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Health, Social Care and Sport Committee
National Assembly for Wales

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Provision of health and social care in the adult prison estate

Inquiry by the National Assembly for Wales' Health, Social Care and Sport Committee Response from BMA Cymru Wales

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the inquiry by the National Assembly for Wales Health, Social Care and Sport on the provision of health and social care in the adult prison estate.

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

RESPONSE

The document below outlines our response per each heading listed on the Terms of Reference.

We feel that it is worth prefacing the response with the caveat that the discussion below refers only to male prisoners, as there are no female prison establishments in Wales. However, the issues described will also affect incarcerated Welsh women, but as

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they are housed exclusively in the English prison estate, the committee’s recommendations are unlikely to apply to these areas.

Planning of services

There is no obvious structure for all staff from prison healthcare departments from across Wales to come together to discuss relevant issues. There is a Prisoner Health Network, which is mainly nurse-led, but not all prison healthcare departments actively engage. Prisoners can move around the Welsh prison estate relatively frequently, so it is important that healthcare departments engage in joined-up thinking, especially around prescribing issues, as what happens in one establishment can have a massive impact at another. We would welcome a formal mechanism for the streamlining of prescribing policies across the Welsh prison estate.

The interface between the community and prison needs tightening up at both ends of the process - at reception and release. Our members who work in these areas report seeing many people who return to prison within days of a previous release having already managed to secure prescriptions for "*commodity*" drugs from their own GP. The process of sending information on release could be improved; too often, prison GPs are completely left out of the loop when patients are released so there is no defined process (or administration time provided) for arranging informative and useful discharge summaries. Likewise, the transfer of individuals to other prison establishments is fraught with similar problems, particularly sudden transfers for security reasons.

From a patient perspective, many prisoners find they lose their place in secondary care waiting lists if they have been referred but then transfer to a different Welsh establishment, often for security reasons. Prisoners often will need re-referral to the secondary care location in the new area post-transfer. This is unacceptable as prisoners are still entitled to equivalence of care despite moving locations. Also, we know that in some establishments prison GPs are prevented from making referrals to health boards outside of the area in which the prison is located. For instance, a prisoner requiring access to a clinic at their local hospital on their release could not be directly referred to said hospital if their prison was located different health board area. This patient would require a further GP appointment for the local referral to take place.

We suggest that the planning of services within prison establishments needs to take into account the turnover of the population, in addition to the number of prisoners per establishment. For instance, we hear that HMP Cardiff has a total population of approximately 900 inmates, but with a turnover of around 100 prisoners per week, which creates significant complexities.

There is no Welsh equivalent of NHS England Health & Justice team which commissions and oversees health services in secure settings in England. Introduction of such a team would be of overall benefit to prison health services and provide effective governance and oversight.

We suggest that it would be helpful if Wales could adopt the same plans as England from 2020 when English patients in English prisons will become registered patients at those prisons. In addition to the widely known health outcome benefits of continuity of care with, one of the benefits of registration will be to reduce the risk to patient safety of "*dual prescribing*". Sometimes patients will continue to obtain prescriptions for desirable or tradeable medications (pregabalin, opioids etc) from their registered GP in the community, if prison GPs review and stop certain medications.

This risk will persist from 2020 for Welsh patients in English prisons, and English patients in Welsh prisons. It would be safer to adopt consistent registration procedures across the English and Welsh prison estate because of the fluidity of transfer of prisoners across the two countries. Registration means that GP records can be imported at the time of reception via GP2GP and exported after release when a patient registers at a new surgery, meaning that all healthcare details from the sentence will be available to the new community GP. Additionally, as previously mentioned, Welsh women are exclusively held in the English prison estate, therefore aligning the approaches to prisoner registration would benefit female prisoners in particular.

However, registration of patients at prisons must be supported by sufficient staffing resources across the healthcare team, to ensure that individuals who are unexpectedly released from court are not left without health services at vulnerable times e.g. bank holiday weekends or Friday afternoons. Additionally, there must be a better interface with justice services to ensure that prison healthcare teams are fully aware of the likelihood of such occurrences to ensure that essential medication supply is not interrupted (as patients may attend court a significant distance from the main prison site).

Demand for services within prisons, and whether they meet needs and address health inequalities

GP provision varies greatly across establishments which of course impacts on the availability of services. We know of one establishment where face-to-face GP provision has been reduced over the last few years from 6 sessions per day to 2-3 sessions currently, despite an increase in that establishment's prison population and turnover. We suggest that there is a possibility that, where prison healthcare is commissioned privately, the number of available GP sessions and nursing shifts is reduced to a minimum in order maximise profit.

There is also a shortage of dental, optical, and sexual health services relative to need. Prior to admission, prisoners may not have attended to their healthcare needs in the community, possibly due to chaotic lifestyles (e.g. drug use, homelessness). Prisoners feel more motivated to address their health needs after their reception into the prison estate, which is to their long-term benefit, but this cannot often be met by current service provision levels.

Other operational issues can affect the delivery of healthcare, for example, if there are insufficient officers on duty to escort prisoners over to locations where care is provided. This is compounded by the fact that prison GPs are also restricted in how many patients they can send out to external hospital appointments in a day, including emergencies. As a result, non-attendance rates are high, often due to difficulties with direct communication between the healthcare department and the prisoners.

Current pressures on services (including workforce, mental health, substance misuse, OOH, links to secondary care)

Members tell us that there is a high expectation on GPs working in prisons to provide '*a gold standard service, when there is currently shoestring provision*'. Insufficient staffing levels means that a great deal of work is done without patient contact. For instance, GPs in prisons must take on responsibility for immediate prescribing without first reviewing patients in the case of new receptions, and often have to reduce or discontinue potentially unsafe combinations of medications without discussion with the patient.

This situation is far from ideal; however our members feel that guidance provided by NHS England Health & Justice teams helps to overcome difficult communication issues. The documentation helps to structure communication in writing to patients when doctors have to make necessary decisions about their medication without first seeing them. This practice is far from ideal but sometimes a necessity, and can often result in time-consuming complaints, hence the usefulness of structured guidance.

Prison healthcare is traditionally nurse-led. In many areas, recruitment and retention difficulties have resulted in cohorts of new nursing staff beginning work at the same time without the benefit of prior prison awareness training, which was traditionally offered as an intensive residential course. This can put pressures on long-term members of the prison healthcare team.

Regarding Out of Hours cover, from a continuity of care perspective ideally this would be provided by the same team as in-hours care. Splitting provision between separate teams could create unintended workload issues as well as possible patient safety concerns. For instance, over weekends an OOH GP may be required to authorise simple prescriptions via telephone, to be administered by the OOH nursing team, but the patient's electronic record would then only be updated on Monday by the in-hours GP.

Members tell us that doctor-led substance misuse provision is scant. GPs are often put in a position whereby they have to prescribe methadone on the basis of a specialist substance misuse review by a nurse without having seen the patient themselves. This is straightforward when the patient is otherwise well, but more risky if they are taking medication that might interact with opioid substitution therapy.

Another pressure on services is that deaths in custody are always (and rightly) investigated. The NHS England Health & Justice team have stated that service pressures are irrelevant when it comes to investigating the care that a deceased person has

received in prison. However, we would suggest that it is incorrect to ignore service pressures and the impact this has on an individual healthcare worker's ability to provide care.

Cell-sharing overcrowding has a huge impact on wellbeing. Prisoners have to share with total strangers, with privacy being compromised. Cellmates may have differing attitudes towards illicit substance misuse and a non-user could be easily exposed to their cellmate's substance use. GPs are often asked to make recommendations for single cells but are only able to recommend in very specific circumstances.

Additionally, Mental health services are under-resourced compared to the huge demand placed on them. There needs to be better availability of psychological interventions for anxiety, depression and PTSD, all of which are overrepresented in the prison population compared with the community.

How services are meeting complex needs of older people in prison

Members have informed us that pockets of good practice exist where the needs of older people have been considered, for instance a multidisciplinary ward round at one prison site in Wales which seeks to identify particular health or social care needs. The round team is comprised of GPs, nurses and Occupational Therapists. However, it is not known if such practice is widespread.

On some of the older parts of the prison estate, access is a particular problem with regard to the care of older people who are reliant on wheelchairs or adapted furniture. For instance, the size of the cells in older Victorian era prisons are too small to accommodate wheelchairs in sufficient space that they can manoeuvre properly.

Funding of services

Increased funding will help improve conditions, in that doctors currently working in prison settings could provide additional clinical sessions, focusing particular attention on known service gaps such as substance misuse prescribing.

However, recruitment is the biggest challenge facing prison health & social care services in the immediate future. The focus needs to be on increasing recruitment, which could be achieved through promotion of prison healthcare in GP training curricula and CPD events.

Any other current barriers to improving services

Members have expressed the belief that awareness of the possibility of working in prisons is lacking within the medical profession, and amongst GPs in particular. This

could be due to the fact there is no dedicated training package. The development of bespoke training could increase awareness and interest.

The creation of hybrid posts by health boards who are responsible for prison healthcare would create attractive portfolio career options for health professionals whilst also increasing staff availability. For example, hybrid part-time prison/part-time health board posts for A&E nurses and Advanced Nurse Practitioners would expand the workforce and enhance this option as a viable career path.

Finally, many pressures on healthcare services in prison could be reduced if community social services were improved. There is an endemic problem where prisoners are released to conditions of homelessness, often leading to relapses in substance misuse or deterioration in mental health. This can easily escalate to re-offending and a return to prison. It would be more economic and socially responsible to provide social housing than to pay for people to be detained in prison and continue this cycle.

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