I think the intentions that are coming out of the initiative are tremendous, and the direction is fantastic. We just need to ensure that we remember the right focus. The fact that the SPS is appointing throughcare officers to help to look after prisoners when they go back into the community is a fantastic step forward, because, until the transfer happened, the SPS's authority—and everything else—stopped at the gate. There is a fantastic opportunity to weave all those different things together into something that will support people well.

The Convener: I think that I speak for the committee when I say that none of us wanted that situation to continue, because it was so wasteful.

Mark McEwan: The opening of HMP Grampian next year might make a difference. It is a different type of prison, in as much as its population will be broadly indigenous to the area, so it might offer an example of a new structure for prisons and make some of the things that we have discussed much easier.

It will be much easier for Grampian prisoners to be seen by Grampian NHS staff in a Grampian prison. There will also be better involvement from local third sector groups, which will be able to see the prisoners in prison and when they come out—the same people will be involved.

We will wait and see, but I have great hope that the opening of that prison will be a big step forward for community prisons and community-facing prisoners.

Sandra White: I certainly concur with all the comments that have been made. I have visited

Barlinnie, and the amount of work that has been going on is fantastic. That includes work on anger management, for example, and work by the SPS and voluntary organisations.

One thing struck me when I spoke to young males in particular. We constantly talk about the revolving-door syndrome, and we do not want reoffending to occur continuously. We have talked about substance misuse today, but I am a wee bit concerned that we have not yet quite achieved the necessary throughcare and continuity.

As Jayne Miller said, each NHS board is looking at different ways to combat substance misuse and deal with people who are involved in it. She mentioned networking and the electronic summary with regard to collecting information, and continuity has also been mentioned.

Do you have a timescale for that? Are NHS boards working together? Is one idea better than another? I am a wee bit concerned that everything has not gelled yet. Perhaps it is too soon, but I would like to see some form of continuity. People who come out of prison need a mentor, such as someone from the SPS or someone whom they know, such as a doctor. They need access to help to enable them to stop their substance misuse.

The Convener: I am watching the negotiations that are going on between Ms Miller and Ms Hawkins—I should have sat you side by side. I suggested that to the clerks, but perhaps Alison McInnes wants to sit in the middle. Which one of you will take that question?

Anne Hawkins: I will start.

Sandra White mentioned the need to work with people to reduce their addiction, in anticipation that they will ultimately become drug or alcohol free. That is a big ask. As the committee will know, a piece of work is going on just now that is looking at the whole approach to addictions treatment. The people round this table will have views on that, and we perhaps do not want to get into a debate about recovery versus treatment, methadone and other such issues.

We are trying to ensure that, when someone leaves prison, they are immediately picked up by local services, so that there is no gap when people are not getting their methadone. The challenge for us is to work with people in prison to reduce addiction—that is, addiction to prescribed medication as well as addictions that are being treated with methadone or other treatments. While we have people in that safe place, if I can call it that, and they are a captive audience, we can work with them.

The work is extremely challenging, given that, for all sorts of reasons, people do not want to reduce their prescribed medication. Most of the complaints that we receive involve those who are making efforts to reduce their prescribed medication or methadone level. We work with people on the benefits of doing that and we look at the consequences for the prison system of the fact that people with addiction are more likely to get involved in fracas with other prisoners. The process has to be managed carefully with the governor and other staff in each prison. We look at the way the prison regime works and how we can work with the different prisoners. It is a complicated issue.

Everyone is trying hard to ensure that people do not fall between two stools when they leave prison and that they are picked up by local services. We know that if people overdose when they leave prison, the probability of death is higher.

The Convener: Before we move to Mr White, I see that Graeme Pearson wants to come in. Is it on the same tack, Graeme?

Graeme Pearson (South Scotland) (Lab): I will let Mr White speak first.

Pete White: First, we need to take it on board that it is rarely a surprise when someone leaves prison through the gate. It is important that, from the beginning, rather than in the last few weeks of a sentence, we plan that pathway—sorry, trajectory.

The Convener: The jargon just obtruded.

Pete White: Yes; it catches you.

Planning should start as soon as possible, at the beginning of the sentence and not at the end.

Secondly, what passes as immediate service in the wider community is sometimes not sufficiently immediate for someone who is released on a Friday, because the gap from Friday to Monday is a dangerous two days in between. That can lead to many sad problems. A tremendous model of a holistic approach that has already been accepted across Scotland is getting it right for every child. It would be marvellous to have that all-embracing shared goal—not just for the individual but for all the services that are involved—to use as a template for some of what is being talked about here.

Graeme Pearson: I thank the witnesses for taking the time to come and speak to us. I am glad that I gave ground to Mr White, because he saved me from saying much of what he said just now, which I have also said at previous meetings.

In dealing with the issue of drug and alcohol problems, one of the frustrations is that there seems to be a confused message across Scotland about expectations, such as what goals to set and agree between the various players and what we expect prisoners to manage during their time in

prison, or, indeed, what it is possible for them to manage, with all the other problems that they have.

My final point, before coming on to my questions, is that I want to record that we do not expect prisons to solve all the problems for us. It is almost as though, once we put someone in prison, we aim to sort all the baggage that they bring with them. If that was the case, the rest of us would be queueing up at the prison gate to come in for a visit.

The Convener: Speak for yourself, Mr Pearson.

Graeme Pearson: Having said that, let me be small-minded and raise some issues with the witnesses.

The Scottish Public Services Ombudsman's overview this month reported serious concerns about prisoners being denied access to complaints procedures. The ombudsman indicates that, although he raised those concerns back in January, he discovered that there continues to be an issue across the prison service. There seems to be a difficulty in allowing prisoners to go beyond the feedback stage. Such is the concern that he includes the issue in this month's report. What is happening in the community? Why is the ombudsman commenting on the matter and what is going to be done about it?

Anne Hawkins: I do not know whether everyone has read the ombudsman's report, but he was commenting on a particular case in which an individual had to ask for a feedback form on more than one occasion before they could go to the full complaints procedure. Obviously, a number of comments have been made about that. In recent months, the ombudsman has worked his way around every board and has met all the chief executives to talk about complaints in general and how they are dealt with. I believe that, at every meeting—I was at the one in Glasgow—he raised the issue of prison complaints and being satisfied that complaints are being dealt with appropriately. After all, it is only relatively recently that the ombudsman process has applied to prison complaints as a whole and not just the NHS element.

As the ombudsman's report points out, the general complaints process requires the NHS to record all feedback, including compliments—which we get, although it does not happen that often—and report it, as well as reporting on formal complaints. My understanding is that prior to the transfer every healthcare issue that was raised in the prison service was dealt with and responded to as a formal complaint. In the health service, we have always tried to resolve the issue with the individual informally before they go into the formal complaints process. We meet them, hear what their issue is and try to sort it, and if we cannot do so, we escalate it to a formal complaint.

Prisoners liked the process of making a complaint, getting a response and then in many cases making a claim for compensation for whatever it was. It has been difficult to implement the informal approach and the feedback form that enables it, because people have not responded positively to it. However, it is not meant to be a constraint and someone who has a complaint has every right to go straight to the formal complaints process. Even then, we can still try to resolve the issue informally; hopefully, we will able to do so and that will be the end of the matter.

That is basically the process. The feedback form is used to record feedback, because that is what we have to do formally.

Pete White: I understand that there have been a lot of positive changes to the complaints procedure in prisons over the past few years and that a great number of matters have been resolved quite effectively in each wing and each prison. However, if the process of complaining involves the prisoner having to fill in a form, it rules out half the prison population in the short-term wings, because those people cannot read or write.

Secondly, having an informal intervention to prevent a complaint from becoming formalised is a tremendous way of sorting things out on both sides of the fence. The individual's issue might get sorted out but, on the other hand, it never gets recorded as a complaint, which means that figures and targets can be looked at differently and trends across prisons and indeed the whole estate can be missed. The new process for the independent monitoring of prisons that I understand is coming in will include a national overview of complaints to allow us to see whether there is a trend of small, low-grade complaints that might not seem important to us in this room, but which might be a major issue for people in prison and could get out of proportion and lead to other problems. It would be good to get the complaints procedure sorted out in a realistic way that not only solves the problem but takes on board all complaints to let us see whether there are trends that would otherwise not be a problem.

As for prisoners hoping to get a complaint resolved in such a way that they are able to make a claim, I have to say that, in my experience, that is a bit of a generalisation.

Anne Hawkins: I think that I said that that is what happened in the past.

Pete White: Thank you—that is fine.

Anne Hawkins: It has certainly not been my recent experience.

All the feedback has to be recorded and, in NHS Greater Glasgow and Clyde, it is reported through the clinical governance process. There is a form to identify every single issue that has been raised in the feedback and the response that was made. Things are tracked and the trends can be seen. In fact, most people seem to get their issues resolved quite satisfactorily through the informal approach.

Pete White: I am not sure that that is the case.

The Convener: Can Mr McEwan or Mr Gibbons give me an example of a complaint?

10:15

Frank Gibbons: The majority of the complaints that I deal with every day that reach the stage of a comments form or become a formal complaint will be about prescription drugs, and most of them will mention a drug called gabapentin, which is a drug of choice for people and one that they like to be prescribed. They will say that the general practitioner has prescribed them X, but they wanted Y. Some of it will be only comments that they are not happy that that has happened, but some will say that they want to take issue with that somewhere else, or they will ask for a second opinion.

A point that has probably been overlooked but which people should understand is that, under the old complaints system, the Scottish Prison Service would deal with complaints and legal claims; whereas, when a prisoner now makes a legal claim, the NHS does not go through the complaints process but just deals with the claim. Prisoners found that hard to understand at first. For example, the NHS will say that it will deal with a legal claim that a prisoner has written to their lawyer about, but it will not deal with the original complaint. I think that that is a far more effective system, because it means that two bodies are not answering the same complaint. However, it took a wee while for people to understand the process and it was a bit frustrating.

The Convener: I think that Mr McEwan wants to come in.

Mark McEwan: Certain groups of prisoners are perhaps more manipulative or more inclined to make a complaint. We have noticed that our complaints have gone down in number since we moved the sex-offending population from Peterhead. I suspect that, wherever they have moved to, the number of complaints will have gone up. There are many different cultures among prisoners, and some do more complaining than others.

Graeme Pearson: To return to the ombudsman's point, he is referring to not just one case but dozens. He refers to the "Can I Help You?" guidance, which was published more than a year ago. Many public services deal with manipulative customers or clients—in this case, it is prisoners—but complaints systems can still address such complaints and can probably recognise their shade. The ombudsman's point is about tracking how services are delivered to see whether there are underlying problems. If prisoners are being denied access to complaints forms—the ombudsman has evidence that that has happened—it would be nice to hear from the communities that are represented here how they will deal with that for the future so that we will know from their performance measures that complaints are properly recorded and responded to. If we do not record them, then everything is fine, but only because we do not know whether we have a problem.

On informal reviews and their conclusion, someone outside the prison might say that it is easy to indicate that a complaint has been resolved, but the relationship in the prison between the prisoner and the authorities can sometimes be difficult if the prisoner wants to stand on their rights, which is what the complaints form is there to initiate. It would therefore be nice to hear about how we will deal with all that in future.

Mark McEwan: A key principle to which most of us are signed up, regardless of which health board we come from, is to make the service in prison as close as possible to the services that people receive in their community. I caution against creating a system or approach in prisons that is different from that deployed in the community. I feel that that is important in rehabilitating and preparing people for life in the community. So I would not favour creating special complaints systems in prisons that are vastly different from those in the community.

Graeme Pearson: We are talking about a Government guideline—"Can I Help You?"—that sets the procedures in place. A standard of complaints recording must be maintained. That is not to make your lives hard. However, if guidelines exist and have introduced a process and you have decided that you are not going to use them, you had better write to the cabinet secretary and let him know.

Anne Hawkins: All boards have had to review their complaints process in line with that. I am sure that all the other boards have done what we did, which was to ensure that the prison complaints process sat within the board complaints process.

We have had discussions with our three governors about how we can ensure that information on how to make a complaint is available in the halls and the health centres. We

have posters up. We have talked about the posters, and Frank Gibbons and I have had conversations about them. Although we have put up posters that explain the ombudsman's process, the ombudsman will not take a complaint unless it has first been dealt with locally.

The important point is that boards now must record all feedback. Pete White's point about people not being able to fill in the forms themselves is absolutely well made. It is not always the prisoner himself or herself who will fill in the form, but it is important to record the complaint or issue somewhere so that we know at a more senior level that all the issues are being picked up and logged.

Graeme Pearson: With respect, as they say, the issue that the ombudsman is talking about is specific: it is about complaint forms not being made available to prisoners. They are being denied the forms. Whether or not they can read or write, it is impossible for them to make a complaint if they do not get the bit of paper to write on.

Will part of the process be for you to look around the estate and, if staff members are denying forms, to re-educate them so that the appropriate processes will be in place?

Anne Hawkins: Often, the forms will be given by prison officers, not necessarily by health staff. When I read the ombudsman's report, I felt that we should take the issue back to the network at our next meeting and have a discussion with all the boards about the complaints process and the learning to take from the report. That is what we need to do. We need to check what everybody is doing.

Pete White: There are a number of points that we can take on board. There is a suggestion that a cohort of prisoners have a tendency to complain and be difficult. We can parallel that with some of the prison staff, occasionally. In the good old days when a screw was a screw and not an officer, a certain attitude was applied. The numbers of staff who behave like that are diminishing greatly, and I am pleased about that. If we are effective in reducing the prison population through reducing reoffending, the number of prisoners who cause complaints by being difficult inside will also reduce.

It is a cultural change that we have to get through. The denial of access to a complaint form is one of the simplest, lowest-grade forms of control and, where we get control and restriction like that, people fight against it in their own way. If there was a greater sense of purpose towards helping people to recognise their abilities and responsibility for taking decisions, we would find that there was a better balance in their behaviour. That could help us in many other ways, too.

Frank Gibbons: When the new process was introduced, one thing that should not have been overlooked—I overlooked it and I work in the prison—is that the prison is an institution and the staff have spent longer there than most of the prisoners. It takes a long time for people to understand their role in any new process and we had to spend some time working out basic processes for what should happen when somebody requests a complaint form. I thought that it would be fairly straightforward, but it turned out not to be.

The process now is that the prisoner asks to see the nurse. That means that, if the prisoner cannot fill out the form, the nurse can act as an advocate. Previously, the officers in the gallery handed a CP3 form, which was a medical complaint form, to the prisoners. A bit more work is involved now, because the nurse comes in, she needs a room, and she and the prisoner sit down. When a lot of folk asked for complaint forms, initially, the officers said, "We don't have complaint forms now. You need to deal with the NHS—it's nothing to do with us," so, technically speaking, some people were denied a complaint form.

I had a meeting with Martin MacDonald, who is the deputy governor at Barlinnie. We decided that, should that come about, we will say to prisoners that they will fill out a CP1 form, which is a prisoner complaint form that goes to the first-line manager, and then a CP2 form, which goes to the deputy governor, will be filled out to say that the prisoner cannot submit a medical or healthcare complaint. That lets the deputy governor know that his staff have a bit of an issue. Martin MacDonald has met with every first-line manager in our establishment to say that that should happen, and we sort of replicated that in Greenock and Low Moss. The process has bedded in. It is starting to pick up now and is nearer to something that I recognise and appreciate.

Although we could say that a lot of prisoner complaints are manipulative and are complaints about the same thing, there are a number of complaints that we take very seriously. We see complaints about situations where things have fallen short for people, for various reasons. The good thing about the clinical governance groups is that they are learning from those to look at how to prevent such things from happening again. Communication is getting better, and I hope that it will get better over time.

There were issues at the start, and it took us a wee while to bottom out why the complaint thing was an issue.

Graeme Pearson: Thanks very much for that. I hope that discussing the issue today will help to deliver further understanding. I think that it is still a difficulty. An organisation learns from its

complaints procedures if it sees them in a positive light.

I will ask a brief question, and I do not expect that a long time is available to you to answer it. Issues have been raised on occasion about the budget transfer from the old SPS to the health service and whether there was enough money to deliver the required services. Having experienced 18 months of the transfer, are the witnesses reasonably comfortable with the way that things are working? Is there enough money in the purse to do what is necessary, given the current constraints?

Mark McEwan: Broadly speaking, the transfer was sufficient to run the service as it is, certainly in NHS Grampian. In our review of expenditure, we are recording a slight underspend against the budget that we were given.

Our big challenge is that, as the prison service redesigns its estate and redistributes prisoners, those budgets need to be reviewed. The directors of finance in the NHS will do that by the end of the year. They are using a component of the national resource allocation committee to reconsider the budgets. We need to do that so that, for example, we do not end up with a situation in 2014 in which NHS Grampian has a female prisoner population but no budget for that. Conversely, somewhere such as NHS Forth Valley might not have a prison in its area, but it might have a prison budget, so it is fairly fundamental that there is a review of how the budget is to be redistributed.

The Convener: As NHS Forth Valley has been mentioned, would Joe McGhee like to comment?

Joe McGhee: I will highlight one area that is causing concern: the future needs of prisoners, especially Glenochil's sex offender population. A considerable amount—approximately 150—of its prisoners are fairly elderly, with long-term conditions. We have never really factored that in.

For instance, we have three individuals who require palliative care and one on dialysis. Some long-term prisoners have very complex healthcare needs that we did not have on the horizon at the beginning of the transfer. We need to consider that. I appreciate that, in an ideal world, we might consider compassionate leave for some individuals. However, because of certain characteristics of the Glenochil prison population, it would be impossible to release some prisoners back to the local community. The prison will be there for those individuals for the rest of their lives. Many of those prisoners are now presenting with significant long-term conditions that we need to address. The budget might be appropriate now, but there will be a real issue five or 10 years hence.

10:30

Ruth Parker (Scottish Prison Service): The Prison Service has undergone a significant amount of change since the transfer. In particular, we opened HMP Low Moss, which has required an increase in service provision by NHS Greater Glasgow and Clyde. There has also been, as Mr McGhee rightly says, the transfer of sex offenders from Peterhead to Glenochil and, in Mr McEwan's area, the change of population to local prisoners up in Peterhead. In addition, we have the on-going work for the new HMP Grampian, which will bring further changes, and the outcome of the commission on women's offenders report has involved significant planning and has meant some transfer of females from Cornton Vale to Polmont. There has been significant change and, although the prison population sits around 8,000, it is likely to increase to some 9,500 in the years ahead.

As Mr McGhee has highlighted, there are complex needs in the whole population—whether among young people or women—and there are emerging issues with managing older people, including historical sex offenders serving long-term sentences, whom Mr McGhee spoke about. The SPS has a duty of care in managing the prison population and we work closely with health boards to share, as soon as we can, any information about planned transfers, whether that involves the opening of new prisons or short-term planned or unplanned transfers.

The Convener: You say that the prison population is to reach 9,500.

Ruth Parker: Yes. The figure is projected to be 9,500 by 2020.

The Convener: If we ended the practice of early release, what would the figure be? That is one of the issues, is it not?

Ruth Parker: Yes. It would be significantly more.

The Convener: Ending early release would create another funding problem, although in principle I am in favour of it.

Graeme Pearson: What are the proportions within that forecast of 9,500? There has always been a worry about the number of remand prisoners. Does that figure of 9,500 include both long-term and short-term prisoners? If so, what are the forecast proportions?

Ruth Parker: I do not have that level of detail.

Graeme Pearson: I am just asking for a global number.

The Convener: It would be useful to know how that figure could be broken down into the categories that have been mentioned plus what the figure is projected to be if we end early

release. That would give us some idea of the pressures on the Prison Service, not least on the health side of it. I was not aware that, for various reasons of public safety, so many older prisoners cannot be released, and I had not really considered the cost of that.

Alison McInnes has been waiting for a wee while. After she has asked her questions, I will let Anne Hawkins in and then Roderick Campbell.

Alison McInnes: Mr McEwan said that you want to get to the point at which there is an equivalence of provision of healthcare in prisons and in the community. One area where we have quite a long way to go before we get there is mental health. I read with interest the interim report of the national prisoner healthcare network's mental health sub-group, which was submitted to the committee. It sets out in detail the challenges that we face in that area. How are you going to take that work forward? What is your vision? When do you think that we will get to the point of having an equivalence of care? The report on Cornton Vale by Her Majesty's chief inspector of prisons made it clear that he believes that many women in that prison ought to be in a psychiatric hospital rather than in a prison.

Anne Hawkins: I will kick off on that. The Mental Welfare Commission for Scotland is about to undertake a review of the mental health needs of women prisoners. It will be interesting to see what comes out of that.

The report that you have is a draft report that is out to consultation just now. All the health boards are looking at it and will respond. The report raises some issues that people would not necessarily agree with. For example, there are issues about potentially running a joint mental health and alcohol service, which is not something that every board would want to do. It depends on the size of the prison and what is feasible. I recognise that there can be co-morbidities, but my preference would be for the bigger prisons to have separate services.

A big issue for us, which is identified in the report, is personality disorder and how we tackle it. We have kicked off some work in Glasgow in that regard. The homelessness service, which was mentioned, includes services for people with personality disorder, so we will offer training to prison officers and staff in dealing with such people. That is a first step towards understanding the issues that people have and improving working relationships.

NHS Greater Glasgow and Clyde is probably at the stage that most boards are at: we are measuring our local services against the recommendations in the report and considering what we need to do differently. A critical point is to do with ensuring that the forensic mental health service links appropriately with prisons, so that people are not sitting in prison waiting for an NHS bed, if that can be avoided—that has happened.

That is my initial response; people might want to add to it.

Alison McInnes: I would be interested to hear from NHS Forth Valley.

Joe McGhee: The majority of women in Cornton Vale prison, which is in the NHS Forth Valley area, have chaotic lifestyles, as you said. It is tragic that many of the women actually want to come into prison, because that is the only time when they can really engage with health services. We have to ask ourselves whether prison is the right environment for such women—I suggest that it is not. We are undertaking a needs assessment on the back of the Mental Welfare Commission for Scotland's visits, and I hope that that will give us a more accurate picture. Anecdotally, we find that a lot of women almost want to come into prison, so that they can get healthcare, because they have such a chaotic lifestyle in the community that they are not engaged with services. Prison seems to offer them a safe environment.

The Convener: I recall a sheriff saying that he did not want to put a woman in prison but would do so for her sake, so that she could get help. That was a terrible indictment of what was going on outside. Prison offered the only opportunity for her to get the attention that she needed.

Jayne Miller: I want to bring to the committee's attention some of the work that is going on in telehealth. A psychiatrist in NHS Lothian is doing good work with patients—there are female and male prisoners in Lothian. The first assessment is a face-to-face meeting, but he does quite a bit of follow-up via telehealth. All boards are looking with interest at the approach, which seems to be producing good results. The psychiatrist is also working with people who have challenging behaviour, and we await with interest what will come out of that work.

The Convener: I hope that something happens. The Parliament has been hearing about telehealth for far too long—we were talking about it when I chaired the Health and Sport Committee.

Jayne Miller: It has tremendous potential.

The Convener: Everyone says that, but things seem to move at a slug's pace.

Colin Keir: As I recall, telecare was brought in in Lothian a year or two back and has generally been effective.

The Convener: Forgive me if I say that we have been talking about how wonderful telecare is for

seven or eight years. The slugs in my garden move quite fast—

Colin Keir: It certainly seems to be working in Edinburgh.

The Convener: Good for Edinburgh. I hope that the pace of progress accelerates and we are not here talking about telecare's potential in four years' time.

I bring in Mr White, who has been waiting.

Pete White: It is an appalling reflection on our society that a woman is sent to jail for her care. We should be appalled by that. It is also appalling that prison numbers might go up by 20 per cent in the next five to 10 years.

We could consider how the health of the public at large, including prisoners, could be addressed more imaginatively and constructively. We could change the options that are available to the people who sit on the bench and hand down jail sentences, so that they could sentence people to something that is perhaps more restrictive than a drug treatment and testing order but which gives them a chance to address the problems behind their offending behaviour without going to prison and perhaps without having to leave their home and community.

It has to be a robust and imaginative process, but it would be one thing that we could do that would cut down the number of people in prison. It would also improve family conditions and community conditions for everybody. It is worth noting that the SPS has taken on board an operational review in which it is considering the asset-based approach towards prisoners. If you take the asset-based approach and see where someone's strong points are rather than look for the deficits, the approach towards addictions, for example, can perhaps take on a different angle.

There is a tremendous opportunity here, as I said at the beginning. The transition that we are going through can offer great change. That great change is not just one that comes through in reports; it is one that comes through for human beings in the street and in their homes and also in prison.

The Convener: I asked a question at First Minister's question time about home detention in Sweden. I think that the Government is exploring a similar option. Part of the home detention would involve various types of rehabilitation that are suitable to that individual rather than putting them in prison—

Pete White: Absolutely.

The Convener: And they may keep their job and their family if that is suitable.

Pete White: Yes, I have discussed some imaginative options with one progressive sheriff.

The Convener: There is one progressive sheriff in Scotland—that is the headline.

Pete White: Yes, exactly.

The Convener: You are not naming him or her.

Pete White: I am sure that there must be more but, as an institution, the bench is perhaps even more resistant to change than prison officers used to be.

The Convener: Heavens, you were doing so well. Some of them are not bad.

Ruth Parker: On the point about women and videoconferencing that was discussed earlier, Inverclyde will give us opportunities for innovative ways of working. We want to work with our health colleagues on the development of that establishment and to take forward some of what works in the evidence base—in particular in relation to women with mental health problems and addiction issues. We have started that process and that dialogue.

The Convener: Alison, do you want to come back in?

Alison McInnes: No, but we need to monitor progress in that area.

The Convener: Of course, we have a special and separate interest in what happens to Cornton Vale and the women in it.

Sandra White: Convener, you—and Graeme Pearson too, I think—mentioned the increase in the number of prisoners by 2020. I think that you asked for a breakdown of what that would mean. I am probably the newest member of the Justice Committee and I have been really impressed by the work that the committee does.

The Convener: You do not get to ask extra questions for saying that.

Sandra White: No. I am just a bit puzzled. With all the good work that is going on—in prisons, in addiction services and in trying to stop people reoffending—I want to know where the figures come from that, broken down, show that there will be an increase. I am concerned about that, given that I thought that a lot of good work was going on to decrease the prison population. Is that not what it is all about?

The Convener: I am sure that Ms Parker will provide us with her sources.

Sandra White: I just wanted to ask about that.

Ruth Parker: It is a prison population projection and it is based on work that the SPS is doing in

partnership with the Scottish Government. It looks at statistical information for the future.

The Convener: So it is not from the *Daily Record*.

Sandra White: I did not say that.

The Convener: I know that you did not. We will get the details and the breakdown because it is a figure that requires us to look at it.

Sandra White: I am just really interested in it and I thought that it would be relevant.

Ruth Parker: Justice analytical services in the Scottish Government are also looking at sub-groups, such as women and young offenders, so that information can be made available to the committee.

The Convener: Are you happy, Sandra?

Sandra White: I will be when I see the figures.

Roderick Campbell (North East Fife) (SNP): My question is geared more towards Anne Hawkins and Jayne Miller. We are three quarters of the way through your network. What work do you still have to cover in the remaining six months? What is outstanding?

10:45

Anne Hawkins: It is not our network. It is the boards' network and the SPS's network—it is the network of everybody who is involved in it. Jayne will probably summarise what we still have to do.

Members will have seen in the papers for today's meeting the reports that have already been produced—the mental health report in particular is a good piece of work that has drawn together contributors from all the boards—but there are a number of pieces of work still outstanding.

The network will not necessarily come to a stop in November 2013. We are currently reviewing how we can go forward and whether the network should function in the same way in future. We have issued a questionnaire to get people's views on that, and we will have further discussions about what we should do. Personally, I think that we still need something. We need a forum where we can discuss emerging issues and share learning, because there is a lot of shared learning and there are different approaches because of different systems. Whether the future forum has the same shape and form is a matter for debate. I will let Jayne Miller summarise what we have achieved and what we have still to do.

Jayne Miller: We spent the first three or four months of the network developing the work plan, getting everything out on to the table and finding out what boards wanted us to do. We took on what we called legacy issues—pieces of work that started pre-transfer—together with a lot of new work. As with most things, we could probably work for the next 10 years, because people would always find something for us to look at next.

As Anne Hawkins said, the report on mental health has been produced. We have also just reviewed the information sharing protocol, which is about to go out to boards for sign-off, and we are doing some work on records and how we transfer them, to ensure that the electronic work goes on.

Work will continue for the next 18 months on the clinical IT system, to introduce a prescribing module. That is the easy bit, because it is the same as it would be in a practice. However, prisons work mainly as a primary care service but with a little bit of hospital service—the administration of medicines—so work is needed to make the IT system fit that sort of prescribing administration, which will take some development.

On performance measurement, we have developed a set of short-term indicators, which I have shared with the committee. It is out for comment and I hope that boards will sign up to collecting that information. We will then move on to look at some more long-term indicators. On throughcare, we are working with the third sector to see where that work goes, and we have already talked about substance abuse.

The work plan will be more or less delivered by the end of November, but there will still be work that we want to continue, and it is our job to get a view from boards about how they want to do that in future, whether we need the network to continue as it is or whether it will take a different form.

Ruth Parker: As a member of the network, I am well aware of the work that has been done and of what has been achieved.

The Convener: I am going to ask a round-up question. Please be frank—not that you have not been frank so far. What are the pluses and minuses of the transfer of healthcare in the Prison Service to the NHS? The big test is whether prisoners are getting any healthier and whether care is continuing through.

Pete White: The number of pluses is one, and that is that the transfer has started. The transition to the NHS is fantastic and the opportunity lies ahead of us to make the process of the NHS linking up all the way through a prison sentence and back to the community a reality. That is one less disconnect for the prisoner from the community, so I am all for it.

Frank Gibbons: I can see improvements in many areas. They may not have come to fruition yet, but there are certainly huge advantages. I am

not sure what the negatives would be at the moment.

The Convener: Has there not been friction among your own staff because they are no longer responsible for certain things?

Frank Gibbons: No, but I think that things have taken a while for some staff. When members of staff who worked for the Scottish Prison Service are first subject to TUPE and join the bigger NHS, they can feel that the service is inferior, but I hope that a lot of the individuals have proved themselves to be worthy professionals in the NHS and that they have as much to take forward. We have certainly benefited from the expertise in the NHS, which is a huge resource for us. Overall, people who have made the transition probably feel better supported, although it would perhaps be worth checking that in all areas.

Ruth Parker: The work of the network has achieved things to date, but there is obviously a need to move that forward. The legacy issues have now been addressed or will be addressed in the next six months or so. There is an opportunity for improved throughcare, as Pete White said, particularly in the pathway of substance misuse, and to consider how health outcomes can contribute to reduced reoffending.

Mark McEwan: I suppose that there are two things, one of which is the continuity of care between the community and prison, which has been mentioned. There is an opportunity for the Government and boards in having a literally captive audience of core health inequality people. Addressing health inequalities is certainly on our board agenda in Grampian. It is well recognised that we have a big opportunity. That would be a plus.

On the negatives, with the benefit of hindsight, I think that we should have tied together the care of people in police custody and the prison health service at the outset. I sound like a broken record, because I say that quite a lot. Those things have almost developed as two separate projects, but there are the same people at different stages in the pathway between the community and prison and back to the community. That was a missed opportunity, but I think that we are addressing it now.

The Convener: Perhaps we can come back to that.

Joe McGhee: The whole transfer process is a learning experience for all of us. It is encouraging that healthcare staff who work in prison have greater access to the wider NHS for clinical supervision. They are now encouraged to develop their nurse-led clinics far more than perhaps they previously were, for example, and obviously that is having an impact on the prison population. We seem to be learning new things every day.

There is an area that is causing a slight concern for us. I hinted earlier at the issue of the ageing prison population and how we deal with it. We have talked about healthcare provision, but there is also the social care provision for prisoners. Who meets their personal care in the prison establishment? That is a question that we must address. We aim to mirror in our prisons what is delivered in the community through addiction services, for example, but who undertakes tasks that relate to personal care and assisting the elderly prisoner population? We have to have further discussion about that.

The Convener: Who currently does that?

Joe McGhee: Currently, no overnight healthcare is delivered in our prisons. Therefore, if a prisoner requires care overnight, the prison might have to access a local authority that commissions separately. Agency cover might need to go in. That is a problem that we must consider for the future, especially as that cohort will increase.

Dr Groden: One key change has been around the provision of medical services to prisoners. There is more regulation and governance in place. Under the previous agency arrangements, there was a transitional workforce moving in and out who had less accountability to any organisation, and less support and training to meet their development needs in dealing with that population. The direct employment of medical cover through the health service has been a key change in improving the quality and some of the controls in place around the service.

One challenge that there has been and which still exists is the processing issues that we have to deal with as part of general healthcare in prisons. We cannot develop a lot of services that we want to develop because we are constrained by some of the procedures that are in place for processing prisoners when they come through. In a prison such as Barlinnie, which has a high volume of prisoners coming through, you often cannot deal with prisoners' wider health needs because you are busy ticking the boxes and dealing with prescribing issues and so on, for which there are processes. We have started to make some inroads with that, but we might need to agree some changes to what has to be delivered in order to free up valuable nurse and doctor time to deal with some of the health inequalities.

The Convener: What changes?

Dr Groden: For instance, every prisoner who is admitted through Barlinnie sees an SPS guard, then gets seen by a nurse, then has to see one of the doctors within 24 hours, regardless of the

nurse assessment. If we had a better triage system of nurse assessment, only those individuals with medical needs would have to see the doctor. I worked in Low Moss processing individuals who had no medical needs and had already seen a nurse, so any hidden needs could have been identified earlier.

We have issues around prescribing and cardexes, which have to be reviewed three-monthly. We have inherited a system whereby doctors were reviewing the cardex and not the patient and did not have time to review patients who were started on new medication, because they were going through a churn of paperwork to try to meet the requirements of the service. We still have not cracked that issue. We have inherited systems that militate against allocating time to improving health inequalities or dealing better with long-term conditions management.

Dr Lesley Graham (NHS Scotland): You asked earlier whether we knew whether the health of prisoners had got better or worse. That is one of the down sides: we still cannot answer that question. Jayne Miller said that the development by the network of the performance measures will go some way to enabling us to answer that question. I say to Mr Pearson that complaints are one of the indicators that we have put in.

On the up side, there is a coming together of health, justice and social care, so things are being done together instead of separately, and there is a recognition that there are common problems and common solutions.

Jayne Miller: There has been a tremendous learning curve for health boards. Traditionally, boards did not really get involved with the prison population, because the care was provided by the SPS—apart from some of the outreach services that went into prisons—but they are now much more aware of the health needs of prisoners. As Frank Gibbons said, the staff have access to the much wider NHS now, so they know their way around a health board. In the past, the SPS might have asked for help, but did not necessarily know where to go or what services were available. Now the staff are part of the NHS, which is a huge advantage.

The challenge for the network is to encourage all boards to sign up to some of the guidance that we are putting out. Although we are developing guidance nationally, boards deliver the care, which is absolutely right. The challenge is to get the boards to sign up and be part of what we are trying to do nationally.

The Convener: I will give you the last word, Ms Hawkins.

Anne Hawkins: The negatives include the financial position for NHS Ayrshire and Arran in particular, which has had a particular budget pressure. This year, it is covering things from its uplift. If NHS Ayrshire and Arran were here, that is what it would say.

I want to pick up on what Ruth Parker said about the potential for the prison population to rise, which clearly would give us concern from a strategic perspective because it might bring additional financial pressures. However, I think that that is far outweighed by the positives. To mirror what others have already said, from a strategic perspective, the relationships between criminal justice, health and local authorities have changed quite dramatically, as have the opportunities for health to influence and be involved in planning processes.

Our being involved in the planning process for the new Peterhead prison, or the new women's prison at Greenock, or being able to influence the new women's justice centre in Glasgow, would never have happened before. We now have the knowledge to be able to influence such projects.

When people went into prison before we had responsibility for the service, their health was forgotten about, but it is not forgotten about now. As Mark McEwan said, they feature on the health board's agenda. We all have our health improvement plans, and we are looking at issues for prisoners such as smoking and sexual health in just the same way as we do for the general community. I think that there are huge positives.

The Convener: I do not want any more questions from members, but there is nothing to stop members writing to the witnesses and asking questions outwith the committee meetings. That was a very interesting round-up; some issues were plopped in at the last minute. If the witnesses want to give the committee anything further that they did not think to say at the time, write to me as convener and we will circulate it to the other members. Thank you very much; that was a very useful follow-up.

11:00

Meeting suspended.

11:03

On resuming—

Subordinate Legislation

Children's Legal Assistance (Fees) (Miscellaneous Amendments) (Scotland) Regulations 2013 (SSI 2013/144)

The Convener: Item 3 is consideration of one negative instrument. The regulations make provision for the fees that can be charged by solicitors and counsel when providing assistance by way of representation or legal aid in relation to hearings and proceedings under the Children's Hearings (Scotland) Act 2011. The Subordinate Legislation Committee is content with the regulations—it is content with something! That is excellent.

Do members have any comments on the regulations?

Members: No.

The Convener: Are members therefore content to make no recommendation on the regulations?

Members *indicated agreement.*

11:04

Meeting continued in private until 12:38.

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